Malignant melanomas are the common malignancies with ability to metastasize to the liver (1); moreover, acute hepatic failure was also described after liver metastasis of malignant melanomas (2). The percentage of metastatic melanomas of unknown origin was reported to range from 2.3-4.7% (3,5). The most commonly observed areas of metastatic melanomas of unknown origin were regional lymph nodes, subcutaneous areas, abdominal viscera, and tissues such as brain and lung (3,5). To our knowledge, there is only one case in the English literature of liver metastasis without origin, but this patient also presented with metastasis to the skin and lung (5). Extensive exclusion criteria of malignant melanomas of unknown origin were noted by Das Gupta et al. in 1965 (3). Patients undergoing prior excision of suspicious melanocytic or pigmented lesions despite different areas; patients with a history of orbital enucleation or exenteration; patients with scars in the region of the infiltrated lymph node drainage area; and patients without any examination of ophthalmic and genital areas were not included in the diagnosis of malignant melanomas of unknown origin. Upper airway and lower gastrointestinal examination (4), chest CT and/or X-ray, abdominal USG or CT, lymph node USG of palpable lymphadenopathy, and cranial CT or magnetic resonance imaging should be investigated before reaching the diagnosis of malignant melanomas of unknown origin (5).

In conclusion, metastatic liver malignant melanoma of unknown origin is a rare manifestation of malignant melanomas, and its diagnosis should be made only after fulfilling the exclusion criteria.

REFERENCES

1. Chang AE, Karnel LH, Menck HR. The National Cancer Data Base report on cutaneous and noncutaneous melanoma: a summary of 84 836 cases from the past decade. Cancer 1998; 83: 1664-78.
2. Kaplan GG, Medlicott S, Culleton B, Laupland KB. Acute hepatic failure and multi-system organ failure secondary to replacement of the liver with metastatic melanoma. BMC Cancer 2005; 5: 67.
3. Das Gupta T, Bowden L, Berg JW. Malignant melanoma of unknown primary origin. Surg Gynecol Obstet 1963; 117: 341-5.
4. Reintgen DS, McCarthy KS, Woodard B, et al. Metastatic malignant melanoma with an unknown primary origin. Surg Gynecol Obstet 1983; 156: 335-40.
5. Schlagenhauff B, Stroebel W, Ellwonger V, et al. Metastatic melanoma of unknown primary origin shows prognostic similarities to regional metastatic melanoma: recommendations for initial staging examinations. Cancer 1997; 80: 60-5.

Özgür YENİOVA[1], Akif ALTINBAŞ[1], Osman ERSOY[2], Musa AYDINLI[2], Yusuf BAYRAKTAR[2]

Departments of [1]Internal Medicine, [2]Division of Gastroenterology, Hacettepe University, School of Medicine, Ankara

Huge congenital epidermoid spleen cyst in an adult

Erişkin vakada dev konjenital epidermoid kist

To the Editor,

Spleen cysts are rare in clinical practice. They are classified essentially as parasitic or non- parasitic based on their etiology and as true or pseudo based on the presence or absence of lining epithelium. Primary cysts (true with own lining) represent 30-40% of all cysts and occur mostly in children. Secondary cysts (pseudocysts with no lining) are more frequent. The pathogenesis of true cysts

Address for correspondence: Murat KALAYCI
Department of General Surgery, Yeditepe University Faculty of Medicine, İstanbul, Turkey
E-mail: drmuratkalayci@yahoo.com

Manuscript received: 02.03.2011 **Accepted:** 07.03.2011

doi: 10.4318/tjg.2012.0372

is unknown and numerous hypotheses are given by different authors (1,2). The familial occurrence of epidermoid cysts of the spleen is rare (3). Ultrasound and computerized tomography (CT) are useful for the diagnosis. A microscopic examination of the surgical specimen is the only way to make the diagnosis of an epidermoid cyst. The histological characteristic of epidermoid cyst is the presence of an epidermoid epithelial cyst lining of the surface. Although the number of cases of splenic cyst is increasing with advances in diagnostic modalities, epidermoid cyst of the spleen is still rare. Here, we present a patient with a giant epidermoid spleen cyst with a maximum diameter of approximately 20 cm according to preoperative imaging studies.

A 23-year-old female was admitted to our hospital with an abdominal pain localized in the left upper quadrant that had started two days before. The physical examination revealed a palpable mass on the left upper quadrant. Ultrasonography revealed a giant cyst. Maximum diameter of the cyst was 20 cm. Similarly, CT scan revealed a homogeneous, low-attenuated giant cyst in widespread contact with the spleen (Figure 1). Biochemical analyses were normal. Surgery was planned, and pathological examination of the spleen showed an epidermoid congenital cyst (Figures 2, 3). The remaining spleen parenchyma was atrophic. The postoperative course was free of complications, and the patient was discharged from the hospital four days after surgery.

Congenital epidermoid splenic cysts are rare in the literature. The cystic fluid can be thin and serous, but cysts with turbid and viscous fluid have been reported as well. The cyst presents as an asymptomatic abdominal mass or with pain in the left upper quadrant due to enlargement, hemorrhage, rupture, or infection. Conventional treatment of a non-parasitic cyst is total splenectomy, but alternative treatment options including aspiration, internal and external marsupialization, partial splenectomy, and partial cystectomy (decapsulation) have been reported. These treatments can be per-

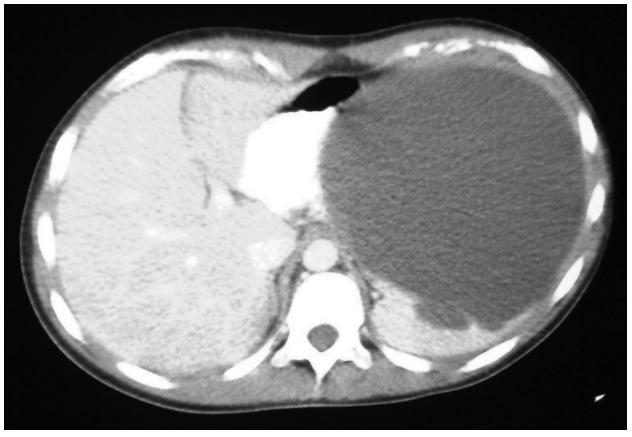

Figure 1. Computerized imaging of the spleen cyst.

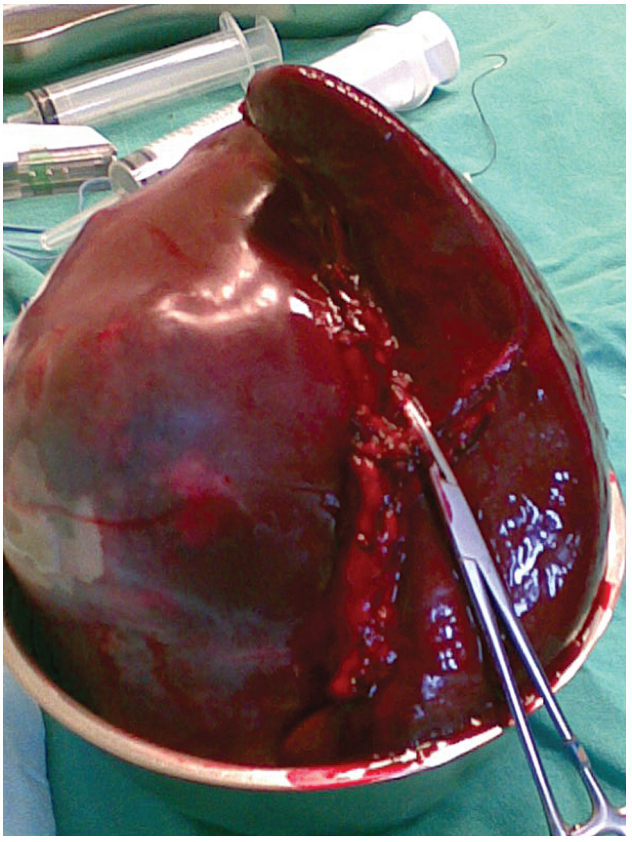

Figure 2. Spleen with huge cyst material.

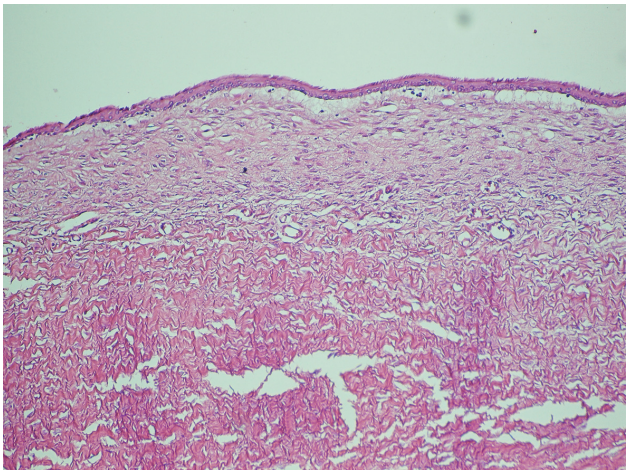

Figure 3. Microscopy of the cyst wall shows the stratified squamous lining epithelium.

formed by open or laparoscopic surgery (4-6). Follow-up is recommended for small asymptomatic cysts, up to 5 cm in diameter. In our patient, the cyst was very large and centrally located, and spleen parenchyma was thin, as it was almost completely occupied by the mass. We preferred a laparotomy, and splenectomy was performed.

In conclusion, we present a young adult case with a long-standing, huge, and asymptomatic congenital epidermoid cyst.

REFERENCES

1. Herdepen P, Strupoval L, Visokai V, Kostlivˇ K. Laparoscopic management of epidermoid spleen cyst. Rozhl Chir 2007; 86: 313-7.
2. Dillemans B, Mottrie A, Decoster M, Gruwez JA. Epidermoid cysts of the spleen. Acta Chir Belg 1993; 93: 265-7.
3. Kubo M, Yamane M, Miyatani K, et al. Familial epidermoid cysts of the spleen: report of two cases. Surg Today 2006; 36: 853-6.
4. Gaudio M, Brizio R, Medri L, et al. Epidermoid cyst of the spleen. Presentation of a case. Pathologica 1990; 82: 465-70.
5. Di Carlo I, Fasone MA, Toro A. Epidermoid cyst of the spleen in the laparoscopic era. Dig Surg 2005; 22: 53-4.
6. Sakamoto Y, Yunotani S, Edakuni G, et al. Laparoscopic splenectomy for a giant splenic epidermoid cyst: report of a case. Surg Today 1999; 29: 1268-72.

Murat KALAYCI[1], Ümit AKYÜZ[2], Alp DEMİRAĞ[1], Ferda ÖZKAN[3], Özcan GÖKÇE[1]

Departments of [1]General Surgery, [2]Gastroenterology and [3]Pathology, Yeditepe University School of Medicine, İstanbul

Tuberculous peritonitis case at advanced age presenting with chylous ascites

İleri yaşta şilöz asit ile prezente olan tüberküloz peritonit olgusu

INTRODUCTION

Chylous ascites is defined as peritoneal fluid accumulation with milky appearance rich in triglycerides. It is detected in the abdominal cavity in association with thoracic or intestinal fluid accumulation. Our case was a tuberculous peritonitis case emerging suddenly at an advanced age and presenting with chylous ascites.

CASE REPORT

A 65-year-old male patient referred to our hospital with the complaint of progressive abdominal bloating increasing within the last month. He reported night sweating, weight loss, fatigue, and widespread abdominal pain.

Evaluation of laboratory parameters revealed mild anemia and also high C-reactive protein (CRP) and erythrocyte sedimentation rate (ESR) levels. Of tumor markers, only Ca-125 was found to be high (500 U/ml). According to examination of the ascitic fluid, it was of chylous consistency, with a white cell count of 800/mm^3 (lymphocyte-dominant) - 386/mm^3), total protein 5.8 g/dl, albumin 2.5 g/dl, glucose 56 mg/dl (simultaneous blood glucose: 94 mg/dl), lactate dehydrogenase (LDH): 211 U/L, triglyceride: 1632 mg/dl, and adenosine deaminase (ADA): 38 IU/L. Serum-ascites albumin gradient (SAAG) was calculated to be 0.9. Test for acid-resistant bacilli (ARB), which were investigated twice in ascitic fluid, was negative, and in cytological examination, benign mesothelial cells were reported to be present.

In abdominal ultrasonography (USG), the liver was found to be of normal size with regular bor-

Address for correspondence: Ahmet Tarık EMİNLER
Department of Gastroenterology, Uludağ University, School of Medicine, Bursa, Turkey
E-mail: eminler@yahoo.com

Manuscript received: 21.03.2011 **Accepted:** 18.04.2011

doi: 10.4318/tjg.2012.0382

Presented at 5th Hepatogastroenterology Congress, 2006 Antalya