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Case Report on Ovarian Cyst with Moderate Ascites

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Abstract:

Introduction: Functional cysts, ovarian torsion, and benign neoplasia are the most frequent ovarian masses in early teens. The laparoscopic approach to large ovarian cysts in children may be challenging due to the limited operating space and increased risk of leakage. This study looks at the role of laparoscopic surgery in the treatment of adnexal disease in young girls.
Important clinical findings:- A 42 yr old female child admit in A.V.B.R. hospital on date 11/5/21 with chief complaint is pain in abdomen , tenderness in right iliac fossa ,dull and aching, distension in abdomen and fluid thrilled .
Diagnostic evaluation:-She is 42 year female patient. All diagnostic test are done. Ultrasonography, complete blood count, CECT abdomen .
Therapeutic Intervention:- patient was treated Inj ceftriaxone 1 gm (BD),inj pan 40 mg (Odin Tramadol 100mg with 100 ml NS (sod), Inj Emset 4mg (TDS),tab siltstone (OD), protein powder 2tsp,inj antineutron with 100 ml NS(OD).

Outcome :-Patient general condition was improved .

Nursing perspectives: - Administered fluid replacement i.e. NS and DNS monitor vital sign and check blood pressure per hourly. Maintain intake and output chart and provided adequate rest and sleep to the patient. Administrator medication according to doctor, order.

Conclusion :- Patient was admitted in A.V.B.R. Hospital with chief complaint of pain in abdomen, tenderness in right iliac fossa, dull and aching, distension in abdomen and fluid thrilled Reduce with proper treatment ,now patient in good condition

KEYWORDS- Abdominal Distention, Ascites, Giant Ovarian Cyst

INTRODUCTION:

Despite the fact that A physiological or practical cyst is most likely an ovarian cyst seen in a young girl. [1] Germ cell tumours, epithelial mobile tumours, and stromal cellular tumours are the three types of ovarian neoplasms that are designated based entirely on the anatomic tissue from which they arise.[2] Epithelial cell tumours (serous or mucinous cyst adenomas) are more frequent in people in their fourth or fifth decades of life, but they should also be evaluated as a differential diagnosis in children because they're the second most common benign ovarian tumour in adolescents. [2] Only a few examples of large serous

cyst adenomas in teenagers have been described, despite the fact that these tumours can grow to massive sizes. We mention one such case involving a 11-12-year female who was admitted to our sanatorium for the investigation of a increase in abdominal distention. It could no longer be visible with the naked eye because of the cystic form of the mass and its full-size size.[3] The majority of ovarian MCAs are unilateral, with only 5% providing bilaterally, and the peak incidence occurs in girls aged 30 to 50.[4] MCA is characterized by a massive cystic mass filled with sticky gelatinous fluid that is frequently multiloculated. Mucinous tumours are benign in the great majority of cases (75%), with 10% being borderline and 15% being carcinomas.[5]

The cyst's size and form, as well as the patient's age and menopausal state, are all factors to consider, all play a role in ovarian cyst management. Cysts are treated surgically by cyst excision (open or laparoscopic) or cystectomy with oophorectomy.[6,7]

Patient information :-A 42 year old female was admitted on dated 11/5/21 pain abdomen , tenderness in right iliac fossa ,dull and aching, distension in abdomen and fluid thrilled .,and doctor the case was right ovarian cyst with moderate ascites.

Patient specific information :- A 42 year old female was admitted on dated 11/5/21 pain in abdomen since 8 days , tenderness in right iliac fossa ,dull and aching, distension in abdomen and fluid thrilled .,and doctor the case was right ovarian cyst with moderate ascite. Weakness and nausea vomiting.

Primary concern and symptoms of patient:- year old female was admitted on dated 11/5/21 pain in abdomen since 8 days , tenderness in right iliac fossa ,dull and aching, distension in abdomen and fluid thrilled .,and doctor the case was right ovarian cyst with moderate ascites. Weakness and nausea vomiting.

Medical, family, and psychosocial history:

Medical history: Patient having a no any past medical history such as diabetes mellitus , hypertension ,and asthma .

Family history:-she belongs to join family and mentally stable, no any hereditary disease in family. Patient is conscious and oriented ,she had maintained the good relationship with doctor s and nurses as well as with other patients.

Psychosocial history:- patient belong to middle class family . Patient is mentally stable ,she maintain the good relationship with other doctors and nurses patient and relatives she cooperate with doctor and nurse .

Patient relevant past intervention with outcomes: my patient was diagnosed with right ovarian cyst with moderate ascites. from that onward she was admitted to hospital for treatment of the disease and her health was improved . **Clinical findings:-**

General examination :-

Physical examination :- on palpation – tenderness present lump seen in lower abdomen , infection – abdominal distention , percussion – fluid present ,

State of health :-state of consciousness –consciousness ,body build thin, breath order absent , good hygiene

Vital signs : temp 37.8c pulse ,80b/m , blood pressure ,110/70 mmHg ,spo2 -96

Time line:- patient taken treatment for the health problems in A.V.B .R. hospital

Diagnostic assessment:-

Diagnostic testing (such as physical examination , laboratory testing , imaging , survey)

USG ABDOMEN- no obvious abnormalities noted in present scan .

CECT ABDOMEN:- gross ascite ? cause kindly correlate clinically .

CBC:- Hb-8.6 g / dl,MCHC- 32.3g/dl,MCV-71.2fl, total RBC -3.45, platelet count -2.97 lacs/ cu.mm ,ESR- 44 mm/hr.,CRP-18.40 mg/l.

Diagnosis: - after all diagnostic assessment the diagnosis is made as ovarian cyst with moderate ascitis .

Prognosis:-Prognosis good.

Therapeutic intervention-

Patient was treated inj ceftriaxone 1 gm (BD),inj pan 40 mg (Odin Tramadol 100mg with 100 ml NS (sod),inj emset 4mg (TDS),tab. Lasilactone (OD), protein powder 2tsp,inj antineutron with 100 ml NS(OD).

Nursing perspectives: - Administered fluid replacement i.e. NS and DNS monitor vital sign and check blood pressure per hourly . Maintain intake and output chart and provided adequate rest and sleep to the patient. Administer medication according to doctor, order.

Fallow up and outcomes:-patient is still admit in hospital about 25 days and her condition is improved.

Discussion:

The combination of pleural effusion and ascites in conjunction with a benign ovarian tumour is known as Meigs syndrome. After the tumour is removed, the ascites and pleural effusion disappear promptly. Meigs and Cass originally reported on a group of seven individuals who developed ascites and pleural effusions due to benign ovarian fibroma. After the ovaries were removed, the ascites and pleural effusion went away.[8] Fibromas account for roughly 4% of ovarian tumours, and Meigs syndrome occurs in about 1% to 2% of those cases, making it a rare occurrence.[9]

Despite reports of instances in infants and women under the age of 30, Meigs syndrome is more common in postmenopausal women with a median age of roughly 50 years. [10]

The aetiology of ascites and pleural effusion development is completely unknown. Several possibilities were urged to be avoided. Meigs and colleagues**.** [11]

It has been suggested that ascitic fluid has an influence on edematous fibromas that may leak fluid. Every other theory suggests that the tumor's burden on pelvic and abdominal lymphatics obstructs lymphatic outflow, causing intraperitoneal fluid buildup. The pathogenesis of ascites and hydrothorax expresso has been linked to inflammatory cytokines (IL-1B, IL-6, IL-8, and TNF A).[12]

The pleural effusion is assumed to be caused by ascitic fluid entering the pleural space through the diaphragm, either through congenital defects that are more common on the right or through the diaphragmatic lymphatic system. Pleural fluid can be found on either the left or right side of the chest. In one case, 65% of the pleural effusions were discovered in the lungs. [13]

CA-125 antigen is a large-molecular-weight glycoprotein that is identified with a monoclonal antibody (OC-125). By a long way, it's a tumour marker associated to ovarian cancer. Improved CA-125 values have been reported in the literature in persons with Meigs syndrome.[14]

A serum CA-125 level of more than 1000 U/mL is rare. According to immunohistochemistry studies, antigen production in the mesothelial cells rather than the fibroma causes the elevation in serum CA-125 in patients with Meigs syndrome. [15]

According to a review of instances of Meigs syndrome with improved serum CA-one hundred twenty five stages, the volume of ascites was plainly correlated with bigger ranges of CA-125, but the tumour length was not linearly associated with CA-one hundred twenty five tiers**.** [16]

The appearance of fibromas on ultrasonography is generic, and the range of CT findings in ovarian fibroma is wide.[17] The difficulty to confirm an ovarian benign tumour on imaging, as well as the presence of ascites/pleural effusion and a rise of CA-125, necessitates tissue prognosis.

The treatment is exploratory laparotomy, which includes ovarian mass biopsy, lymph node biopsies, omentum biopsy, and pelvic washings. In ladies of reproductive age, a unilateral salpingo-oophorectomy is performed.[18]

Patients with malignant pleural effusion and ascites should employ tunnelled drainage catheters. The complication costs were equal in a retrospective study comparing patients who underwent abdominal pleurx catheter installation and recurrent vast extent paracentesis, although pleurx reduced the number of separate impacted person stumbles and was linked to improved patient satisfaction. [19]

There were no abnormalities in our patient's lungs or pleura for biopsy, so he underwent thoracoscopy and pleurodesis for symptom management. Meigs syndrome has a good prognosis, with only 1% of fibromas progressing to fibrosarcoma.[20]

After the tumour is removed, the pleural effusion and ascites clear up within a few weeks. We wish to utilise chest ultrasound to track the course of pleural effusion since it is significantly more accurate than chest x-rays in detecting residual pleural effusion and can detect volumes as tiny as three to five ml. [21] Studies on related aspects of ascites and ovarian lesions were reported[22-25]**.** Other related studies were reviewed[26-27]**.**

Conclusion:

Our data suggest that the presence of ascites on a preoperative physical examination or imaging examination is a strong predictor of ovarian cancer in women with a pelvic mass. Because nearly half of borderline tumours and 83 percent of early-stage malignant ovarian tumours do not create ascites, the lack of ascites does not always indicate a benign condition. A novel association between the stage of malignancy and the prevalence as well as the amount of ascites has also been discovered. Despite the rarity of big ovarian tumours, Pediatricians should be aware of their symptoms and include ovarian loads as a possible cause of stomach distention in their differential diagnosis. Pediatricians should encourage families to seek medical help as soon as possible if stomach distension persists, Because ultrasound might create ascites, it should not be employed as the primary imaging modality, especially in the case of large ovarian cysts. This case report emphasizes the necessity of incorporating ovarian hundreds in the differential analysis of a patient with stomach distention without symptoms or signs and symptoms of hepatic, renal, or cardiac disease. It's also vital to encourage the general people to seek medical attention as soon as possible in order to avoid headaches like ovarian torsion and rupturing.

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