Large complex ovarian cyst managed by laparoscopy

Dipak J. Limbachiya, Ankit Chaudhari, Grishma P. Agrawal*

INTRODUCTION

Large ovarian cyst and accumulation of pus inside, is an uncommon condition but its prompt diagnosis and management is vital. It can be a functional cyst like follicular cyst, corpus luteum cyst, theca lutein cyst, chocolate cyst or it can be a neoplastic one. Symptomatic patients commonly present with abdominal pain, although most of the patients are asymptomatic and the cysts were found accidently by bimanual examination or ultrasound. Pain can present as dull ache or pain in the lower back or abdomen. Sometimes patients present with prolonged infertility and a huge ovarian cyst is an accidental finding. Acute severe pain can occur in complicated ovarian cysts, torsion, infarction, or hemorrhage. Torsion of cyst, infection and adhesion formation are rare presentations but have increased morbidity.

Any evaluation of a patient with an ovarian cyst should include an abdominal and pelvic examination including a bimanual pelvic examination. Treatment depends on combination of clinical, bio chemical markers like CA-125 as well as sonography findings. If cyst seems to be infected then FNAC and culture sensitivity are also useful.

CASE REPORT

A 27 years old patient, nulligravida presented with complaint of dull pain in lower abdomen with moderate intensity, relieved intermittently by taking analgesics along with low grade fever on and off since six months. She also complained of continuous episodes of vomiting since two days bilious in nature but small in amount. Her menstrual cycle was normal. She had primary infertility of ten years. She had no significant past history.

Her ultrasonography suggested $12 \times 10^6$ cm sized cystic lesion with low level internal echoes with septa in Pouch of Douglas. Left ovary was not visualised separately. Another $7 \times 6$ cm sized haemorrhagic cyst was seen adjacent to it. Uterus and right ovary were normal. Her CA-125 was 13.73. Blood reports showed thrombocytosis. Rest other investigations were normal. Patient was taken for laparoscopy. Intra operatively, there was a large left ovarian cyst adherent to the rectum and omentum, due to pressure effect, there was left hydro
ureter. Right ovary and uterus were normal. Left oophorectomy was done and the cyst was sent for frozen section.

**Figure 1: Specimen of removed ovarian cyst.**

After removal of the cyst. Patient needed antibiotics according to the sensitivity of organism cultured from pus. Ovarian mass >6 cm in diameter needs visualization with laparoscopy or exploratory laparotomy. In a systematic review, that included six randomized controlled trials comparing the laparoscopic approach to laparotomy for ovarian cysts has shown reduced febrile morbidity, less postoperative pain, lower rates of postoperative complications, earlier discharge from hospital and lower overall cost. Some surgeons limited laparoscopic surgery to ovarian cyst of size less than 10 cm. For apparently benign, extremely large ovarian cysts, only few surgeons advocate laparoscopic management. Intra operative frozen biopsy helps to complete extensive surgery in a single sitting if any malignant potential of the cyst is found. Patient can resume her normal lifestyle earlier as compared to open surgery.

**CONCLUSION**

Large ovarian cyst can be removed by different ways according to the factors like expertise of surgeon, fertility of patient, pre-operative reports and availability of instruments. But the best way is to remove it by minimal invasive techniques and intra operative frozen biopsy. It prevents unnecessary repeat surgery and helps in radical cure if required in a single sitting.

**Funding:** No funding sources  
**Conflict of interest:** None declared  
**Ethical approval:** Not required

**REFERENCES**
