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CASE REPORT

Huge mesenteric cyst: Pelvic cysts differential diagnoses dilemma

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KEYWORDS

Mesenteric cyst;
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Abstract *Introduction:* Simple mesothelial cyst is a rare mesenteric cyst of mesothelial origin. The size is up to 10 cm. It is usually asymptomatic, but occasionally non-specific symptoms, which makes correct preoperative diagnosis difficult.
Case presentation: A 30-year-old woman presented with abdominal discomfort and distention to our hospital. Examination revealed soft abdominal mass. The laboratory examination was unremarkable. Abdominal imaging showed a huge cystic mass of 30 cm. Excision of the cyst was performed by midline laparotomy. The histopathological diagnosis was simple mesothelial cyst.
Conclusion: Peritoneal simple mesothelial cyst is a quite rare abdominal tumor, that must be considered in differential diagnosis of pelvic cystic lesions. The treatment of choice is surgical excision of the cyst.

1. Introduction

Mesenteric cysts are rare, abdominal tumors, and they are benign growths with malignant transformation reported in 3% of cases (1–4). The incidence has been estimated to be 1 in 100,000 in the adult population and 1 in 20,000 in the pediatric population (1–3). They present in the first decade of life (5) with a 1:1 male to female ratio (1,6).

Less than 1000 cases have been reported in the literature. While 40% of cases are incidental findings found on physical examination or imaging, they can cause non-specific abdominal symptoms. 10% of cases can present with bowel obstruction, volvulus, torsion or shock. The lack of characteristic clinical and radiological features presents a diagnostic difficulty. The mainstay in imaging is computerized tomography (CT). Complete surgical excision is the treatment of choice. This can be accomplished by laparotomy or by minimally invasive surgery (3,4).

Perrot classification showed that peritoneal simple mesothelial cyst (PSMC), benign cystic mesothelioma and malignant cystic mesothelioma are mesenteric cysts (MC) of mesothelial origin (5) and other MC types are dermoid cysts and cysts of lymphatic, enteric or urogenital origin (5). PSMC is very rare, with about 900 reported MC cases in the literature (6,7). The cyst ranges from a few centimeters to 40 cm (8,9). They are usually asymptomatic, but occasionally non-specific symptoms which makes correct preoperative diagnosis difficult.

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We present the case of a woman with a giant mesothelial cyst that was managed by surgical excision, which is the treatment of choice.

2. Case report

A 30-year-old lady presented with a distended abdomen with abdominal pain since three months. G1P1, with previous I CS since 3 years she was diagnosed with huge ovarian cyst after six months by her doctor and performed midline laparotomy but found nothing and abdomen closed. She complained after one year of a renal colic and stone was diagnosed and removed by lithotripsy. After six months, she complained of abdominal pain with abdominal cyst diagnosed on ultrasound of query non-gynecologic origin, and ultrasound guided aspiration was performed by a surgeon for 200 cc serous clear fluid that was free of cells on histopathology. After 9 months, another cyst appeared on ultrasound, and CT was performed revealed left ovarian cyst about 20 cm with compression of the left ureter with hydronephrosis on that side (Figs. 1–3); then, she was admitted to our hospital (Shatby maternity hospital, a tertiary hospital of capacity 350 beds covering 4 provinces in Egypt) and she was vitally stable with abdominal pain. There was no evident abdominal distension and there was a deep mobile mass on abdominal palpation in the left upper quadrant with absent masses on PV examination. Ultrasound by experienced gynecologist revealed 20 cm abdominopelvic unilocular cyst on the left side near the kidney separable of both ovaries and distant from them with hydronephrosis, suspicious of mesenteric cyst. Her laboratory investigations were normal (FBC, renal function test, coagulations, LFTs). Tumor marker CA-125 was also normal. Midline laparotomy was performed revealed deep huge left mesenteric cyst. The cyst originated from the small bowel mesentery. It was adherent within the small bowel to the left side of the sigmoid colon, and posterior aspect of the left kidney. It was surgically excised and sent for histopathology. Macroscopically the mass was unilocular and contained approximately serous

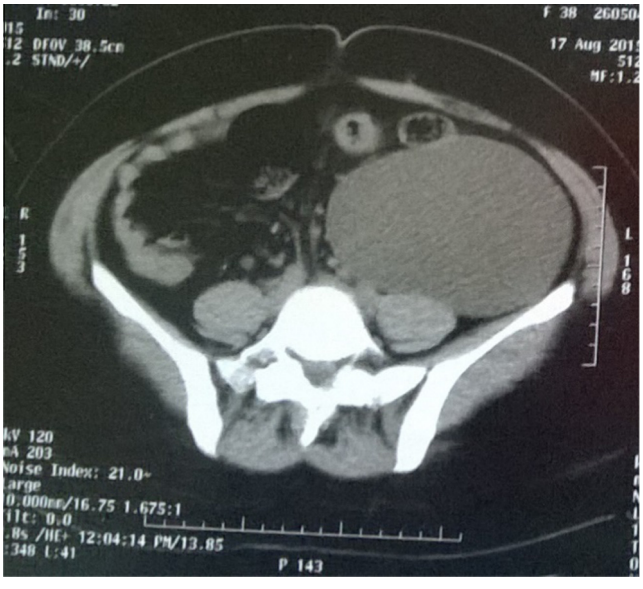

Fig. 1 CT showing pelviabdominal cyst on left side.

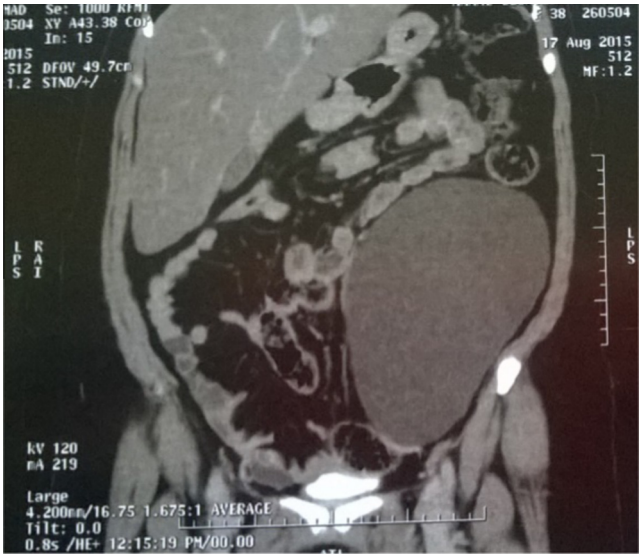

Fig. 2 CT showing huge pelviabdominal cyst.

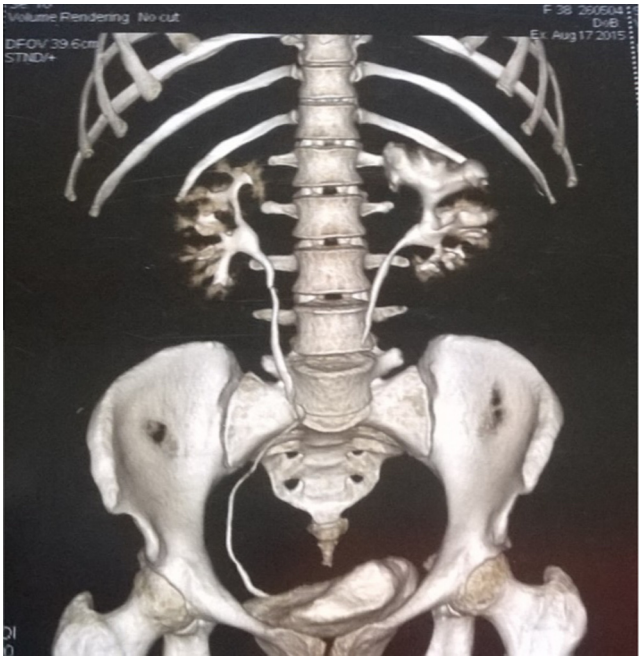

Fig. 3 CT showing compressed ureter with hydronephrosis on the left side.

fluid. The histopathological diagnosis was simple mesothelial cyst lined by regular mesothelial cells showing no atypia and no mitosis. No intra-operative complications were recorded. The patient had a quick recovery and was discharged shortly after the procedure.

3. Discussion

Mesenteric cysts can occur in the mesentery from the duodenum to the rectum (10). They occur more in the small intestine (66%) than the large intestine (33%). In the large bowel most arise from the right colon and ileum but rarely in the