A MODIFIED TECHNIQUE OF OVARIAN CYSTECTOMY

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SUMMARY

A modified and simple technique of Ovarian cystectomy is described. The technique has been tried with success in more than twenty cases without difficulty.

INTRODUCTION

In unmarried, nulliparous and low parity women, operation on ovary and tube must be carefully planned. Ovarian and tubal conservation in this group of patients is most important, not only for preservation of ovarian function but also for future fertility concern.

But very often, in Benign ovarian cyst and tumour, the operation ends up in an Ovariotomy or salpingo - oophorectomy. These patients might suffer from the problem of ovarian dysfunction, infertility or subfertility in future.

To prevent these problems, the correct operation in this group is ovarian cystectomy or resection of tumour with preservation of healthy portion of ovary and Fallopian tube even when contralateral ovary and tube looks clinically normal.

It is true that in huge ovarian mass, ovarian cystectomy operation is often difficult due to destortion of Anatomy and difficulty in recognition of healthy portion of ovarian tissue due to over stretching. Moreover in conventional technique of ovarian cystectomy, difficulty in dissecting the capsule from underlying thin wall cyst through proper plane of cleavage during separation and mobilisation of tumour, constant oozing of blood from dissected vascular capsule, makes the operation more cumbursome. Also in most occasions during dissection

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in conventional technique the cyst ruptures and soils the operation field.

In fact these difficulties lead the surgeon to complete the operation by more simple technique of ovariotomy specially when the other ovary and tube looks healthy. This tendency of simplification of the operation is to be avoided for future benefit of patients.

TECHNIQUE

Abdomen is opened preferably by low midline incision which help easy approach of tumour. A circumferential pursestring suture is placed at the capsule of the cyst with No. 1 chromic atraumatic catgut about 2"-3" away from the centre of the pedicle which includes the thickened portion of capsule which contains functioning ovarian tissue to be preserved, within the pursestring suture.

Recognition of healthy ovarian tissue is sometimes difficult at this stage of operation when the cyst is too large, but preserving relatively thickened capsule at hilum is enough to keep functioning ovarian tissue. When the tubal conservation is to be considered, the suture must includes the tube and mesosalpinx.

Then by scalpel, a careful circular incision is made over the capsule of the cyst just outside the purstring suture placed. The capsule is then dissected free from underlying thin walled cyst most carefully through proper plane of cleavage with tooth forceps, handle of scalpel and scissor with precaution not to rupture the cyst wall. On mobilisation of cyst from capsule for a short distance and in all direction in a circular fashion, the purstring suture is tried gently. On tying the suture, the remaining portion of the capsule separates by the tension of the tied knot and slips off from the tense cyst wall and also ligates all vascular connections of the tumour at the bottom of the cyst. Thus the cyst freed from preserved ovarian tissue separated by pursestring knot. The cyst is then removed by incising the attachment at the bottom with connecting stump by scalpel or scissor.

One or two separate mattress stitches may be placed to reinforced the pursestring suture or for proper haemostasis.

Prior to cyst dissection, temporary haemostasis may be achieved by a rubber tourniquet or by light ring forceps guarded with rubber or sponge swab, applied at the ovario-pelvic ligament. Care must be taken the Fallopion tube is not included or compressed.

The other ovary and tube is then inspected and abdomen closed in layers.

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