

EDİTÖRE MEKTUP / LETTER TO THE EDITOR

Cystic lymphangioma of the ascending colon and cecum

Çıkan kolon ve çekumun kistik lenfanjiomu

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Dear Editor,

Cystic lymphangiomas are benign lesions, and rarely seen in the colon. They are usually localized in the neck, skin, axilla regions. The first colonic lymphangioma was determined by Chisholm and Hillkowitz in 1931¹. We present a case of cystic lymphangioma of the ascending colon and cecum.

A 39-year-old woman with upper left quadrant pain was admitted to our hospital. The physical examination at this time was normal except for splenomegaly and laboratory parameters were normal. The examination of a stool examination for presence occult blood was normal. First, the patient was evaluated with ultrasonography. Abdominal ultrasonography

showed splenomegaly. Then, abdominal computed tomography (CT) was performed with oral and intravenous contrast media. CT showed eccentric lesion located at the lateral wall of the ascending colon. The lesion extended around the cecum. CT density of this lesion was high density as 30 HU on precontrast image and 35 HU on postcontrast image and no enhancement and fat content was seen. The size of lesion was 3.7x2.6 cm (Figure 1-3) The finding of colonoscopy was edema in the rectum and cecum and the result of biopsy was consistent with acute colitis. Because of nonspecific findings, operation was performed and subserosal cystic lesion of ascending colon and cecum was excised. The histopathological diagnosis was submucosal and serosal cystic lymphangioma.

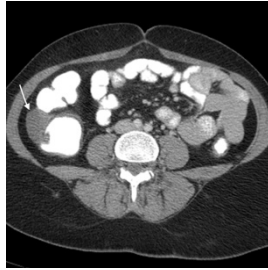


Figure 1. Axial CT image of abdomen with oral and intravenous contrast media shows eccentric, hypodense lesion of the ascending colon (arrow).



Figure 2. Axial CT image of abdomen with oral and intravenous contrast media shows eccentric, hypodense lesion of the cecum (arrow).



Figure 3. Coronal CT image of the abdomen with oral and intravenous contrast media shows eccentric lesion of the ascending colon (arrow).

Lymphangiomas of the colon are benign tumors, they are rarely detected. Intraabdominal lymphangiomas are rare and comprise less than 5% of all lymphangiomas². The first case was

determined by Chisholm and Hillkowitz in 1932. Fleming and Carlson reported 1 lymphangioma of the descending colon found in 453,708 roentgenographic examinations in 1970³. Huguet et

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al. showed that approximately 95 % of colorectal lymphangiomas were in patients from Japan². The most common location of the colonic lymphangioma were the transverse colon, ascending colon, and cecum, respectively. The location of the our case was ascending colon and cecum. Matsuda et al⁴ reported that the tumor size was identified in 210 cases, with the maximum diameter ranging from 0.5 to 23.0 cm (mean 2.8 ± 2.1 cm). The size of the our case was 3.7x2.6 cm.

The complaints of the patients with lymphangioma are abdominal pain, bloody stool, or diarrhea. But, usually, the patients have nonspecific findings and symptoms. In some cases, ileus, invagination, protein-losing enteropathy have been reported as complications¹. Our patient had pain in the upper left quadrant.

In the literature, most lymphangiomas were detected in patients older than 40 years of age (peak incidence, 41-50 years and 61-70 years). The male-to-female ratio was 1.39:1, for a slight predominance in men². Our patient was 39-year-old woman.

The classification of lymphangioma was performed by Wegener et al⁵. The classification is related to the size of the lymphatic cavity and the nature of the lymphatic wall. There are three types: simple, cavernous, and cystic. Cystic lymphangioma is the most common type. The characterization of lymphangioma is the flat epithelial endothelium and lymphoid tissue, small lymphatic spaces, smooth muscle, and foam cells.

The diagnosis of lymphangioma in the colon has usually been made by colonoscopy, barium enema, ultrasonography, CT, magnetic resonance imaging (MRI). Recently, colonoscopy is the most useful test, but, in the past, barium enema study used to be the most diagnostic procedure.

The findings of the colonoscopy are a round and smooth appearance, a broad base, a pale blue or transparent color, and presence of the cushion sign when pressure is applied with forceps to the surface⁶. Unfortunately, the colonoscopy finding of this case was nonspecific, and consistent with colitis. We thought that negative colonoscopy might be related to peripheral location of lesion.

The findings of the barium enema are a smooth surface and morphologic change occurring with change in physical position⁷. We did not perform barium enema. In addition to, ultrasonography of

the our patient was normal.

CT and MRI generally show the lymphangioma as a multi-loculated cyst-like structure and septation⁸. Our patient had the eccentric lesion of the ascending colon and cecum on CT. The differential diagnosis of the lymphangioma include other submucosal lesions such as lipoma, leiomyoma, cyst, and cavernous hemangioma, carcinoid, carcinoma, mucocele, adenomatous polyp, enteric duplication, mesothelial cyst, and myogenic or neurogenic submucosal tumor⁶. The lesion in our case had high density, but had no enhancement and fat content. Therefore, lipoma, hemangioma, carcinoid, carcinoma were excluded. We thought that lesion might be other lesions as lymphangioma, other cystic lesions and leiomyoma.

The indication for operation in the colonic lymphangioma is equivocal. Surgery is required to prevent recurrence, rupture, torsion, and bleeding in such patients, especially, in the young women⁹. In our case, operation was performed and subserosal cystic lesion of ascending colon and cecum was excised.

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