Cautiously, especially if claiming high diagnostic accuracy. The problem of differentiating cystic lesions with or without malignant potential is currently not the clinically relevant one; it is rather to define those lesions that are likely to progress to overt malignancy. A large number of incidental cystic lesions in the pancreas are side-branch IPMNs (6) that are known to have a malignant potential; what is not known, however, is which lesions are going to progress and should be resected.

A number of features and risk factors have been identified that better stratify side branch IPMNs (4). Nonetheless, even when applying these factors, the controversy remains, because some centers advocate surgery for most of these lesions (7), while others favor a more conservative approach (4).

The present paper does not help in better stratification of these lesions. MUC1 expression was present in seven of 14 side-branch IPMNs, but no information is presented with regards to whether those lesions had higher grades of dysplasia or were in situ cancers. Main-duct IPMNs, on the other hand, were MUC1-negative in two of three cases, which is in line with what is known about the MUC1 profile of these lesions; ie, 50% of main-duct IPMNs show intestinal differentiation and do not express MUC1. Main-duct IPMNs have a higher risk to progress to invasive cancers and are generally an indication for surgery (4).

In conclusion, the study of Jabbar et al. shows that proteomic mucin profiling can identify cystic lesions with malignant potential. This is where we have been for several years; ie, with modern imaging, EUS/cyst fluid analysis, and cytology, we can fairly well identify those lesions. What we cannot reliably answer at the moment is a different, yet highly important clinical question, namely: What is the risk of malignant transformation? And, thus, what is the best therapy for patients harboring these cysts?

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