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Mesenteric cyst: drained and marsupialised laparoscopically avoiding enterectomy

Riad Al-Harfoushi,¹ Lynn Stevenson,² Norman Binnie¹

¹Surgery Department, Aberdeen Royal Infirmary, Aberdeen, UK;

²Surgery Department, Morriston Hospital, Swansea, UK

Correspondence to Dr Riad Al-Harfoushi, al_harfoushi@hotmail.com

DESCRIPTION

A 61-year-old man attended the outpatient department with vague abdominal discomfort associated with left flank pain. After investigation he was diagnosed with a symptomatic mesenteric cyst. US scan (figure 1) of the abdomen revealed a 20×14×25 thin-walled peritoneal cyst. The cyst was laying between the spleen and the anterior aspect of the left kidney. The origin of the cyst not identified. CT scan (figure 2) confirmed the presence of a 25.7×14×20 cm cystic lesion. The left kidney was displaced posterior-inferiorly and the spleen was displaced superiorly. The CT was also unable to successfully determine the origin of this cyst. A diagnostic laparoscopy was the best option for the patient. Intraoperatively the presence of the cyst was confirmed. It was a mesenteric cyst close to the origin of small bowel mesentery. It contained 3.3 litres of straw coloured fluid. The lining of the cyst was smooth and benign looking. Therefore, the cyst was drained and de-roofed laparoscopically and the drainage opening marsupialised.

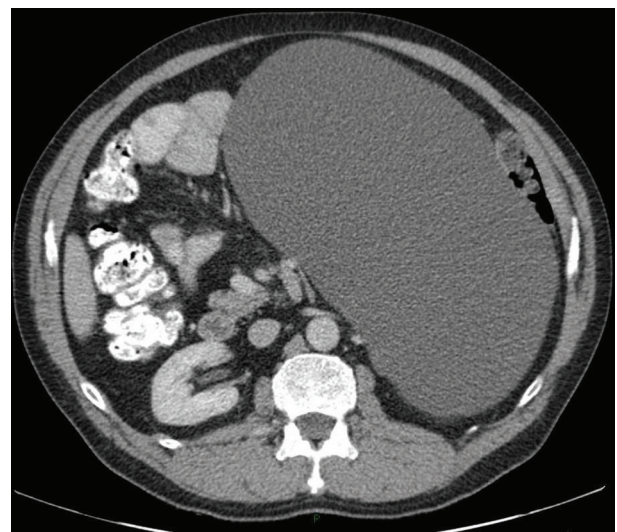


Figure 2 CT scan.

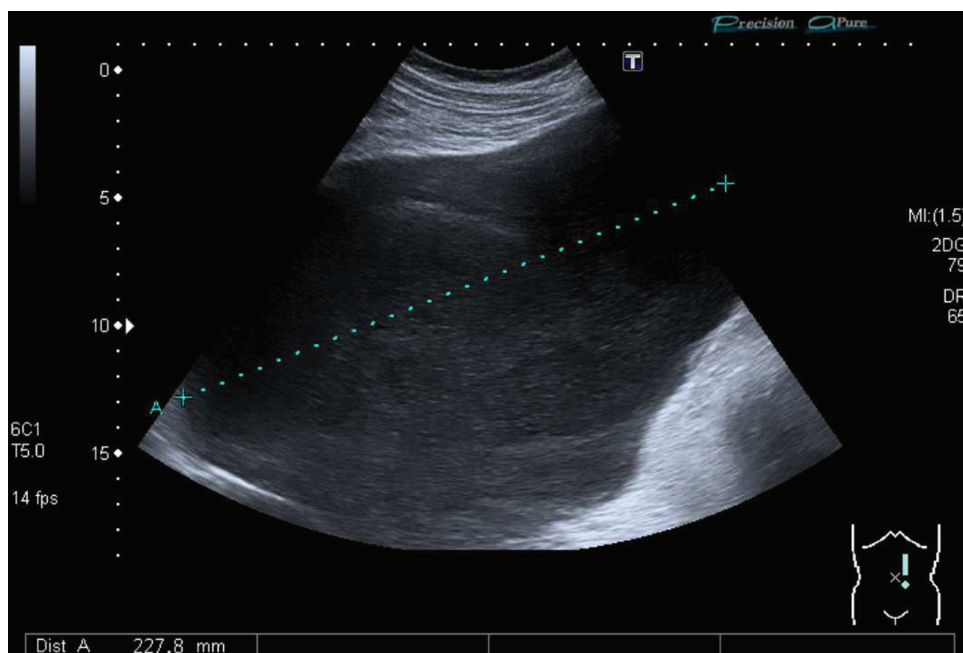


Figure 1 US scan.

Learning points

- ▶ Mesenteric cysts (MC) are one of the rarest intra-abdominal lesions. They are found in approximately 1 of every 100 000 adult admissions to hospital. MC are of an unknown aetiology, one of the leading theories suggest that they are benign proliferations of ectopic lymphatics that fail to communicate with remaining lymphatic system.¹
- ▶ Although MC are usually asymptomatic and found incidentally, they can cause vague non-specific symptoms such as: abdominal pain and distention, with possibly associated nausea and vomiting. More acute symptoms are reported with cystic rupture, haemorrhage or torsion of the cyst. Their size could range up to 10 cm.²
- ▶ The treatment of choice is surgical excision through a laparotomy or laparoscopically. 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.³
- ▶ As MC are rare, there are essentially no large clinical trials to determine optimum management. We therefore encourage all cases of MC to be reported so that optimum outcome can be determined.

Competing interests None.

Patient consent Obtained.

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