

Letter to the Editor

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Respected Editorial Committee of the Colombian Journal of Gastroenterology:

Please receive a warm greeting.

I have read the article “ Case Series of Drainage of Pancreatic Pseudocysts Guided by Echoendoscopy without Fluoroscopy” by doctors Martín A. Gómez Zuleta et al., (1) and I have been struck by the mention it made that drainage of pseudocysts is indicated when there is a possibility of pancreatic cystic malignancy. Textually the article says (page 161, section Introduction):

“Indications for drainage of pseudocysts are persistent pain, gastric obstruction, duodenal obstruction, biliary obstruction, ascites, pleural effusion, progressive enlargement during imaging follow-up, signs of infection or bleeding, possible malignancy and sizes larger than 6 cm.”

It is important to clarify that precisely one of the contraindications for endoscopic drainage of a pancreatic pseudocyst is the suspicion of another diagnosis, such as a cystic pancreatic neoplasm, since the management of the latter is totally different (in many cases surgical, but never endoscopic drainage). (2, 3)

Gustavo Adolfo Reyes Medina, MD

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Response to the letter to the Editor

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Editorial Committee of the Colombian Review of Gastroenterology

Dear Sirs:

I read the letter of Dr. Reyes with interest. On one hand, I welcome references to articles that our magazine publishes including criticism because this increases our visibility and can help increase the level of our classification. On the other hand, I understand that when we wrote that one indication for drainage of a pseudocyst is the possibility of cystic pancreatic malignancy we may have caused some initial confusion. Nevertheless, this is repeatedly stated in the literature including in a very recent article (1 - 4). I will expand on the answer to try to clarify the subject.

In general, cystic lesions of the pancreas are divided into neoplastic lesions and non-neoplastic lesions. The former are true cysts and the latter are divided into lesions with epithelium and lesions without epithelium. Pseudocysts of the pancreas are among those without epithelium and in some cases are very difficult to diagnose. On the one hand, a finding of a cystic lesion in a patient who had pancreatitis one or two months earlier and who does not have septa or mural nodules is highly suggestive of pseudocysts. This is an indication for drainage as noted in our article. Nevertheless, sometimes the picture it is not so clear. In clinical practice, cystic lesions are sometimes found without septa or nodules in patients who apparently do not have any history of pancreatitis. These patients could be suspected of being at risk for malignancy, and it is these lesions that should be punctured in order to establish a prognosis, especially by measuring levels of amylases, carcinoembryonic antigen (CEA) and mucin. If the lesion has a very high amylase level with a low CEA level, it should be diagnosed as a pseudocyst, but if the lesion has low levels of amylase and a high ACE level with mucin, a mucinous cyst should be suspected. If it has elevated amylase with a high ACE level, it is suggestive of intraductal papillary mucinous neoplasia. On the other hand, it is clear that if a patient who is suspected of this suspicion is going to be drained, it does not necessarily mean that a stent should be placed for drainage. It can be drained through a number 19 puncture needle as demonstrated by Dr. Ardengh. (5) Finally, it is also clear that

neoplastic cystic lesions (true cysts) should not be drained for the reasons that Dr. Reyes notes.

Cordially,
Martín Alonso Gómez Zuleta, MD

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