Removal of a voluminous serous papillary paraovarian cystadenoma by endoscopic surgery. A case report

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Summary

A case of a right paraovarian cystadenoma (7.3 litres) in a young woman, 19 years old, who was treated by laparoscopy is described. The advantages of endoscopic surgery are evaluated.

Key words: Paraovarian cystadenoma; Laparoscopy; Endoscopic surgery.

Introduction

As has become well known in the last few years endoscopic surgery is also affirmed in the treatment of complex forms of gynecological pathologies with a low biological and economic cost, minor incidence of infection, minor risk of adhesions and also shorter hospitalization.

In the last decade endoscopic surgery has particularly developed in ovarian pathology because it is also possible to evaluate the nature of the cyst with color doppler ultrasound diagnostics before surgical intervention [4].

The purpose of the present case report was to add some significant experience to the worldwide case histories especially because of the enormous volume of the cyst in our case treated with endoscopic surgery.

Case Report

A young 19-year-old woman noticed a gradual increase in abdominal volume over a period of six months.

At the gynecological exam with ultrasound a large right ovarian cyst over 30 cm in diameter was revealed, without vegetative or septic formation and with thin a vascular walls. The uterus was retroversioflexed with normal volume. The right ovary was in cystic transformation. The left ovary was multifollicular measuring 4.9x2.7 cm in size.

Given the characteristics of the cystic formation we decided to perform endoscopic surgery on 18/12/99; such technique allowed the removal of a right paraovarian serous cystadenoma containing 7.3 litres of intracystic liquid.

To avoid an abrupt fall in endoabdominal pressure, we decided to first partially empty the cyst with a Verres needle directly introduced into the cystic cavity transabdominally (ecographically guided); subsequently another Verres needle was used for the pneumoperitoneum to maintain a certain endoabdominal pressure.

The following technique was used: First a Verres needle was inserted into the cystic cavity midway between the umbilicus and the anterio-superior iliac spine. Four litres of intracystic serous liquid were aspirated. With a second Verres needle introduced into the umbilicus site four litres of CO_2 were insufflated for the pneumoperitoneum. An optically guided 10 mm trocar was introduced. Then two other 10 mm trocars were placed laterally, one on the right and one on the left, 5 cm from the first. The voluminous right paraovarian serous cyst was partially emptied. The remaining 3.3 litres were aspirated for a total of 7.3 litres. The entire cystic wall was detached from the mesosalpinges; the cyst was enucleated after hemostasis. The uterus and the ovaries appeared normal. Removal of the cyst was performed with an 18 mm trocar.

The pathological exam confirmed a serous papillary cystadenoma.

Conclusions

The case described, interesting because of the large volume of the cyst (greater than 30 cm, 7.3 litres of liquid), further confirms the adequacy of endoscopic surgery in that it allows an intervention which is less traumatic and more conservative with short hospitalization. Our patient has conserved all the genital organs, had no abdominal scarring nor any inflammatory or functional complications.

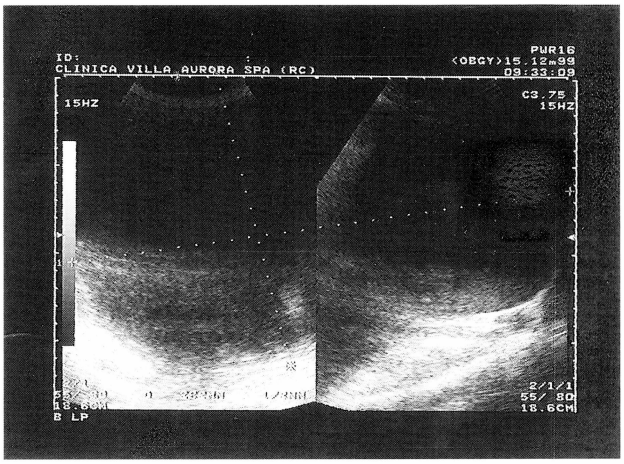

Figure 1. — Abdomino-pelvic ecography. Given the great size of the cyst two pictures were superimposed to show the dimension of the cyst.

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