Supplementary File 1
Questions of the survey

Q1 What is your speciality? (single answer)
- Medical Oncology
- Radiation Oncology
- General Surgery
- HPB surgery
- Other (please specify)

Q2 Through which association did you receive this survey? (single answer)
- E-AHPBA
- EORTC

Q3 For how long have you been treating patients with pancreatic cancer? (single answer)
- <5 years
- 5-10 years
- >10 years

Q4 What does borderline resectable mean to you? (multiple answers possible)
- The primary tumor can only be resected by surgeons with particular expertise
- The resection of the primary tumor inherits a high risk for (incomplete) R1 resection
- The tumor can be resected R0, but the oncological outcome after surgery is questionable
- The morbidity of a resection of the primary tumor exceeds the normal morbidity by far
- Is not important – either a tumor is resectable or not

Q5 What defines borderline resectability in your opinion? (multiple answers possible)
- Tumor contact to the portal (PV)/superior mesenteric (SMV) veins on imaging – likelihood of a PV/SMV resection
- Tumor contact to the hepatic or mesenteric arteries on imaging
- Tumor contact to the PV/SMV up to 180° on imaging
- Tumor contact to celiac, hepatic or mesenteric arteries up to 180° on imaging
- Tumor contact to the PV/SMV of more than 180° on preoperative imaging
- Tumor contact to the celiac/hepatic or superior mesenteric arteries of more than 180° on imaging
- Tumor related portal vein thrombosis on imaging
- Resectability cannot be assessed on imaging only
- Other (please specify)

Q6 What defines locally advanced disease in your opinion? (multiple answers possible)
- Locally advanced disease is equivalent to borderline resectability
- Locally advanced disease means a locally resectable disease with infiltration of mesenteric vascular structures
- Locally advanced disease describes a locally unresectable disease without evidence of metastases

Q7 Which of the following treatment aims hold true for patients with pancreatic cancer? (multiple answers possible)
- Palliative treatment – relief of symptoms
- Palliative treatment – patient cure possible
- Adjuvant treatment – reducing the risk of disease recurrence after complete tumor resection
- Adjuvant treatment – any treatment after surgery
Q8 Which treatment aims do you associate with neoadjuvant therapy for pancreatic cancer? (multiple answers possible)
- preoperative treatment of micrometastases
- achieving secondary resectability in locally unresectable disease
- achieving resectability/disease stabilization in oligometastasized disease with the aim of surgical treatment
- increasing the R0 resection rate (e.g. in borderline resectable cancer)
- decreasing the risk of distant metastases after an apparently curative resection by a preoperative treatment
- increasing the size of the resection margin (in resectable or borderline resectable cancer)

Q9 What are the theoretical advantages of neoadjuvant over adjuvant treatment?
(multiple answers possible)
- better treatment tolerability of neoadjuvant treatment
- higher dosage possible during neoadjuvant treatment
- lower surgical complication rate after neoadjuvant treatment
- better oncological patient selection by neoadjuvant treatment (patients with progressive disease under neoadjuvant treatment are excluded)
- better vascular supply of the tumor for neoadjuvant treatment