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CLINICAL CASE

Gastrocolic omental cyst in an adult: Case presentation and review of literature☆

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KEYWORDS
Lymphangioma;
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Abstract
Background: Mesenteric lymphangioma are rare tumours. They usually present early on in life, if congenital, or soon after trauma. The usual sites of presentation of lymphangiomas are in the neck, and axillae. In the abdomen they are more common in the mesentery, primarily of the ileum, or retroperitoneal.
Objective: A rare case is presented of a mesenteric lymphangioma.
Clinical case: It involves an elderly African-American male, many years after trauma, and characterised with early satiety, causing weight loss, but without gastric outlet obstruction or vomiting. Its diagnosis, management and review of literature are presented.
Conclusions: Mesenteric cysts are rare tumours that should be included as differential diagnosis in elderly patients with a history of previous abdominal trauma.

PALABRAS CLAVE
Linfagioma;
Mesentérico;
Tumor

Quiste omental gastrocólico en un adulto: presentación de un caso y revisión de la bibliografía

Resumen
Antecedentes: Los linfangiomas mesentéricos son tumores poco frecuentes que suelen presentarse temprano en la vida, si son congénitos, o poco después de un trauma. Los sitios habituales de presentación son en el cuello, en la axila o en la cavidad abdominal; dentro de esta, el sitio más común es en el mesenterio, principalmente del íleon, o retroperitoneal.

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Objetivo: Mostramos este caso clínico poco frecuente de un linfangioma mesentérico.
Caso clínico: Masculino afroamericano que presentó aumento de volumen muchos años después de un traumatismo, caracterizándose clínicamente por: saciedad temprana y pérdida de peso, pero sin obstrucción de la salida gástrica, náuseas o vómitos. Exponemos su diagnóstico, manejo y revisión de la bibliografía.
Conclusiones: Los quistes mesentéricos son poco frecuentes; sin embargo, deben tenerse en cuenta como diagnóstico diferencial cuando un paciente presenta un cuadro clínico con aumento de volumen e historia de un trauma abdominal previo.

Background

Cystic lymphangioma is a rare, benign lesion, classified as a hamartoma. It is formed by a single layer of endothelial cells, connective tissue and smooth muscle fibres.[1] It generally occurs in areas surrounded by connective tissue.

They present most commonly in infancy, with an incidence of 1/20,000.[2] Sixty-five percent are present at birth and 90% are diagnosed in children under 2 years of age. In adults, the incidence is between 1/100,000 and 1/250,000.[3] Cystic lymphangioma can present in any part of the body, the neck being the most common (75%), the axillary region (20%) and the mediastinum, oesophagus, spleen, liver and other abdominal organs (4%).[4] They present in the mesentery in approximately 1% of cases, and within this group they are most commonly found in the small bowel (85%), mesocolon (10%) and retroperitoneum (5%).[5]

In the adult population, cysts are generally asymptomatic, but they can present with different symptoms depending on their location, size and the organ affected. Paediatric patients present a clinical picture with a shorter duration and with more acute symptoms, and therefore they frequently require emergency surgery.

Because the most common location of cystic lymphangioma is the ileum, the main symptom is chronic abdominal pain and abdominal distension.[6] However, cases have been described of acute pain and peritonitis due to rupture,[7] torsion, infection, due to a volvulus or intestinal obstruction secondary to the cyst.[8] In a study by De Perrot et al.[9] the most common physical finding, present in up to 61% of patients, was a compressible abdominal mass.

Objective

We present a case of a gastrocolic omental cyst in a male in the sixth decade of life.

Clinical case

We present the case of a 67-year-old man, an African American war veteran with a previous history of exploratory laparotomy (37 years ago) for a liver injury secondary to a firearm wound in the upper right quadrant, for which a right subcostal incision was made. The patient did not know the details of this procedure, but stated that none of his abdominal organs had been resected.

He consulted with increased abdominal volume, which he presented many years after the liver injury, accompanied by early satiety and a feeling of gastric fullness after small meals, progressing to nausea without vomiting or diarrhoea, and significant weight loss of 10 kg over 6 months. On physical examination the abdomen was soft, not painful and not distended. The increased volume was palpable in the upper right quadrant, below the subcostal incision. It had smooth edges and was not mobile on palpation. The laboratory tests that included viral hepatitis serology and alpha-fetoprotein were normal.

An abdominal CT scan was performed which revealed a cystic lesion contiguous to the lower face of the left liver lobe. This was confirmed by MRI, which showed a cystic lesion with a clear plane between it and the liver. The cyst was in front of the head of pancreas and the duodenum, and therefore an endoscopic ultrasound was performed which confirmed that it was not in continuity with the pancreas or the pancreatic duct. We attempted to take a sample of the fluid during this procedure, but this was not possible. Most of the results confirmed the diagnosis of a benign cyst; we therefore decided to observe the patient over 6 weeks. During this time the patient's symptoms persisted, he was therefore scheduled for laparotomy (Fig. 1) due to the history of previous surgery to the right hypochondrium, near the lesion in question. We decided that laparotomy provided better access than laparoscopy due to the adhesions and because little was known about the previous procedure.

With the patient under general anaesthetic, we palpated the right hypochondrium where the edges of the cyst were palpable and easily delineated. We decided to start with an 8 cm incision in the midline.

After extensive adhesiolysis, we observed a mobile, clearly translucent cystic lesion of 14 cm × 10 cm × 10 cm under the liver, anterior and lateral to the pylorus in the area of the gastrocolic mesentery. After careful dissection, we ligated the vessels of the omentum near the surface of the cyst. A sample of the fluid was taken, which was translucent, slightly yellow and had no subnatant matter and no bile, blood, pus or mucus were found. Haemostasis was performed, and we examined the mesentery of the transverse