Newly Diagnosed with Pancreatic Cancer?

What Every Patient Should Know Before Treatment Begins

"The most important decision in pancreatic cancer care is often the first one—choosing the right team to guide you from the very beginning."

Receiving a diagnosis of pancreatic cancer changes life in an instant.

For most patients and families, the days that follow are filled with uncertainty. There are appointments to schedule, scans to obtain, specialists to meet, and treatment decisions that seem impossibly urgent. Well-intentioned friends encourage you to "start treatment immediately." The internet offers thousands of articles, many of which are contradictory or outdated.

It is completely understandable to feel overwhelmed.

As a surgical oncologist who specializes in pancreatic cancer, I have learned that one of the most important ways we can help patients is by slowing down just enough to ensure that the **right decisions** are made at the **right time**.

Pancreatic ductal adenocarcinoma (PDAC), the most common form of pancreatic cancer, is an aggressive disease. It deserves prompt attention. But prompt should never mean rushed.

Before chemotherapy is started.

Before surgery is scheduled.

Before radiation therapy is recommended.

Every patient deserves a careful evaluation that answers one fundamental question:

> **What is the best treatment for this specific patient, with this specific tumor, at this specific point in time?**

That answer depends on obtaining the right information first.

A Diagnosis Is Only the Beginning

One of the biggest misconceptions about pancreatic cancer is that the diagnosis itself determines the treatment.

It does not.

Two patients may both be told they have pancreatic cancer yet require completely different treatment strategies.

One patient may benefit from surgery immediately.

Another may achieve the best outcome by receiving several months of chemotherapy before surgery.

A third patient may require radiation therapy as part of treatment.

A fourth may have cancer that has already spread beyond the pancreas and should begin systemic therapy rather than undergo an operation.

The difference is not the diagnosis.

The difference is the **stage of the disease**, the biology of the tumor, and the expertise of the team evaluating it.

The goal of the first few weeks after diagnosis is not simply to begin treatment as quickly as possible.

The goal is to understand the disease well enough to begin **the right treatment**.

What High-Quality Pancreatic Cancer Care Looks Like

Excellent pancreatic cancer care follows a deliberate process.

Although every patient is different, the sequence usually looks something like this:

Diagnosis → High-quality staging imaging → Tissue confirmation → Multidisciplinary evaluation → Personalized treatment recommendation → Treatment begins

Each step builds upon the previous one.

Skipping a step—or making decisions before all of the necessary information is available—can lead to treatment recommendations that may not reflect the patient's best options.

The Most Important Scan You May Never Have Heard Of

If there is one study every patient should know about, it is the **pancreas-protocol CT scan**.

Many patients assume that all CT scans are essentially the same.

They are not.

A routine CT scan performed in an emergency department may identify a mass in the pancreas.

A pancreas-protocol CT scan is specifically designed to answer the questions that determine treatment.

Is the tumor confined to the pancreas?

Is it touching the superior mesenteric vein?

Has it narrowed the portal vein?

Is the superior mesenteric artery involved?

Is the common hepatic artery involved?

Is there subtle evidence that the cancer has spread beyond the pancreas?

These details cannot be appreciated reliably on every CT scan. Specialized pancreatic imaging uses carefully timed intravenous contrast and thin-slice imaging to define the relationship between the tumor and the major blood vessels surrounding the pancreas.

Those relationships are often what determine whether surgery is recommended immediately, after chemotherapy, or not at the time of diagnosis.

Simply put:

The quality of the CT scan directly influences the quality of the treatment plan.

Looking Beyond the Pancreas

Just as important as understanding the tumor itself is determining whether the cancer has spread elsewhere.

For this reason, most patients should undergo a **CT scan of the chest** during their initial evaluation. The lungs are one of the more common sites of distant spread, and identifying metastatic disease before treatment begins can substantially change the recommended approach.

Some patients may also benefit from additional studies, including:

- MRI of the abdomen
- Additional imaging tests, when needed, to answer specific questions about the cancer

Blood tests also play an important role.

Many patients will have a CA 19-9 level measured. While this tumor marker can provide valuable information and may help monitor response to treatment, it is only one piece of the puzzle. Treatment decisions should never be based on a CA 19-9 value alone.

The Four Words Every Patient Should Hear

After reviewing the imaging, every patient deserves a clear explanation of which treatment category best describes their disease.

This conversation is one of the most important discussions that occurs after diagnosis.

Unfortunately, many patients leave their first appointment knowing only that they have pancreatic cancer.

That is not enough.

Every patient should know whether their cancer is:

- **Upfront resectable**
- **Borderline resectable**
- **Locally advanced**
- **Metastatic**

These are not simply staging terms.

They represent four different treatment pathways.

Understanding which category applies to you will help you understand why one treatment is recommended over another.

Upfront Resectable Pancreatic Cancer

When a pancreatic cancer is considered **upfront resectable**, imaging suggests that the tumor can be removed safely and completely, with a high likelihood of achieving an R0 resection. An R0 resection means that no microscopic cancer cells are found at the edges (margins) of the tissue removed during surgery.

Many patients hear the word “resectable” and immediately assume surgery should happen as soon as possible.

Modern pancreatic cancer care is more nuanced.

Depending on the characteristics of the tumor, your overall health, your CA 19-9 level, and your treating team's philosophy, chemotherapy before surgery may still be recommended. This approach can treat microscopic cancer cells early, provide information about the biology of the tumor, and improve the chances of long-term success in selected patients.

The key message is this:

Resectable means surgery is possible. It does not automatically determine the order of treatment.

Borderline Resectable Pancreatic Cancer

Some tumors partially involve nearby veins or arteries but remain potentially removable.

This situation is referred to as **borderline resectable pancreatic cancer**.

For many of these patients, chemotherapy is recommended before surgery. Some patients may also receive radiation therapy depending on their individual circumstances.

The purpose of treatment before surgery is not simply to shrink the tumor. It also allows physicians to observe how the cancer behaves. Patients whose disease remains controlled during treatment are often the ones most likely to benefit from a complex operation.

Locally Advanced Pancreatic Cancer

Locally advanced pancreatic cancer means the tumor involves nearby blood vessels extensively enough that surgery is not recommended at the time of diagnosis.

Years ago, this often meant surgery would never be an option.

Today, that is no longer always true.

Modern chemotherapy regimens, improved radiation techniques, and advances in pancreatic surgery have allowed carefully selected patients with locally advanced disease to undergo successful surgery after an excellent response to treatment.

Although not every patient will become a surgical candidate, this diagnosis should not be interpreted as the end of available options.

Metastatic Pancreatic Cancer

Metastatic pancreatic cancer means the cancer has spread beyond the pancreas to distant organs, most commonly the liver, lungs, or lining of the abdomen.

Treatment focuses on therapies that treat cancer throughout the body, including chemotherapy, targeted therapy for eligible patients, and clinical trials.

Supportive care—including nutrition, symptom management, and palliative care—is an important part of comprehensive treatment and should be integrated early alongside cancer-directed therapy.

Why a Multidisciplinary Team Matters

No single physician can provide every aspect of pancreatic cancer care.

High-quality treatment increasingly depends on collaboration.

The best treatment recommendations emerge when specialists from multiple disciplines review each patient's case together.

A multidisciplinary pancreas program often includes:

- Surgical oncologists
- Medical oncologists
- Radiation oncologists
- Gastroenterologists
- Diagnostic radiologists
- Pathologists
- Genetic counselors
- Dietitians
- Palliative care specialists
- Oncology nurses and advanced practice providers

Many comprehensive cancer centers review every newly diagnosed patient at a multidisciplinary tumor board, where imaging, pathology, and treatment options are discussed before recommendations are finalized.

This collaborative approach helps ensure that every reasonable treatment option has been considered.

Experience Matters

Pancreatic surgery is one of the most technically demanding operations performed in modern medicine.

Research has consistently demonstrated that hospitals and surgeons performing higher volumes of pancreatic surgery generally achieve better outcomes, including lower complication rates and improved long-term survival.

Receiving care at an experienced pancreas center does not necessarily mean every aspect of treatment must occur there. Many patients receive chemotherapy closer to home while maintaining close communication with a specialized pancreatic cancer team.

For some patients, obtaining a second opinion at a high-volume pancreas center can provide reassurance that the proposed treatment plan is appropriate—or identify additional options that may not have been discussed initially.

Questions Every Patient Should Ask

The quality of your care begins with asking good questions.

Consider discussing the following with your healthcare team:

- Have I had a pancreas-protocol CT scan?
- Have I had a CT scan of my chest?
- Has my biopsy confirmed pancreatic ductal adenocarcinoma?
- Has my case been reviewed by a multidisciplinary pancreas team?
- Is my cancer upfront resectable, borderline resectable, locally advanced, or metastatic?
- Why are you recommending this treatment sequence?
- Should I undergo germline genetic testing?
- Should my tumor undergo molecular profiling?
- Am I eligible for a clinical trial?
- Would a second opinion at a specialized pancreas center be helpful?

The Bottom Line

A diagnosis of pancreatic cancer is frightening.

But patients should know that treatment decisions are better when they are informed by accurate imaging, multidisciplinary expertise, and thoughtful planning.

Every patient deserves to understand not only **that** they have pancreatic cancer, but also **what type of pancreatic cancer they have from a treatment standpoint, why a particular strategy is being recommended, and what alternatives exist.**

Knowledge cannot eliminate the uncertainty of a pancreatic cancer diagnosis.

It can, however, help patients become informed partners in one of the most important decisions they will ever make.

That partnership begins with understanding what excellent pancreatic cancer care looks like—and making sure you receive it.