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A COMPLICATED CASE REPORT OF OVARIAN CYSTECTOMY WITH STENTING IN BILATERAL RENAL CALCULI WITH OVARIAN CYST PATIENT

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Abstract: Ovarian cyst is a common reproductive age of women problems and it is the fourth most common problem in India. It can be divided into two. They are physiological cyst and pathological cyst. Follicular and luteal cyst are physiological cysts and ovarian tumours are pathological cysts. The cause of ovarian cyst is unknown. An ovarian cyst is diagnosed with histopathological studies, blood reports, Sonography, magnetic resonance imaging (MRI), computed tomography (CT), CA-125 report, transvaginal ultrasound, ultrasonography, clinical examinations and endocystic markers. The management of ovarian cyst is laparotomy and laproscopic procedures. The ovarian cystectomy/ oophorectomy is performed by laproscopy with less postoperative pain than laparotomy. The common operative complications of laproscopic ovarian cystectomy such as visceral damage, transfusion rate, infection, thromboembolism, and perioperative mortality. A case report of 48 years old female patient admitted in the emergency department had an loin pain for one week and abdominal pain for 1 ½ years with difficulty of micturition. The physician diagnosed the patient had ovarian cyst with bilateral renal calculi. So the physician recommended the patient to do procedure of laproscopic right ovarian cystectomy with stenting. Multiple complications treated the disease in one patient was very challengable to the physicians. Further investigations and the patient recovery details are briefly explained in this case report.

Index Terms **- Ovarian cyst, Bilateral renal calculi, VUJ calculi, Cystectomy.**

I. INTRODUCTION

An ovarian cyst is a common gynaecological problem and fourth most common cyst in India. It can be affect most commonly in pre and postmenopausal women (1). The prevalence of ovarian cyst women with using contraceptives was lower than women using no contraceptives or intrauterine contraceptive devices (6). It falls into two basic categories: Physiological and pathological. Follicle and luteal cysts are examples of physiological cysts. Ovarian tumours are pathological cysts which can be kind of benign, malignant or borderline. Malignant tumors are more common in older females, although benign tumors are more common in younger girls. Ovarian cysts are mostly asymptomatic and disappear spontaneously. If ovarian cyst size is large, it may cause abdominal discomfort. If cyst may press the bladder may cause frequent urination (1).

The ovarian cyst may cause menstrual irregularities, pain and rare intraperitoneal bleeding. Ovarian cyst can be diagnosed with histopathological studies and other imaging studies. The cyst can be described in simple cyst walls, small in size, and rarely bilateral (3). The frequent use of transvaginal ultrasound (TVU) can be used to detect the simple ovarian cysts among postmenopausal women (4). In effective diagnosis of transvaginal ultrasound is contact initial to women can cause pelvic pain (5). Ultrasonography is used for symptom- free, or identify the silent cysts in 3-7% of the population. Many physicians suggested the diagnosis of ovarian cyst is clinical examinations, ultrasonography and a study of blood reports and endocystic markers (9).

Laproscopy is the gold standard surgical procedure to manage benign ovarian cysts. Benefits may include reduced postoperative analgesic requirement, earlier mobilization, reduce changes of deep venous thrombosis (DVT), earlier discharge from the hospital and return to normal activity (2). In this technique, most of the surgeons handled by so called stripping technique. Two grasping forceps are used to pull the cyst wall and ovarian parenchyma in opposite direction to develop the cleavage plane. Using CO_2 laser or bipolar forceps, hemostasis is determined by following removal of cystic wall. The ovarian margins are allowed to heal naturally by secondary intention, and the remaining ovarian tissue is not sutured (7). Previous studies suggested the ultrasound- guided cyst puncture was safe (10). Many studies have been increasing the power of management for ovarian cyst, because expectant management have same effectiveness as hormonal management (8).

II. CASE DESCRIPTION

A 48 years old female admitted in the emergency department with the complaints of right loin pain for one week and lower abdominal pain for 1 ½ years with difficulty of micturition. The patient had past medical history of hypertension and hypothyroidism for 6 years, LSCS done on 26 years back and hysterectomy done on 14 years back. The past medication history of Tab. Amlokind (Amlodipine) 5 mg and Tab. Thyronorm (Thyroxine sodium) 100 mcg should be taken. On vital signs, blood pressure was increased. On laboratory investigations, serum eGFR and PDW levels are decreased. Total bilirubin, indirect bilirubin and serum chloride levels are increased. CA-125 test was normal. On CT whole abdomen report shows that mild hydroureteronephrosis, 2 middle ureteric calculi of each measuring 7 mm, VUJ calculus seen, Bilateral renal calculi, large unilocular cystic mass lesion seen in the right ovary and it measures about 9.5 X 7.0 cms features of right ovarian cyst, hepatomegaly with fatty changes. On physical examination patient was conscious, oriented and afebrile.

III. TREATMENT

From the above investigation, the physician suggested to do surgical procedure of laproscopic right ovarian cystectomy with stenting. It is a minimally invasive technique used to remove the cyst in ovary. At procedure patient should be placed in lithotomy position and uterine manipulator was placed. 5mm port is inserted on the patient right side and the port is placed 1cm lateral to the surface of McBurney's point- one third of the way between the anterior superior iliac spine (ASIS) and umbilicus. Port sites may vary depending on size of the cyst, previous surgeries and surgeon preference. Two 5mm ports are placed. one on the right side and the other in the high- suprapubic position. Once the cyst had identified, the ovary can be repaired. The bilateral renal calculi should be repaired in same procedure of laproscopic and to remove the calculi and placed stent in bilateral. After the procedure patient have pain. So the physician suggested to give the medications of Inj. Cefixime 1.5gm IV BD, Inj. Pantoprazole 40mg, Inj. Ondansetron 4mg IV BD, Inj. Cefotaxim 1gm IV BD should be given. If pain occurs Inj. Drotaverine hydrochloride should be given. If fever may occur Inj Isopar (paravetamol) IV should be given. After 2 days of surgical procedure patient was discharged to given the medications of Tab. Cefixime 200mg BD, Tab. Ranitidine 150mg BD B/F, Tab. Paracetamol 650mg BD, Tab. Tamsulosin hydrochloride 0.2mg BD should be given for 15 days. The physician informed the patient after 15 days stent should be removed. If any other complications related to the medications or whether any symptoms may occur, consult the physician immediately.

IV. CASE DISCUSSION

Many case reports, review articles are reported about the ovarian cysts and renal calculi. But in this study have been identified the multiple calculi with ovarian cyst in one patient to do challenging task of surgical procedure of Laproscopic ovarian cystectomy with stenting. Already patient known case of hypertension and hypothyroidism for 6 years on regular treatment so in this case was very complicated to do the surgical procedures to the physicians.

V. CONCLUSION

In future studies, in this case report is very useful to the physicians and other health care professionals. Many complications to treat the disease in one patient is very challengeable to the physicians. Future clinical trials can be used to manage the ovarian cyst and to recover the patient health. People should educate the cause of ovarian cyst and to prevent the further complications. We the health care professionals to aware the ovarian cyst causes, risk factors, how to manage the ovarian cyst, and prevention. In this awareness will be very useful for many women to make them prevent from this type of disease.

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