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**Circulating tumor DNA as a liquid biopsy target for detection of pancreatic cancer**

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**Abstract**

Most pancreatic cancer patients present with advanced metastatic disease, resulting in extremely poor 5-year survival, mainly because of the lack of a reliable modality for early detection and limited therapeutic options for advanced disease. Therefore, there is a need for minimally-invasive diagnostic tools for detecting pancreatic cancer at an early stage, when curative surgery and also novel therapeutic approaches including precision medicine may be feasible. The “liquid biopsy” addresses these unmet clinical needs based on the concept that simple peripheral blood sampling and detection of circulating tumor DNA (ctDNA) could provide diagnostic information. In this review, we provide an overview of the current status of blood-based tests for diagnosis of pancreatic cancer and the potential utility of ctDNA for precision medicine. We also discuss challenges that remain to be addressed in developing practical ctDNA-based liquid biopsy approaches for early diagnosis of pancreatic cancer.

**Key words:** Liquid biopsy; Circulating tumor DNA; Pancreatic cancer; Biomarker; Precision medicine

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**Core tip:** There is a need for minimally-invasive diagnostic tools for detecting pancreatic cancer at an early stage and also novel therapeutic approaches including precision medicine may be feasible. The “liquid biopsy” addresses these unmet clinical needs based on the concept that simple peripheral blood sampling and detection of circulating tumor DNA (ctDNA) could provide diagnostic information. In this topic, we provide an overview of the current status of blood-based tests for diagnosis of pancreatic cancer and the potential utility of ctDNA for precision medicine. We also discuss challenges that remain to be addressed in developing practical ctDNA-based liquid biopsy.

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**INTRODUCTION**

Pancreatic ductal adenocarcinoma (PDAC) is the most common type of pancreatic cancer, representing about 80% of all cases. It is a devastating disease with a 5-year survival rate of only approximately 4%-7% (http://seer.cancer.gov/statfacts/html/pancreas.html), and this figure has not improved in recent decades. Although surgical resection is the only curative treatment for PDAC, only 15% to 20% of patients present with resectable disease and the majority are diagnosed with locally advanced or metastatic cancer[1]. This situation is mainly a consequence of the aggressive nature of this disease and the lack of an efficient method for detection of early-stage lesions. In addition, very early stage organ metastasis is often observed in patients which are treated with potentially curative surgery. This suggests that occult tumor cells may be present in blood even with small lesions

 Currently the detection and diagnosis of pancreatic cancer largely rely on imaging modalities, including ultrasonography, computed tomography (CT), positron emission tomography (PET), magnetic resonance imaging (MRI) and endoscopic ultrasonography (EUS)[1]. However, early-stage pancreatic cancers and very small metastases are difficult to detect even if combinations of these modalities are employed. In addition, these modalities require expensive equipment and specialist technicians. Although blood-based tumor biomarkers, such as carcinoembryonic antigen (CEA) and carbohydrate antigen (CA) 19-9, are much cheaper, simple and minimally invasive alternatives, the sensitivity and specificity of these currently used tumor biomarkers are not sufficient for effective early detection of pancreatic cancer. Despite recent progress in understanding of the disease at the molecular level, no reliable blood-based biomarker for screening of pancreatic cancer has yet become clinically available.

 The problem is compounded by the few viable therapeutic options for patients with advanced pancreatic cancer who are not eligible for resection. Chemotherapy for pancreatic cancer patients is limited, and cytotoxic drugs, such as gemcitabine, which have been the standard chemotherapeutic drugs for patients with advanced disease for many years, provide limited survival advantage[1]. Personalized therapies based on cancer-specific alterations are currently not conducted in clinical practice for pancreatic cancer.

 In this context, new effective biomarkers are required to improve diagnosis, disease monitoring and process of therapeutic choice of PDAC. As tumor-derived somatic gene alterations can be detected in circulating tumor DNA (ctDNA) from cancer patients, ctDNA could provide a less-invasive diagnostic tool based on the concept of “liquid biopsy”. In this review, we summarize the current status of ctDNA analysis, and discuss the potential clinical utility of liquid biopsy for pancreatic cancer.

**OVERVIEW OF LIQUID BIOPSY IN CANCER**

The concept of detecting tumor-specific molecular alterations by analysis of bodily fluids, including peripheral blood, of cancer patients is termed “liquid biopsy” (Figure 1). Cell-free DNA (cfDNA) consists of small double-stranded DNA fragments found in blood. In 1948, Mandel and Metais firstly reported the presence of cfDNA in the circulation[2]. Tumor-derived cfDNA, now commonly known as circulating tumor DNA (ctDNA), was described in 1989[3]. The clinical utility of cfDNA in plasma and serum has been an active area of research in a variety of clinical settings. Indeed, evaluation of fetal cfDNA in the circulation of pregnant women is becoming a routine diagnostic test for high-risk patients in the clinic. To date, cfDNA has been the main target of liquid biopsy for cancer detection, together with exosomes, micro-RNA (miRNA) and circulating tumor cells (CTCs). In the oncology setting, ctDNA is expected to provide a minimally-invasive approach for cancer diagnosis, monitoring of chemotherapy-resistant mutations, and overcoming the problem of tumor heterogeneity[4-6].

 It has been suggested that cancer patients have higher levels of cfDNA than healthy individuals[7], although an increase is also observed with a variety of other physiological and pathological conditions, including exercise, inflammation, exposure to smoking, sepsis and trauma[8]. cfDNA is shed into the bloodstream *via* apoptosis, necrosis, direct release from viable cells, and lysis of circulating cells, but the major sources are now thought to be apoptotic and necrotic cells. In fact, the length of cfDNA fragments in the circulation often shows a characteristic laddering pattern with multiples of 170-180 base pairs, which is a well-known feature of apoptosis[7]. Apoptosis is programmed even for many normal cells on a daily basis and it has been suggested that a large fraction of cfDNA is derived from bone marrow and liver in healthy individuals[9]. However, in a tumor mass, hyperproliferation and rapid cellular turnover of cancer cells can lead to very greatly increased programmed cell death. Features of intratumoral microenvironments such as hypoxia may also lead to necrosis. Cellular debris from apoptotic or necrotic cells is normally phagocytozed by infiltrating macrophages and the cellular components are cleared. However, this clearance mechanism does not proceed effectively in a tumor mass, leading to accumulation of cellular debris, including DNA, and its release into the circulation[5,7,10].

 Although total cfDNA may be generally increased in patients with cancer, the sensitivity and specificity for cancer detection are low, and the utility as a cancer biomarker is questionable. On the other hand, tumor DNA can be discriminated from normal cfDNA by detecting tumor-specific somatic mutations that exist only in the genomes of cancer or precancerous cells, but not in the genomes of their normal counterparts. This assures the specificity of ctDNA as a cancer biomarker.

 However, detection of ctDNA has in practice proven challenging, since the percentage of ctDNA may be very low (< 1.0% in many cases) in total cfDNA[5,11]. Traditional methods such as Sanger sequencing or pyrosequencing can detect mutated tumor-derived DNA fragments only in patients with a high tumor burden and a large amount of ctDNA. However, recent advances in sequencing technologies, including the digital polymerase chain reaction and next-generation sequencing, have made it possible to detect ctDNA present at relatively low frequencies in blood, and there has been an explosive increase of studies of clinical utility of ctDNA[12-14].

**METHODS FOR DETECTION OF CTDNA**

The digital polymerase chain reaction (dPCR) is now one of the major methods to sensitively detect genomic alterations in cfDNA. In 2003, a PCR-based digital approach, named BEAMing (Beads, Emulsion, Amplification, and Magnetics) was first described[15]. Using emulsion PCR and flow cytometry, BEAMing can efficiently identify rare mutations with allele fractions as low as 0.01%[16].

Nowadays several dPCR systems, including droplet-based platforms, are commercially available. Generally, the sensitivity of a droplet dPCR system depends on the number of droplets. One of the most widely used droplet dPCR devices, the QX200 Droplet Digital PCR System (Bio-Rad Laboratories) generates 20,000 nanoliter-sized droplets. The RainDrop Digital PCR System (RainDance Technologies) can perform “single-molecule” PCR for up to 10 million picoliter-sized droplets, and therefore possesses very high sensitivity. In addition, multiplex assays are possible in the RainDrop system by using combinations of two color probes (up to 10 targets)[17].

 Next-generation sequencing (NGS) is also widely applied to analyze genomic alterations in cfDNA. Unlike dPCR, NGS techniques can analyze multiple, broad regions of interest. Even whole-genome sequencing or whole-exome sequencing of cfDNA from advanced cancer patients has been reported, and various alterations, including single nucleotide variants (SNV), copy number alterations (CNA) and structural alterations of DNA, were detected[13,18,19]. However, only genomic alterations with high allele frequencies may be appropriate with these platforms, since deep genome-wide analysis, especially whole-genome sequencing, is quite costly and not feasible in the routine clinical context. Therefore, global genomic analyses can be applied for only cfDNA samples from advanced cancer patients with high tumor burden. On the other hand, targeted sequencing can be performed at relatively low cost. By focusing on clinically important genes, mutations can be detected with higher sensitivity compared to genome-wide analyses.

 Amplicon sequencing is one of the major techniques for analyzing mutations in specific genomic regions. Ion AmpliSeq Technology (Thermo Fisher Scientific) is a widely used targeted sequencing platform. Highly multiplex PCR followed by NGS, such as Ion Ion Personal Genome Machine (Ion PGM), allows deep sequencing of target regions with as little as 10 ng input DNA at low cost and with a short turnaround time. However, the Ion Ampliseq system has issues such as a relatively high error rate in detection of small insertions and deletions (indels)[20].

 Target enrichment techniques, namely target capture-based platforms, are widely used for analyzing gene alterations of cancer. In principle, fragmented genomic DNA is hybridized with DNA/RNA probes designed for capturing targeted regions, and the enriched DNA libraries are analyzed by NGS. The SureSelect Target Enrichment System (Agilent Technologies) is widely employed for targeted sequencing in combination with the Illumina paired-end sequencing platform, which has a relatively low error rate amongst high-throughput sequencing instruments[21]. Although the manufacturer’s protocol for the SureSelect Target Enrichment System requires at least 200 ng of input DNA, the amount can be reduced by using particular library preparation kits, such as the KAPA Hyper Prep Kit (KAPA Biosystems)[22].

 In addition to these commercially available technologies, various highly sensitive sequencing methods have been developed for detecting ctDNA. In an amplicon-based system, Safe-SeqS (Safe-Sequencing System), individual DNA molecules are tagged with a unique identifier, then amplified and sequenced. According to the original paper, the error rate could be lowered to 9 × 10-6 by taking into account unique identifiers[23]. Forshew *et al*[24] reported a method termed Tam-Seq (Tagged-Amplicon deep Sequencing) in 2012. They detected somatic mutations in cfDNA at a 2% allele frequency. In the case of non-small cell lung cancer, another method for profiling ctDNA, CAPP-Seq (Cancer Personalized Profiling by deep Sequencing), has been described[25]. In addition to methods for detecting SNVs, Personalized Analysis of Rearranged Ends (PARE) identifies cancer-specific genome rearrangements, and it has been shown that such alterations can be used as personalized cancer biomarkers[26].

**CTDNA AS A BIOMARKER FOR PANCREATIC CANCER**

Clinical utility of ctDNA has been investigated in various types of cancer. For diagnosis, the most commonly mutated genes are considered to be best suited for analysis as blood-based biomarkers. However, even within a single tumor type, the mutation profile generally varies from patient to patient. Even if a single gene is commonly mutated in a particular cancer type, the altered locus can vary, especially in tumor suppressor genes such as *TP53*. For this reason, among others, it is not simple to utilize tumor-derived DNA in plasma for the diagnosis of many cancer types without information about actual mutations in the tumor tissues themselves.

 The molecular genetics landscape of PDAC has been studied by whole-genome or exome sequencing and somatic alterations associated with this disease have been identified[28-31]. Four genes, *KRAS*, *CDKN2A*, *TP53* and *SMAD4*, are commonly mutated or modified epigenetically in PDAC, and dozens of candidate driver genes are altered at low frequency (< 5%)[27-30]. Clonal evolution of pancreatic cancer has also been investigated and it has been exhibited that genetic heterogeneity arise during subclonal evolution[4]. Since point mutations of *KRAS* are particularly commonly observed in PDAC and 90% of all *KRAS* mutations occur in codon 12 or 13, these have been a focus of attention. To date, many studies have confirmed that mutant *KRAS* can be detected in plasma or serum from patients with PDAC, although detection methods applied were diverse[22,31-36].

 In the early 21st century, several research groups investigated the potential use of *KRAS* mutation in cfDNA as a biomarker of pancreatic cancer and demonstrated that such mutations were more frequently detected in the blood of PDAC patients than in individuals suffering from chronic pancreatitis[31,32]. It has also been suggested that sensitivity and specificity for detection of PDAC can be improved by combining *KRAS* mutations in blood with increase in the serum CA19-9 level[32,33]. Maire *et al*[31] reported that the sensitivity and specificity of serum *KRAS* mutations for the diagnosis of pancreatic cancer were 47 and 87%, respectively, whereas the combination of serum *KRAS* mutations and CA19-9 had a sensitivity and specificity of 98 and 77%, respectively. Analysis by Däbritz *et al*[32] also suggested that detectable *KRAS* mutations in the plasma were associated with progressive disease (75%), whereas the association was more evident when combining plasma *KRAS* mutations and elevated CA19-9 (92%). Furthermore, it has been reported that the presence of mutant *KRAS* in the circulation is associated with poor prognosis of patients with pancreatic cancer[23,33-36]. Multivariate analysis also showed that *KRAS* mutations in plasma DNA were stronger prognostic factor for survival (hazard ratio 7.39, *P* < 0.001) than elevated CA19-9 (hazard ratio 2.49, *P* = 0.087)[33]. Thus, *KRAS* mutant cfDNA could be useful as a predictive biomarker for treatment decisions.

 One of the major potential applications of ctDNA is disease monitoring. Tjensvoll *et al*[36] reported that changes in mutant *KRAS* levels in the circulation correlated with radiological imaging data and CA19-9 levels during the course of chemotherapy. They suggested the utility of *KRAS* mutant cfDNA for monitoring treatment efficacy and tumor progression in pancreatic cancer patients. Our own experiments further suggested that the detectability of *KRAS* mutant cfDNA is associated with the presence of distant organ metastasis, and thus ctDNA might be also useful to monitor tiny distant metastases that are hard to detect by routine imaging tests[22].

 As mentioned above, currently available tumor biomarkers, such as CA19-9, are insufficient to detect PDAC due to low sensitivity and low specificity. Somatic mutations, on the other hand, are highly specific to DNA derived from cancer or precancerous cells. Especially, *KRAS* is the most frequently mutated gene in PDAC and the mutations occur at the very early stage of carcinogenesis. As technology advances, ctDNA discriminated by *KRAS* mutation may have great potential as a blood-based biomarker for PDAC.

**DETECTING TARGETABLE GENOMIC ALTERATIONS IN CTDNA**

It is noteworthy that various other cancer-related genes are mutated at relatively low frequencies in PDAC. Importantly, it has been indicated that 20% of patients with pancreatic cancer have somatic alterations in genes that are potential targets of therapies approved by the U.S. Food and Drug Administration (FDA) for oncologic indications or therapies in published prospective clinical studies[37]. This suggests that genomic profiling in pancreatic cancer could be useful to design precision treatment strategies. Due to improvements of sequencing technologies, global or highly multiplexed genomic analysis of ctDNA is becoming feasible using NGS. Analyzing ctDNA has also been proposed as an alternative method to tissue biopsy in the setting of precision medicine, which relies on the presence of specific targets. Although tumor tissue biopsy is the gold standard for molecular screening of cancer, some patients are precluded from molecular screening because of difficulty in obtaining a tissue biopsy or insufficient tumor content in the available specimens[38]. Indeed, adequate biopsy tissues for molecular diagnosis are often difficult to acquire in pancreatic cancer patients. Very importantly, taking tissue biopsies is invasive and therefore not without clinical complications. Zill *et al*[39] analyzed 54 genes in tumor tissues and cfDNA samples using a commercially available gene panel, and demonstrated that a large proportion of mutations in pancreatic and biliary cancer could be detected in both. Although 35% of patients had an insufficient quantity or quality of tissue biopsy samples for sequencing analysis in their cohort, sequencing of cfDNA identified somatic mutations in many of these cases. We also have reported targeted deep sequencing analysis of cfDNA using a modified SureSelect-Illumina platform and an original gene panel for pancreatic cancer[22]. Our gene panel consisted of 60 genes, including 17 potentially actionable examples. In order to apply the SureSelect Target Enrichment System for the small amounts of cfDNA samples, we modified the library preparation conditions by combination with a KAPA Hyper Prep Kit. In our protocol, input cfDNA could be reduced to as little as 5 ng. As prescreening for sequencing analysis, dPCR assays were first performed to determine the mutational status of *KRAS* in plasma cfDNA of 259 patients with PDAC. We then carried out targeted deep sequencing in 48 patients, including 43 cases that were considered to have ≥ 1% tumor DNA in total cfDNA based on dPCR *KRAS* assay and 5 patients with obvious distant organ metastasis, even though they were negative for *KRAS* mutation in plasma on dPCR assay. We found somatic mutations in potentially targetable genes in 14 of 48 patients (29.2%). In addition, we analyzed somatic copy number alterations using targeted sequencing data for cfDNA, and potentially targetable gene amplifications, such as in *CCND1* and *ERBB2*, were also detected. At present, as NGS assays are still costly and the sensitivities of standard sequencing technologies are limited, targeted deep sequencing of cfDNA may not be practical in clinical settings for all patients. Since *KRAS* mutation is a good cancer biomarker in pancreatic cancer patients, our two-step approach combining dPCR and NGS could be cost-effective and applicable in the clinic. It may be possible to apply such ctDNA assays to broader range of patients by using a larger volume of plasma because the sensitivities of these assays should depend on the amount of input cfDNA. In addition, the use of novel techniques, including molecular barcoding, and error reduction methods by bioinformatics approaches could improve the sensitivities of sequencing analysis[40,41]. Thus, the available data indicate that liquid biopsy has great potential for diagnosis and treatment design in pancreatic cancer in diverse clinical settings.

**EARLY DETECTION OF PANCREATIC CANCER BY LIQUID BIOPSY**

Although PDAC is a highly aggressive disease, the investigation of clonal evolution of this disease and mathematical modeling of the rate of mutation acquisition suggests that there is an 11.7-year period from acquisition of the initiating mutation to full transformation in a pancreatic cell, and another 6.8 years are needed to develop the first metastatic subclone[4]. This model implies that there is a substantial time window for early detection of PDAC. Early diagnosis could have a major impact on patient survival, and therefore new effective biomarkers are urgently needed to improve prognosis.

 At present, clinical screening for early detection of PDAC has only limited effectiveness, and liquid biopsy appears to be a promising approach to overcome this problem. In general, however, detection of ctDNA is still challenging in early-stage cancer patients because of the high background levels of normal cfDNA. *KRAS* mutation has been proposed as a biomarker in cfDNA for detection of PDAC, but in early-stage malignant disease (and also in some metastatic cancers), ctDNA may be extremely rare in total cfDNA (0.01% or less)[23,25,39]. Although many analyses of ctDNA have been reported in various cancer types, the vast majority of those studies were analyses of advanced-stage cancer patients, with metastasis or high tumor burden, and the utility of detecting ctDNA in patients with early-stage lesions has been poorly investigated[14,25,42].

 A multicenter study of liquid biopsies in 846 patients with 15 cancer types (including PDAC), using digital technologies and ~5 mL plasma, reported a detection rate of ctDNA of 80% in patients with advanced cancer, but only 47% in cases of localized cancer[12]. This finding implies that current technologies for ctDNA analysis are still insufficiently sensitive for reliable detection of early-stage cancers. Novel detection methods with much higher sensitivity are required. The same study also demonstrated that detection rates for ctDNA differ depending on the type of cancer[12]. The factors determining ctDNA levels are still not completely understood, but may include tumor burden and spatial proximity to the vasculature, in addition to type. Detailed analyses and accumulation of larger numbers of experimental data for patients with pancreatic cancer in various clinical situations are needed to develop ctDNA analysis that would be practical for early diagnosis.

 In addition to peripheral blood, other body fluids such as pancreatic juice may be a secondary source of tumor DNA for liquid biopsy. While collection of pancreatic juice is invasive, as it requires endoscopic techniques which are much more intricate than simple drawing of blood, pancreatic juice would be expected to contain a much higher concentration of tumor DNA. Indeed, mutant *KRAS* has been detected in pancreatic juice from pancreatic cancer patients[43,44].

 Not only genetic alterations, but also epigenetic aberrations, such as DNA hypermethylation, occur during pancreatic carcinogenesis. Aberrant DNA methylation seems to occur in early-stage tumors, resulting in inactivation of tumor suppressor genes or gain-of-function of oncogenic signaling pathways[45,46]. Genes that are aberrantly methylated in a high proportion of pancreatic cancer patients could thus be biomarkers for cancer screening. Methylation of several genes (including *NPTX2*, *SFRP1* and *SPARK*) has been detected in pancreatic juice samples, and allow distinction of patients with chronic pancreatitis or normal individuals from cancer cases[47]. Detecting tumor-specific epigenetic alterations in cfDNA could be an attractive option for diagnosis of pancreatic cancer by means of a liquid biopsy approach, since epigenetic markers, including aberrant DNA methylation, can be also found in ctDNA. Indeed, Joo *et al*[48] demonstrated this possibility with promoter methylation of *BNC1* and *ADAMTS1*. In the future, it may be worth investigating the feasibility of utilizing combinatorial approaches with multiple blood-based biomarkers, including genomic mutations in ctDNA and epigenetic alterations in ctDNA, as a strategy to improve sensitivity and specificity in the diagnosis of early-stage pancreatic cancer.

**CONCLUSIONS AND FUTURE DIRECTIONS**

Although pancreatic cancer is a highly lethal disease with limited treatment options, a novel diagnostic test able to accurately detect the disease at an early stage, when curative surgery may be feasible, should greatly improve the prognosis. Minimally-invasive blood tests might also be useful for cancer screening. A number of studies have already detected genomic alterations in blood from patients with pancreatic cancer, confirming the potential value of liquid biopsy approaches. In addition, detecting actionable genomic alterations in ctDNA might provide a less-invasive approach for precision medicine even in PDAC, which is often inaccessible for tumor tissue biopsy.

 However, at present there is still insufficient concrete evidence of the utility of ctDNA analysis regarding treatment of pancreatic cancer, and several issues need to be addressed. One of the most urgent is improvement of sensitivity. While the prospects for technological development and analytical advances seem promising, implementation of new ctDNA analyses for pancreatic cancer screening will depend on demonstration of clinical validity in large prospective studies. Especially for investigating the feasibility of utilizing ctDNA for early diagnosis, it is particularly important to analyze samples from patients with early-stage disease, although this will presumably only be possible with a generalized screening approach. Prospective follow-up and sequential blood sampling of individuals at high risk of pancreatic cancer (*e.g.*, those with a family history of pancreatic cancer or chronic pancreatitis) might thus be essential. Another issue is the diverse range of methods used so far for processing of blood samples and extraction of cfDNA. It will be important to standardize preanalytical processes for cfDNA analysis, such as blood sample acquisition, plasma separation, sample storage, cfDNA extraction and quantification. This issue has only just begun to be discussed. Recently, there are an increasing number of new products for cfDNA processing including blood collection tubes (*e.g.*, Cell-Free DNA BCT® (Streck) and Cell-Free DNA Collection Tube (Roche)) and cfDNA extraction kits (*e.g.*, Quick-cfDNA™ Serum & Plasma Kit (Zymo Research), Maxwell® RSC ccfDNA Plasma Kit (Promega), and MagMAX™ Cell-Free DNA Isolation Kit (Thermo Fisher Scientific)). For sequencing of cfDNA, new library preparation kits optimized for small amounts of fragmented DNA, such as Accel-NGS® DNA Library Kits (Swift Biosciences) and ThruPLEX® Plasma-seq Kit (Rubicon Genomics), have also been available. It is worth evaluating the new products to establish standardized methods of ctDNA analysis. In view of the potential benefit to patients of a liquid biopsy approach using ctDNA for early detection of pancreatic cancer, we believe work to address these issues should be a high priority.

**REFERENCES**

1 **Kamisawa T**, Wood LD, Itoi T, Takaori K. Pancreatic cancer. *Lancet* 2016; **388**: 73-85 [PMID: 26830752 DOI: 10.1016/S0140-6736(16)00141-0]

2 **Mandel P**, Metais P. *C R Seances Soc Biol Fil* 1948; **142**: 241-243 [PMID: 18875018]

3 **Stroun M**, Anker P, Maurice P, Lyautey J, Lederrey C, Beljanski M. Neoplastic characteristics of the DNA found in the plasma of cancer patients. *Oncology* 1989; **46**: 318-322 [PMID: 2779946]

4 **Yachida S**, Jones S, Bozic I, Antal T, Leary R, Fu B, Kamiyama M, Hruban RH, Eshleman JR, Nowak MA, Velculescu VE, Kinzler KW, Vogelstein B, Iacobuzio-Donahue CA. Distant metastasis occurs late during the genetic evolution of pancreatic cancer. *Nature* 2010; **467**: 1114-1117 [PMID: 20981102 DOI: 10.1038/nature09515]

5 **Diaz LA**, Bardelli A. Liquid biopsies: genotyping circulating tumor DNA. *J Clin Oncol* 2014; **32**: 579-586 [PMID: 24449238 DOI: 10.1200/JCO.2012.45.2011]

6 **Campbell PJ**, Yachida S, Mudie LJ, Stephens PJ, Pleasance ED, Stebbings LA, Morsberger LA, Latimer C, McLaren S, Lin ML, McBride DJ, Varela I, Nik-Zainal SA, Leroy C, Jia M, Menzies A, Butler AP, Teague JW, Griffin CA, Burton J, Swerdlow H, Quail MA, Stratton MR, Iacobuzio-Donahue C, Futreal PA. The patterns and dynamics of genomic instability in metastatic pancreatic cancer. *Nature* 2010; **467**: 1109-1113 [PMID: 20981101 DOI: 10.1038/nature09460]

7 **Jahr S**, Hentze H, Englisch S, Hardt D, Fackelmayer FO, Hesch RD, Knippers R. DNA fragments in the blood plasma of cancer patients: quantitations and evidence for their origin from apoptotic and necrotic cells. *Cancer Res* 2001; **61**: 1659-1665 [PMID: 11245480]

8 **Schwarzenbach H**, Hoon DS, Pantel K. Cell-free nucleic acids as biomarkers in cancer patients. *Nat Rev Cancer* 2011; **11**: 426-437 [PMID: 21562580 DOI: 10.1038/nrc3066]

9 **Sun K**, Jiang P, Chan KC, Wong J, Cheng YK, Liang RH, Chan WK, Ma ES, Chan SL, Cheng SH, Chan RW, Tong YK, Ng SS, Wong RS, Hui DS, Leung TN, Leung TY, Lai PB, Chiu RW, Lo YM. Plasma DNA tissue mapping by genome-wide methylation sequencing for noninvasive prenatal, cancer, and transplantation assessments. *Proc Natl Acad Sci U S A* 2015; **112**: E5503-E5512 [PMID: 26392541 DOI: 10.1073/pnas.1508736112]

10 **Choi JJ**, Reich CF, Pisetsky DS. The role of macrophages in the in vitro generation of extracellular DNA from apoptotic and necrotic cells. *Immunology* 2005; **115**: 55-62 [PMID: 15819697 DOI: 10.1111/j.1365-2567.2005.02130.x]

11 **Diehl F**, Li M, Dressman D, He Y, Shen D, Szabo S, Diaz LA, Goodman SN, David KA, Juhl H, Kinzler KW, Vogelstein B. Detection and quantification of mutations in the plasma of patients with colorectal tumors. *Proc Natl Acad Sci U S A* 2005; **102**: 16368-16373 [PMID: 16258065 DOI: 10.1073/pnas.0507904102]

12 **Bettegowda C**, Sausen M, Leary RJ, Kinde I, Wang Y, Agrawal N, Bartlett BR, Wang H, Luber B, Alani RM, Antonarakis ES, Azad NS, Bardelli A, Brem H, Cameron JL, Lee CC, Fecher LA, Gallia GL, Gibbs P, Le D, Giuntoli RL, Goggins M, Hogarty MD, Holdhoff M, Hong SM, Jiao Y, Juhl HH, Kim JJ, Siravegna G, Laheru DA, Lauricella C, Lim M, Lipson EJ, Marie SK, Netto GJ, Oliner KS, Olivi A, Olsson L, Riggins GJ, Sartore-Bianchi A, Schmidt K, Shih lM, Oba-Shinjo SM, Siena S, Theodorescu D, Tie J, Harkins TT, Veronese S, Wang TL, Weingart JD, Wolfgang CL, Wood LD, Xing D, Hruban RH, Wu J, Allen PJ, Schmidt CM, Choti MA, Velculescu VE, Kinzler KW, Vogelstein B, Papadopoulos N, Diaz LA. Detection of circulating tumor DNA in early- and late-stage human malignancies. *Sci Transl Med* 2014; **6**: 224ra24 [PMID: 24553385 DOI: 10.1126/scitranslmed.3007094]

13 **Murtaza M**, Dawson SJ, Tsui DW, Gale D, Forshew T, Piskorz AM, Parkinson C, Chin SF, Kingsbury Z, Wong AS, Marass F, Humphray S, Hadfield J, Bentley D, Chin TM, Brenton JD, Caldas C, Rosenfeld N. Non-invasive analysis of acquired resistance to cancer therapy by sequencing of plasma DNA. *Nature* 2013; **497**: 108-112 [PMID: 23563269 DOI: 10.1038/nature12065]

14 **Ignatiadis M**, Lee M, Jeffrey SS. Circulating Tumor Cells and Circulating Tumor DNA: Challenges and Opportunities on the Path to Clinical Utility. *Clin Cancer Res* 2015; **21**: 4786-4800 [PMID: 26527805 DOI: 10.1158/1078-0432.CCR-14-1190]

15 **Dressman D**, Yan H, Traverso G, Kinzler KW, Vogelstein B. Transforming single DNA molecules into fluorescent magnetic particles for detection and enumeration of genetic variations. *Proc Natl Acad Sci U S A* 2003; **100**: 8817-8822 [PMID: 12857956 DOI: 10.1073/pnas.1133470100]

16 **Li M**, Diehl F, Dressman D, Vogelstein B, Kinzler KW. BEAMing up for detection and quantification of rare sequence variants. *Nat Methods* 2006; **3**: 95-97 [PMID: 16432518 DOI: 10.1038/nmeth850]

17 **Baker M**. Digital PCR hits its stride. *Nat Methods* 2012; **9**: 541-544.

18 **Leary RJ**, Sausen M, Kinde I, Papadopoulos N, Carpten JD, Craig D, O'Shaughnessy J, Kinzler KW, Parmigiani G, Vogelstein B, Diaz LA, Velculescu VE. Detection of chromosomal alterations in the circulation of cancer patients with whole-genome sequencing. *Sci Transl Med* 2012; **4**: 162ra154 [PMID: 23197571 DOI: 10.1126/scitranslmed.3004742]

19 **Chan KC**, Jiang P, Zheng YW, Liao GJ, Sun H, Wong J, Siu SS, Chan WC, Chan SL, Chan AT, Lai PB, Chiu RW, Lo YM. Cancer genome scanning in plasma: detection of tumor-associated copy number aberrations, single-nucleotide variants, and tumoral heterogeneity by massively parallel sequencing. *Clin Chem* 2013; **59**: 211-224 [PMID: 23065472 DOI: 10.1373/clinchem.2012.196014]

20 **Yeo ZX**, Chan M, Yap YS, Ang P, Rozen S, Lee AS. Improving indel detection specificity of the Ion Torrent PGM benchtop sequencer. *PLoS One* 2012; **7**: e45798 [PMID: 23029247 DOI: 10.1371/journal.pone.0045798]

21 **Loman NJ**, Misra RV, Dallman TJ, Constantinidou C, Gharbia SE, Wain J, Pallen MJ. Performance comparison of benchtop high-throughput sequencing platforms. *Nat Biotechnol* 2012; **30**: 434-439 [PMID: 22522955 DOI: 10.1038/nbt.2198]

22 **Takai E**, Totoki Y, Nakamura H, Morizane C, Nara S, Hama N, Suzuki M, Furukawa E, Kato M, Hayashi H, Kohno T, Ueno H, Shimada K, Okusaka T, Nakagama H, Shibata T, Yachida S. Clinical utility of circulating tumor DNA for molecular assessment in pancreatic cancer. *Sci Rep* 2015; **5**: 18425 [PMID: 26669280 DOI: 10.1038/srep18425]

23 **Kinde I**, Wu J, Papadopoulos N, Kinzler KW, Vogelstein B. Detection and quantification of rare mutations with massively parallel sequencing. *Proc Natl Acad Sci U S A* 2011; **108**: 9530-9535 [PMID: 21586637 DOI: 10.1073/pnas.1105422108]

24 **Forshew T**, Murtaza M, Parkinson C, Gale D, Tsui DW, Kaper F, Dawson SJ, Piskorz AM, Jimenez-Linan M, Bentley D, Hadfield J, May AP, Caldas C, Brenton JD, Rosenfeld N. Noninvasive identification and monitoring of cancer mutations by targeted deep sequencing of plasma DNA. *Sci Transl Med* 2012; **4**: 136ra68 [PMID: 22649089 DOI: 10.1126/scitranslmed.3003726]

25 **Newman AM**, Bratman SV, To J, Wynne JF, Eclov NC, Modlin LA, Liu CL, Neal JW, Wakelee HA, Merritt RE, Shrager JB, Loo BW, Alizadeh AA, Diehn M. An ultrasensitive method for quantitating circulating tumor DNA with broad patient coverage. *Nat Med* 2014; **20**: 548-554 [PMID: 24705333 DOI: 10.1038/nm.3519]

26 **Leary RJ**, Kinde I, Diehl F, Schmidt K, Clouser C, Duncan C, Antipova A, Lee C, McKernan K, De La Vega FM, Kinzler KW, Vogelstein B, Diaz LA, Velculescu VE. Development of personalized tumor biomarkers using massively parallel sequencing. *Sci Transl Med* 2010; **2**: 20ra14 [PMID: 20371490 DOI: 10.1126/scitranslmed.3000702]

27 **Jones S**, Zhang X, Parsons DW, Lin JC, Leary RJ, Angenendt P, Mankoo P, Carter H, Kamiyama H, Jimeno A, Hong SM, Fu B, Lin MT, Calhoun ES, Kamiyama M, Walter K, Nikolskaya T, Nikolsky Y, Hartigan J, Smith DR, Hidalgo M, Leach SD, Klein AP, Jaffee EM, Goggins M, Maitra A, Iacobuzio-Donahue C, Eshleman JR, Kern SE, Hruban RH, Karchin R, Papadopoulos N, Parmigiani G, Vogelstein B, Velculescu VE, Kinzler KW. Core signaling pathways in human pancreatic cancers revealed by global genomic analyses. *Science* 2008; **321**: 1801-1806 [PMID: 18772397 DOI: 10.1126/science.1164368]

28 **Biankin AV**, Waddell N, Kassahn KS, Gingras MC, Muthuswamy LB, Johns AL, Miller DK, Wilson PJ, Patch AM, Wu J, Chang DK, Cowley MJ, Gardiner BB, Song S, Harliwong I, Idrisoglu S, Nourse C, Nourbakhsh E, Manning S, Wani S, Gongora M, Pajic M, Scarlett CJ, Gill AJ, Pinho AV, Rooman I, Anderson M, Holmes O, Leonard C, Taylor D, Wood S, Xu Q, Nones K, Fink JL, Christ A, Bruxner T, Cloonan N, Kolle G, Newell F, Pinese M, Mead RS, Humphris JL, Kaplan W, Jones MD, Colvin EK, Nagrial AM, Humphrey ES, Chou A, Chin VT, Chantrill LA, Mawson A, Samra JS, Kench JG, Lovell JA, Daly RJ, Merrett ND, Toon C, Epari K, Nguyen NQ, Barbour A, Zeps N, Australian Pancreatic Cancer Genome I, Kakkar N, Zhao F, Wu YQ, Wang M, Muzny DM, Fisher WE, Brunicardi FC, Hodges SE, Reid JG, Drummond J, Chang K, Han Y, Lewis LR, Dinh H, Buhay CJ, Beck T, Timms L, Sam M, Begley K, Brown A, Pai D, Panchal A, Buchner N, De Borja R, Denroche RE, Yung CK, Serra S, Onetto N, Mukhopadhyay D, Tsao MS, Shaw PA, Petersen GM, Gallinger S, Hruban RH, Maitra A, Iacobuzio-Donahue CA, Schulick RD, Wolfgang CL, Morgan RA, Lawlor RT, Capelli P, Corbo V, Scardoni M, Tortora G, Tempero MA, Mann KM, Jenkins NA, Perez-Mancera PA, Adams DJ, Largaespada DA, Wessels LF, Rust AG, Stein LD, Tuveson DA, Copeland NG, Musgrove EA, Scarpa A, Eshleman JR, Hudson TJ, Sutherland RL, Wheeler DA, Pearson JV, McPherson JD, Gibbs RA, Grimmond SM. Pancreatic cancer genomes reveal aberrations in axon guidance pathway genes. *Nature* 2012; **491**: 399-405 [PMID: 23103869 DOI: 10.1038/nature11547]

29 **Waddell N**, Pajic M, Patch AM, Chang DK, Kassahn KS, Bailey P, Johns AL, Miller D, Nones K, Quek K, Quinn MC, Robertson AJ, Fadlullah MZ, Bruxner TJ, Christ AN, Harliwong I, Idrisoglu S, Manning S, Nourse C, Nourbakhsh E, Wani S, Wilson PJ, Markham E, Cloonan N, Anderson MJ, Fink JL, Holmes O, Kazakoff SH, Leonard C, Newell F, Poudel B, Song S, Taylor D, Waddell N, Wood S, Xu Q, Wu J, Pinese M, Cowley MJ, Lee HC, Jones MD, Nagrial AM, Humphris J, Chantrill LA, Chin V, Steinmann AM, Mawson A, Humphrey ES, Colvin EK, Chou A, Scarlett CJ, Pinho AV, Giry-Laterriere M, Rooman I, Samra JS, Kench JG, Pettitt JA, Merrett ND, Toon C, Epari K, Nguyen NQ, Barbour A, Zeps N, Jamieson NB, Graham JS, Niclou SP, Bjerkvig R, Grützmann R, Aust D, Hruban RH, Maitra A, Iacobuzio-Donahue CA, Wolfgang CL, Morgan RA, Lawlor RT, Corbo V, Bassi C, Falconi M, Zamboni G, Tortora G, Tempero MA, Gill AJ, Eshleman JR, Pilarsky C, Scarpa A, Musgrove EA, Pearson JV, Biankin AV, Grimmond SM. Whole genomes redefine the mutational landscape of pancreatic cancer. *Nature* 2015; **518**: 495-501 [PMID: 25719666 DOI: 10.1038/nature14169]

30 **Bailey P**, Chang DK, Nones K, Johns AL, Patch AM, Gingras MC, Miller DK, Christ AN, Bruxner TJ, Quinn MC, Nourse C, Murtaugh LC, Harliwong I, Idrisoglu S, Manning S, Nourbakhsh E, Wani S, Fink L, Holmes O, Chin V, Anderson MJ, Kazakoff S, Leonard C, Newell F, Waddell N, Wood S, Xu Q, Wilson PJ, Cloonan N, Kassahn KS, Taylor D, Quek K, Robertson A, Pantano L, Mincarelli L, Sanchez LN, Evers L, Wu J, Pinese M, Cowley MJ, Jones MD, Colvin EK, Nagrial AM, Humphrey ES, Chantrill LA, Mawson A, Humphris J, Chou A, Pajic M, Scarlett CJ, Pinho AV, Giry-Laterriere M, Rooman I, Samra JS, Kench JG, Lovell JA, Merrett ND, Toon CW, Epari K, Nguyen NQ, Barbour A, Zeps N, Moran-Jones K, Jamieson NB, Graham JS, Duthie F, Oien K, Hair J, Grützmann R, Maitra A, Iacobuzio-Donahue CA, Wolfgang CL, Morgan RA, Lawlor RT, Corbo V, Bassi C, Rusev B, Capelli P, Salvia R, Tortora G, Mukhopadhyay D, Petersen GM, Munzy DM, Fisher WE, Karim SA, Eshleman JR, Hruban RH, Pilarsky C, Morton JP, Sansom OJ, Scarpa A, Musgrove EA, Bailey UM, Hofmann O, Sutherland RL, Wheeler DA, Gill AJ, Gibbs RA, Pearson JV, Waddell N, Biankin AV, Grimmond SM. Genomic analyses identify molecular subtypes of pancreatic cancer. *Nature* 2016; **531**: 47-52 [PMID: 26909576 DOI: 10.1038/nature16965]

31 **Maire F**, Micard S, Hammel P, Voitot H, Lévy P, Cugnenc PH, Ruszniewski P, Puig PL. Differential diagnosis between chronic pancreatitis and pancreatic cancer: value of the detection of KRAS2 mutations in circulating DNA. *Br J Cancer* 2002; **87**: 551-554 [PMID: 12189555 DOI: 10.1038/sj.bjc.6600475]

32 **Däbritz J**, Preston R, Hänfler J, Oettle H. K-ras mutations in the plasma correspond to computed tomographic findings in patients with pancreatic cancer. *Pancreas* 2012; **41**: 323-325 [PMID: 22044911 DOI: 10.1097/MPA.0b013e3182289118]

33 **Chen H**, Tu H, Meng ZQ, Chen Z, Wang P, Liu LM. K-ras mutational status predicts poor prognosis in unresectable pancreatic cancer. *Eur J Surg Oncol* 2010; **36**: 657-662 [PMID: 20542658 DOI: 10.1016/j.ejso.2010.05.014]

34 **Kinugasa H**, Nouso K, Miyahara K, Morimoto Y, Dohi C, Tsutsumi K, Kato H, Matsubara T, Okada H, Yamamoto K. Detection of K-ras gene mutation by liquid biopsy in patients with pancreatic cancer. *Cancer* 2015; **121**: 2271-2280 [PMID: 25823825 DOI: 10.1002/cncr.29364]

35 **Sausen M**, Phallen J, Adleff V, Jones S, Leary RJ, Barrett MT, Anagnostou V, Parpart-Li S, Murphy D, Kay Li Q, Hruban CA, Scharpf R, White JR, O'Dwyer PJ, Allen PJ, Eshleman JR, Thompson CB, Klimstra DS, Linehan DC, Maitra A, Hruban RH, Diaz LA, Von Hoff DD, Johansen JS, Drebin JA, Velculescu VE. Clinical implications of genomic alterations in the tumour and circulation of pancreatic cancer patients. *Nat Commun* 2015; **6**: 7686 [PMID: 26154128 DOI: 10.1038/ncomms8686]

36 **Tjensvoll K**, Lapin M, Buhl T, Oltedal S, Steen-Ottosen Berry K, Gilje B, Søreide JA, Javle M, Nordgård O, Smaaland R. Clinical relevance of circulating KRAS mutated DNA in plasma from patients with advanced pancreatic cancer. *Mol Oncol* 2016; **10**: 635-643 [PMID: 26725968 DOI: 10.1016/j.molonc.2015.11.012]

37 **Jones S**, Anagnostou V, Lytle K, Parpart-Li S, Nesselbush M, Riley DR, Shukla M, Chesnick B, Kadan M, Papp E, Galens KG, Murphy D, Zhang T, Kann L, Sausen M, Angiuoli SV, Diaz LA, Velculescu VE. Personalized genomic analyses for cancer mutation discovery and interpretation. *Sci Transl Med* 2015; **7**: 283ra53 [PMID: 25877891 DOI: 10.1126/scitranslmed.aaa7161]

38 **Frampton GM**, Fichtenholtz A, Otto GA, Wang K, Downing SR, He J, Schnall-Levin M, White J, Sanford EM, An P, Sun J, Juhn F, Brennan K, Iwanik K, Maillet A, Buell J, White E, Zhao M, Balasubramanian S, Terzic S, Richards T, Banning V, Garcia L, Mahoney K, Zwirko Z, Donahue A, Beltran H, Mosquera JM, Rubin MA, Dogan S, Hedvat CV, Berger MF, Pusztai L, Lechner M, Boshoff C, Jarosz M, Vietz C, Parker A, Miller VA, Ross JS, Curran J, Cronin MT, Stephens PJ, Lipson D, Yelensky R. Development and validation of a clinical cancer genomic profiling test based on massively parallel DNA sequencing. *Nat Biotechnol* 2013; **31**: 1023-1031 [PMID: 24142049 DOI: 10.1038/nbt.2696]

39 **Zill OA**, Greene C, Sebisanovic D, Siew LM, Leng J, Vu M, Hendifar AE, Wang Z, Atreya CE, Kelley RK, Van Loon K, Ko AH, Tempero MA, Bivona TG, Munster PN, Talasaz A, Collisson EA. Cell-Free DNA Next-Generation Sequencing in Pancreatobiliary Carcinomas. *Cancer Discov* 2015; **5**: 1040-1048 [PMID: 26109333 DOI: 10.1158/2159-8290.CD-15-0274]

40 **Kukita Y**, Matoba R, Uchida J, Hamakawa T, Doki Y, Imamura F, Kato K. High-fidelity target sequencing of individual molecules identified using barcode sequences: de novo detection and absolute quantitation of mutations in plasma cell-free DNA from cancer patients. *DNA Res* 2015; **22**: 269-277 [PMID: 26126624 DOI: 10.1093/dnares/dsv010]

41 **Newman AM**, Lovejoy AF, Klass DM, Kurtz DM, Chabon JJ, Scherer F, Stehr H, Liu CL, Bratman SV, Say C, Zhou L, Carter JN, West RB, Sledge GW, Shrager JB, Loo BW, Neal JW, Wakelee HA, Diehn M, Alizadeh AA. Integrated digital error suppression for improved detection of circulating tumor DNA. *Nat Biotechnol* 2016; **34**: 547-555 [PMID: 27018799 DOI: 10.1038/nbt.3520]

42 **Beaver JA**, Jelovac D, Balukrishna S, Cochran RL, Croessmann S, Zabransky DJ, Wong HY, Valda Toro P, Cidado J, Blair BG, Chu D, Burns T, Higgins MJ, Stearns V, Jacobs L, Habibi M, Lange J, Hurley PJ, Lauring J, VanDenBerg DA, Kessler J, Jeter S, Samuels ML, Maar D, Cope L, Cimino-Mathews A, Argani P, Wolff AC, Park BH. Detection of cancer DNA in plasma of patients with early-stage breast cancer. *Clin Cancer Res* 2014; **20**: 2643-2650 [PMID: 24504125 DOI: 10.1158/1078-0432.CCR-13-2933]

43 **Shi C**, Fukushima N, Abe T, Bian Y, Hua L, Wendelburg BJ, Yeo CJ, Hruban RH, Goggins MG, Eshleman JR. Sensitive and quantitative detection of KRAS2 gene mutations in pancreatic duct juice differentiates patients with pancreatic cancer from chronic pancreatitis, potential for early detection. *Cancer Biol Ther* 2008; **7**: 353-360 [PMID: 18075308]

44 **Eshleman JR**, Norris AL, Sadakari Y, Debeljak M, Borges M, Harrington C, Lin E, Brant A, Barkley T, Almario JA, Topazian M, Farrell J, Syngal S, Lee JH, Yu J, Hruban RH, Kanda M, Canto MI, Goggins M. KRAS and guanine nucleotide-binding protein mutations in pancreatic juice collected from the duodenum of patients at high risk for neoplasia undergoing endoscopic ultrasound. *Clin Gastroenterol Hepatol* 2015; **13**: 963-9.e4 [PMID: 25481712 DOI: 10.1016/j.cgh.2014.11.028]

45 **Baylin SB**, Ohm JE. Epigenetic gene silencing in cancer - a mechanism for early oncogenic pathway addiction? *Nat Rev Cancer* 2006; **6**: 107-116 [PMID: 16491070 DOI: 10.1038/nrc1799]

46 **Fukushige S**, Horii A. Road to early detection of pancreatic cancer: Attempts to utilize epigenetic biomarkers. *Cancer Lett* 2014; **342**: 231-237 [PMID: 22450751 DOI: 10.1016/j.canlet.2012.03.022]

47 **Matsubayashi H**, Canto M, Sato N, Klein A, Abe T, Yamashita K, Yeo CJ, Kalloo A, Hruban R, Goggins M. DNA methylation alterations in the pancreatic juice of patients with suspected pancreatic disease. *Cancer Res* 2006; **66**: 1208-1217 [PMID: 16424060 DOI: 10.1158/0008-5472.CAN-05-2664]

48 **Yi JM**, Guzzetta AA, Bailey VJ, Downing SR, Van Neste L, Chiappinelli KB, Keeley BP, Stark A, Herrera A, Wolfgang C, Pappou EP, Iacobuzio-Donahue CA, Goggins MG, Herman JG, Wang TH, Baylin SB, Ahuja N. Novel methylation biomarker panel for the early detection of pancreatic cancer. *Clin Cancer Res* 2013; **19**: 6544-6555 [PMID: 24088737 DOI: 10.1158/1078-0432.CCR-12-3224]

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**Figure 1 Liquid biopsy for pancreatic cancer.** Circulating tumor DNA (ctDNA) can be isolated from plasma as a liquid biopsy approach. Genomic alterations detected could then have various clinical applications in pancreatic cancer cases. As ctDNA is released not only from primary tumors, but also metastases, its analysis might overcome the problem of tumor heterogeneity.