Reply to Kadayifci and Brugge

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We thank Drs. Kadayifci and Brugge for their valuable comments. They discussed the utility of performing endosonography-guided fine-needle aspiration (EUS-FNA) for the differential diagnosis of cystic lesions in the pancreas. We agree that the differential diagnosis of pancreatic cystic lesions can be aided by analyzing fluids for carcinoembryonic antigen and amylose levels, and by performing cytology, GNAs mutation analysis, and confocal endomicroscopy [1–3]. In our study [4], patients with branch duct intraductal papillary mucinous neoplasms (IPMNs; cystic lesions connected to the pancreatic duct) underwent surgery because they had symptoms, mural nodules, or concomitant pancreatic ductal adenocarcinomas (PDACs). Pathological diagnosis of all of the resected cystic lesions connected to the pancreatic duct showed that they were branch duct IPMNs. During the same study period, some patients who had pancreatic cystic lesions that were not connected to the pancreatic duct underwent surgery; however, in these cases, the cystic lesions consisted of serous cystic neoplasms, mucinous cystic neoplasms, branch duct IPMNs, and other types of cystic lesions. In other words, the differential diagnosis of cystic lesions that are not connected to the pancreatic duct is difficult and sometimes requires interventional diagnostic methods [1–3], as mentioned by Drs. Kadayifci and Brugge. The diagnostic criteria employed in our study [4], which depended on the detection of a connection between the lesion and the pancreatic duct, and of mural nodules, were limited by the fact that pathological diagnoses of the resected branch duct IPMNs in 25 of 42 patients revealed them to be benign. As suggested, it is important to avoid unnecessary surgery; thus, EUS-FNA, including cytology and cyst fluid analysis, to predict malignancy can help in this regard [2,5,6]. With respect to the surveillance of branch duct IPMN according to size stratification [7], patients were followed at fixed intervals with semiannual EUS, and annual EUS, computed tomography, and magnetic resonance imaging, irrespective of the cyst size [4]. The aim of our study was to investigate the role of follow-up with EUS for the detection of IPMN-derived and IPMN-concomitant PDACs [4]. Therefore, we needed to use a unified interval period for follow-up (semiannual EUS). The results showed that IPMN-concomitant PDACs occurred during follow-up in patients with branch duct IPMNs of 20 mm or less (see Table 2 in our study) [4]. This means that size stratification may not be useful for the detection of IPMN-concomitant PDACs [4].

Competing interests: None

References


Correction


Figure 2 in the abovementioned article was inadvertently published recording the number of patients with hyperplasia as n=7. This number is incorrect and the number of patients with hyperplasia should be recorded as n=1.