Despite sustained efforts, intensive research has not been proven successful to reveal risk factors, which relevantly influence early diagnostics or effective treatment of pancreatic carcinoma. Principally, it must be noted, that currently no ideal tumor marker exists for the (early) detection of pancreatic carcinoma. The most important imaging modalities are high-resolution computed tomography, abdominal ultrasound, and endosonography. Surgical procedures in therapy have become more and more standardised and lead to a decrease in morbidity and mortality on the one hand and to an increase in resectability on the other hand. Pylorus-preserving partial pancreaticoduodenectomy is the treatment of choice for a tumor of the pancreatic head, whereas resection of the left pancreas (including splenectomy) is the standard therapy for carcinomas of the pancreatic tail. In all cases, a local systematic lymphadenectomy is mandatory; hence the prognostic gain of an extended lymphadenectomy remains indeterminate. An infiltration of mesenteric and portal veins does not prevent resectability, as long as by venous resection an R0 status can be achieved. However arterial involvement in general excludes resection. Patients with marginally resectable or locally non-resectable tumors should be recruited into neoadjuvant radiochemotherapy trials since one third of these patients could be considered for potentially curative resection. However the majority of
pancreatic cancer patients show locally unresectable or metastasized disease and therefore palliative treatment concepts are needed. Both, endoscopic or percutaneous stenting procedures and operative bypass surgery, are safe and reach high success rates.