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Original Research Paper

General Surgery

GIANT OVARIAN CYST PRESENTING AS EPIGASTRIC MASS-A CASE REPORT

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ABSTRACT Giant ovarian cysts (GOCs) are rare tumours of the ovary presenting with diameters greater than 10 cm. Ovarian cysts are generally asymptomatic at early stages causing symptoms only after reaching enormous dimensions, and consequently they are often diagnosed late. Majority of GOCs are benign and are generally treated by surgical excision either by cystectomy or salpingo-oophorectomy. Malignant ovarian cysts (MOC) constitute over 10% of GOCs and are treated by total abdominal hysterectomy with bilateral salpingo-oophorectomy ± omentectomy .We encountered a 65 years old female who presented with the history of progressively increasing distension of upper abdomen for last 6 months. Abdominal examination revealed a uniformly large cystic mass in the epigastrium with ill-defined lower border. There was uniform fullness in both the flanks. Contrast enhanced Computed Tomography suggested large well defined intra peritoneal cystic lesion with few thin internal sepatations probably cystic lesion from the ovary. Laparotomy was done and there was a large cystic mass arising from the pelvis which was excised with membranes intact. Bilateral oophorectomy with appendectomy was done. Histologically it was found to be mucinous cystadenoma.

KEYWORDS : Giant Ovarian cyst, Abdominal distension, Ascites, Mucinous Cyst Adenoma

INTRODUCTION

Cystic abdominal tumors are extremely common and now they are diagnosed more frequently and earlier due to availability of better imaging modalities. Now a days ovarian cysts rarely grow immense due to the fact that ultrasonography scanning permits early detection and appropriate treatment. Occasionally, ovarian cysts reach enormous dimensions without raising any symptom. A few cases of giant ovarian cysts have been sporadically reported in the literature.[1-3] Giant ovarian cysts (GOCs) are rare tumours of the ovary presenting with diameters greater than 10 cm.[4,5] Ovarian cysts are generally asymptomatic at early stages causing symptoms only after reaching enormous dimensions, and consequently they are often diagnosed late.[4,6,7] The clinical symptoms of ovarian cysts are usually progressive abdominal distension, nonspecific diffuse abdominal pain, vaginal bleeding and symptoms related to organs compression such as constipation, early satiety, vomiting and frequent micturition.[6,8-11] The actual incidence of GOCs in postmenopausal women is unknown since good imaging modalities now lead to early diagnosis and removal before they develop into huge intra-abdominal masses. Majority of GOCs are benign and are generally treated by surgical excision either by cystectomy or salpingo-oophorectomy.[5-7,9] Malignant ovarian cysts (MOC) constitute over 10% of GOCs and are treated by total abdominal hysterectomy with bilateral salpingo-oophorectomy ± omentectomy .[8]

CASE REPORT

Herein we present a 65 years old female who presented with the history of progressively increasing distension of upper abdomen for last 6 months (Figure 1). Patient used to experience mild to moderate diffuse pain abdomen, without any special character. Abdominal examination revealed a uniformly large cystic mass in the epigastrium with ill-defined lower border. There was uniform fullness in both the flanks. All other relevant investigations for general anaesthesia were within normal limits. Ultrasound report suggested multilocular cystic lesion with dense internal echoes measuring 21 x 18 x 19 cm (volume-3980cc) arising from pelvis and displacing bowel loops peripherally, no solid components no internal vascularity and few septations noted, ovarian in origin probably benign. CECT suggested large well defined intra peritoneal cystic lesion 23 x 22 x 18 cm with few thin internal sepatations. Both ovaries not separately visualised. No free fluid and no significant lymphadenopathy. Carcinoembryonic antigens (CEA) and Cancer antigen 125 (CA-125) was found to be normal. Laparotomy was done and abdomen opened with infraumblical midline incision. There was a large cystic mass with white glistening cyst wall arising from the pelvis (Figure 2). The cyst was excised with membranes intact and it measured 30× 22 × 18 cm. Bilateral oophorectomy with appendectomy was done. (Figure 3). Histopathology revealed mucinous cystadenoma. The postoperative period was uneventful and she was discharged on the 5th postoperative day.

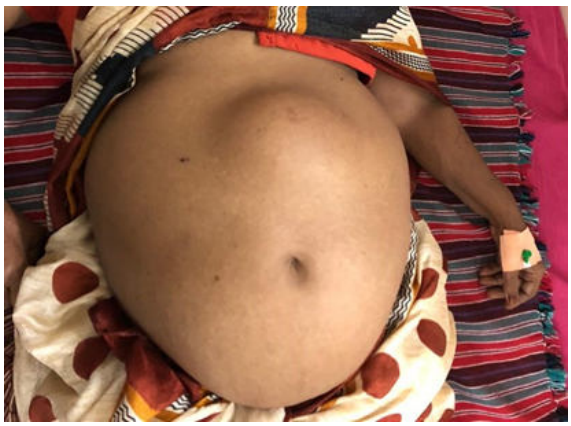

Figure 1

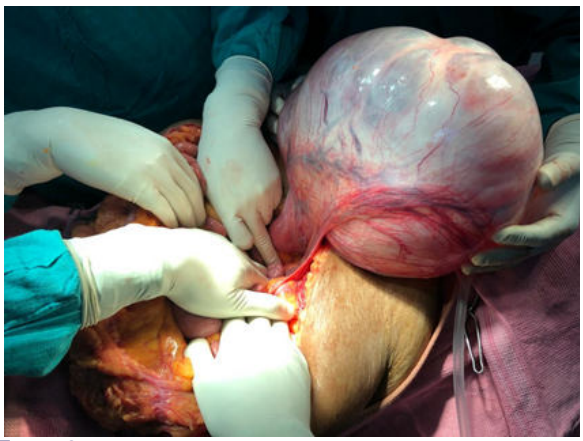

Figure 2

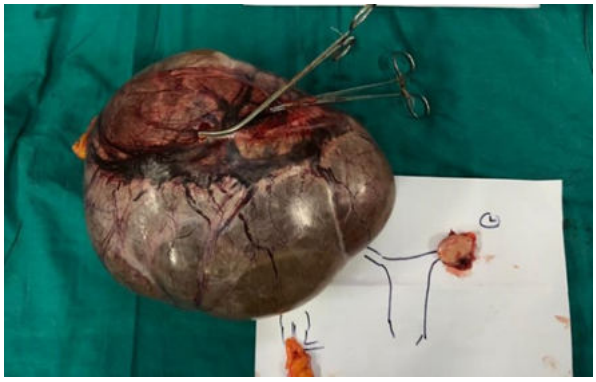

Figure 3

DISCUSSION

Giant ovarian cysts constitute a challenging condition in general practice because of their nonspecific clinical features and findings from physical examination resulting to a wide range of differential diagnoses. These differential diagnoses include pelvic endometriosis, intra-abdominal pregnancy, intra-abdominal cysts from varying origins (omentum, ovary, kidney, liver, pancreas, cystic lymphangiomas, choledochal cysts), hydronephrosis and accentuated obesity. Despite being asymptomatic, GOCs can cause serious complications like torsion, suppuration, obstruction, and perforation necessitating urgent admission. Many GOCs can present with signs and symptoms of ascites due to their large nature and can mimic ascites. Radiological imaging studies play a central role in the diagnosis of GOCs. The widespread use of imaging modalities in recent days have resulted in the rarity of GOCs as they are frequently diagnosed and excised earlier.[5-8]

Malignant ovarian cysts constitute over 10% of all GOCs and their signs and symptoms are vague and non-specific especially in early stages of the disease, making it necessary to exclude its possibility in all cases of ovarian cysts.[8] Tumour markers like CA 125, CEA , beta human chorionic gonadotropin and alpha fetoprotein play an important role in early diagnosis, management and follow-up of patients with MOCs . These tumour markers are not frequently included amongst investigations for ovarian cysts in most centres, although their role in early diagnosis and management of MOCs cannot be overlooked. Though they are not wholly specific or sensitive to ovarian malignancies, they help in determining the various sub-types of ovarian cancers. Occasionally, ovarian cysts reach enormous dimensions without causing any marked symptoms.[12] GOCs as large as 148.6 kg have been reported.[5] With good imaging modalities in recent years, such volumes of ovarian cysts are hardly encountered due to early diagnoses and management. Although Giant/Large Ovarian Cyst Cysts have not been clearly defined yet it is said that Ovarian cysts more than 10cms are considered as Large Ovarian cysts. Two histopathological variant are Serous and Mucinous. Majority are benign.[12] Although Laparoscopic surgery has been contemplated in small to moderate sized ovarian cysts yet there is hardly any case report of Laparoscopic removal of Giant/Large Ovarian cyst. Hence laparotomy and total excision of cysts in these situations is the treatment of choice until or unless laparoscopic surgery is clubbed with pre-operative decompression of the cyst under ultrasound or CECT guided aspiration.[5]

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