Case report

Cysticlymphangioma of the adrenal gland : Case Report

Abstract :

Cysticlymphangioma of the adrenal gland is a rare benigntumor. It isgenerallyasymptomatic and itsfindingismost of the time unexpected.
Itsdiagnosis can beguided by imaging, in particular by echography and tomodensitometry.
The diagnostic certaintyisobtained by anatomopathologicalexamination of the operativespecimen
The treatment of choiceissurgery, with a total ablation of the lesion .Theirprognosisis excellent, howeverrecurrences can beseen in case of incompleteresection of the cyst. Whichrequiresregular monitoring in thesepatients.
Wereport a case of a patient withcysticlymphangiomawhowastreatedwithsurgicalresection.

Keywords: Cysticlymphangioma, adrenal gland, cystictumor

1. Introduction :

Cysticlymphangiomais a rare benign malformative tumor of the lymphaticvesselswithvarious locations, encountered in bothadults and children. The lymphangiomawas first described by Redenbacher[1]in 1828, but itsconnection to the lymphatic system wasestablishedhalf a century later by Koester [2]. Itsoriginremains a subject of debate; however, the congenital malformative theoryiscurrently the mostaccepted.

Typically, the lesionissingular. When the involvementis multifocal, itisreferred to as lymphangiomatosis. Cysticlymphangiomas can befound in anyanatomical site withlymphatic circulation, but theymostcommonlyoccur in the cervical and axillaryregions.

Adrenalcysticlymphangiomas are rare benigntumor formations knownsince the late 17th century. Greiselius made the first description during an autopsy for massive cystichemorrhage. The largestserieswaspublished by Abeshouse et al. [3]in 1959, whichincluded 155 cases, 57% of whichwerediscoveredduringautopsies[4].. Adrenalcysticlesions are rare, with an incidence of approximately 0.06% in the general population. Adrenalcysts are classified as endothelialcysts, pseudocysts, epithelialcysts, and parasiticcysts. Endothelialcysts (20% to 32% of all adrenalcysts) are furthersubdividedintolymphangiomatous and angiomatoussubgroups.[5]

Adrenalcysticlymphangiomas are oftenasymptomatic and are difficult to diagnose preoperatively. Ultrasound and CT scans play a significantrole in the exploration of thesetumors. Diagnosis relies on histology. Surgical exploration isoftenindicated in cases of diagnostic uncertainty. The treatment of choiceissurgical.

We report a case of an adrenalcysticlymphangiomawith a review of the literature.

2. Casepresentation :

A 55-year-old patient, with no medicalhistory, wasadmitted for the management of an abdominal mass.

The abdominal examinationrevealed a mobile, palpable, painless mass in the right hypochondriumwith a cysticappearance and well-definededges. The restof the physicalexaminationwasunremarkable.

Abdominal ultrasoundshowed a large multicystic mass with a thickenedwall and a honeycombappearance, suggesting a hydatidcyst of the liver, classified as stage III according to GHARBI's classification.

A CT scan of the abdomen and pelvis revealed a large cystic mass measuring 180 x 140 mm, displacing the right hemidiaphragm and pushing the right kidneydownward, consistent witheither a hydatidcyst of the liver or a cysticlivertumor (Figure 1).

Abdominal MRI confirmed the diagnosis of a multicystic mass of the right adrenal gland (Figure 2).

The patient wasoperated on via a right subcostal approachwithcomplete excision of the right adrenalcystic mass (Figures 3 and 4).

The pathological report favored a cysticlymphangioma of the adrenal gland.

Postoperativerecoverywasuncomplicated, with good clinical and radiologicalprogress. Twoyearslater, therewas no sign of recurrence.

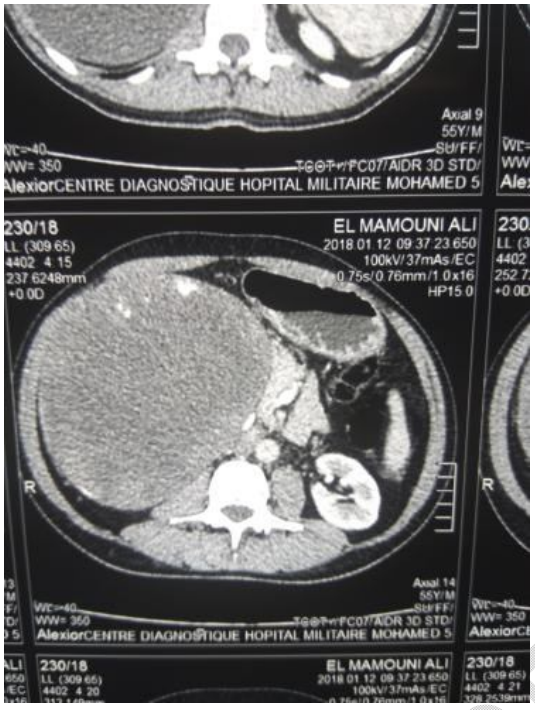

Figure 1: Abdominal scan showing a large right adrenal mass displacing the right kidney downward.

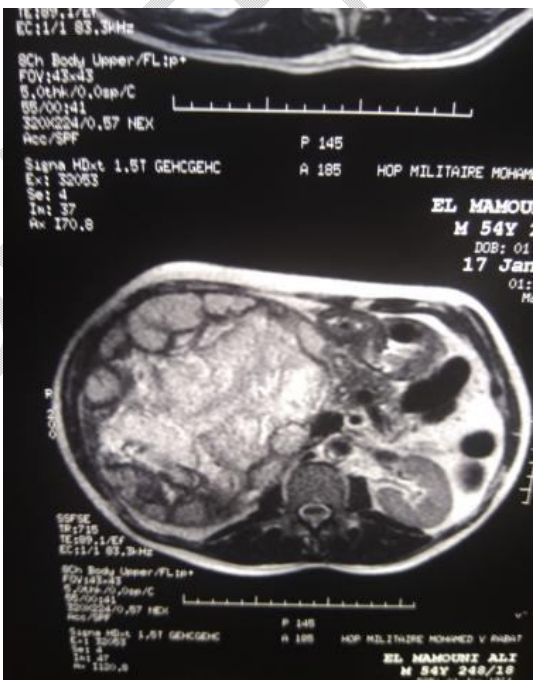

Figure 2 : Abdominal MRI showing a large multilocularcystic mass in the right adrenal gland.

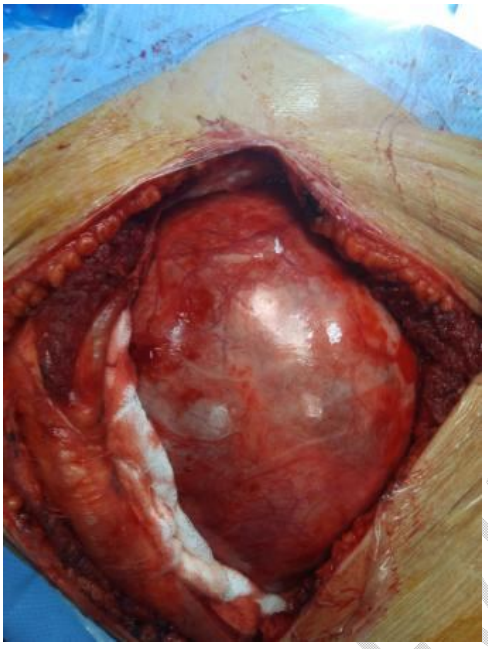

Figure 3 : Operativeviewshowing the right adrenal cystic mass.

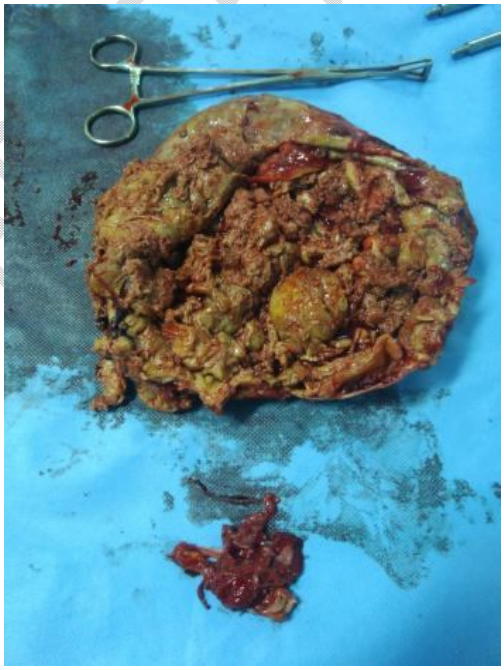

Figure 4 : Image showing the adrenal mass afteropening the theoperativespecimen

3. Discussion :

Cysticlymphangiomas are rare benigntumors. Their incidence isestimated at 1 in 100,000 hospitalizations [6]. Theytypicallyoccurnearlymphaticregions, such as the cervical and axillary areas (95%) [7]. The remaining 5% are found in the abdominal, mediastinal, or thoraciccavities [7]. Cysticadrenallymphangiomasaccount for 45% of benigncysticadrenaltumorsaccording to Ghandur-Mnayney [8]. Adrenalcysticlesions are rare, with an incidence of about 0.06% in the general population [9]. The onset of symptomsusuallyoccursbetween the ages of 30 and 50, withpeak incidence in the fourthdecade of life [10].

Regardingetiology and pathogenesis, a congenitaloriginiscurrentlyconsidered the mostlikely by mostauthors. Cysticadrenallymphangiomas are generallyasymptomatic and discoveredincidentally, as in the case of our patient. Observedfunctionalsigns are non-specific.

Computedtomography (CT) is an excellent initial diagnostic tool in adults. It confirms the mass syndrome, localization, size, and relationshipswithneighboringorgans. It has the advantage of differentiatingbetweenfluid-filled and solidtumors. There is no enhancementaftercontrast injection. On CT, the cysticadrenallymphangiomaisidentified as a homogeneous hypodense lesion, non-enhancing, withsmoothborders and a thinwall (<3.5 mm) [11].

Magnetic resonanceimaging (MRI), as a secondaryapproach, allows for betterdelineation of the cyst'srelationships and content. On MRI, cysticadrenallymphangiomas are generallyhomogeneous, withlow signal intensity on T1-weighted images and high signal intensity on T2-weighted images, withoutinternalenhancement. MRI is more sensitive for detectingintracystichemorrhages and complicatedcysts, which show high signal intensity on both T1 and T2-weighted images [11].

Surgicaltreatmentis the preferredapproach, consisting of completeresection of the lesion, especially for masses largerthan 5 cm. Adrenalectomy can beperformed via laparotomy or laparoscopy [12]. For our patient, whohad an 18 cm adrenal mass, adrenalectomywasperformed via laparotomy.

The prognosis for abdominal cysticlymphangiomasis excellent whenresectioniscomplete. Recurrenceis the main complication if the resectionis partial. Someauthors have reported a recurrence rate rangingfrom 10 to 15% (9.5% in the STEYAERT series) in cases of incompletecystresection, whichnecessitatesregularultrasound monitoring for these patients. In our case, with a two-year follow-up, there has been no recurrence.

4. Conclusion :

Cysticlymphangioma of the adrenal gland is a rare benigntumor. It isusuallyasymptomatic, and itsdiscoveryismostoften incidental. Diagnosis can besuggested by imaging, particularlyultrasound and computedtomography (CT). Definitivediagnosisisachievedthroughpathologicalexamination of the surgicalspecimen.

Complications can occur, includingintrakystichemorrhage, infection, and cyst rupture, althoughmalignant transformation is rare. The preferredtreatmentissurgical, involvingcomplete excision of the lesion. With the advent of laparoscopy and mastery of its techniques, resection of thiscystusingthismethodmaybe more beneficial.

The prognosisis excellent; however, recurrences can occur in cases of incompletecystresection, necessitatingregular monitoring of these patients.

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