CASE REPORT

Giant Left Ovarian Cyst Masquerading as the Right Ovarian Cyst: A Case Report

Anubhav Singh[1], Anshika Singh[2], Abhishek Anand[3], Saurabh Singh[4], Santosh Tiwari[5]

ABSTRACT

Giant ovarian cysts are tumors of the ovary presenting with diameters >10 cm. These giant tumors are rare in current medical practice in both developed and developing nations because they are diagnosed and managed early due to the availability of good imaging modalities. The aim of this case report is to show how a huge cystic ovarian mass can mislead and occupied opposite quadrant reported on ultrasound as the right ovarian cyst though it was originating from the left side. Reporting such cases help to increase the suspicion of its possibility and avoid any misdiagnosis and improper treatment.

Keywords: Giant, Ovarian cyst, Exploratory laparotomy, Abdominal distension, Ultrasound scan.

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INTRODUCTION

Giant ovarian cysts (GOCs) are tumors of the ovary presenting with diameters >10 cm.[1,2] These giant tumors are rare in current medical practice in both developed and developing nations because they are diagnosed and managed early due to the availability of good imaging modalities.[3,4] Ovarian cysts are generally asymptomatic at early stages causing symptoms only after reaching enormous dimensions, and consequently, they are often diagnosed late.[1,5,6] The clinical symptoms of ovarian cysts are usually progressive abdominal distension, non-specific diffuse abdominal pain, vaginal bleeding, and symptoms related to organs compression such as constipation, early satiety, vomiting, and frequent micturition.[5,7-10]. Majority of GOCs are benign and are generally treated by surgical excision either by cystectomy or salpingo-oophorectomy.[2,6] Malignant ovarian cysts constitute over 10% of GOCs and are treated by total abdominal hysterectomy with bilateral salpingo-oophorectomy ± omentectomy.[6]

CASE REPORT

A 38-year-old lady presented in our hospital emergency with chief complaints of a gradually increasing huge abdominal swelling noticed 4 months back now associated with pain for the past few days. She denied any genitourinary or gastrointestinal symptoms. On general examination, she was in pain with normal vitals except tachycardia. There was no icterus or edema. Abdominal examination showed generalized distension with a dull note on percussion. The liver and spleen were not palpable. Based on sonographic examinations, a huge abdominal echogenic mass occupying the entire abdomen and pelvic cavity was seen revealing a giant right ovarian cyst, measuring 13.1 cm × 11.2 cm × 13.1 cm (volume 1005 cm^3) with bowel loops displaced peripherally. Uterus was seen separately. There was no free fluid in peritoneal cavity. Following counseling and consent, an exploratory laparotomy was arranged for diagnostic and

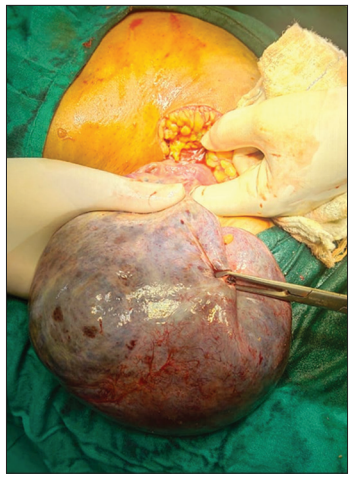

Figure 1: Giant left ovarian cyst after aspiration taken out through incision

[1,2]Consultant, [3]Resident, [4]Consultant Physician, [5]Consultant Anesthesiologist

[1]General and Laparoscopic Surgeon, Experience Clinic, Ayodhya, Uttar Pradesh, India

[2]Women and Child Health, Experience Clinic, Ayodhya, Uttar Pradesh, India

[3]Department of Family Medicine, Apollo Gleneagles Hospital, Kolkata, West Bengal, India

[4]Department of Medicine, Awadhesh Singh Nurshing Home, Vikramjot Basti, Uttar Pradesh, India

[5]Private Practice, Ayodhya, Uttar Pradesh, India

Corresponding Author: Anubhav Singh, Consultant, General and Laparoscopic Surgeon, Experience Clinic, Ayodhya, Uttar Pradesh, India. e-mail: singhanubhav5@gmail.com

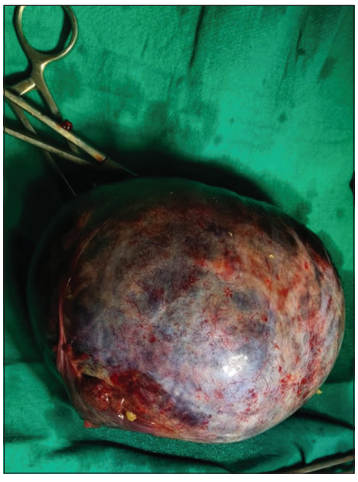

Figure 2: Remaining cyst with its wall after removal

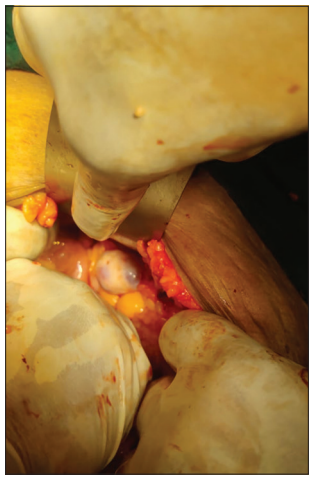

Figure 3: Normal right ovary

therapeutic purposes. Low midline incision extending up to the umbilicus was realized under spinal anesthesia. After opening the parietal peritoneum, an irregular, hemorrhagic, necrotic, and dark red in appearance cystic mass was noted which was originating from the left ovary twisted and came to the right side so on ultrasound scan reported as the right ovarian cyst [Figure 1]. The mass was so large that it could not be excised without a large abdominal incision, so we drained the intracystic fluid (4 l of hematic fluid) after creation of a small hole in the mass until we could excise the cystic mass [Figure 2]. The left ovary was included in the mass and the left fallopian tube was adherent to the surface of the cyst. Complete excision of the cyst with left salpingo-oophorectomy was performed. The right ovary was normal [Figure 3].

DISCUSSION

GOCs constitute a challenging condition in general practice because of their non-specific clinical features and findings from physical examination resulting to a wide range of differential diagnosis.[10] These differential diagnoses include pelvic endometriosis,

Intra-abdominal pregnancy, intra-abdominal cysts from varying origins (omentum, ovary, kidney, liver, pancreas, cystic lymphangioma, and choledochal cysts), hydronephrosis, and accentuated obesity.[5,10] Despite being asymptomatic, GOCs can cause serious complications such as torsion, suppuration, obstruction, and perforation necessitating urgent admission.[9] Many GOCs can present with signs and symptoms of ascites due to their large nature and they are commonly mistaken for it.[5] When confronted with extremely large, apparently benign ovarian cysts, only few surgeons advocate laparoscopic management. In our patient, laparoscopic excision was not contemplated due to huge size of the cyst. We successfully decompressed and totally excised the large cyst with ipsilateral salpingo-oophorectomy through an infraumbilical midline laparotomy incision which revealed that it is a left GOC occupying right adnexal region due to its huge size and twisting.

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