CASE REPORT

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Spontaneous remission of sclerosing mesenteritis

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Sclerosing mesenteritis is a rare fibroinflammatory disorder mostly affecting the small bowel mesentery with unknown etiology. Its clinical presentation varies according to the pathologic stages of sclerosing mesenteritis. In the early stages, nonspecific abdominal symptoms are usually seen, whereas severe small intestinal obstructive symptoms predominate in late stages. Diagnosis is usually obtained with the use of imaging techniques like computerized tomography and magnetic resonance imaging. Sclerosing mesenteritis is a self-limiting disease, and complete remission is seen in most patients. Medical and surgical treatment is reserved for symptomatic and complicated cases, respectively. In this paper, we describe a case of sclerosing mesenteritis in a 31-year-old male patient who presented with abdominal pain and weight loss. He was diagnosed as sclerosing mesenteritis with the help of two consecutive computerized tomographys. The mass spontaneously and completely disappeared in one month.

Key words: Sclerosing mesenteritis, diagnosis, spontaneous remission

Sklerozan mezenteritin spontan remisyonu

Sklerozan mezenterit, sıklıkla ince barsak mezenterini etkileyen, bilinen bir etyolojsi olmayan ve nadir görülen bir fibroinflamatuar bozukluktur. Hastalığın patolojik evresine göre klinik başvuru değişmektedir. Erken evrelerde nonspesifik abdominal semptomlar görülürken, ileri evrelerde ince barsak obstrüktif semptomları hastalığa hakim olmaktadır. Tanı bilgisayarlı tomografi ve magnetik rezonans görüntüleme gibi radyolojik tekniklerle sıklıkla yapılmaktadır. Sklerozan mezenterit kendini sınırlayan bir hastalık olup, hastaların çoğunluğunda tam gerileme görülmektedir. Tıbbi ve cerrahi tedavi semptomatik ve komplike olgular için düşünülmelidir. Bu yazıda, karın ağrısı ve kilo kaybı ile başvuran 31 yaşındaki bir sklerozan mezenterit olgusu tanımlandı. Bir ay ara ile çekilen iki bilgisayarlı tomografi yardımı ile sklerozan mezenterit tanısı kondu. Kitle spontan olarak, herhangi bir tedavi olmaksızın kayboldu.

Anahtar kelimeler: Sklerozan mezenterit, tanı, remisyon

INTRODUCTION

Sclerosing mesenteritis (SM) is a rare nonspecific fibroinflammatory disorder of unknown etiology that usually affects the small bowel mesentery (1-4). It is now considered as a single disease with two pathological subgroups. When inflammation and fat necrosis predominate over fibrosis, the condition is known as mesenteric panniculitis; when fibrosis and retraction predominate, the result is retractile or SM (2).

Sclerosing mesenteritis (SM) has a variable clinical course ranging from nonspecific abdominal discomfort to small bowel obstruction and perforation (1,5). Because of its rarity, the atypical clinical manifestation and physicians' lack of familiarity with the disease, preoperative diagnosis can be very difficult (4). However, with the advent of imaging technology like computerized tomography (CT), it is possible to diagnose this condition without pathological analysis (2).

In this report, we aimed to present a case of SM in a young male patient.

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CASE REPORT

A 31-year-old male patient presented with abdominal pain and loss of 10% of his total body weight over approximately one month. The abdominal pain, mainly located around the umbilicus, was severe and intermittent in nature. Loss of appetite, nausea and vomiting were also marked. He had suffered similar pain attacks for several years, with the last attack being the most severe. He is a current smoker, of 10 pack years. According to the physical examination, the patient appeared well and had stable vital signs; the remainder of the examination was unremarkable. The laboratory profile of routine blood tests and renal and hepatic function tests was normal. Abdominal CT scan demonstrated a soft tissue mass around the small bowel mesentery and an obliteration of the superior mesenteric vein (SMV) (Figure 1). Intravenous pyelogram showed a normal urinary anatomy. The evaluation of imaging findings led to a possible diagnosis of SM. However, during this time, the severity of the symptoms gradually decreased in intensity without any treatment over a period of one month. A new abdominal CT scan revealed continuation of the obliteration of SMV, new collateral formation around it and complete remission of the mass (Figure 2). After three months, the general status of the patient was normal, the symptoms had disappeared totally, and no recurrence was observed.

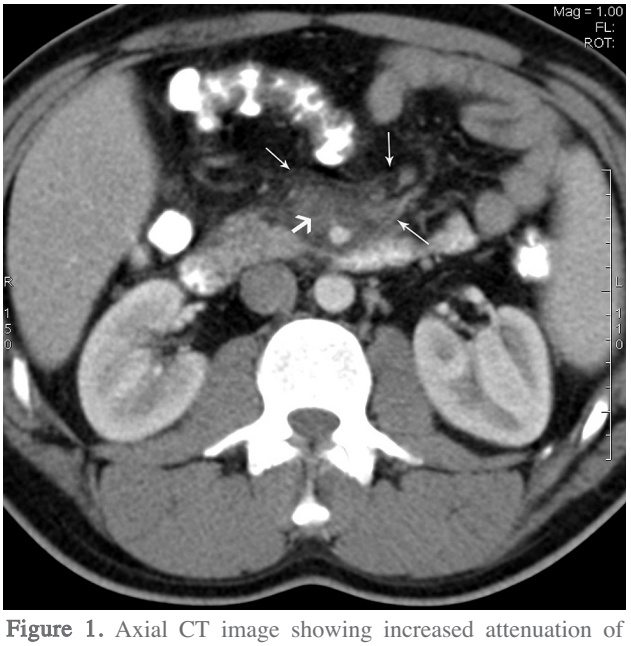

Figure 1. Axial CT image showing increased attenuation of small bowel mesenteric fat (thin arrows) and obliteration of SMV (thick arrow).

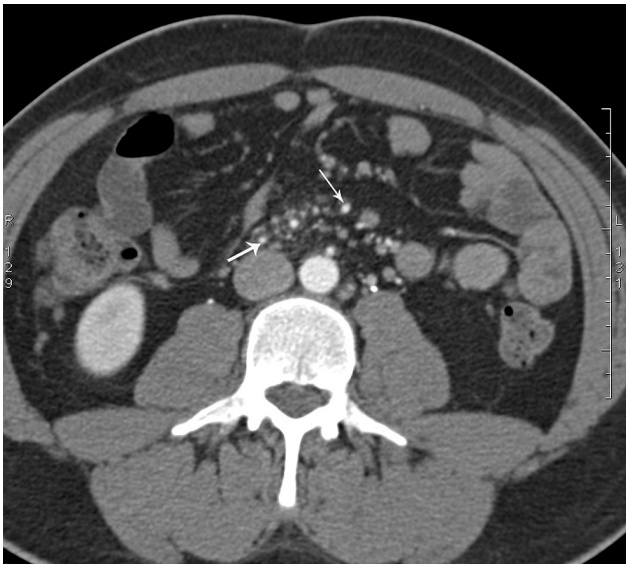

Figure 2. Axial CT image showing complete disappearance of the mass and new collateral formation (arrows).

DISCUSSION

The exact pathophysiology of SM is unknown, although various predisposing factors have been postulated, including trauma, previous abdominal surgery, cigarette smoking, coexisting malignancy, mesenteric thrombosis, and pancreatitis (1-3). In our case, cigarette smoking was the only possible etiologic factor for SM.

Most studies indicate that SM is a disease of middle-aged or older adults and more commonly seen in male patients (1,2). However, there are a few case reports showing the occurrence of SM in young patients, as in our case (3,5).

In most of the cases, SM involves the small bowel mesentery, although it may sometimes involve the sigmoid, and rarely, the mesocolon, peripancreatic region or omentum (2).

Most symptoms associated with SM are caused by the direct mechanical effect of the mesenteric mass encasing the bowel, blood vessels and lymphatics, and they vary according to the underlying pathologic stage of SM (1). The wide variety of these manifestations causes difficulty in the diagnosis of SM in clinical practice (1,2). It is possible and feasible to diagnose SM and differentiate it from other mesenteric diseases including carcinomatosis, carcinoid tumor, lymphoma, liposarcoma, and desmoid tumor with the advent of imaging technology like CT or magnetic resonance imaging (MRI) (1,2,6). The CT features vary according to

the pathological subgroups of SM. It is usually visualized as a heterogeneous mass with a large fat component, which is an important feature for the differentiation of SM from other mesenteric pathologies, and interposed linear bands with a soft tissue density in cases of mesenteric panniculitis, or as a homogeneous mass of soft tissue density in cases of retractile or SM (2-4). With these imaging findings, unless there is a high clinical suspicion of an alternate diagnosis, there is no need to perform an exploratory laparotomy or laparoscopy to diagnose SM (1). The two consecutive CT scans of our patient revealed the possible diagnosis of SM, and complete remission of the mass and collateral formation around the SMV in one month. Although the mass had completely disappeared, it is interesting that the obliteration of the SMV and new collateral formation around it persisted after one month.

Spontaneous remission of SM is usually seen in most cases, as in our patient (2,4,5). In general, medical treatment has been reserved only for symptomatic cases, with different degrees of success (2). Surgery may be attempted if medical therapy fails or in the presence of life-threatening complications such as bowel obstruction or perforation (2). However, it should be kept in mind that attempted surgical resection or debulking usually does not result in resolution of the symptoms or prevent disease progression (1).

In conclusion, SM is a rare clinical entity with unknown etiology. Its nonspecific clinical presentation causes difficulty in the diagnosis. With the use of CT, it is possible and feasible to diagnose SM without the necessity of pathologic analysis. Spontaneous remission is seen in most cases. Medical and surgical treatment is reserved for symptomatic and complicated cases, respectively.

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