Image Quiz

Chronic Abdominal Pain in a Child

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A 6-year-old boy presented to our out patients department with recurrent lower abdominal pain. Pain was started 2 years before intermittently, but it worsened over the past 6 months. Pain aggravated after eating meals. Patient's parent also gave a history of episodes of abdominal distension and constipation. Other symptoms, as well as his past history and family history, were otherwise unremarkable. Physical examination revealed a slightly distended abdomen. There was a huge intra-abdominal mass occupying the center of the abdomen. It was a single mass, freely mobile, firm in consistency, smooth surfaced with well defined margins, and nonballotable. Routine blood tests, including renal function and urine analysis, were normal. Computed tomography of the abdomen and pelvis revealed a huge heterogeneous mass extending from epigastrium to pelvis [Figure 1]. The entire small bowel loop was displaced laterally by the mass. There was no lymphadenopathy, and invasion of mass into the adjacent organ.

QUESTION

Q1. What is the diagnosis?

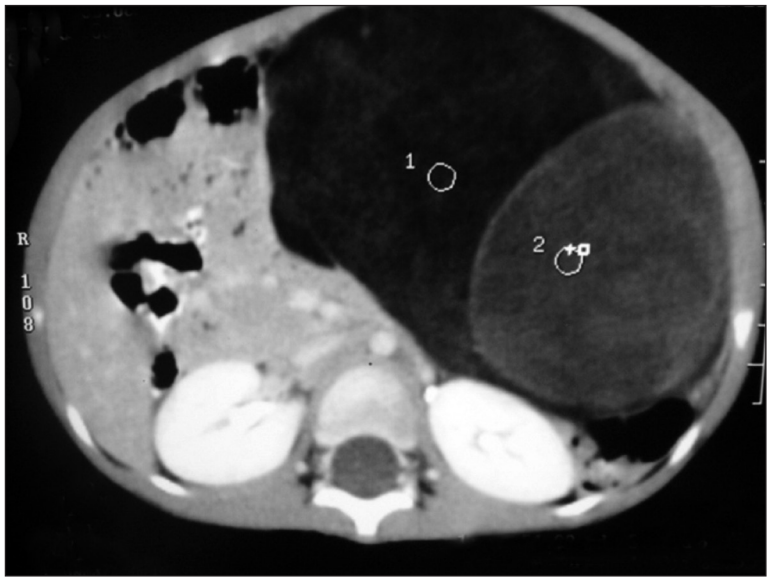

Figure 1: Contrast-enhanced computed tomography showing a huge heterogeneous mass occupying left abdomen; anteromedial to colon and shift of whole of small bowel to the right side.

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ANSWER

Surgical resection of the giant mass was advised. The surgical exploration showed an encapsulated, yellowish mass originating from the ileal mesentery. Some segment of the ileum appeared to be "stretched" over the fatty mesenteric mass; however, its luminal patency was preserved in spite of luminal narrowing by compression. Lymphadenopathy or fluid collection was not observed. Surgical removal of the fatty mass, with preservation of the affected ileal loop was performed without difficulty. Microscopically, the mass was diagnosed a mesenteric lipoma. Any evidence of necrosis or malignancy was not observed. Patient had no postoperative complications and is free of any signs of disease recurrence 18 months after the operation.

DISCUSSION

Lipoma can arise in any location in which fat is normally present, while reported mesenteric lipomas have been very rare.[1] Primary mesenteric tumors, often hard to detect, are usually diagnosed upon laparotomy or necroscopy because of their slow growth and infrequent complications.[1,2] They usually allow the passage of intestinal contents, and therefore do not cause obstructive symptoms.[1] They can attain enormous size and may present as an abdominal mass, pain, distention, intestinal obstruction, weight loss, or anorexia, or they can be totally incidental. Benign cystic tumors occur more frequently than solid tumors.

In the differential diagnosis of mesenteric lipoma, lipoblastoma, lymphangioma and lymphangiolipoma, neuroblastoma, and lymphoma should all be considered.[1] Mesenteric lipomas are rare but should be considered in the differential diagnosis of patients with a soft and painless abdominal mass.

Radiological evaluation of mesenteric masses is best carried out with a computed tomographic scan; lipoma has the appearance of subcutaneous fat and arises from the peritoneal cavity rather than the adjacent solid organs.[3]

Clinicians should pay attention to the well-defined and even encapsulated mesenteric lipoma which may be misdiagnosed as mesenteric fat because the mesentery is rich in fat. In addition, mesenteric lipomas may undergo malignant degeneration and fatty necrosis, and entire resection is the treatment of choice.[2]

The recurrence rate of lipomas is <5% and is usually due to incomplete excision.[2] Nevertheless, resection with or if possible without the affected intestinal loop remains the best and the most recommended form of treatment owing to lipomas' small malignant potential, low recurrence rate, and chances of volvulus.[4]

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