

Case Report

Chronic constipation: An unusual presentation of a Giant Serous Cystadenoma of ovary

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Abstract

Benign ovarian cysts are fairly common. However, some of them may attain a large size and may prove to be malignant also. Here we report a case of 48 years old female presenting with chronic constipation due to a large ovarian cyst which was misdiagnosed on CT as mesenteric cyst. This case is being reported because of its large size, unusual presentation and missed diagnosis.

Introduction

Many ovarian tumors presents as cysts. The most common cystic ovarian neoplasms are serous tumors, 70% of which are benign, 20- 25% malignant and 5-10% are borderline cases¹. Clinical presentation of huge ovarian cysts have become rare as most of them are diagnosed and treated early. Sometimes identification of the source of these cysts become difficult and are often misdiagnosed as mesenteric cyst.

Case Report

A 48 years old female presented with chronic constipation since one year and vague abdominal discomfort to the Surgical Outpatient Department. She was a nullipara but without any specific gynaecological complaints. On examination she was well built and slightly obese. Abdominal examination revealed distended abdomen mainly localized to its lower part. On palpation a cystic lump was felt in the lower abdomen with ill defined margins. Lower end of the mass could not be reached and upper margin was reaching almost to the epigastric region. Fluid thrill was present but there was no shifting dullness. On vaginal examination, uterus was felt but size could not be ascertained. Forniceal fullness was present. Rest of the systemic examination was normal. Patient was then subjected to radiological investigations. Ultrasonogram of the abdomen showed a large

cyst occupying whole of the abdomen the origin of which could not be ascertained. Computerised Tomography of the patient revealed a large abdominopelvic mass suggestive of mesenteric cyst (Fig.I). All laboratory investigations were within normal limit. Blood investigation were; Hemoglobin- 11.0 gm%, Total leukocyte count - 4500 cells/mm³ and differential count showed polymorphs 67%, lymphocytes 30% and eosinophils 3%. Platelet count was 1.65 lakhs. Total serum protein was 6.9g/dl with serum albumin 3.5g/dl.

Exploratory laparotomy showed a huge cystic mass arising from the left ovary which was excised completely with preservation of the ovary. The removed cyst measured 28×20×15 cms and weighed 12 kgs. (Fig.II).The content of the cyst was clear fluid without any localized thickening or septations . Right adnexa was within normal limit. Specimen was sent for histopathological examination. On opening approximately 10 litres of clear serous fluid oozed out. Cyst was unilocular with papery thin wall and prominent vessels on outer surface. Inner surface was smooth. No solid area or papillary projection was seen. No hemorrhage or necrosis was present. Histopathological diagnosis of benign serous cystadenoma was given. The patient had uneventful postoperative recovery and was discharged after stitch removal.

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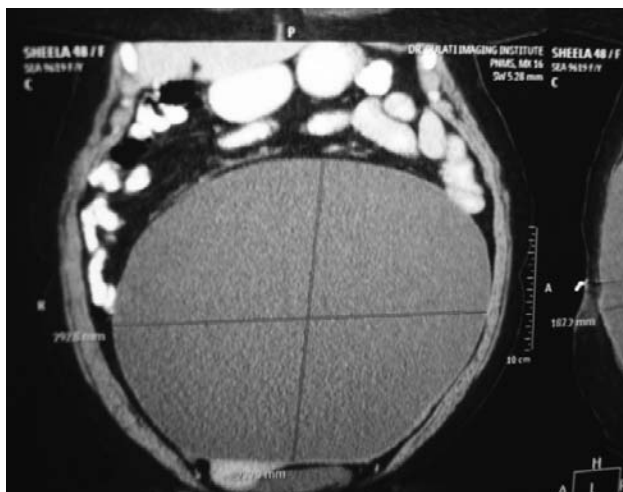


Fig. I- CT scan shows large abdominopelvic mass suggestive of Mesentric cyst

Discussion

Ovarian neoplasm may be divided into three main groups depending on the cell of origin- epithelial, stromal and germ cell. The epithelial tumors are by far the most common type. The commonest benign tumor is the benign cystic teratoma. However according to some studies it is serous cystadenoma². The most common type of epithelial neoplasm encountered was benign cystadenoma, of which 75% were serous cystadenoma and 25% were mucinous cystadenoma³. An ovarian cyst can be of any size ranging from size of a ball to larger than a full term pregnancy and fewer than 10% have menstrual irregularities. Nowadays presentation of huge ovarian cysts has become rare as most of them are diagnosed and treated early. However, most of these cysts are asymptomatic, rarely may they cause clinical

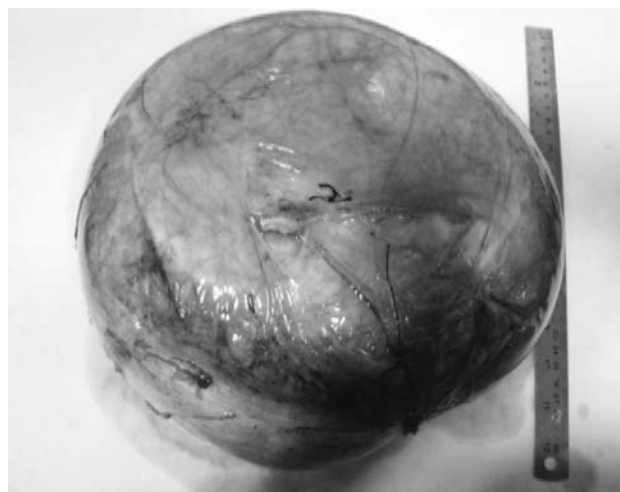


Fig. II - Giant ovarian cyst after excission

cal symptoms such as increased abdominal girth, lower abdominal pain, unexplained bleeding and bowel obstruction⁴. Occasionally ovarian cyst may reach enormous dimensions without raising any symptoms.

Sometimes it becomes very difficult to identify the source of these cysts and are misdiagnosed as mesenteric cyst⁵. However when an adnexal mass is suspected, transvaginal ultrasound is the imaging modality of choice. Other than ultrasound, CT or MRI is useful for larger masses and examining the abdomen for metastasis⁶. 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 laparotomic or laparoscopic cyst excision or cystectomy with oophorectomy.

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