



How Long Should Patients with Cystic Lesions of the Pancreas Be Followed?

Caitlin A. McIntyre, MD, Peter J. Allen, MD*

Department of Surgery, Hepatopancreatobiliary Service, Memorial Sloan Kettering Cancer Center, 1275 York Avenue, New York, NY 10065, USA

Keywords

• Pancreatic cyst • IPMN • Mucinous cystic neoplasm • Surveillance • Resection

Key points

- Pancreatic cystic neoplasms with a low risk for malignancy should undergo initial radiologic surveillance, and resection is indicated if high-risk features develop within the cyst.
- Surveillance should be continued indefinitely for patients with suspected mucinous neoplasms, as the risk of developing invasive carcinoma does not seem to decrease over time.
- Patients who undergo partial pancreatectomy for noninvasive intraductal papillary mucinous neoplasms are at an increased risk for both disease recurrence and pancreatic cancer in their pancreatic remnant; thus, long-term surveillance is recommended.
- Surgical resection for noninvasive mucinous cystic neoplasms is curative, and patients do not have a documented increase in risk in their pancreatic remnant.
- Patients with presumed serous cystadenoma should be monitored for local growth.

INTRODUCTION

Pancreatic cystic lesions have been increasingly identified on cross-sectional imaging studies and have been reported to be present in approximately 2.6% of patients who have undergone computed tomography (CT) imaging and up

Disclosures: The authors have nothing to disclose.

*Corresponding author. Department of Surgery, Hepatopancreatobiliary Service, Memorial Sloan Kettering Cancer Center, 1275 York Avenue, C-896, New York, NY 10065. *E-mail address:* allenp@mskcc.org

to 13.5% of patients who have undergone MRI studies performed for reasons unrelated to the pancreas [1,2]. Many of these lesions will be precancerous in nature; because of this, there has been an increased focus on the management of asymptomatic pancreatic cysts. Pancreatic cystic neoplasms (PCNs) include malignant, premalignant, and benign lesions and are managed based on their presumed biological behavior. Premalignant pancreatic cysts are precursors to pancreatic cancer and include mucinous cystic neoplasms (MCNs) and intraductal papillary mucinous neoplasms (IPMNs). Benign lesions, such as serous cystadenoma (SCA), are presumed to have nil metastatic potential; however, even these may increase in size and cause local symptoms, such as biliary or gastric outlet obstruction.

MCNs are defined by ovarian-type stroma on pathologic evaluation and are, thus, almost exclusively seen in women. These neoplasms are most typically unilocular, present as a single lesion, and most commonly detected in the fifth decade of life [3]. Both MCNs and IPMNs produce mucin but differ with respect to their histopathologic appearance and in their connection with the pancreatic ductal system. MCNs do not typically have direct communication with the pancreatic duct. Up to 12% of resected MCNs harbor invasive carcinoma; the risk of malignancy has been reported to correlate with increased cyst size, age, and the presence of a nodule [4–6]. Patients with both noninvasive and microinvasive disease experience excellent long-term disease-specific outcomes, and surgical resection is curative in this subset of patients [4,7].

IPMNs are the most common cystic lesion of the pancreas accounting for approximately 35% of pancreatic cysts [8]. IPMNs are well-established precursors to pancreatic ductal adenocarcinoma. In contrast to MCN, these lesions are more commonly found in males and older patients and may be seen throughout the gland [3]. IPMNs may contain a spectrum of low-grade, moderate-grade or high-grade dysplasia and can progress to invasive carcinoma. Radiographically, these have been classified according to their involvement with the ductal system and are typically classified as main-duct IPMN (MD-IPMN), branch-duct IPMN (BD-IPMN), or mixed-duct IPMN based on whether the main pancreatic duct is dilated. The importance of this classification system is that the risk of high-grade dysplasia or invasive carcinoma differs based on main duct involvement. This risk is highest in those with MD-IPMN, with the risk of invasive disease being approximately 25% to 40%. In patients with BD-IPMN, this risk is between 15% and 20% in resected patients [9]. Patients with IPMN-associated carcinoma have been reported to experience significant heterogeneity in a long-term disease-specific outcome. This outcome depends on the histopathologic form of carcinoma (tubular vs colloid) and the stage of disease at presentation [10,11].

Serous cystic neoplasms (SCNs) are predominantly benign cystic lesions of the pancreas most commonly seen in women and distributed uniformly throughout the pancreas [12]. They are characterized by a distinctive honeycomb pattern on CT and do not connect with the pancreatic duct. Most of these lesions have an indolent course; less than 30 cases of invasive serous

Download English Version:

<https://daneshyari.com/en/article/8830490>

Download Persian Version:

<https://daneshyari.com/article/8830490>

[Daneshyari.com](https://daneshyari.com)