Case Article

Intra-abdominal lymphangioma with ascriasis as diagnostic predicament

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Background:
Lymphangiomas are rare tumours. About 90% of lymphangiomas manifest in children at the age of three years[1]. The sex ratio is roughly equal in childhood[2]. In young patients lymphangiomas are preferentially located in head, neck and axilla, but they also occur sporadically in various parenchymal organs e.g. spleen, liver and bones. When it is diffuse as multifocal disease [lymphangiomatosis] during adulthood, it develops as superficial cutaneous lymphangioma or as intra-abdominal lymphangiomas. The male to female ratio for intra-abdominal lymphangiomas[3] is 3:1. Here we present a case of intra-abdominal lymphangioma in a 14- year old boy who presented as a diagnostic dilemma.

Key words: Intra-abdominal lymphangioma

A 14-years old male presented with a recurrent episodes of sub-acute intestinal obstruction. Clinical examination revealed vague abdominal mass in the left side of the abdomen. Exploration laparotomy showed an extensive mass in the mesentery of the small bowel, causing narrowing of the lumen Fig 1 and 2.

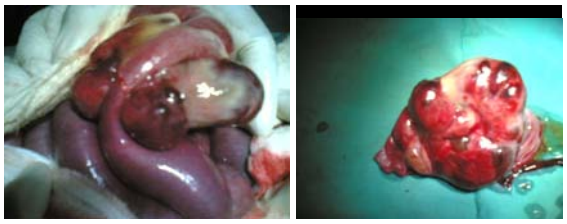
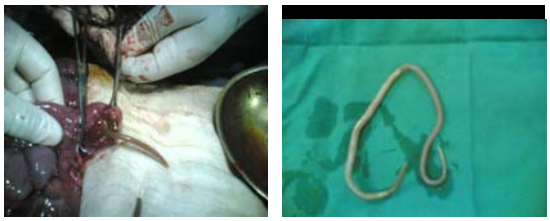


Fig 1 and 2 showing the tumour before and after excision

The mass infiltrated the bowel. Extensive resection of the mass and part of engulfed ileum was done. After resection was complete and immediately before the anastomosis we saw a warm of ascaris coming from distal part of ilieal lumen as shown in fig 3 and 4.



Figres3 and 4 showing ascaris worm emerging from the small bowel.

Post-operative was uneventful without any lymphatic discharge. Histopathology confirmed lymphangioma showing multi-cystic spaces lined by flat low lying epithelium with surrounding tissue of scattered lymphoid cells as seen in fig 6. Two years follow up, till the patient lastly seen abdomen shown no recurrence.

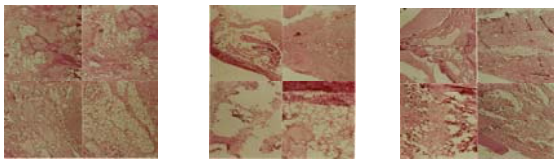


Fig 6,7 and 8 showing the histopathology of lymphangioma.

Discussion

Intra-abdominal cystic lymphangioma of mesentery is a rare congenital lesion with relatively low growth potential. It is typically found in young adult and presents with chronic features in younger children. Malformations are aggressive[2] lymphangiomas prone to recurrence and infiltrating growth. Our patient presented with abdominal mass infiltrating the bowel. However, these lesions usually present as painless abdominal distention or with complications like volvulus, infections, intra-cyctical haemorrhage and intestinal obstruction. It is difficult to be diagnosed without high index of suspicious. In our case

ultrasound was not done, however, most of the cases can be diagnosed using abdomen ultrasound[3]. In some cases confirmation of the diagnoses may require additional investigations like CT scan of the abdomen or magnetic resonance imagining[4,5]. Nevertheless, like in our case, the final diagnoses should be established by histo-pathological examination[4]. Cystic lymphangioma can be enucleated completely without compromising the bowel vascularity. However, in cases of infiltrative lymphangioma, like our case; resection of involved part of the mesentry along with the bowel is recommended. A common post-operative complication is persistence lymphatic leak with or without infection. Other modalities of treatment for unresectable intra abdominal lymphangimas include sclerotheraby with doxycycline or alcohol intra-lesional injection[6-9]. We recommend that abdominal ultrasound supplemented by CT scan with the high index of suspicion for lymphangioma. However, histo-pathological examination is the cornerstone to confirm the diagnosis. The association of intra-abdominal lymphangioma and ascriasis in our case may be coincidental finding. Yet, the association of both conditions is a real diagnostic predicament to the surgeon that merits reporting.

References

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