A 62-year-old man with a history of a cholecystectomy presented with longstanding right upper quadrant pain. A computed tomography (CT) scan demonstrated a normal spleen with incidental small adjacent splenules and a 2.4 × 2.3-cm cystic lesion in the tail of the pancreas. The pancreatic cystic lesion (PCL) had not been seen on a CT scan 2 years earlier, while an interim CT scan had revealed a lesion of 1.1 × 1.1 cm.

An endoscopic ultrasound (EUS) demonstrated a 2.5 × 2.2-cm anechoic cystic lesion within the pancreatic tail. During EUS, needle-based confocal endomicroscopy (nCLE) demonstrated cellular cords with many red blood cells within the cystic lesion (Fig. 1a; Video 1). Following nCLE, cyst fluid obtained by fine needle aspiration (FNA) revealed non-diagnostic cytology, an amylase of 183 U/L, and a carcinoembryonic antigen (CEA) level of 2663 ng/mL.

The elevated CEA and increasing size of the PCL were key determinants for the patient to undergo a laparoscopic distal pancreatectomy and splenectomy. An ex vivo nCLE examination of the cyst was performed as per the study protocol (Fig. 1b; Video 1). Surgical histopathology revealed a benign epidermoid cyst with mural ectopic splenic tissue, compatible with an epidermoid cyst of an accessory spleen (Fig. 2). The diagnosis was confirmed as being an epidermoid cyst in an intrapancreatic accessory spleen (IPAS).

An IPAS can be difficult to distinguish by cross-sectional imaging and is often evaluated for neoplastic potential [1]. This is the first report of in vivo EUS-guided nCLE visualization of an epidermoid cyst within an IPAS. The cyst with its thin epithelial lacked characteristic nCLE features, but the splenic tissue demonstrated cords of cells suggestive of splenic red pulp. Additional features of other common PCLs were not observed [2]. This study adds to the growing body of literature describing EUS-guided nCLE in PCLs.

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Competing interests: None

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