

Retractile Mesenteritis Involving the Colon: Pathologic and Radiologic Correlation (Case Report)

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Retractile mesenteritis is a disease of the mesentery that results in fat necrosis, chronic inflammation, and fibrosis [1]. It is characterized clinically by abdominal pain, diarrhea, and weight loss [2]. It involves the mesentery of both small intestine and colon and can occur independently or in association with other disorders predisposing to fibrosis, such as carcinoid tumor and retroperitoneal fibrosis [3].

The etiology of this disorder is unknown. Of various potential causes, ischemia of the mesentery has been favored, but evidence for this is meager [4]. We studied a patient with retractile mesenteritis involving the colon using colonoscopy, CT, angiography, and barium enema. The results of these studies and the examination of the resected specimen suggest that retractile mesenteritis is the end result of a complicated pathologic process that begins with angiomatoid proliferation, localized intravascular coagulation, ischemia, and necrosis and progresses to fibrosis. Ischemia, which represents only one stage in the process, may be responsible for the colonic change that occurs in the disease.

Case Report

A 58-year-old man was admitted with a 4-month history of abdominal pain, diarrhea, and weight loss. Physical examination revealed a tender mass in the left abdomen. On colonoscopy the rectum was unremarkable. The mucosa of the sigmoid and descending portions of the colon were engorged, edematous, and heaped up, but no ulceration was seen. The histology of a biopsy specimen was normal.

Barium enema examination demonstrated rigidity of the sigmoid and descending colon with thickening and distortion of rugal folds on the mesenteric border (Fig. 1). In addition, there was a smooth extrinsic impression on the medial wall of the descending colon presumably caused by thickened mesentery. The appearance of the remainder of the colon was normal. CT revealed narrowing of the lumen of the involved portions of the colon with marked colonic wall thickening. There was a lobulated, low-density mass in the mesentery suggesting fatty infiltration (Fig. 2). An inferior mesenteric arteriogram showed that the terminal arterial branches were diminished in number and constricted, indicating diminished perfusion of the mesentery and colonic wall (Fig. 3). Venous drainage was delayed. A second barium

enema 2 weeks later revealed submucosal edema of the sigmoid and descending colon with "thumbprinting."

Because of lack of clinical improvement and a tender mass in the left lower abdomen, a decision was made to operate to establish a diagnosis. The descending and sigmoid portions of the colon were resected with the adjacent mesentery and pericolic fat. At surgery, the thickened, lobulated mesentery was found to form a firm, fatty mass with red-brownish discoloration (Fig. 4).

The mucosa of the resected colon contained several areas of pseudomembrane formation but was otherwise intact. Microscopic examination showed extensive mesenteric fat necrosis characterized by xanthogranulomatosis and fibrosis, focal mucosal ulceration, pseudomembrane formation, and submucosal edema. There was a remarkable degree of colonic wall thickening. The most striking finding was angiomatoid proliferation of vessels in the mesenteric adipose tissue, submucosa, and muscular wall of the colon (Fig. 5). Fibrinoid necrosis and microthrombi were common in these small vessels indicating active intravascular coagulation (Fig. 5). The large arteries showed only minimal intimal thickening.

The patient made an uneventful postoperative recovery and was discharged with a diverting colostomy and Hartmann's pouch.

Discussion

The pathology of retractile mesenteritis is thought to be mesenteric panniculitis with subsequent fibrosis [5]. Various terms have been used to describe these predominant features: primary liposclerosis, mesenteric lipomatosis, mesenteric panniculitis, chronic fibrosing mesenteritis, and mesenteric lipofibromatosis.

Previously described radiologic features of retractile mesenteritis [3, 6, 7] include narrowing and rigidity of a segment of colon with thumbprinting and mesenteric mass. Adjacent intestinal loops may be displaced or separated by thickened mesentery. Mesenteric fibrosis may cause kinking and angulation of the intestine. The prominent CT finding is a low-density mass with linear strands in the mesentery. Irregularity of the mesenteric arterial branches and venous congestion have been mentioned as angiographic manifestations. Most of these findings were seen in our patient.

Received January 6, 1986; accepted after revision March 29, 1986.

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Cumulated Index Medicus ,1995 *The Mesenteric Organ in Health and Disease* Eli D. Ehrenpreis,John C. Alverdy,Steven D. Wexner,2021-09-02 Recent discoveries and clarifications of known information about the mesentery have now established that these complex structures function together as an individual organ within the human body As such conditions that affect the mesentery can now be grouped within a single area of study and clinical practice The various aspects of mesenteric diseases have not been brought together in a single source and this book aims to bring them together for the first time It will cover general areas such as anatomy histology and physiology of the mesentery A description of diagnostic procedures used to evaluate patients with mesenteric disorders will follow A practical survey with detailed descriptions of medical surgical and neoplastic disorders of the mesentery is also be included This book is intended to be a guide for clinical practitioners including gastroenterologists general surgeons colorectal surgeons primary care physicians nurse practitioners and physician assistants who manage patients with mesenteric disorders Current List of Medical Literature ,1959 Includes section Recent book acquisitions varies Recent United States publications formerly published separately by the U S Army Medical Library Index Medicus ,2001 **Atlas of Gynecologic Surgical Pathology E-Book** Philip B. Clement,Jennifer Stall,Robert H. Young,2019-01-30 Comprehensive in scope and easy to use Atlas of Gynecologic Surgical Pathology 4th Edition provides the current authoritative information you need to effectively sign out cases in female genital pathology In this 4th Edition internationally renowned authors Drs Philip B Clement and Robert H Young are joined by new co author Dr Jennifer Stall to continue this bestselling atlas s tradition of excellence Hundreds of superb pathologic images diagnostic pearls and fully updated content make this practical bench side resource ideal for minimizing risks in reporting both routine and difficult cases Comprehensively discusses the differential diagnosis of female genital tract neoplasms and their many mimics from the perspective of their varied microscopic features Highlights important aspects of the clinical background including age of patient history of other tumors and distribution of disease Stresses helpful aspects of gross features and the importance of thorough sampling Emphasizes practically important immunohistochemical findings relevant to establishing the correct diagnosis Includes newly described variants and new histologic entities Considers molecular aspects of the entities discussed Includes the latest classification and staging systems for gynecologic diseases and disorders with up to date information on staging Includes hundreds of high quality pathologic images including new images contributed by Dr Jennifer Stall from her review of the late Dr Robert E Scully s vast collection of cases Features tables listing differential diagnoses of each tumor and tumor like entity to help you identify key points to consider in problem areas Gastrointestinal Disease: Ch.49.Diarrhea. Ch.50.History of Dicke's discovery of the gluten-free diet for celiac sprue. Ch.51.Celiac sprue. Ch.52.Tropical sprue. Ch.53.Enteric bacterial flora and bacterial overgrowth syndrome. Ch.54.Whipple's disease. Ch.55.Infectious diarrhea and bacterial food poisoning. Ch.56.Pseudomembranous

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Systemic Fibroinflammatory Disorders Augusto Vaglio, 2017-01-09 This book provides detailed information on the nosology pathology pathogenesis clinical presentation diagnosis and treatment of fibro inflammatory disorders rare diseases that often display systemic organ involvement Among the conditions considered are IgG4 related disease sclerosing cholangitis Hashimoto's and Riedel's thyroiditis retroperitoneal fibrosis chronic periaortitis mediastinal fibrosis Erdheim Chester disease gadolinium induced fibrosis and sclerosing mesenteritis This group of entities is still poorly defined and is characterized by the common denominator of chronic inflammatory infiltrate admixed with abundant fibrosis IgG4 related disease is the prototypical example Systemic Fibroinflammatory Disorders is the first book to draw together information on these conditions As these diseases often require an interdisciplinary approach the book is addressed to specialists of different disciplines especially internists rheumatologists nephrologists clinical immunologists and hematologists

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Ruebner, Carolyn K. Montgomery, 1982 **Sleisenger and Fordtran's Gastrointestinal and Liver Disease E-Book** Mark

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