A CASE OF OVARIAN CYST, BECOMING PARASITIC AFTER DETACHMENT AT PEDICLE, ASSOCIATED WITH PREGNANCY

by

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Torsion of an ovarian cyst is quite a common complication. In these cases commonly there occurs venous engorgement of the tumour, due to torsion of veins in the pedicle, leading to interstitial haemorrhages in the wall of the tumour and into the loculi. It is, however, extremely rare for the arterial supply to be so involved as to lead to necrosis and atrophy of the pedicle leading to detachment of the tumour. Such a detached tumour may find a new blood supply from adhesions to some other structures in the abdomen and become parasitic. Author came across one such rare case which is described below.

Case Report. Patient, a middle-aged widow of 40, was admitted to Kamla Raja Hospital, Gwalior, on 10-3-61 in the afternoon with the history of swelling in the lower abdomen for the last 10 years which she noticed 8 days after her last delivery, and 2½ months' amenorrhoea. She complained of an attack of acute pain in the lower abdomen 8 days back, after taking a purgative to relieve her constipation. She also had vomiting and tenderness in the abdominal swelling. Some local treatment relieved her for 3 days when the pain recurred and came off and on, sometimes mild and at others severe in nature. There was no more vomiting.

She had had 8 full-term normal deliveries out of which 4 children are living. The last labour was 10 years back and since then the patient observed swelling in the lower abdomen. She has been a widow for the last five years.

Menstrual history was normal. General examination revealed patient to be slightly anaemic and poorly nourished. Her blood pressure on admission was 110/64 mm. Hg. and pulse 92 per minute.

On abdominal palpation a tense, tender, partially mobile swelling, about the size of 20 weeks' pregnancy, was detected in the lower abdomen slightly more on the left side. There was no free fluid in the peritoneal cavity. Uterus was felt separate and was about the size of 14 weeks' pregnancy.

Per vaginam cervix was felt directed downwards and backwards. Uterus was enlarged to 14 weeks' pregnancy and soft. Lower pole of the abdominal mass could be felt separate from the uterus through the left fornix. On visualization cervix was found to be discoloured bluish.

All the routine investigations were done and apart from haemoglobin which was only 9.86 gms. per 100 ml., everything else was normal.

The patient was diagnosed as a case of twisted ovarian cyst associated with pregnancy and was operated by the author the same evening. On opening the abdomen the peritoneum and the omentum were found to be thickened and adherent to the tumour. The blood vessels between the omentum and the tumour (from which the tumour was evidently getting its blood supply) were ligated, adhesions separated and the tumour removed. The tumour had no pedicle anywhere connecting it with any pelvic structure. Right side tube and ovary were normal. On the left side the ovary, ovarian ligament and the fimbrial end of the tube were missing

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and there was some fibrosis at their site but no raw area suggestive of recent rupture.

Description of Tumour and Its Histopathology. The tumour was oval in shape, 5"x4" in size, smooth with black haemorrhagic spots and prominent veins. Fimbrial end of the tube could be identified at one pole. There was no pedicle.

Cut surface showed yellowish granular semi-solid material inside the cyst. Lining wall of the cyst was smooth. Microscopically, the section showed absence of lining epithelium due to which the nature of the cyst could not be decided. The walls of the cyst showed evidence of congestion with dilated vessels, haemorrhagic spots and inflammatory cells. It also showed areas of hyalinisation and fatty infiltration.

Discussion

Shaw mentions that in about 12% of the cases of ovarian tumour which come for operation, the tumour shows torsion or axial rotation of the pedicle. He further mentions that the rotation may even go to the extent of three complete circles. The common result of the rotation is that the veins in the pedicle become occluded, the tumour becomes congested. After some time there occur interstitial haemorrhages in the wall of the tumour and into the loculi. The event is attended by severe acute abdominal pain and signs of peritoneal irritation. If neglected, the condition persists and adhesions form to the neighbouring structures like omantum and intestines. It is, however, extremely rare for occlusion of the arteries in the pedicle to reach such a stage as to lead to necrosis of the tumour or of the pedicle—in latter case leading to detachment of the tumour. In such cases the detached tumour becomes parasitic to structures to which it has become adherent by vascular connections. The case reported here is one of such rare types.

It is interesting that the subject gave history of pain in abdomen for only 8 days. It is highly unlikely that in this short period the tumour underwent torsion leading to pedicle necrosis, separation of tumour and its becoming parasitic by developing vascular adhesions. It appears that the patient must have had attacks of milder pain before 8 days when the torsion started but neglected it.

Another point of interest in the case is the associated pregnancy. The subject being a widow perhaps lied about the duration of the amenorrhoea as both vaginal examination and at operation the pregnancy was found to be of longer duration than the history of amenorrhoea given by the patient. The pregnancy appeared to be normal. On discharge the patient still had her pregnancy undisturbed.

Summary

A case of ovarian cyst which underwent torsion and necrosis of the pedicle associated with a normal pregnancy has been described. The tumour got separated at the pedicle and formed parasitic adhesions with omentum and peritoneum. The case is of interest on account of the rarity of the complication.