

**RESEARCH ARTICLE****A RARE PRESENTATION OF MESENTERIC CYST****DR AKHEEL AHMED, DR SRIKAR BILLA**

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Key words:***Corresponding Author****DR AKHEEL AHMED****Abstract**

Aim: Aim is to report a case of rare presentation of mesenteric cyst i.e., infected mesenteric cyst.

Mesenteric cysts are rare intraabdominal lesions of childhood. Symptoms are extremely variable and are related to the size and position of the cyst, with no pathognomonic signs in the uncomplicated patients. Mesenteric cysts may cause abdominal distension or pain. It may also present with acute symptoms secondary to complications such as obstruction (volvulus, extrinsic compression or entrapment in pelvis), rupture, and hemorrhage into cyst, infection or abscess formation. The most common acute presentation in children is small bowel obstruction with a possible volvulus and an associated intestinal infarction. Infected mesenteric cyst and/or perforation are very rare complications of a very unusual lesion. Ultrasonography (USG) and computed tomography (CT) are the best preoperative diagnostic tools. The treatment of choice is an urgent laparotomy and complete cyst removal.

Case: We report a case of 16yrs old boy who presented with right iliac fossa pain. He was diagnosed clinically as an appendicular lump. USG and CT revealed a cystic mass. Laparotomy was done, which revealed a huge multiloculated cystic mass in the ileal mesentery. Resection and ileo-ileostomy was done.

Conclusion: Acute presentations of the mesenteric cyst are rare and can be misdiagnosed as common abdominal diseases at presentation, such as appendicitis, ovarian torsion, diverticulitis and small bowel obstruction. USG and CT scanning are the most useful imaging modalities for diagnosing mesenteric cysts preoperatively. Surgical removal is the only treatment for these lesions.

*Copy Right, IJAR, 2015,. All rights reserved***INTRODUCTION**

Mesenteric cyst was first observed in 1507 by an Italian anatomist, Benevienne while performing an autopsy on 8 years-old child and first successful resection was performed by Tallaux in 1880. [1, 2]

These cysts may occur in every part of the mesentery, from duodenum to rectum. Most frequently cysts are localized in small bowel mesentery (ileum in 60%) and right mesocolon (ascending colon in 40%). [3] Mesenteric Cysts are classified based on the histopathological features into 6 groups: 1) cysts of lymphatic origin, 2) cysts of mesothelial origin, 3) cysts of enteric origin, 4) cysts of Urogenital origin, 5) mature cystic teratoma and 6) pseudocysts. [4]

There is no pathognomonic sign and patient usually comes with non-specific symptoms such as abdominal mass or acute abdominal pain. [5, 6] Therefore these cysts are usually diagnosed during the surgery. [6] Lack of characteristic clinical features and radiological signs presents difficulties for diagnosis of mesenteric cysts. [7]

A variety of diagnostic modalities can be used to confirm the presence of a mesenteric cyst, but USG and CT scanning tend to be favored methods. Bliss *et al* claim that USG imaging is the most reliable way to diagnose a mesenteric cyst. [7]

The treatment of the mesenteric cyst is excision of the cyst totally. Thus recurrence rate is very low. [8] We present a case that came to our emergency department with acute abdomen, which was misdiagnosed as an appendicular lump. USG & CT revealed a cystic mass with septations. He was operated - segmental resection of the ileum with cyst and ileo-ileostomy was done. HPE revealed infected mesenteric cyst of lymphatic origin.

CASE REPORT

A 16yrs old boy came to our emergency department with right lower abdominal pain of 3days duration. Pain was associated with nausea, vomiting and constipation. Nothing seemed to alleviate or exacerbate the pain.

Physical examination revealed a body temperature of 101 F, pulse rate of 106/mt, blood pressure of 100/60mm of Hg. Respiratory and cardiac examinations were normal. Abdominal examination revealed a tender mass in the RIF with guarding all over the lower abdomen.

Laboratory tests are as follows Hb -11gm%, WBCs- 27,400/cu.mm; all other parameters were within normal limits. USG abdomen demonstrated a large multiloculated cystic mass occupying the RIF & Hypogastrium. CECT abdomen revealed cystic mass with multiple septations, appendicitis and minimal free fluid.

The patient was resuscitated and laprotomy was performed, which revealed a large cystic mass which is firmly attached to the ileal mesentery and compressing the bowel lumen with dilated loops proximally and collapsed ileum distally [Figure 1, 2]. A segmental resection of the ileum with cyst [Figure 3] and ileo-ileostomy was done. The histopathological examination showed mesenteric cyst of lymphatic origin with superimposed secondary infection. The patient recovered uneventfully and was discharged on the 10th postoperatively. The boy is doing well at 1 year after surgery.

DISCUSSION

Mesenteric cysts are one of the rarest intraabdominal lesions. They are found in approximately 1 of every 1, 00,000 adult admissions to hospital.[9] Mesenteric cysts are of an unknown etiology, one of the leading theories suggest that they are benign proliferations of ectopic lymphatics that fail to communicate with remaining lymphatic system.[10] Mesenteric cysts have been reported from the duodenal to the rectal mesentery but are most commonly located in the ileal mesentery.[11]

Mesenteric cysts vary in their clinical presentation. Although mesenteric cysts are usually asymptomatic and found incidentally, they present with abdominal pain, nausea, vomiting, diarrhea, constipation, weight loss and an abdominal mass. On the other hand, emergency cases resulting from rupture or bleeding of the mesenteric cyst, intestinal obstruction, volvulus, or torsion of the cyst have been reported. Acute presentation due to perforation following abdominal trauma or in an infected cyst is very rare. [11] In acute cases, mesenteric cysts are difficult to palpate due to guarding and a tense abdominal wall.

The treatment of the mesenteric cyst is excision of the cyst totally through a laparotomy or laproscopically. Thus recurrence rate is very low. [8] Yet, it cannot be removed separately because of the configuration near the arteries of cyst. For this reason segmental resection is necessary.[12] If resection is not possible due to the size of the cyst or due to its location deep within the root of the mesentery, the option is partial excision with marsupialisation of the opening of the cyst into the abdominal peritoneal cavity.[9]

In our case, the cyst was so large and the bowel segment was very thin near the cyst, hence segmental resection with end to end anastomosis was performed.

CONCLUSION

Mesenteric cysts are intraabdominal tumors and they vary in their clinical presentation. There are no specific symptoms indicative of mesenteric cysts, which are the reason these lesions are often confused and sometimes misdiagnosed as common abdominal diseases at presentation, such as appendicitis, ovarian torsion, diverticulitis and small bowel obstruction. USG and CT scanning are the most useful imaging modalities for diagnosing mesenteric cysts preoperatively. Surgical removal is the only treatment for these lesions. Bowel resection may be necessary in cases where cysts are close to bowel structures or involve blood vessels that supply the bowel. Once removed, mesenteric cysts rarely recur, and patients have an excellent prognosis.

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