Inter-Hospital Referral Form to the Specialist Pancreatic Service



■ National Surgical Centre for Pancreatic Cancer, St Vincent's University Hospital: Fax (01) 2213601 Tel (01) 2213537 and 2213767 or switchboard (01) 2214000 Bleep 705/648



| Form completed by: Name (| CAPS): | Sign | ature: | Date: | | | | | | | |
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| P | ATIENT DETAILS | | CONS | SULTANT & GP DETAILS | | | | | | | |
| Surname: | First Name: | | Referring consultant: | | | | | | | | |
| Address: | | | Hospital: | Fax: | | | | | | | |
| | | | Telephone: | Mobile: | | | | | | | |
| DOB: Hospital No.: | | | GP Name: | Tel No.: | | | | | | | |
| Tel: | l:Mobile: | | GP Address: | | | | | | | | |
| Male Female | Nale 🔲 Female 🔲 Wheelchair assistance: Yes 🔲 No 🔲 | | | | | | | | | | |
| First language: | | | | | | | | | | | |
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| CLINICAL DETAILS | | | | | | | | | | | |
| Working diagnosis: Has patient been informed of diagnosis? Yes No Date first presented: | | | | | | | | | | | |
| Presenting symptoms: Ab | Presenting symptoms: Abdominal pain Jaundice Anaemia Nausea/vomiting | | | | | | | | | | |
| Dyspepsia Dark urine/pale stool Pruritis Abdominal mass Other: | | | | | | | | | | | |
| Patient BMI: Height: Current weight: Weight loss: | | | | | | | | | | | |
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| Medical co-morbidities: | | | | | | | | | | | |
| Surgical history: | | | | | | | | | | | |
| Medications: | | | | | | | | | | | |
| Anticoagulants: Yes 🔲 No | Allergies: Yes | ☐ No☐ □ | etails: | | | | | | | | |
| Alcohol: Yes 🔲 No 🔲 🛚 | Units per week: | | Smoker: Yes 🔲 No 🗍 | | | | | | | | |
| Silver is a market week. | | | | | | | | | | | |
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| 7 | | INVESTIG | | | | | | | | | |
| Bloods: (tick if results fo | rwarded) FBC | | ATIONS | Ca 19.9 | | | | | | | |
| | rwarded) FBC | INVESTIG | LFTs Coag Tick if reports | Ca 19.9 IgG4 Tick if CD and slides forwarded | | | | | | | |
| Bloods: (tick if results fo | | INVESTICE: | ATIONS LFTs Coag C | Ca 19.9 IgG4 | | | | | | | |
| Bloods: (tick if results fo Radiology/Endoscopy: CT Pancreatic Protocol | | INVESTICE: | LFTs Coag Tick if reports | Ca 19.9 IgG4 Tick if CD and slides forwarded | | | | | | | |
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| Bloods: (tick if results fo Radiology/Endoscopy: CT Pancreatic Protocol CT Thorax | | INVESTICE: | LFTs Coag Tick if reports | Ca 19.9 IgG4 Tick if CD and slides forwarded | | | | | | | |
| Bloods: (tick if results fo Radiology/Endoscopy: CT Pancreatic Protocol CT Thorax CT Abdomen/Pelvis MRI Pancreas EUS (+ FNA) | | INVESTICE: | LFTs Coag Tick if reports | Ca 19.9 IgG4 Tick if CD and slides forwarded | | | | | | | |
| Bloods: (tick if results fo Radiology/Endoscopy: CT Pancreatic Protocol CT Thorax CT Abdomen/Pelvis MRI Pancreas EUS (+ FNA) Cholangiography | | INVESTICE: | LFTs Coag Tick if reports | Ca 19.9 IgG4 Tick if CD and slides forwarded | | | | | | | |
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Thank you for forwarding completed forms and results, which will facilitate timely discussion at MDM



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| Results/additional comments (free text only, images will not paste in here): | | | | |
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| Results/additional comments (| continued): | |
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Inter-Hospital Referral Pathway to the Specialist Pancreatic Service

Patients with suspected pancreatic cancer should be referred urgently, within these timelines or sooner, for specialist MDM opinion

Day GP referral is to a relevant consultant at their local hospital for initial investigation. Early GP referral is recommended, usually prior to a definitive diagnosis being made 1-14 Day Patients with a high level of suspicion should be seen by the local consultant 21-28 within two weeks of GP referral. See algorithm below for investigations Use the national referral form overleaf to refer to the specialist By day pancreatic cancer service Day MDM discussion 35-42 By Day Definitive treatment is commenced

GP advice: a jaundiced patient (age 40+) requires an urgent referral for 'suspected cancer'. The consultant appointment should be within 2 weeks.

Consider urgent CT (within 2 weeks) or OPD referral for patients age 60+ with weight loss AND any of steatorrhoea, back pain, new-onset diabetes.

| Notes | |
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| Dashed arrows indicate imaging that may be undertaken but is not routinely needed. | |
| | |
| ¹ IgG4 is indicated in atypical cases e.g. diffuse pancreatic swelling+/- absence of pancreatic duct dilatation. Do NOT delay referral while awaiting IgG4 results. | |
| ² Transabdominal ultrasound can be performed on patients presenting with jaundice. If this is suspicious or equivocal for pancreatic cancer, undertake a pancreatic protocol CT. | |
| ³ Pancreatic protocol CT is the imaging modality of choice. It should be undertaken within one week of the consultant review. It is required for the MDM discussion. ⁴ MRI pancreas is indicated if CT is contra-indicated or not available. ⁵ Endoscopic Ultrasound (EUS) is a supplemental test (see indications below). ⁶ ERCP is not routinely used; cytological brushings for diagnosis can be taken in those with cholangitis and an unknown pancreatic mass or with jaundice who are unfit for surgery. See additional information below & contact details for HPB service on call. resectable, refer immediately to the relevant pancreatic service | |
| | |

ADDITIONAL INFORMATION

CT pancreatic protocol

Oral contrast: 500-700 cc water PO 20 mins prior.

IV contrast: 150cc 340mg/ml at 4cc/sec

Three Phases:

- 1. Non-contrast diaphragm to iliac crest.
- Late arterial phase pancreas.
 Timing: bolus tracked 25 sec after aorta reaches 120 HU (preferable), or 35-40 sec after injection.
- 3. Portal venous phase diaphragm to iliac crest. Timing: 65-70 sec after injection.

Reconstruction: Non-contrast phase can be reconstructed in 5mm axial slices. Arterial and portal venous phases must be reconstructed in 1mm axial slices to evaluate peripancreatic vascular structures.

If pancreatic cancer is suspected, extend the CT to the chest and pelvis.

Stenting compromises CT staging and histology. It is preferable that potentially resectable patients are NOT stented prior to referral.

The decision to stent should be made in conjunction with the specialist pancreatic centre.

CT should be performed prior to stenting.

To discuss stenting or other clinical queries, please dial the switchboard and ask for the hepato-pancreato-biliary (HPB) surgical fellow or registrar-on-call

SVUH Switchboard: (01) 221 4000

Indications for EUS

- When suspicion of pancreatic cancer remains after a negative or inconclusive pancreatic protocol CT or MRI pancreas
- To characterise an ambiguous pancreatic lesion
- To obtain pathological information in locally advanced disease
- Before neoadjuvant treatment of resectable /borderline resectable tumours when obtaining pathological information is essential.

Though EUS+FNA is usually required, this should NOT delay referral.

The need for a repeat biopsy after a negative FNA should be determined by the relevant pancreatic service.

Endoscopic ultrasound

is available in the following hospitals:

• Beaumont (01) 8093194

Mater University (01) 8032366 / 8032499

Mercy University, Cork (021) 4935639

• St James's (01) 4103985 / 4103942

St Vincent's University (01) 2214416

Tallaght (01) 4144143/4144183