

for your digestion

October 2012 Vol. II, Ed. II

Pancreatic cyst discovered on CT: reassurance, EUS, surgery or hospice?

By Jonathan Myers, D.O., Eugene Gastroenterology Consultants, P.C.

Over the past few decades, cross-sectional imaging, such as CT and MRI, has become increasingly common and sharper in resolution.

Consequently, we are seeing a jump in incidental discoveries of cystic lesions of the pancreas, found in 1 to 3 percent of CTs and up to 20 percent of MRIs.

As a primary care provider, you will probably face the dilemma of what to do when these lesions are discovered. Do you reassure the patient that the cyst is “probably benign” and requires no further action? Do you send the patient for GI consultation? Or do you refer this person to your favorite surgeon for possible resection?

The choices are difficult, and the consequences profound.

We'll focus here on cystic neoplasms of the pancreas. Pseudocysts (commonly following pancreatitis) and solid pancreatic masses are excluded here for sake of brevity.

Pancreatic cystic neoplasms can be categorized broadly: benign, malignant and potentially malignant. Within the benign category is only one entity: serous cystadenoma (SCA). Mucinous cystic lesions are those

that are either malignant or potentially malignant: intraductal papillary mucinous neoplasms (IPMN), mucinous cystic neoplasm (MCN) and solid pseudopapillary tumors (SPT). (See Table 1 for a comparison of these entities.)

As clinicians, typically we are confronted not with a pathologic diagnosis, but with a radiology report: “There is a 2 cm cystic lesion in the tail of the pancreas. Cannot rule out malignancy. Further imaging is recommended.”

There are some radiographic features that are more characteristic (but rarely pathognomonic) of either benign or malignant lesions. For instance, the benign SCA classically appears as a focal, well-demarcated lesion with either honey-combed appearance or central scar (“sunburst” calcification). Conversely, any solid component adjacent to a cyst, peripheral “eggshell” calcification or associated dilation of the pancreatic duct may indicate malignancy and would warrant an aggressive approach.

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We invite your comments and suggestions for topics in future editions. Also, if you would rather receive this newsletter electronically or not at all, email newsletter@eugeneGI.com.



Dr. Myers – with wife, Gabby, and their dog, Sam (right) – on a beach at Hickam Air Force Base in Hawaii last year.

Meet Dr. Jonathan Myers, D.O.

Dr. Myers joined Eugene Gastroenterology Consultants in July after serving 11 years as a U.S. Army physician. His military career included an 8-month tour in Iraq in 2009-10. He was awarded a Bronze Star during his service there. Gregarious and enthusiastic, Dr. Myers helps patients better understand their conditions. He believes this shared knowledge is a crucial part of treatment, and makes it easier for patients and doctors to work together to keep problems under control. When he is not working, he enjoys spending time with his wife, Gabby, and his dog, Sam. He plays racquetball, likes mountain biking and enjoys being outdoors.

Table 1. Key Features of Neoplastic Pancreatic Cysts

	Intraductal Papillary Mucinous Neoplasms	Mucinous Cystic Neoplasms	Serous Cystadenomas	Solid Pseudopapillary Tumors
Gender	Male = Female	Female>Male	Female>Male	Female>Male
Typical age	7th decade	5th – 7th decades	7th decade	2nd – 3rd decades
Symptoms	None; abdominal pain, pancreatitis; weight loss	None; abdominal pain, palpable mass	Usually none; abdominal pain, palpable mass	Usually none; abdominal pain, palpable mass
Findings on imaging	Dilated pancreatic duct; solid component may suggest cancer	Unilocular cyst; septations and calcification may be present	Microcystic/honey-comb with central scar	Solid and cystic mass
Malignant potential	Yes	Yes	No	Yes
Treatment	Pancreatic resection in main duct IPMN; consider resection in branch IPMN versus close observation	Resection	Resection only if symptomatic	Resection

Modified from ACG Practice Guidelines for the Diagnosis and Management of Neoplastic Pancreatic Cysts. Am J Gastro 2007; 102: 2340





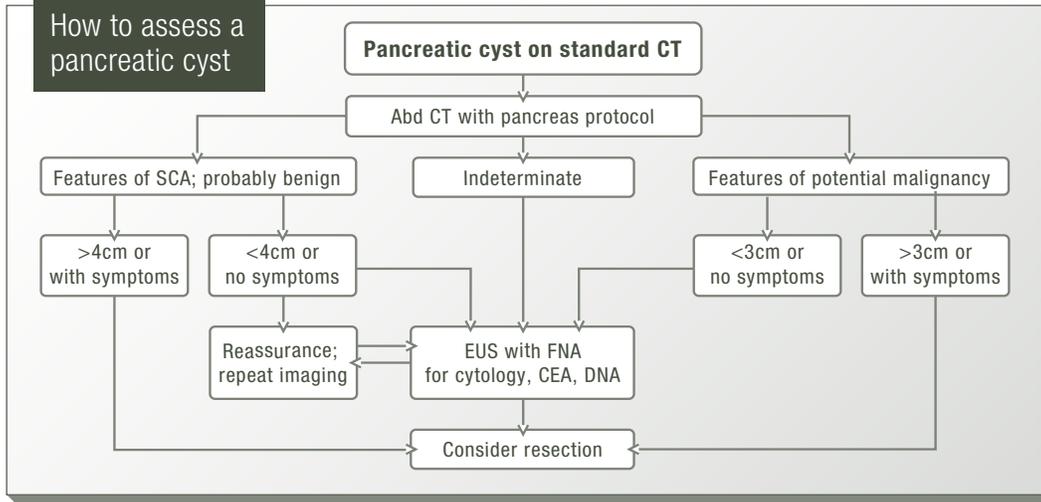
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Management options for cystic pancreatic lesions range from simple observation with repeat imaging to total pancreatectomy. In cases of less certainty, additional testing may be indicated. The most useful evaluation is endoscopic ultrasound with fine-needle

aspiration (EUS with FNA). EUS with FNA has essentially replaced ERCP and MRCP, since these latter two modalities primarily assess ductal anatomy with less precision than EUS.

To assist you in evaluating patients with cystic lesions of the pancreas, we offer an algorithm (see Table 2).

Table 2.



Thank you, Dr. Knecht!

Eugene Gastroenterology Consultants would like to honor Dr. Gregory Knecht on his retirement after 35 fruitful years of service. Beginning Oct. 1, Dr. Knecht will no longer see patients for ongoing care, although he will still perform a limited number of procedures on his established patients. We would like to wish Dr. Knecht the very best during his well-earned retirement. His wisdom, knowledge, enthusiasm and masterful skills will be greatly missed as he enters this new chapter in life.



EGC's Dr. Gregory Knecht with medical office assistants (left to right) Sara, Sheri, Erin and Jan.