

A novel Foley's technique for ovarian giant cyst management: To reduce morbidity

Jyoti Kankanala

ABSTRACT

Introduction: Ovarian cyst is very common. Most of the time they do not present with specific symptoms, hence they are found incidentally on imaging. The management depends upon various factors like age, family history of cancers, size of the cyst and blood test (CA-125). **Case Report:** A 32-year-old female presented with mild abdominal discomfort. Ultrasound and contrast-enhanced computed tomography scan revealed large ovarian cyst. After complete evaluation and counseling patient underwent mini-laparotomy and aspiration of cyst by Foley's method. Spillage was hardly noticed. Complete resection of cyst wall was performed easily. Postoperative recovery was uneventful. **Conclusion:** This technique has been successfully used and shown to decrease morbidity.

Keywords: Abdominal masses, Aspiration of ovarian cyst, Large ovarian cyst

How to cite this article

Kankanala J. A novel Foley's technique for ovarian giant cyst management: To reduce morbidity. J Case Rep Images Gynecol Obstet 2017;3:23–26.

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Received: 17 April 2017

Accepted: 07 June 2017

Published: 11 July 2017

Article ID: 100026Z08JK2017

doi:10.5348/Z08-2017-26-CR-6

INTRODUCTION

Giant ovarian cyst is not defined specifically in literature but in general it has been a norm for a cyst more than 10 cm for some authors, for few on palpation if mass is above the umbilicus they describe it as large or giant cyst. However, imaging has a very important role in taking a decision. In literature, various laparoscopic techniques [1, 2] have been used to manage large ovarian cyst to decrease morbidity. The technique of Foley's was used only after confirming on the contrast-enhanced computed tomography scan that it's a thin walled cystic lesion and no solid components were noticed.

Epithelial tumors are the most common type of all ovarian cancers (60–70%). They consist of both benign and malignant types [3]. The origin and pathogenesis of epithelial ovarian cancer are poorly understood [4]. Despite extensive studies, no precursor lesions have been found [4], complications and survival rate varies depending upon the type and size. Common problems seen are torsion, hemorrhage and rupture.

CASE REPORT

A 32-year-old female, para 3 living 3; all normal vaginal deliveries, tubectomised 10 years ago presented as outpatient with a history of increasing abdominal girth and mild abdominal discomfort. As an outpatient all investigations and preanesthetist checkup were carried out.

The hemoglobin was 10.1 g/dl, random blood sugar was 97 mg/dl, serum creatinine 0.73 mg/dl, viral

screen was negative, 2-D ECHO was normal, X-ray showed normal chest radiography. Contrast-enhanced computed tomography scan (Figure 1) shows right adnexal well defined, fairly large, thin walled minimally enhancing cystic lesion measuring 21x20x22 cm with no evidence of solid components, extending into upper abdomen causing peripheral displacement of bowel loops suggestive of serous cyst of adenoma.

CA-125 (28.7 U/ml) was normal. After detail counseling patient was taken up for minilaparotomy in view to conserve ovary, if frozen report comes negative for any malignancy. On admission patient had normal vital signs and abdomen was grossly uniformly distended. On per speculum exam vulva, vagina, cervix, looked normal. Pap smear was negative for abnormal cells.

The minilaparotomy was performed under combined (epidural and general) anesthesia. Intraoperatively a huge cystic mass was noticed and hydro infiltration on a small area of the cyst wall was done carefully, which was later dissected to over 1 cm and Foley catheter size 18 was inserted with pressure (Figure 2). Foley catheter was retained using 25–30 ml of NS. Then 3.6 liters of cyst fluid was aspirated [2] (Figures 3 and 4). Minimal spillage was noticed. Later a small incision over the ovarian wall hugging the balloon was made. The cyst wall was resected along with 2 cm of ovarian tissue (Figure 5) and sent for frozen section examination and no obvious malignancy was noticed. Ovary was conserved other side ovary was normal looking. The cyst wall was removed intact without intraperitoneal rupture. Histology and cytology reports revealed no malignant cells and serous cyst adenoma was the final histology. Intraoperatively the cyst was seen in

left side but on CT scan it was seen on right side, so the message is that it can be difficult to ascertain on imaging the side some times.



Figure 2: Foley catheter size 18 inserted into the cyst.



Figure 3: Foley's guided aspiration method.



Figure 4: Fluid aspirated.

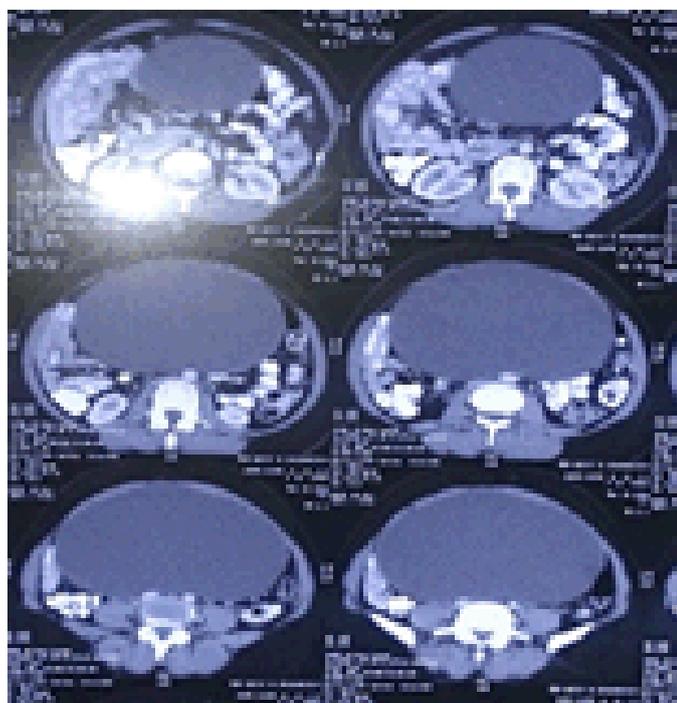


Figure 1: Computed tomography scan with contrast showing thin wall cystic lesion with no solid components.



Figure 5: Intact cyst wall.

DISCUSSION

The definition of huge ovarian cysts has not been well described in literature. Some authors define large ovarian cysts as those more than 10 cm in diameter measured on preoperative scan. Others define large ovarian cysts as those reaching above the umbilicus [1, 2]. In 1922 Spohn, reported one that weighed 148.6 kg, Symmonds, in 1963, reported finding of one cyst that weighed 79.4 kg [5, 6] Ton-Ho Young et al., performed laparotomy with a right sided salpingo-oophorectomy and the patient recovered completely, it too was a benign serous cystadenoma weighing 24 kg [7]. Many cases in literature have mentioned various ways but, in our case Foley's technique is a very novel and easy method that can be learned and applied easily with less chances of spillage and quick recovery in all aspects. This has been used plenty of times and had been useful. Hope this report will guide our clinicians to give their best to the patient.

CONCLUSION

The Foley's technique has been successfully used and shown to decrease morbidity by shorting the hospital stay, by avoiding extensive surgery, low pain score and good body image.

Author Contribution

Jyoti Kankanala – Substantial contributions to conception and design, Acquisition of data, Analysis and interpretation of data, Drafting the article, Revising it critically for important intellectual content, Final approval of the version to be published

Guarantor

The corresponding author is the guarantor of submission.

Conflict of Interest

Authors declare no conflict of interest.

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Article citation: Kankanala J. A novel Foley’s technique for ovarian giant cyst management: To reduce morbidity. J Case Rep Images Gynecol Obstet 2017;3:23–26.



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