



MASSIVE OVARIAN CYST: A CASE REPORT

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ABSTRACT Cystic abdominal swellings are extremely common. Most benign and malignant ovarian swellings are predominantly cystic. Now a day these are diagnosed more frequently and much earlier due to availability of better imaging modalities that's why presentation of massive ovarian cysts has become very rare but still very occasionally we get these cases. These cysts often require excision because of symptoms or the possibility of cancer. Here we present a case of ovarian cyst in a 40 years old woman. The case was evaluated and Total abdominal hysterectomy with bilateral salpingo-oophorectomy was performed. There were no complications during and after procedure and during follow-up.

KEYWORDS : Ovarian Cyst, Massive, Benign, Malignant.

INTRODUCTION

Massive ovarian cysts have not been clearly defined yet. Although sporadically reported in the past, giant ovarian cysts have become rare in current medical practice in both developed and developing nations due to health education and better diagnostic modalities today such huge cysts are hardly reported in the literature and that too in such an elderly age group.¹

The exact mechanisms leading to ovarian cyst formation are unclear. Histologically, they are often divided into those derived from neoplastic growth (ovarian cystic neoplasms) and those created by disruption of normal ovulation (functional ovarian cysts). Differentiation of these is not always clinically apparent using either imaging tools or tumour markers.² Of the different type of ovarian cysts, functional ovarian cysts are common. Of benign ovarian neoplasms, serous and mucinous cystadenomas (surface epithelial neoplasia group) and mature cystic teratomas (germ cell family) are by far the most common.

Most women with ovarian cysts are asymptomatic. If symptoms develop, pain is common and sometimes pressure or ache may be the sole symptom and can result from ovarian capsule stretching. Ovarian cysts found incidentally on routine pelvic examination or during imaging studies for another indication. Findings may vary, but typically masses are mobile, cystic, non-tender, and found lateral to the uterus.³ Occasionally ovarian cysts reach enormous dimensions without raising any symptom.

Sonography is a first-line tool to evaluate pelvic masses. CT or MRI imaging of an ovarian cyst may clarify situations in which anatomy or patient habitus complicates sonographic imaging.⁴

Management of ovarian cysts depends on the patient's age, the size and structure of the cyst and menopausal status. Surgical management of cysts is by open or laparoscopic cyst excision or cystectomy with oophorectomy and sometimes with hysterectomy.⁵

CASE REPORT

A 40 years old female patient presented to the O.P.D. of P.G. Department of *Shalya Tantra* with history of progressively increasing abdominal contour for last 5 months. The distension was painless throughout. Abdominal examination revealed a uniformly large, soft, cystic and non-tender mass extending from pubis to epigastrium and was diffusely distended involving all quadrants (Figure 1). Fluid thrill was present. Umbilicus was centrally placed and not stretched and everted. Ultrasound revealed 20x11 cm. cystic vascular lesion with multiple septations. Both ovaries were not visualised separately. Ultrasound suggested a complex cystic pelvic mass?? Serous cyst adenoma (Figure 2). MRI Pelvis suggested a well-defined cystic lesion

arising from pelvis reaching up to epigastric region measuring approx. 22x13x22 cm. multiple thin internal septa were seen in it. Ovaries could not be seen separately from the mass. Features were suggestive of likely mitotic ovarian cystic lesion (Figure 3). All routine investigations were performed and no specific aetiology was found. In view of large cystic mass laparotomy was planned under spinal anaesthesia. All aseptic measures were employed during procedure. Abdomen was opened with infra-umbilical midline incision. Large cyst mass was seen with white glistening cyst wall. Cyst was excised completely without aspiration/decompression (Figure 4). It was observed that cyst was originating from left ovary. Right Ovary and Uterus were unremarkable. Total Volume of the cyst was calculated to approximate 10 kg. Total abdominal hysterectomy with bilateral salpingo-oophorectomy was done. The cyst and excised uterus was sent for histo-pathological examination. Patient recovered with an uneventful postoperative period and was discharged on 9th post-operative day. Her histopathology report showed benign serous cyst adenoma of the ovary.

DISCUSSION

The definition of huge ovarian cysts has not been well described in the literature. Some authors define large ovarian cysts as those more than 10 cm. in diameter measured on pre-operative scan. Others define large ovarian cysts as those reaching above the umbilicus. The case under report well fits into the criteria of giant/large ovarian cyst, it being 22x13x22 cm. on MRI scan and extending up to epigastrium.

Detection of Ovarian cyst cause considerable worry for women because of fear of malignancy but it is an established fact that many ovarian tumours present as cysts, but all cysts are not tumours. Two histopathological variant are Serous and Mucinous. Serous tumours are most common cystic neoplasm of the ovary, 60% of which are benign, 25% are malignant, and 15% are borderline cases.⁶ Serous tumours usually present as large masses, up to 40 cm in diameter.⁷

The commonest types of ovarian tumours encountered are cystic teratoma, paraovarian cyst, serous cystadenoma, corpus luteal cysts, luteomas etc. Serous cystadenomas are thin walled, translucent cysts usually unilocular, may have few daughter cysts, varying between 20-30 cm. in size. They are often unilateral can be bilateral. 10-15% of them are borderline malignant while 20-40% are malignant. Differential diagnosis includes: uterine leiomyomas, non pregnant horn of bicornuate uterus, appendiceal abscess, diverticular abscess, pelvic kidney, retroperitoneal tumours, ectopic pregnancy and retroverted gravid uterus. Complications of the cysts are torsion of the cyst, rupture, infection, malignancy, impaction of cyst in pelvis causing retention of urine. Some studies have suggested surgical intervention for concerns of malignancy, tumor torsion, tumor rupture or obstruction of labor.⁸

Cysts less than 6 centimetres in diameter and appearing benign on ultrasound are generally treated conservatively as they may undergo spontaneous resolution. Cysts more than 10 centimetres in size are usually resected due to increased risk of malignancy, rupture or torsion. Management of cysts between 6 to 10 centimetres is controversial. If the cysts contain septae, nodules, papillary excrescences or solid components then resection is recommended. Those with simple cystic appearance may be managed expectantly with serial ultrasound surveillance. However they may require emergency exploratory laparotomy for rupture, torsion or infarction. With the advent of imaging techniques the expectant management has become much more common. A simple cystectomy can be performed in the absence of overt malignancy.⁹

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.¹⁰

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FIGURES

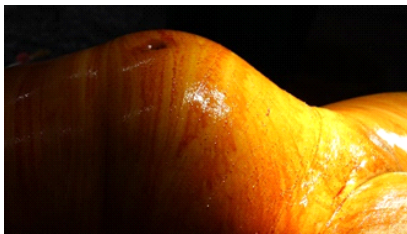


FIGURE 1

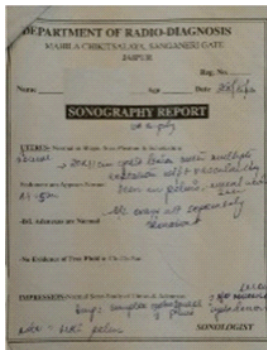


FIGURE 2

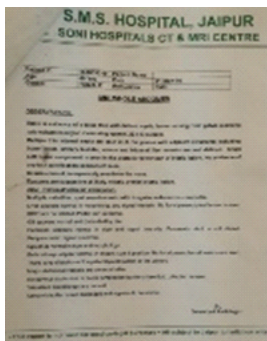


FIGURE 3



FIGURE 4