AN UNUSUAL CASE OF ANAEMIA

by

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LYMPHANGIOMATOUS cysts of the greater omentum are uncommon. They are seldom diagnosed prior to surgery. They may be discovered incidentally at laparotomy or when complications ensue.

This case is reported to emphasise the importance of omental lesions in the differential diagnosis of intra-abdominal abnormalities and because of the unusual mode of presentation.

CASE HISTORY

A two year old boy was admitted to the Belfast City Hospital on 11th November 1972 with a one week history of anorexia, listlessness and increasing pallor. He had been well until one week prior to admission when he had had a 'flu-like illness. There was no relevant past or family history.

On examination, the child was normally developed with no evidence of recent wasting. The most striking feature was marked pallor. He was apyrexial and there was no generalized lymphadenopathy. The cardiovascular and respiratory systems were normal. The abdomen was distended with umbilical eversion. No discrete masses were present. The liver was palpable at the right costal margin but there was no splenomegaly. Bowel sounds were normal. There was dullness to percussion consistent with the presence of ascites.

Haematological investigations revealed the haemoglobin concentration to be 2.8 gm/100 ml with a normal differential white cell count. The direct Coombs test was negative. A paracentesis abdominis was not carried out. Straight x-rays of the abdomen demonstrated bilateral loss of renal and psoas shadows, with an overall ground glass appearance suggestive of ascites. The bowel was displaced upwards and to the right without evidence of intestinal obstruction. An intravenous pyelogram was normal. A provisional diagnosis of an intra-abdominal malignancy with ascites was considered.

The child was transfused with packed cells, leading to a general improvement, though the abdominal distension increased and began to embarrass respiration. An exploratory laparotomy was carried out on 14th November 1972 through a right paramedian incision, when the abdominal cavity was found to be completely filled by a huge, thin walled cyst originating by a narrow pedicle from the omentum of the upper third of the greater curvature of the stomach. No other pathology was present. The cyst was easily removed by ligation and division of the pedicle. It was multilocular, containing 2 litres of heavily blood-stained fluid, of both old and recent origin.

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Histologically the lesion was considered to be a lymphangiomatous cyst. The post operative course was uncomplicated and when reviewed 8 weeks later, the child had completely recovered.

**DISCUSSION**

Since the first lymphangiomatous omental cyst was described by Gairdner (1852), approximately 170 cases have been recorded in the literature. This does not represent the true incidence of the lesion, the more unusual cases only being reported. Most cysts are incidental findings at laparotomy and in their series, Montgomery and Wolman (1935) noted that only a small proportion of cases present with acute symptomatology. The most frequent complications were torsion and infection. This was confirmed by Oliver (1964) who stated that of the cases presenting as an “acute abdominal crisis” more than 90 per cent were misdiagnosed as acute appendicitis. Only one of Oliver’s 17 cases presented with haemorrhage into the cyst necessitating surgical intervention and this is the trend in other reviews.

This case is unusual in exhibiting a profound anaemia with abdominal distension as the only physical sign.

The need for exploratory laparotomy in any case of undiagnosed ascites is stressed, even in the presence of a bloody tap on paracentesis abdominis. This is particularly so where the history is short and the patient’s general condition does not suggest malignancy.

Pathologically, true cysts of the omentum lined by endothelium are five times more common than all the others together, and of these 52 per cent are lymphogenous (Horzan 1935). Most cysts are considered to be congenital though only 30 per cent occur in children below the age of 10 years (Montgomery 1935). The clinical presentation of an acute surgical abdomen caused by omental cysts is almost exclusively a disease of children (Walker 1973). Symptoms are occasionally preceded by a viral infection.

The treatment of the cysts is simple excision, carrying a very low morbidity and recurrence rate.

Hertzler (1919) referred to the omentum as “the Good Samaritan of the abdominal cavity, always ready to render aid but seldom becoming sick itself”. Although rare, abnormalities of the omentum must be considered in the differential diagnosis of intra-abdominal swellings or “ascites”.

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