Lymphangiomas constitute a group of very rare diseases and occur with a frequency of 1/250,000 to 1/20,000 of hospitalizations. Even though they are benign lesions, their complications may turn into a life-threatening condition. They usually occur in children (90%), they are either congenital or they appear before the child’s second birthday. Occasionally they are found in adults. Lymphangiomas are usually localized around neck, but also near armpits and in the groin area. Less than 1% of lymphangiomas are detected in the retroperitoneal space and intestinal mesentery. Vascular lesions derived from lymphatic vessels can be divided into ordinary ones, usually known as capillary, cavernous, and cystic. The cystic tumor (lymphangioma mesenteri) is the least common. It occurs mostly in the retroperitoneal space, mesentery of the colon, or extremely rarely in the mesentery of the small intestine. Preoperative diagnosis is difficult due to non-specific clinical symptoms and non-characteristic image in the diagnostic tests. Lymphangioma complications, such as intestinal obstruction or perforation, and persistent pain, are the cause of exploratory laparotomy. Final diagnosis requires microscopic examination of material collected during an operation.

This article presented the case of a 40-year-old female, operated due to the obstruction of the gastrointestinal tract, in whose case the lymphangioma was recognized in postoperative histopathological examination of the tumor from the jejunal mesentery. Since patients with these tumors have good chances of complete recovery – if there are no serious complications – it appears that the optimal therapeutic procedure should be early surgery, which reduces the possibility of complications.

**Key words:** lymphangioma, cyst, obstruction
- Cystic lymphangiomas (łac. lymphangioma-cysticum). They are the rarest and they are built of large cysts, whose wall consists of enlarged endothelium of lymphatic vessels, and sometimes additionally of collagen and smooth muscles. This type of tumour is not connected with properly functioning lymphatic vessels (1, 4, 5).

The symptoms of lymphangiomas are different and mainly depend on their type and localization. Tumours localized on skin very often grow very large causing face or neck deformations. Those detected near armpit or groin impede everyday life. Lymphangiomas in the proximity of mediastinum, organs or vessels essential for life may manifest in compression syndromes symptoms leading to respiratory disorders, upper limb ischemia, paresthesia and pain. Lymphangioma symptoms (most often of the cystic one) localized in the abdominal cavity are mainly flatulence, pain, nausea, emesis, diarrhea or constipation (6). Complications such as bleeding into hemangiomas, bowel obstruction or volvulus, lesion infection or perforation lead to turbulent peritoneal symptoms. Lesion excision is a treatment of choice and it leads to full recovery of the patient.

**CASE REPORT**

A 40-year-old female patient reported to the hospital due to the pain in upper abdominal and umbilical region. The patient during last 4 years was hospitalized many times and underwent many diagnostic tests. She reported to the internal medicine hospital clinic for the first time in 2010 due to abdominal pain. Medical examination was supplemented by ultrasound examination of the abdominal cavity (fig. 1), detecting a 80 x 49 mm multilocular fluid-filled lesion in the upper abdominal region on the left, forward from the tail of the pancreas. The patient was qualified for further diagnostics with the use of computed tomography. The scan was performed detecting the 10 x 60 x 100 mm fluid-structure lesion in the umbilical and lower abdominal region on the right. The lesion was characterized by uneven lobular external outline, with numerous compartments made of adipose tissue and probably of fibrous tissue. The lesion had a barely demarcated capsule. There was a fairly wide vessel between the compartments, which was identified as superior mesenteric artery branch.

Due to abdominal pain reported by the patient the ultrasound test was performed many times (in 2010, 2011, 2012, 2013 and in 2014) as well as the computed tomography scan (2010, 2013, 2014). These examinations showed gradual lesion enlargement. Additionally in the 2014 CT scan characteristics of lymphadenopathy were identified (enlarged lymph nodes in the caecal region of up to 12 mm) and a poly-cystic lesion localized in the right common iliac artery region of 12 x 10 mm.

In August 2014 the patient was admitted to the Clinical Department of General, Colorectal and Trauma Surgery of the Medical University of Silesia in Sosnowiec due to increased pain severity in the upper abdominal region on the right, fatigue and arterial blood pressure drop (100/60, 90/60). In the basic examination the flatulence, tenderness upon compression of the upper abdominal and umbilical region. No asymmetry of abdominal walls was observed and no nodular lesions were identified by palpation. Basic blood tests were performed and no deviations were noted. Due to the clinical picture after preparation and anaesthetic qualification, exploratory laparotomy was performed. A large lesion of the jejunal region was identified (fig. 2), and it proved to be a large lymphatic cyst extending from the mesentery of the jejunum, covering like a ring one of the loops of the intestine. The cyst was entirely filled with a white, granular fluid with numerous grains (fig. 3 and 4). The

![Fig. 1. Ultrasound of the abdominal cavity – 2010](image)
resection of the loop of the small intestine together with the cystic lesion, and then the end-to-end anastomosis of intestinal stumps was performed. After the procedure the patient was well. There were no complications in the postoperative period. On the 6th day after the surgery the patient was discharged home in a general good condition. Histopathological examination showed: lymphangioma (cysticygroma) mesenteri CD 34 (+/-).

DISCUSSION

Cystic lymphangioma is a lesion occurring very rarely. Specific etiology of this tumour is not known. It is suggested that the occurrence of these lesions is connected with excessive proliferation of the endothelial cells of the lymphatic vessels walls. These vessels create vesicular or nodular lesions when growing, or when getting larger they cause deformation of the regions in which they occur (1, 7). The literature presents the data indicating that some of the intestinal inflammations, surgical procedures performed and radiation may trigger the occurrence of these tumours.

Clinical symptoms of this disease are not specific, thus there is a need to conduct a wide differentia diagnosis. Out of all image tests the ultrasound, the basis of the diagnostics, is the most accessible one, and also computed tomography and magnetic resonance imaging. Performing such tests does not always mean the right diagnosis will be made. Moreover, some of the diseases, like pancreatic cancer and cyst, gastrointestinal tumours (GIST), hemangiomas and lymphangiosarcoma, are often confused with mesenteric lymphangiomas. Hwang claims that FDG – PET is useful in the differentiation of mesenteric lymphangiomas with metastases of colorectal cancer (1).

Even though these tumours are benign, they may often lead to life-threatening conditions, such as infection, volvulus, obstruction or bleeding into the lumen of a cyst that are usually very difficult to manage. The most efficient treatment method is surgery, even though there are methods consisting in the injection of sclerotherapeutic agents consisting of a lyophilized mixture of Streptococcus pyogenes bacteria. With segmental resection it is possible to apply adjuvant radiotherapy as well.
REFERENCES


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