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Editorial

Perplexity in Diagnosis of Pancreatic Lesions

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Cystic lesions of Pancreas are always challenging for Gastroenterologist. In the recent past cystic lesions of pancreas remained undiagnosed and number of patients were diagnosed after surgery. But in new era Endoscopic Ultrasound have made it so much easy and now cystic lesions of pancreas are diagnosed easily and treated well and surgery is needed only in 10 - 25% patients. Only 20% cystic lesions are malignant while others are benign lesions so early diagnosis and treatment of cystic lesions is very important in reducing mortality and morbidity in number of patients. Cystic lesions are broadly classified into 4 types i.e. Serous Cystadenoma, Mucinous cystic Neoplasm (MCN), intraductal papillary Mucinous Neoplasm (IPMN), Pseudopapillary Cystic Neoplasm. Cystic lesions of pancreas should be differentiated from pseudocyst. In pseudocyst there will be no loculations, septations and Calcification. Pseudocyst usually develop after an episode of Acute Pancreatitis or in chronic pancreatitis. Pseudocyst should be treated conservatively and drained when it becomes symptomatic or if there is persistent increase in size of pseudocyst. Pseudocyst should be monitored carefully because it has large number of severe complications like pseudocyst rupture, hemorrhage, hemosuccus pancreatitis, splenic artery aneurysm, splenic artery thrombosis, splenic artery rupture, ARDS, sepsis etc. Symptomatic cystic lesions should be drained via endoscopic approach i.e. Cystogastrostomy or cystoduodenostomy can be done and drain should be left for 5 - 7 days. In order to prevent recurrent pancreatitis stent should be placed in pancreatic duct via ERCP. Surgery can be performed in case of failed endoscopic approach. Every cystic lesion should be diagnosed by aspiration of cystic fluid via EUS. Cystic fluid should be examined carefully and evaluated on basis of following parameters i.e. Viscosity of fluid, tumor markers and cytology. Fluid viscosity increased in pseudocyst and IPMN cystic lesion while tumor markers like CEA and CA 72-4 increased in MCN and IPMN cystic lesions. Cytology will differentiate b/w benign and Malignant lesions. IPMN are mostly malignant and MCN lesions can be benign or malignant while serous cystic adenoma are always benign and usually treated conservatively. ERCP can also aid in diagnosing such lesions and help in confirming the patency of pancreatic duct. Patulous ampulla with fish mouth appearance is hallmark of IPMN while sunburst calcification or Honey comb appearance is hallmark of serous Cystic Adenoma. Benign MCN are managed conservatively and only enucleation is sufficient while pancreatoduodenectomy is option in case of Malignant lesions. While IPMN lesions are managed on type of IPMN. IPMN are usually divided into main duct IPMN, branch duct IPMN and mix type. Surgery is always treatment option for main duct IPMN, while branch duct type IPMN are managed conservatively and surgery is usually performed in case of following criteria i.e. size greater than 3 cm, CEA level > 182, heterogenous lesion and symptomatic lesions. Serous cystic adenoma are managed conservatively and surgery is only performed in case of symptomatic lesions. All pancreatic lesions should be diagnosed properly and FNA should be performed via EUS. Pancreatic lesions like neuroendocrine tumors, tuberculosis, sarcoidosis and Autoimmune pancreatitis (AIP) are also treatable if diagnosed early and all pancreatic lesions are not Malignant. Auto immune pancreatitis present as focal or diffuse enlargement of pancreas and it is close differential of pancreatic CA. Autoimmune Pancreatitis can divided into two types on basis of histology. Presence of plasma cells, storiform fibrosis and raised IgG4 levels are hallmark of Type I pancreatitis. Type I also has extrapancreatic manifestations like siloadenitis, biliary strictures, pseudotumors of adrenal, kidney, pancreas and pituitary gland. Steroids for 8 - 12 weeks will lead to resolution of autoimmune pancreatitis while in case of resistant cases Rituximab can be used. So early diagnosis of Autoimmune pancreatitis is important in order to treat and prevent large number of its complications. Most of the pancreatic lesions are benign and treatable so early diagnosis of pancreatic lesions will reduce morbidity and mortality and also reduce the economic burden as well. Number of new investigations in new era and inventions in medicine have proved that pancreatic lesions are no more night mare to Gastroenterologist and easily treatable if diagnosed properly.