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Mesenteric Cyst Turned out to be a Dermoid: A Case Report.

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ABSTRACT

Dermoid cyst is a cystic teratoma that contains an array of developmentally mature, solid tissues. It frequently consists of skin, hair, and teeth. Other components includes clumps of longhair, pockets of sebum, blood, fat, bone,nails,eyes, cartilage, and thyroid tissue. Dermoid cyst is almost always benign. Rare malignant dermoid cyst usually develops squamous cell carcinoma in adult. Dermoid cysts affect young women around the age of 30. They are discovered during a routine pelvic exam, they cause no symptoms. Dermoid cyst can occur wherever a teratoma can occur. The presence of dermoid other than the ovarian site like Periorbital dermoid ,Spinal dermoid is rare and the incidence is 10% . An interesting case, a 30yr old female G3P1L1A1 presented in obg opd with abdominal pain for 3days with sign and symptoms of appendicitis but in ultrasound it was a Mesenteric cyst. Per operatively it turned out to be a Dermoid cyst that was twice twisted and attached to Mesentry. Confirmed with HPE. Pain and tenderness in RIF need not be only because of Appendicular pathology, neighbouring organs can also be involved. Rarely we can come across with ectopic Dermoids. Which warrants immediate surgical intervention.

Keywords: Dermoid , cyst, teratoma, appendicitis, mesenteric cyst, surgical intervention

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INTRODUCTION

30yrs Mrs. Lakshmi, G3P1L1A1 with prev. full term normal vaginal delivery, with 5months amenorrhea presented with complaints of continuous dull aching abdominal pain associated with nausea fever with mild chills and headache for past 1weeks, which aggravated while doing her routine activities and gives a history of normal, adequate urine output. No h/o burning micturition or abnormal discharge p/v. Patient did not have any other systemic illness.

Patient on examination

She was moderately built. Conscious oriented, looked anemic, febrile, with temperature of 101°F. She had tachycardia of pulse 100bpm. Blood pressure was normal. Cardiovascular and respiratory systems were normal on auscultation.

Per abdomen findings

Uterus enlarged up to 22-24 weeks of gestation , no scars , no enlarged veins

On palpation

Uterus 24weeks size, relaxed, fetal parts felt, fetal heart sounds heard, tenderness present over the right iliac fossa. Radiated to right hypochondria.

Local examination- per speculum – cervix and vaginal appeared healthy, p/v- cervix soft, mid position, external os patulous , internal os closed , uterus around 24 weeks size. Soft, gravid uterus. No show or draining p/v.

Ultrasound findings

Liver, gall bladder, spleen, pancreas, both kidneys and urinary bladder, appeared normal
Uterus – single live intrauterine gestation of 24+/-1week, with no congenital anomalies at the time of scan with a heart rate of 156bpm.

Right Ovary- obscured with bowel gas

Left Ovary – 3.2*2.1

Both adnexa appeared normal.

Mesentry- an hypoechoic mass of size 5*5cm seen.

There was no probe tenderness in the RIF, but appendix appeared to be enlarged .

To correlate clinically.

Patient was treated with IV-FLUIDS, ANTIBIOTICS , ANALGECIS, and ANTIPYRETICS with second hourly temperature , pulse rate, BP and Fetal Heart monitoring done on the day of admission. Since her pain aggravated patient was taken up for emergency surgery with a provisional diagnosis of ?appendicitis.
Abdomen opened . per op finding :



Figure 1: Appendix enlarged and appeared gangrenous and was removed

On further exploration a round soft cystic highly vascular mass of size 5*5cm arising from the mesentery twisted twice was seen, the pedicle was clamped and resected. Continuous fetal heart monitoring was done through out the procedure. Left tube and ovary appeared normal. Right tube was normal but right ovary was absent. After attaining perfect haemostasis abdomen closed in layers.



Figure 2 and 3: On incising the mass, it was found to have positive features of dermoid cyst- tuft of hair present.

Post-operative period was uneventful and was discharged on day 12. Patient continued to have her regular antenatal checkup. Her subsequent antenatal course was uncomplicated. The histo-pathological report confirmed it as dermoid. She was admitted at 39 weeks in spontaneous labour and due to non progress of labour, she was taken up for emergency LSCS. The baby was male and weighed 2.7kg, with Apgar score 7 at 1 minute and 9 at 5 minutes

CONCLUSION

Dermoid cyst is a cystic teratoma that contains an array of developmentally mature, solid tissues. It frequently consists of skin, hair, and teeth. Other components include clumps of long hair, pockets of sebum, blood, fat, bone, nails, eyes, cartilage, and thyroid tissue. Dermoid cyst is almost always benign. Rare malignant dermoid cyst usually develops squamous cell carcinoma in adults. Dermoid cysts affect young women around the age of 30. They are discovered during a routine pelvic exam; they cause no symptoms. Dermoid cyst can occur wherever a teratoma can occur. The presence of dermoid other than the ovarian site like Periorbital dermoid, Spinal dermoid is rare and the incidence is 10%. Surgical removal is usually recommended. The frequency of ovarian tumours is about 1 in 1000 pregnancies and those which are malignant represent about 1 in 15,000 to 32,000 pregnancies. Corpus luteum cyst and benign cystic teratoma contribute two-thirds of the cases. A typical corpus luteum cyst is <3 cm in diameter and usually resolves. Ovarian cysts with diameter ≥6 cm which persist or enlarge beyond 16 weeks' gestation, are at risk of complications and need tissue diagnosis and, therefore, surgical evaluation. Laparoscopy and laparotomy can be performed, most surgical options for adnexal masses in pregnancy are managed ideally in the second trimester after organogenesis is complete decreasing the risk of fetal loss, eliminating the 15% to 20%

background risk of spontaneous miscarriage and allowing for spontaneous regression of the mass. Surgical removal is considered to reduce the risk of undiagnosed malignancy, torsion, infection, rupture, haemorrhage and obstruction of labour. One disadvantage of laparotomy is discomfort of stretching and distension of the laparotomy scar due to the rapidly growing uterus. Risks of laparoscopy include compression of uterine blood flow through elevated intra-abdominal pressure, fetal acidosis, fetal exposure to carbon monoxide from coagulation and uterine injury from cannula placement [1-9].

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