

Giant Omental Cyst Masquerading as Hemorrhagic Ascites

Children with grossly distended, fluid filled abdomen need not always have ascites! Surgical causes should be thought of early in those unresponsive to treatment. A boy with giant omental cyst misdiagnosed and mismanaged as hemorrhagic ascites for about 4-5 years is reported.

A 5-year-old boy was seen with a history of gradually increasing abdominal distension from the age of 6 mo associated with diarrhea but no history of fever, jaundice, dyspnoea or swelling of extremities. He was undergoing repeated 'ascitic' taps from 1.5 yrs age and was on diuretics and anti-tuberculous treatment inspite of negative stains and DNA analysis. While the initial 2 taps were clear (predominant lymphocytes, protein 3.6 g/dL), all later taps were hemorrhagic with no malignant cells. Coagulation profile, renal and liver function tests, serum amylase, echocardiogram, barium meal, duodenal biopsy and Tc99m Sulfur colloid blood pool study were normal. Ultrasonography and computed tomography (CT) scan were reported to be consistent with ascites (*Fig. 1*). He had been seen by 5 doctors and received 2 blood transfusions during this period.

When seen by us, he had normal respiratory and cardiovascular systems. There was pallor but no generalized edema. The abdomen was grossly distended. While recumbent, both flanks were bulging. Fluid thrill was present with no shifting dullness. He weighed 14.6 kg with hemoglobin of 4.6 g/dL. A review of the CT scan showed the bowel loops clustered together posteriorly in the center of the abdomen, suggesting a mass lesion(1). At laparotomy, a thin walled, giant

cyst arising from the greater omentum with multiple septations, lying very close to the abdominal wall and extending all over was excised. It contained 5L of hemorrhagic fluid. The histopathology was compatible with a lymphangioma. Post-operative recovery was quick and at 9 mo follow-up, he remains asymptomatic and weighs 17 kg.

Omental cysts are usually differentiated from ascites by the fact that the flanks do not bulge when the child is recumbent and the cyst will seem to follow as the child moves. However, giant omental cysts as in our case, due to their size and tendency to occupy every available space in the abdomen often do not show these features. The absence of any obvious predisposing factors for fluid retention, in a child with apparent ascites, should alert us. Investigations also need to be interpreted correctly(2). Other surgical lesions like extrarenal Wilms tumor and primary omental leiomyosarcoma can also mimic hemorrhagic ascites(3,4).

Complete surgical excision is curative as these cysts are usually congenital or of benign lymphatic origin(5).

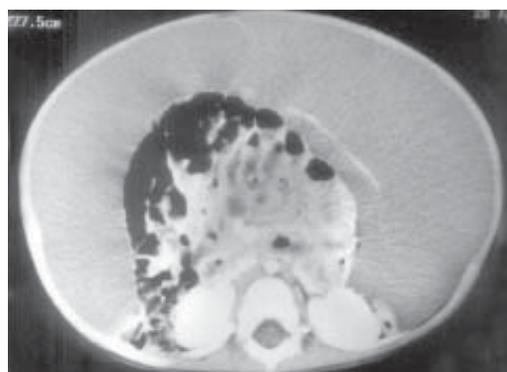


Fig. 1. CT scan of abdomen shows gross ascites (23 HU) with few septations within. Bowel loops are clumped together posteriorly in the central abdomen.

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REFERENCES

1. Haller JO, Schneider M, Kassner EG, Slovis TL, Perl LJ. Sonographic evaluation of

mesenteric and omental masses in children. *Am J Roentgenol* 1978; 130: 269-274.

2. Klin B, Lotan G, Efrati Y, Vinograd I. Giant omental cyst in children presenting as pseudoascites. *Surg Laparosc Endosc* 1997; 7: 291-293.

3. Narasimharao KL, Marwaha RK, Kaushik S, Bharati B, Katariya S, Mitra SK, *et al.* Extrarenal Wilms' tumor. *J Pediatr Surg* 1989; 24: 212-214.

4. Dixon AY, Reed JS, Dow N, Lee SH. Primary omental leiomyosarcoma masquerading as hemorrhagic ascites. *Hum Pathol* 1984; 15: 233-237.

5. Shackelford GD, McAlster WH. Cysts of the omentum. *Pediatr Radiol* 1975; 13:152-155.

Betamethasone Abuse in Infancy

Oral Betamethasone is being prescribed unnecessarily for innocuous conditions like common cold. The ignorant mothers also misuse betamethasone for their babies to make them chubby. These steroid babies develop cushings syndrome, immuno-suppression and serious infections like pneumonia and meningitis. We present two infants with Cushings syndrome due to prolonged betamethasone use.

A four month old male infant born with a birth weight of 2.5 kg presented with chickenpox. On examination, he weighed 11 kg and had cushingoid features. His blood pressure was normal and had multiple papulo-vesicular lesions characteristic of chickenpox. The child had to be treated with oral acyclovir in view of cushingoid features. At fifteen days

of life, a private practitioner had prescribed betamethasone oral drops for upper respiratory tract infection. The mother had noticed increased appetite after betamethasone use and continued the same daily.

A three month old female infant born with a birth weight of 2.6 kg presented with high grade fever for two days associated with multifocal seizures. On examination, she weighed 11 kg (more than 95th centile) and had cushingoid features. Her blood pressure was 80/50 mm Hg. She had an irritable cry and her anterior fontanelle was bulging. CSF showed plenty of pus cells and culture grew H. influenza. The mother had procured 3 vials of oral betamethasone over the counter and had been administering it from birth as a "health tonic". The child was treated with intravenous antibiotics for 10 days and discharged with an advice to stop betamethasone.

The children mentioned above represent