



A CASE REPORT ON GIANT OVARIAN CYST WITH HEMORRHAGIC ASCITIC TAPPING. DR. DISHA BHOJWANI, DR. ARINA CHANDRABABU

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ABSTRACT

Detection of ovarian cysts cause considerable worry for women because of fear of malignancy. Giant cysts require resection because of compressive symptoms or risk of malignancy. Hence, a comprehensive approach to the management of such tumors is essential to negate the secondary effects along with treatment of the primary ovarian tumour.

KEYWORDS

Case Report:

55 years old unmarried lady, nulligravida, postmenopausal, came with complaints of abdominal swelling which grew rapidly over just five months causing orthopnea. There was a history of generalized weakness. There was no history of vomiting or other gastrointestinal disturbances, colicky pain. The patient had no history of the previous medical or surgical illnesses. There was no family history of malignancies. The patient was obese, weighing **105 kg** with an abdominal girth of **122 cm**. Physical examination revealed pallor; she was afebrile with a pulse rate of 88 beats/minute, Blood pressure of 130/80 mmHg and respiratory rate of 22 cycles/minute. Her abdomen was distended and tense with a dull note on percussion. CA-125 was 45.4 IU/ml, CEA-1.6 µg/L, AFP – 3.1 ng/mL. USG was suggestive of an abdomino-pelvic mass, highly vascular on doppler with ascites. CT scan revealed a large predominantly cystic mass of the left ovary with a few solid areas measuring 29x27x34 cm with massive ascites. Ascitic Tap was hemorrhagic with no malignant cells. A provisional diagnosis of a large ovarian mass in a post-menopausal woman with the possibility of malignancy owing to the haemorrhagic ascitic tapping and slightly raised CA-125 level was made. Decision was taken on exploratory laparotomy. Intra-operatively No ascites found. Instead the capsule of cyst was flush with peritoneum all over. A huge multicystic tumour arising from the left ovary was seen occupying the whole abdomen and pelvis extending up to the diaphragm. The cyst was multi-loculated with cystic and solid components. The tumour was seen displacing the spleen, liver and bowel loops. Decompression of the cyst was done by controlled drainage of fluid intra-operatively and weighing 10 kg was removed en bloc. Total abdominal hysterectomy along with bilateral salpingo-oophorectomy was done. There was no pelvic or para-aortic lymphadenopathy. The right ovary measuring 3x2 cm and appeared normal. The post-operative period was uneventful. Patient weighed 90 kg on day 7 post surgery and her abdominal girth was reduced to **103 cm**.

HISTOPATHOLOGY:

Left ovary revealed serous cystadenoma with secondary haemorrhagic changes.

No malignant changes seen in the rest of the specimen

Discussion: Many ovarian tumors present as cysts, but all cysts are not tumors. The most common cystic ovarian neoplasms are serous tumors, depending on age, 60% of which are benign, 25% are malignant, and 15% are borderline cases. Serous tumors usually present as large masses, up to 40 cm in diameter. The definition of giant ovarian cysts has not been well described in the literature. Some authors define large ovarian cysts as those more than 10 cm in diameter, other defined as those reaching above the umbilicus. Our case fits into the criteria of giant ovarian cyst, being 29x27x34 cm on CT and extending up to diaphragm. The clinical symptoms of giant ovarian cyst are usually progressive increase of abdominal circumference and pressure, non specific diffuse abdominal pain, and other symptoms related to organ compression. In the presence of abdominal cystic masses of unknown origin on ultrasound with evidence of ascites, the aspiration of fluid is to be avoided since it

might lead to cyst perforation which in turn can cause possible dissemination of malignant cells. But in this case patient was complaining of orthopnea for which ascitic tapping was done. Relatively simple ultrasound-based rules can be used to diagnose ovarian malignancy, such as the International Ovarian Tumor Analysis (IOTA) rules. Five simple (M) rules were used to predict malignancy: (1) irregular solid tumor; (2) ascites; (3) at least four papillary structures; (4) irregular multilocular-solid tumor (5) very high color content on color Doppler examination. Five simple (B) rules were used to suggest a benign tumor: (1) unilocular cyst; (2) presence of solid components where the largest solid component is <7 mm in largest diameter; (3) acoustic shadows; (4) smooth multilocular tumor less than 100 mm in largest diameter; and (5) no detectable blood flow on Doppler examination. Three criteria could be combined in a risk of malignancy index (RMI) which is simply calculated using the product of the serum CA 125 level (U/ml), the ultrasound scan result (expressed as a score of 0, 1 or 3) and the menopausal status (1 if premenopausal and 3 if postmenopausal). This index was statistically virtually an effective discriminant between cancer and benign lesions. Using an RMI cut-off level of 200, the sensitivity was 85% and the specificity was 97%. Patients with an RMI score of greater than 200 had, on average, 42 times the risk of.

CONCLUSION: Giant ovarian cysts have become rare in current medical practice in both developed and developing nations due to the widespread use of modern imaging techniques such as ultrasound and CT Scan. Detection of ovarian cysts cause considerable worry for women because of fear of malignancy although it is an established fact that many ovarian tumours present as cysts. But this case proves even in modern era USG & CT scan can be misleading and laprotomy is still the **GOLD STANDARD** for establishing diagnosis.



Post-operative specimen of left ovary measuring after controlled drainage.

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