CASE REPORT

A rare case report of sclerosing mesenteritis presenting as a huge abdominal mass

H. G. M. Rudraiah, Siddharth Vijay Kalke, Aniruddha Desai

Department of General Surgery, JJM Medical College, Davangere, Karnataka, India

Abstract

IGG4 sclerosing mesenteritis is a very rare occurrence in the elderly which is often missed or undiagnosed. We present a very rare case of 70-year-old female who presented with vague abdominal discomfort associated with a huge intra-abdominal mass of size 18 cm*10 cm hard in consistency in the left hypochondrium slightly extending into the left lumbar region not associated with any bleeding per rectum, anemia, constipation, or features suggestive of obstruction. Diagnostic dilemma was established when contrast-enhanced computed tomography abdomen revealed neoplasia of the transverse colon with luminal narrowing, fine-needle aspiration cytology of the mass revealed desmoid tumor, and colonoscopy revealed no luminal narrowing or mass lesion. Hence, the appropriate treatment plan the intraoperative challenges, and geriatric outcomes were taken into consideration.

Keywords:
Carcinoid, desmoid, sclerosing mesenteritis

Introduction

Sclerosing mesenteritis is a very rare occurrence in the elderly often missed or undiagnosed. It is generally reported 2 times more common in men than women. It affects adipose tissue and results in mass formation by inflammation, scarring, and fibrosis. It affects the bowel mesentery and practically every organ in the body. In most cases cause is idiopathic and some rare associations are detected like vasculitis, Gardener’s syndrome, carcinoid syndrome, trauma, previous abdominal surgery. The different names of this condition include mesenteric lipodystrophy, retractile or liposclerotic mesenteritis, mesenteric Weber-Christian disease, xanthogranulomatous mesenteritis, mesenteric lipogranuloma, and systemic nodular panniculitis.

Case Report

A 70-year-old female patient presented to our OPD with vague abdominal discomfort. On examination, the patient had a huge abdominal mass measuring 18 cm*10 cm in the left hypochondrium extending slightly in the left lumbar region. Mass was hard in consistency freely mobile intra-abdominal. The patient had no complaints of bleeding per rectum, constipation or obstruction, or any features of subacute obstruction. Routine blood picture was non-specific, and the patient had no anemia or occult blood in stool routine. The patient was a known case of hypertension for 20 years with nicotine smoking and alcohol intake as addictions.

Contrast-enhanced computed tomography (CT) abdomen pelvis (Figure 2 and 3)

It revealed short segment asymmetrical bowel wall thickening of distal part of transverse colon with luminal narrowing. Diffuse mesenteric stranding and thickening were seen in the left pericolonic space with edema of the left anterior abdominal wall.

USG-guided fine-needle aspiration cytology (FNAC)

It revealed desmoid tumor as the diagnosis.

Colonoscopy

It revealed normal colonic mucosal study with no luminal narrowing of transverse colon or mass lesion.

Histopathology

Mass showing lesional tissue arising from and infiltrating the serosa, surrounding fat, and muscle. Long sweeping fascicles of fibroblasts and myofibroblasts separated by hyalized collagen with moderate lymphoplasmacytic infiltrate. Lymphoid follicles are seen at the infiltrating edge. All above features are suggestive of sclerosing mesenteritis.

Treatment

The patient underwent exploratory laparotomy with a transverse incision in the left hypochondrium. Intraoperatively, a mass of size 14 cm*8 cm was noted involving the serosa of
Sclerosing mesenteritis as a huge abdominal mass

Rudraiah, et al.

Journal of Advanced Clinical & Research Insights ● Vol. 5:5 ● Sep-Oct 2018

171

transverse colon and the overlying muscles [Figure 5]. Resection of the mass along with the involved colon was done and an end-to-end anastomosis was done. Muscle defect was approximated primarily without tension. Postoperatively, the patient improved symptomatically without any leaks. The patient was started on low-dose prednisolone on discharge to avoid recurrence and was followed up at 1, 2, and 6 months with no signs of local recurrence.

Discussion

No standard protocols exist for the management of sclerosing mesenteritis. Due to high incidence of a missed diagnosis and difficulty in distinguishing from carcinomas and other conditions like desmoids tumor, we decided to go ahead with surgery and confirm the diagnosis with histopathology [Figure 6].[10] In this case, CT reported as a neoplastic mass and FNAC was suggestive of desmoids tumor so surgical excision was planned. The sclerosis had involved the muscle and transverse colon serosa so resection and end-to-end anastomosis was planned instead of immunosuppressive therapy for which the patient was non-compliant. Some authors try medical therapy such as cyclophosphamide, azathioprine, tamoxifen, and prednisolone, but our patient was non-compliant for the same.[11]

Conclusion

Our case illustrates that the diagnosis of sclerosing mesenteritis can be difficult preoperatively. Tissue diagnosis is absolutely essential to avoid misdiagnosing a malignancy as sclerosing mesenteritis on radiological appearance. It is a benign disease with favorable prognosis.[1-3] Till today, only 300 reported cases are seen.[12] Hardly, any patient can be diagnosed preoperatively.
without surgery. Thus, our case study will serve as a reference point and a future learning opportunity for other scholars who deal with sclerosing mesenteritis.

References


How to cite this article: Rudraiah HGM, Kalke SV, Desai A. A rare case report of sclerosing mesenteritis presenting as a huge abdominal mass. J Adv Clin Res Insights 2018; 5: 170-172