

LAPAROSCOPIC MANAGEMENT OF A LARGE OVARIAN CYST: A CASE REPORT

INTRODUCTION

Laparoscopy is the gold standard in the treatment of benign adnexal masses. Generally, laparotomy is preferred to manage a large cyst due to the chance of malignancy and space constraints.

Here we report a case of a huge ovarian cyst that was managed laparoscopically.

CASE REPORT

We present a case of a 31-year-old female with an Ovarian Cyst. She had noticed a gradual enlargement of her abdomen and increasing weight 2 years ago. At the time of presentation, her MRI report showed a massive ovarian cyst that filled her entire omen. It was measured at 22.48 cm in height, 18.92 cm in the transverse axis at the level of the umbilicus, and 8.03 cm anteroposteriorly. It was a unilocular cyst with normal CA125 (12.3 miu/l). There was a small fibroid 2cm to 3cm in the posterior wall of the uterus, otherwise unremarkable pelvic organs. Considering her clinical presentation, it was managed laparoscopically with the reconstruction of the ovary. The open technique (Hasson's) was used for entry. The site was the midpoint between the umbilicus and the xiphisternum (Lee Huang.).

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After entering into the peritoneal cavity the cyst wall was separated from the anterior abdominal wall using blind discretion with a finger. The attempt to inflate the peritoneum with gas was not successful as the abdomen had already distended. Then using the Verrus needle the cyst content was tested by a 10cc syringe, after confirming it was serous the cyst was drained. The same entry site was used for the 10mm main troche and sealed with a Ligaclip followed by routine cystectomy and reconstruction of the ovary.

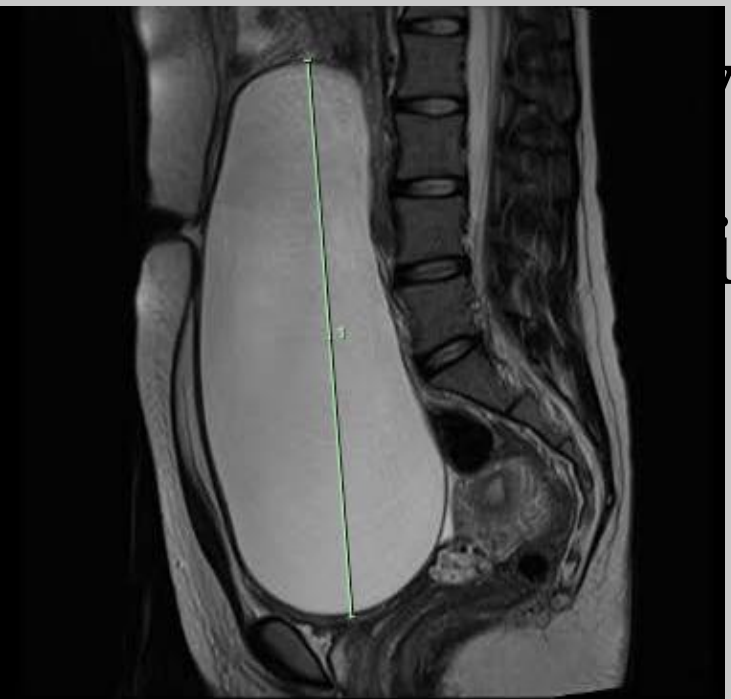


Figure 1:sagittal view of MRI Abdomen

DISCUSSION

Performing laparoscopy for a huge ovarian cyst is a challenging task. Generally, a mass of more than 24 weeks size gravid uterus is managed by laparotomy. However, considering the age, patient’s fertility wishes, benign characteristics noted in the imaging and tumor markers, and cosmetic reasons the decision was to perform a laparoscopy which is the best treatment with the least morbidity and minimum scar.

In this type of patient, the critical step is the safe entry and inducing pneumoperitoneum. Accordingly, the concept of non-umbilical entry is used to avoid catastrophic complications which could be associated with the first blind umbilical entry. Looking at these recent guidelines, we fall in a safe zone to use the non-umbilical entry technique universally in all patients. In our case, we have combined 2 techniques highlighted in the literature to decompress the cyst: draining the cyst via a Veress needle similar to the method used by Nagele & Magos (1996) and laparoscopically aspirating the cyst using the open Hasson's technique for trocar insertion as done by Thakur et al (2018) [9].

Laparoscopic surgery has replaced most open surgeries recently because of its better magnification, reduced invasiveness, and shorter hospitalization.

It is considered the gold standard treatment for small to moderate-size ovarian cysts, but when confronted with extremely large and apparently benign cysts, only a few surgeons advocate laparoscopic management due to technical difficulties like space constraints, risk of cyst rupture and spillage of cyst content to the peritoneal cavity

CONCLUSION

No consensus for the size limitations of ovarian cysts is decided to be a contraindication for laparoscopic management to date. Thus, a combination of different techniques and meticulous surgical approaches would help to manage complicated cases like this.

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