Cause of Secondary Infertility – Bilateral Dermoid Cyst

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A 28 years old woman was admitted in Malhotra Nursing and Maternity Home, Agra with chief complaint of secondary infertility of 5 years duration on 2.9.99. She also complained only of dysmenorrhoea, lower abdominal pain and backache off and on.

Menstrual History

Menarche – 14 years

After Menarche menstrual cycle for first 9 years was of 2-3 days/28 days, regular, normal flow but with dysmenorrhoea.

For the last 5 years – scanty menses of 1-2 days with spotting/30-35 days with dysmenorrhoea, LMP-5 days ago.

Obstetric History

Married for 7 years. She had a full term normal female baby 5 years ago.

Past History

Not significant

Personal History

Vegetarian, non smoker, educated belonging to high socio-economic status.

Family History

No history of ovarian cyst or of infertility in maternal or paternal side.

General and Systemic Examination

Average built, not anaemic, no obvious lymphadenopathy, general condition good, thyroid not palpable, no pedal oedema.

Lungs clear

Pulse – 88/mt, regular, good in volume

Heart – S_1S_2 normal. No murmer. BP – 130/80 mm Hg
P/A No distention
Liver spleen – Not enlarged
No ascitis/No lump or tenderness felt

Investigations
Hb – 10.4 gm%
TLC – 9800
DLC – $P_{62}L_{32}E1$
Urine < R Nil
M/E
B. Sugar ® - 79 mg%
HIV – Negative
Hbs Ag – Negative
ABO-Rh – A +ve
X-ray chest – NAD
EKG – WNL

Gynaecological Examination

Normal Cervix and vagina

P/v – ut. Anteverted, normal size, normal mobility, B/L Fornices clear with no tenderness

Sonosalpingography – Bilateral patent tubes.

USG – Normal uterus with normal endometrial canal on sonohysterography. Both ovaries were enlarged

and each contained a small hyperechoic mass, 1.6 x 1.6 cm in the right ovary and 2.5 x 2.5 cm. in the left ovary. (Fig 1 & 2)

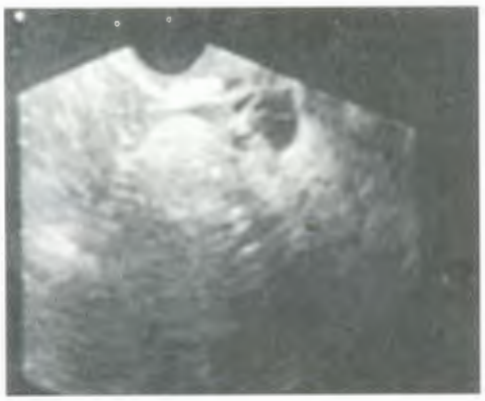

Fig 1: Mass left ovary (TVS)

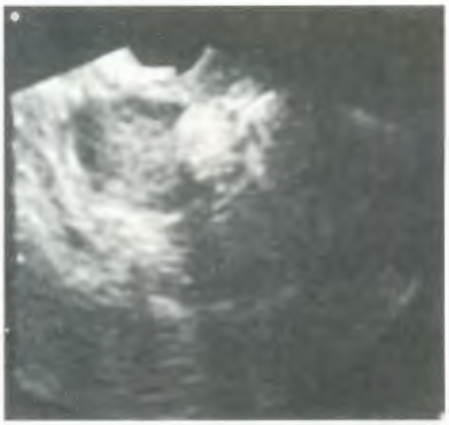

Fig 2: Mass in Right ovary (TVS)

There was no follicular activity

X-ray lumbar spine – NAD

MRI – Lobulated space occupying lesion (SOL) in the left ovary suggestive of lipomatous tissue. Local lesion in the right ovary of hypo to hyper – intensity on T_1 and T_2 weighted sequences. (Fig 3)

A diagnosis of Bilateral ovarian dermoids was made.

Operative laparoscopy was done on 28.9.99 which confirmed bilateral ovarian dermoid cysts. Bilateral cystectomy was done laparoscopically and sent for histopathological examination.

Histopathological Examination

Confirmed bilateral ovarian dermoid cyst. (Fig 4 & 5)

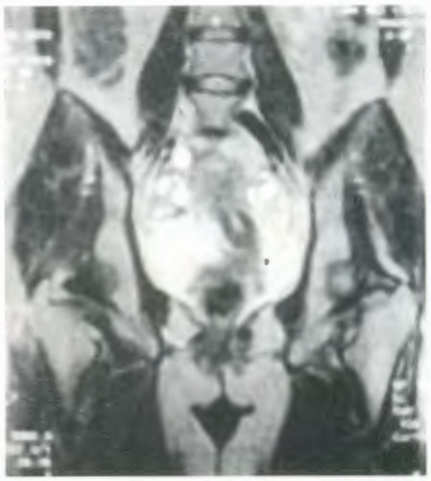

Fig 3: M.R.I. (Bilateral Mass)

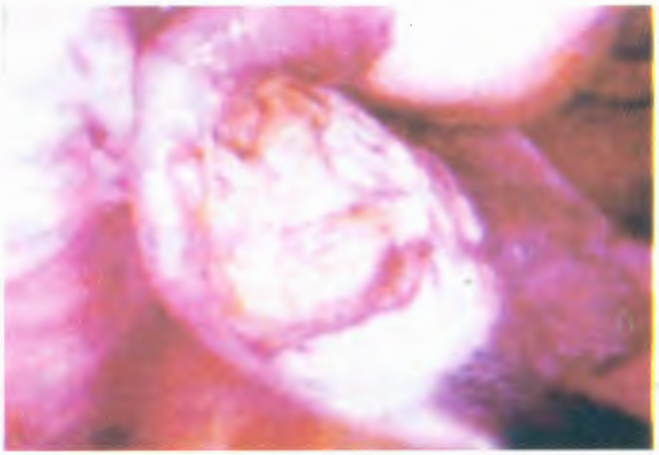

Fig 4: Left Ovarian Dermoid

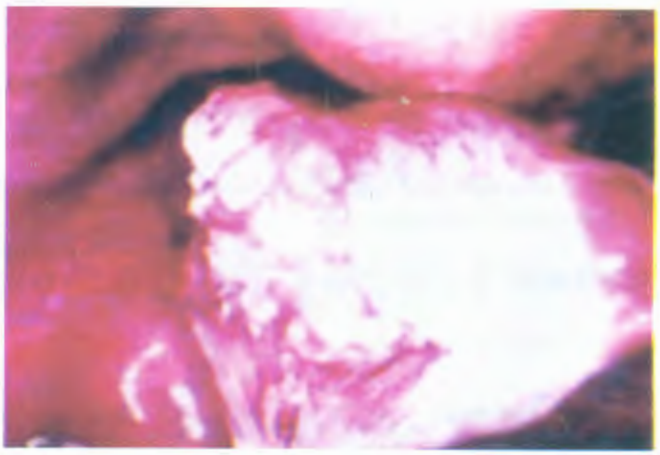

Fig 5: Right Ovarian Dermoid

Follow up – The patient is coming for follow up, she is having regular periods of normal flow and the latest ultrasound report shows –

Normal uterus with normal endometrium

Bilateral normal ovaries with follicular activity.

Discussion

Complex ovarian masses that contain both cystic and solid components are mostly dermoid cysts. The cysts are usually solitary, spherical or ovoid and on ultrasound echogenic. They contain a solid area of hair and calcified material along with 'buttery' sebum which tends to layer anteriorly due to its lower specific gravity. This is a good sonographic sign. Ultrasound (TVS) is the modality of choice of diagnosis and has 84% sensitivity and 90% specificity. Infertility in such cases is due to ovulatory disturbances and the method of choice for treatment is laproscopic cystectomy. Prognosis of subsequent fertility is very good.