A 35-year-old female presented to us with progressive distension of abdomen and dull aching abdominal pain for about 5 to 6 months. There was no history of vomiting, weight loss or loss of appetite. Her menstrual history was normal and obstetric history was G2P2L2A0. On per abdominal examination there was distention, and a mass measuring 18 x 18 cms was felt. The large mass was soft to cystic and involving whole of the abdomen. It was extending from the epigastric to the pelvis, upper and lower border were not palpable but lateral borders were felt. It was mobile, non tender and cystic with a smooth surface. Routine blood investigations were within normal limits. An abdominal Ultrasound examination was performed, and it showed a giant cystic lesion with internal septations, extending from epigastric to pelvis. The origin of the cystic lesion could not be established. CT scan showed a large mass lesion located in the midline, with imaging characteristics favoring diagnosis of omental or peritoneal cyst probably lymphangioma. Possibility of duplication cyst was less likely. The uterus and adnexa were normal. Patient underwent a laparotomy, intra operative findings were a cystic lesion arising from the greater omentum. The cyst was displacing the stomach anteriorly and extending into the pelvis. Lateral extents were from right lobe of liver to spleen. It was filling the abdominal cavity and had displaced all intrabdominal viscera posteriorly. It was excised in toto and sent for histopathological examination. The gross appearance was of a huge thin walled cyst, filled with clear fluid and had multiple septae. Histopathological examination revealed that lesion was lined by a single layer of cuboidal cells lined with lymph. These findings were consistent with lymphatic cyst of omentum. Post operative recovery was uneventful.

**Discussion**

Omental cysts are rare and are mostly derived from lymphatic tissue. They are present in the lesser or greater omentum and are lined by endothelium. Omental cyst occurs in all age groups, but most often presents in children and young adults. Gairdner published the first report of an omental cyst in 1852. Omental cysts are thought to represent benign proliferations of ectopic lymphatics that lack communication with the normal lymphatic system.

**Etiological theories**

1. Failure of the embryonic lymph channels to join the venous system
2. Failure of the leaves of the mesentery to fuse
3. Trauma
4. Neoplasms
5. Degeneration of lymph nodes

**Classification of omental cysts**

- Embryonic/developmental
- Traumatic
- Neoplastic
- Infectious

Marc de Perrot proposed a more comprehensive classification based on the histological identity of the epithelial lining when present. Lymphatic cysts (simple lymphatic cyst and lymphangioma). Mesothelial cysts (simple mesothelial cyst, benign cystic mesothelioma, and malignant cystic mesothelioma). Enteric cysts (including enteric duplication cyst). Urogenital cysts. Mature cystic teratoma (dermoid cysts). Pseudo cysts (infectious and traumatic cysts). These cysts are lined by a distinct membrane similar to cavernous lymphangioma.
It shows abnormal localized collection of fluid that may be bloody, serous or chylous. The cyst often has a flaccid consistency and tends to occupy the dependent parts of the abdominal cavity. They may mimic ascites. In ascites there is abdominal distension, rolling of the umbilicus, scrotal swelling, and bulging flanks with fluctuation, shifting dullness, and a fluid wave on palpation. Partial bowel resection is required in some cases. Laparoscopic surgery is performed in selected cases when the preoperative diagnosis is certain. The rarity of these lesions and lack of characteristic clinical features may present diagnostic difficulties. Most cases are asymptomatic. The clinical presentation relates to size, location, and complications, such as bowel obstruction, perforation, peritonitis, volvulus, or malignant degeneration. Presenting symptoms include abdominal distension, pain, and vomiting, mimicking appendicitis or an acute abdomen. A painless, asymptomatic, compressible, and freely movable abdominal mass may be the mode of presentation. Mesenteric lymphatic cysts may cause complete or partial intestinal obstruction or torsion of the small bowel 10,11. A hemorrhagic or ruptured mesenteric cyst following trauma 12-14 is an abdominal emergency.

Differential diagnosis – duplication cyst enteric cyst pseudo cyst of pancreas cystic teratoma ovarian cyst. Presence of septa, compression of bowel, lack of fluid in dependent recess is suggestive of lymphangioma. Omental cysts can be simple or multiple, unicellular or multilocular, and they may contain hemorrhagic, serous, chylous, or infected fluid. Omental cysts can be discovered as an incidental finding during laparotomy for another condition, or they can present as a chronic or acute abdomen. Chronic symptoms include progressive abdominal distension and pain. The mass may be huge, mimicking ascites. The most common mode of acute presentation is that of a small-bowel obstruction, which may be associated with intestinal volvulus or infarction, hemorrhage into the cyst, infection, rupture, cystic torsion, and obstruction of the urinary and biliary tract. The imaging modality of choice is abdominal ultrasonography. Ultrasound demonstrates fluid-filled cystic structure, commonly with thin internal septations and sometimes with internal echoes from debris, hemorrhage, or infection. These can be confused with large ovarian cysts in females. Abdominal computed tomography (CT) scanning adds little additional information, although it can reveal that the cyst is not arising from another organ such as the kidney, pancreas, or ovary. The goal of surgical therapy is complete excision of the cyst. 15. Omental cysts can be removed without endangering the adjacent bowel. If the cyst is encountered incidentally, it should be removed as the operative mortality for excision is negligible. There is no documented evidence to show that these cysts may undergo malignant degeneration or they may recur. Prognosis is excellent with complete excision.

Conclusion Clinical presentation of omental cysts will depend upon the size of the cyst. Small cysts may be asymptomatic or present with acute abdomen while a big omental cyst may mimic ascites. Complete surgical excision of the cyst is must to prevent recurrence. Omental cysts can be excised without damage to the surrounding structures. Consent written informed consent was obtained from the patient for publication of this case report and accompanying images. There is no conflict of interest.