Case Report

Omental Lymphangioma in Adults—Rare Presentation
Report of a Case

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1. Introduction

Lymphangioma is an uncommon benign lesion that is due to result from a developmental failure of lymphatic system/inflammation of lymphatics causing obstruction. Lymphangiomas occur in many anatomical locations. Most cases (95%) are found in the neck and axillary regions, whereas other sites, such as the mesentery, retroperitoneum, abdominal viscera, bone, lung, and mediastinum are unusual. Although rare abdominal lymphangiomas are more common in boys than in girls, they usually occur during childhood. They are reported to occur most commonly in the mesentery, followed by omentum, mesocolon, and retroperitoneum. They arise in all age groups and have variable presentation. But they are extremely rare in adult population [1]. Lymphangiomas are thought to result from a developmental failure of lymphatic system. Another possibility includes inflammation of lymphatic system leading to obstruction and subsequent development of lymphangioma. They are often confused with mesenteric cysts that arise from mesothelial, not lymphatic tissue. This differentiation is important because lymphangiomas often behave in an invasive and aggressive manner, whereas mesothelial cysts do not. Despite being difficult to differentiate between imaging studies, they are histologically distinct from one another. Lymphangiomas have an endothelial lining, foam cells, and a wall that contains lymphatic spaces, lymphoid tissues, and smooth muscles. Treatment is surgical excision.

2. Case Report

A 35-year-old female patient presented with a history of pain abdomen. On examination abdominal lump of size $10 \times 12$ cm, occupying the right lumbar region extending to umbilical region smooth surface, soft in consistency, retroperitoneal in position, was identified. Routine blood investigations show no obvious abnormality. As ultrasound abdomen shows $10 \times 12$ cm cystic anechoic lesion with multiple septations seen suggestive of lymphangioma. CECT abdomen was done showing multiseptate cystic mass with contrast enhancement of cyst walls suggestive of lymphangioma arising from omentum. Laparotomy done, intraoperatively a $10 \times 12$ cm cystic mass occupying umbilical, right lumbar regions extended up to sub hepatic region
3. Discussion

The etiology of lymphangiomas remains unclear. Because lymphangiomas occur mainly in children, the majority of cases are thought to derive from a congenital abnormality of lymphatic system. Clinical presentation can be variable and nonspecific. Acute symptoms include acute abdomen, distension, vomiting, and fever. Chronic symptoms include progressive abdominal distension and pain. Plain radiographs may show noncalcified soft tissue mass, displacement of intestinal loops and small bowel obstruction. Ultrasonography and CECT are highly sensitive tests that can be used in diagnosis [2]. Sonographically lymphangiomas are anechoic cystic masses that have posterior acoustic enhancement. They can be multilocular with internal septa. Sometimes internal dermis even solid echogenicity with a honey comb pattern, can be demonstrated. Their variable echogenicity is accounted for by the various contents that are possible. CECT can provide information regarding anatomical location, adjacent organ involvement, size, and complications. On CT scan lymphangiomas are thin walled multiseptated cystic masses. The attenuation of the fluid ranges from that of clear/complicated fluid to that of fat, depending on various contents. The cyst wall and septa can show enhancement after intravenous injection of contrast. Calcification is uncommon [3]. Complications of lymphangiomas include hemorrhage, infection, torsion, and small bowel obstruction [4]. Konen et al. suggested that progressive enlargement, multiplication, thickening of septa, and increased echogenicity of cystic fluid are signs which suggest complications that require urgent treatment. For confirmation of diagnosis ultrasound/CEPT abdomen should be done. However there can be no specific radiological features to differentiate between these options—histological evaluation may be necessary. Ascites and lymphangioma can also be difficult to differentiate [11]. The presence of septa, compression on adjacent intestinal loops, and lack of fluid in the dependent recess of peritoneum between leaves of small bowel mesentery suggest lymphangioma [12–14]. Malignant degeneration to low grade sarcoma has been reported but is rare. For the present case laparotomy done under general anaesthesia, a 10×12 cm cystic swelling arising from omentum, was identified. Complete excision of the cyst was done. Histopathological examination shows features of lymphangioma. During follow-up period of two years no recurrence was identified.

4. Conclusion

Omental lymphangioma is very rare presentation among abdominal lymphangiomas specifically in adults. Complete excision is the treatment of choice. Long-term followup is required to detect recurrence.

Acknowledgment

The authors thank the patient for giving consent for publication. This paper has not been published previously and is not currently under consideration for publication elsewhere.

References


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