

Case Report

Giant paratubaric cysts

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ABSTRACT

Giant paratubaric cysts are mostly benign tumors, with incidence of 10%. The incidence rate of these neoplasms is 2% to 3% including cystitis, papillary carcinoma and serous papillary neoplasms, the course of disease begins with abdominal pain or increase in size of lower hemi abdomen, becoming complicated in approximately 3% of cases. The diagnosis is made with transabdominal or transvaginal ultrasound, abdominal and pelvis tomography or magnetic resonance. The treatment of small cysts is expectant and the large size is surgical way. We present the case of a 35-year-old woman who began her current condition three years after her pregnancy, with urination urgency, abdominal pain and sensation of abdominal mass, who was diagnosed and protocolized in a public second level hospital in Mexico City, treated with opened surgery, and good postoperative evolution.

Keywords: Giant paratubaric cysts, Serous papillary neoplasms, Abdominal pain, Abdominal mass

INTRODUCTION

Giant paratubaric cysts are mostly benign tumors, with incidence of 10%. The incidence rate of these neoplasms is 2% to 3% including cystitis, papillary carcinoma and serous papillary neoplasms.^{1,2} They are usually between 1 and 8 cm², giant cysts are extremely rare and the preoperative diagnosis is complicated, they are located in the broad ligament of the uterus, between the ovary and the fallopian tube, show slow and progressive growth, arise from embryonic remains.^{3,4}

Course of disease begins with abdominal pain or increased in size of the lower hemi abdomen, becoming complicated in approximately 3% of cases.¹⁻⁵ Classification: These lesions are classified according to their histology in serous or simple cysts, and according to their embryonic origin in mesothelial cysts (68%), mullerians (30%) and wolffians (2%). They are most often diagnosed between the ages of 30-40.³⁻⁶

The diagnosis is made with transabdominal or transvaginal ultrasound, computed tomography (CT) of abdomen and pelvis and magnetic resonance.⁷ The complications are rapid growth, intracystic hemorrhage, perforation with hemoperitoneum, and torsion.^{8,9} The differential diagnosis is appendicitis, hydrosálpinx, hernia incarcerated, ectopic pregnancy, mesenteric cyst and abdominal lymphangioma.⁴⁻¹⁰

CASE REPORT

A 35-year-old woman, hypothyroidism diagnosed 8 years ago in treatment with levothyroxine, pituitary adenoma diagnosed 8 years ago in treatment with cabergoline for 5 years; allergic to contrast medium and indometacin. Current condition started 3 years ago during pregnancy follow diagnosis cyst in right annex, 4 months ago begins with urinary urgency, abdominal pain, feeling of abdominal mass, in the physical examination, Glasgow 15, distended abdomen, normal peristalsis, presence of

abdominal mass in right flank, well defined, painful to palpation.

Laboratories

Leukocytes 7 k/ul, hemoglobin 14 g/dl, platelets 328.0 k/ul, creatinine 0.6 mg/dl, sodium 140 mmol/l, potassium 3.9 mmol/l, non-pathological urine examination, simple CT, Figure 1 and 2 shows, hypodense lesion, thin septa occupying pelvic and abdominal cavity, dependent on right attachment in relation to serous cystadenoma, compresses the bladder and displaces adjacent structures.

Results

By findings of physical examination and tomography with diagnostic impression of cystoadenoma; according to regional hospital resources, exploratory laparotomy with right salpingo-oophorectomy was performed, shown in Figure 3 and 4; with bleeding of 50 cc during procedure without complications, leave the patient on surveillance starting diet at 8 hours, discharge 24 hours after the procedure and send piece to pathology postsurgical.

With histopathological report, cystic tissue specimen measuring 17×17×3 cm, color light brown. When it was cut, transparent liquid, inner surface light brown and smooth, and soft with diagnosis of simple parasalpingeal cyst.

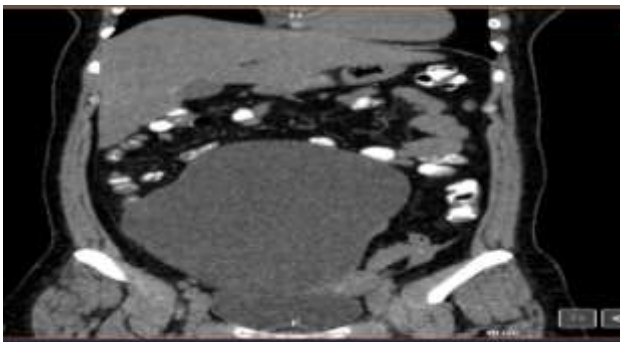


Figure 1: Abdominopélvica CT scan of abdomen and pelvis large cyst of 10 by 14 cm occupying the abdominal cavity.



Figure 2: Abdominopélvica CT (cross section). Cystic mass of defined contours and thin walls.



Figure 3: Cystic mass resection in the transoperative.



Figure 4: Appearance of the giant postoperative cyst.

DISCUSSION

Annexed tumors are one of the most common causes of gynaecological surgery. Seventy-five percent are found in the ovary, 10-17% in the tubal and only 5-10% are paratubers. They can be benign or malignant tumors.¹⁻³ Depending on their embryonic origin, they can be mesothelial cysts (68%), müllerian or paramesonephric cysts (30%) and wolffian or mesoafrican cysts (2%).³⁻⁷ There are few cases of giant tumours described. Cystoadenomas are benign tumors (80%), they are usually small, simple cysts on the ligament, most often in fertile women.⁴⁻⁹ The clinical manifestations are the result of the growth of the cyst (bloating and abdominal pain), torsion, bleeding, infection or perforation of the cyst, which cause acute abdominal pain.⁵ Diagnosis requires physical examination, and imaging tests (ultrasound, CT, and other). Ultrasound is the first study to perform, the tomography defines the size.⁶ The treatment of choice is by laparoscopic route, has less short-term and long-term morbidity with better esthetic result.⁷⁻⁸

CONCLUSION

The incidence of the giant paratubercular cyst is reported in 10%, the incidence of this neoplasia is 2%; the clinical picture is characterized by abdominal pain and sensation

of mass, paraclinical studies do not confirm the diagnosis, being necessary a postsurgical and histopathological diagnosis. It was found that an open surgery procedure is still a feasible therapeutic option for limited resources with good postoperative evolution.

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