University Hospitals Bristol NHS
NHS Foundation Trust

THE HEPATOBILIARY SURGICAL UNIT

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Our Upper GI Specialist Nurses are the keyworkers for Upper GI cancer patients only. They are there to help coordinate their care, promote continuity and to be a point of contact to access information and advice.

VOICEMAIL AVAILABLE ON ALL UPPER GI AND APPOINTMENTS TELEPHONE NUMBERS

Severn Hepatopancreaticobiliary Centre

Post-treatment follow-up guidance June 2019 v1.9

This document summarises our guidance on follow up strategies for patient after major hepatobiliary resections. As always this is guidance and follow up can be modified at an individual clinicians discretion on a patient specific basis.

Network MDT review of imaging is not required if it is completely unchanged however we are happy to review any images if there is concern or a change in relevant tumour markers.

1. Neuroendocrine tumours

If not undertaken pre-operatively gut hormone profile including chromogranin A and B and octreotide scan.

Then

Chromoganin A and B and CT thorax abdomen and pelvis 6 monthly for one year then yearly afterwards

Ref. Neuroendocrinology 2016; 103:153–171 DOI: 10.1159/000443171

(For high grade NETS followed every 3–6 months during the first 2–3 years following surgery, and then every 6–12 months up to 5 years. Conventional imaging (CT scan or MRI) should be performed during these follow-up visits, but testing for general tumour markers (i.e., chromogranin A or NSE) are only indicated if elevated at diagnosis.)

Ref. Neuroendocrinology 2016;103:186–194 DOI: 10.1159/000443172

2. Cholangiocarcinoma

Ca19-9 estimation and CT scans at 6 months for 2 years and yearly afterwards

Earlier CT scanning / Ca 19-9 estimation if symptoms suggest possible recurrence

This is a change from a purely clinical follow up. This has been precipitated by relatively recent guidance although the evidence to support this is weak and clinician discretion is advised. We have also taken advice from a co-author of the ESMO guidance (Juan Valle at the Christie in Manchester - See Appendix 1)

Ref. Ann Oncol (2016) 27 (suppl 5): v28-v37)

3. Pancreatic adenocarcinoma

ESMO state "Considering the poor prognosis of the disease upon diagnosis of a recurrence, there is no evidence that regular follow-up after initial therapy with curative intent has any impact on the outcome. Follow-up visits should concentrate on symptoms, nutrition, and psycho-social support, recommendations for follow-up. There is no evidence that regular follow-up after initial therapy with curative intent is useful."

Ref. Cancer of the pancreas: ESMO Clinical Practice Guidelines for diagnosis, treatment and follow-up., Ducreux M, Sa Cuhna A, Caramella C, et al. Ann Oncol 2015; 25 (Suppl 5): v56-v68

Pragmatically suggest

Six-monthly clinical follow up and Ca19-9 estimation for 2 years, then yearly after this for five years. CT only if new symptomatic concerns to provide prognostic information.

4. Ampullary adenocarcinoma

Currently similar strategies to pancreatic adenocarcinoma apply with some work from the USA suggesting that CT may have a role however evidence to support the use of CT is very limited. https://emedicine.medscape.com/article/276413-followup

5. Duodenal adenocarcinoma

Currently similar strategies to pancreatic adenocarcinoma apply with some work from the USA perhaps suggesting that CT may have a role however, again evidence to support the use of CT is very limited and no published guidance is available.

6. Hepatocellular carcinoma

Hepatocellular carcinoma follow-up

Post resection

Years 0-2:	six-monthly CT scan and AFP measurement
Years 3-5:	six-monthly alternate CT and USS scan (with AFP measurement)
After 5 years*:	six-monthly USS scan with and AFP measurement

Post-ablation

At 6 weeks:	CT scan
At 3 and 6 months:	CT scan with AFP measurement
Year 2:	six-monthly CT with and AFP measurement
Years 3-5:	six-monthly alternate CT and USS scan (with AFP measurement)
After 5 years*:	six-monthly USS scan with and AFP measurement

Post TACE

At 6 weeks:	CT scan
At 3 and 6 months:	CT scan with AFP measurement
Year 2:	six-monthly CT with and AFP measurement
Years 3-5:	six-monthly alternate CT and USS scan (with AFP measurement)
After 5 years:	six-monthly USS scan with and AFP measurement

Systemic therapy

CT scan and AFP measurement (if raised at diagnosis) every 3 months

*For patients without cirrhosis or risk-factors for non-cirrhotic HCC (Hepatitis B, Family History, NASH, liver adenomas) who have had a single lesion curatively treated it may be appropriate to discontinue follow up imaging at 5 years.

ESMO suggests "follow -up of patients who underwent radical treatments (resection or RFA) should consist of the clinical evaluation of liver decompensation and the early detection of recurrence by dynamic CT or MRI studies every 3 months in the first 2 years and surveillance every 6 months later on [III, A]. Patients with recurrence following radical therapies may still be candidates for curative therapies."

Annals of Oncology 23 (Supplement 7): vii41–vii48, 2012

7. Pancreatic cystic lesions

Mucinous cystic neoplasms – "MCN"

No follow up scanning

"MCNs are almost always solitary and complete resection of a non-invasive MCN is curative, thus necessitating no postoperative surveillance."
Pancreatology 12 (2012) 183-197

IPMN

"All patients with IPMN, including even those with non-invasive IPMN with negative surgical margin, should undergo surveillance after resection to detect the development of a new IPMN requiring surgery or concomitant PDAC. These significant lesions often develop more than 5 -10 years after initial operation and thus surveillance should continue as long as the patient remains fit.

Cross-sectional imaging at least twice a year is recommended in those with higher risks such as family history of pancreas cancer , a surgical margin positive for HGD, and non-intestinal subtype of resected IPMN, whilst every 6-12 months would suffice in those without high risk factors."
Pancreatology 17 (2017) 738-53

Pragmatically

<u>High risk patients (family history of pancreas cancer , a surgical margin positive for HGD, and non-intestinal subtype of resected IPMN)</u>

Six monthly scans long term (until unfit)

<u>Low risk patients (None of above risk factors)</u>

Six monthly for two years then yearly (until unfit)

Appendix 1

From Professor Juan Valle, Professor of Medical Oncology Christie, Manchester.

Dear Jonathan

Many thanks for your enquiry; as you will be aware, the evidence base for biliary tract cancer is (on the whole) rather sparse. The follow-up schedule after resectional surgery is based on the fact that most patients will relapse (if they do) in the first two years. You are correct that the gains from palliative chemotherapy are modest. Given that disease relapse impacts on patients' performance status, we feel it is important to identify disease relapse at a stage where a patient may be considered for combination chemotherapy (shown to be better than monotherapy) as well as clinical trials. You will be aware that in the BILCAP study, the CT scans were at 6 and 12 months (rather than 3-monthsly) and this is more representative of UK practice (more frequent scanning is practiced in Austria and Germany, where the follow-up is more intense). In the absence of a stronger evidence base (this is acknowledged to be only level IV efidence) , it would not be unreasonable to align your local protocol to the BILCAP study.

Best wishes

Juan

From: Rees, Jonathan Richard Edward [mailto:Jonathan.Rees@UHBristol.nhs.uk]
Sent: 24 March 2018 08:31
To: 'Juan.Valle@manchester.ac.uk'
Cc: Upper GI Nurses
Subject: ESMO Biliary Cancer Follow up Guidance

Dear Professor Valle,

I am writing as regarding guidance for cholangiocarcinoma follow up that you co-authored. I sent an enquiry to ESMO and have not had a response after a month hence my direct e mail.

I wonder if you have any references that support the follow up guidance for cholangiocarcinoma , we are rather perplexed why low quality evidence grade 4 has such a strong recommendation and an additional explanation would be really helpful.

We are concerned that an aggressive follow up regime uses extensive resources but the gains from palliative therapies is very limited whether recurrence is detected early or late.

I hope you can give me some guidance and we will then incorporate this into our follow up protocols.

Very many thanks

Kind regards

Jonathan Rees

Jonathan RE Rees MSc PhD FHEA FRCS(Gen.Surg.)

Consultant in Hepatobiliary Surgery, Lead for HpB MDT

Surgical Lead and Unit Tutor Year 3 MBChB

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