Large Benign Ovarian Cyst with Sub Acute Intestinal Obstruction

Shivangi Jaiswal, Gurpreet Kaur, Shalini Kesharwani
Department of Obstetric and Gynecology, People's Medical College and Research Centre, Bhopal

Case Report

ABSTRACT

Sub acute intestinal obstruction is one of the most common problem faced by surgeons all over the world. However its association with ovarian tumor in rarely seen. It is more commonly seen with adhesions and neoplasm. Despite technological advances in diagnostic techniques, the diagnosis could only be made on surgery. Here is one such case where female presented with symptoms mainly mimicking pressure symptoms of ovarian cyst ,but on surgery sub acute intestinal obstruction was found.

KEY WORDS: benign, ovarian cyst, torsion, SAIO

INTRODUCTION:

Ovarian mass are often cystic, and are a common problem met in Gynaecological OPD[1]. Large masses usually present as abdominal distention, pain or discomfortdepending on location, size anddegree of compression. Acute abdomino- pelvic pain incidence comprised about 1.5% of OPD visits, and 5% of IPDs. Acute presentation may be in the form of severe pain and vomiting, and may be due to torsion of the ovarian mass or cyst. Rarely, they may present with sub-acute intestinal obstruction.

CASE REPORT:

A 35 yr old lady presented with chief complain of progressive abdominal distension since 1 year. There was generalized pain in abdomen off and on, since 3-4 days, and constipation since 1 week. It was also associated with vomiting off and on since 2-3 days which was projectile.

Her menstrual cycles were regular, and there was no history of overdue. Her Obstetric history is P6L4A2 with previous 2 LSCS and CTT done 4 years ago. There was a history of laparotomy done for ovarian cyst 5 years back.

Corresponding Author:
Dr Shivangi Jaiswal
PG 2nd Year,
Department of Obstetric and Gyncology,
People's College of Medical Sciences and
Research Centre, Bhopal- 462037
Phone No.: 9479876639
E-mail: shivangij21@gmail.com

On general examination, patient was Ambulatory, conscious and oriented. Her Pulse was 90 bpm, and BP was 124/90 mmhg. On examining per abdomen, a firm non-tender mass of 30-32 weeks size with restricted mobility was palpable, fluid thrill was present. On Per vaginum examination, uterus was anteverted, multiparous size, mobile, and felt separated from the mass; movements were not transmitted to mass. Bilateral fornices was free, and mass could not be felt in either fornix or posterior fornix.

Transvaginal sonography showed large cystic lesion in right adnexa extending up to epigastric possibly of ovarian cyst, and minimal right side hydronephrosis. On CECT, there was alarge peripherally enhancing cystic lesion arising from right side of pelvis extending up to epigastric region - ? *Ovarian origin* probably benign. Serum CA-125 was within normal limits. All other laboratory parameter were within normal limit.

Patient underwent surgery and Exploratory Laparotomywith Omental biopsy was done. A huge twisted Left ovarian cyst of 20x17cm (3 twists) along with swollen fallopian tube (swollen and dark congested)was found . Mesentery was pulled up with twisted and distended recto sigmoid and descending colon. Twist of the bowel was about 180 degree which could have lead to volvulus. Exploration was done .Peritoneal surfaces and liver surface was smooth. Ascitic fluid of around 500ml was found, which was straw colored, and sent for cytology.Left salpingo-oophorectomy was done. Right ovary and tube was absent. Uterus was left behind as bladder was plastered

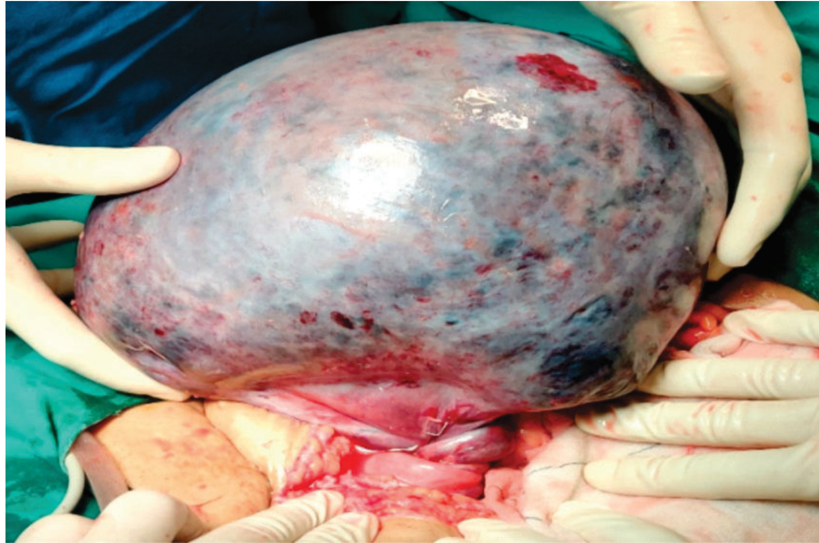

Figure 1: Huge hemorrhagic ovarian cyst, with 3 twists including intestine and mesentery.

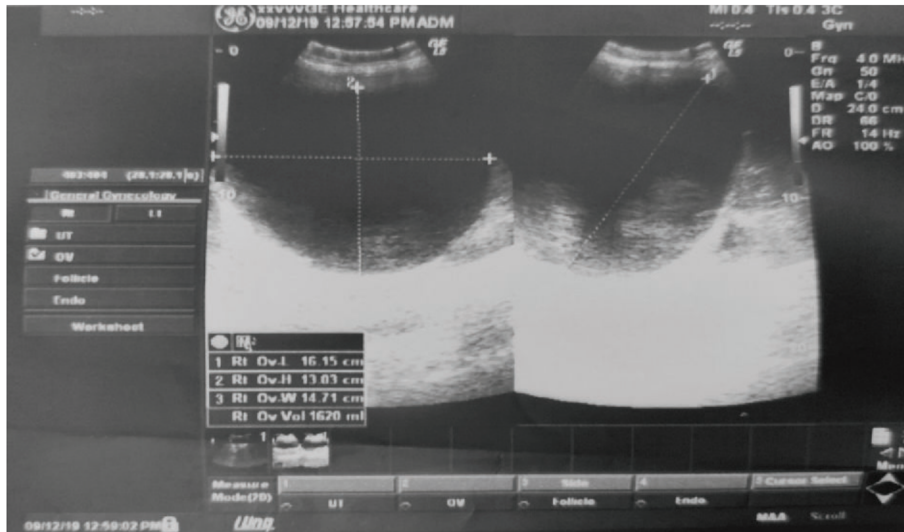

Figure 2: USG showing large cystic ovarian cyst.

to anterior surface of uterus, and was densely adherent. Omental biopsy was taken.

On Cut section of ovarian cyst, uniloculated, smooth lining,and filled with haemorrhagic serous fluid.Sample was sent for Histopathology examination which was evident of Haemorrhagic benign ovarian cyst with ovarin endometriosis. Patient stood procedure well. Her post-op period was uneventful.

DISCUSSION:

Sub acute intestinal obstruction is a rare presentation of ovarian tumors, but is a deadly presentation. Interestingly, ability of ovary to form cyst doesn't end with menopause. In the elderly, it may be seen with ovarian cancer. It is usually due to adhesions, and may be also be related to tumor growth and blockage[2]. It is frequently present in association with pleural effusion and ascites. In the neonatal period, the incidence of ovarian cysts complicated with intestinal obstruction is 3%, but is seldom seen in adult age group[3]. Torsion is less commonly observed on left side due to recto-sigmoid[4]. Diagnosis is difficult, and in majority of cases intra-operatively diagnosis is made. Delay in diagnosis, associated co-morbidities and advancing age are the reasons for high mortality .

CONCLUSION:

Torsion in ovarian tumors may not always

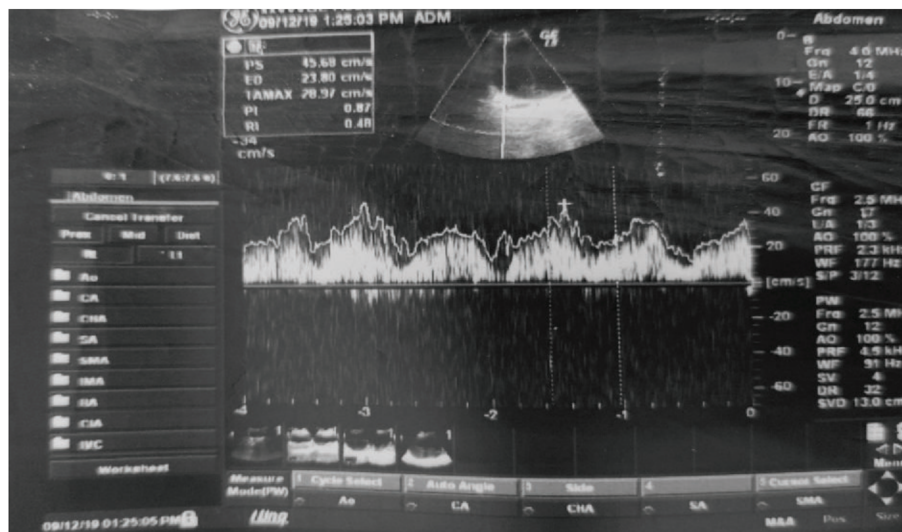

Figure 3 : USG Color Doppler showed maintained vascularity.

present with dramatic symptoms and signs, and may present as SAIO. In the present case, the features of SAIO was because of trapping and twisting of bowel mesentery with the ovarian torsion. Delay in management as it presents with unusual symptom, may be dangerous, and hence emergent intervention must be done.

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Cite this article as: Jaiswal S, Kaur G, Kesharwani S. Large Benign Ovarian Cyst with Sub Acute Intestinal Obstruction. PJSR ;2020:13(2):60-62.
Source of Support : Nil, Conflict of Interest: None declared.