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LETTER TO EDITOR

Growing threat of pancreatic cancer: reflections from the evidence

Creciente amenaza del cáncer de páncreas: reflexiones desde la evidencia

Ameaça crescente do câncer de pâncreas: reflexões baseadas em evidências

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Dear Editor:

Pancreatic Cancer (PC) is a deadly disease with a worldwide incidence on the rise. Considering the high mortality rate and the forecast of its rise as the second leading cause of cancer-related death by The Global Cancer Observatory, it is essential to contribute to the optimization of patient diagnosis, treatment, and prognosis.(1)

In 2020, it accounted for 495,773 new cases per inhabitant-year (4.9 cases/100,000 people-year), and the number of deaths from this disease was 466,003 (4.5 cases/100,000 people-year).(2) In Cuba, it ranks ninth in mortality from malignant tumors, with 389 women dying (a rate of 6.9) and 445 men (a rate of 7.9) per 100,000 inhabitants. Population estimates indicate that the number of new cases will increase in the coming decades, reaching 24 million new cases by 2035.(3)

This disease can originate in either the exocrine or endocrine cells of the pancreas; however, about 95% originate in the exocrine tissue. It has the worst prognosis of all malignant tumors, with an overall 5-year survival rate ranging from 5% to 11%, which is largely attributed to late stage at diagnosis, meaning only 20% of patients are treated with curative intent.(1)

It most frequently presents in patients between 65 and 70 years of age. It rarely occurs under the age of 60, in which case, an association with a genetic alteration should be ruled out. Smoking, low consumption of fruits and vegetables, high caloric intake, obesity, type 2 diabetes, and chronic pancreatitis have been identified as risk factors. The ABO blood group is also a hereditary condition that increases the risk of developing it.[3] The first sign may manifest as diabetes or pancreatitis.[4]

Tumors of the pancreatic head present with jaundice, steatorrhea, and weight loss. Jaundice is caused by compression or infiltration of the intrapancreatic common bile duct; it is usually progressive and painless and is frequently accompanied by pruritus, choluria, and acholia. Clinical signs that may be found include: mucocutaneous jaundice, occasional palpation of an abdominal mass, or ascites (a sign of poor prognosis). Palpation of a distended gallbladder (Courvoisier-Terrier sign), due to obstruction of the common bile duct, is frequent but not constant.[2] This finding refers to the so-called "Courvoisier's law," which states that "dilation of the gallbladder is rare in common bile duct obstruction due to gallstones, and frequent in obstructions of another nature."[5] Recurrent migratory thrombophlebitis (Trousseau's sign of malignancy) may appear, and obstruction of the splenic vein can cause splenomegaly and portal hypertension with gastric and esophageal varices.[3]

Tumors of the pancreatic body and tail have an insidious presentation, with symptoms taking longer to appear and originating mainly from the compression of neighboring structures. Intense abdominal pain in the epigastrium, typically radiating in a belt-like pattern or to the back, is a frequent symptom; while manifestations of systemic involvement, such as asthenia, anorexia, and weight loss, are early. Metastatic disease is often present at diagnosis.

This complication most frequently affects the liver, peritoneum, and lungs; and less commonly, the bones. Signs of advanced and incurable disease include: an abdominal mass, ascites, adenopathies (especially in the left supraclavicular area: Virchow's node), and the presence of a palpable mass in the umbilical region ("Sister Mary Joseph nodule"), which sometimes appears as the first sign.[2]

Clinically, they are classified as resectable, borderline, unresectable or locally advanced, and metastatic. In cases where the tumor is resectable, the only curative treatment is radical surgery, and the therapeutic approach will depend on the tumor's location. Pancreatoduodenectomy is the surgical choice, a procedure known worldwide as the Whipple Procedure. On the other hand, for tumors located in the body and tail of the pancreas, a corporo-caudal pancreatectomy should be performed. However, nearly 80% of pancreatic cancers resected with curative intent present with recurrence and/or metastasis, which is why chemotherapy associated with surgery has shown better results than surgery alone. Nevertheless, despite constant attempts to improve patient treatment, the real impact has been minimal compared to the successes achieved in managing other types of cancer.[1]

Finally, we can add that the lethality of pancreatic cancer is largely an avoidable consequence of its diagnosis at advanced stages. The vague symptomatology and the lack of feasible screening methods do not exempt us from the responsibility of maintaining a high index of suspicion, especially in patients with risk factors. Understanding and recognizing its diverse clinical presentations is the first step to change this grim outlook. We urge the medical community to prioritize continuous education on this entity, as early detection remains the only way to significantly impact patient survival.

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