

Thick Inflammatory Pseudocyst In The Mouth

Sorin Cimpean*

Catholic University of Louvain, Av Dr. Gaston Thérassé, 1 5530, Yvoir Belgium

Author's Information:

Sorin Cimpean*

Catholic University of Louvain, Av Dr. Gaston Thérassé, 1 5530, Yvoir Belgium

Received Date: Dec 22, 2022

Accepted Date: Jan 06, 2023

Published Date: Jan 18, 2023

Abstract

Background: Inflammatory omental pseudo-cysts are extremely uncommon, and there aren't many studies on them, particularly when they develop after trauma. This article's goal is to offer a situation, along with possible management solutions and quick outcomes.

Clinical Case: We present the case of a 47-year-old patient who has been experiencing diarrhoea, nausea, and abdominal pain for the past three weeks. He was found to have a sizable pseudo-inflammatory cyst, and it was first removed by laparoscopic surgery after being first successfully treated with percutaneous radiological draining.

Conclusions: Although the CT scan provides for a better characterization of the lesion and its relationship with the other abdominal organs, echography is still the initial exam performed. Despite the fact that the surgical procedure was the most effective approach

Keywords

Surgical resection; Pseudocysts; Inflammatory; Traumatism; Omental mass

Introduction

The omentum, which connects the stomach to surrounding organs, is a double-layered outgrowth of the peritoneum. The omentum commonly becomes implicated in infectious, inflammatory, neoplastic, vascular, and traumatic processes in addition to its physiological duties (visceral fixation and protection against any peritoneal abnormalities) [1,2].

The gastroepiploic vessels are small, semi-mobile blood vessels in the adipose tissue. The thickness can vary, although it often depends on the patient's BMI [3,4]. Computed tomography is the main diagnostic technique for the assessment of omental disorders [1,5].

There are very few examples of the inflammatory pseudo-cysts reported in the literature, and they are quite uncommon. We provide an uncommon case of a male patient, age 47, with considerable clinical

complaints and pseudo-cystic formation in the larger omentum.

Case Presentation

A 47-year-old man was admitted to our hospital's emergency room with 3 weeks' worth of diarrhoea, nausea, and stomach pain. Furadantine was used to treat the patient's urinary infection.

Medical records revealed paraplegia following a complicated polytraumatism in 1978 and a leg fracture that required surgery in 1990. The patient had a control CT scan in 2012, and no abnormalities were discovered.

His vital values were 37.9°C, 95 bpm, 118/76 mmHg, and 99% oxygen saturation when he arrived. During the physical examination, it was discovered that there was generalised abdominal sensibility without abdominal guarding as well as a feeling of abdominal mass that extended from the epigastric to the hypogastric area.

On the right side, a positive Giordano indication was discovered. Cardiorespiratory examination found no abnormalities. Leukocytosis was 11,800/mm³ (normal range: 3,70–9,50 10³/mm³) and C-reactive protein was 170 (normal range: 15.00). The rest went as usual.

An abdominal collection of 6/15 cm and basinet dilatation of 45 mm on the left and 40 mm on the right were both seen on the echography. A CT scan revealed an abdominal collection with thin, contrast-enhanced walls that measured 25 axial /8 cm on the anterior-posterior. Hematoma was ruled out due to the homogeneity of the urine collection, and the diagnosis was either an omental infected cyst or urine collection.

Under echography, the collection was drained while exteriorizing 2.5 l of clear liquid. Bacteriological testing was negative after 48 hours, as were the results of the urea, creatinine, amylase, and lipase dose tests. The patient received painkillers, showed positive results, and was released 7 days later. Three weeks later, a procedure was scheduled. Antibiotics weren't included. The patient showed good improvement, and at his request, he was discharged on December 25, 2015. In three weeks, a laparoscopic investigation of the peritoneal cavity was planned.

The patient presented to the emergency room two weeks later with epigastric and right hypochondria discomfort that had been accompanied by nausea and vomiting for the previous day. The patient hadn't had a bowel movement in three or four days, and it happened that morning. The critical parameters were typical. Leukocytosis (17,270/mm³) and C-Reactive Protein-28 were detected in the lab examination. A swollen and widespread sensitivity of the abdomen was discovered during the clinical examination.

There was a laparoscopic exploration. The great omentum was applied on the anterior abdominal wall with a pseudo-cyst that contains pus and necrotic omentum, surrounded by an inflammatory wall, according to a

laparoscopy that reveals significant adhesions. All of the inflammatory mass was removed.

With the exception of a urinary infection, the postoperative course was unremarkable. On the second postoperative day, the patient started oral intake and was gradually transitioned to a soft diet.

Unspecific inflammatory wall was discovered during the anatomic-pathological examination.

Discussion

The large omentum's lesions are quite rare. Despite their rarity (overall frequency of 1:140,000 general hospital admissions and around 1:20,000 paediatric hospital admissions), the mesenteric cysts [2] or the omental cysts [6,7] are well characterised in the literature.[8,9].

The idiopathic (favored by a medial tight insertion on the transverse colon) omental torsion with necrosis [4] and inflammatory process is also mentioned. A suspicion of encysted ascites can change the course of the conversation, particularly if it is in the medial position [10]. Ascites may seem like large intraabdominal cysts [6]. Exceptionally, incidences of hemoperitoneum and omental torsion-related anaemia in children have been documented [11]. Actinomycosis and paragonimiasis are two infections that can cause solid or cystic mass lesions [1].

The anatomic-pathological examination supports the pseudo-inflammatory cyst's origin.

In the literature, cases of posttraumatic pseudocyst of the greater omentum have been reported [12,13]; they typically develop in relation to solid abdominal organs and result from the organisation of fluid or blood collection after trauma. In our case, however, there is no apparent connection to the patient's four years prior to the trauma. Although the pathophysiology in our case is unclear, it is more likely to be secondary [14].

A primitive aetiology was found in 8–10% of cases in a series of 1500 patients with acute inflammatory involvement of the larger omentum and a secondary one in 90–92% [9]. Aside from the past trauma, we do not discover any other triggers or predisposing variables [15]. Abdominal CT with contrast enhancement and/or ultrasound are examples of diagnostic tools [9,16].

Conclusion

We discuss a case of a large pseudo-inflammatory cyst that was first successfully treated by percutaneous radiological drainage.

Despite the initial conservative stance, the surgical treatment turned out to be the most reliable approach. For us, a CT scan is the most effective diagnostic tool since it provides an accurate description of the lesion and its relationship to the other abdominal organs. We believe that the conservative strategy should be the initial goal due to the patient's low morbidity if there are no peritoneal indications or a mildly altered biology. If conservative measures fail, immediate surgery is required. For the final therapy, a straightforward excision is sufficient.

References

1. oo E, Kim JH, Kim MJ, Yu JS, Chung J, et al. (2007) Greater and Lesser Omenta: Normal Anatomy and Pathologic Processes. *Radiographics* 27: 707-720.
2. Dash AP, Mishra T, Ibrarullah M (2011) A Rare Presentation of Mass Abdomen. *Indian J Surg* 73: 236-237.
3. Bonafe T, Nicola R, Kovacs J (2014) Differential Considerations for Omental Fat Infiltration and Thickening on CT. *J Am Osteopath Coll Radiol* 3: 22-24.
4. Barai KP, Knight BC (2011) Diagnosis and management of idiopathic omental infarction: A case report. *Int J Surg Case Rep* 2: 138-140.
5. Lin HL, Kuo LC, Chen CW, Lin YK, Lee WC (2009) Inflammatory omental cyst adjacent to the transverse colon mimicking appendicitis in an adult patient. *J Formos Med Assoc* 108: 433-435.
6. Joshi N, Yadav S, Singh B, Gupta A (2010) Omental cyst presenting as tubercular ascites. *J Infect Dev Ctries* 4: 183-186.
7. Fernández Ramos J, Vázquez Rueda F, Azpilicueta Idarreta M, Díaz Aguila C (2009) Quiste mesotelial gigante de omento mayor. *Anales de Pediatría* 71: 180-181.
8. Mesenteric and Omental Cysts: History of the Procedure, Epidemiology, Etiology.
9. Vanek VW, Phillips AK (1984) Retroperitoneal, mesenteric, and omental cysts. *Arch Surg* 119: 838-842.
10. Danielson J, Naji H, Sköldenberg E, Christofferson R (2010) Ascites could be an abdominal cyst. *Lakartidningen* 107: 2330-2331.
11. Ahmed A, Jabbour G, Zitoun A, Latif E, Matbouly ME, et al. (1990) Anemia as One of Presenting Symptoms in an Adult with Cyst and Torsion of the Omentum-A Case Report. *Chirurgia (Bucur)* 110: 474-477.
12. Ratan SK, Roychoudhary S, Bhardwaj M (2001) Posttraumatic Pseudocyst of the Greater Omentum: Report of a Case. *Surg Today* 31: 719-721.
13. Sokol BG, Kashtalian MA, Tsybaliuk IN, Sapozhnikov SM, Kirsanov IV (1993) A case of traumatic cyst of the greater omentum. *Klin Khir* 6: 71-72.
14. Tăranu T, Tăranu T, Petreuş T (2002) Surgery experience regarding the pathology of the greater omentum. *Rev Med Chir Soc Med Nat Iasi* 106: 157-160.

15. Zaleta-Cruz JL, Rojas-Méndez J, Garza-Serna U, González-Ruvalcaba R, Ortiz de Elguea-Lizarraga J, et al. (2016) Omental torsion. Case Report Cir Cir.
16. Nakano T, Kobayashi M, Usui T, Hanazaki K (2007) Omental pseudocyst. Radiat Med 25: 364-367.
17. Motie MR, Asadi M (2011) Large omental cyst: a case report and review of the literature. Acta Med Iran 49: 690.
18. Debnath B, Biswas SK, Mallick AK (2008) Omental cyst masquerading as ascites. J Indian Med Assoc 106: 536-537.
19. Egozi EI, Ricketts RR (1997) Mesenteric and omental cysts in children. Am Surg 63: 287-290.