with OS (4). To avoid unnecessary interventions, comprehensive geriatric assessment should be recommended for the optimum management of older patients (5), as in our case.

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Mesenteric fibromatosis: A case report

Mezenterik fibromatozis: Olgu sunumu

To the Editor,

Mesenteric fibromatosis (MF) accounts for approximately 8% of all cases with fibromatosis. The mesentery of the small bowel is frequently involved; however, it can originate from ileocolic mesentery, gastrocolic ligament, omentum, and retroperitoneum (1). Since the value of the pathological diagnosis of gastrointestinal stromal tumor (GIST) has been increasing with the introduction of recent and successful biological therapy protocols, it is important to establish the differential diagnosis of MF.

A 54-year-old male was admitted to the hospital with abdominal pain. Examination of the abdomen showed a palpable mass without tenderness in the lower quadrant. Ultrasonography revealed a mass 10 cm in diameter; however, its origin could not be determined. It was thought to be an intestinal tumor, and resection of the ileal segment with mass was performed. Pathological examination demonstrated the small bowel segment with an adjacent large mass with regular contours measuring 12x11x8.5 cm. The tumor, settled in the mesentery of the bowel, was firm and nodular and fairly well circumscribed. Opening the bowel revealed a mucosal surface with entirely normal appearance. The cut surface of the tumor exhibited a grey-brownish, coarsely trabeculated surface (Figure 1a). The samples taken from the tumor had a similar spindle-shaped appearance without atypia in a collagenous stroma (Figure 1b). Immunohis-

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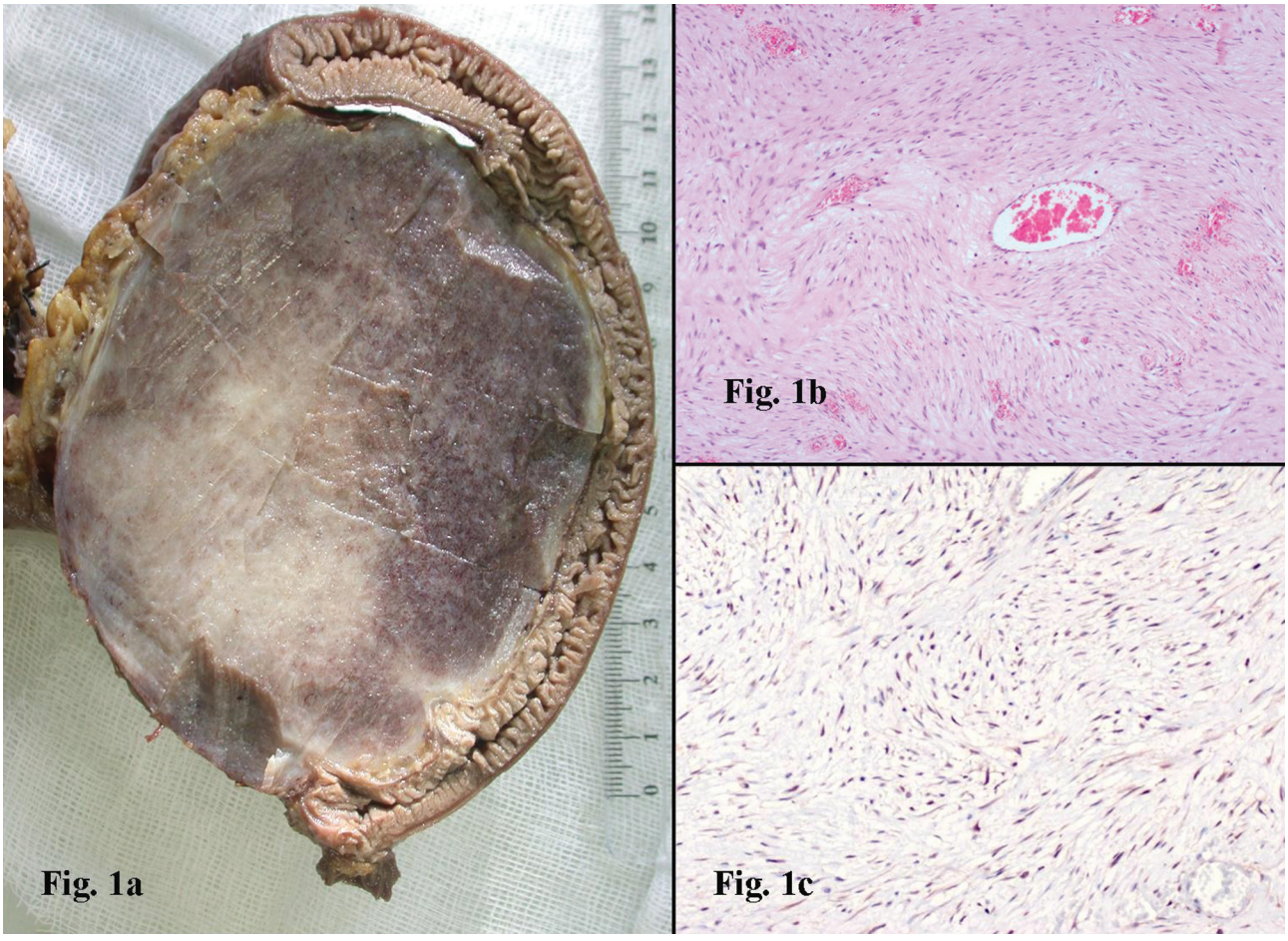

Figure 1. (a) Gross appearance of the small bowel together with the lesion. The large, circumscribed mass has coarsely trabeculated cut surface. **(b)** Conventional hematoxylin and eosin-stained section shows the proliferation of bland spindle-shaped cells. Note the thin-walled vessels with perivascular edema (x200). **(c)** Tumor cells exhibit strong nuclear expression of ß-catenin (x400).

tochemically, the tumor cells were all negative for CD117, CD34, actin, desmin, and S-100, whereas they showed strong nuclear ß-catenin staining (Figure 1c). These histopathologic and immunohistochemical features yielded the diagnosis of MF.

Intra-abdominal lesions with spindle-cell morphology are relatively rare, and the similarity of their histological appearance to that of other lesions frequently leads to misdiagnosis (2). GISTs are the most common mesenchymal tumor of the GI tract, and a new treatment strategy has recently emerged that is highly effective. As a result, clinicians give special attention to GISTs and a specimen with this suspected diagnosis is important to pathologists. Sclerosing mesenteritis and inflammatory myofibroblastic tumor must also be considered in the differential diagnosis (3, 4). However, the vastness of the reports emphasizing the distinction of MF and GIST in the literature is an important indicator of the chaos in this field (5-7). It was demonstrated that 52% of 25 cases with MF had been misdiagnosed, and the most frequent incorrect diagnosis was GIST (6). Compared with GIST, the extremely uniform pattern is characteristic for MF. Immunohistochemically, CD117 and CD34 negativity and strong nuclear ß-catenin staining, not seen in GIST, were helpful in establishing a differential diagnosis (5, 7).

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A rare cause of palpable mass located at the suprapubic area: Abscess of omphalomesenteric duct cyst

Suprapubik bölge yerleşimli palpabl kitlenin nadir bir nedeni: Omfalomezenterik kanal kisti apsesi

To the Editor,

Embryonic remnants of the umbilicus may cause various problems after birth, such as omphalomesenteric duct pathologies. If the omphalomesenteric duct does not regress, a fistula between the ileum and umbilicus, sinus formation, cysts, or Meckel's diverticulum can develop (1).

A 49–year-old female admitted to our unit with fever, lower midabdominal pain and a palpable mass. Her medical history revealed that she underwent cesarean section 15 years before. She had hypertension, asthma and moderate mitral valve stenosis. On physical examination, axillary body temperature was 38.3°C, blood pressure: 140/80 mmHg and heart rate: 110/min. Lower abdominal quadrants were tender. White blood cell count was 15300 mm^3 and C-reactive protein level was 70 U/ml. Ultrasonography demonstrated a hypoechoic cystic lesion localized at the anterosuperior part of the bladder. Computed tomography showed a 6x2 cm lesion, located between the anterior wall of the bladder and the abdominal wall, below the umbilicus (Figure 1a). Fine needle aspiration was performed and leukocytes, gram-positive diplococci and gram-negative bacilli were seen on microscopic evaluation. In the surgical exploration, the cystic lesion was seen under the abdominal wall and there was no attachment to other intraabdominal organs. Total cystectomy was performed later (Figure 1b). The abscess culture grew Pseudomonas spp. Ciprofloxacin 500 mg tablets per oral twice a day was initiated. The wall of the cyst was composed of a wide smooth muscle layer and mucinous prismatic intestinal epithelium resembling bile duct epithelium (Figure 1c). Omphalomesenteric cyst was diagnosed in light of these histopathologic findings. The patient recovered uneventfully after the operation.

Only a few cases regarding omphalomesenteric duct remnant-related diseases have been reported in adults (2). Abdominal pain, rectal bleeding, ileus, umbilical hernia, and efflux are the symptoms of omphalomesenteric duct cyst (3). The diagnosis of an omphalomesenteric duct cyst due to an abscess is extremely rare in adults. Conventional sur-

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