A PARASITIC OVARIAN DERMOID CYST

(A Case Report)

by

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and

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Introduction

Unilateral agenesis of ovary and fallopian tube is a rare congenital anomaly. The parasitic uterine fibromyoma are now and again repeated in gynaecology. However, a parasitic ovarian tumour is rare. A case of parasitic ovarian benign cystic teratoma drawing its blood supply from vessels in mesentery and omentum is being reported because of its parity.

CASE REPORT

Mrs. K. 21 years old para I was admitted on 7-4-1979 in gynaecologic ward of Medical College Hospital, Rohtak (Haryana) with the complaints of a mass in the abdomen for the last 10 months. The tumour was about 3" x 3" size near the umbilical region. It acquired the present size rapidly to occupy almost whole of the abdominal cavity. There is no history of pain previous to the childbirth. Patient complained of intermittent and severe pain in the abdomen for the last 4 months which was not related to anything. No history of loss of appetite. She had frequency of micturition for the last 4 months. No history of gastrointestinal upsets.

Menstrual History: Menarche at 14 years. Menstrual cycles 3-4/30 regular, moderate, painless. Lactational amenorrhoea for the last 10 months.

General physical examination and systemic examination were normal except that the patient was poorly nourished and anaemic.

On abdominal examination, a well defined swelling, filling almost whole of the abdominal cavity, flanks were also full more so on the left side. The swelling was smooth, tense cystic, non-tender and slightly mobile in both axis, dull on percussion. Lower border of the mass was not reached. There was no evidence of free fluid in the abdominal cavity.

On vaginal examination, cervix pointing forwards, uterus was retroverted, retroflexed normal size. A tense cystic, non-tender mass which was continuous with the abdominal mass, was felt separately in the anterior and both lateral fornices slightly mobile from above downwards more so on the left side. No internal ballotment was present.

A provisional diagnosis of an ovarian cyst was made.

Investigations: Routine blood count and urine were within normal limits. Blood pressure was 120/80 mm/Hg.

Blood urea—20 mg%, blood sugar—60 mg%, blood group—B positive.

Postoperative I.V.P.: Both kidneys showed good excretory function. Double pelvis and double ureter on the right side upto sacroiliac joint, Ureter draining the upper pole was dilated upto sacroiliac joint. No abnormality of pelvis and ureter on left side.

Laparotomy was done on 15-4-1979 under spinal anaesthesia. There was huge ovarian cyst filling almost whole of the abdomen. The tube was stretched enlarged and oedematous on the ovarian tumour with a definite fimbrial end. There were adhesions of the mass with the omentum (Photograph I). Adhesions were separated and the pedicle of the cyst was formed by a portion of the mesentery on the left side.

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The surface of the tumour at places was irregular, lobulated, the consistency varying from cystic to hard at places. Uterus and the right side fallopian tube and ovary were normal but the ovary was slightly enlarged. On the left side fallopian tube and ovary were missing. It was just 1 cm of the left tube, isthmic portion which was attached with it. It appeared as if the meso-ovarium has been snapped off (Photograph II). The cyst was carefully dissected of the mesentery after clamping the blood vessels entering in the pedicle. The pedical was clamped cut and ligated. Nothing was done except peritonizing stump with interrupted catgut suture. Abdomen closed in layers.

Post-operative recovery was uneventful

Gross: 11″ x 9″ lobulated cystic mass at places. There were solid areas. Tumour weight was 4.5 kg.

Cut section: Cyst contained plenty of sebaceous material and hair and few solid areas.

Discussion

Padumbidri (1978) reported one case of parasitic ovarian tumour which was a fibroma of ovary in mesocolon and another case reported by the same author (1978) which was a parasitic dermoid cyst of ovary. The present case is similar to that reported by Padumbidri (1978) because it was parasitic ovarian dermoid cyst.

Summary

An interesting case of parasitic ovarian cystic teratoma is described. The mechanism by which this tumour can become parasitic is explained.

References

1. Padumbidri, V.: J. Obstet. Gynec. India. **28: 117, 1978.**
2. Padumbidri, V.: J. Obstet. Gynec. India. **28: 1154, 1978.**

See Figs. on Art Paper IX