

Impact of a centralised pancreaticobiliary tumour board on the diagnosis of pancreatic lesions

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Abstract

Background and study aims: Since 2019, pancreatic surgery in Belgium has been centralised to high-volume centres to improve care quality and reduce postoperative morbidity and mortality. All patients who are potential surgical candidates are discussed preoperatively at a centralised multidisciplinary board (MCCC = Multidisciplinair Consult Complexe Chirurgie). Typically, patients with a (possible) malignancy have already been evaluated by a multidisciplinary tumour board (MDT) in the referring hospital. This study aimed to assess the impact of the MCCC on the diagnosis of solid and cystic pancreatic lesions and to analyse referral patterns.

Patients and methods: This single-centre, non-interventional retrospective study included 217 patients with a newly diagnosed pancreatic lesion, discussed at the MCCC of Ghent University Hospital between July 1, 2019, and December 31, 2021. The influence of the MCCC on the diagnosis of pancreatic lesions was analysed.

Results: Among 217 patients (median age 65 years; 50% male), the most frequent diagnoses were pancreatic adenocarcinoma (n=99; 45,6%), IPMN (12%) and pancreatitis (7%). The MCCC altered the initial diagnostic assessment in 18,4% of cases. Among benign referrals, 20% (5/25) were ultimately found malignant, likely altering treatment. None of the 166 patients referred with a malignant diagnosis were reclassified as benign. During the first three years after centralisation, referral quality remained unchanged, with 12% unspecified lesions annually.

Summary: Centralisation may over time affect referral quality as expertise concentrates. Initial diagnosis and staging still occur in referring hospitals and are first discussed locally. This early analysis shows stable referral appropriateness after centralisation. Ongoing monitoring is needed to evaluate long-term effects of centralisation on diagnostic quality and early detection. (*Acta gastroenterol belg.*, 2026, 89, 33-41).

Keywords: Centralisation, pancreatic surgery, tumour board, referral quality, diagnostic accuracy.

Introduction

Pancreatic cancer (PC) is the 7th leading cause of cancer-related death in both sexes, despite ranking only the 12th most common malignancy worldwide (1, 2). In Belgium, there was a 104% increase in new diagnoses of PC between 2004 and 2021 (3). The 5-year overall survival rate remains only 8-10% and mortality is projected to rise by 42% between 2019 and 2039, mainly among individuals over 80 years (4). The poor prognosis of PC largely reflects the lack of early detection, with most patients presenting with unresectable disease, as well as limited advances in therapeutic management (1, 5-8). For the 15-20% of patients with resectable disease, 5-year overall survival may reach 20-25% following surgery (1, 5).

Historically, pancreatic surgery has been regarded as a procedure associated with high postoperative morbidity (8, 9). Global research has demonstrated that centralising pancreatic surgery lowers postoperative mortality due to the clear volume-outcome relationship (9, 10). In Belgium, from July 2019 onwards, the government centralised pancreatic surgery to 15 recognized expert centres. Key measures included: (1) minimum surgical volume, (2) mandatory multidisciplinary discussions (MCCC – “multidisciplinair consult complexe chirurgie”) and (3) systematic registration of all major resections.

These MCCC discussions include the participation of a surgeon, a gastro-enterologist with certified expertise in oncology or a medical oncologist, an anesthesiologist or intensivist, the referring medical specialist, a pathologist, a radiologist and, when appropriate, the general practitioner. These measures support quality control and promote regular interdisciplinary communication (3). Importantly, MCCCs not only provide oversight of complex surgical cases but also enhance diagnostic accuracy, support structured planning for further investigations, and guide appropriate management for patients with indeterminate or unclear lesions, thereby potentially improving patient outcomes even before surgical intervention.

While centralisation aims to improve outcomes through concentrated expertise, concerns exist that diagnostic expertise in referring hospitals may diminish over time. Outcomes in pancreatic cancer are influenced by multiple factors beyond surgical mortality, including early detection, accurate staging, timely referral, appropriate perioperative management, and access to adjuvant therapies (5-7).

Centralisation of expertise may, over time, impact the adequacy of referrals. If small premalignant lesions are no longer recognized in referring centres, adequate staging procedures or referrals may be delayed, ultimately affecting survival outcomes.

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The impact of MCCC in reviewing pancreaticobiliary diseases is still being evaluated (11, 12). This study assesses the impact of a centralised MCCC on the diagnosis of solid and cystic pancreatic lesions and evaluates early referral patterns after national centralisation.

Materials and methods

This is a single-centre, non-interventional retrospective study to evaluate the influence of the centralisation of pancreatic surgery and the implementation of a centralised MCCC on the diagnosis of pancreatic lesions in referral centres. Information on subsequent treatment decisions or management changes was not systematically collected. By means of a review of the electronic patient file (EPD), the preliminary suggestion of the multidisciplinary team from a referral centre was compared to the advice provided by the MCCC at Ghent University Hospital, in order to assess the influence of this centralised board. Adult patients (≥ 16 years of age), discussed at the pancreas MCCC of UZ Ghent from 01/07/2019 to 31/12/2021, were included. Eligible patients had pancreatic lesions with suspected or confirmed malignancy and were either referred from another institution or newly diagnosed at Ghent University Hospital. Only first-time MCCC presentations for a new pancreatic lesion were included. Patients whose lesions were not referred for MCCC discussion, for example due to comorbidities, patient preference, or other clinical reasons, were not included in this study; no data are available on the size or characteristics of this undiscussed group. Exclusion criteria included patients with prior pancreatic surgery with a definitive pathological diagnosis of focal pancreatitis, known chronic pancreatitis, known pancreatic carcinoma, cholangiocarcinoma, neuroendocrine tumours (NETs) or other extra-pancreatic pathologies. Each MCCC decision was evaluated at a fixed time point, with a uniform follow-up period of 6 months to assess whether a repeat MCCC discussion occurred and whether the histopathological diagnosis was subsequently revised. Since the follow-up duration was identical for all cases, no median or range is reported.

Patient data were pseudonymised by assigning a unique study identifier to each participant, ensuring confidentiality while allowing for data linkage. The following data were collected: age, sex, origin of referral (hospital or general practitioner), type and report of the specific imaging modality used to (potentially) establish the diagnosis, the anatomopathological report and the MCCC report including the indication for MCCC referral and the given recommendation. These data were documented by the treating referring physician in the patient's electronic medical record (EPD) prior to the MCCC meeting. After the MCCC discussion, the MCCC chair – typically a digestive

oncologist – recorded the final recommendation: either additional imaging and/or biopsy was advised, or a treatment plan was established. We extracted these data from the patient's medical record. Based on imaging reports and/or the proposed treatment plan, lesions were categorized as either benign or malignant. Cases were considered "unspecified" when the referral to the MCCC did not include a clear diagnostic label (benign or malignant) despite prior diagnostic work-up. These referrals were typically accompanied by open-ended requests such as "pancreatic lesion, please advise," reflecting diagnostic uncertainty. Cases were classified as 'unknown' when no histopathological confirmation was obtained within the fixed 6-month follow-up period due to comorbidities, patient preference, death, or when the MCCC deemed the lesion radiologically benign with high confidence and no biopsy was indicated.

An opt-out informed consent was used, where participants were required to explicitly indicate non-consent for participation or the use of their pseudonymized data. If no opt-out was registered, consent for the study was assumed.

The study protocol was approved by the Ethics Committee of the Ghent University Hospital. (25th of November 2022 with reference code 'THE-2022-0245').

Results

Patient inclusion and exclusion criteria

As seen on Figure 1, a total of 436 unique patients were discussed at the MCCC between July 2019 and December 2021. Of these, 219 patients were excluded, including 82 patients discussed solely to evaluate resectability and 137 patients excluded for other reasons (see Table 1). The remaining 217 patients met all eligibility criteria and were included for final analysis. Among them, 166 were referred with a suspicion of malignancy, 25 with a presumed benign lesion and 26 were categorized as 'unspecified' at the time of referral.

The extra-pancreatic pathology group included both benign and malignant diagnoses, among which were non-pancreatic malignancies presenting with a new peri-pancreatic abnormality. Examples included liver abscesses, duodenal polyps, stricture of the ductus choledochus, ampullar carcinoma, GIST, hepatocellular carcinoma, low-grade appendiceal mucinous neoplasms, hamartoma, familial adenomatous polyposis, lymphangioma, paraganglioma, schwannoma and metastases from breast, oesophageal, gastric and renal cell carcinoma.

These 217 included patients were discussed to establish an accurate diagnosis related to a solid or cystic lesion in the pancreas. The main question from

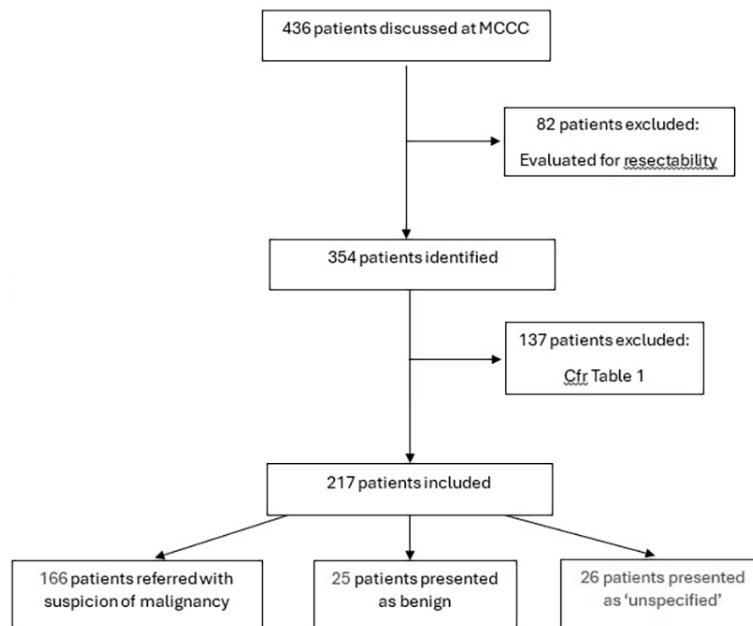


Figure 1. — Flow diagram illustrating patient inclusion and exclusion in the study.

Table 1. — Exclusion criteria.

Exclusion criteria	n	%
Extra-pancreatic pathology	39	28,5%
Cholangiocarcinoma	29	21,2%
Known pancreatitis	28	20,4%
Postoperative discussion	19	13,9%
Consent: opted out	10	7,3%
Known pancreatic carcinoma	6	4,4%
NET	5	3,6%
2nd discussion at MCCC	1	0,7%
Total	137	100,0%

the referring physician was to discuss the further management plan, depending on the correct diagnosis.

Patient demographics and referral origin

The median age at the time of presentation was 65 years (range 16-93) and 49,8% patients were male (n = 108), as seen in Table 2.

Table 2. — Demographic characteristics of the study population.

Characteristics	n	%
Total	217	100
Sex		
Male	108	49.8
Female	109	50.2
Median age (range), years	65 (16–93)	

Referrals originated from general practitioners, 36 Belgian referring centres, or two international centres located in the Netherlands and Portugal. A detailed breakdown is presented in Table 3.

Table 3. — Origin of referral.

Origin of referral centres	n	%
Province East Flanders	155	71,4%
Province West Flanders	22	10,1%
General practitioner	20	9,2%
the Netherlands	13	6,0%
Province Antwerp	3	1,4%
Province Flemish Brabant	1	0,5%
Portugal	1	0,5%
Unknown	2	1%
Total	217	100%

Lesions were classified as benign, (pre-)malignant or unknown, as illustrated in Figure 3. The corresponding histopathological diagnoses that informed this classification are listed in Table 4. Because not all lesions require or allow histopathological confirmation, pathology was only available for a subset of cases (n=190; 87,6%). The 3 most frequently diagnosed lesions, as confirmed by the final pathological diagnosis after surgery or biopsy, were pancreatic adenocarcinoma (n = 99; 45,6%), followed by IPMN (n = 27; 12,4%) and pancreatitis (n = 14; 6,5%). In twelve percent of cases (n = 27), further work-up, as suggested by the MCCC, was never performed due to comorbidities, patients' preference or death, and thus classified as 'unknown' in the final pathological diagnosis (see Figure 3). This category also encompasses lesions considered radiologically benign with high confidence, for which histopathological confirmation is neither indicated nor routinely pursued.

Of the 166 patients referred as 'malignant', 18 (10,8%) already had a histopathological confirmation prior to the MCCC discussion. In 134 cases (80,7%), pathological confirmation was subsequently obtained or guided through MCCC recommendations. In the remaining 14 patients (8,4%), no pathological confirmation was available due to comorbidities, patient preference or death.

Imaging modalities used prior to MCCC

The most specific imaging modality used to establish the diagnosis and to present the case at the MCCC,

was a contrast enhanced CT scan in 54,4% of the cases, followed by MRI (30,9%), PET-CT (8,3%) and EUS (6,5%).

Figure 2 summarises all imaging modalities performed prior to referral to the MCCC, with CT and combination of CT and MRI being the most frequently used.

Recommendation of the MCCC for suspected lesions

In cases with a suspected malignant lesion (n=204), the MCCC recommended either further investigations (CT, MRI, EUS, PET-CT, or Gallium DOTA), surgery, or additional follow-up, as shown in Figure 3. Among the cases with a suspected malignant lesion, the MCCC recommended additional diagnostic investigations in 78 patients (38,2%), highlighting persistent diagnostic uncertainty at referral. The most frequently proposed exam was EUS alone (n=49; 62,8%), followed by CT alone (n=17; 21,8%). Combined modalities were suggested less often, including PET-CT + EUS (n=4), MRI + EUS (n=3), CT + EUS (n=3) and Gallium-DOTA + EUS (n=1). In one case, PET-CT alone was advised.

Of the 78 patients in whom the MCCC recommended further diagnostic work-up, 13 (16,7%) were eventually reclassified. Taken together, a diagnostic revision occurred in 23% (n=47) of cases initially considered malignant, due to surgery, further work-up or follow-up, with likely consequences for subsequent management.

The mean number of all imaging or diagnostic procedures performed, was similar between patients

Table 4. — Classification and number of lesions as benign or (pre-)malignant based on final histopathological diagnosis.

Classification of lesions											
Benign	n	%	(Pre-)malignant	n	%	Unknown	n	%			
Pancreatitis	14	6,5%	Adenocarcinoma	99	45,6%						
Serous cystadenoma	9	4,1%	IPMN	27	12,4%						
Pseudocyst	2	0,9%	Ampullary carcinoma	12	5,5%						
Accessory spleen	1	0,5%	Duodenal carcinoma	5	2,3%						
Bulboduodenal polyp	1	0,5%	Metastases of a solid tumor	5	2,3%						
Duodenal diverticulum	1	0,5%	Adenosquamous carcinoma	3	1,4%						
Nesidioblastosis	1	0,5%	Mucinous cystadenoma	3	1,4%						
Schwannoma	1	0,5%	Solid pseudopapillary neoplasms	2	0,9%						
			Acinar cell carcinoma	1	0,5%						
			B-cel lymphoma	1	0,5%						
			Hepatoid carcinoma	1	0,5%						
			Pancreatic Intraepithelial Neoplasia	1	0,5%						
Total	30	13,8%	Total	160	73,7%				Total	27	12,4%

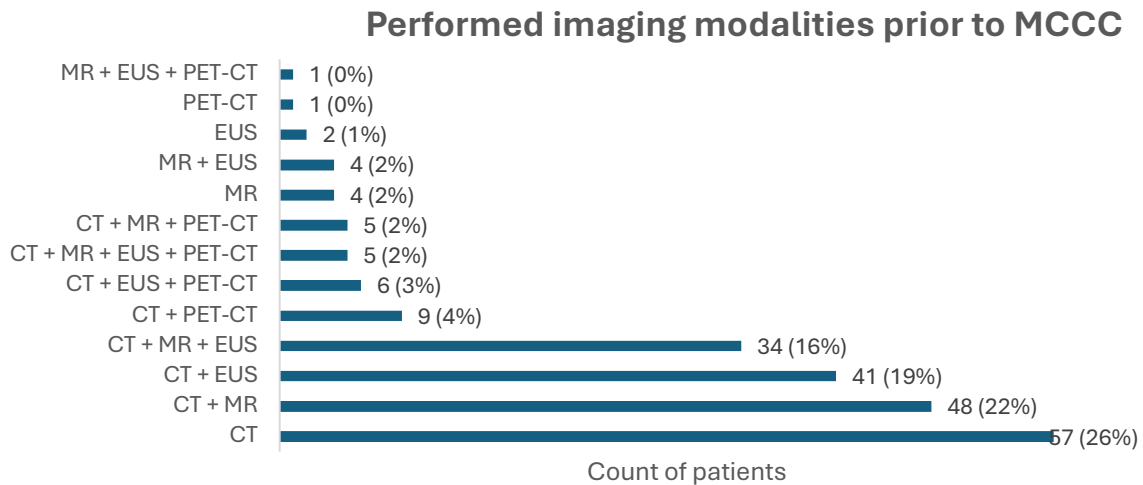


Figure 2. — Performed imaging modalities prior to MCCC.

with a change in diagnosis (2.42 per patient) and those without (2.58 per patient), indicating that the number of investigations alone does not appear to predict diagnostic revision.

Specificity of referral diagnoses

Of the 217 cases introduced as a new diagnosis at the MCCC, 191 cases (88%) were referred with a specific ‘characterised diagnosis’, either benign or malignant, based on prior diagnostic work-up in the referring hospital. The remaining 26 cases (12%) were

unspecified lesions. The absolute number of those unspecified cases did not change significantly over the years: 10 cases in 2019 (18,9%), 8 cases in 2020 (8,2%) and 8 cases in 2021 (16,3%).

Accuracy of referrals and diagnostic performance of the MCCC

Malignant referrals: A total of 166 patients were referred as malignant diagnosis (Figure 4) from the referring hospitals. None of those cases were reassessed as benign at the MCCC. After MCCC discussion, 139

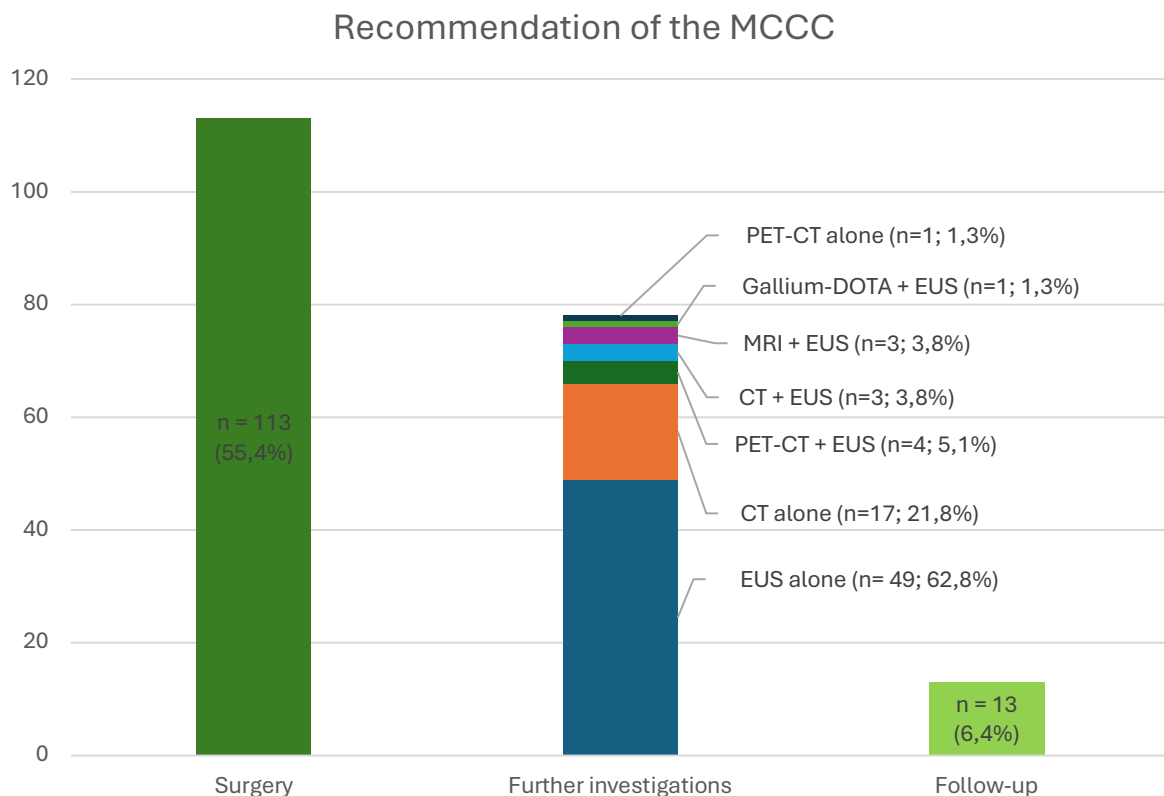


Figure 3. — Recommendation of the MCCC for suspected lesions (n=204).

patients (84%) were confirmed as malignant, 13 patients (8%) were found to be benign, and 14 patients (8%) had an unknown final diagnosis (classified as ‘unknown’). In those unknown cases, no further histopathological work-up was performed due to comorbidities, patient preference, or death. This indicates that referring hospitals overestimated malignancy in approximately 16% of cases (13 benign + 14 unknown out of 166 cases).

Cases initially referred as benign: A total of 25 patients were referred as benign (Figure 4). Of these, 11 patients (44%) were confirmed as benign after MCCC discussion, while 14 patients (56%) were found to be malignant or required further diagnostic work-up/follow-up.

- Among these 14 cases, 3 were confirmed (pre-)malignant following additional MCCC-recommended testing (1 pancreatic adenocarcinoma, 2 side-branch IPMN), 5 were confirmed benign (2 serous cystadenomas, 1 chronic pancreatitis, 1 ampulloma, 1 pseudocyst), and 6 had no definitive pathological diagnosis despite further assessment. For these 6, additional assessments recommended by the MCCC included EUS with puncture, although the puncture did not provide definitive diagnostic clarity (resulting in presumptive diagnoses of lipoma, serous cystadenoma, or pseudocyst), image review suggesting chronic pancreatitis, or, in one case, a conservative approach requested by the patient.
- Among the 11 lesions considered benign by the MCCC, 8 patients were ultimately confirmed as

benign, 2 patients were found to be malignant, and 1 patient had an unknown final diagnosis. Two cases initially considered benign by both the referring hospital and the MCCC were ultimately found to be malignant: both pancreatic adenocarcinoma, highlighting the diagnostic challenge of small or radiologically subtle pancreatic lesions.

Unspecified referrals: A total of 26 patients were referred as unspecified at initial referral (Figure 4). After MCCC discussion, 24 patients were considered malignant and 2 benign. Ultimately, 15 patients were classified as malignant, 4 patients as benign, and 5 patients remained with an unknown final diagnosis. This highlights that even when referring hospitals could not provide a clear initial assessment, the majority of cases were confirmed as malignant at the MCCC, while a minority required further follow-up or were found benign. Of the 2 lesions considered benign at the MCCC, 1 was identified as malignant (adenocarcinoma) and 1 as unknown (assessed on imaging as a small IPMN). MCCC clarified diagnosis in 100% of cases (n=26).

Overall diagnostic performance of the MCCC

Out of the 204 cases considered as (pre)malignant at the MCCC, 157 (77%) were proven to be malignant, 22 (11%) were benign and we do not have a final diagnosis in 25 (12%) cases. Thus the MCCC overestimated

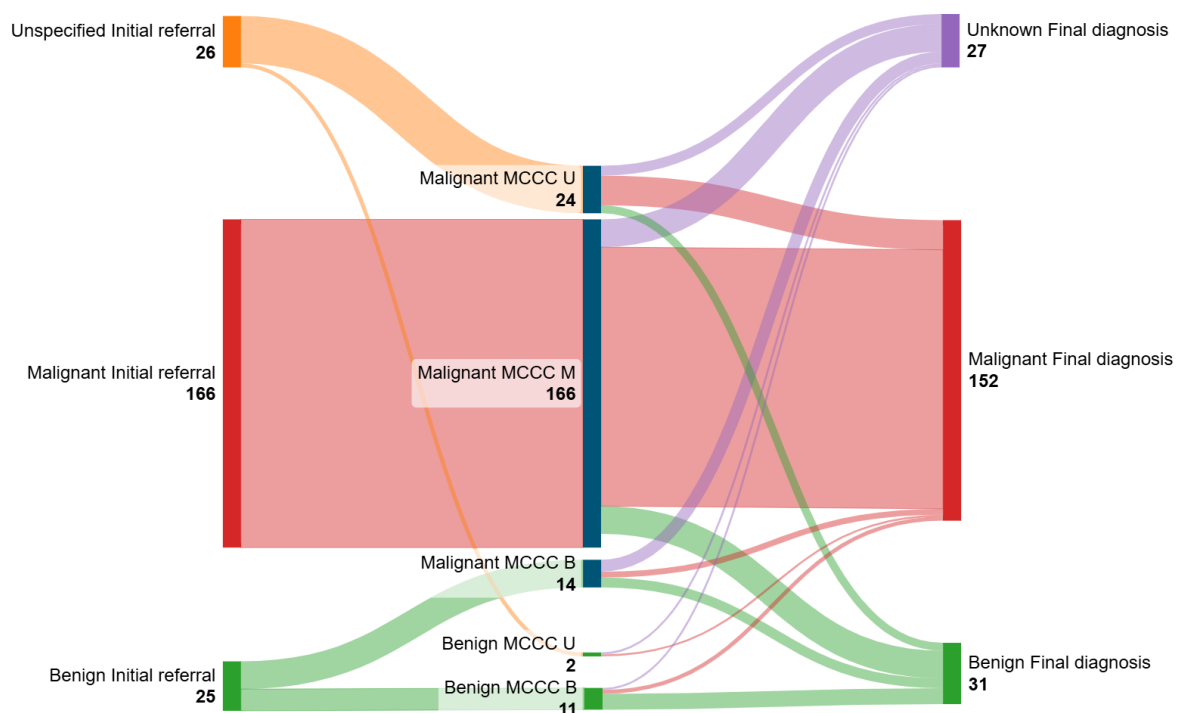


Figure 4. — Sankey diagram of change in diagnosis from initial referral to MCCC to final diagnosis.

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malignancy in approximately 10% of cases, similar to the referring hospitals. For initially benign referrals, MCCC discussion led to additional diagnostic procedures in all 14 cases, providing clarification in most, though management impact was not systematically recorded.

Summary of diagnostic outcomes

Of the 25 cases initially assessed as benign in the referring hospital, 14 were considered malignant by the MCCC. Among the 14 cases classified as malignant by the MCCC, the final diagnosis was known in 8 patients (3 malignant and 5 benign), with 6 cases remaining without a definitive pathological outcome. Similarly, among the 11 cases classified as benign by the MCCC, the final diagnosis was known in 10 patients (2 malignant and 8 benign), with 1 case remaining unknown. Based on these 18 patients with known outcomes, the MCCC correctly classified 3 as malignant, resulting in a Positive Predictive Value (PPV) of 37,5%, and incorrectly classified 5 as benign, resulting in a Negative Predictive Value (NPV) of 62,5%.

The MCCC proved particularly effective in ruling out malignancy, highlighting its added value in diagnostically ambiguous cases. However, the MCCC failed to correct malignant overestimations made by referring hospitals: all patients referred as malignant remained classified as such.

However, PPV and NPV were calculated only for the subset with known outcomes. The potential impact of these unknown outcomes should be acknowledged. Depending on the actual diagnoses of the 7 patients with unknown outcomes, the calculated PPV and NPV could change substantially:

- In a best-case scenario, where all unknown outcomes are correctly predicted by the MCCC, PPV could increase to 55% and NPV to 100%.
- In a worst-case scenario, where all unknown outcomes are incorrectly predicted, PPV could drop to 15% and NPV to 50%.
- Under a realistic mixed scenario, assuming the unknown outcomes follow a similar distribution as the known cases, PPV and NPV would remain close to the initially calculated values (approximately 44% and 69%, respectively), but with increased uncertainty.

Diagnostic changes after referral

Among the 217 patients discussed at the MCCC, 40 (18,4%) experienced a change in diagnosis after MCCC discussion. This indicates that nearly one in five patients had their initial referral reassessed, highlighting the significant clinical value of the MCCC in ensuring accurate diagnosis and guiding appropriate patient management.

Subgroup analysis of internal versus referred patients

Specificity of diagnosis

A subgroup analysis comparing internal (UZ Gent) and externally referred patients was performed to account for potential differences in the MCCC's impact, as internal patients may have had earlier access to specialised diagnostics, while referred patients reflect the centralisation process central to the study's hypothesis. Among 215 patients with known origin, 46 were internal (7 unspecified lesions, 39 characterised lesions) and 169 were referred (17 unspecified lesions, 152 characterised lesions); 2 patients had unknown origin, as seen in Table 5.

A Chi-square test comparing internal and referred patients (excluding the unknowns) showed no statistically significant difference in the proportion of unspecified lesions versus characterised lesions at referral ($\chi^2 = 0.91$, $p = 0.34$), suggesting that the MCCC's impact on diagnostic clarification applies similarly to both internal and referred patients.

Diagnostic changes: internal vs external referrals

As seen in Table 6, among the 169 referred patients, 29 (17.2%) experienced a change in diagnosis after MCCC discussion. In the 46 internal patients, 9 (19.6%) had a diagnostic change.

Statistical analysis using a Chi-square test showed no significant difference between the groups in the proportion of patients with a changed diagnosis ($\chi^2 = 0.026$, $df = 1$, $p = 0.872$), suggesting that the MCCC's diagnostic impact was similar for both internal and referred cases. These findings indicate that the MCCC

Table 5. — Contingency table of referral diagnoses to MCCC by patient origin. Percentages are calculated within each patient origin group.

	Unspecified lesion	Characterised lesion	Total
Internal patients (UZ Gent)	7 (15,2%)	39 (84,8%)	46
Referred patients	17 (10,1%)	152 (89,9%)	169
Unknown	2	0	2
Total	26 (11,2%)	191 (88,8%)	217

Table 6. — Changes in diagnosis after MCCC discussion: internal vs referred patients.

	Diagnosis corrected by MCCC	Total
Internal patients (UZ Gent)	9 (19,6%)	46
Referred patients	29 (17,2%)	169
Total	38 (17,7%)	215

contributed to diagnostic clarification in both groups, particularly for lesions initially considered benign or unspecified, and that the overall pattern of diagnostic change did not differ significantly between internal and referred patients.

Discussion

Centralisation of pancreatic surgery in Belgium was introduced to improve oncological outcomes by concentrating expertise, standardising perioperative pathways and ensuring multidisciplinary evaluation of potentially resectable cases (7, 11-14). In this early post-centralisation analysis, we assessed the diagnostic impact of a centralised multidisciplinary complex surgery meeting (MCCC) on newly detected pancreatic lesions and evaluated whether referral quality changed during the first years of centralisation.

Referral quality remained stable throughout the study period. Only 12% of cases were submitted without a characterised diagnosis, and this proportion did not increase over time. This suggests that, despite reduced surgical volumes in referring centres, diagnostic proficiency during initial work-up was preserved. The large majority of referrals (88%) contained a clearly formulated working diagnosis, indicating that pre-referral assessment remains clinically meaningful.

The centralised MCCC provided substantial diagnostic refinement. Across all cases, 18.4% experienced a change in diagnostic interpretation following multidisciplinary review. For comparison, Pawlik et al noted that 48 out of 203 (23.6%) patients had alterations in treatment recommendations when the decisions between the outside institution and the multidisciplinary clinic were compared (15). Importantly, the board frequently recommended additional diagnostic testing: 78 of 204 patients with a suspected malignant lesion (38.2%) required further evaluation after MCCC discussion. Endoscopic ultrasound (EUS) was the most frequently recommended test (n = 49; 62.8%), followed by contrast-enhanced CT (n = 17; 21.8%), whereas combined imaging modalities (CT+EUS, MRI+EUS, PET-CT+EUS or Gallium-DOTA+EUS) were recommended less frequently. These additional examinations resulted in diagnostic reclassification in 13 of the 78 patients (16.7%), demonstrating a direct and clinically relevant impact of MCCC-guided work-up on diagnostic accuracy and clinical decision-making.

The diagnostic impact of the MCCC cannot be interpreted without considering the extent of pre-

referral histopathological confirmation. Among patients referred with a suspicion of malignancy, only 18 of 166 (10.8%) had histopathological confirmation prior to MCCC discussion. Consequently, nearly 90% of malignancy-labelled referrals lacked definitive tissue diagnosis before MCCC evaluation, and the majority of final confirmations (134/166; 80.7%) were obtained following investigations initiated or guided by the MCCC. This indicates that the board functioned primarily as a diagnostic completion platform rather than a confirmatory step, and that its contribution is not overstated but reflects an actual gap in pre-referral diagnostic standardisation.

Diagnostic refinement occurred predominantly in benign or unspecified referrals. Among cases initially considered benign, 12% were ultimately proven malignant, highlighting the difficulty of identifying small or radiologically subtle pancreatic cancers. Two malignancies that were not suspected at the time of MCCC discussion were characterised by small size and non-specific imaging features, illustrating the intrinsic limitations of current radiological strategies rather than shortcomings of multidisciplinary evaluation. Conversely, none of the cases labelled malignant at referral were reclassified as benign by the MCCC. Although 16% later proved benign or remained without final histopathology, this proportion should be interpreted cautiously: in many cases, further diagnostic procedures were withheld due to comorbidities, clinical deterioration, or patient preference.

The diagnostic contribution of the MCCC was consistent for internally managed and externally referred patients, indicating that the added value of centralised multidisciplinary review is independent of patient origin. Management changes were not systematically captured in this study; therefore, subgroup comparisons between internal and external patients were limited to diagnostic parameters only. Furthermore, the MCCC played a central role in structuring and completing the diagnostic trajectory: most pathological confirmations were obtained following MCCC recommendations, underscoring that expert multidisciplinary review has an essential function early in the work-up of pancreatic lesions, not solely at the point of surgical decision-making.

This study has limitations. The single-centre retrospective design limits generalisability, and final diagnoses were unavailable for a subset of patients. The 6-month follow-up interval may be insufficient to confidently exclude malignancy in radiologically

indeterminate lesions. We did not evaluate downstream therapeutic consequences or patient outcomes beyond diagnostic classification; therefore, the full impact of reclassification on prognosis remains unknown. Additionally, the early time frame may not capture long-term diagnostic evolution in referring centres after centralisation.

In conclusion, during the first years following national centralisation of pancreatic surgery in Belgium, referral quality remained stable, and the centralised MCCC demonstrated clear diagnostic value. Nearly 40% of patients with suspected malignant lesions required additional diagnostic testing following MCCC review, leading to diagnostic reclassification in 16.7% of these cases. Overall, multidisciplinary evaluation altered the diagnostic interpretation in almost one in five patients, particularly among benign or undefined lesions. These findings highlight that MCCC functions not only as a forum for surgical decision-making but also as a crucial platform for completing and standardising the diagnostic work-up of pancreatic lesions. Long-term monitoring will be essential to ensure that these early benefits are maintained and to determine whether further measures are needed to safeguard diagnostic quality as centralisation evolves.

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