Sclerosing mesenteritis progressing to ureteral obstruction

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Sclerosing mesenteritis is part of a spectrum of benign, inflammatory diseases of the abdominal mesentery. It has been called retractile mesenteritis, and other forms include mesenteric panniculitis and mesenteric lipodystrophy. The disease rarely involves the retroperitoneum. We present a case of sclerosing mesenteritis that progressed to ureteral involvement.

Key Words: sclerosing mesenteritis, ureteral obstruction, retractile mesenteritis

Introduction

Sclerosing mesenteritis is part of a spectrum of benign, inflammatory diseases of the abdominal mesentery.[1] The disease rarely involves the retroperitoneum.[3] We present a case of sclerosing mesenteritis that progressed to ureteral involvement.

Case report

A healthy, asymptomatic 70 year-old woman presented to her family physician after undergoing a routine, unremarkable EGD and colonoscopy. For unknown reasons, a CT scan of the abdomen and pelvis was ordered at that time and incidentally revealed prominence at the pancreatic head with peripancreatic stranding, and a mildly dilated common bile duct. An ERCP was unremarkable. A CT scan 2 months later showed less prominence of the pancreatic head, but increased nonspecific inflammatory stranding of the mesentery with inferior extension. The patient self-referred herself to a general surgeon because of concern over the pancreatic mass. Further inquiry disclosed only a vague, diffuse abdominal pain that by report had been present for many years. Laboratory values including CEA and Ca-19-9 levels were normal. A pancreatic protocol CT scan demonstrated further extension inferiorly of the mesenteric inflammatory changes, including the mesentery anterior to the inferior vena cava. There was also extrahepatic dilatation of the common hepatic duct. It was felt an exploration was warranted because of these findings. Laparotomy exposed bulky lymphadenopathy at the root of the small bowel mesentery. The other abdominal organs were unremarkable. Biopsies from the area of bulky lymphadenopathy revealed reactive fibrosis, chronic inflammation associated with focal fat necrosis, and no evidence of malignancy.

A CT scan 3 months post-op showed a large, heterogenous mesenteric mass anterior to the vena cava, and located right of midline, Figure 1. There was hydronephrosis of the right kidney with a dilated right ureter to the level of the mass, Figure 2. The other abdominal and retroperitoneal organs were normal. The patient was asymptomatic without a palpable mass. The

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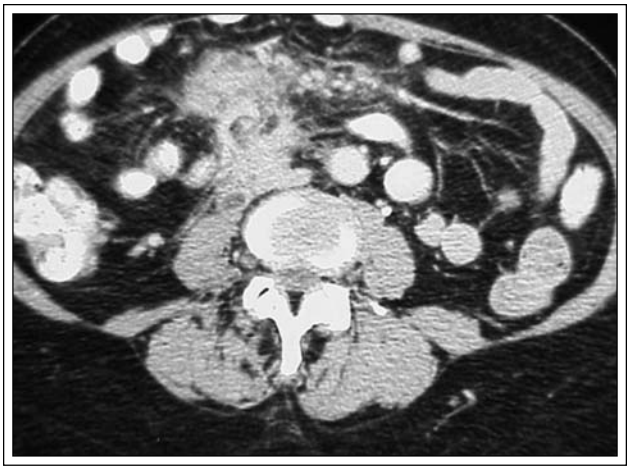

Figure 1. Mass encasing right ureter.

patient underwent a second laparotomy for ureterolysis and placement of a right ureteral stent. The exploration revealed a retroperitoneal small bowel mesenteric inflammatory process that encased the right ureter. No other abdominal or retroperitoneal organs were involved. Biopsies of the mass demonstrated fibrosis only. Right ureterolysis with an omental wrap was performed and secured lateral to the fibrotic process. The patient was started on steroid therapy. The ureteral stent was removed 3 months post-operatively.

At 6 months post-op a CT scan showed no evidence of an intraabdominal mass, Figure 3. The right kidney was noted to be atrophic as compared to the left, and without evidence of hydronephrosis. The other abdominal and pelvic organs appeared unremarkable. The patient continues to do well at follow-up 30 months post-op. She has stable renal function and no evidence of recurrence of the intraabdominal mass.

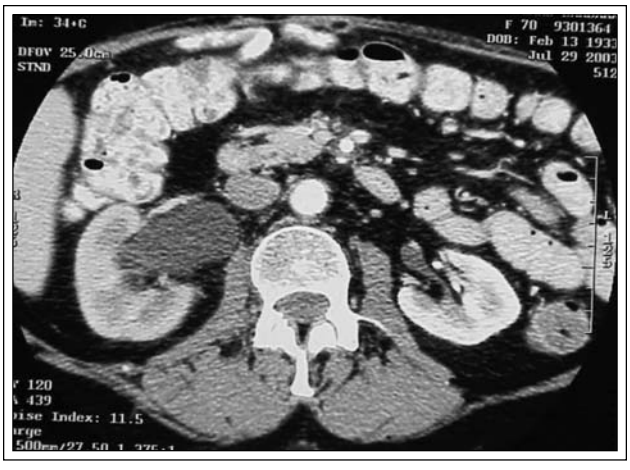

Figure 2. Preoperative right hydronephrosis.

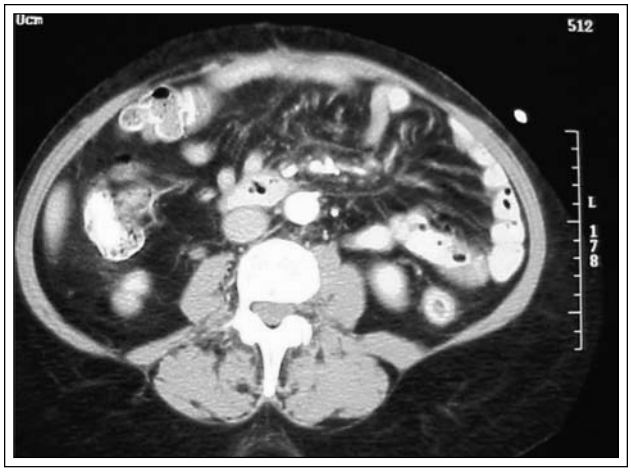

Figure 3. No evidence of mass 6 months post-op.

Discussion

Sclerosing mesenteritis is a rare inflammatory disease of the mesentery that is of unknown etiology.[3] It has been called retractile mesenteritis, and other forms include mesenteric panniculitis and mesenteric lipodystrophy.[1] Males are affected two to three times more often.[2] Presentation normally is over age fifty, but ranges from the first to the ninth decade.[2] The presentation is usually nonspecific, and can be an incidental finding.[1] The disease can progress to fibrosis causing intestinal and other visceral obstruction.[2] Sclerosing mesenteritis can mimic malignancy on CT scan.[3] Definitive diagnosis is by surgical biopsy.[1-3] The disease is slowly progressive, but most commonly there will be spontaneous recovery, or arrest of the disease.[2] Therapy consists of steroids, immunosuppressive agents, colchicine, or oral progesterone.[1,3] Surgery may be necessary for obstructed abdominal or pelvic viscera.[1-3] The prognosis is good, and death of these patients is usually from unrelated causes.[2] □

References

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