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Case Study Of Huge Abdominal Lump And Its Management

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Abstract-

Abdominal lumps in women can present a diagnostic challenge due to a wide range of possible etiologies. Ovarian cysts, although common, may rarely attain enormous sizes and present as huge abdominal masses, mimicking other intra-abdominal or retroperitoneal pathologies.In this case we report a case of a woman who presented with a progressively enlarging abdominal lump associated with abdominal distension and discomfort. Clinical examination revealed a large, non-tender abdominal mass occupying most of the abdomen.

Keywords - Abdominal Lump , Cystadenocarcinoma , Laparotomy, Ovarian Mass

Introduction-

Abdominal lumps in women are a common clinical presentation and may arise from a variety of gynecological and non-gynecological causes. The differential diagnosis includes uterine fibroids, ascites, gastrointestinal tumors, retroperitoneal masses, and ovarian pathologies. Among these, ovarian cysts are frequently encountered in routine gynecological practice; however, they are usually detected at an early stage due to widespread use of ultrasonography and other imaging modalities.

Occasionally, ovarian cysts may grow to an exceptionally large size, occupying most of the abdominal cavity and presenting as a huge abdominal lump. Such giant ovarian cysts are now rarely seen, particularly in developed healthcare settings, but they continue to pose significant diagnostic and therapeutic challenges. Their slow and often asymptomatic growth allows them to remain undetected until they cause marked abdominal distension, pressure symptoms, or cosmetic concerns. In some cases, preoperative clinical and radiological evaluation may not clearly identify the ovarian origin of the mass, leading to diagnostic uncertainty.

Surgical exploration remains both a diagnostic and therapeutic approach in such presentations. Definitive diagnosis is often established intraoperatively and confirmed by histopathological examination. This report highlights a case of a huge abdominal lump that was ultimately diagnosed as a giant ovarian cyst after surgery, emphasizing the importance of considering ovarian cysts in the differential diagnosis of large abdominal masses in women and discussing the clinical challenges associated with their management.

Case presentation- Chief Complaints-

A 45 years old female patient visited OPD of our hospital for abdominal distension, pain in abdomen at suprapubic and B/L lumbar region , nausea since 6 months.

History of present illness-

Approximately since 6 months the patient has pain in abdomen at suprapubic and B/ L lumbar region, nausea . For which she visited our OPD for immediate surgical intervention.

History of past illness-

Other than the present complaints, the patient had surgical history of two LSCS and Laparoscopic TL with no any Known Medical history.

Laboratory examinations-

Hb- 13.9 gm/dl

WBC- 7548/cmm

Plat- 2.54 lakh/cmm

Sr Creat- 0.72 mg/dl

Ca 125 - 99.3 U/ml

Imaging Examination-

USG (Abdo + Pelvis)

Huge cystic mass with internal septae as well as solid mural nodules is

seen in abdomen and pelvis. Its organ of origin is difficult to determine,

however possibility of ovarian origin is very likely.

CT (Abdo + Pelvis)

- The multiphasic CECT study reveal a large pelvico-abdominal complex cystic lesion arising from the right adnexa, likely ovarian as described above.Bulky cystic left ovary is also noted.
- These findings require correlation with CA125 levels to rule out ovarian neoplastic lesions.
- Mass effect with displacement of the pelvic organs and bowel loops, as described above.

A double moiety in the right kidney with fullness of right PC systems due to lower ureteric compression

- No other significant abnormality.

Final Diagnosis-

Physical , Laboratory and Imaging findings indicated the huge abdominal lump ? Ovarian mass

Treatment-

After diagnosing, intravenously administered antibiotics- Inj Cefuroxime 1.5 gm IV BD, Inj Metronidazole 500mg IV TDS , Inj Pantoprazole 40 mg IV BD

Exploratory Laparotomy with Panhysterectomy was performed.

Position - Supine

Anaesthesia - General Anaesthesia

Procedure

-A midline vertical incision taken 5cm below from Xiphisternum upto the suprapubic region

-Abdomen opened layer wise i.e. skin, superficial fascia, deep fascia, rectus sheath, rectus muscle, peritoneum. Once the abdomen is opened, the pelvic pathology is carefully evaluated and the abdomen explored.

-After the abdomen has been explored, A huge Right sided ovarian mass identified , slight Trendelenburg position given.

-The round ligaments and utero-ovarian ligaments are grasped on each side with a Kocher clamp, elevating the uterus out of the pelvis.

-Paired clamp are placed in infundibulo-pelvic ligament. A window is created in broad ligament medial to IP ligament, tissues in between cut and transfixed using Vicryl 1.0 .

-Paired clamp placed on uterine artery at the level of internal os. Ligament ,tissues in between cut and transfixed using Vicryl 1.0 .

-Uterus pulled forward to make uterosacral ligament prominent. Clamp placed over uterosacral ligaments close to cervix, ligamets cut.The peritoneum in between ligament dissected down. And clamps replaced by sutures.clamps are placed close to cervix on paracervical tissue containing cervical artery, cut and transfixed.

-Whole Uterus , B/L ovaries with Right ovarian mass and B/L salpinx removed from abdomen.

-Edges of vaginal vault are grasped with allis forceps and vault closed using Vicryl 1.0 .

-Both the ureters traced and no evidence of Hydronephrosis / Pyonephrosis found.

-Haemostasis achieved.

-Wash with Normal Saline given.

-ADK drain no. 28 placed in pelvis and drain fixed using Mersilk 1.0

-Peritoneum, rectus muscle, rectus sheath closed using Loop Ethilon, Skin closed using Ethilon 2.O

-Dressing with Betadine done.

Fig 1- Preoperative Image.

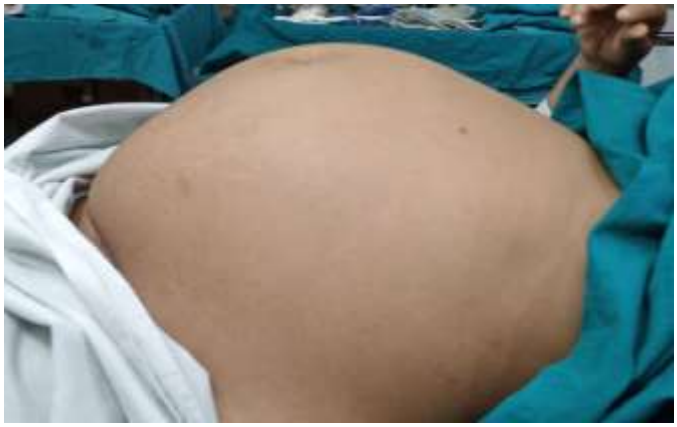


Fig 2 - Dissection

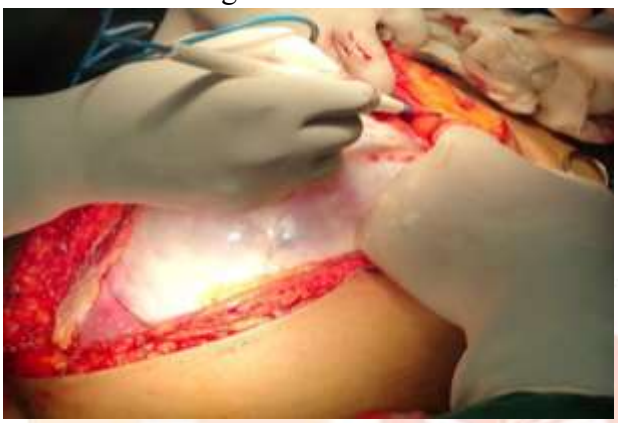


Fig 3 - Intra Operative Images

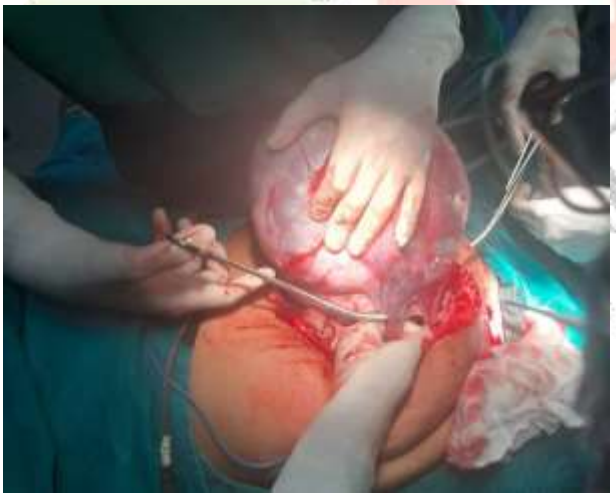
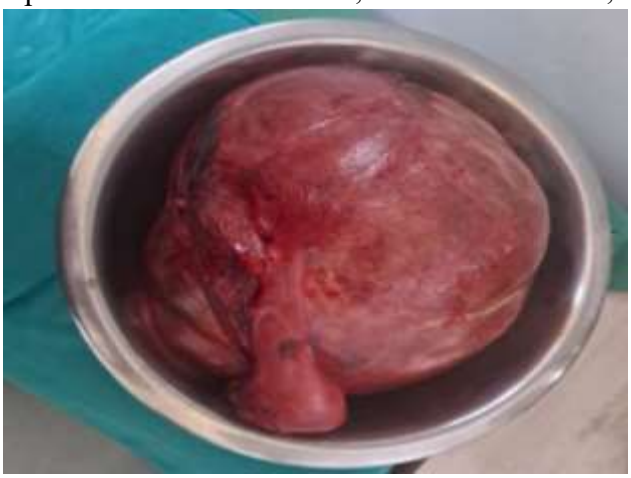


Fig 4- Specimen with B/L ovaries, B/L Uterine tubes , Uterus



The Specimen was sent for Histo-pathological Examination
Result :
- Right ovarian mass - Well differentiated mucinous cystadenocarcinoma.
- Cervix – Chronic cervicitis.
- Endometrium – Proliferative phase.
- Myometrium – Leiomyoma
- Bilateral fallopian tubes – Unremarkable.
- Left ovary - Follicular cyst.

On POD - 3 ADK drain was removed under all aseptic precautions.
On POD - 5 Dressing of Operative site done.
On POD - 12 All skin sutures removed.

Patient was discharged from hospital and PET CT scan was advised on the OPD basis follow up.

PET CT Scan Report :

·Post hysterectomy status, Post-operative inflammatory changes seen.
·No other metabolically active disease noted elsewhere.

Outcome and Follow up-

The patient experienced no complications during the early postoperative period. Six days after surgery the patient recovered and discharged. The patient was able to carry out daily activities without any post operative complications.

Discussion-

Ovarian masses are a common gynecological problem and may present with a wide spectrum of clinical features ranging from asymptomatic incidental findings to severe abdominal pain, pressure symptoms, or features suggestive of malignancy. The management of an ovarian mass depends on the patient's age, menopausal status, clinical presentation, imaging findings, tumor markers, and suspicion of malignancy.

In the present case, a pan-hysterectomy (total hysterectomy with bilateral salpingo-oophorectomy) was performed for a right-sided ovarian mass. This surgical approach is often considered in women who have completed their family, are peri- or post-menopausal, or when there is a significant risk of malignancy. Removal of the uterus along with both ovaries and fallopian tubes helps in eliminating the primary pathology, reducing the risk of future gynecological malignancies and preventing recurrence.

Right-sided ovarian masses may include benign conditions such as serous or mucinous cystadenomas, dermoid cysts, or endometriomas, as well as malignant ovarian tumors. Preoperative evaluation using ultrasonography, CT or MRI, and tumor markers like CA-125 plays a crucial role in surgical planning. In cases where imaging shows complex masses, solid components or rapid growth, a more radical surgical approach is justified.

Conclusion-

Pan-hysterectomy performed for a huge right-sided ovarian mass is a definitive and effective surgical approach, particularly when the mass is large, symptomatic or suspected to be malignant. The procedure allows complete removal of the disease, reduces the risk of residual pathology and facilitates accurate histopathological diagnosis. Early surgical intervention, meticulous operative technique and proper preoperative evaluation are crucial to minimize complications and improve patient outcomes. Overall, pan

hysterectomy remains a safe and reliable option in managing extensive ovarian masses when fertility preservation is not a priority.

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