A 52-year-old woman presented with weight loss, asthenia and epigastralgia. Computed tomography (CT) showed a 10 cm polycystic tumor in the pancreatic head, with Wirsung duct dilatation (17 mm), ample contact of the tumor with the superior mesenteric vein, involvement of the portal vein, gastroduodenal artery and compression of the duodenum (Fig. 1). The serum levels of CA19.9 and CEA were normal. Endoscopic ultrasound (EUS) revealed a large solid-cystic lesion occupying the pancreatic head (Fig. 2). The Wirsung duct was tortuous,
CEA levels of 47.9 ng/mL. A total pancreatectomy with portal reconstruction and splenectomy was performed. The pathological findings revealed a microcystic serous cystadenoma (Fig. 3).

**DISCUSSION**

Differential diagnosis includes mucinous cystic neoplasms, neuroendocrine tumors, lymphangiomas, acinar cell cystadenocarcinomas, and serous cystadenocarcinomas (1). In clinical practice, cystic fluid analysis should be interpreted in combination with CT/magnetic resonance imaging and EUS to help in the diagnosis of unclear cases (2,3). Histologically, serous cystic neoplasms appear as epithelial cells connected by occluding junctions and belt desmosomes and have a central scar. Immunohistochemically, they are positive for cytokeratins 7, 8, 18, and 19. They can also be positive for CA19-9 and B72.3, being negative for CEA (3). The presence of symptoms and/or the inability to definitively exclude a premalignant or
malignant tumor are considered as indications for surgical resection (3). Locally aggressive behavior tumors, with surrounding vessels or peripancreatic lymph nodes, were described in 5.1% of resected serous cystic neoplasms. Large tumor size and tumor location in the head of the pancreas were considered as independent risk factors for this aggressive behavior and to justify surgical resection (3). Finally, we recommend that cystic tumors with inconclusive clinical and imaging features should be radically treated.

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