



ORIGINAL RESEARCH PAPER

Gynaecology

TORSION OF PARAOVARIAN CYSTADENOFIBROMA - A RARE CASE REPORT

KEY WORDS: torsion, paraovarian cyst, cystadenofibroma.

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ABSTRACT

Background: Para-ovarian cysts (POC) account for approximately 10% of adnexal masses which usually present in women aged 30-40 years [1]. Mostly small and asymptomatic, although when occasionally large these may result in pelvic pain [2]. POCs mostly arise in the broad ligament as thin walled and unilocular cysts. On imaging, it is difficult to reliably differentiate a POC from an ovarian cyst. In this case report we present a rare case of para ovarian cyst in a 20 yr unmarried girl.

CASE REPORT

20 year unmarried girl reported to surgical emergency with acute pain abdomen for one day and one episode of vomiting. The patient had no previous history of similar episodes in the past and denied fever, chills, headache, dysuria, constipation, diarrhea, menorrhagia or dysmenorrhea. Her remaining medical and surgical history was unremarkable. Clinically the patient was haemodynamically stable and her haematology and biochemistry results were within normal limits. P/A examination revealed right iliac fossa tenderness, no distension, guarding or rigidity. Differential diagnosis of appendicitis and torsion ovarian cyst was made. The scan showed a Right adnexal cyst 6.7x4.3x3.3 cm with internal echoes appearing to arise from rt ovary; normal left ovary and uterus. There was no evidence of free intraperitoneal fluid collection. Patient was shifted to Gynaecology unit subsequently and conservative management was advised. Patient was kept nil per oral and started on i.v fluids, iv antibiotics, analgesic. However in the observation period severe rt iliac fossa pain developed with rise in pulse rate. Emergency Laparotomy was done. Intraoperative – rt ovary was oedematous along with torsion of rt paraovarian cyst measuring 7x5x3cm. Torsion was released and rt paraovarian cystectomy done with preservation of ovaries. Both tubes, ovary and uterus were normal. No ascites. Grossly cyst was smooth walled, contained clear fluid with few papillary excrescences. The cyst was sent for histopathology. HPE shows cyst wall lined by cubical epithelium with underlying fibrocollagenous tissue with papillary projections and few areas. Impression of para-ovarian cyst. Benign papillary cystadenofibroma was made.

DISCUSSION

Acute appendicitis, ectopic pregnancy, pelvic inflammatory disease, twisted ovarian cyst and degenerative leiomyoma are few differential diagnosis of paraovarian cyst torsion [3]. Para-ovarian cyst torsion is rare, leading to delay in its diagnosis [4]. Paraovarian cysts mostly originate from the mesothelium covering the peritoneum (68%) and are lined with flattened epithelium (5). They may also arise from paramesonephric (Mullerian) remnants (30%) and mesonephric (Wolffian) remnants (2%) (6). Cysts which originate from paramesonephric remnants are lined with secretory, ciliated columnar or cuboidal epithelium and are usually benign.

Paraovarian cysts can be seen at any age but are most commonly encountered in the third and fourth decades. In spite of causing rare symptoms, complications due to torsion, internal haemorrhage and rupture massive sizes are seen (7). Paraovarian and paratubal cysts are usually found in the mesosalpinx between the ovary and fallopian tube. These adnexal cysts may be classified as paratubal or paraovarian depending on their proximity to either the tube or the ovary (8). Clinically it is difficult to distinguish a paraovarian cyst from an ovarian cyst. Therefore imaging is frequently used to reveal the diagnosis. Besides this, sonographic diagnosis of such cysts is not always possible as it requires awareness and experience. However as per some studies paraovarian and paratubal cysts are difficult to diagnose before surgery with the use transvaginal sonography. Paraovarian cysts are generally benign rarely they can be borderline or malignant.

CONCLUSION-

According to many reports, when a sonographic/ CT study shows the ovaries close to a pelvic cyst, paraovarian cyst is one of the first diagnostic choices and accordingly the treatment plan could be selected with a cyst aspiration followed by laparoscopic cystectomy or laparotomy. Physicians should maintain a high index of suspicion for this uncommon cyst which is often difficult to diagnose both clinically and radiologically.

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