

# Ileus Caused With Big Cyst-adenoma of the Ovary

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## Case Report

Mrs. S.I., a 50-year-old multiparous woman presented with a short history of big pelvic mass. Mrs. S.I. had experienced no bleeding per vagina since attaining menopause 4 years earlier. The patient was kept on Department of Surgery because dominant symptoms included abdominal pain and distension, qualm, retch and obstipation in last 4-5 days. After surgical examination and native X-ray of abdomen, surgeons established diagnosis *Tumor abdominis per magnus. Ileus*. Native X-ray of abdomen showed intestinal distension and shadows of levels. Shortly after, the patient was rerouted on Department of Gynecology with invested nasal-gastric suction sonde.

During examination, Mrs. S.I. was a normally developed women with body weight about 70 kg. Examination of heart, lung, breast, neck, head and organs revealed no abnormality. Examination of abdomen and pelvis showed big pelvic tumor mass, which was volubly and bulbous form. Abdomen was distended, dolorous on palpation and showed tympanums sounds on percussion. There was no lymphadenopathy.

On gynecological examination, the external genitalia were normal. Examination under specula showed usual altitude and elasticity of vagina. There were no abnormalities on the cervix of uteri. On bimanual examination, internal genitalia were impossible to differentiate, except big mobile tumor mass. The size of tumor mass was adequate to the size of uterus in 28th week of gestation. We could not precisely locate the starting point of tumor (Figure 1.).

## Summary

- Compressive ileus was diagnosed in a 50-year-old multiparous with a big cystic tumor of pelvis.
- This complication is relative rare in relation to other complications of ovarian cystic tumor.
- Protocol for managements of ovarian tumors considers radical examination including Doppler ultrasonography, tumor markers screening, cytological examination of ascites or peritoneal rinse, endoscopic examination etc.
- Nevertheless, complications of big ovarian tumors might inflict urgent surgical intervention without any time for screening malignancy of the tumor.
- Management in this case included abdominal laparotomy, cystectomy and classical hysterectomy with bilateral salpingo-oophorectomy and extempore pathologic verification of tumor type.



Figure 1. Appearance of patient's abdomen before surgical intervention.

## Investigations

Mrs. S.I. was subfebrile with paleness and anhydrous mucoses. *Facies Hypocratica* also was presented. The patient felt broken, apprehensive, and disgorge. Baseline hematological investigations were normal with hemoglobin of 105 g/L. Blood urea was 10.1 mmol/L, glucose 9.6 mmol/L, creatinine 107  $\mu$ mol/L. Chest X-ray was normal. Blood pressure was 80/50 mm Hg, radial pulse was 140, and respiratory rate was 24/min., rectal temperature 40,2° C.

Ultrasound of superior abdomen was normal. Ultrasonic examination of pelvis showed big cystic tumor separated on several parts with thin walls. Some parts of tumor were impregnated with anechogenic structure, but one of the parts was hyperechogenic (figure 2.). We did not detect ascites or free fluid in peritoneal cavity. Anesthesiologist and specialist for internal medicine did not find any abnormalities or contraindications for urgent surgical intervention.

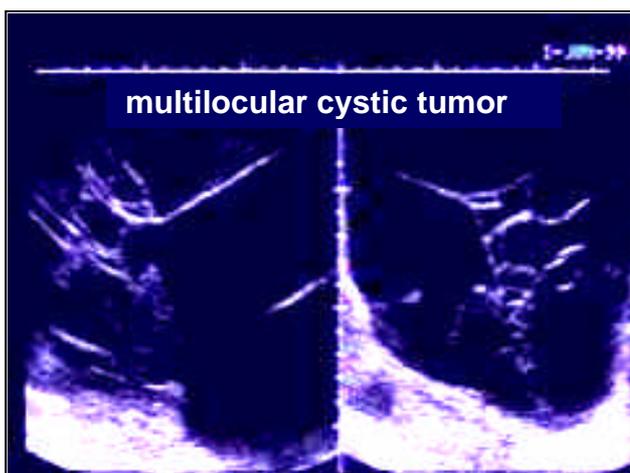


Figure 2. Ultrasound pictures of big cystic tumor with several ventricles.

## Managements

Treatment options were discussed between gynecologists, surgeons, anesthesiologist and pathologist, and we made the decision to proceed to explorative laparotomy and evacuation of tumor. Beside our dilemmas about tumor's malignant nature, the generally bad status of patient inflicted urgent surgical interventions. Mrs. S.I. was treated with crystalloids solutions with a view to correct electrolyte abnormality.

We made medial suprapubic laparotomy, and explored abdomen, and detected a big cyst on left and a smaller one on right ovary. There were normal uterus and tubes and no adhesions between cysts and environmental organs. Small intestine was distended and hyperemic.

The big cyst was born on laparotomy; was taken up in stalk and removed (figure 3).



Figure 3. Big cystic tumor from left ovary after bearing.

We sidled to the uterus and right ovary with a smaller cyst. After cystectomy of smaller cyst and extempore verification that tumors were cyst-adenoma, we made a classical hysterectomy with bilateral salpingo-oophorectomy (figure 4).



Figure 4. Uterus, right ovary and the cyst.

The cyst from left ovary had dimensions 20X30X20 cm and 5.5 kg weight. There were 3 separated chambers with different matter. The biggest contained transparent serous fluid, the second chamber contained complicities mucous fluid, and the third chamber contained transparent mucous fluid. The cyst from right ovary

had dimensions 6X6 cm and 350 gr. weight with transparent, serous, liquid structure (figure 5). We made peritoneal washing for cytological examinations and we took the swab from peritoneum and fimbrial complex.

Extempore pathologic and cytological examinations of cyst and washing precipitation proved bilateral benign cyst-adenoma ovary.

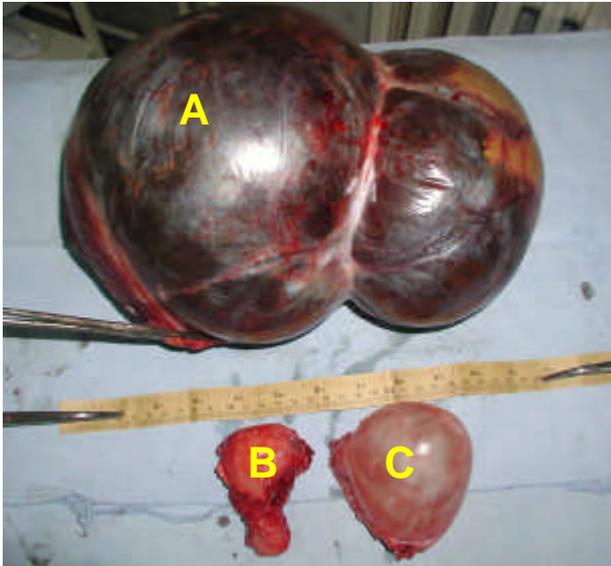


Figure 5. (A) The cyst from left ovary, (B) uterus and (C) the cyst from right ovary.

## Discussion

Serous and mucinous cyst-adenoma can grow up to enormous dimension. Symptomatology mostly depends on complications of cysts. The most frequent complications of big benign cyst-adenoma are torquation, rupture, infection and/or abscessing of the cyst, malignant alteration, creating adhesions and vascular anastomoses with environmental organs, pressure on small intestine and/or colon and development of ileus.<sup>1,2</sup>

Although every ovarian tumor must be managed like malignant, including vaginal Doppler ultrasonography, screening of tumor markers, puncture of Douglas cavity and cytological examination of peritoneal washing or ascites, complications of big cystic tumors can be the source of an urgent state like ileus.<sup>3</sup> In this case, there was no time for detailed examination of tumor for malignancy, because the state of patient demanded urgent laparotomy.

## References

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