# Removal of an Ovarian Tumour weighing 36 kilograms
# Case Report

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There are difficulties in removing very large abdominal tumours. We are presenting this case of ovarian tunour weighing 36 kgm. to highlight the difficulties encountered in its removal.

A 60 years old female presented with huge abdominal swelling for the last 8 years. The patient was in menopause for the last 7 years. On examination, she had pulse rate of 80 beats/min, blood pressure 126/82mm of Hg, edema feet, a large cystic mass filling the whole abdomen (fig.1).

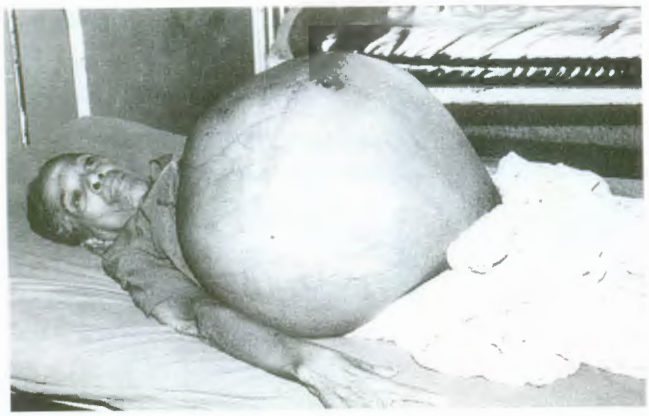

Figure. 1: Preoperative Photograph of the patient

On per rectal and vaginal examinations, the mass was felt and uterus could not be palpated. A clinical diagnosis of ovarian cyst was made. Routine investigations were normal except Hb 9 gm%. Ultrasonogram of abdomen showed an ovarian cyst with internal echoes and hydronephrosis of left kidney. IVP did not show excretion of dye in any film due to large ovarian cyst. Exploratory laparotomy was done under general anaesthesia with transverse supraumbilical incision. Cyst wall was badly adherent to parietal wall and opened accidentally while making the incision. Approximately forty litres of fluid was drained. Cyst was occupying the whole abdomen, from undersurface of the liver to pelvis. Liver, spleen and right kidney were normal. Left kidney was hydronephrotic. Uterus could not be identified. Origin of the feeding vessels arising obliquely from aorta confirmed that it was an ovarian tumour. Cyst wall excised completely except a small piece in the pelvis which could not be separated without doing harm to right ureter. Incision was closed in layers with No.1 prolene with tube drains in both flanks. Blood loss was 300 ml. Surgery lasted 6 hours and 15 minutes. There was marked fall of blood pressure after 5 hours of surgery. For the last one hour blood pressure was not recordable and peripheral pulses were not felt. She was given massive fluid support, three blood transfusions during surgery and put on dopamine drip. She developed arrest while shifting her out of operation theatre. She was revived successfully and shifted to ICU. Ventilatory support was withdrawn after 4 hours. Dopamine drip was continued for 4 days. She developed lung signs on second postoperative day due to fluid overload. It was treated with furosemide and deriphyllin. Drainage tubes were removed on second postoperative day and oral feeding started on third day. She was in ICU for 5 days. She received altogether 6 units of blood transfusion. Wound healed well and she was discharged home (fig.2). There was a difference of 36 Kilograms in weight of the patient before and after surgery. Since we could not remove the tumour intact, we called it a 36 kilo tumour on this ground, which is likely to be more, not less. Histopathology report showed serous cystadenoma of ovary.

Figure.2: Postoperative Photograph at the rate of discharge

The case clearly highlights difficulties encountered in removal of a very large tumour from the abdomen. And one must be prepared to tackle any emergency arising out of it.