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Endoscopic ultrasonography of the upper gastrointestinal tract: take a look at the pancreas!

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We read with great interest the article by Martinez *et al* [1], in which the authors described a study of 298 patients without known pancreatic disease who underwent upper gastrointestinal (GI)-tract endoscopic ultrasound (EUS) to evaluate conditions unrelated to the pancreas. In this study, incidental pancreatic cysts previously undetected by cross-sectional imaging studies, such as computed tomography and/or magnetic resonance imaging, were diagnosed in 21.5% of the patients. Some of these lesions were intraductal papillary mucinous neoplasms (IPMNs) that deserve follow up for the risk of neoplastic evolution. In our opinion, this study raises two important points. First of all, it confirms the high diagnostic accuracy of EUS for evaluating pancreatic abnormalities with a higher resolution than other imaging techniques for small lesions [2,3]. In this regard, we have recently found that, in about 15% of patients with chronic asymptomatic pancreatic hyperenzymemia, EUS was able to detect pancreatic abnormalities not found with other imaging modalities [3], including IPMN lesions that required follow up for the risk of neoplastic evolution. Likewise, in 57 patients with normal liver enzymes referred for EUS after prior negative imaging studies, abnormal EUS findings were observed in 21% of patients; they included periampullary diverticula, ampullary adenomas, chronic pancreatitis, biliary stones, and even one pancreatic cancer not previously detected by the other imaging modalities [4].

Furthermore, this study highlights that when EUS examination of the upper GI tract has been planned, a complete exploration of every structure accessible to this technique—not restricted only to the lesion for which the EUS was indicated—should be mandatory. Unfortunately, this approach is considered time-consuming and, as standard criteria to define the completeness of upper GI-tract EUS examination are lacking, most endoscopists would limit the examination to the initial indication. Indeed, unlike other radiological and endoscopic explorations in which a comprehensive exploration of every visible structure is mandatory, there is no such definition of a standard EUS procedure. Several useful quality indicators for EUS have been published, but a commonly accepted definition of how to perform a complete EUS examination has not yet been provided [5].

Considering that most pancreatic cancer patients are diagnosed as unresectable and that there is no screening program for detection of early pancreatic cancer in the general population, it would probably be worth looking for pancreatic lesions in every upper GI-tract EUS, regardless of the primary indication, especially in patients in otherwise healthy condition.

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Authors' reply

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Thank you very much for your comments which we entirely agree with. Those who perform endoscopic

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ultrasound (EUS) are accustomed to spotting lesions not seen in other imaging tests on a daily basis. A detailed examination of all structures visible by EUS, particularly of the pancreas, gives us the opportunity to detect lesions that can be treated in their early stages—especially cystic lesions of the pancreas. However, the detection of these lesions can significantly increase the demand for EUS in already overloaded endoscopy units. We sincerely believe that a standardization of the EUS procedure must be implemented.