SUNTEXT REVIEWS

SunText Review of Case Reports & Images
ISSN: 2766-4589

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Volume 3:4

Mesenteric Cystic Lymphangioma: A Rare Case Report

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Received date: 20 November 2022; **Accepted date:** 23 November 2022; **Published date:** 26 November 2022

Citation: Stefanidis I, Polychroni D, Kouskos E (2022) Mesenteric Cystic Lymphangioma: A Rare Case Report. SunText Rev Case Rep Image 3(4): 163.

DOI: https://doi.org/10.51737/2766-4589.2022.063

Clinical Image

Mesenteric cystic lymphangioma is a rare, benign tumour originated from lymphatics vessels. It accounts less than 1% from all lymphangiomas in total. The incidence is threefold in men. Approximately 70% are originated from small bowel mesentery. They can grow to a massive size. Involvement of the small bowel mesentery can be diffuse or localized. The majority of patients are initially asymptomatic. Clinical image is depending upon size and location of the lesion. It includes vague symptoms such as nausea, abdominal pain / distention and palpable mass. Complications associated with mesenteric cystic lymphangioma include hemorrhage, rupture, torsion, intestinal obstruction (due to volvulus), extraneous compression or infiltration of adjacent organs. Abdominal computed tomography and/or magnetic resonance imaging are necessary modalities for the preoperative diagnosis. CT angiogram can be useful in massive tumour cases where vascular involvement is strongly suspected. Definitive diagnosis is based upon surgical resection and histopathological investigation. Immunohistochemistry tissue analysis is positive for D2-40 (specific marker for lymphatic endothelial cells). Histopathological is characterized from dilated lymphatic spaces with smooth muscle and endothelial cells. A healthy 76-year-old man was referred to our hospital with painless abdominal distention that progressively increased over a course of 1 year. Free medical history, without previous abdominal operations. Physical examination revealed a large palpable mass located at the anterior abdominal wall. Ultrasound imaging described a 14 cm cystic mass. Laboratory examination data and tumour markers (CA 19-9, CEA) results were normal. Abdominal MRI scan with gadolinium contrast medium showed a 14 cm monolocular mesenteric cyst, without visceral or vascular infiltration. The patient progressed to a midline exploratory laparotomy. The tumour was completely separated from the mesentery (en block surgical resection). Neoplasm examination described a whitish mass of approximately 15.5 x 15 x 8 cm in size, consisting of cystic and solid components. Histopathological examination revealed cystic mesenteric lymphangioma with extensive foci of ossification. Immunohistochemistry analysis revealed endothelial cells stained positive for ERG, D2-40 (podoplanin) and negative for WT1, calretinin. The patient had an uneventful post-operative recovery. He was discharged from our hospital on postoperative day 6. There was no recurrence at the 1-year follow up. Optimal treatment of mesenteric cystic lymphangioma is complete surgical resection, occasionally including removal of the adjacent small bowel in order to achieve en block excision. Postoperative recurrence rates are low, unless the tumour was incompletely resected. Long term prognosis following complete resection is generally very good.

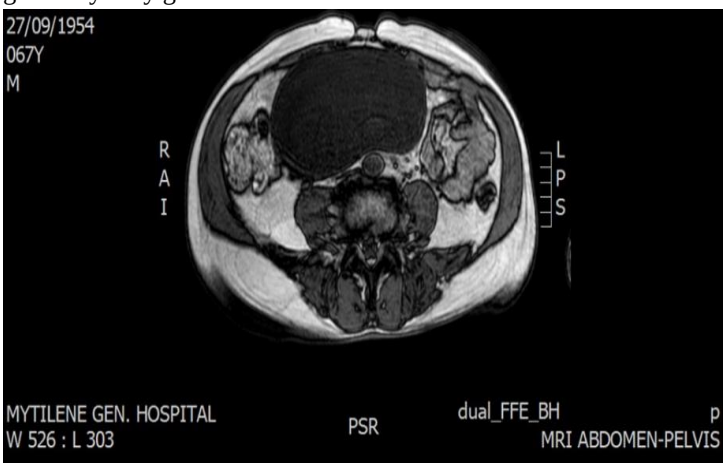
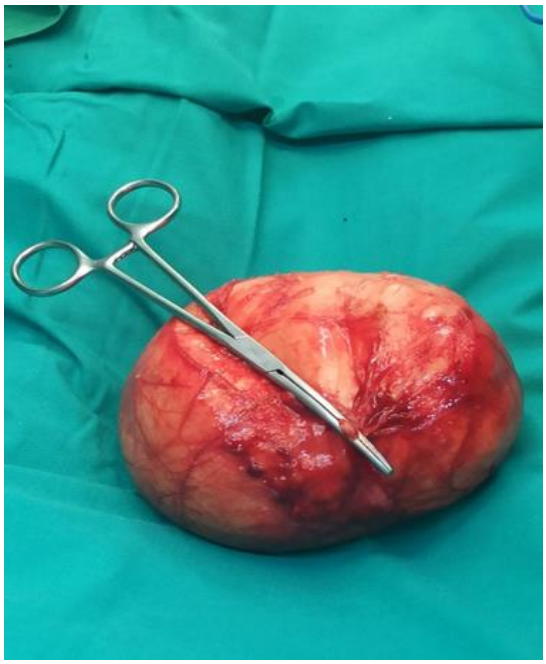
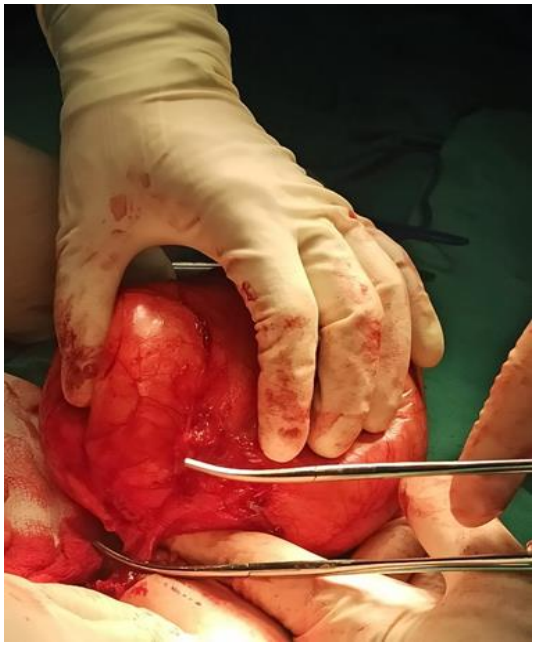


Figure 1: *Abdominal MRI scan showing a huge cystic mass with clear margin, without contrast enhancement.*



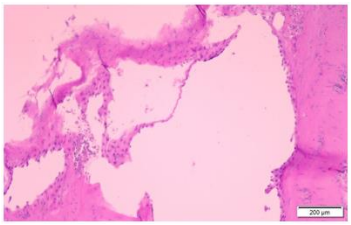
2a



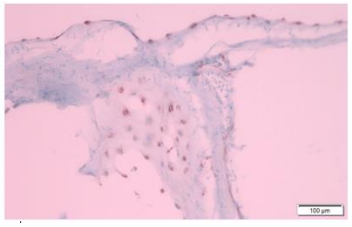
2b

Figure 2a: *Soft, milky white mass involved the small bowel mesentery, with smooth outer surface.*

Figure 2b: *Intraoperative photographs showing the cystic lesion.*



3a



3b

Figure 3a*: Histopathology (hematoxylin and eosin). Numerous dilatated lymphatic vessels (x200). Lymphocytic aggregates in a small line of cells at the cystic wall.*

Figure 3b*: Immunohistochemistry analysis for ERG vascular stain marker (x200). Positive expression of cells which invest distended spaces.*