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## Surgical image

### **Cystic mass appended to the greater curvature of the stomach? cystic lymphangioma of the greater omentum**

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**Key words:** cystic lymphangioma, omentum, cystic lesion

A 50-year-old man, with no remarkable antecedent history or comorbidity, was admitted through the emergency department for abdominal pain with epigastric discomfort of one week's duration. Physical examination identified a palpable epigastric and peri-umbilical mass associated with abdominal tenderness but without true guarding. Abdomino-pelvic computerized tomography (CT) showed a supra-vesical mass measuring 10 x 8.6 x 14.2 cm overlying the proximal portion of the mesenteric vessels (Fig 1). Abdominal magnetic resonance imaging (MRI) showed a multilocular liquid structure with parietal enhancement after injection of gadolinium (Fig 2). Exploratory laparotomy found a soft, whitish, cystic tumor in the greater omentum, approximately 10 cm from the greater curvature (Fig 3 and Fig 4). Resection was achieved without gastrointestinal, tumoral or vascular violation. Pathology confirmed the diagnosis of cystic lymphangioma (CL).

CL are rare benign tumors [1]. They can be discovered at almost any age, but present most often in childhood. Most of these tumors are cervical or axillary, more rarely mediastinal or abdominal (5-10% of cases).

Most patients with CL are initially asymptomatic. Abdominal symptoms appear progressively. The clinical picture can occasionally be more disruptive when complications such as torsion, rupture, bleeding, intestinal obstruction, or compression of adjacent organs occur [2]. The rarity and clinical silent progression are often reasons for difficulty in pre-operative diagnosis. Abdominal CT and MRI are necessary to define these intra-abdominal cystic images and eliminate such lesions as pancreatic pseudocysts, appendicular cysts or mesothelioma from the differential diagnosis. Imaging is generally typical and demonstrates a

unilocular or multilocular cystic mass, with or without contrast enhancement of the wall or septa. Exploratory laparoscopy can be proposed for doubtful diagnosis or evaluation of resectability. However, laparotomy represents the treatment of choice to achieve complete surgical resection [3,4]. Recurrence occurs in 40% of patients in case of incomplete resection.

Conflicts of interest: none

## References

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## Legends to Figures

Figure 1: Sagittal slice of abdominopelvic CT: well defined hypodense mass (A), homogenous contents, located behind the bladder (B). This 10 cm x 8.6 cm x 14.2 cm mass compresses the rectum (C) posteriorly.

Figure 2: Sagittal slice of MRI: cystic mass (A) providing a homogeneous multilocular (\*) liquid T2 hypersignal, with enhanced walls after injection of gadolinium.

Figure 3: Intra-operative view of the stomach (A) and the cystic mass (C) appended to the greater omentum (B).

Figure 4: Intra-operative view of the cystic mass (A) appended to the omentum (B). (C) and (D) represent the mesentery and jejunum.









