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Clinical Research

RARE CASE OF GIANT MESENTERIC CYST : A CASE REPORT

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ABSTRACT A38 year old male who presented with abdominal pain and mass.. On physical examination there was an irregular mass of size 40x20 cm occupying the epigastrium, umbilical, right hypochondrium, right lumbar and right iliac fossa. Renal angle fullness noted bilaterally, swelling moves with respiration. In our case CT showed a very large multilocular, hypoattenuated cystic lesion measuring 35x32x25 cms occupying entire peritoneal cavity with multiple thin and thick internal septations .Exploratory laporotamy done The cyst originated between the leaves of mesentery of distal ileum ,ascending and transverse colon ,densly adherent to peritoneum, posterior wall of stomach, right kidney and pancreas. Cyst decompressed in 3 locations. Right hemicolectomy done followed by ileo -transverse anastomosis in 2 layers. Post operative period was uneventful, patient was dischared on 16 th post operative day .Histopatology identified the mass as mesenteric cyst –benign mucinous cystadenoma.

KEYWORDS :

INTRODUCTION

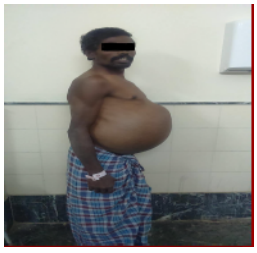
Mesenteric cysts are rare , benign growths with malignant transformation reported in 3% of cases [1-4]. The incidence - 1 in 100,000 (adult population) - 1 in 20,000 in the pediatric population [1-3] - often present in the first decade of life [5] with a 1:1 male : female preponderance [1].

First described - during an autopsy in 1507 by an Italian anatomist, BENVENNI. 40% of cases incidental finding> 50% of cases – incidental finding with a palpable mass present [3]. 10% of cases - present as acute abdomen due to bowel obstruction, volvulus and torsion or as shock secondary to bleeding or rupture [2,4]. Less often they can present with non-specific abdominal symptoms including abdominal pain, anorexia, bowel habit changes, or nausea/vomiting.

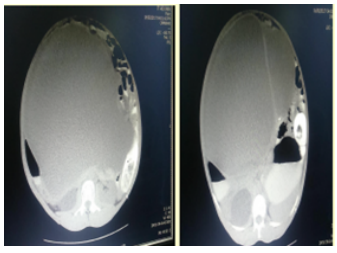
CASE REPORT

Our case is a 37yrs old male who presented with a distended abdomen, abdominal pain and abdominal mass. (Fig:1) On physical examination there was an irregular mass of size 40x20 cm occupying the epigastrium , umbilical, right hypochondrium, right lumbar and right iliac fossa. Renal angle fullness noted bilaterally, swelling moved with respiration. His laboratory investigations were normal. ultrasound report shows complex heterogenous abdomino-pelvic mass lesion with B/L hydroureteronephrosis (R > L). On CECT differential diagnosis are peritoneal mucinous cystic Neoplasm and cystic lymphangioma (exact source could not be identified due to large size of the lesion)(Fig :2) .

FIGURE:1



FI FIGURE:2GU



An exploratory laparotomy was performed under General anaesthesia using midline incision. Firstly ,10 litres of thick mucinous content was aspirated from the cyst then dissection followed. The cyst originated between the leaves of mesentry of distal ileum , ascending and transverse colon ,densely adherent to peritoneum , posterior wall of stomach , right kidney and the pancreas. A large dissection was done , cyst decompressed in 3 locations , dissection attempted to find plane between cyst and mesenteric leaves after opening lesser sac .(Fig:3). Right hemicolectomy done followed by ileotransverse anastomosis in 2 layers. Histopathology – Features suggestive of Mesenteric cyst – Benign mucinous cystadenoma. Post operative period was uneventful. Follow up – on 4 months of follow up patient had no recurrence

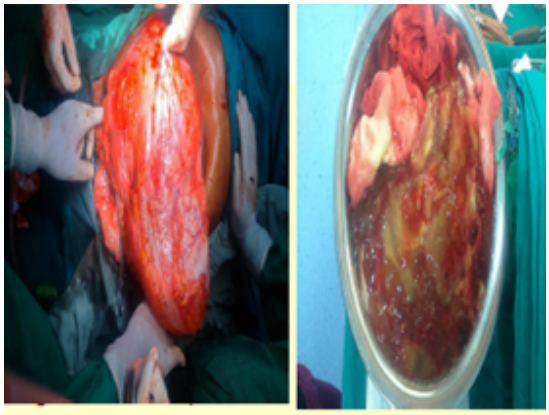


FIGURE 3

DISCUSSION

This case report demonstrates the presentation, diagnosis and surgical management of a large mesenteric cyst which was found incidentally with abdominal distension on physical examination. On CT, mesenteric cysts can occur anywhere in the mesentery, from the duodenum to the rectum, and may extend into the retroperitoneum. Localization of these cysts proves to be difficult pre-operatively. CT imaging is important in the management of these cysts as they can help aid the decision to pursue a laparoscopic or open laparotomy approach, when surgical resection is the goal. Other treatment options include drainage, marsupialization and enucleation which were previously thought to be the treatment of choice [2,3,5]. Bowel resection is required in a one third of adult and 50-60% of pediatric cases[5]. Partial excision is not indicated as there is a high recurrence rate with this modality [5]. Average recurrence rates in a study with 162 adults and children were 6.1% in one study, and were more likely to occur in partial resections [5].

CONCLUSION

We have demonstrated that simple per operative controlled aspiration/drainage, followed by complete resection using laparotomy approach is a successful surgical option of a very large mesenteric cyst. Surgical resection is considered the mainstay for therapy as recurrence may occur without complete resection [2,3].

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