

## A RARE CASE OF A HUGE OVARIAN CYST OPERATED DURING CAESAREAN SECTION

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### ABSTRACT

#### BACKGROUND

A 22-year-old Gravida 4, Para 2, Living 2, MTP 1, previous 2 lower segment caesarean sections with 36 weeks of gestation presented with scar tenderness. An emergency lower segment caesarean section was performed. A huge ovarian cyst was found during lower segment caesarean section which was successfully excised. The patient had good fetomaternal outcome.

#### KEYWORDS

Ovarian Cyst, Caesarean Section, Torsion of Cyst, Adnexal Mass, Cystectomy, Malignancy.

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#### INTRODUCTION

The frequency of ovarian cysts in pregnancy is reported to be 1 in 1000 pregnancies.<sup>1</sup> Malignant ovarian cysts in pregnancy are rare the frequency of which is about 1 in 15,000 to 32,000 pregnancies.<sup>2</sup> Corpus luteum cyst and benign cystic teratoma contribute to two-thirds of the cases. Corpus luteal cysts are usually less than 3 cm in diameter and resolves spontaneously. Ovarian cysts with diameter greater than 6 cm which persist or enlarge beyond 16 weeks gestation, are at risk of complications and need tissue diagnosis and, therefore, surgical evaluation.

#### CASE REPORT

A 22-year-old gravida 4, para 2, living 2, MTP 1, with previous two lower segment caesarean sections with 36 weeks of gestation presented to tertiary care hospital with scar tenderness. Patient was registered at a tertiary care hospital for antenatal care. Routine obstetric ultrasound examination failed to reveal presence of any concomitant ovarian cyst. A 2.8 kg male child with good Apgar score was delivered by emergency lower segment caesarean section. While doing tubal ligation a left sided twisted ovarian cyst of 20 x 18 x 10 cm size was found (Figure No. 1, 2 and 4). Ovarian cyst was exteriorized. There was no evidence of gangrene or haemorrhage within the cyst. 1.5 litres of cyst fluid was aspirated and sent for cytological examination. Cyst wall was separated from surrounding ovarian tissue completely and sent for histopathological examination. Ovarian reconstruction was done. Right ovary was normal in size with multiple follicles (Figure No. 3). Post-operative course was uneventful. Histopathology report was suggestive of mucinous cystadenoma of ovary.

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**Fig. 1: Left Sided Huge Ovarian Cyst Measuring 20x18x10cm**



**Fig. 2: Postpartum Uterus with**

**Left Sided Ovarian Cyst****Fig. 3: Right Ovary with Multiple Follicles****Fig. 4: Twisted Left Ovarian Cyst****DISCUSSION**

Adnexal masses in pregnancy are managed ideally in the second trimester after organogenesis is completed, thereby decreasing the risk of fetal loss. Spontaneous regression of the mass may occur during the first trimester.<sup>3</sup> in our case, the patient was asymptomatic and the cyst was not diagnosed during second trimester.

She required emergency caesarean section for obstetric indication and cystectomy was performed successfully during the caesarean section.

The management of an ovarian mass in pregnancy has always put obstetricians in great dilemma. Undiagnosed malignancy, torsion, infection, rupture, haemorrhage and obstruction of labour are known complications of a persistent ovarian cyst.<sup>4,5</sup> Emergency surgery may be required for these complications. Emergency surgeries may cause a higher risk of foetal loss as compared with elective surgeries. Obstruction of labour may arise in 17% to 21% of these cases further complicating the delivery. Various treatment modalities of ovarian cysts during pregnancy include procedures ranging from aspiration of the cyst to oophorectomy.

**CONCLUSION**

Ovarian cyst if diagnosed early should be operated in the second trimester. However, if a cyst is diagnosed late in pregnancy and if Caesarean section is indicated for maternal or foetal cause, then ovarian cystectomy can be done during Caesarean section with good foetomaternal outcome. Further operative procedures and the risks associated with persistence of cyst like torsion and haemorrhage can thus be prevented.

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