HUGE OVARIAN TUMOUR

(A Case Report)

by

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Summary

A case report of a benign ovarian tumour weighing 110 is being reported for its clinical curiosity in modern gynaecological practice. These days one hardly comes across such a case which is completely curable by surgical treatment, if detected and treated early. Due to its huge size, this case though benign presented great technical difficulty during anaesthesia and operation.

Ugly abdominal scar (as evident in photograph No. III) following operation could have been prevented, if patient would have come earlier.

Case report

Mrs. M. D. aged 40 years, was seen by one of us on 16th September, 1977, with history of swelling of abdomen for 5 years. The swelling gradually increased in size. Her menstrual cycles were normal and regular previously, but menstruation stopped 2 years back. She was para 7. All were full term normal deliveries, 3 alive, 4 died due to some disease. Her last child was 3 years old.

On examination, she was of thin built with typical ovarian cachexia (common to benign and malignant ovarian tumour) weighing 198 lbs., but had no evidence of anaemia. General examination did not reveal any other abnormality. Supraclavicular gland was not enlarged. On abdominal examination, there was undue symmetrical smooth enlargement of abdomen. Varicose veins were present on the surface. On deep palpation, margins of lump could not be defined. Abdomen was tense. On percussion, there was dullness in the centre. There was no tenderness anywhere. No evidence of ascitis was present. Height of tumour from the pubic symphysis was 35" and circumference of abdomen at the level of umbilicus was 47" (Figs. 1 and 2).

On pelvic examination, uterus was normal in size and was felt seperately, cervix was healthy. All fornices were full due to tense cystic tumour.

Routine investigations of urine, blood were normal. Hb was 90%, chest x-ray showed upward displacement of diaphragm on both sides. A clinical diagnosis of cystic benign ovarian tumour was made.

As pre-operative treatment she was advised breathing exercise from the day she was admitted. High bowel wash were given two days before operation.

She was operated on 24th September, 1977 under open ether anaesthesia. But as there was risk of sudden respiratory arrest during operation with such a huge abdominal tumour,

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she was always kept in light plane and respiratory depressant drugs were not used as premedication.

A right paramedian incision from pubic symphysis to xiphisternum was made. After opening the abdomen, the tumour was separated with finger dissection from anterior peritoneum to which it was adherent. As it was not possible to deliver the tumour as such, even with such an incision, it was tapped by making a small opening and fluid content of tumour was drained gradually with sucker up to 28 litres, till the tumour reduced to a size which could be delivered through the abdominal wound. The opening was then closed by artery forceps and tumour was separated from sides and posteriorly. There was slight adhesion of the tumour to the liver, which was separated easily without any injury to the liver. The left ovary and uterus were normal and healthy. The capsule of the tumour was intact and clinical diagnosis of benign ovarian tumour was confirmed on laparotomy. A right-sided salpingo-ovariotomy was done. As desired by the patient, she was sterilized by left sided salpingectomy as well. Plication of round ligament was done to keep the uterus in anteverted position. All the other pelvic and abdominal organs were normal. Redundant abdominal wall was excised. Abdomen was closed in layers.

Postoperative period was uneventful except transient fall of blood pressure immediately after operation, which settled with usual treatment. Stitches were removed on 10th and 12th postoperative day. Patient was weighed again on 10th day of operation. It was 88 lbs.

Wound was healthy but the scar was very ugly due to wrinkling of abdominal wall around the scar, in spite of our best effort of doing a short of plastic surgery (Figs. 3 and 4).

Specimen

Gross appearance — Tumour was grayish in colour, almost round in shape and was cystic in consistancy. The fluid almost looked serous with brownish tinge because of the fact that it had become old, hence typical mucus nature was not present. Exact circumference of the tumour could not be measured because of drainage of fluid from the tumour. Weight of tumour was 48.5 lbs. after removal of 28 litres of fluid. Total weight was 110 lbs.

Cut Section: In cut section it was unilocular containing serous fluid with brownish tinge.

History: Histologically it was benign pseudomucinous cystadenoma (Fig. 5).

After operation she was kept for about a month for observation. She was advised to report again after a month or earlier if she had any trouble but had informed us that she would come to us only when she had symptoms. And as she did not come again, we presume that she has no problem.

Discussion

The object of reporting this case is to emphasize the role of general practitioner who can play important role in guiding and educating such patients of ovarian tumour to attend nearest hospital with facilities of surgical treatment.

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See Figs. on Art Paper XVI-XVII