CASE REPORT

Removal of Large 7.6 kg Conjoined Ovarian Tumors Vaginally

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Case Report

A 32-year female, unmarried, presented herself in the emergency ward of our hospital with the complaint of severe pain in abdomen for a day against a backdrop of dull aching lower abdominal pain of 1-month duration. She had gained 5 kg in 1 month. There was no significant past and family history. General physical examination was unremarkable. On abdominal examination, a mass corresponding to 32–34 weeks uterus was palpable on the right side contiguous with a 20 week's mass on the left side. Routine blood investigations were normal.

CT of whole abdomen revealed a well-defined encapsulated multiloculated lesion on the left side of the abdomen and pelvis, measuring approx 16.5 cm × 10.8 cm × 9.6 cm (Fig. 1a). Another well-defined multiloculated cystic lesion was seen on the right side of abdomen and pelvis, measuring 27.4 cm × 14.4 cm × 10.4 cm (Fig. 1a) with multiple, irregular, thick, and thin enhancing septae within it, adjoining this mass.

Tumor Markers were Normal

After a fully informed counseling session with the patients and her parents, the patient was taken up for examination under anesthesia and decision for vaginal ovarian cystectomy was undertaken. The mass was fixed by abdominal pressure. A colpotomy was performed and the pouch of Douglas entered. The lower parts of both the uterosacrals were incised at the medial attachment to the posterior aspect of the cervix. Under vision, a laparoscopic needle was used to puncture the cyst, and the cyst was held with Kocher's forceps and fixed with a silk stitch. A small incision made, and clear mucinous fluid was drained. Other part of the cyst was entered, and about 500 cm³ of sebaceous material with hair was removed. The cyst wall at the puncture site was enlarged with scissors. One of the cysts had solid contents in it. Contents of the ovarian cyst were removed piecemeal, and the residual cyst was exteriorized through the vagina. Clamp was applied at the ovarian ligament, and meso-ovarian tissue and the ovary were separated from the tube.

Total weight of the specimen was 7.6 kg (1.1 kg solid contents and 6.5 kg fluid) (Fig. 1b). Uterosacrals were reapproximated to the posterior surface of the cervix. Colpotomy scar was closed. Blood loss was 100 ml. In the postoperative period, patient was comfortable. The following morning she mobilized easily. She was discharged after 56 h. The histopathology confirmed a dermoid cystic tumor and a mucinous cyst adenoma of the left ovary.

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Fig. 1 **a** CT scan report showing large and small conjoined tumor masses from the left ovary seen filling almost the entire pelvic and abdominal cavity. **b** Solid components of the tumor masses removed weighing 1.1 kg

Discussion

This approach allows for direct visual approach to the organs being treated; surgical trauma to the bowel and other pelvic viscera is limited, with no spillage into the peritoneal cavity. The absence of an abdominal scar not only allows for a rapid postoperative recovery being least immunotraumatic to the body, but also, of course, offers a cosmetic advantage.

Massi et al. [1] operated 54 patients of benign adnexal masses by vaginal route and found it to be a useful and cost effective approach for the treatment of selected cases of adnexal masses. Shirish S. Sheth [2] reported his experience of managing ovarian dermoids via the vaginal route. A series of 26 cases were managed with or without hysterectomy, and the vaginal approach was found to be successful in all patients.

Conclusion

The adoption of transvaginal approach for removal of ovarian masses reduces intraoperative blood loss, decreases operative time, reduces chances of intraperitoneal spill, is cosmetically well acceptable, is less immunotraumatic to the patient, and assures excellent postoperative recovery.

References

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