ORIGINAL RESEARCH PAPER

Obstetrics & Gynaecology

MYSTERY OF A GIANT CYST IN AN ADOLESCENT GIRL.

KEY WORDS:

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Introduction

Most abdominal Cyst derive from the ovary. Ovarian cysts in 57% of cases were represented by cystadenoma , teratoma in 29% ,and follicular cyst in 7% of cases. The range of differential diagnosis is wide.Unfortunately imagining studies not always determine it's origin.Sometimes, it becomes very difficult to identify the source of these cyst and misdiagnosed as paraovarian or mesenteric Cyst. For absolute diagnosis we have to do laparotomy.

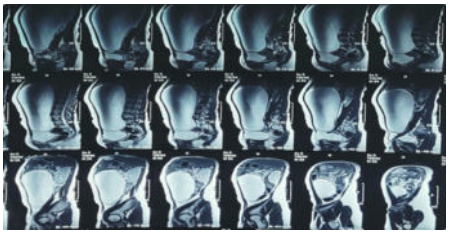
Case report

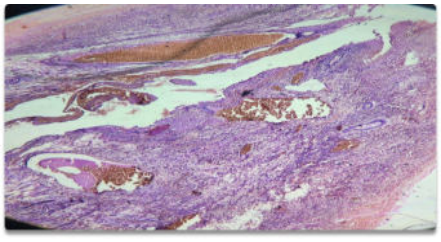
A 14-year-old postmenarchal girl was referred to us in view of a large abdominal mass. Ultrasonography of the abdomen had been reported as ovarian tumour. She had presented with a history of abdominal pain and distension since last 6 days. a/w constipation since 4 days .The patient had attained menarche at the age of 12 years. No significant past and family history. On examination - Vital parameters were stable. There was no pallor, icterus, oedema or lymph node enlargement. The abdomen was grossly distended. We palpated a large smooth, firm, mobile,non-tender mass arising from the pelvis and extending up to the xiphisternum .

Investigation – Basic Test were normal
1. CEA – 1.09 (0-3 ng /ml)
2. CA125 14.05 (0- 35 u/ml)
3. E2 – 112.60 (12- 160 pg/ml)
4. CA 19-9 – 7.6 (0 – 37 u/ml)
5. AFP – 1.7 (0- 8.7 ng /ml)
6. B HCG - < 2

USG – s/o Ovarian tumour??

MRI – Large cystic lesion 26 x 21 x 13 cm , Mod hydroureteronephrosis and mild right kidney enlargement. s/o peritoneal/ mesenteric Cyst. Left ovary not well visualised, Right ovary and uterus normal.





Management

Exploratory laparotomy with frozen section was performed. We took 2-3 inches suprapubic incision and aspirated 6-7 liters of straw-coloured fluid from the cyst sent for cytology. Cystectomy done with preservation of ovarian tissue. Cyst sent for frozen and showed serous cystadenoma of ovary. The Intraoperative and postoperative course was otherwise uneventful and we discharged the patient on the 5th postoperative day. At follow up a month later, the child was doing well. Cytology of the fluid showed – no malignant cells. Histo-pathological examination of the cyst wall was reported as juvenile solitary follicular cyst with no evidence of malignancy.

Discussion

Adolescent ovarian masses are a rare and, generally, not malignant. They occur due to the imperfection of the ovulation process and/or the persistence of the follicle. According to the analysis of scientific literature, the average age of patients with giant benign ovarian tumors is 14.28±1.72 years; ovarian cysts in 57% of cases were represented by cystadenoma , teratoma in 29% ,and follicular cyst in 7% of cases. The most common clinical signs are rapidly expanding abdominal distension and a palpable mass; these findings may be accompanied by nonspecific abdominal pain, vomiting, constipation, ovary torsion, and rupture. A conservative procedure, namely, ovarian cystectomy, should be considered the treatment of choice to preserve fertility. Despite the advanced technologies of instrumental research, sometimes it is difficult to determine the location of the cyst . Therefore, such preliminary diagnoses as ascites and intestinal disorders are made. Our initial diagnosis was serous cystadenoma of ovary. Only on subsequent histopathology of the lesion was a diagnosis of gaint follicular cyst of the ovary established. The diagnostic approach should be directed to differentiating benign conditions like follicular cysts from neoplastic lesions.

Conclusion

Early diagnosis of ovarian tumours in adolescents is important. Since most of these tumours are benign, surgical treatment should be conservative to minimise the risk of subsequent infertility.

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