INTRACYSTIC HAEMORRHAGE IN A OVARIAN TUMOUR FOLLOWING A NORMAL DELIVERY

(A Case Report)

by

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Ovarian tumours during pregnancy or puerperium are not infrequent. They may pose a challenging problem, as most of them are missed during pregnancy and are detected for the first time in puerperium, threatening the life of the patient.

Here is a case report of huge ovarian tumour detected after normal delivery.

CASE REPORT

Mrs. K., 24 years was admitted on 11-8 1976 at 2-50 p.m. in emergency stating that she had full term normal delivery of first baby at home, while the second baby is still inside. She was having vomiting for the last three days. Labour pains subsided after the delivery of first baby.

Menstrual History

Her previous cycles were normal, 28-30 days; she conceived during lactational amenorrhoea.

Obstetric History

She had 2 full term normal deliveries, first 2 years back male alive, second 3 days back, male died after two days of birth.

General examination

General condition of the patient was poor. She was pale, anaemic, tongue was dry. Skin was cold and clammy. She was perspiring, Pulse 140/mt. Resp 30/mt. B.P. 130[80 mm of reg.

Urine for albumin sugar and acetone was negative. Cardiovascular and respiratory systems were normal.

Abdominal examination

Abdomen was filled with a swelling rising upto xiphisternum and extending into the flanks of variable consistency. Abdomen was tense and tender. No presentation could be made out F.H.S. absent.

Vaginal examination

OS was open. Exact size of the uterus could not be made out as bimanual examination was not possible. Body of the uterus felt in the anterior fornix about 14-16 weeks' size. Fundus of the uterus could not be identified. On digital examination cavity was found intact as far as finger could be reached. Bleeding per vaginam present.

General condition of patient was deteriorating, B.P. fell to 90/60 mm of mg. She became dyspnoeic and air hunger started. Laparotomy was decided keeping in view the diagnosis of? Ovarian cyst undergone torsion? Intraperitoneal haemorrhage due to ruptured ovarian cyst? Ruptured horn of bicornuate uterus? Two units of blood were arranged. One unit started before laparotomy under gas, oxygen ether anaesthesia. Abdomen was opened by subumbilical midline incision Abdomen was filled by a blackish grey coloured swelling upto the xiphisternum and the incision had to be extended

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above the umbilicus. Swelling was right sided ovarian cyst. There was no twist of pedicle. There were no adhesions. Cyst was multinodular; uterus was anteverted, 14-16 weeks' size. Left tube and ovary were healthy. During the delivery of the tumour from the wound one locula was ruptured accidently discharging brownish mucinous material.

Right sided salpingo-ovariotomy was done. Stump was covered with round ligament. On left side simple plication of round ligament was done. Lomodex was put inside before closing the abdomen. B.P. fell to 70 mm rig. Patient could be revived. Postoperative period remained uneventful.

Macroscopic appearence

Cyst was about 50 cms. in diameter, 15 lbs. in weight, multilocular and of variable consistency. Strips of healthy ovarian tissue were seen. The cut surface showed fresh blood and organised blood clots in the various loculas along with the pseudomucinous material.

Histopathology: pseudo-mucinous cystadenoma ovary.

Discussion

The history of the case report is very interesting. This huge ovarian tumour was missed during the pregnancy. Excessive enlargement of abdomen was mistaken for twins. Vomiting was taken as normal phenomenon of labour. She waited for 3 days for the delivery of second baby, then and then she came to seek medical aid. Picture of acute abdomen was because of haemorrhage in the cyst. Haemorrhage in the cyst might be due to stress of labour, manipulation done for the expression of placenta or by massage of abdomen to hasten the delivery of second baby. She was pale and collapsing because of slow leakage of blood into the ovarian cyst, supported by presence of organised blood clots in the cyst. Fresh bleeding might have resulted due to repeated vomiting and long, ardous journey to the Hospital.

Various papers had been published showing the frequency of ovarian tumour complicating pregnancy from time to time. All the varieties of tumour from simple cyst to very rare form of disgerminoma have been reported but dermoids remain the most common (Spencer, 1920; Booth, 1963; Achari, 1968). Booth reported an incidence of 12.2% for pseudomucinous cystadenoma. Roy Chowdhury (1968) reported 7 cases of pseudomucious cystadenoma out of 30 ovarian cysts.

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