Mucinous cystic neoplasms of the mesentery: a case report and review of the literature

Georgios Metaxas*1, Athanasios Tangalos2, Polyxeni Pappa2 and Irene Papageorgiou3

Address: 1University Hospital of South Manchester, The Nightingale and Genesis Prevention Centre, Southmoor Road, M239LT, Manchester UK, 2Helena Venizelos General Hospital, 2nd Department of Surgery, GR-11521, Athens, Greece and 3Drama General Hospital, Department of Surgery, Drama, Greece

Email: Georgios Metaxas* - geometa@hotmail.com; Athanasios Tangalos - vtangalos@hotmail.com; Polyxeni Pappa - papol@ath.forthnet.gr; Irene Papageorgiou - irene.pap@live.com

* Corresponding author

Abstract

Background: Mucinous cystic neoplasms arise in the ovary and various extra-ovarian sites. While their pathogenesis remains conjectural, their similarities suggest a common pathway of development. There have been rare reports involving the mesentery as a primary tumour site.

Case presentation: A cystic mass of uncertain origin was demonstrated radiologically in a 22 year old female with chronic abdominal pain. At laparotomy, the mass was fixed within the colonic mesentery. Histology demonstrated a benign mucinous cystadenoma.

Methods and results: We review the literature on mucinous cystic neoplasms of the mesentery and report on the pathogenesis, biologic behavior, diagnosis and treatment of similar extra-ovarian tumors. We propose an updated classification of mesenteric cysts and cystic tumors.

Conclusion: Mucinous cystic neoplasms of the mesentery present almost exclusively in women and must be considered in the differential diagnosis of mesenteric tumors. Only full histological examination of a mucinous cystic neoplasm can exclude a borderline or malignant component. An updated classification of mesenteric cysts and cystic tumors is proposed.

Background

Cysts of the mesentery, retroperitoneum and omentum present with similar incidence in both sexes, varying between 1:260,000 and 1:27,000 in adults and 1:20,000 in children. They are usually incidental, or present with unspecific and chronic symptoms involving abdominal pain, distention, a palpable mass, gastrointestinal and urinary obstruction [1-3]. Acute manifestation is more often described in children and infants and may be associated with rupture [4-8], hemorrhage [9], torsion [10], infection or complicated hernia [11]. A 3% malignancy rate has been demonstrated [1].

Mucinous cystic neoplasms

Mucinous cystic neoplasms (MCNs) arise in the ovary and various extra-ovarian sites, predominantly but not exclusively [1,12-16] in adult females. The similarities between ovarian [17] and extra-ovarian MCNs suggest a common pathway of development. The cyst wall of extra-ovarian MCNs [18] is lined by mucin-secreting flat, cuboidal and/
or columnar epithelium associated with an underlying subepithelial ovarian like stroma (OLS). OLS is documented by histological features (spindle shaped cells and myofibroblastic proliferation on electron microscope study) and immunohistochemistry (positivity for vimentin, α-smooth muscle actin and desmin) [19-22]. Although the presence of OLS is considered a requisite diagnostic criterion for MCNs, this is not always identified. MCNs have been extensively described in the pancreas [18-27], the appendix [28-30] and the hepatobiliary tract [31,32] and more rarely in the retroperitoneum [33-35] paratesticular tissues [36-41], lung [42-44] breast [45-47], spleen [18,48,49] bowel [50] and the mesentery.

Case presentation
A 22 year old white-Caucasian female, with otherwise unremarkable history, presented with chronic, left sided, vague abdominal pain. There were no abnormal findings on clinical examination. Ultrasound (US), computerized tomography (CT) and magnetic resonance (MR) scans (Fig. 1a, b) demonstrated a unilocular cystic mass measuring 8.5 × 6 × 3.5 cm and lying medially to the descending colon. No definite preoperative diagnosis could be established. At laparotomy the mass was fixed within the descending and sigmoid colonic mesentery (Fig. 2). As there were no firm adhesions or shared blood supply (Fig. 3), enucleation was easily performed. The cyst had a macroscopically thin and smooth wall and contained white-yellowish fluid. The cyst wall was examined in its entirety. Histology demonstrated two distinct components: an outer ovarian-like stromal layer, composed of densely packed spindle-shaped cells (Fig. 4) and an inner epithelial layer, consisting of cuboidal and columnar mucinous cells (Fig. 5, 6). Immunohistochemical study of the stromal cells demonstrated positivity for vimentin, actin, and desmin. The epithelial cells showed positivity for cytokeratin-7 (Fig. 6), CA-125 (Fig. 7), CEA, and CA 19-9 and negative expression of cytokeratin-20. There was no cellular atypia. The overall features suggested a benign neoplasm of epithelial origin with the appearance of an ovarian mucinous cystadenoma. The patient recovered uneventfully and remained well on annual follow-up with abdominal US.

Discussion
There are thirteen documented cases of mesenteric MCNs in the literature prior to this report (Table 1). Five of those originated from the mesentery of the small intestine [15,18,51-53], one from the mesoappendix [54] and seven from the mesocolon [55-60]. The only male patient was a five year old child with an unresectable neoplasm [15]. Clinical presentation typically involved chronic abdominal pain (n = 8) and distention (n = 5). Three patients were asymptomatic and one presented with acute manifestation of symptoms. Interestingly, preoperative imaging was inconclusive in nine cases, suggested ovarian origin in four cases, and mesenteric origin in only one case. No pathognomonic malignant features were illustrated. Pathology reported nine benign mucinous cystadenomas (including the present case), three borderline MCNs, (based on the presence of atypical nuclei, pseudostatification, glandular arrangements and lack of invasion) and two carcinomas. The median age at diagnosis of benign mesenteric MCNs was 26.1 yrs, compared to 35.2 yrs for non-benign tumours. One of the carcinomas [51] was thought to be the result of malignant transformation following earlier incomplete excisions of a recurrent benign tumour. One of the patients with a borderline tumour, presented with metastatic disease in the mediastinal lymph nodes four years after removal, which may
represent a missed invasive focus due to incomplete examination of the entire neoplasm wall. This patient had initially undergone a partial colectomy and salpingo-oophorectomy [55]. Another two patients underwent partial colectomies due to cyst wall adhesions, while enucleation of the tumor was performed in six. Partial cystectomy was performed in two unresectable tumors. Immunohistochemistry was reported in four cases. There was no report of ectopic ovarian tissue or evidence of teratomatous development. There was no association between the age and tumor size.

**Pathogenesis and biologic behavior of extra-ovarian MCNs**

The origin of extra-ovarian MCNs has been sporadically attributed to implanted or ectopic ovarian tissue [61], supernumerary ovaries [62,63] or mono-phyletic development of a teratoma component [64-66]. A recent concept linked the development of hepatic and pancreatic MCNs to the migration of epithelial cells from the embry-
onic gonads during early foetal life [67]. The most widely
accepted theories for the pathogenesis of extra-ovarian
MCNs include: Coelomic metaplasia of epithelial cells or
invaginated peritoneum along the course of ovarian
descent, mucinous metaplasia in pre-existing mesothelial
cysts and neoplastic differentiation of epithelial cells from
a secondary extragenital Mullerian system [1,2,51,68-71].

According to the WHO classification (ICD 10), MCNs are
divided into benign adenomas, borderline tumours, non-
invasive (in situ) and invasive carcinomas. The malignant
potential of all MCNs is supported by observations of
malignant transformation of benign neoplasms during
long term follow up [24,51]. Other authors noticed a fre-
quent concurrence of benign and focally borderline or/
and malignant epithelium [21,72,73]. Also, as illustrated
in the present study and previous pancreatic MCNs series
[72,74], the median age at diagnosis is higher for malig-
nant MCNs, which implies progression from adenoma to
carcinoma. Consequently, failure to excise or study the
entire cyst wall may result in the miscategorization of a
neoplasm [75].

When differentiating mucinous from non mucinous neo-
plasms and non neoplastic cysts and evaluating their
malignant potential, the following features may have a
positive predictive but not pathognomonic value: Patient
age and tumour size [27,74], multilocularity, presence of
calcifications [58], intracystic papillary projections or
mural nodules [20], presence or lack of OLS [20,76],
nuclei atypia, co-expression of (a6)-integrin and p53
immunoactivity [20,77], high viscosity and/or high levels
of CEA in the cyst fluid and positivity of other tumours
markers (Ca 19-9, Ca-125, Ca 15-3) [24,78,79]. Oestro-
gen and progesterone receptor positivity in stromal cells
varies [80].

Classification of mesenteric cysts and cystic tumors
None of the recognized classifications of mesenteric cysts
[81-85], has included MCNs up to date. Malignant mes-
othelioma is suggested as the only potential primary cystic
malignancy in the mesentry. We found three more cases
of primary mesenteric cystic neoplasms in the literature
[86-88], as well as reports of mesenteric hydatid [8,89-
92] and tuberculous cysts [93-95]. In view of the existing
data, we propose an updated classification of mesenteric
cysts and cystic tumors, as shown in the Appendix.

Diagnosis and treatment
There is no definitive diagnostic test. Radiological exami-
nations may suggest the origin of a cyst, but cannot
exclude the malignant potential of an MCN [35,82,84,96-
99]. Guided aspiration cytology and fluid analysis is rarely
diagnostic, has a high false negative incidence [100] and
may only be helpful in the complicated management of
pancreatic cystic masses [101,102]. The definite diagnosis
remains postoperative and therefore intra-operative fro-
zen section does not have any use. Following exclusion of
non-surgical conditions, complete excision is the only
treatment option for all mesenteric neoplasms [103-105]
because of their malignant potential as well as the high
recurrence rate of benign tumors – such as lymphangi-
omas and mesotheliomas – after incomplete resection
[106-108]. Open or laparoscopic approach depends on
the surgeon’s skills, as more complicated resections may
be required [109-111]. Only one mesenteric MCN has
been treated laparoscopically up to date, by a gynaecolo-
gist [54].
Conclusion

Mucinous cystic neoplasms of the mesentery present almost exclusively in women and must be considered in the differential diagnosis of mesenteric tumors. Whilst there are no pathognomonic diagnostic criteria, a mesenteric cyst should be approached as potentially malignant especially in adults. Only complete excision and full histological examination of a mucinous cystic neoplasm can exclude a borderline or malignant component. We propose an updated classification of mesenteric cysts.

Consent

Written informed consent was obtained from the patient for publication of this case report and any accompanying images. A copy of the written consent is available for review by the Editor-in-Chief of this journal.

Competing interests

The authors declare that they have no competing interests.

Table 1: Reported cases of mesenteric mucinous cystic neoplasms of the large intestine (1–8), small intestine (9–13) and appendix (14).

<table>
<thead>
<tr>
<th>No.</th>
<th>Reference</th>
<th>Age</th>
<th>Sex</th>
<th>Clinical presentation</th>
<th>Imaging tests – correlated diagnosis</th>
<th>Size (cm)</th>
<th>Site</th>
<th>Operation</th>
<th>Histology – Immunohistochemistry</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.</td>
<td>38 F</td>
<td>Pain, distention</td>
<td>US, Uncertain</td>
<td>11</td>
<td>Descending colon</td>
<td>Colectomy Salpingo-oophorectomy</td>
<td>Borderline malignant MCN</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>McEvoy et al. (1997) [56]</td>
<td>24 F</td>
<td>Pain, constipation distension</td>
<td>US, Ovarian origin</td>
<td>20 × 15</td>
<td>Sigmoid colon</td>
<td>Enucleation</td>
<td>Benign mucinous cystadenoma (CAM 5.2, CEA)+, Factor VIII -</td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>Linden et al. (2000) [58]</td>
<td>32 F</td>
<td>Incidental finding</td>
<td>US, CT, Uncertain</td>
<td>13 × 10 × 10</td>
<td>Transverse colon</td>
<td>Enucleation</td>
<td>Mucinous cystadenocarcinoma</td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>Vrettos et al. (2000) [59]</td>
<td>38 F</td>
<td>Pain, nausea, vomiting, distention, oedema of the lower limbs</td>
<td>US, CT, Mesenteric cyst</td>
<td>17 × 12</td>
<td>Sigmoid colon</td>
<td>Enucleation</td>
<td>Borderline malignant MCN</td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>Talwar et al. (2004) [57]</td>
<td>32 F</td>
<td>Acute pain, vomiting, urinary frequency, constipation</td>
<td>US, Ovarian origin</td>
<td>10 × 7 × 5</td>
<td>Descending colon</td>
<td>Left hemicolectomy</td>
<td>Borderline malignant MCN</td>
<td></td>
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<tr>
<td>7.</td>
<td>Swaveling et al. (2008) [60]</td>
<td>18 F</td>
<td>Asymptomatic abdominal swelling</td>
<td>US, CT, Uncertain</td>
<td>15</td>
<td>Right hemicolon</td>
<td>Enucleation</td>
<td>Benign mucinous cystadenoma</td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td>Present case</td>
<td>22 F</td>
<td>Pain</td>
<td>US, CT, MRI, Uncertain</td>
<td>8.5 × 6 × 3.5</td>
<td>Descending + sigmoid colon</td>
<td>Enucleation</td>
<td>Benign mucinous cystadenoma (CK7, CEA, CA19-9, CA125, actin, desmin, vimentin)+, ck20(-)</td>
<td></td>
</tr>
<tr>
<td>10.</td>
<td>Bury and Pricolo (1994) [51]</td>
<td>36 F</td>
<td>Pain, recurrent unresectable cysts in a 13 year period, N/A</td>
<td>CT</td>
<td>*</td>
<td>Small intestine Unspecified</td>
<td>Partial cyst resections</td>
<td>Incomplete excision, transformation to carcinoma CK+, EMA, CEA, B72.3, Leu M1</td>
<td></td>
</tr>
<tr>
<td>11.</td>
<td>Czubalski et al. (2004) [53]</td>
<td>38 F</td>
<td>Ovarian origin</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>Benign mucinous cystadenoma</td>
<td></td>
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<tr>
<td>12.</td>
<td>Shiho et al (2006) [18]</td>
<td>14 F</td>
<td>*</td>
<td>*</td>
<td>15</td>
<td>*</td>
<td>*</td>
<td>Benign mucinous cystadenoma</td>
<td></td>
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<tr>
<td>14.</td>
<td>Felemban &amp; Tulandi (2000) [54]</td>
<td>20 F</td>
<td>Abdominal pain, backache</td>
<td>US, Ovarian origin</td>
<td>7.6 × 7 × 5.3</td>
<td>Appendix</td>
<td>Lap. Enucleation, appendicectomy</td>
<td>Benign mucinous cystadenoma</td>
<td></td>
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Authors' contributions
GM and AT were involved in the treatment of the patient, study design and drafting of the manuscript. GM also reviewed literature, prepared the tables and figures and edited the final version. PP and IP collected case details and helped in the literature search and drafting of the manuscript. All authors read and approved the final manuscript.

Appendix
Proposed updated classification of mesenteric cysts and cystic tumors

Mesenteric Cysts and Cystic Tumors
Cysts of lymphatic origin
- Simple lymphatic cyst
- Lymphangioma

Cysts of mesothelial origin
- Simple mesothelial cyst
- Benign cystic mesothelioma
- Malignant cystic mesothelioma

Cysts of enteric origin
- Enteric duplication cyst
- Enteric cyst

Mucinous cystic neoplasms
- Mucinous cystadenoma
- Borderline malignant mucinous cystic neoplasm
- Mucinous cystadenocarcinoma

Cysts of urogenital origin

Miscellaneous neoplasms
- Mature cystic teratoma
- Neuroendocrine carcinoma
- Cystic spindle cell tumor

Non – neoplastic cysts
- Hydatid cyst
- Tuberculous cyst
- Non – pancreatic pseudocysts
- Haematoma
- Abscess

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References

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