



MESOTHELIAL INCLUSION CYST-A RARE CASE REPORT

Gynaecology

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ABSTRACT

Mesothelial Inclusion Cyst [MIC] is a rare benign condition attached to the serosal surface of visceral organs in the abdominopelvis. It can occur in relation to ovaries and uterus, urinary bladder, intestines, cul de sac and appendix. This condition is rare and has only 150 cases reported in the literature. Here we report a 35 year old female with MIC occurring in relation to uterus and ovaries.

KEYWORDS

Mesothelium, Peritoneum, Abdominopelvic cyst.

INTRODUCTION

Mesothelial Inclusion Cyst [MIC] is an uncommon abdominopelvic cyst also known as Peritoneal Pseudocyst/Multicystic benign mesothelioma/Peritoneal Inclusion Cyst. MICs occur predominantly in relation to the peritoneum and results from a non neoplastic reactive mesothelial proliferation. 84% of MICs occur in women of reproductive age group with remainder occurring in either sex and of all ages. Here we report a case of MIC in a premenopausal woman.

CASE REPORT

A 35 years old female P1L1A2 came with H/O vague pain in lower abdomen for the past 6 months. Her first delivery was a full term vaginal delivery. Second was induced MTP in first trimester. Third was ruptured ectopic pregnancy in right fallopian tube for which she underwent Laparotomy and Right SalpingoOophorectomy at Government Rajaji Hospital, Madurai. During the procedure adhesions were present between posterior wall of uterus and rectum and sigmoid colon for which adhesiolysis was done 9 months back. Her menstrual history revealed oligomenorrhoea. Last menstrual period was 20 days back. Physical examination revealed normal external genitalia with signs of mild vaginitis. On per vaginal examination, no cervical tenderness or palpable mass felt.

Her renal function tests and blood counts were within normal limits. Urine examination was normal. CA-125 was 15U/ml. [Normal upto 35U/ml]. Ultrasonography [USG] of the abdomen & pelvis was ordered which revealed a large thin walled pelvic cystic lesion with multiple septations measuring 13.7x12.9x7.6cms, showing left ovary attached to the left lateral wall of the cyst, S/O Peritoneal inclusion cyst. Right ovary could not be visualised. Uterus anteverted and normal in size with normal myometrium. No focal lesions. Endometrial thickness 5mm. Patient was started on Oral contraceptive pills to temporarily suppress the process, after examining her breast, lipid profile, and explaining warning symptoms of DVT. She was advised MRI and image guided aspiration and sclero therapy. But patient was not desirous of fertility and not willing for invasive procedures and was lost for followup.



fig 1&2 showing multilocular cyst in relation to left ovary and uterus.

DISCUSSION

Mesothelial Inclusion Cyst is common in premenopausal women with active ovaries with a H/O previous abdominal or pelvic surgery, trauma, pelvic inflammatory disease or endometriosis. They are usually caused by accumulation of ovarian fluid that is contained by peritoneal adhesions. The normal peritoneum absorbs fluid easily. However, the absorptive capacity is greatly diminished in the presence of mechanical injury, inflammation and peritoneal adhesions. MIC s were considered as benign with excellent prognosis.

Sawh et al have shown that a proportion of MIC s are estrogen receptor carriers and hence their growth and progress may be dependent on hormonal influence. Such hormone sensitivity of MIC s has been targeted as a therapeutic option with some success.

At USG, MIC appears as an anechoic cystic mass, with invagination of the surrounding structures into the cyst. Lack of a discrete limiting wall, absence of mural nodularity, minimal internal debris and Spiderweb pattern from an entrapped ovary are other features. In MRI they tend to appear as irregular cystic masses. Signal characteristics are T1-Hypointense; T2-Hyperintense; T1c+[Gd]-enhancing cyst

walls. To date, USG remains the best studied modality for imaging diagnosis although MRI may aid in clarifying the diagnosis.

Management options are Conservative management with GnRH analogs, SERMs, Megestrol or with oral contraceptives to suppress ovulation and observation with serial imaging is the first line and feasible option for asymptomatic, incidentally discovered cases. But it is only suppressive, not curative and discontinuing treatment will result in recurrence.

Image guided transvaginal fluid aspiration & sclerotherapy have been attempted with partial success. Potassium-Titanyl-Phosphate [KTP] Laser ablation is a minimally invasive surgical option.

Surgical resection of adhesions is necessary only in selected cases. Indications of surgical excision include an elevated CA-125, USG appearance consistent with malignancy, Persistence of recurrence of cysts or symptoms despite hormonal therapy and infertility with an otherwise negative evaluation. Recent studies advocate additional intra peritoneal chemotherapy to decrease recurrence but these remain preliminary involving a few patients.

CONCLUSION

MIC remains a rare intra abdominal pathology. Despite full spectrum of treatment options, because of lack of full knowledge of underlying pathology, long term outcome and complication rates, there is no clear standard of treatment. Management can be tailored to the individual and desire for fertility. The purpose of reporting this case is its rarity of presentation.

COMPLIANCE WITH ETHICAL STANDARDS

Conflict of interest: None declared

Informed consent: obtained from the participant of this study

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