Review Article

Journal Of Clinical & Medical Images Case Reports

Open Access, Volume - 2

A fluid filled retroperitoneal cyst in an elderly woman causing right lower quadrant abdominal, flank and back pain: A large mesenteric cyst fused to an atrophic ovary and fallopian tube case report

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Received Date : Apr 18, 2022
Accepted Date : June 09, 2022
Published Date : Jun 24, 2022
Archived : www.jcmimagescasereports.org

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Abstract

Mesenteric cysts account for 1 in 100,000 adult admissions. Symptoms range over a broad spectrum and include abdominal pain, distention, mass and obstruction. Diagnosis of this often requires an imaging study. Herein is reported the case of an 81 year-old female patient that presented to the emergency room with a several month history of progressive, lingering abdominal and back pain, that experienced an acute exacerbation. A CT scan showed a large fluid filled cystic structure that was adjacent to the ileocecal junction. A diagnostic laparoscopy with excision of the cystic structure was performed with oophorectomy and salpingectomy as these structures were adhered to the structure, no bowel resection was required. Pathologic analysis was consistent with a benign mesenteric cyst with an atrophic ovary and fallopian tube. Complete excision of a suspected mesenteric cyst is advised. Minimally invasive techniques are excellent tools for both diagnosis and excision of these structures.

Introduction

Mesenteric cysts account for 1 in 100,000 adult admissions [1]. Symptoms range over a broad spectrum and include abdominal pain, distention, mass and obstruction [2, 3]. Diagnosis of this often requires an imaging study. The location of these cysts can vary. Complete excision of the cysts is typically performed to rule out malignancy [4].

Presentation of case

Herein is reported the case of an 81 year-old female patient that presented to the emergency room with a several month history of progressive, lingering abdominal and back pain, that experienced an acute exacerbation. Physical exam was consistent with right lower quadrant abdominal, flank, and back pain. No mass could be appreciated on exam. A CT scan showed a large fluid filled cystic structure that was adjacent to the ileocecal junction (Figure1, Figure 2). A prompt diagnostic laparoscopy with excision of the cystic structure was performed with oophorectomy and salpingectomy as these structures were adhered to the structure, no bowel resection was required (Figure 3, Figure 4). The patient had an uneventful postoperative course occurred, and was discharged on post operative day 3. Pathologic analysis was consistent with a benign mesenteric cyst with an atrophic ovary and fallopian tube (Figure 5). The patient was seen in follow up as an outpatient and she noted resolution of her symptoms, of pain in her back, abdomen and flank.

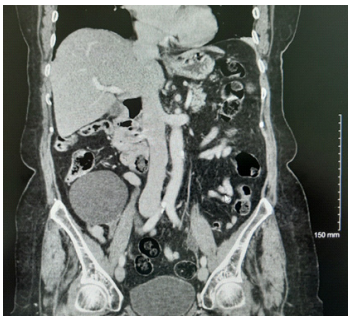

***Figure 1:** Coronal view of CT demonstrating mesenteric cyst.*

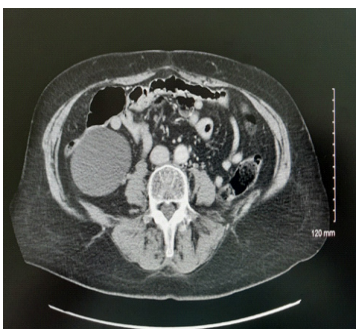

***Figure 2:** Axial view of CT showing mesenteric cyst.*

Citation: James G Chambers. A fluid filled retroperitoneal cyst in an elderly woman causing right lower quadrant abdominal, flank and back pain: A large mesenteric cyst fused to an atrophic ovary and fallopian tube case report. J Clin Med Img Case Rep. 2022; 2(3): 1179.

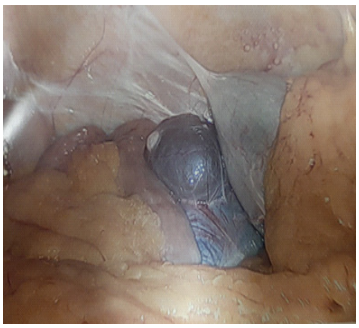

Figure 3: *Intraoperative view of cyst during diagnostic laparoscopy.*

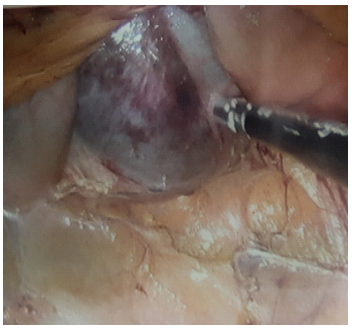

Figure 4: *Intraoperative view of cyst during laparoscopy.*

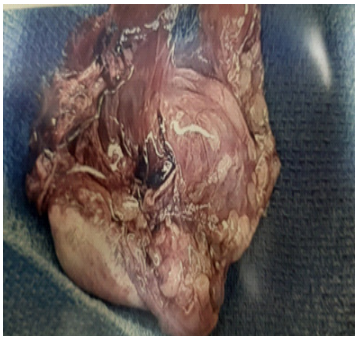

Figure 5: *Gross view of cyst upon excision.*

Discussion

Mesenteric cysts can present in a variety of locations, sizes and with varied symptoms. Diagnostic laparoscopy is an excellent tool to evaluate these structures and laparoscopic techniques can provide a means for complete resection [5]. In patients that are surgical candidates it is suggested that these be excised as there have been some reports that these structures may harbor malignancy.

Conclusion

Complete excision of a suspected mesenteric cysts are advised, this may require a bowel resection, and in this case the cyst can be associated with tubo-ovarian structures by local extension. Minimally invasive techniques are excellent tools for both diagnosis and excision of these structures.

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