

CHYLOUS MESENTERIC CYST: CASE REPORT

Cisto mesentérico quiloso: relato de caso

Luiz Ronaldo **ALBERTI**, Leandro Tibúrcio **REGINA**, Gustavo Mariani **BOLINA**, Andy **PETROIANU**

From General Surgery Service and Post-Graduation in Health Sciences of Santa Casa de Belo Horizonte, Belo Horizonte, MG, Brasil.

Correspondência:

Andy Petroianu,
e-mail:petroian@medicina.ufmg.br

Conflict of interest: none
Financial source: none

Submitted: 14/07/2009
Accepted for publication: 25/01/2011

and smooth, measuring 12.9 x 11.6 x 9.9 cm, located on the left flank, in the mesenteric region, displacing adjacent structures, suggestive of mesenteric cyst (Figure 1A). Laparotomy revealed a cystic mass, with approximately 10 cm in diameter, thin-walled, smooth, yellowish, with tortuous vessels on the surface, without adherence to adjacent structures, located in mesojejunum about 50 cm from the duodenojejunal flexure (Figure 1B). The cyst was completely removed and its content was whitish odorless liquid, suggesting be chylous. Pathology revealed a benign mesothelial cyst mesenteric (Figure 1C). The patient recovered uneventfully and was discharged on the second day after surgery, asymptomatic.

INTRODUCTION

Mesenteric cysts are rare abdominal tumors, which can affect individuals of any age. There is a predominance of females in the fourth decade of life and usually cause no symptoms and is diagnosed occasionally. They are classified as mesothelial cysts or lymphangiomas and can originate in lymphatic tissue, vascular, nervous and connective tissue. Treatment consists of withdrawal or wide opening. In some cases, may be required segmental bowel resection. The prognosis is good.

The aim of this paper is to present the case of a patient with a large chylous cyst in mesojejunum, resected by laparotomy.

CASE REPORT

Female, 40 years old, obese, with hypertension and diabetic, was admitted to General Surgery Service of Santa Casa de Belo Horizonte, MG, Brasil with a history of continuous abdominal pain and low intensity in the left hypochondrium and epigastrium, without irradiation, during about three months. The pain improved with common painkillers, was associated with episodes of nausea, vomiting and postprandial fullness. After a month of onset of symptoms she noticed a mass in the upper abdomen. There was no trauma in the region, fever, melena or hematochezia.

The mass was palpable from the epigastrium to the left flank with a hard consistency, little mobility, smooth surface and painful. The abdominal computed tomography showed cystic formation with thin walls

DISCUSSION

Mesenteric cysts are rare abdominal tumors. There are approximately 820 cases reported in the literature since its first description in 1507 by Benevieni, Italian anatomist at autopsy of a girl of eight years^{3,6,7,9,10}. The first description of a chylous mesenteric cyst was in 1842, by Rokitanski¹¹. The first performed successful resection of a mesenteric cyst and in 1883 made the first partial removal of the cyst^{7,11}.

The incidence of treatment of these cysts is a case for every 100,000 to 250,000 hospitalizations^{5,9,10,11,12}. They manifest themselves at any age, however, two thirds of cases are diagnosed in people over 10 years of age, predominantly female, in the third and fourth decades of life^{6,7,11}.

The cysts can occur anywhere in the intestine from the duodenum to the rectum, however most affects the ileum followed by the ascending colon being most frequently in the small intestine and colon^{6,7,10,12}. Its cause is still unclear, but it is believed that may result from malformation of abdominal lymphatic ducts in the background are blind or sequelae of trauma, infections or neoplasms^{5,10}.

Most cases are asymptomatic and discovered incidentally during workup for other diseases, but may present with signs of acute or chronic abdominal pain, bowel obstruction, nausea and vomiting or even as an acute abdomen and shock due to rupture infection or torsion^{5,6,9,10}. The diagnosis is suspected in

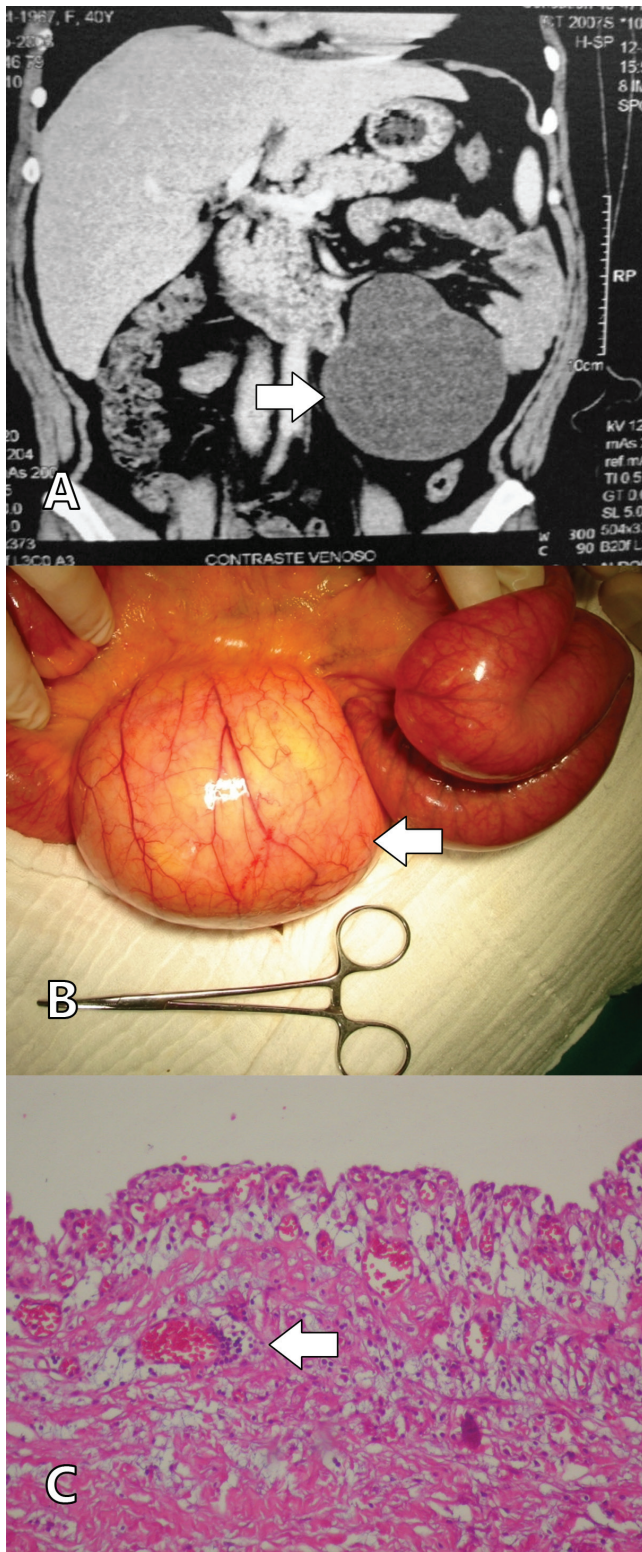


FIGURE 1 - A) abdominal computed tomography showing a cystic lesion in the left flank of the abdomen displacing adjacent intestinal loop; B) operative image of the cystic mesojejunum mass; C) microscopic image (HE) of the cyst wall showing fibrous connective tissue with areas of hemorrhage, fibrosis and inflammatory infiltrate

the abdomen, with the aid of the signal of Tillaux - mobilization of the cyst as a whole on deep abdominal palpation⁴. Confirmation occurs with ultrasonography and CT scan to help differentiate between solid and cystic masses and to assess involvement of adjacent structures^{5,8,10,11,13}.

Laboratory tests are not useful in these cases. The differential diagnosis is made with lymphangioma and mesotheliomas. Its malignant degeneration is rare, 3 to 4% of cases⁹.

Treatment consists primarily of removing the cyst or its capsule accompanied by biopsy of it, which can preferably be achieved by laparoscopy^{2,12}. The recurrence reaches 13.6%, being associated with the technique. The postoperative follow-up is accomplished through periodic ultrasound exams^{5,9}. The prognosis is good, with total remission of symptoms¹⁰.

REFERÊNCIAS

1. Adams JT. Parede Abdominal, Omento, Mesentério e Retroperitônio. In Swartz SI. et al. Princípios de Cirurgia. 5ª Ed, Rio de Janeiro: Guanabara Koogan;1991. p .1264-1266.
2. Al-Haifi MB, Abdulmad AM, Juma TH. Laparoscopic Excision of Mesenteric Cyst: Case Report. Kuwait Medical Journal 2007;39(2):167-169.
3. Block FB. Chylous mesenteric cyst: Case report. Annals of Surgery 1948; 128:158-160.
4. Cònsolo FS, Cardoso AAP, Monge M, Santos P, Hernandez PM. Formação Cística de Túnica Serosa de Cólon Ascendente – Relato de caso. RAMB 2005;55(1/2),36-39.
5. Duldulao MP, Thiruchitrabalam A, Kaul A. Mesenteric cyst: A rare cause of lower abdominal pain. Surg Rounds 2008; 31(3): 123-127.
6. Filho FAC, Landim FM, Perdigo FB. Linfangioma Cístico do Mesentério: Uma Rara Apresentação de Abdômen Agudo. Rev. Col. Bras. Cir. 1999;27(2):139-140.
7. Fraga MR, Cavalcante AFS, Benício IB, Pereira AA, Leite CAC, Dias RP. Cisto Mesentérico. Rev. Ped. Ceará 2004;5(1):34-37.
8. Fujita N, Noda Y, Kobayashi G ET AL. Chylous cyst of the mesentery: US and CT diagnosis. Abdom. Imaging 1995;20(3):259-261.
9. Garcia RP, López ET, Ovalle JLR. Quiste mesentérico: Descripción de um caso. Cirujano General 2001; 23(2): 109-112.
10. Miliaras S, Trygonis S, Papandoniou A, Trygonis C, Kiskinis D. Mesenteric Cyst of the Descending Colon: Report of a Case. Acta chir belg 2006;106: 714-716.
11. Miljkovic D, Gmijovic D, Radojkovic G, Radovanovic Z. Mesenteric cyst. Arch Oncol 2007; 15(3-4): 91-93.
12. Sahin DA, Akbulut G, Saykol V, San O, Tokyol C, Dilek ON. Laparoscopic Enucleation of Mesenteric Cyst: A Case Report. The Mount Sinai Journal of Medicine 2006;73(7):1019-1020.
13. Simeone DM, Prankoff T, Mesenteric Cyst. Images in Clinical Medicine 1999;341(9):659.