Case Report

A Case of Pseudocyst

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A case of 35 years old lady who presented with pain abdomen. On examination a large cyst identified. Loaparotomy was done and cyst was excised. H/P showed pseudo cyst. The post operative recovery was uneventful and the patient recovered fully.

Key Words: Cyst, laparotomy

Cysts are fluid filled cavities lined by epithelium. The incidence of ovarian cysts varies between 2.7% in various studies. Cysts can be benign or malignant. By far the incidence of benign cysts is much higher[1]. Presence of loculi, septations or solid areas point to possibility of malignancy, during reproductive age groups[2], small follicular cysts are a chance finding on ultrasonography[3].

Eighty to eighty five percent cysts are benign. . Pain, torsion and rupture of cyst usually require emergency management. Laparotomy is carried out when haemoperitoneum is present[4].

Conservative or laparoscopic management is not an option when complications like rupture, torsion or pain occurs.

Ultrasonographic cyst aspiration may be carried out but this does not yield histopathology specimen for analysis.

Pain, torsion and rupture of cyst are features suggestive of malignancy and require laparotomy. Sometimes ultrasonographically guided cyst aspiration may be carried out but this does not yield H/P specimen for analysis.

Case Report:

Mrs. G.J., P_4 married for the last 17 years presented to out patient department with complain of pain in the right iliac fossa for the last 1½ months. The pain was gradual in onset, radiating to any site and was not associated with intake of food. The pain was relieved temporarily by intake of analgesics.

There was no associated urinary or bowel complaints, no vaginal discharge or dysparunea was present.

The patient had had four c-sections, all for cephalo pelvic disproportion. During her fourth section uterine atony was seen and sub-total hysterectomy was carried out 6 years ago.

The patient was not addicted to any drug and there was no significant past medical history. The age of menarche was 14 years and she had surgical menopause 6 years ago. Cervical smear was never done.

Clinical examination revealed protuberant abdomen with pfennensteil scar, central inverted umbilical and no visceromegaly. Tenderness was felt in the right iliac fossa on deep palpation. Pelvic examination rendered atrophic but healthy looking cervix. A cystic mass of 6x5cm was felt in the right fomix which was tender on bimanual examination left fomix was clear.

On examination:

Rectal examination showed normal tone of anal sphincter; rectal mucosa was intact. A mass is felt but origin of the mass could not be determined. The investigations carried out showed a haemoglobin level of 12.7gm/dl, random blood sugar level of 105gm/dl, serum creatinine of 0.9mg/dl. The liver function tests were normal and patient's hepatitis B surface antigen was positive.

Rectal examination showed that there was no palpable mass in the pouch of Douglas. Ultrasound examination revealed uterine stump and a 8x10cm cyst with no septations or debris in right adnexal region. Left ovary was not visualized. A diagnosis of right ovarian cyst was made and laparotomy was planned.

The operation was performed under general anaesthesia. Abdomen was opened by excising the previous pfennensteil scar, adhesions were seen to be present between uterine stump and the cyst. An 8x10 cystic swelling was seen in the right adnexal region. No ovarian tissue could be identified on the right side. Left ovary was not visualized. The swelling was anteriorly adherent to the bladder while posteriorly it was adherent to the small intestine. Straw coloured fluid was aspirated from the cyst and sent for cytology. The cyst wall was excised and sent for histopathology. Abdomen was closed in layers. Postoperative recovery was uneventful and patient was discharged on 10th postoperative day.

Histopathology confirmed the diagnosis of pseudocyst??

Discussion:

Cysts are cavities lined by epithelium. A pseudocyst is a fluid filled cavity which is not actually lined by continuous epithelium. Usually pseudocysts are seen in the pancreas. Rarely a pseudocyst may be present in the abdominal cavity. It appears like an ovarian cyst and is lined by peritoneum. Clinically it is very difficult to classify or label a cyst as a "pseudo cyst".

The management of such a pseudo cyst has a very low incidence 0.01% approximately. Due to repeated surgeries and adhesion formation an area gets walled off

by peritoneum and gradually grows in size, becoming fluid filled and thus forming a pseudo cyst.

References:

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