Because of the ever-increasing sensitivity and use of cross-sectional imaging, especially magnetic resonance imaging, centers around the world are faced with an overwhelming number of branch-duct (BD) intraductal papillary mucinous neoplasms (IPMNs) or suspected BD-IPMNs, of which the vast majority will never progress to cancer. The study by Capurso and colleagues1 addresses this problem by asking which factors can be easily measured in clinical practice that could help us sort out patients who may not need any follow-up and rather concentrate time and precious imaging resources on patients who are in need. The fact that size alone does not matter is not surprising. The first European guidelines on cystic tumors already upsized the cutoff for surgery to 40 mm (compared with the 30 mm of the International Association of Pancreatology guidelines).2 The most recent evidence-based European guidelines consider a 40-mm cutoff as a relative indication for surgery only. Most recently, in a large surgical IPMN series, a cyst diameter more than 40 mm, per se, was not associated with an increased risk for cancer.3

In the study by Capurso et al1 of more than 500 patients followed for more than 5 years, initial cyst size greater than 15 mm, a higher body mass index (>26.4 [body mass index is calculated as weight in kilograms divided by height in meters squared]), heavy smoking, and the blood group type AA were clearly associated with the risk for progression of BD-IPMN. The potential impact of this finding can be relevant: to have a simple way to distinguish those in need of surveillance from those who have less risk to progress may have consequences, not only from an economical point of view. It will also relieve many of these patients with incidental findings from the burden of a potentially life-threatening disease—or major pancreatic surgery carrying its own rate of morbidity and mortality and impact on quality of life.

It would have been interesting to understand whether any differences could be observed using different (and maybe less aggressive) guidelines for the management of BD-IPMNs, but it is clear that this can be difficult to do in a retrospective way. Another limitation of the study by Capurso et al1 is the focus on the progress of BD-IPMN, not the malignant conversion. The authors rightly argue that of the worrisome features or high-risk stigmata, growth is a proxy for later malignant neoplasms. One can only hope that the cohort so carefully selected and analyzed will be followed up and in some years time the investigators could report back on the true malignant conversion rate in those individuals who now have been described to be prone to progression.

Finally, there are 2 unavoidable biases that occur in every study involving a population of patients with IPMN under surveillance. First, the accuracy in diagnosis of cystic lesions is not very high. In every study of this kind, some of the patients probably do not have a real IPMN. Second, the actual goal of IPMN treatment is to catch high-grade dysplasia. Theoretically, we should be able to investigate predictor factors of high-grade dysplasia, but unfortunately, we do not yet have any clinical or diagnostic tools able to achieve this goal.

As with all initial findings, the findings by Capurso et al1 need to be corroborated and validated in independent prospective clinical trials. We hope that investigators familiar with the subject will turn their attention to this issue at hand.
ARTICLE INFORMATION
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