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Pelvic mesenteric cysts mimicking gynecologic adnexal mass

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Abstract: Differential diagnosis of the pelvic masses includes gynecologic and non-gynecologic pathologies. Among non-gynecologic causes mesenteric cysts are rare pathologies. They are mostly asymptomatic but may present with abdominal pain. In this report we summarized a case of pelvic mesenteric cyst, which was persistent for 6 months and treated as an endometrioma in this time.
Keywords: pelvic masses, mesenteric cysts, endometrioma.

INTRODUCTION

In daily practice gynecologist are usually successful to diagnose and differentiate adnexal masses. In most of the time physical examination and transvaginal ultrasound are sufficient for diagnosis. In women adnexal masses mostly originate from genital system [1]. However, in some cases this is not true. Non-gynecologic adnexal masses can be originated from appendix, bladder or intestines [2]. In these occasions 'appendicular abscess and mucocels, bladder diverticula, diverticular abscess, nerve sheath tumors, pelvic kidneys, and ureteral diverticula are the most common ones. Mesenteric cysts are not common causes of non-gynecologic adnexal mass, So preoperative diagnosis and treatment of mesenteric cysts are difficult since they are rare and lack of specific symptoms.

CASE REPORT

A 23 years old G1P1 woman referred to our unit for a persisting adnexal mass for 6 months. She was asymptomatic except mild pelvic pain. She was receiving daily dienogest (2 mg/day) (Visanne) for the last 5 months. In this time there were no change in pain complaint and mass size. She was offered an open surgery for the mass so she admitted to our unit for a laparoscopic choice.

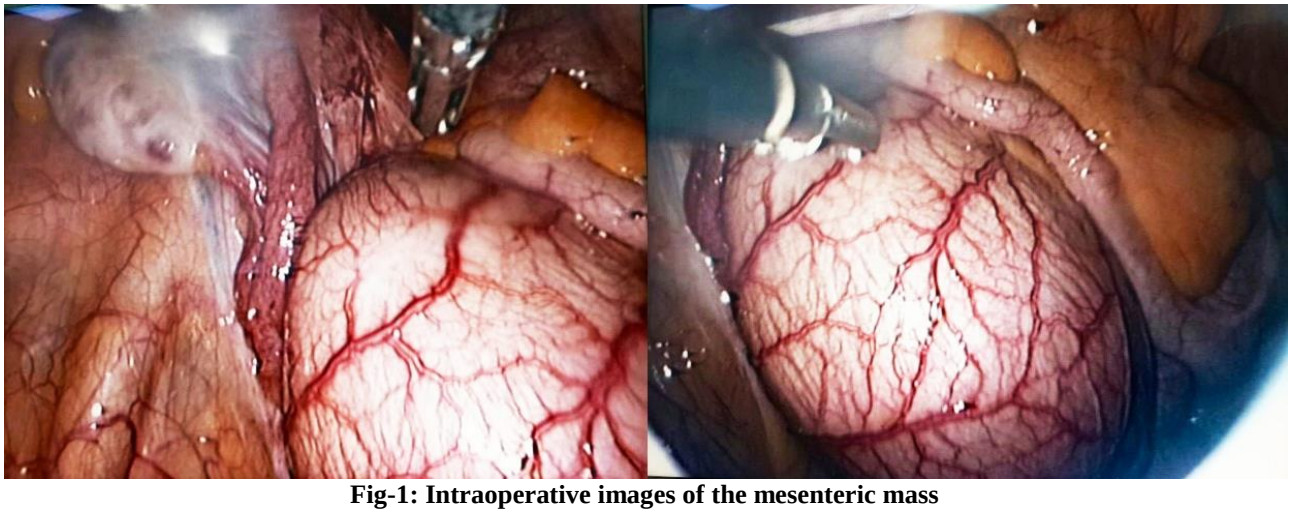

Fig-1: Intraoperative images of the mesenteric mass

Fig-2: Sonographic appearance of the mass

Vaginal examination revealed a mobile, painless semi-solid, 5-6cm mass in the right adnexa. In rectal examination, there was a solid, heterogeneous mass in the right adnexa next to the uterus (Figure I). It was about 6 cm in size. Left adnexa were normal. At first sight it seemed to be a dermoid mass, an endometrioma or a uterine myoma. Laboratory tests were in normal levels including tumor markers and Ca-125. She was informed about the findings and offered single port laparoscopic removal of the mass for the exact diagnosis. It was surprising to see a normal genital system in the laparoscopy. Both of the ovaries, tubes, and the uterus were normal. There were no ascites or blood in the pelvis. However, there was a mobile, semi-solid, smooth surfaced mass just next to the right ovary and the fallopian tube. The mass was originating from the cecum next to the appendix. There was an increase in the vascularization but there were no irregularity or vegetation on the mass wall. The patient was consulted to the general surgeons.

General surgeon indicated that the mass was a mesenteric cyst and since there were no sign of inflammation, necrosis, bleeding, vegetation, or irregularity on the mass and colonic obstruction findings surgical treatment was not necessary for the patient.

DISCUSSION

The term adnexa indicate the region including the ovaries and the tubes next to the uterus. So in general differential diagnosis of the adnexal masses includes ovarian or tubal pathologies. Most of the adnexal masses are gynecologic in origin in women. However, it is possible to see intestinal, retroperitoneal or metastatic masses in this region.

Mesenteric cysts are rare tumors mostly seen in the small intestine. These cysts can be seen in any part of the intestines from the duodenum to the rectal mesentery but are most commonly located in the ileac mesentery [3-5]. The leading theory about the development of the mesenteric cysts is the benign proliferation of ectopic lymphatic focus [6]. Trauma, neoplasia or lymph node degeneration may contribute to mesenteric cyst development [7]. They are mostly asymptomatic. Abdominal pain is the most common symptom but may mimic other diseases such as acute appendicitis, ovarian torsion or diverticulitis according to their origin. In our case the only symptom was the persistent mild pelvic pain.

Currently ultrasonography is a routine part of genital exam for gynecologists. It is highly effective for the differential diagnosis of pelvic masses. Typical sonographic features of mesenteric cysts are cystic or solid mass, showing echoes of debris, hemorrhage, or infection in ultrasound. As it is seen all of these features are not characteristic for mesenteric cysts. They can be

seen in benign or malignant ovarian cysts and any other tubal pathology. Computed tomography (CT) can be used for preoperative diagnosis of mesenteric cysts. However, for adnexal masses CT examination is not routine. The need of CT is questionable for a case like this in which the mass was seen accurately with sonography.

Complete excision of the cyst is the choice of the treatment when the cyst became symptomatic or complicated. It is possible to resect the cyst via laparoscopy or conventional open technique. There are case series about successful laparoscopic surgery in the literature with high cure rates [4, 5, 8]. The recurrence rate of mesenteric cysts is very low after surgery.

It can be discussible for this case whether there was a need for elective surgical treatment or not. Consulted intestinal surgeon indicated that it was not necessary to resect the cyst in this case since the patient was asymptomatic and the cyst was not complicated. Some patients may require bowel resection for complete resection of the cyst. As a conclusion it must be kept in mind that some of the adnexal masses can be non-gynecologic in origin.

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