A 50-year-old female was referred for incidental finding of a pancreatic cyst. The cyst was detected on MRI of lumbar spine during workup for chronic low back pain. No prior imaging. She denied abdominal pain, jaundice, and weight loss. She reported minimal alcohol use and no history of pancreatitis. No family history of pancreatic disease. Physical exam was normal. Blood work revealed normal liver function test (total bilirubin 0.7 mg/dL, alkaline phosphatase 72 U/L, AST 18 U/L ALT 19 U/L) and normal pancreatic enzymes (amylase 87 U/L, lipase 26 U/L). CA19-9 was normal. Patient underwent CT abdomen with contrast to characterize the cyst (Image A). This was followed with an upper endoscopic ultrasound (EUS) with fine needle aspiration (FNA). FNA aspirate was ~7 mL of milky fluid. The analysis of the cystic fluid returned triglycerides 2100 mg/dL, amylase 70 U/L, and CEA 0.3 ng/mL. Cytology revealed no tumor cells, abundant lymphocytes. What is the likely diagnosis?

A. Pancreatic pseudocyst
B. Serous cystadenoma
C. Pancreatic cystic lymphangioma
D. Mucinous cystic neoplasm
E. Intraductal papillary mucinous neoplasm (IPMN)

**ANSWER: C**

**Rationale:** The CT abdomen shows a pancreatic body cyst, partially septated, 4 x 2 x 2.5 cm in size with no solid component or peripheral enhancement. Biliary and pancreatic ducts were normal in diameter. Upper EUS showed an anechoic cyst with fine septation measuring ~50 mm in greatest dimension. The cyst did not seem to arise from the pancreas or the gastric wall. Doppler ruled out a vascular structure. Normal pancreatic parenchyma, pancreatic and bile ducts. No lymphadenopathy. Pancreatic cystic lymphangioma (PCL) is a rare benign tumor of lymphatic system comprising 0.2% of all pancreatic lesions. PCL occurs mostly in young and female population. PCLs are most commonly found in the body and tail of the pancreas. Majority of PCLs are asymptomatic and mostly found as incidental findings although rarely it can present with palpable mass, pain, nausea, or weight loss. While conventional imaging studies - abdominal US, CT, MRI, have limitation to differentiate PCL from various pancreatic cystic lesions, EUS-FNA can provide confirmatory diagnostic information combined with fluid analysis. There was no report of malignant transformation of pancreatic lymphangioma. Conservative management with clinical follow-up and surveillance images (CT or EUS) is reasonable for asymptomatic patients. Surgical resection is the gold standard if it becomes symptomatic.