PRIMARY ISOLATED OVARIAN ABSCESS

by

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Introduction

The oophoritis not preceded by salpingitis is rare; its acute stage nearly always subsides, without any ill effect, but occasionally it may develop into ovarian abscess. The infection is contracted from some near source of infection in the pelvis through blood vessels or lymphatics or by a direct peritoneal extension or involing ovary through the corpus luteum, or by a haematogenous spread of infection from some distant infective focus.

CASE REPORT

K, a 20-year-old married woman, gravida 1, para 1, noticed a small lump in the right iliac fossa, when she felt mild pain in the area, 5 months after her uneventful normal delivery and 7 months before her present admission on 10-9-1981. The mild pain has been continuing and the lump had since then gradually increased in size, which on examination appeared to be about 13 cm in diameter, firm in consistency and having a smooth surface. The patient had a scanty flow during the menstrual phase of 3 days in her menstrual cycle of 30 days during the period of last 5 months of the complaints. There was no history of fever, pelvic inflammation, genital instrumentation or any other relevent antecedent. All the routine laboratory investigations had normal findings, except for the blood profile. The total leucocyte count—12000 per cmm of blood, differential count had 51% lymphocytes and ESR—50 mm during first hour.

Taking it to be a case of ovarian tumour, laparotomy was performed. The ovarian mass had a few easily separable adhesions with large intestine, omentum and fimbrial end of normal looking fallopian tube. The ovarian mass and the ipsilateral fallopian tube were removed. The ovarian mass was a rounded cystic structure, 9 cm in diameter. It had a greyish white smooth glistening external surface. The bisection revealed that the cystic mass was uniloculated bounded by 0.5 cm thick wall, and filled with yellowish pus-like thick liquid. The grayish-white cut surface of the wall had yellowish tan in its inner layers, and its internal surface was finely granular. Histologically the serial sections from the wall had shown a uniform pattern of the lesion—a nonspecific chronic inflammatory picture. The inner surface of the wall was granular and necrotic, having a large number of degenerated neutrophils. Next to it there were groups of so-called pseudoxanthomatous cells. The outer most layer was fibrotic encapsulated by tunica albuginea. There were also a large number of lymphocytes, plasma cells and neutrophils in the entire thickness of the wall, mainly in its middle layers. The fimbrial end of the fallopian tube had mild chronic inflammation, the entire endosalpinx was intact.

Summary

The aetiopathogenesis, clinical and morphological findings of a rare entity, the primary isolated ovarian abscess are described.

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See Fig. on Art Paper IX