

Mesenteric panniculitis

A case report

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Summary: We reviewed the clinical history, and the physical, laboratory and ultrasonography examinations of a young female suffering from mesenteric panniculitis.

In our case, as well as those described by other authors, definitive diagnosis was histological and our patient has had a benign course of the disease.

Key words:

INTRODUCTION

Mesenteric panniculitis is a rare inflammatory disease where the adipose tissue of the mesentery is involved^(1, 2, 3). This disorder has a male-female ratio of 1.8-1.5⁽⁴⁾.

Secondary forms of this disease have been described as well⁽⁵⁾ following abdominal traumas⁽⁶⁾, intestinal infections, pelvic infected neoplasias, hormonal estrogenic influence⁽⁷⁾ or local PG excess⁽²⁾.

Abdominal pain, anorexia, nausea, vomiting, weight loss⁽⁸⁻⁹⁾ and poorly defined abdominal masses⁽¹⁾ represent the more relevant signs of mesenteric panniculitis, which frequently are followed by leucocytosis and increased VES⁽¹⁰⁾.

Although these symptoms occur, diagnosis can only be made following histological analysis of abdominal masses.

In fact, angiographic examinations or CT scans are useful only for suggesting mesenteric panniculitis diagnoses.

Histological studies of abdominal masses which characterize this disease reveal a thick mesentery with steatonecrosis areas and hemorrhage zones, inflammatory mononuclear infiltration, foamy macrophages and fibroconnective tissue⁽²⁾.

Rarely is thrombosis of the mesenteric vein the cause of death of these patients⁽²⁾.

We present a case of mesenteric panniculitis because of the rarity of this condition.

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CASE REPORT

A young female, 30 years old, came under our observation with a six month history of asthenia, anorexia and weight loss associated in the last two months with recurrent abdominal pain and fever.

Physical examination revealed an irregular abdominal mass (reaching to O.T.).

Laboratory studies were characterized by a modest anemia and increased VES (Isth 65; 2nd h 85; I, K, 53.57).

Ultrasonography showed an uterus pushed on the right by a complex abdominal mass (mm 115×79×88) and a liquid zone in Douglas.

These observations suggested an ovarian neoplasia diagnosis.

Subsequent surgical exploration revealed a strong adhesion between the peritoneum, side fasciae and abdominal organs.

A difficult incision in the peritoneum showed a mass formed by a thick and tough omentum, tenaciously adherent to the parietal peritoneum on the left.

The left ovary was transformed into a limp white-grey mass adherent to the fallopian tube, Douglas and back of the uterus.

Histological examination of the ovarian mass and resected omentum, respectively, showed a dermoid cyst and infiltrate inflammation characterized by histiocytes, fibroblasts and lymphoforming granulomas.

Therefore, a mesenteric panniculitis secondary to a dermoid cyst was diagnosed.

Post-operatively the patient has done well.

At subsequent follow-up, after long term anti-inflammatory therapy she is in a good state of health. The patient is rarely affected by slight abdominal and pelvic pain.

Up to now, ultrasonography has shown two non-homogeneous masses on the left and on the hind part of the uterus, probably due to post-surgical adhesions.

At present the patient remains under our observation.

DISCUSSION

From this experience we draw the following conclusions. Mesenteric panniculitis is a generally benign disease with a doubtful etiopathogenesis.

In our case, a broken dermoid cyst seems to be the cause of the disorder.

Physical examination and laboratory tests are generally not helpful in diagnosing mesenteric panniculitis.

Differential diagnosis for neoplasia can be suggested by ultrasonography and CT, but definitive diagnosis requires surgical biopsy and histological examination⁽¹⁰⁾.

Until today surgical therapy has been the most useful⁽¹¹⁾.

Anti-inflammatory therapy has been shown to be useful in some cases⁽⁷⁾, as well as in our case.

Although the nature of this disorder is benign, more efficacious diagnostic and therapeutic techniques could avoid some lethal complications of mesenteric panniculitis.

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