

Therapeutic Approach to Cystic Neoplasms of the Pancreas



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KEYWORDS

- Pancreatic cysts • IPMN • Serous cystadenoma • Mucinous cystic neoplasms
- Pancreatectomy

KEY POINTS

- Resection should be considered whenever the risk of malignancy is higher than the risk of the operation.
- Serous cystadenomas are considered benign and should be followed radiographically, unless symptomatic.
- Mucinous cystic neoplasms are typically resected as they are most frequently seen in young women and typically occur in the pancreatic body or tail.
- Management of branch duct IPMN is selective with resection indicated for symptomatic lesions and those with high risk or worrisome features.
- Main duct IPMN should generally be resected as there is presumed risk of high-grade dysplasia or invasive disease.

INTRODUCTION

Cystic neoplasms of the pancreas are being diagnosed more frequently given the widespread use of high-quality imaging studies (computed tomography [CT] and MRI). The reported prevalence of incidental pancreatic cysts is about 2.6% on CT imaging and has been reported as high as 13.5% on MRI.^{1,2}

The 3 most common subtypes of cystic neoplasms are serous cystadenoma (SCA), mucinous cystic neoplasm (MCN), and intraductal papillary mucinous neoplasm (IPMN). The latter represent most neoplastic cystic lesions and are of particular

The authors have nothing to disclose.

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Surg Oncol Clin N Am 25 (2016) 351–361
<http://dx.doi.org/10.1016/j.soc.2015.11.006>

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importance to surgeons because these lesions are considered precancerous. IPMN and MCN represent the only radiographically identifiable precursor lesions of pancreatic cancer.³ For detailed discussion of the different classifications, subtypes, and diagnostic evaluation of cystic neoplasms, (See [Ferrone CR: Spectrum and Classification of Cystic Neoplasms of the Pancreas](#), in this issue).

Management of cystic neoplasms of the pancreas is challenging because it involves decision making in the setting of imperfect diagnostic information. The decision between operative resection and radiographic surveillance must balance the risk of a significant operative procedure that has measurable associated mortality with the risk of malignant progression if radiographic surveillance is chosen.

Resection of all pancreatic cysts is no longer appropriate. The vast majority of lesions now identified are asymptomatic, small (<2 cm), and benign. The risk of malignant progression in this group of patients is lower than the risk of operative resection.³

This article focuses on the therapeutic approach to the 3 major subtypes of cystic neoplasms of the pancreas (IPMN, MCN, and SCA), with the understanding that determining the histopathology of a given cystic lesion, based on imaging and cyst fluid analysis, is considered the cornerstone for managing these cysts. Treatment recommendations are usually based on the natural history, biological behavior, and risk of malignancy for each histologic subtype ([Fig. 1](#)). Histopathology of small cysts can be hard to determine without resection and represent a clinical dilemma.

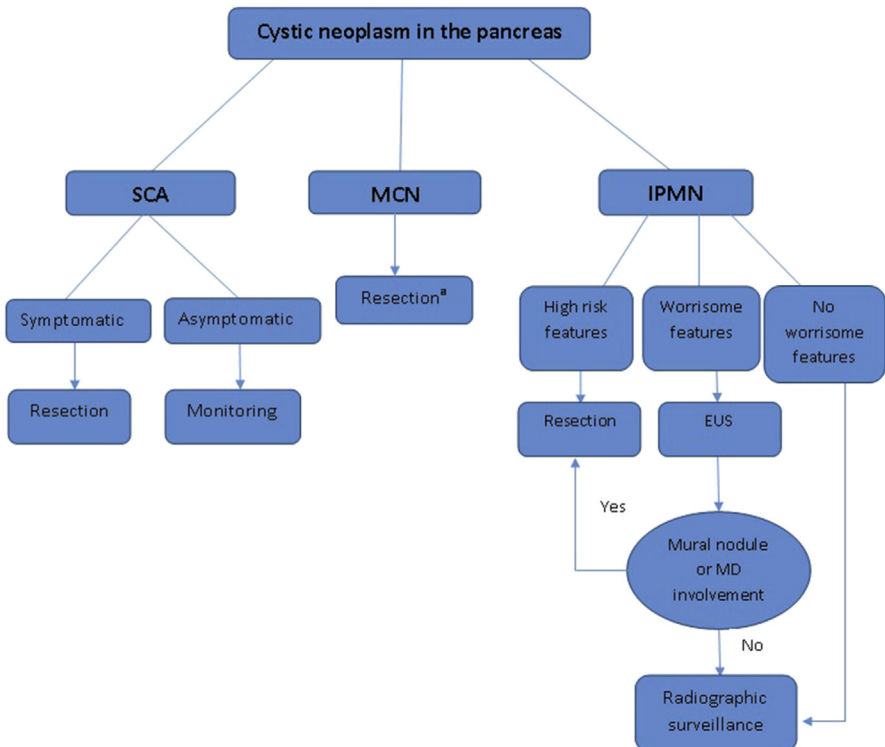


Fig. 1. Overview of management of different types of cystic neoplasms of the pancreas. EUS, endoscopic ultrasound; MD, main duct. ^a Monitoring in elderly with no worrisome features.

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