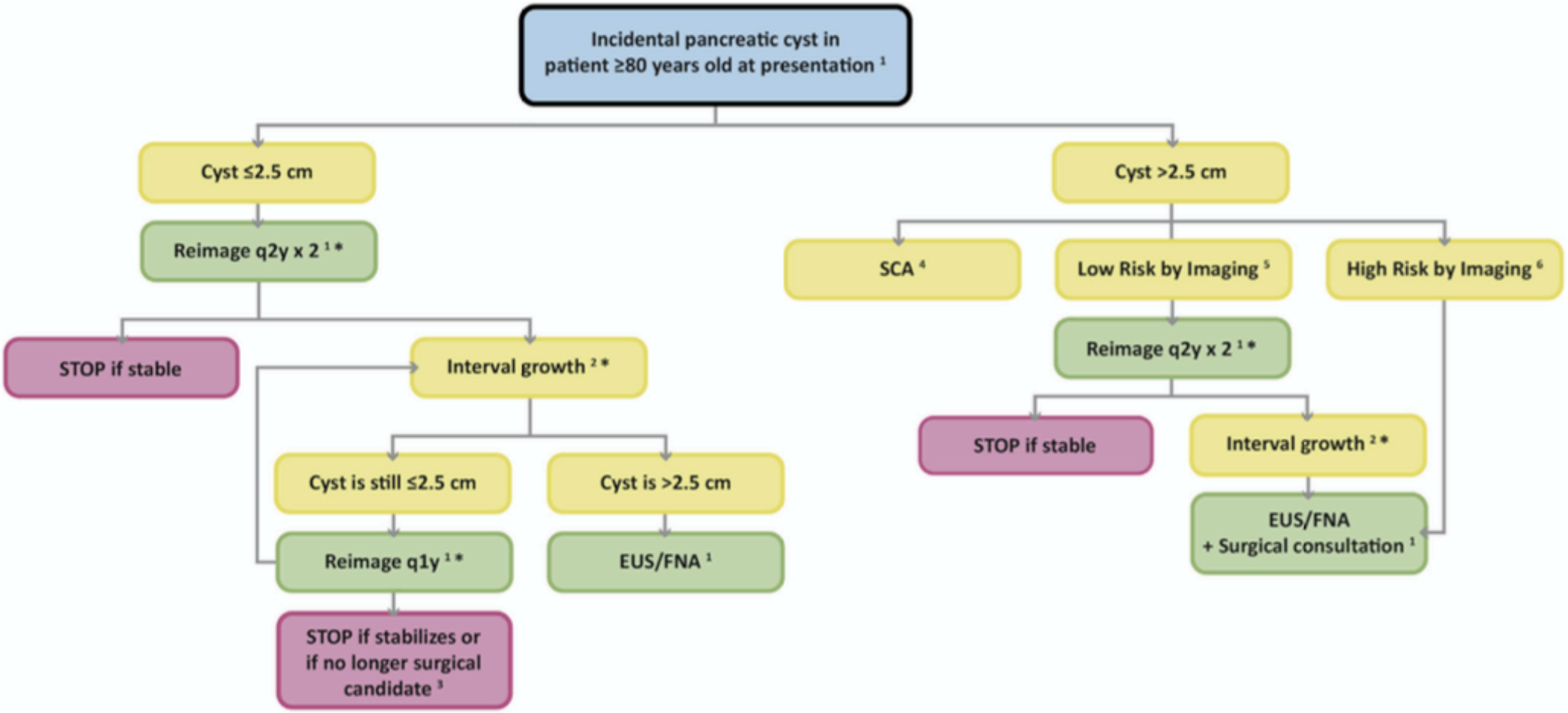

LEGEND

1 The decision to pursue imaging follow-up and/or EUS/FNA should be anchored to a patient's overall health and preferences; such work-up is only advised if the patient is a surgical candidate.

2 Growth defined as 100% increase in longest axis diameter (on axial or coronal image) for cysts <5mm, 50% increase for cysts ≥5mm and <15mm, and 20% increase for cysts ≥15mm. No growth = stable.

3 The decision to discontinue imaging follow-up is dependent on a patient's surgical candidacy and preferences, and the duration of the cyst's stability.

4 For SCA>4cm, surgical consultation for consideration of resection is advised.

5 Low-risk features: no mural nodule, no wall thickening, normal caliber MPD, no peripheral Ca++. If surgery is contemplated for low-risk cysts, EUS/FNA is strongly advised before the procedure.

6 High-risk features: mural nodules, wall thickening, MPD ≥7mm maximal diameter, peripheral Ca++. All patients with "high risk stigmata" (extrahepatic biliary obstruction/jaundice, enhancing mural nodule, MPD ≥ 10mm) at time of cyst detection should undergo immediate clinical evaluation for surgery if they are surgical candidates.

*Appearance of any mural nodule, wall thickening, dilation of MPD ≥7mm, or extrahepatic biliary obstruction/jaundice should prompt consideration of immediate EUS/FNA and surgical evaluation regardless of size or amount of growth.