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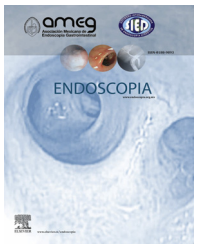

CLINICAL CASE

Intraductal papillary mucinous neoplasia and pancreatic cancer: A rare but real association

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KEYWORDS
Intraductal papillary mucinous neoplasm;
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Abstract The management of patients with an incidentally detected pancreatic cyst is a significant clinical challenge. More than 80% are detected as incidental findings on CT scan or MRI. A case is presented of a 41-year-old patient with an asymptomatic pancreatic cyst which was detected during a check-up.

PALABRAS CLAVE
Neoplasia papilar mucinosa intraductal;
Páncreas;
Diagnóstico;
Tumores;
Tomografía computarizada

Neoplasia papilar mucinosa intraductal y desarrollo de cáncer de páncreas: poco frecuente pero real

Resumen El tratamiento de los pacientes con un quiste pancreático incidentalmente detectado es un reto clínico considerable. Más del 80% son detectados como hallazgos incidentales durante la realización de una TAC o RM. Presentamos un caso de un paciente de 41 años con un quiste pancreático asintomático detectado durante una revisión.

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Introduction

Intraductal papillary mucinous neoplasia (IPMNs) was first described in 1982. Since then, its classification and management have evolved dramatically.[1] The true prevalence of IPMNs is unknown. Most patients are asymptomatic at the time of diagnosis, and the cysts are usually discovered as an incidental finding on imaging.[2] The use of computed tomography (CT) and magnetic resonance imaging (MRI) may partially explain the recent rise in prevalence of these lesions.[3] The detection rate of pancreatic cysts by conventional MRI has been estimated to be as high as 13.5% in asymptomatic populations.[4] IPMNs represent about 20–50% of all pancreatic cystic neoplasms and 38% of resected pancreatic cysts. The average age of diagnosis peaks at 60–70 years old, with a slightly higher prevalence in men and with recurrent acute pancreatitis without recognized biliary or alcoholic etiology as the most frequent expression.[5] There are three varieties, the main duct tumor (MDT), the branch duct tumor (BDT), and mixed, having different incidences of malignancy and prognoses.[6] The MDT has a frequency malignancy of 62% (36–100%) and BDT has a 2–3% of malignancy annual risk.[7] At the time of diagnostics of IPMNs, approximately 10–20% of cases harbor invasive carcinoma, 10–20% in situ carcinoma, and the remaining 60–80% intraductal or intracystic adenoma with low degree dysplasia. There are some risk factors for malignancy in IPMNs such as size $\geq$3 cm, a dilated main pancreatic duct, or the presence of an associated solid component, and if there present more than 2 risk factors, should be performed de EUS–FNA that has a sensitivity of approximately 60% and a specificity of 90% for the risk of malignancy in IPMNs.[8] The molecular analyses of the cyst fluid for diagnosis are still evolving and there is not marker that distinguishes benign from malignant.[7] Histologically, the gastric type is typically low grade, with normally small percentage developing into carcinoma, although if a carcinoma does develop in these patients, it is usually of the tubular type and behaves a conventional pancreatic ductal adenocarcinoma. In the published series, resectability in patients with IPMNs was 90–100%, while mortality and morbidity in patients with cancer related to IPMN were similar to those related to pancreatic surgery for ductal adenocarcinoma. Five-year survival is 100% for adenomas, 80–90% for in situ carcinomas, and 50–70% for invasive carcinomas.[8–10] Therefore, an integral approach is important to make a correct diagnosis and initiate the proper management as soon as possible.

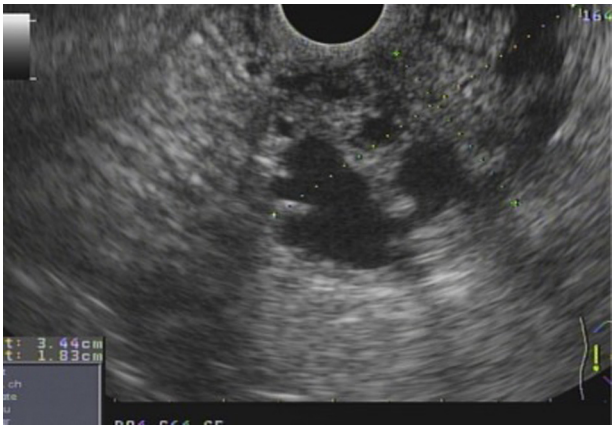

Figure 2 EUS-FNA reported a cystic tumor in the pancreas head with a diameter of 3.4 × 3.2 cm, without vascular involvement, and with no communication with the pancreatic duct observed.

Case presentation

In November 2014, a 41-year-old female with an asymptomatic history was admitted for general check-up. She had relevant health record, and on physical examination the only thing that stood out was a BMI of 27 kg/m^2. During studies, non-contrast CT detected a hypodense cystic lesion located in the head and uncinate process of the pancreas that measured 20 × 11 mm (Fig. 1). In January 2015, an endoscopic ultrasonography-guided fine-needle aspiration (EUS-FNA) was made, with a heterogeneous cystic tumor, with solid part, located in the head of the pancreas without

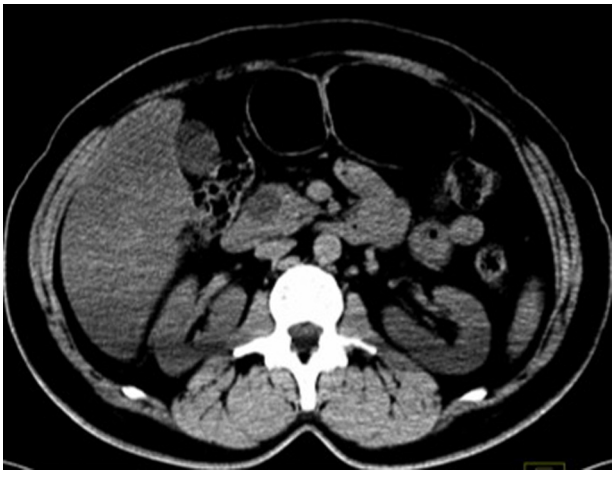

Figure 1 CT scan with hypodense cystic lesion located in the head and uncinate process of the pancreas that measures 20 × 11 mm.

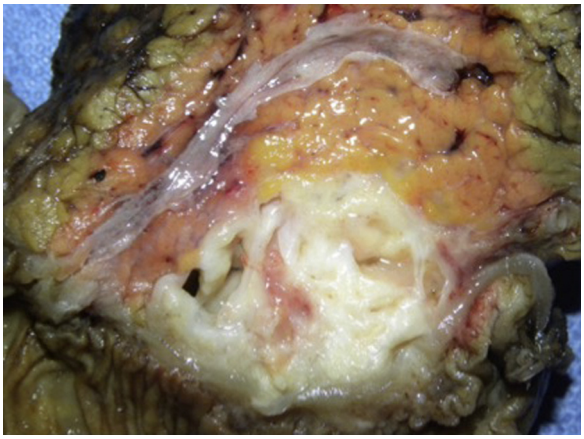

Figure 3 The histopathological findings were compatible with infiltrative ductal adenocarcinoma of intestinal type originating in intraductal papillary mucinous neoplasia with dysplasia high and low degree.