Laparoscopic treatment of a mesenteric cyst

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A 45-year-old male patient was admitted to our hospital with dyspeptic symptoms. Imaging studies had revealed 2 cm of mesenteric cyst 5 years previously. In the course of his controls the patient was referred to our hospital because of enlargement of the cyst by size and development of a solid component of the cyst content. Physical examination was normal. No abdominal mass was palpated. Tm markers and other blood samples were normal in laboratory tests. Computerised tomography revealed a 48 × 45 mm hypodense heterogenic contrast uptake lesion 5 cm above the iliac bifurcation. The lesion seemed to be derived from the intestinal wall (Figure 1 A, B).

Because of the imaging patterns and the growth of the cyst, a minimally invasive surgical approach was decided on for the patient. In the operation 4 ports were used to access the abdomen. Two 5-mm ports were placed in the right inferior and left superior abdominal quadrant. Two 10-mm ports were placed in the umbilicus and left inferior abdominal quadrant. In the laparoscopic exploration the cystic mass was seen on the mid mesojejunum (Figure 2). The mass was enucleated by blunt and sharp dissection with a harmonic scalpel. One running arterial vessel into the mass was encountered during dissection and was ligated with hem-o-lok clip and divided. An Endobag was used to take the specimen out of the abdominal cavity through the umbilical port orifice. The postoperative course was uneventful and the patient was discharged on the second postoperative day. Finally, the histopathological examination report was of a benign cystic mass.

Mesenteric cysts are rare benign abdominal lesions with no classical clinical features. They have an incidence that is less than 1 in 100,000 patients [1]. Frequently they are benign and asymptomatic. They can also present with different symptoms such as abdominal pain, nausea, vomiting, anorexia, and changing of intestinal habitus. Mesenteric cysts are hard to diagnose accurately before surgery because of the rarity of the lesion and no specific symptoms. The treatment of choice is the complete surgical excision, which may be safely performed by laparoscopy [2]. Simple aspiration and drainage of the cyst is not recommended because of the high incidence of recurrence rates. Laparoscopic

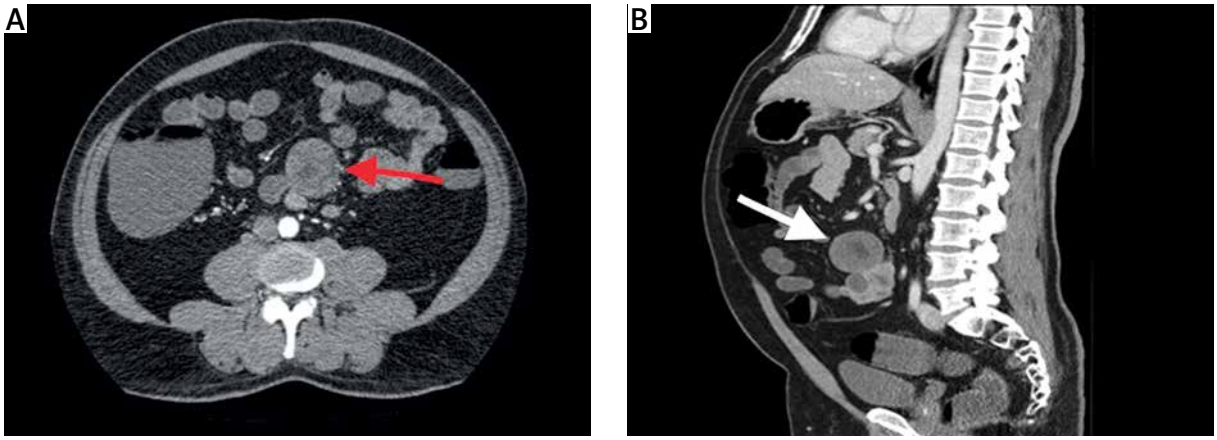

Figure 1. A – Computerised tomography shows heterogenic structure of the cyst marked with red arrow. **B** – Sagittal slice of the CT image indicating mesenteric cyst marked with white arrow

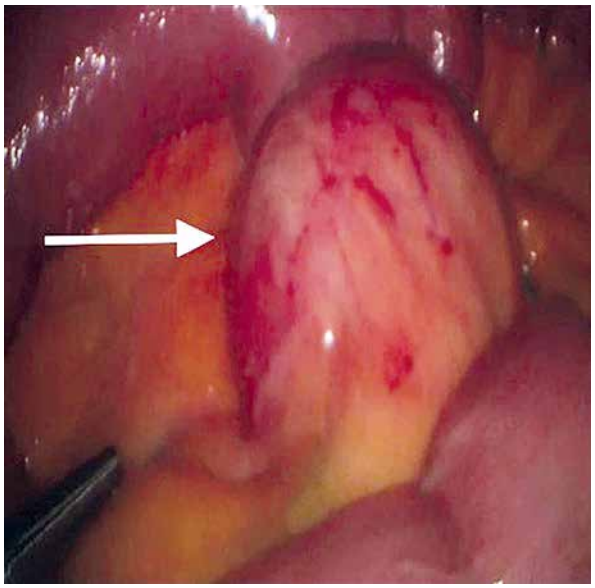

Figure 2. Laparoscopic camera view of the mesenteric cyst marked with white arrow

resection provides less pain, shorter hospital stay, and early recovery for the patient [3]. In this case, we present a patient with a mesenteric cyst that was growing during 5-year follow up and was treated with laparoscopic excision.

Conflict of interest

The authors declare no conflict of interest.

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