

LARGE OVARIAN CYSTS

Obstetrics & Gynaecology

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ABSTRACT

Cystic abdominal tumors are very common. However, Presentation of large ovarian cysts has become rare as most of them are diagnosed and treated early owing to new diagnostic modalities. Epithelial tumours of the ovary account for 60% of all ovarian tumors and 40% of benign tumors [1]. They are classified as benign, borderline, or malignant tumors. Ovarian cystadenomas are common benign epithelial neoplasms which carry an excellent prognosis. Mucinous tumors of the ovary represent a variety of neoplastic disorders, including benign mucinous cystadenoma, pseudomyxoma peritonei, mucinous tumours of low malignant potential (borderline), and invasive mucinous ovarian carcinoma. Benign tumours like mucinous and serous tumours sometimes attain unusually large size which require operative intervention. The study enumerates the various cases of unusually large sized tumours with diagnosis.

KEYWORDS

cystic tumours, serous cystadenoma. Mucinous cystadenoma

INTRODUCTION:

Large ovarian cysts have become rare as most of them are diagnosed and treated early. Yet, there are reports of patients with large benign abdominal cysts; of which many of them are serous cyst adenoma of ovary. Mucinous cyst adenomas (MCAs) of the ovary are known for their potential to grow to massive extents and are often incidentally diagnosed or patient presents as lump in abdomen.

Mucinous tumours represent 8% to 10% of epithelial ovarian tumours. They may reach enormous size, filling entire abdominal cavity. These cystic tumours have loculi lined with mucin secreting epithelium. Borderline mucinous tumours are of low malignant potential and are difficult to diagnose.

Mucinous carcinoma shows bilateral tumours in 8% to 10% of cases. The mucinous lesions are confined to ovary in 95% to 98% cases.

Case Report 1:

Patient Mrs. ABC, 50 years old, post-menopausal women, Para-2, Living-2, Abortion-1 with previous normal deliveries, came with the complaint of progressive abdominal distension and pain in abdomen since 2 years. The patient was a known case of hypertension and hypothyroidism and was on medication for the same.



Fig 1 Showing Distended Abdomen

On examination of abdomen, the cyst was 36 week size, cystic in consistency, non-tender. On per vaginal examination, uterus was of normal size, no adnexal tenderness seen and bilateral fornices were free. Tumour markers were done. CA125 was marginally raised, other markers were in normal range.

Tumour marker	Reported Readings	Normal range
CA 125	42.5	<35U/mL

HE4	71	Premenopausal ≤ 70pMol/L Postmenopausal ≤ 140
CEA	3.52	0-2.5ng/mL
AFP	4.82	10-20ng/mL
Beta-HCG	7.48	Premenopausal < 5IU/L Postmenopausal < 14IU/L

USG Report revealed 22 x 20 x 19 cm (VOL: 4464cc) size cystic lesion with multiple varying size cysts and echoes within, noted in extending from bilateral adnexa upto epigastric region and both ovaries not seen separately.

CT scan showed a large well defined hypodense round shaped lesion measuring approximately 24 x 22 x 24.9 cm with peripherally enhancing walls (maximum thickness of wall 4mm) and enhancing internal septae within is seen predominantly in lower abdomen and pelvis antero superiorly to urinary bladder and uterus from which right ovary is not seen separately. No fat component, calcification or solid mural nodule was seen. The lesion was extending from L1 vertebral body to inferior border of S4.

Patient was explained about all the risk associated and was planned for abdominal hysterectomy and oophorectomy after fitness was attained. Intraoperatively a huge cystic lesion with circumferential diameter of around 50cm with loculi was visualised. Fluid aspirated appeared to be mucinous. Specimen was sent for histopathology and cytology.

Postoperatively patient was on iv antibiotic and analgesic. Postoperative period was uneventful. Histopathology confirmed benign mucinous cystadenoma.



Figure2: Intraoperatively visualised huge ovarian cyst.

Case Report 2:

Patient Mrs. XYZ, 22years old, Para-1, Living-1 (previous LSCS) came to OPD with complain of mass in abdomen and increased abdominal size.

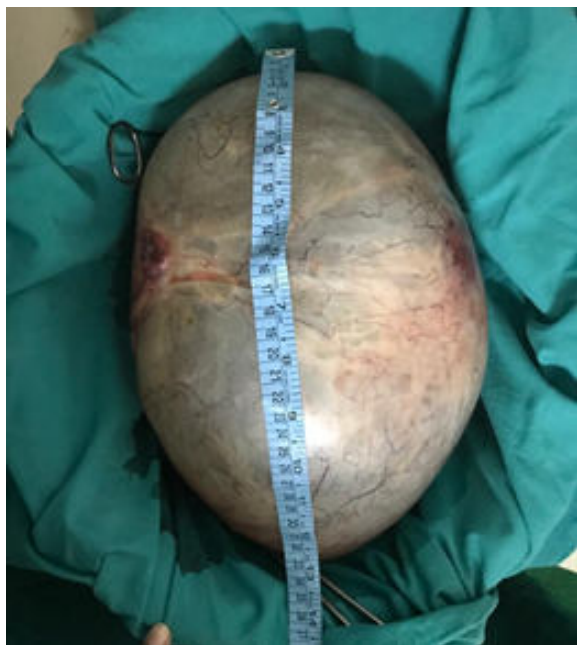
On examination, patient was vitally stable, per abdominal examination showed mass distending to a fundal height corresponding to 36-week size, non-tender on palpation, per speculum examination showed cervix and vagina to be healthy and per vagina examination revealed bilateral fornices to be free with no cervical motion tenderness.

USG was done which showed a large anechoic cystic lesion with smaller cysts and few septations seen within extending from upper abdomen till pelvis s/o large complex ovarian cyst/ Loculated ascites/ Mesenteric cyst.



CECT was done which revealed well defined hypodense complex right ovarian cystic lesion with peripherally enhancing walls and enhancing internal septae within.

Tumour markers were within normal range.



Patient was explained about all the high risk associated and was posted for Exploratory laparotomy with cystectomy with Right salpingo-oophorectomy. Intraoperatively a giant cystic mass with a circumferential diameter of around 30cm was visualised. Specimen was sent for histopathology and cytology which confirmed serous cystadenoma of ovary. Post-operative period was uneventful. Patient was on iv antibiotic and analgesic and was discharged on day 7.

Case Report 3:

Patient Mrs. PQR, 22 years old, nulligravida, with complain of pain in

abdomen and irregular menses came to OPD.

On examination of abdomen, it was soft non tender, mass in abdomen felt cystic in consistency, non-tender. On per vaginal examination, uterus was of normal size, no adnexal tenderness seen and bilateral fornices were free.

USG was done which showed 7.3 x 8.3 x 7.4 cm sized cystic area noted in pelvis arising from left adnexa with septa and low echo's without any obvious vascularity suggestive of haemorrhagic cyst. left ovary could not be visualised separately.

After taking consents patient was posted for Laparoscopic cystectomy where cyst measuring 7 x 7 x 6cm was visualised cystic fluid was aspirated by puncturing the cyst wall. Cystic fluid was serous in nature. Postoperative period was uneventful. Patient was on intravenous antibiotic and analgesic on Day 4. Histopathology report showed serous cystadenoma

DISCUSSION:

Large ovarian cysts have become rare in current medical practice in both developed and developing nations. The same is attributed to the widespread use of modern imaging techniques such as ultrasound and CT. [4][5]. Symptomatic patients commonly present with abdominal pain, although most of the patients are asymptomatic and the cysts were found accidentally by bimanual examination or ultrasound. Pain can present as dull ache or pain in the lower back or abdomen. Acute pain is seen in complicated ovarian cysts, torsion, infarction, or haemorrhage. Laparoscopic cystectomy was the modality of choice for treatment. In one trial comparing mini-laparotomy with laparoscopy for the surgical management of benign ovarian tumours, cyst rupture occurred more often in the laparoscopy group, but only in a subgroup of women with cysts diameter larger than 70 mm [3].

Although studies have claimed successful removal of giant/large ovarian cyst laparoscopically [6][7][8][9][10] yet there are hardly few studies that has claimed laparoscopic removal of large ovarian cysts. Nagele & Magos [11] did ultrasonographically guided drainage followed by laparoscopic excision of a large ovarian cyst, whereas O. Ates et. al. [11] also adopted same procedure to treat giant ovarian cyst.

CONCLUSION:

In this paper we have reported cases of giant ovarian tumour. Most gynaecologist consider such huge mass as malignant, as normally tumours do not reach this size, usually due to earlier radiological investigation done to detect mass. However, cases presented were of serous and mucinous cystadenoma.

Usually, Ovarian cysts more than 7 cm in diameter are considered as Large Ovarian cysts. Two histopathological variant are Serous and Mucinous cystadenoma

Tumours of such giant size are expected to be malignant in nature however the cases reported were benign. Laparoscopic excision of cyst could be done in such cases, however it is not done incase we suspect mucinous cystadenoma since there are chances of pseudomyxoma peritonei.

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