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Summary

Panel discussion: Future treatment for resectable pancreatic cancer: Cut, treat or personalise?

UEG Week Barcelona 2026 | Presentation

Digestive Oncology | Surgery | Pancreas | Mechanisms & Personalised Medicine

October 19, 2026

Panel discussion on treatment selection for pancreatic cancer explored neoadjuvant chemotherapy timing, biomarker-guided approaches including ctDNA and organoid testing, and surgical decision-making for resectable and borderline resectable disease.

KEY POINTS

- The speakers reported that gemcitabine-paclitaxel failed in the adjuvant setting according to the APEX trial, with no established role in the neoadjuvant setting, and that studies including SWOG did not demonstrate superiority of one neoadjuvant chemotherapy regimen over another.
- Modified folfirinox was recommended by speakers if the patient can tolerate it upfront, with treatment choice between folfirinox and gemcitabine-based regimens depending on patient physical condition and comorbidity.
- Speakers stated that the absolute ctDNA cut-off level to guide pre-operative decisions is not yet known, but ctDNA may have a future role in the neoadjuvant setting for monitoring tumour response in borderline resectable or locally advanced disease.
- One speaker recommended that neoadjuvant chemotherapy for resectable pancreatic cancer should only be used in the clinical trial setting, following national or international guidelines.
- Speakers reported that even in experienced hands 30% of organoids do not grow, limiting widespread clinical application, though genomic and transcriptomic correlation with original tumours is very high.
- Institutional practices varied: one centre considers any venous involvement as borderline resectable and recommends neoadjuvant therapy, while primary resection was recommended for tumour marker CA19-9 below 500 without evidence of metastases, with laparoscopy advised to rule out peritoneal disease when CA19-9 is elevated.

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