Case Snippets

Giant mesenteric cyst of abdomen herniating into scrotum

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Cystic mesenteric tumors are rare abdominal neoplasms. We report a 55-year-old man with recurrent benign mesothelioma arising from the left colonic mesentery and extending into the scrotal sac. He recovered well after excision of the abdominal and scrotal mass. [Indian J Gastroenterol 2004;23:74-75]

Key words: Cystic tumors, mesothelioma

Mesenteric cyst is a rare abdominal tumor. Since the first report by Benevienal in 1507, only 820 cases have been reported. Though commonly found in the ileal and right colonic mesentery, mesenteric cysts can be localized anywhere in the mesentery.

A 55-year-old man, nonsmoker, nonalcoholic, was admitted with complaints of progressive, painless distention of the abdomen for one and a half years, progressively increasing bilateral scrotal swelling, dyspnea on exertion, and early satiety for one year. There was no history of pedal edema, jaundice, abdominal pain, fever, GI bleed, constipation or vomiting. There was a history of bilateral hydrocele repair with eversion of sac 3 years earlier; six months later the patient developed right inguinal hernia, with multiloculated ascites. Exploratory laparotomy done at a district hospital revealed a 7 cm x 5 cm cystic mass, which was incompletely excised due to bowel adhesions. Histology of the specimen revealed a benign mesothelioma with no evidence of malignancy. One year later, the patient noticed progressive abdominal distension; six months later there was progressive bilateral scrotal swelling because of which he had difficulty in walking.

Examination revealed generalized distension of abdomen with scar of previous surgery, without any organomegaly; there was shifting dullness and fluid thrill. The scrotal sac was massively enlarged, was cystic in consistency at places, nontender, and the testes could not be palpated separately.

References


Fig: Abdominal aortogram (anterolateral view) showing tight SMA stenosis with post-stenotic dilatation (arrow).

Investigations: Mild normocytic anemia with 70-mm sedimentation rate. Lipid profile and renal parameters were normal. Tests for rheumatoid factor and antinuclear antibody were negative. Plain abdominal radiograph, ultrasonography and endoscopy were normal. CT scan showed normal gastrointestinal tract but was remarkable for diffuse narrowing and thickening of the abdominal aortic wall. Aortogram showed tight superior mesenteric artery (SMA) stenosis with post-stenotic dilatation (Fig), re-formation of the infrarenal aorta at the femoral artery bilaterally, with patent femoral and popliteal arteries.

Takayasu arteritis involving the abdominal aorta, causing chronic mesenteric ischemia, was considered and the patient was treated with parenteral hydrocortisone, 100 mg 6 hourly for one week, followed by SMA balloon angioplasty. Postangioplasty aortogram showed greatly improved flow across the stenosis with good runoff; the patient had marked symptomatic improvement. Following angioplasty he was put on oral prednisone for 3 months. He is asymptomatic 9 months later; repeat aortogram showed no stenosis.

Takayasu arteritis, an idiopathic large vessel vasculitis in young individuals, affects the aorta and its major branches. Women are affected about 10 times more often than men. Morbidity results from arterial stenosis and organ ischemia. Chronic mesenteric ischemia is a very rare clinical presentation. Patients with mesenteric artery involvement usually require surgical intervention, either graft bypass or transaortic endarterectomy.

Our patient had involvement of only the abdominal aorta, i.e., middle aortic syndrome, with patent distal arteries. He was treated successfully with an initial course of corticosteroids followed by balloon angioplasty of the SMA, followed again by a course of steroids.
However this was not feasible in our patient because of previous incomplete excision, extensive adhesions with bowel, and the huge size of the swelling.

References


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Spontaneous gall bladder perforation: a rare entity in infants

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Spontaneous gall bladder perforation in infants is rare. We report a 3-month-old male infant who presented with progressive abdominal distension, low-grade fever, bilateral hydrocele and acoelic stools. Ultrasonography showed free fluid in the peritoneal cavity, which was bile-stained on paracentesis. Surgical exploration revealed sterile biliary peritonitis and a gangrenous gall bladder. Partial cholecystectomy with external biliary drainage resulted in satisfactory recovery. [Indian J Gastroenterol 2004;23:75-76]

Key words: Cholecystitis, gangrenous

Spontaneous gall bladder perforation has been reported to account for 3% to 10% of gall bladder perforations in adults; its incidence and etiopathogenesis in infants is unknown. This rare entity presents in infants with features of subacute peritonitis and biliary obstruction.

A 3-month-old male infant presented with progressive abdominal distension, low-grade fever, acoelic stools and bilateral scrotal swelling for 7 days. The child appeared active and alert and was feeding vigorously. On examination he had mild icterus, fever, and bilateral hydrocele with gre attach discoloration of the scrotum. The abdomen was distended and non tender, and liver was palpable 3 cm below the costal margin. Rectal examination was normal.

Investigations: hemoglobin 9 g/dL, WBC 13000/mm³, serum bilirubin 3.2 mg/dL, AST 150 U/L, ALT 190 U/L, alkaline phosphatase 50 U/L, and normal renal function tests. Ultrasonography showed free fluid in the peritoneal cavity and hepatomegaly. Paracentesis revealed sterile bile-stained ascitic fluid.

Abdominal exploration after resuscitation revealed approximately 750 mL of bile-stained ascites with gangrenous...