ADRENALPSEUDOCYST-A CASE REPORT

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INTRODUCTION

Cysts of the adrenal gland are rare and are usually discovered incidentally. Large adrenal cysts can present with severe abdominal pain and can be complicated by haemorrhage, rupture or infection.[1] The majority of adrenal pseudocysts are benign cystic masses originating within the adrenal cortex or medulla that are enclosed by a fibrous wall. Their pathogenesis may lie in repeated episodes of trauma, infection or bleeding.[2]

CASE REPORT

A 40 years old lady with no relevant medical or surgical history in the past presented to the OPD with complaints of right sided abdominal pain and vomiting since 2 weeks. Her symptoms had gradually aggravated and became severe in the past 3 days. No any urinary symptoms.

On examination, her vitals were stable. Abdomen was soft and non tender. No palpable mass or lump.

Routine blood and urine analysis was found to be within normal limits

USG abdomen was done which showed features suggestive of solitary unilocular simple liver cyst. As a part of pre-operative work up , CT abdomen was done which showed a large well defined non enhancing cystic lesion with few specs of calcification along the wall, arising from the right adrenal – likely to be adrenal cyst.

Laparoscopic right adrenalectomy was done under GA . Right subcostal ports were made and pneumoperitonium created by open technique. 10mm camera ports, one 10mm and two 5mm working ports were made. Liver retracted and right triangular ligament was divided . Adrenal cyst of approximately 5mm size was identified and dissected. Turbid fluid contents were seen. Large vessels were doubly clipped and divided and dissection was completed. Haemostasis was achieved and counts were confirmed. Specimen was placed in a bag and retrieved by the 10mm port. 10mm ports-rectus closed by no1 vicryl. Skin closed with 3-0 vicrylrapide.

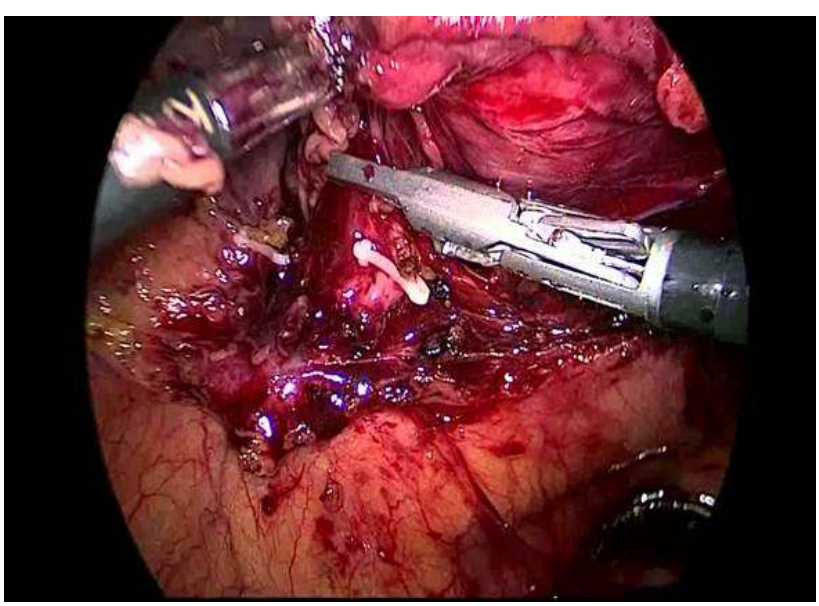

Figure 1 – Laproscopic view of adrenal cyst dissection.

Post operative period was uneventful and patient was managed with antibiotics, analgesics and supportive care.

Histopathological examination of the specimen confirmed it to bepseudocyst of adrenal gland.

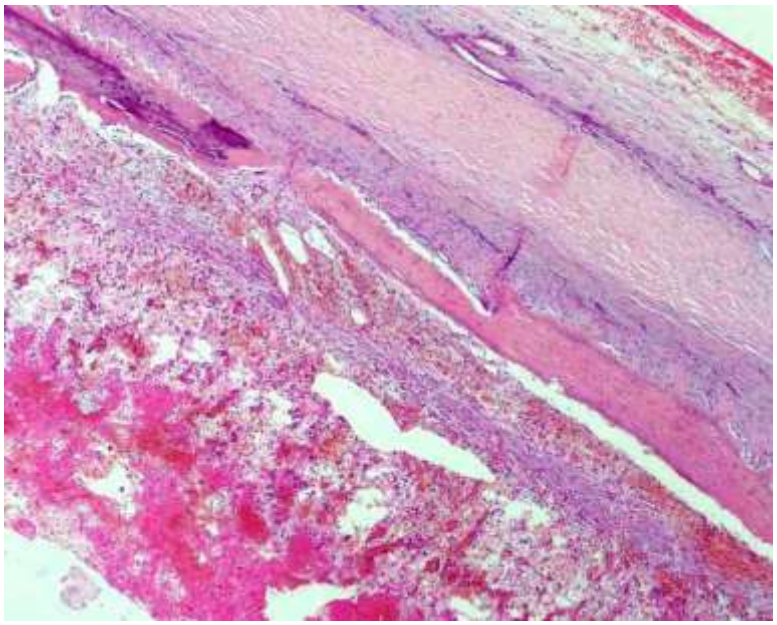

Figure 2 – Histology showing fibrin ,necrotic debris, adrenal cortical cells.

DISCUSSION

Due to increased availability of CT scanning, adrenal pseudocysts are now being encountered at higher levels than previously. However, adrenal pseudocysts are still rare and account for 32–80% of all adrenal cysts. Only 7% of all reported adrenal pseudocysts are malignant and the risk increases with size, in particular if over 6 cm.[3] Although USG, MRI and CT scan can all be used to evaluate abdominal cysts, CT scanning is the gold standard being able to identify small tumours with 100% sensitivity. Surgical excision of all lesions greater than 4 cm is recomended,especially if any suspicion of malignancy or if the tumour is hormonally active. Patients with smaller tumours less than 4 cm should have repeat CT scan at 3 months after diagnosis and should be monitored for 18 months.

CONCLUSION

Adrenal cysts are uncommon, but the increasing use of CT scanning has resulted in an increasing number of incidentalomas being discovered. Surgical resection is the treatment of choice.

REFERENCES

1. Ujam AB,PetersCJ,TadrousPJ,WebsterJJ,SteerK,IslaAM.Adrenalpseudocyst: Diagnosis and laparoscopic management – A case report
2. Int J Surg Case Rep.2011; 2(8): 306–308.
3. Carvounis E. Vascular adrenal cysts a brief review of the literature. Arch Pathol Lab Med. 2006;130(November):1722–1724.
4. Kim B.S., Joo S.H., Choi S.I. Laparoscopic resection of an adrenal pseudocyst mimicking a retroperitoneal mucinous cystic neoplasm. World J Gastroenterol.2009;15(June (23)):2923–2926