A Rare Case of Recurrent Ovarian Cystadenoma

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Mrs. R. B. a 30 yr. old patient was admitted in May 1998 at LTMMC and LTMGH Mumbai with a complaint of abdominal distension which had increased in size since the last six months, with persistent abdominal pain. The patient was a resident of Raipur and had a past H/O being explored for a lump in the abdomen three times earlier in a private hospital at Raipur. The first exploration was done for a huge ovarian cyst for which cystectomy was done. The H/P report was not available. Lump recurred after 8 months for which repeat exploration was done. It turned out to be a gravid uterus, therefore an emergency LSCS was done. The baby was preterm and died after 2 days. The lump recurred after 6 months, was re-explored and a TAH with B/L salphingo-ophorectomy was done. The H/P revealed a cystadenoma with a normal uterus.

At present O/E she was a frail looking woman who looked older than her age of 30 years. P/A revealed a huge mass of about 28 weeks gestation size, with 3 vertical scars on the abdomen. The mass was tense, cystic with restricted mobility. The P/V findings showed a complex mass arising from the left fornix which was non tender, fixed and immobile. Supraclavicular lymph nodes were not palpable. X-ray chest was normal. Routine investigations were found to be normal. Her BUN was raised 65mg% & S. creatinine was 2.5mg%. USG showed a 30x15x18 cms mass in the adnexa showing multiple echoes and septae most probably ovarian in origin with a tentative diagnosis of cystadenocarcinoma. Her Ca 125 was within normal limits. CT scan corresponded with the ultrasonography findings. The IVP report showed hydronephrotic changes in both the kidneys with the mass pressing on both the ureters. A decision to explore the mass was taken with prior percutaneous nephrostomy. A bilateral percutaneous nephrostomy with a nephrogram was done which showed that the left side was blocked with patent right sided percutaneous nephrostomy. Cystoscopy was done and a D J stent was passed on the left side.

On exploration there was a huge mass occupying the abdomen which was smooth walled, with multiple adhesions to the bowels and the bladder and had distorted the anatomy. There was minimal ascitic fluid. The peritoneal washings were sent for cytology. The mass was seen to be arising from the left side. An inadvertent entry was made into the bladder and colon. The mass was removed by separating the adhesions. A part of the colon which was beneath the mass showed signs of non-viability and hence resection anastomosis with a terminal colostomy was done. The bladder was sutured in 2 layers. Tension sutures were taken for the abdomen. The patient was put on Inj Cefotaxime, Inj Amikacin & Inj Metronidazole. The entire surgery lasted for nearly 6 hours and she was transfused with 5 units of blood. The patient stood the surgery well. The post operative period was uneventful. Colostomy closure was done after 6 weeks after a normal cologram. The cytology report was normal. The H/P report showed it to be a cystadenoma with gangrenous changes in the bowel. The patient went home after 8 weeks of hospitalisation. The patient was discharged on conjugated equine estrogen and calcium. The mass has not recurred since then.

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