

Diagnosis and Prognosis of Pancreatic Cystic Lesions

Ciara Warfvinge*

Department of Digestive Diseases and Internal Medicine, Sant Orsola-Malpighi Hospital Bologna, Emilia-Romagna, Italy

DESCRIPTION

There are no general guidelines for assessing and treating pancreatic cystic lesions. A pancreatic cystic tumour should be distinguished from a pseudocyst (10%-37% false diagnosis rate). Following that, using clinical presentation, patient age, sex, imaging findings, and Endoscopic Ultrasound-guided Fine-Needle Aspiration Biopsy (EUS-FNA) results as indicators, one should attempt to identify the cystic tumour type and malignant potential. Imaging studies like helical CT and Magnetic Resonance Imaging (MRI) with Magnetic Resonance Cholangiopancreatography (MRCP) provide valuable information. EUS is a valuable diagnostic tool for pancreatic disease because it can look not only at the lesion (number and size of cysts, solid components, papillary projections, number and thickness of septa, mural nodules, etc.), but also at the remaining pancreatic parenchyma for additional abnormalities. EUS is also used as a preoperative tool to look for signs of malignancy and to clearly define the size, margins, and potential communication with the pancreatic ductal system. Mural nodules within the cyst, focal wall thickening, adjacent solid component, and collateral vessels should all raise the possibility of cancer. The presence or absence of at least two of three features (mural nodules, septa, and parenchymal changes) provided sensitivity and specificity of 94% and 85% for the presence or absence of malignancy, respectively.

A new EUS-based scoring system for predicting malignancy in BDT-IPMN (Branch Duct Tumors-Intraductal Papillary Mucinous Neoplasm) patients has been suggested. It has been suggested that for patients under the age of 65, a lesion of 2 cm can be used to determine more aggressive management, whereas for older patients, a lesion of 3 cm without the presence of mural nodules can be observed. The risks of cancer must always be

balanced against the risks of pancreatic surgery. Pancreatic cysts 3 cm in size without a solid component or dilated pancreatic ducts should be re-evaluated by MRI in 1 year and every 2 years thereafter for a total of 5 years if there is no change in size and other features, according to their recommendations. Cysts with two or more high-risk characteristics, such as a dilated main pancreatic duct, a size greater than 3 cm, or the presence of a solid component, should, on the other hand, be subjected to EUS-FNA, as well as suspicious findings on EUS and EUS-FNA, should have the cystic lesion surgically resected to reduce cancer mortality. A streamlined algorithm for monitoring and treating pancreatic cystic neoplasms is suggested. The EUS-FNA technique is the same for solid and cystic lesions. Broad-spectrum antibiotic prophylaxis is recommended for cystic lesions prior to puncture and should be continued for at least 48 hours. To avoid complications, try to aspirate all of the cystic fluid with a single needle pass. Molecular analysis of cyst fluid aspiration is being studied as a diagnostic tool for the risk assessment of cystic pancreatic neoplasms, particularly for smaller cysts that do not meet resection size criteria.

CONCLUSION

The sensitivity of cytology varies according to the endoscopist's and cytologist's expertise. Because of sampling error, some cytology specimens are false negative. To improve diagnostic accuracy, cytology should be supplemented with measurements of CEA, amylase levels, and mucin stain. The measurement of CEA in the fluid is especially useful for distinguishing serous from mucinous lesions, but there may be some overlap. A CEA level of 5 ng/mL indicates a serous cystadenoma, whereas values >400 ng/mL have nearly 100% specificity in distinguishing mucinous cystic neoplasms from pseudocysts.

Correspondence to: Ciara Warfvinge, Department of Digestive Diseases and Internal Medicine, Sant Orsola-Malpighi Hospital Bologna, Emilia-Romagna, Italy, E-mail: Ciarawarv@uci.edu

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