Huge Ovarian Cyst

Samina Naz[1], Azra Sultana[2], Furrukh Naheed[3]

ABSTRACT

A 24 year old female presented with complaint of abdominal distension, difficulty in breathing and restlessness. Ultrasonographic examination revealed that there was a huge cystic collection with internal debris, multiple septation involving whole abdomen and pelvis, originating from left ovary. Her laparotomy was done; a huge ovarian cyst of about 25x30 cm was removed. Post-operative recovery was smooth. Histopathological examination revealed that it was mucinous cyst adenoma. The purpose of this case presentation to report one of the huge ovarian cyst from our Centre and to highlight the diagnostic finding.

Keywords: Huge ovarian cyst, mucinous cyst adenoma

INTRODUCTION

Ovarian tumors are one of the common health problems. They may be asymptomatic, found on routine ultrasonographic examination or symptomatic from mild to life threatening. Most remarkable description of giant ovarian cyst are those of Spohn, who in 1922 reported one that weighted 148.6Kg (328 Lb), and Symmonds, who in 1963 reported one that weighted 79.4Kg (175 lb)[1,2]. They have become rarer as imaging modalities improve and diagnosis are made earlier. A case of 66 year old post menopausal woman from south India presented with a huge serous cyst adenoma of 23 kg has been reported[3]. A giant ovarian cyst has a significant morbidity. The purpose of this study is to highlight the differential diagnosis minimal in vasive test to reach the diagnosis and to report one of the huge ovarian cyst in our centre.

CASE REPORT

A 24 year old woman residing in a far remote area, presented with a complaint of abdominal distension, difficulty in breathing and restlessness. She was para 4+0, her last delivery was 4 months back in her village without any complication. After that she noticed a swelling in abdomen which gradually increased in size. The size of swelling so much increased that it occupied the whole abdomen. She was unable to walk and lie down due to dyspnea. She had no history of fever, cough and jaundice. Her menstrual cycles were regular. Meanwhile she migrated to Karachi as a flood victim.

On examination patient was ill looking, but well oriented to time and space. General physical examination revealed that she had paler and bilateral pedal odema. Her vitals were normal. Her weight was 55 Kg. on abdominal examination, abdomen was grossly distended. Abdominal girth was 45 inches at the level of umbilicus. Fluid thrill was present and gut sounds were audible in the flanks. Rest of the examination was unremarkable. Provisional diagnosis of ascites and ovarian cyst was made. Her hematological investigations revealed that she had Hb 12.4gm/dl, TLC 11200/cumm, RBS 80 mg/dl, urea 40 mg/dl ,serum albumin 3.8 gm/dl, HBsAg and antiHCV were nonreactive. Urinary analysis revealed that RBCs 1-2, WBCs 2-4 and epithelial cells 2-4 HPF. Abdominal ultrasonography revealed that there was a huge cystic collection with internal debris, multiple septations involving the whole abdomen and pelvis originating from left ovary while right ovary was normal. Mild hydronephrosis was seen on left side. X-ray chest was normal except raised dome of diaphragm on both sides.

1: Associate Professor, Dept. of Obste and Gynae 2: Professor of Gynae, 3: Associate Professor Dept. of Obst and Gynae
Baqai Medical University, Karachi, Pakistan.

Finally a diagnosis of ovarian mass made and surgery was planned. Informed written consent was taken from the husband. Abdomen was opened via pfennenstiel incision. There was a huge cyst occupying the whole abdomen. There were few adhesions between the cyst and anterior abdominal wall which were dissected. The cyst was difficult to deliver from the abdomen so purse string suture applied on the cyst and about 7500 ml of mucinous fluid was drained through suction. Later the pedicle was clamped, cut and ligated, and cyst was excised. The specimen sent for histopathological examination which confirmed the diagnosis of mucinous cystadenoma. Patient recovery was very smooth without any complications.

DISCUSSION

Ovarian neoplasms may be divided by origin cell type into three main groups: epithelial, stromal and germ cell. Taken as a group, the epithelial tumors are by far the most common type.[4] Mikos T, et al reported a case of giant ovarian cyst in 59 years old postmenopausal woman weighing 73 kg at admission presenting with dyspnoea and abdominal distension.[5] In our patient of 24 years old with regular menstrual history weighing 55 kg at admission presented with abdominal distension, difficulty in breathing and restlessness. Huge ovarian cyst mimicking ascites, pseudo pancreatic cysts, huge hydronephrosis, urinary retention, urinary bladder diverticulum and large uterine tumor has been reported in the Iiterature.[6] In our case provisional diagnosis of ascites and ovarian cyst was made. Our patient seeks advice late to hospital due to illiteracy, due to flood in her village and financial constraint.

Specific sonographic features pathognomonic of ovarian cyst are intraperitoneal origin, liver and kidney compression and Doppler ultrasonography revealing a vascular pedicle. The combination of ultrasound techniques (morphologic assessment, color Doppler flow imaging, and Doppler indexes) have been found to perform well (sensitivity = 84%, specificity = 82%, positive likelihood ratio = 4.69) compared to computed tomography (sensitivity = 81%, specificity = 87%, positive likelihood ratio = 6.81) in the diagnosis of ovarian lesions.[7]

In our patient ultrasonographic examination revealed that there was a huge cystic collection with internal debris, multiple septations involving the whole abdomen and pelvis originating from left ovary, while right ovary was normal. Mild hydronephrosis was seen on both sides with hydrouretes.

In a study conducted in Lady Reading Hospital Peshawar on 68 patients, out of which benign tumors were 61 (89.71%) and malignant ovarian tumors were 7 (10.29%). The commonest histological pattern observed were epithelial tumors (76.5%) including both benign and malignant tumors. The commonest benign tumor was serous cyst adenoma (24%) followed by mature cystic teratoma (18%). Common malignant ovarian tumors were granulosa cell tumors and Endometriod carcinoma (each 28.5 %).[9] In our patient the histopathological report revealed that it was mucinous cystadenoma.

CONCLUSION

Huge ovarian cyst is unique in this modern era of technology. In view of its potential morbidity it is recommended that Patient with abdominal distension or abdominal mass should be encouraged to seek medical advice from specialist or consultant clinics or in a well-equipped hospital.

Noninvasive technique like ultrasonography should be the priority to diagnose such a case of huge ovarian cyst.

Technological innovations coupled with surgical expertise can ameliorate morbidity and mortality rates.

REFERENCES

1. Young TH, Lee HS. Images in clinical medicine. Giant Ovarian Cyst N Engl JMed 2008; 358(20):e22.

2. Sima M. Giant paraovarian cyst. J Obstet Gynecol India. 2006; 56:352-353.
3. Sujatha JJ, Babu SC, Giant ovarian serous cystadenoma in postmenopausalwoman, a case report. Cases J 2009; 2: 7875.
4. Mulayim B, Gurakan H, Dagli V, Mulayim S, Aydin O, Akkaya H. Unaware of a giant serous cyst adenoma: a case report. Arch Gynaecol Obstet. 2006; 273(6):381—383.
5. Mikos T, Tabakoudis GP, Pados G, Eugenidis NP, Assimakopoulos E. Failure of ultrasound to diagnose a giant ovarian cyst: A case report. Cases J. 2009; 2: 6909.1.
6. Menahem S, Shvartzman P. Giant ovarian cyst mimicking ascites. J Fram Pract. 1993: 39: 47981.
7. Kinkel K, Hricak H, Lu Y, Tsuda k, Filly RA. US characterization of ovarianmasses: A meta-analysis. Radiology 2000; 217: 803-811.
8. Yasmin S, Yasmin A, Asif M. Clinicohistological pattern of ovarian tumours in Peshawar region. J Ayub Med Coll Abbottabad. 2008; 20: 11-3.

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   i) Jones J, Fletter B. Complications after cardiopulmonary resuscitation, Am.J Public Health 1994; 12:687-8.

   ii) Cox DR, Oake J. Analysis of survival date. London, Chapman Hall, 1984; 2-5