SciMedCentral

Annals of Clinical Pathology

Case Report

Giant Mesenteric Cyst: A Case Report

Polat FR*, Duran Y, and Sakallı O

Department of Surgery, Dr. Namık Kemal University Medical Faculty, Turkey

***Corresponding author**

Fatin R. Polat, Associate Proffesor of Surgery, Department of Surgery, Division of General Surgery, NK University School of Medicine, Tekirdag, Turkey, Tel: 905323961224; Email: polat22@hotmail.com

Submitted: 24 April 2017

Accepted: 08 May 2017

Published: 10 May 2017

ISSN: 2373-9282

Keywords

- Abdominal pain
- Mesenteric cyst

Abstract

Mesenteric cyst is uncommonbenign lesion. Its etiology remains unknown. Mesenteric cyst may be asymptomatic or symptomatic. Treatment of the cyst is surgically excised. The cyst almost invariablyrecurs after surgery. The aim of this literature is to demonstrate a rare case of mesenteric cyst with literature reviews emphasizing on the clinical presentations and surgical treatment.

ABBREVIATIONS

MRI: Magnetic Resonance Imaging; CT: Computerized Tomography

INTRODUCTION

Mesenteric Cyst is uncommon [1]. Cysts of the mesentery are benign lesions with an incidence of less than 1 in 100,000 [2]. The etiology of such cysts remains unknown. Mesenteric cysts may be asymptomatic or cause acute or chronic symptoms of a mass lesion [2]. When symptomatic, simple mesenteric cysts are surgically excised but almost invariably recur after excision [2]. The aim of this study is to an mesenteric cyst has been presented and relevant literature reviewed.

Mesenteric cyst is an uncommon benign lesion of unknown etiology with an incidence of less than 1 in 100,000 [1] usually seen in the elderly. Mesenteric cyst may be asymptomatic or sympatomatic. Usually the patient is referred to with swelling and pain. When symptomatic, simple mesenteric cysts are surgically excised but almost invariably recur after excision [2]. The aim of this study is to an mesenteric cyst has been presented and relevant literature reviewed.

CASE PRESENTATION

A 90-year-old, woman presented with a 2-year history of diffuse abdominal pain, discomfort and nonspecific symptoms such as anorexia, nausea, vomiting. The patient lives in the village. Have not applied to a doctor before. Pre-Surgery Patient has not received any treatment. On physical examination, a huge (non-tender) abdominal mass was palpated at the central abdomen. MRI of the whole abdomen demonstrated a huge cyst in the abdomenmeasuring 40x35cm (Figure 1). We suggested surgical approach for management of the cyst. Preoperative Hematologic and biochemical tests were normal. Exploratory laparotomy was performed and revealed a pink-greymesenteric cyst measuring 53 cm in diameter and 8690 gm. The cyst showed no connection to the bowel wall and other organs (Figure 2). The cyst was completely excised (ligated pedicle with silk) and the adjacent bowel was also resected. There is not any solid component. The content of the cyst was serous fluid and the cyst wall thickness was thin. The pathologic diagnosis was consistent with mesenteric cyst wall. The patient had no immediate complication and was discharged 3 days after operation.

CONCLUSION

Mesenteric cysts are rare, with a reported incidence of 0.5-1 per 100,000 admissions [1,2]. The etiology of such cysts remains unknown, but several theories regarding their development exist, including degeneration of the mesenteric lymphatics or peritoneal inclusions arising as congenital anomalies [2].

Mesenteric cysts may be asymptomatic or cause acute or chronic symptoms of a mass lesion [1,2]. Acute pain is generally caused by rupture or torsion of the cyst or from acute hemorrhage

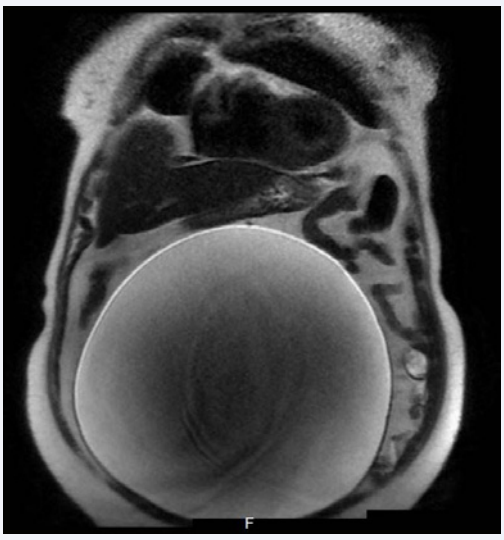

Figure 1 Giant cyst in the MRI image.

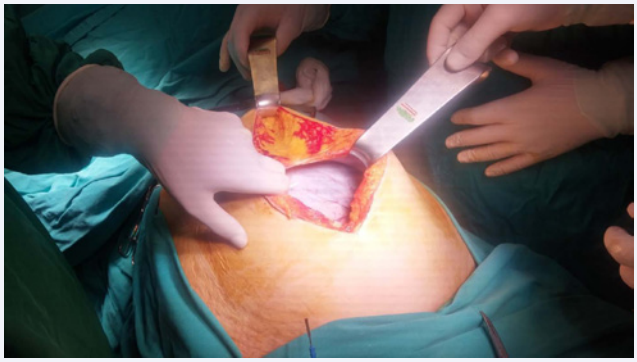

Figure 2 Intraoperative figure of the cyst.

into the cyst cavity. Mesenteric cysts may also cause intermittent abdominal pain secondary to compression of adjacent structures or reversible torsion of the cyst. Mesenteric cysts can also be the cause of nonspecific symptoms such as anorexia, nausea, vomiting, fatigue, and weight loss. Physical examination may reveal a mass lesion that is mobile only from the patient's right to left or left to right (Tillaux's sign), in contrast to the findings with omental cysts, which should be freely mobile in all directions [1-3].

CT, Ultrasound, and MRI all have been used to evaluate patients with mesenteric cysts. Cysts generally appear unilocular without solid component on imaging. CT or MRI scans along with contrast studies of the gastrointestinal and urinary tracts reveal the cystic nature and location of the mass [2,3]. The mass is often large, smooth, round, compressible, and more mobile transversely than longitudinally.

The differential diagnosis includes pancreatic pseudocysts, enteric duplication (in children), inflammatory cysts, and retroperitoneal tumors. Less frequently, they may be multiple or multilocular or difficult to distinguish from solid mesenteric tumors with cystic components such as a cystic stromal tumor or mesothelioma. Mesenteric cystic lymphangioma may present as numerous, often large cysts in the setting of abdominal pain [3].

These can be difficult to treat and almost invariably recur after excision. When symptomatic, simple mesenteric cysts are surgically excised either openly or laparoscopically. Most lesions are benign, and enucleation suffices. Segmental resection may be necessary for cysts that impinge upon the bowel wall or its blood supply. Cyst unroofing or marsupialization is not recommended because mesenteric cysts have a high propensity to recur after drainage alone [2]. On rare occasion, adjacent mesentery or bowel may be densely adherent to the cyst, or mesenteric vessels must be sacrificed in order to achieve complete excision. In this case, segmental bowel resection inclusive of the adjacent mesentery is performed. Recurrences are more frequent with retroperitoneal cysts, because they may not be amenable to complete excision, and marsupialization may be required instead [2,3].

REFERENCES

1. Gerard M. Doherty. The peritoneum & its functions. Current Surgical Diagnosis & Treatment, Doherty, Gerard M.; Way, Lawrence W(Editors). 12th Edition: McGraw-Hill. 2016; 493-507.
2. Neal E. Seymour and Robert L. Bell. Abdominal Wall, Omentum, Mesentery, and Retroperitoneum. Schwartz's Principles of Surgery, F. Charles Brunicardi(Editor), Tenth Edition: McGraw-Hill. 2010; 1449-1450.
3. Neeralagi CS, Surag KR, Kumar Y, Lakkanna S, Raj P. Mesenteric Teratoma in Elderly Female: A Rare Case Report. J Clin Diagn Res. 2017; 11: PD01-PD02.

Cite this article

Polat FR, Duran Y, Sakallı O (2017) Giant Mesenteric Cyst: A Case Report. Ann Clin Pathol 5(3): 1114.