Intraperitoneal Inclusion Cyst Presenting as Intestinal Obstruction: A Clinical Dilemma

Amit Gupta, Utkarsh Kumar, Durga Sowmya S, Rishit Mani, Jaydeep Jain, Ashok Singh, and Sweety Gupta

Abstract—Peritoneal inclusion cysts have been described in females of reproductive age. It is a rare cause of intestinal obstruction. Causes include pelvic inflammatory disease and prior abdominal surgery. We here present a case of young female of peritoneal inclusion cyst who presented with intestinal obstruction.

Index Terms—Peritoneum; Inclusion cyst; pelvic mass.

I. INTRODUCTION

Peritoneal inclusion cyst (PIC) (also known as a peritoneal pseudocyst and benign cystic mesothelioma, Entrapped ovarian cyst, Inflammatory cyst of Pelvic peritoneum occurs due to non-neoplastic reactive proliferation of mesothelial tissue. Peritoneal inclusion cysts occur in premenopausal women having history of previous abdominal or pelvic surgery, trauma, pelvic inflammatory disease, or endometriosis. It appears in relation to the peritoneum. GnRH analogs, oral contraceptives to suppress ovulation, medication for pain may be tried for conservative management. USG-guided transvaginal fluid aspiration and sclerotherapy have been attempted with less success rate. Surgical resection (recurrence rate is 30-50%) can be done in symptomatic case. Though occurrence of metaplasia have been seen occasionally but peritoneal inclusion cysts have no malignant potential.

II. CASE REPORT

24 years female patient presented to surgical emergency with chief complaints of pain in lower abdomen for 1 week, insidious onset, continuous, diffuse, non-radiating, mild to moderate intensity, no aggravating and relieving factors. She also had history of abdominal distension since 3 days and non-passage of flatus and stool since 2 days. She had history of abdominal trauma 5 years back for which exploratory laparotomy was done. There was no history of fever, vomiting, jaundice, weight loss or loss of appetite. Bladder habit were normal. On physical examination there was pallor. Abdomen was distended with diffuse tenderness, shifting dullness was absent. A vertical scar mark of size 5cm was present in paraumbilical area. A lump of size 20x15cm, smooth, cystic, side to side mobility was present, well defined upper and lateral margin, lower margin not palpable involving umbilical, hypogastric, right and left lumbar and right and left iliac fossa. No hepatosplenomegaly. On percussion dullness was present over the lump. Bowel sound were absent. On digital rectal examination rectum was empty. Routine blood tests including a complete blood cell count and chemistry studies were normal. CA 125 was 30 U/ml. Abdominal ultrasonography showed loculated fluid occupying whole lower abdomen and pelvis with free floating and dependent debris with bowel loops shifted upwards. CECT abdomen and pelvis reported a large well defined multi-loculated abdomino-pelvic cystic lesion measuring 10.5x21.5x22.5cm (APxTRxCC). Lesion was displacing bilateral ovaries; however bilateral ovaries were normal in morphology. No mural nodule or calcific foci was seen within. Lesion appeared to be located in mesentery displacing the bowel loops laterally and superiorly suggestive of peritoneal inclusion cyst. (Figure 1)

Patient was considered for exploratory laparotomy and cyst excision. Intraoperative finding revealed cyst of size 21x22cm involving pelvic peritoneum densely adhered to anterior abdominal wall, bowel loops and urinary bladder. (Figure 2)
Peritoneal inclusion cyst is a non-malignant mesothelial proliferation in reproductive females having previous surgery, trauma, pelvic infection. It has a nonspecific appearance on imaging and requires histological diagnosis. Prognosis is good after complete surgical resection since it is benign condition. Follow-up of these patients is essential to detect recurrence rate.

REFERENCES


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