ORIGINAL RESEARCH PAPER

General Surgery

CASE SERIES OF CYSTIC LYMHANGIOMAS

KEY WORDS:

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INTRODUCTION

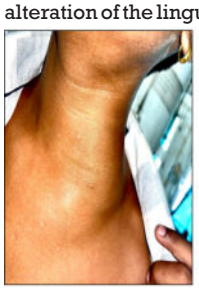
Cystic lymphangioma (CL) in adult is a very rare pathology. Its etiology remains unclear, but it is supposed to be congenital or to be a result of obstruction and lymph fluid retention of developing lymphatic vessels. It generally occurs in the head and neck region, probably because of the rich lymphatics in this area. It can be easily misdiagnosed with other cervicofacial masses.Head and neck is the mainly affected region and symptoms due to local compression can occur related to the location and the size of the tumor.

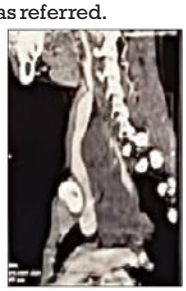
CASE 1

Neck lymphangioma

A 13 year-old male without personal and familiar history of tumors presented to our department on May, 2023 with a left-sided painless cervical swelling, onset was referred to be 2 months before he came to our attention. The mass presented with a progressively enlargement. Neither history of trauma nor recent upper respiratory tract infections were referred. Compressive symptoms were not also referred.

On physical examination, the mass was located in the left side of Lower neck region. Skin overlying the mass was not compromised. It was soft to tender in consistency, lobular with well- defined margins, painless and freely movable, and cervical lymphadenopathy was not clinically detected . Normal function of the facial nerve was observed. No alteration of the lingual nerve sensitivity was referred.





Investigation

USG s/o approx 27x86x8 mm sized intercoommunicating cystic lesion with internal echoes within few septations in anterior left side neck region s/o lymphangioma

CT scan s/o there is thin walled cystic hypodense non enhancing lesion in left lower neck in clavicular fossa at thyroid level measures approx 8.9x9.0x10.1cm in size extending downwards in left superior mediastinum. It causing encasement of great vessels of superior mediastinum. no invasion. Tiny calcific foci within. no fat. There is mass effect on trachea with its right lateral displacement.likely to be lymphangioma.

Management and complications

Surgery was performed under general anesthesia. Horizontal incision was made about two fingers above the clavicle .The mass was cleaved from the surrounding structure and completely removed, and then the surgical specimen was sent for histopathological examination.

Microscopically, the mass was composed by a variety of dilated lymph vessels involved in a fibrovascular stroma Diagnose of completely excised CL was done. Whispering and deepening of voice with left eye ptosis was observed 15 days after surgery.

CASE 2

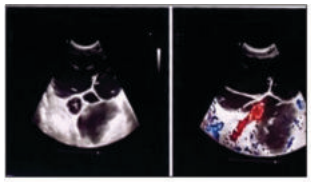
Abdominal Lymphangioma

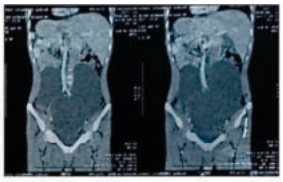
A 23 years old male presented with complain of painless abdominal mass for 2 years associated with early satiety and nausea, vomiting.

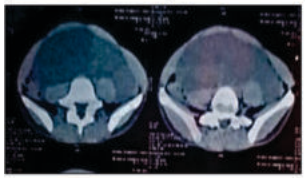
On physical examination, mass of approx 10 ×7 cm palpated over mid abdomen with no tenderness and any skin changes .

Ultrasonography suggestive of approx 9×14×25cm sized well defined multiloculated lesion loculated in peritoneal cavity with multiple septation and internal vascularity within it.superiorly it extends from epigastric region and inferiorly reaches to pelvis. right laterally lesion extends from right subhepatic region RIF region.posteriorly the lesion abuts aorta and IVC with preserved facial plane, with normal doppler perceptible flow. S/o lymphangioma.

Ct scan suggestive of insinuating hypodense septated retroperitoneum based abdominopelvic lesion measures 11 ×20×23cm . It causes encasement of abdominal aorta and IVC causing compression of IVC and right common iliac vessels. It encases the inferior mesenteric artery and its branches and causes displacement of the bowel loops.







CASE 3

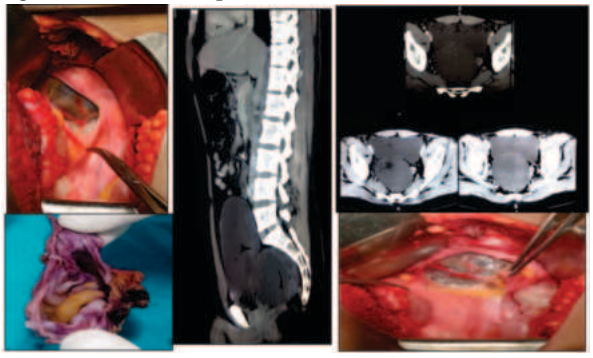
Pelvic lymphangioma

20 years old male patient with non-significant past medical or surgical history, was referred to our center for further investigations regarding the diagnosis of an intraabdominal mass versus an abdominal abscess. The patient complained of abdominal pain and fever for 10 days duration. The pain

was located in the hypogastric area non radiating, and associated with nausea, vomiting and anorexia. Upon physical examination, an hypogastric tenderness was observed associated with guarding to palpation. Otherwise, the abdomen was soft and lax. The suspected mass could not be palpated

Ultrasonography revealed approx 79 ×84 × 27mm sized well-defined thinned Wall(Wall thickness < 1mm) cystic lesion with dense echoes and debris qithin is noted in pelvis midline in posterior to urinary bladder. Anteriorly lesion abuts and indents posterior wall of the urinary bladder. left laterally lesion abuts and causes mild displacement of rectum. There is no communication between lesion and bladder . s/o benign cystic lesion - enteric duplication cyst more likely.

Subsequent computed tomography (CT) imaging with intravenous contrast revealed a well defined cystic lesion of size 81× 91 × 83mm is seen in presacral region posterior to urinary bladder. Anteriorly lesion is abutting the posterior wall of urinary bladder and seminal vesicles .Posteriorly lesion is abutting bilateral piriformis muscle and upper part of rectum / rectosigmoid junction.On left side, lesion is abutting the sigmoid colon causing its mild displacement and compression.On right side, lesion is in close proximity with right internal iliac and pudendal vessels.



Management

Multidisciplinary team decision was made to excise the mass. Intraoperative findings include: Well defined cystic lesions (8.0 × 9.0 × 8.0 cm) on the sigmoid mesocolon. Sigmoid colon loops were healthy and viable. Complete excision of the mass was performed with preservation of the attached sigmoid colon through a midline laparotomy incision.

Postoperatively, a nasogastric (NG) tube was inserted, and Medications were stopped at day 5 and the NG tube was removed at day 3 postoperatively. The patient was doing well, vitally stable, passed flatus on day 2, passed stool at day 4 and discharged after 5 days postoperatively. The patient was followed 1 week after the surgery in an outpatient clinic, the wound was healthy, not infected with normal bowel motion and no fever spikes, abdominal pain or abdominal distention

Histopathological examination of the excised mass revealed a cystic lymphangiomas with giant cells in cystic wall. No eviedence of caseous necrosis and No evidence of malignancy was observed.

DISCUSSION

- cystic lymphangiomas are rare benign lesions characterized by lymphatic vessels malformation with an unknown etiology.
- Although, mesenteric cystic lymphangiomas are rare but should be included in the differential diagnosis of abdominal pain.
- Surgical resection of cystic lymphangiomas should be performed as fast as possible to avoid many serios complications.

REFERENCES

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