

3. Levy AD, Rimola J, Mehrotra AK, et al. From the archives of the AFIP: benign fibrous tumors and tumorlike lesions of the mesentery: radiologic-pathologic correlation. *Radiographics* 2006; 26: 245-64.
4. Isenberg J, Bollmann R, Keller HW. Idiopathic sclerosing mesenteritis. Case report and differential diagnosis of a rare disease picture. *Chirurg* 2001; 72: 742-5.
5. Montgomery E, Torbenson MS, Kaushal M, et al. Beta-catenin immunohistochemistry separates mesenteric fibromatosis from gastrointestinal stromal tumor and sclerosing mesenteritis. *Am J Surg Pathol* 2002; 26: 1296-301.
6. Rodriguez JA, Guarda LA, Rosai J. Mesenteric fibromatosis with involvement of the gastrointestinal tract. A GIST simulator: a study of 25 cases. *Am J Clin Pathol* 2004; 121: 93-8.
7. Carlson JW, Fletcher CD. Immunohistochemistry for beta-catenin in the differential diagnosis of spindle cell lesions: analysis of a series and review of the literature. *Histopathology* 2007; 51: 509-14.

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A rare cause of palpable mass located at the suprapubic area: Abscess of omphalomesenteric duct cyst

Suprapubik bölge yerleşimli palpabl kitlenin nadir bir nedeni: Omfalomezenterik kanal kisti apsesi

To the Editor,

Embryonic remnants of the umbilicus may cause various problems after birth, such as omphalomesenteric duct pathologies. If the omphalomesenteric duct does not regress, a fistula between the ileum and umbilicus, sinus formation, cysts, or Meckel's diverticulum can develop (1).

A 49-year-old female admitted to our unit with fever, lower midabdominal pain and a palpable mass. Her medical history revealed that she underwent cesarean section 15 years before. She had hypertension, asthma and moderate mitral valve stenosis. On physical examination, axillary body temperature was 38.3°C, blood pressure: 140/80 mmHg and heart rate: 110/min. Lower abdominal quadrants were tender. White blood cell count was 15300 mm³ and C-reactive protein level was 70 U/ml. Ultrasonography demonstrated a hypoechoic cystic lesion localized at the anterosuperior part of the bladder. Computed tomography showed a 6x2 cm lesion, located between the anterior wall of the bladder and the abdominal wall, below the umbilicus (Figure 1a). Fine needle aspiration was

performed and leukocytes, gram-positive diplococci and gram-negative bacilli were seen on microscopic evaluation. In the surgical exploration, the cystic lesion was seen under the abdominal wall and there was no attachment to other intraabdominal organs. Total cystectomy was performed later (Figure 1b). The abscess culture grew *Pseudomonas* spp. Ciprofloxacin 500 mg tablets per oral twice a day was initiated. The wall of the cyst was composed of a wide smooth muscle layer and mucinous prismatic intestinal epithelium resembling bile duct epithelium (Figure 1c). Omphalomesenteric cyst was diagnosed in light of these histopathologic findings. The patient recovered uneventfully after the operation.

Only a few cases regarding omphalomesenteric duct remnant-related diseases have been reported in adults (2). Abdominal pain, rectal bleeding, ileus, umbilical hernia, and efflux are the symptoms of omphalomesenteric duct cyst (3). The diagnosis of an omphalomesenteric duct cyst due to an abscess is extremely rare in adults. Conventional sur-

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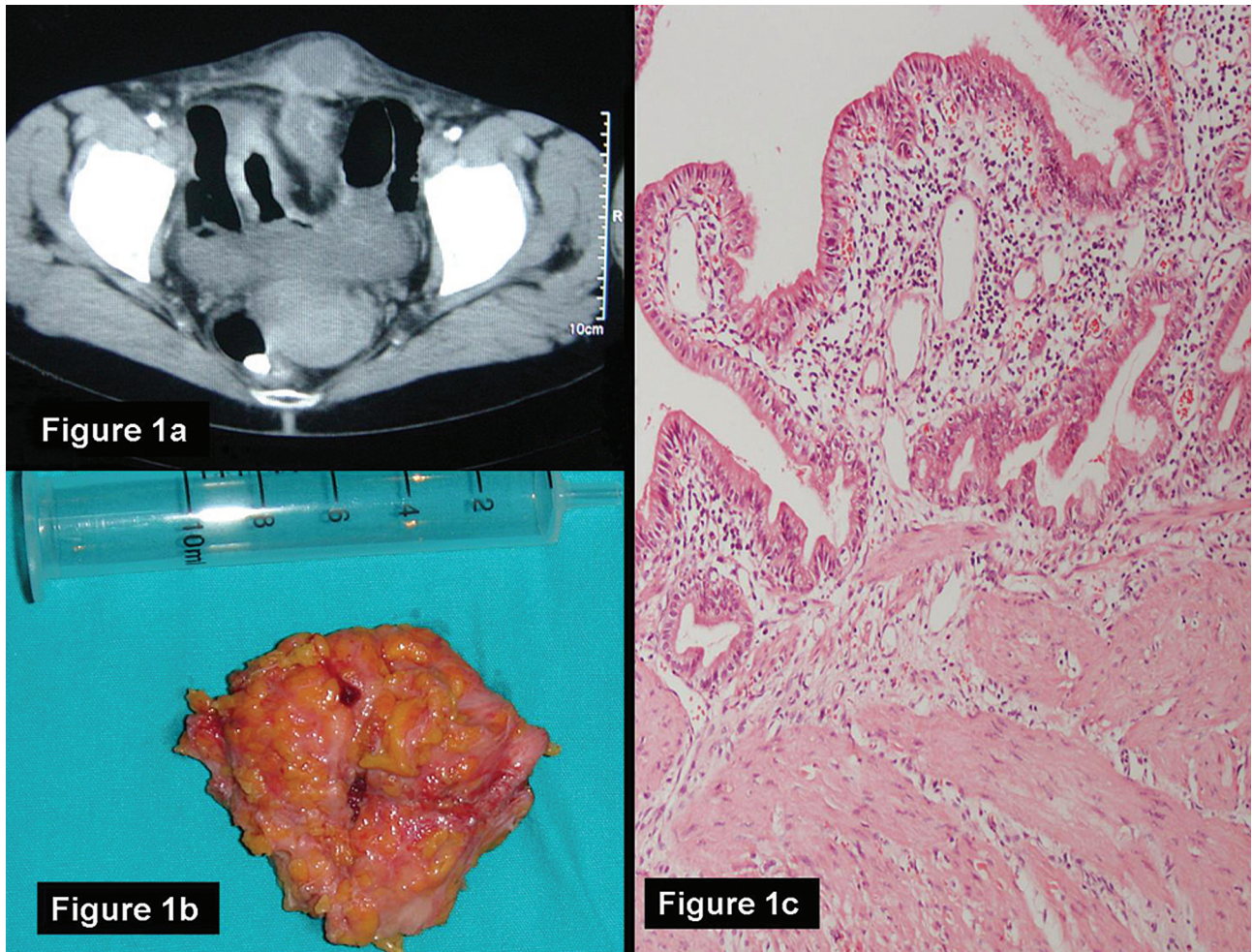


Figure 1. (a) Computerized tomography demonstrated the 6x2 cm lesion between the anterior wall of the bladder and the abdominal wall. (b) The resected cystic lesion. (c) The cyst wall was composed of a wide smooth muscle layer and mucinous prismatic intestinal epithelium that resembled bile duct epithelium.

gery and laparoscopy are the recommended treatment alternatives for symptomatic lesions (4). We performed conventional surgery in our patient and excised the cystic lesion. If the omphalomesenteric cysts are left without excision, fistula, intestinal perforation and recurrent infections can be seen. Gastrointestinal epithelium lies down in the omp-

halomesenteric cysts. This is an important factor for distinguishing between urachal cysts and omphalomesenteric cysts (5). The omphalomesenteric cyst-related pathologies should be remembered during the diagnosis and treatment of a palpable mass located on the suprapubic area of the abdominal wall.

REFERENCES

1. Khati NJ, Enquist EG, Javitt MC. Imaging of the umbilicus and periumbilical region. *Radiographics* 1998; 18: 413-31.
2. Sawada F, Yoshimura R, Ito K, et al. Adult case of an omphalomesenteric cyst resected by laparoscopic-assisted surgery. *World J Gastroenterol* 2006; 12: 825-7.
3. Lassen PM, Harris MJ, Kearse WS Jr, Argueso LR. Laparoscopic management of incidentally noted omphalomesenteric duct remnant. *J Endourol* 1994; 8: 49-51.
4. Schmid SW, Schafer M, Krahenbühl L, Büchler MW. The role of laparoscopy in symptomatic Meckel's diverticulum. *Surg Endosc* 1999; 13: 1047-9.
5. Ratan SK, Rattan KN, Kalra R, et al. Omphalomesenteric duct cyst as a content of omphalocele. *Indian J Pediatr* 2007; 74: 500-2.

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