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Congenital Lymphangiomatosis of Greater Omentum

Omental cysts have been reported occasionally in the Western literature and sporadically from India, but congenital lymphangiomatosis of greater omentum is a distinct rarity(1-6). We wish to report a case having interesting clinical course and presenting as a case of intractable loculated ascites.

A 3-year-old male child had progressive enlargement of abdomen since birth. His father had open pulmonary tuberculosis. At the age of 15 months he was taken to a family physician who noted a cystic mass occupying mainly the right side of abdomen. After abdominal paracentesis, he was diagnosed to have loculated tuberculous ascites. He was put on isoniazid, rifampicin and ethambutol for one year. While on treatment, he had abdominal paracentesis twice.

However, the mass reappeared again and parents took him to an ESIS hospital. He was put on second course of antitubercular drugs for about 10 months with intermittent diuretics and aspirations of loculated abdominal mass repeatedly without apparent relief. he had also received all kinds of antimalarials and antibiotics and for associated fever with rigors. He was referred to several General Surgeons who preferred to treat him conservatively.

The protein content of the aspirated fluid varied between 14 to 22 g/L in initial samples and between 30 to 60 g/L in subsequent samples. Cytological examination had shown persistent RBCs and polymorphonuclear cell counts which varied from 50 to 720 cells/cumm.

He developed persistent pyrexia and features of subacute intestinal obstruction and was, therefore, referred to us for further management. On examination, he was malnourished, anemic, cachexic and had high grade fever. The abdomen was protruberant containing tender, lobulated, cystic, ill defined, relatively fixed masses occupying nearly whole of the abdomen with fullness of the flanks and marked widening of upper abdomen. These multiple irregular intra-abdominal lumps of various sizes were dull on percussion.

Laboratory investigations showed anemia, hypoproteinemia, polymorphonuclear leucocytosis, high ESR and negative Mantoux test. Chest *X*-ray showed marked elevation of both domes of diaphragm. Plain *X*-ray abdomen showed ground glass appearance with a few loops of intestine in left upper abdomen and gross widening of upper abdomen. Ultrasound showed multiple cystic lesions, some of them were clearly echoluscent especially near both flexures of the colon and others showed mixed echogenicity (*Fig.*) The cysts were situated just beneath the anterior abdominal wall pushing the intestine posteriorly. This was confirmed by lateral films of *X*-ray abdomen and barium meal study which was essentially normal.

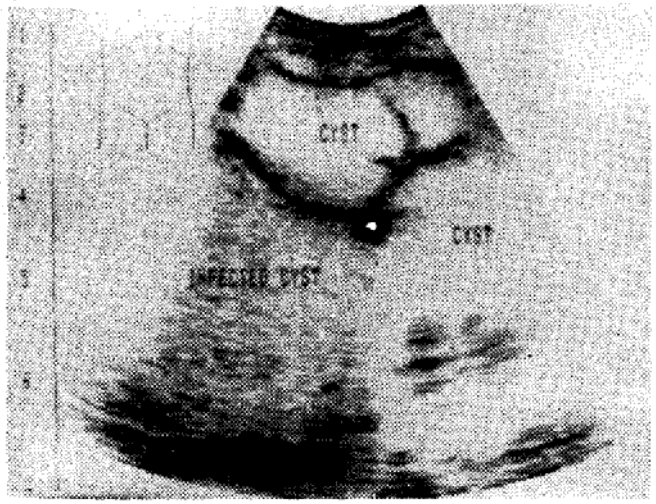

Fig. Abdominal ultrasound showing multiple cystic lesions.

At exploration, multiple greater omental lymphatic cysts of varying sizes from 0.5 to 8 cm diameter spread all over the greater omentum were found. The cysts in hepatic and splenic flexure region and alongwith greater curvature of stomach and transverse colon were well preserved containing clear serous fluid while lower cysts were filled with hemorrhagic and purulent material. All the cysts were excised and total greater omentectomy and incidental appendectomy were carried out. Postoperative recovery was uneventful. Histological examination confirmed it to be congenital lymphangiomatosis of greater omentum with infection and hemorrhage in several cysts.

One should think in terms of congenital lesions of mesentry or omentum rather than inflammatory process especially when the refilling was persistent and not at all responding to medical treatment. In order to reach to a diagnosis-peritoneoscopy would have been the best choice in the beginning. But ultimately surgery should have been carried out rather than waiting for response to 2 courses of antitubercular treatment.

Protruberant abdomen with double the width of upper abdomen in comparison to infraumbilical region should suggest upper abdominal lesion. The lesions were dull to percussion and without clear fluid thrill. Protein contents and cytological examinations of initial aspirate suggested transudate but subsequently suggested secondary infection.

In plain *X*-ray abdomen, intestinal gas pattern is pushed forwards when there is a mesenteric cyst and backwards when the cyst is in the greater omentum(5). Ultrasound is diagnostic and shows multiple cystic lesions just beneath the anterior abdominal wall. Omental lymphangiomatosis should be treated by total omentectomy by clamping and dividing flush with the stomach and transverse colon. In a fresh case, usually a plane of loose areolar tissue can be found after opening the peritoneum. This lends itself well to easy blunt dissection and it is practically never necessary to resect the bowel(6). While these unusual manifestations are potentially life threatening, early recognition and appropriate resection of these lesions are associated with an excellent long term prognosis.

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Childhood Obesity and Hypertension

The recent article on childhood obesity and hypertension was timely and an eye opener(1). I would like to express the following comments.

During the follow up period of six months, only nine out of sixteen children with persistent hypertension could be investigated. Of these six had hypercholesterolemia. It remains to be clarified whether these six children were obese or not, because if so, the said metabolic disorder becomes additional high risk factor in the etiopathogenesis of hypertension.

In a review of 404 children studied prospectively, the authors conclude that most obese 5% of children at age 6-7 years were all in the most obese 10% of 13-14 year-old and, retrospectively, 44% of the most obese 10% of 13-14-year-old were in the most obese 5% of age at 6-7 years. This shows very accurate tracking of the most obese children remaining in the same obese state over the span between ages 6 and 14 years(2). After the age of 5 years, there is a statistically significant tendency for fat children to become fat adults(3). These observations add to the significance of early therapeutic intervention and advice to families with obese children, so aptly brought out by authors of the study referred to in the beginning(1).

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Parental Attitudes to Pediatric Intravenous Procedures

Acute illness and intravenous procedures may be one of the major event in a child's life. A search of medical literature yields limited data on the parental attitudes and preferences for these procedures(1). We conducted this study to find out parental attitudes towards basic pediatric procedures of intravenous sampling and/or intravenous placement and whether parents would prefer to remain present with the child during these procedures.

The parents of children who were admitted to pediatric wards in the Depart-