From: "ROOT" <root@sctimst.ac.in>
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Date: 24/09/2024 08:36 AM
Subject: Invitation for CGR

Greetings from AIIMS, Rishikesh !!

The CGR will be held on the **Sept 24, 2024** in **CPD Hall**, AIIMS Rishikesh from **8:00 AM to 9:00 AM**. You can join online through the following link:

Meeting link:

https://aiimsrishikesh.webex.com/aiimsrishikesh/j.php?MTID=m1256285142cabca1650e140cbd814d5f

Tuesday, Sept 24, 2024, 8:00 AM | (UTC+05:30) Chennai, Kolkata, Mumbai, New Delhi

Meeting number: 2519 731 9190

Meeting password: 290924

The Clinical handout of the case to be discussed is attached herewith.

Thanks & Regards

Regional Resource Centre
Dept of Telemedicine
AIIMS Rishikesh

All India Institute of Medical Sciences Rishikesh

अखिल भारतीय आयुर्विज्ञान संस्थान ऋषिकेश

CLINICAL GRAND ROUNDS

Department of General Surgery, 24th September 2024

Name: Mrs A	Age/Sex: 52 /F	Residence: Udham Singh Nagar, Uttarakhand
UHID: 20240018365		
Case Presenter-	Consultant in charge- Prof. Somprakas Basu	

Dr. Parth Maheshwari (JR General Surgery) **Dr. Bibek Keshari (JR Radiology)** **Dr. Zahed Ali (JR Pathology)**	**Dr. Navin Kumar** **Dr. Udit Chauhan** **Dr. Ravi Hari Phulware**

Chief complaints-

- Pain in upper abdomen x 5yrs
- Abdominal Fullness x 4 yrs
- Lump in upper abdomen x 1 yr

Brief History:

- The patient was in good health 5 years ago when she had an open cholecystectomy at an outside hospital. One week after her discharge, she began experiencing upper abdominal pain and was referred to a higher-level facility. The pain was dull aching, progressively worsening, and radiates to her back. It occurred intermittently without clear triggers for worsening and was relieved by medication. Over the past five years, she had multiple hospital visits in various cities, where she received pain medications. She also had history of hospitalization before in a local hospital with complains of abdominal pain 4 yrs back where she was managed conservatively and discharged. (no documents available)
- For the past 4 years, she has also experienced a feeling of abdominal fullness and had a non-progressive lump in her upper abdomen for the last 1 year. The patient had not reported any symptoms such as fever, vomiting, jaundice, melena, rectal bleeding, loss of appetite, or weight loss.
- Her surgical history includes a hysterectomy 22 years ago and an open cholecystectomy done 5 years ago.
- She had no history of diabetes, hypertension, COPD, asthma, Ischemic heart disease, thyroid disorder or tuberculosis. She is a non-smoker and non-alcoholic, with no reported changes in bowel or bladder habits. Her sleep was disturbed because of pain. She is married and has three children. She reached surgical menopause 22 years ago after hysterectomy.

Examination-

General Examination

- Conscious and oriented to time, place and person with average built, well hydrated and nourished.

- No pallor, Icterus, clubbing, cyanosis, pedal edema, Generalized Lymphadenopathy.
- Weight: 55 kg, Height: 150 cm, BMI: 24.4 Kg/m^2

Vitals

- Afebrile to touch.
- Pulse rate: 90 bpm, right radial artery, regular rhythm, good volume, with no radio radial or radio femoral delay.
- BP: 120/80 mm of Hg, in supine position, right arm.
- Respiratory rate: 20 breaths/min, abdomino-thoracic type.
- Saturation: 98% on room air.

Systemic examination

- CNS: No focal neurological deficit, reflexes intact, power 5/5 in all four limbs, GCS 15/15.
- Respiratory: Bilateral air entry present, NVBS, no added sounds.
- CVS: S1 S2 heard, no murmurs heard.
- Musculoskeletal: No skeletal deformity, no gait abnormality.

Abdominal examination

- On inspection abdomen is non distended, umbilicus in midline and inverted. Scar mark present in right hypochondrial region about 6 cm in length extending till midline. A Vertical midline scar in lower half of abdomen. No dilated veins, no visible peristalsis, all quadrants moving proportionately with respiration. B/L flanks appear normal.
- On abdominal palpation, no local rise of temperature and no tenderness present. A lump of 7 x 5 cm palpable in epigastric region globular in shape, firm uniform in consistency, smooth surface, well defined margins, freely mobile in vertical as well as horizontal direction, also moves with respiration.
- On percussion dull note over the lump, tympanic note on rest of abdomen. Shifting dullness was absent.
- On auscultation, bowel sounds heard.
- DRE was unremarkable.

Clinical Diagnosis –

- **Omental Cyst**
- **Mesenteric Cyst**

Based on the clinical findings, diagnosis of omental cyst / mesenteric cyst was made and patient was advised for following investigations.

Investigations-

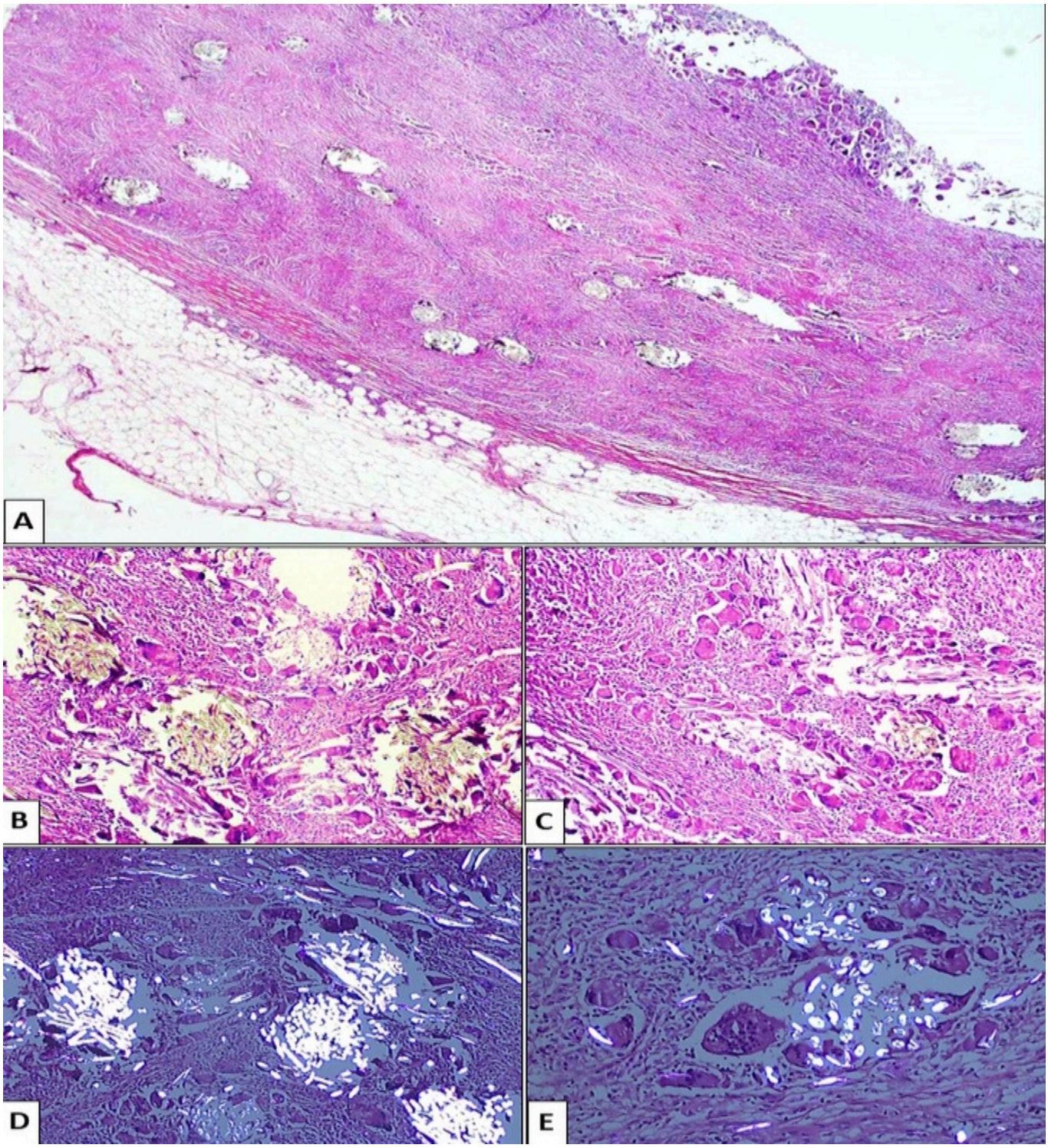
Hb	10.7
TLC	6.61k
Platelets	171k
TB/DB	0.68/0.06
SGOT/SGPT	26/37
ALP/GGT	97/24
Albumin/Globulin	4.2/3.3
Urea/Cr	36/0.81
Na/K/Ca	140/4.1/9.6
Ca	9.6
PT/INR	9.8/0.84
Viral marker	NR
LIPASE	29.2
AMYLASE	66.6

USG Whole Abdomen

- A well defined heteroechoic lesion of size 3.9 x 4.2 x 5.3 cm is seen in the epigastrium. Posterior Acoustic shadowing is seen.
- Gall bladder not visualised. S/P cholecystectomy.
- Possibility of Dermoid cyst.

CECT Abdomen + Pelvis

- Well-defined thin-walled heterodense lesion of size 5.6 x 5.9 x 6.1 with calcification is seen in the anterior mesentery in the epigastric region. Few foci of fat content seen within the lesion. On post contrast lesion shows no evidence of enhancement.
- Superiorly, it is abutting the greater curvature of stomach and inferiorly the transverse colon, both with maintained fat planes. Anteriorly, it is abutting the anterior abdominal wall.
- On USG correlation, the lesion appears solid-cystic.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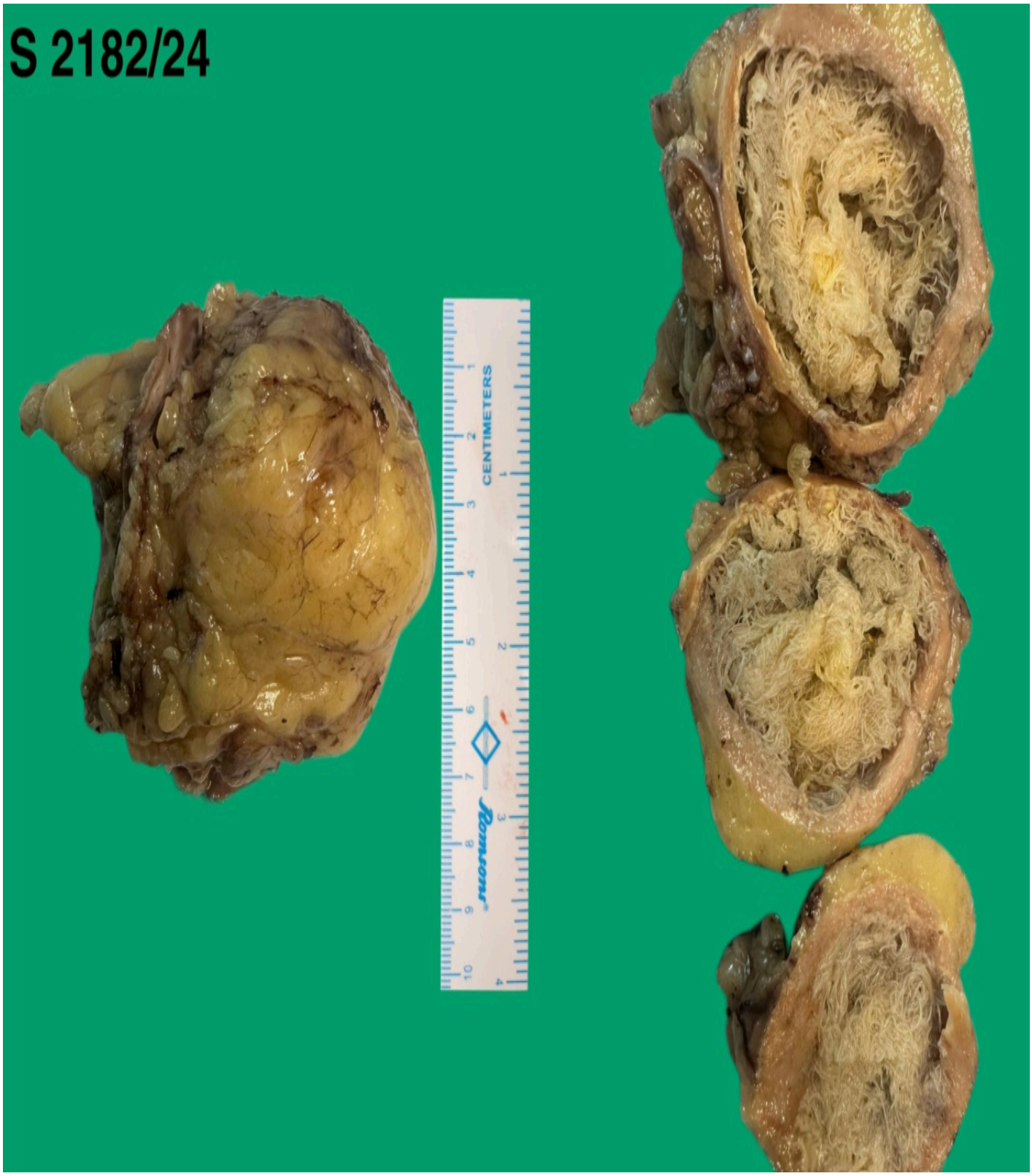

Final Diagnosis- Gossypiboma

Summary-

A 52 yr old female presented with 5-year history of upper abdominal pain, fullness, and a lump in upper abdomen which led to a clinical diagnosis of a well-defined, calcified omental cyst / mesenteric cyst. The lump was found in the epigastric region and was firm, smooth, and 7 x 5 cm in size. Imaging revealed a heterodense lesion with fat components and calcification which was diagnosed to be omental teratoma / infected omental lymphangioma. The patient underwent exploratory laparotomy with excision of the cyst. Intraoperative

findings confirmed a firm, well-defined mass arising from the greater omentum. Histopathology identified the cyst as a gossypiboma, a foreign body granuloma caused by retained surgical material.