

Preface

A Symposium on Pancreatic Cancer: Time for a Paradigm Shift. An Overview and Personal Reflections



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Editor

We can easily forgive a child who is afraid of the dark; the real tragedy of life is when men (adults) are afraid of the light.

—Plato

Insanity—doing the same thing over and over again and expecting a different outcome

—Einstein

This issue of the *Surgical Clinics of North America* is devoted to the Pancreas and Pancreatic Cancer. I previously edited a similar issue for the *Surgical Clinics of North America* in June 2002. Despite the diagnostic and therapeutic advances in medicine over the past 30 years, including significant advances in oncology, the cure rate for pancreatic cancer is dismal and unchanged for 50 years. Yet many believe the only chance for cure remains surgical resection, which has proven to be unwarranted optimism. The concept that pancreatic cancer is a systemic disease that has metastasized before the cancer is diagnosed is difficult for many surgeons to accept. This is analogous to the treatment of breast cancer before its systemic nature was accepted, a process that took many years and was hardly, but not heartily, embraced. In the 1970s, there was evidence that minimal breast procedures (ie, lumpectomy), had similar outcomes as radical procedures because both represented local control of a disease that too often was systemic at presentation. I had completed a surgical residency at the Mayo Clinic in 1970 when this concept was introduced and overlooked

by most surgeons. The rationale presented to most patients was “the best chance for breast cancer cure was with a traditional procedure” (modified radical or radical mastectomy).

After completing my military Service, I joined the Surgical Staff of the Cleveland Clinic, the home of minimal and conservative breast cancer procedures. I was never pressured to adapt this approach, but the evidence, outcomes, and patient wishes facilitated my operative choices. My senior associates, Crile, Hermann, Hoerr, and Esselstyn, were inspirational and masterful mentors. The lessons of breast cancer had come after radical surgery for thyroid cancer had been shown to be disfiguring and unnecessary and offered no better survival than a conservative approach. Somewhat sadly in both instances, the next generation of surgeons found ways to circumvent these data and has reintroduced bilateral mastectomy and total thyroidectomy using cosmesis, safe surgery, and multicentricity of microscopic tumors as substitutes for wisdom, natural history of latent tumors, experience, the published literature, and common sense.

It is no surprise that many pancreatic surgeons continue the fruitless mantra that surgery is the “first and best” approach to pancreatic cancer.

Pancreatic cancer is a lethal disease the mortality of which nearly equals its incidence. For nearly a century and continuing today, the misplaced emphasis on “first, best, and only chance of cure” has clouded the evidence that pancreatic cancer is a systemic disease, and surgery, a form of local control, could be curative. Since symptomatic patients have late-stage disease, open-minded and newer approaches are needed, and tradition and repetitive treatment patterns need be set aside. Treating a systemic disease with local therapy is in kindest terms “too little, too late,” and in blunt terms absurd. The case for extending the magnitude of surgery by total pancreatectomy, vein resection, and radical node resection does not influence cure rate or survival. While these techniques are done with lower risk on patients with less advanced disease, they do not improve survival. Why do we continue this misplaced emphasis, and false optimism and security to patients, mostly elderly, who if provided the facts and likely outcome might quickly focus on the true issues: life, survival, cure, and options and alternatives to “standard of care”? This is discussed in an article on prevention or early detection. The availability of so many diagnostic tests to evaluate pancreatic disease and pancreatic masses is examined, and recommendations are made by multispecialists: gastroenterology, radiology, and surgery. Too often multiple endoscopic and imaging procedures add expense and not enlightenment. Surgeons contemplating invasive procedures may prioritize and utilize the available tests differently, plus they have an advantage of direct visualization by laparoscopy or surgery. The value and efficacy for screening pancreatic cancer in at-risk patients are critically examined, including arbitrary times between screenings.

Incidental pancreatic cystic lesions and neuroendocrine tumors in asymptomatic patients are detected with increasing frequency, often in elderly patients. Concerns for malignancy and inaccuracies in preoperative diagnosis make decision making an uncertainty. Several series have been reported, and management ranges from selective to aggressive. The rationale for each is addressed. Preoperative biliary stenting and postoperative drainage after pancreatic surgery once considered essential are being used always, selectively, and never. The rationale and results are reviewed by advocates and agnostics.

The important issue of neoadjuvant therapy and timing of surgery for pancreatic cancer is reviewed by the most experienced group, who has adapted its use. The issue of actual long-term survival is reported, addressed, and reviewed in surgical and population studies. Despite attempts to present survival in the most favorable light and bias,

long-term survivors are few and even fewer in population studies. Radiation therapy is more popular in the United States than in Europe, and its many forms and timing are clarified as well as the evidence for its use in primary, adjuvant, neoadjuvant, and metastatic disease. Clarification is most welcome. The efficacy and outcomes with systemic adjuvant and neoadjuvant therapy are controversial as well. Where we are with these modalities is reviewed. Nonoperative ablation of pancreatic lesions using sound waves is finding adaption for other solid lesions, and its early use in pancreatic lesions is reviewed. Finally, applications of transplantation and vascular and pancreatic surgery for unusual lesions that invade the celiac and superior mesenteric vessels are described and unusual pancreatic lesions and their pathology reviewed.

Why procedures learned years ago in residency or fellowship continue long after outcomes indicate they need modification or elimination is unclear. In medicine and surgery, tradition is strong and common sense too often not common practice. Ineffective therapies persist because nothing better has displaced them. Frequently, the reluctance to try newer approaches requires an open-minded and objective assessment of actual data. For pancreatic cancer, that is certainly true. The suggestion that this disease may require a paradigm shift in therapy warrants closer scrutiny. Continuing ineffective therapies because nothing better or proven is available is far from a ringing endorsement of present treatments.

This issue is less how I do it and more why and what are the data, what are the actual outcomes, what are present options, and what realistically lies ahead?

The contributors are uniquely qualified, thoughtful, and experienced clinicians who address specific issues. Fresh and different viewpoints are long overdue.

To John G. Vassallo, editor, and Ronald Martin, MD, consulting editor to the *Surgical Clinics of North America*, a heartfelt thanks for their input, encouragement, and assistance in preparation of this issue, and to the development editors Meredith Madeira and Colleen Dietzler, thank you. Vignesh Viswanathan checked all references, the structure, and my editing. Thank you for your detail and accuracy.

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To Howard University College of Medicine, my classmates of 1965, and its fabulous faculty, who provided an unforgettable opportunity for me and then my son, David, we are forever humbled and grateful and two of its proudest alumni!!

The Mayo Clinic provided a unique and extraordinary experience by allowing me to train and do a fellowship year at Rochester, Minnesota. My fellow residents and the surgical, medical, and administrative faculty were modest, thoughtful, highly skilled, and open-minded professionals. I was privileged by the opportunity, friendships, and education. The dignity and compassion that were extended to every patient was the consummate of professionalism. Donald McIlrath, MD took me under his wing and taught me much about surgery and life, and I have never forgotten his influence.

The Cleveland Clinic and its staff welcomed me warmly when I joined the surgical department. Unique individuals with varied interests, they were led by George Crile Jr. "Barney" as he was called had retired from surgery but was a visionary and an influence on world surgery. He enlightened many and was a clear, logical thinker, charismatic, and a great influence on me and many others. Bob Hermann, Stan Hoerr, and Caldwell "Essy" Esselstyn were great influences, friends, more experienced colleagues, and mentors. They each had a unique viewpoint on so many issues, and my good fortune was to be a colleague to each. I continue the close friendship and counsel with Essy—an ongoing benefit of the Cleveland Clinic.

I am a person of faith who was blessed by the things that really matter. How else to explain my odyssey from Brooklyn and Laurelton, New York? My late parents, Philip and Lillian, and their families were extraordinary and ideal for me and my brother, Gerald, and sister, Amy. They loved and taught us much. Their shoulders, upon which we sat and stood, provided us a deeper view and understanding of ethics, values, respect, kindness, and love of family, learning, friends, and work. My children, Jeff, David, and Beth (and Nick), continue this and are passing it on to their progeny, Lilly, Leo and Holden, Oliver, Griffin, and Laurel.

During the preparation of this issue, my brother and closest friend, Gerald, died suddenly. I dedicate this to him, the many patients I have been privileged to treat and care for, and the patients and families afflicted with Pancreatic Cancer, who suffer greatly, and the fortunate and lucky few who survive.

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