Information Snapshot – **Dr Laurence Webber**

Update on the Pancreatic Cysts

Background

- Seen increasingly on high quality cross sectional imaging (CT and MRI/MRCP)
- Benign non-neoplastic
  - Occlusion cyst (blocked duct)
  - Post pancreatitis pseudocyst (ruptured duct/ parenchyma) or walled off necrosis
  - Lymphoepithelial cyst (congenital inclusion)
  - Hydatid disease
- Benign neoplastic
  - Serous cystadenoma (rare case reports of transformation only)
  - Potential for malignancy
  - Mucinous cystic neoplasm (MCN)
  - Intraductal papillary mucinous neoplasm (IPMN)
  - Solid pseudopapillary tumour (SPN)
- Malignant (rare)
  - Cystadenocarcinoma (acinar cell/ pancreatic ductal)
  - Cystic neuroendocrine tumour
  - Cystic metastasis to pancreas
  - Cystic teratoma

Management

- <5mm cyst, if asymptomatic, no imaging generally required
- >5mm cyst, bloods and MRCP as per below
- If 'high risk' features present, or malignant appearing, workup as per pancreatic cancer, resect when appropriate
- If no malignant features, assess MRI findings
  - No worrisome features – MRI surveillance based on size
    - ➔ <1cm - 6 months then 2 yearly
    - ➔ 1-2cm - 6m, 6m, 12m, 12m
    - ➔ 2-3cm – EUS and assess more frequently
  - Worrisome features – Endoscopic Ultrasound
    - ➔ Assess cyst wall nature, sample fluid, CEA and lipase level in cyst, gene studies on cyst aspirate (KRAS, GNAS, vHL)
- If EUS suspicious, may workup for resection
- If EUS reassuring – continue MRI surveillance
- Most series end surveillance for unchanging cysts @ 5y

Tanaka M, Fernández-Del Castillo C, Kamisawa T, Jang JY, Levy P, Ohtsuka T, Salvia R, Shimizu Y, Tada M, Wolfgang CL. Revisions of international consensus Fukuoka guidelines for the management of IPMN of the pancreas. (2017) Pancreatology : official journal of the International

Workup

- History to assess for risks for pancreatic cancer and symptoms of cyst
  - Smoking, diabetes, family history, pancreatitis, obesity
- Examination to exclude advanced neoplasia
- Bloods
  - Ca19-9, CEA, Ca 125, LFT, Lipase
- Imaging - Contrast enhanced MRCP can determine 'worrisome features'
  - Size of largest cyst >3cm
  - Enhancement in wall/nodules
  - Relationship to, strictures in, and diameter of main duct
  - Presence of pancreatitis change
  - Nodal enlargement
  - Growth rate >2mm per year
  - Dilation of bile duct / jaundice

About Dr Webber

Hollywood Medical Centre
Suite 41, 85 Monash Avenue
Nedlands WA 6009

T: **08 6389 0244**
F: 08 6389 0255

Dr Laurence Webber is a Laparoscopic and Robotic Hepatopancreaticobiliary Upper GI and General Surgeon who holds GESA accreditation for Upper and Lower Endoscopy and ERCP. He regularly consults at Hollywood Medical Centre and can see new cases within a day or two. He is available for urgent consultations as required. Dr Webber works as part of a multidisciplinary cancer care team. He has public appointment as a Consultant Upper GI Surgeon at Fiona Stanley / Fremantle Hospitals, and provides a visiting service to Narrogin Hospital. Click here for more information on Dr Webber

MR0021852 HPH INFORMATION SNAPSHOT - Pancreatic Cysts Dr Laurie Webber A4 0720.V2