stenting without fluoroscopy, guided by ultrasound, has been reported as case reports, but no cases have been reported of biliary stent insertion without the guidance of any imaging method.

In conclusion, in patients with impaired general status and those unfavorable for transport to the endoscopy room for ERCP, bedside NBD or stenting is beneficial if biliary decompression is obligatory. This case is original since, to our knowledge, there has been no other case report of bedside biliary stenting in the literature, and the procedure yields a successful result.

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Giant mesenteric cyst can present as pseudoascites with raised Ca125

Dev mezenterik kist, yüksek Ca125 ve asit yanılgısı ile prezente olabilir

To the Editor,

A mesenteric cyst is one of the rarest abdominal tumors. Mesenteric cysts, with sizes varying from a few centimeters (cm) to more than 30 cm in diameter, may occur in the small bowel mesentery, the transverse mesocolon, and the root of the mesentery with retroperitoneal extension (1-3). The clinical presentation relates to the size, location, and complications, such as bowel obstruction, perforation, volvulus, or malignant degeneration. Presenting symptoms include abdominal distension, pain, and vomiting, often mimicking appendicitis or an acute abdomen (3, 4).

A 57-year-old female patient presented to our clinic with abdominal distension and pain. An examination revealed the presence of dullness and an extremely distended abdomen. The routine laboratory results were normal. The tumor marker results showed a high Ca125 concentration of 221.9 U/ml (0-35 U/ml).

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She had a diagnostic paracentesis. The serum ascites albumin gradient was 4.2. Biochemical analysis of the ascitic fluid was transudate. An abdominal ultrasonography (US) showed a well-circumscribed giant anechoic mass, extending from the xiphoid down beyond the symphysis pubis. Magnetic resonance (MR) imaging of the abdomen revealed a large well-defined cystic mass, measuring 14 x 29 x 22 cm. The mass was evaluated as hypointense in T1-weighted and hyperintense in T2-weighted MR images (Figure 1).

A therapeutic laparotomy was performed. A mesenteric cyst derived from the terminal ileum with a dimension of nearly 30 cm was observed. A cystectomy was performed. The findings obtained from the histopathologic examination showed a single layer of mesothelial cell lines in the cyst and a mesothelial endothelium containing smooth muscle fiber and lymphoid tissue. The Ca125 had decreased to within a normal range at the sixth postoperative month. Four years postoperatively, the patient is doing well and there has been no recurrence of the cyst.

In this case, the giant mesenteric cyst mimicked ascites with abdominal distension and shifting dullness. Ultrasonography is the diagnostic method of choice. MR and computed tomography are performed in select cases—when the preoperative diagnosis is uncertain. The treatment of choice is complete excision to avoid recurrence and possible malignant transformation (5).

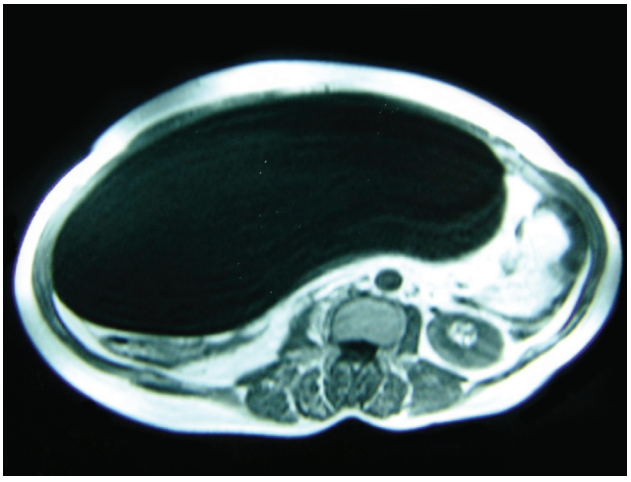

Figure 1. Abdominal MRI scan: the giant abdominal tumor can be seen filling almost the entire abdominal cavity, displacing the small intestine, colon, pancreas, spleen and the left kidney.

Although a very high level of Ca125 is associated with a malignant process, it can also be found in benign conditions such as in a giant mesenteric cyst. This case emphasizes the association of high levels of Ca125 with benign conditions (6).

Mesenteric cysts should be considered in the differential diagnosis of abdominal distension, ascites, acute abdominal pain, and mass or bowel obstruction. For this reason, clinicians must consider processes other than ascites in the differential diagnosis of abdominal distension, even when US examination indicates ascites.

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