Editorial

Pancreas cancer: why bother?

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Through the decades, the nihilism surrounding the diagnosis and outcome of pancreas cancer has been tenacious, in spite of growing evidence that some patients can enjoy long term survival if selected carefully and managed thoughtfully in a multidisciplinary (MDC) fashion. This month's *Journal of Gastrointestinal Oncology* (*JGO*) focuses on dispelling this nihilism and replacing it with evidence based management of pancreas cancer, starting with defining who is resectable?

Imaging has been the corner stone for selecting patients who maybe operative candidates, those that maybe borderline or frankly unresectable. Morgan *et al.* walks us through the variety of imaging modalities with a focus on what are the strengths and weaknesses of each. It all begins here! Appropriate interpretation and categorization of imaging findings can make the difference between the selecting a patient for neoadjuvant therapy *vs.* undergoing a needless exploratory laparotomy that finds the tumor unresectable.

Tissue is the issue… this is the mantra that defines the world of cancer. In that vein, pathology stands above all in defining the types of cancers, as well as, the extent of tumor in resections. Ultimately the molecular evaluation of these tumors is what we hope will provide better clues as to prognosis and potential treatment targets. Brosens *et al.* have been at the forefront in probing deeper and deeper into the pancreas cancer cells, looking for the mechanisms that lead to the aggressive tumor biology of this diagnosis.

The most common pancreas lesion that is currently filling pancreas clinics across the nation and the world is not solid lesions but cystic ones. The tidal wave of imaging findings of lesions that can become cancer in the pancreas is important to note. Bruggie *et al.* has spent his career defining these lesions and trying to set standards around who maybe watched and who needs surgery, today. A truly vexing challenge that is like solid pancreas lesions requires multiple invested parties to select the best treatment option.

Surgery… Whipple… these are words that all pancreas cancer patients want to hear and yet know on a visceral level that it means they are putting all their chips on the table! The importance of surgery and the changes that have occurred in the last two decades is the next chapter in this issue. We outline how surgery has changed in our center as expertise evolved and MDCs where born to rally all the necessary players in order to make the outcome worth the effort. Pushing the envelope of what can be done and perhaps with less "trauma" to the patient, Martini *et al.* bring us up-to-date on the brave new world of robotic Whipples. This is followed by Kooby's group that was systemically looked at the safety in terms of oncological outcomes for performing laparoscopic distal pancreatectomies for cancer.

Treating cancer, especially, pancreas cancer is based on three modalities: chemo, radiation and surgery. It has long been understood that the difficult recover from surgery can limit who may complete the other two modalities and even how much they can tolerate. Several studies have noted that up to 30% of patients post operatively do not complete all of their therapy. This has been the lifelong study of Evans et al in defining the role of neoadjuvant chemotherapy in the management of pancreas cancer. A controversial topic to be sure, however, a complying argument is made for doing chemo first… and I invite you to challenge your thoughts in this regard. On a more traditional note, Ma *et al.* discuss the numerous new combinational therapies that are starting to push the DFS curves and even OS to the "right".

Local *vs.* distant failure is a challenge in any cancer paradigm. In pancreas cancer the management of the resection bed post operatively with radiation has been a controversial topic depending on which side of the Atlantic you are. Willett *et al.* tackle this broad topic to highlight

timing and advantages of radiation in the multidisciplinary management of pancreas cancer.

Finally, Jones *et al*. reviews the pain management of patients that are not resectable or have recurrences in and around the celiac plexus. Several approaches are discussed with an intriguing surgical disruption of the splanchnic nerves with in the chest, as a better and perhaps longer term quality of life improvement.

This issue on pancreas cancer has one goal: think of the patient and their best options for long term survival! The authors of the articles that follow know that the successes in pancreas cancer treatment have been slow and encumbered by a lack of referrals to appropriate MDC teams, nihilism about prognosis and general misunderstanding about the complex treatment paradigms that are used to fight for our patients' lives. These authors are every bit as tenacious about finding hope and cures for this disease as those who dismiss pancreas cancer (inappropriately) as incurable.

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