

*Letter to Editor*

# Intestinal obstruction as a presentation of a huge ovarian cyst

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Dear Editor,

An ovarian cyst is a fluid-filled sac in an ovary, surrounded by a very thin wall, located within the ovary (Reding D et al., 2008). The study of Mohan H et al. in 2006 reveals that it can develop from the neonatal period to post menopause. They occur most often, however, during a woman's childbearing years (Wani S et al., 2002 and Moslemi K et al., 2010). Asymptomatic ovarian mass is a diagnostic challenge for any gynecologist or surgeon. Accurate clinical assessment and expert radiological diagnosis can provide a better management protocol. A 42-year-old Indian married and multiparous woman presented in outpatient door with a history of gradually increasing abdominal swelling since 5-6 months with constipation. There was no history of colicky pain, fainting attacks, vomiting or other gastrointestinal attacks. She had no previous history of any illnesses, allergies or operations. She gave history of normal regular menses. On general examination, Pallor was present and vital signs were normal. There was no icterus, edema, or lymphadenopathy. On clinical examination, lump was freely mobile with cystic consistency and non tender. Percussion note was dull all over the abdomen. Abdominal bowel sounds were heard normally. The abdominal skin was tensed but non-tender. She was admitted into the female surgery ward. Routine blood and urine investigations were within normal limit. Chest and abdominal roentgenogram was normal. Ultrasonography of the abdomen and pelvis revealed massive intraperitoneal mass with cystic collection completely filling the peritoneal cavity. Radiological diagnosis confirmed on abdominal computer tomography. After an extensive workup, diagnostic dilemma was there. We

shifted patient for barium enema to rule out any bowel pathology. During Barium enema, she went into retention of enema with features of sub acute intestinal obstruction. Therefore, decision of emergency laparotomy was taken. After pre-operative preparation, the patient was taken for laparotomy and underwent laparotomy with a midline incision, extending from epigastric region to hypo gastric region. Intraoperatively, a thick whitish fibrous capsule was encasing the huge mass and multiple adhesions between the mass and bowel loops. The root of the mass was attached to the fallopian tube at the right side. The mass was so large. The cyst measured 42 x 35 x 32 cm, extended up to the undersurface of the diaphragm, and totally weighted 9 kg. The mass originated from the right ovarian region, so we excised the cyst with the ipsilateral fallopian tube and ovary. The right ovary was included in the mass. The right fallopian tube was adherent to the surface of the cyst. There was no free fluid in the abdomen. Histopathological examination confirmed serous cystadenoma of the ovary. The post operative period was uneventful. The patient was discharged on 11<sup>th</sup> postoperative day. She was doing well on follow-up. Mohan et al. (2005) and Karim et al. (2011) mentioned that any ovarian follicle that is larger than about two centimeters is termed an ovarian cyst. According to Reding et al. (2008), most ovarian cysts are functional in nature, and harmless.

Wani et al. (2002) revealed that the maximum number of ovarian cysts diagnose in nearly all premenopausal women, and in up to 14.8% of postmenopausal women. As per Zanetta et al. (1996), Surgery may be required to remove cysts larger than 5 centimeters in diameter.

Malkan et al. (2009) mentioned that in these lesions typically benign tumors accounting for 15% of ovarian are characteristically unilateral, only 5% presenting bilaterally, and the peak incidence occurs among women who are between 30 and 50 years of age. Ovarian neoplasms may be epithelial, stromal, and germ cell. Taken as a group, the epithelial tumors are the most common type. In general, ovarian MCAs tend to be present with abdominal distention. Various studies al. (1979); Grobe et al. (1983); Rattan et al. (1996); Semchyshyn S et al. (1977); Wootton-Gorges SL et al. (2005); Zamir D et al. (1996); Zanini P et al. (1996), ascites is another entity that must be included in the list of differential diagnoses. Other diagnoses may be mesenteric cysts, cysts arising from retroperitoneal structures. As per Wani et al. (2002), ovarian cysts are usually diagnosed by either ultrasound or CT scan. Ishioka et al. (2004) mentioned in the literature that the management of ovarian cysts depends on the patient's age, the size and structure of the cyst and menopausal status. Surgical management of cysts is by laparotomy or laparoscopic cyst excision or cystectomy with oophorectomy.

neoplasms and up to 80% of all mucinous tumors. One study done by Hart WR (2005) showed that ovarian MCAs Rodríguez et al. (2002) and Nwobodo E (2010) revealed that the vast majority of mucinous tumors are benign (75%), 10% borderline, and 15% carcinomas. One of the major differential diagnoses mentioned in one study of ovarian cysts by Walker AR et al. (1973) is omental cysts. These masses may be simple or multiple, may be huge, and simulating ascites. As per several studies (Chen S et Kar T et al. (2005) and Yusuf L et al. (2002) revealed that the treatment for cysts depends on the size of the cyst and symptoms. For small, asymptomatic cysts, the wait and see approach with regular check-ups will most likely be recommended. For more serious cases, where cysts are large and persisting, doctors may suggest surgery. Some surgeries can be performed to successfully remove the cyst without hurting the ovaries, while others may require removal of one or both ovaries. Asymptomatic ovarian mass is a challenge for any gynecologist or surgeon to make accurate diagnosis before any management intervention. Perfect clinical approach, radiological evaluation and gross literature knowledge regarding pathophysiology can provide a better outcome and future after treatment.

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