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Incidental pancreatic lesions – A diagnostic and management challenge

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The term “incidental lesion” denotes any lesion that is diagnosed by chance, by happenstance, usually with imaging techniques for a different condition unrelated to it. The widespread use of imaging tests with ever increasing quality and availability has led to finding an ever increasing number of incidental lesions, in this case in the pancreas (1).

Incidental lesion type may be highly variable, with highly varying significance. The biological nature of incidental lesions includes a wide range of neoplasms: ductal adenocarcinoma, intraductal mucinous neoplasm, mucinous cystadenoma, serous cystadenoma, non-functioning endocrine tumors, acinar cell carcinoma, solid pseudopapillary neoplasm, etc. In a series reported by Lahat et al., small ductal adenocarcinoma was the most common finding (2). However, in our daily practice cystic lesions are common, most of them with no malignant potential, and a majority of guidelines recommend conservative management once mucinous cystadenomas and mucinous intraductal tumors have been ruled out (3).

In a series assessed with abdominal CT cystic lesions were incidentally found in up to 3% of individuals (4); in contrast, MRI may identify them in up to 19% of cases (5). According to the currently available literature, the number of incidental lesions increases with age, even rising up to 30% in the elderly (6).

In this issue of *The Spanish Journal of Digestive Diseases (Revista Española de Enfermedades Digestivas)*, Hurtado-Pardo et al. (7) report on their extensive series of incidental pancreatic lesions, with pathology diagnoses based on surgical specimens, which amount to approximately 30% of their pancreatectomies. Theirs is a

retrospective study with data collected between 1995 and 2018, where diagnosis was primarily made using CT scans and EUS, and a majority of confirmations were provided by FNAP. The number of incidental cases that were not intervened upon is not specified, hence their outcome cannot be assessed.

When an incidental lesion is identified attempts at discerning its origin, whether ductal or parenchymal, as well as its biological nature and malignant or benign potential should be made. Based on this estimation a management approach is suggested, and surgery is indicated as needed.

In their series solid lesions predominate over cystic lesions (64 *versus* 36), which is explained by the nature or malignant potential of the former, and therefore their surgical indication, whereas most cystic lesions can be managed conservatively. This is also reflected by their results, with disease-free periods in 100% of cystic lesions, 79% of solid endocrine tumors, and down to 57.7% of solid ductal carcinomas.

Not many reported series allow an estimation of survival for incidental lesions. In a study by Bouquot et al. (8) 32% of pancreatectomies correspond to incidental lesions. Finally, only 50% of lesions were malignancies and had surgical indications, with morbidity and mortality within the range of their experience, according to which incidental lesion overtreatment is advised against in symptomatic patients.

Out of every 100 patients the diagnosis is made with cytology in 71, with EUS in 67, and with CT in 4. Correlation with surgical diagnosis is very high.

As reported by the authors, pancreatic resection, especially cephalic duodenopancreatectomy, is associated with high morbidity and mortality rates, and often requires reintervention, hence preoperative cytological confirmation is required. In this respect, it is very important that these lesions be managed in specialist centers with access to laparoscopic surgery on the pancreas body and tail, which will reduce the rate of complications (9).

To conclude, deciding when these lesions should be treated is challenging at times. In the absence of symptoms, without a histological diagnosis, surgery should be indicated with caution. For a cystic lesion at the head of the pancreas an expectant attitude is likely easier to adopt, whereas for a suspect solid lesion in the pancreatic body or tail surgery will be more easily indicated.

I agree with the authors on the need to follow up cystic lesions that presently do not qualify for surgery but represent a diagnostic challenge and have an uncertain prognosis. Now, it only remains for me to congratulate the authors, and thank them for sharing their data, which will surely benefit the treatment of these conditions.

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