Manuscript Accepted **Early View Article**

Early View Article: Online published version of an accepted article before publication in the final form.

Journal Name: Journal of Case Reports and Images in Obstetrics and Gynecology

Type of Article: Case Report

Title: A Novel Foley's Technique for ovarian giant cyst management –To reduce morbidity

Authors: Jyoti Kankanala

doi: To be assigned

Early view version published: June 9, 2017

How to cite the article: Kankanala J. A Novel Foley's Technique for ovarian giant cyst management –To reduce morbidity. Journal of Case Reports and Images in Obstetrics and Gynecology. Forthcoming 2017.

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AUTHORS:

Dr Jyoti Kankanala[1]

AFFILIATIONS:

[1]MRCOG, DFFP, DNB, DGO, Working as a consultant Obstetrician and Gynaecologist, Citizens hospital, Hyderabad, Telangana, India,

CORRESPONDING AUTHOR DETAILS

Dr. Jyoti Kankanala

MRCOG, DFFP, DNB, DGO, Working as a consultant Obstetrician and Gynaecologist, Citizens hospital, Hyderabad, Telangana, India,

Email: Jyoti.kankanala@gmail.com

Short Running Title: Sujyo's technique for large ovarian cyst.

Guarantor of Submission: The corresponding author is the guarantor of submission.

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ABSTRACT

Introduction: Ovarian cyst is very common. Most of the times they don't present with a specific symptoms, hence found incidentally on imaging. The management depends upon various factors like age, family history of cancers, size of cyst and blood test (CA125).Case Report: I report a case of 32years young woman presented with mild abdominal discomfort. Ultrasound and CT contrast revealed Large ovarian cyst .After complete evaluation and counseling patient underwent minilaparotomy,aspiration of cyst by Foley's(sujyo)method .Spillage hardly noticed .Complete resection of cyst wall performed easily .Post operative recovery was uneventful.Conclusion :This technique has been successfully used and shown to decrease morbidity .

Keywords: Large ovarian cyst, abdominal masses, Aspiration of ovarian cyst.

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INTRODUCTION

Giant ovarian cyst is not defined specifically in literature but in general it has been a norm as more then 10 cm for some authors ,for few if on Palpation if mass above the umbilicus they describe it as large or giant.How ever Imaging has a role a very important role in taking a decision.The technique of Foley's ,where in size 18 was used after confirming on the CT constrast that it's a thin walled cystic lesion and no solid components were noticed.

In literature various laparoscopic techniques [3,4]have been used to manage large ovarian cyst to decrease morbidity.

Epithelial tumours are the most common type of all ovarian cancers(60-70%).They consist of both bening and malignant types[1]. The origin and pathogenesis of epithelial ovarian cancer are poorly understood [2]. Despite extensive studies, no precursor lesions have been found [2], 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 Para3Living3, all normal vaginal deliveries, tubectomised 10 yrs ago. Presented as outpatient with a history of increasing abdominal girth and mild abdominal discomfort. As an outpatient all investigations and preanaesthetist checkup carried out.

The hemoglobin was 10.1 g/dl,random blood sugars were 97mg/dl,serum creatinine 0.73mg/dl, viral screen being negative,2-D ECHO was normal ,X-Ray showed normal chest radiography,CT Contrast[Fig1] shows Right adnexa well defined fairly large thin walled minimally enhancing cystic lesion measuring 21x20x22cm with no evidence of solid components ,extending into upper abdomen causing peripheral displacement of bowel loops S/O serous Cyst adenoma .Advice histopathological correlation.

CA 125 (28.7) was normal. After detail counseling patient was taken up for minilaparotomy and in view to conserve ovary if frozen report comes negative for any malignancy, agreeded upon and understands that would always follow final histology report. On admission normal vital signs and abdomen grossly uniformly distended, Per speculum vulva and vagina looked normal and cervix normal looking and pap smears were negative for abnormal cells.

The mini laparotomy performed under combined (epidural and general) an aesthesia. Intraoperatively a huge cystic mass was noticed and hydro infiltration on a small area of the cyst wall done carefully, later dissected for over 1cm and Foleys size 18 inserted with pressure ,[Fig2].Foleys catheter retained using 25-30ml of NS [Fig3] .Then cyst fluid was aspirated [Fig3] around 3.6 liters [4].Hardly any spillage was noticed. Later a small incision over the ovary which was hugged to the balloon was made. Balloon as guide, the cyst wall was resected along with 2 cm of ovarian tissue and sent for frozen and no obvious malignancy was noticed so ovary was conserved other side ovary was normal looking. So the cyst wall, we removed it intact without intraperitoneal rupture. Histology and cytology report reveals no malignant cells and serous cyst adenoma as the final histology confirmation. The side intraoperatively was left ovarian cyst but on CT it was right side, so the message is it can be difficult to ascertain on imaging the side yet times.

DISCUSSION

The definition of huge ovarian cysts has not been well described in the literature. Some authors define large ovarian cysts as those more than 10 cms in diameter measured on pre-operative scan. Others define large ovarian cysts as those reaching above the umbilicus [3, 4] . In 1922 Spohn, reported one that weighed 148.6 kg, and of Symmonds, who in 1963 79 reported finding one 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 bening serous cystadenoma weighing 24 kgs [7]. Many cases in literature have mentioned various ways but in our case this is a very Foleys (sujyo's) technique novel and easy method was the morbidity is almost nil and chances of spillage too was almost nil.

This have been used plenty of times and had been useful. Hope this report will guide our clinicians who always brainstorm to give there best to the patient

CONCLUSION

This 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.

CONFLICT OF INTEREST

NONE

AUTHOR'S CONTRIBUTIONS

Data collection,formation of article,revisiting the article and revision of article.

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FIGURE LEGENDS

Figure 1: CT WITH CONTRAST shows thin wall cystic lesion with no solid components.

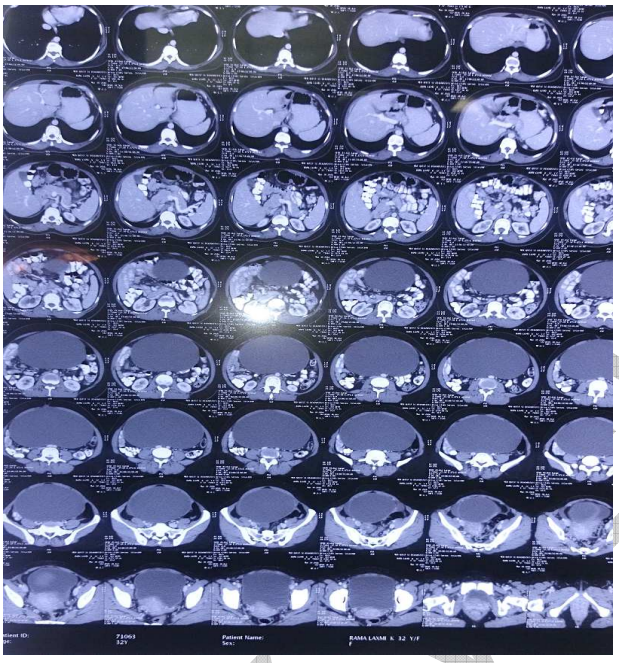
Figure 2: Foleys size 18 inserted.

Figure 3: Foleys Guided Aspiration (sujyo)Method

Figure 4: Fluid Aspirated

Figure 5: Large cyst wall Intact

FIGURES



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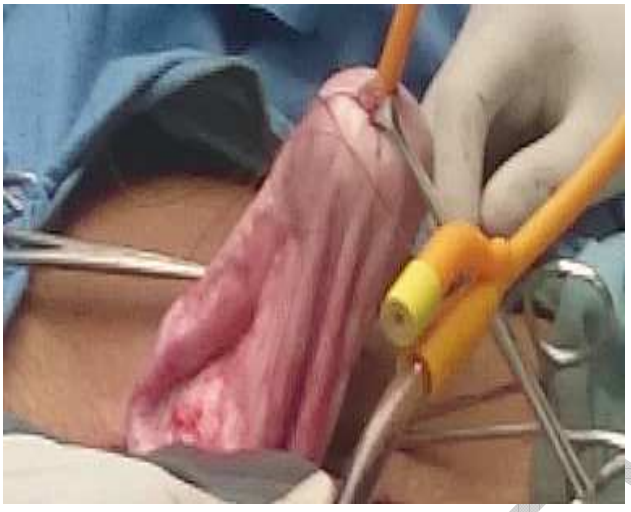


Figure 3: Foleys Guided Aspiration (sujyo)Method

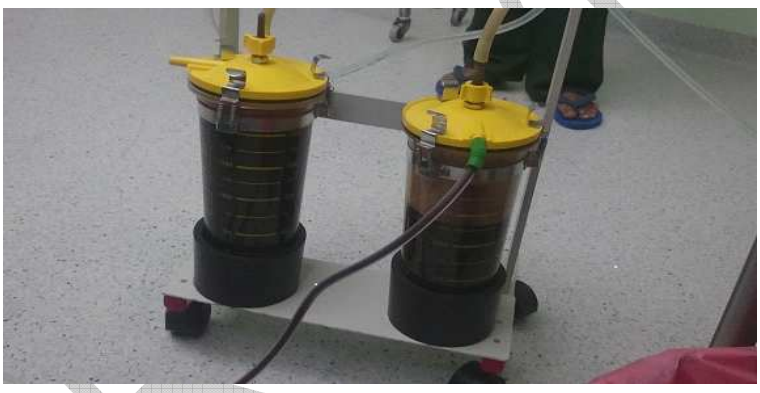
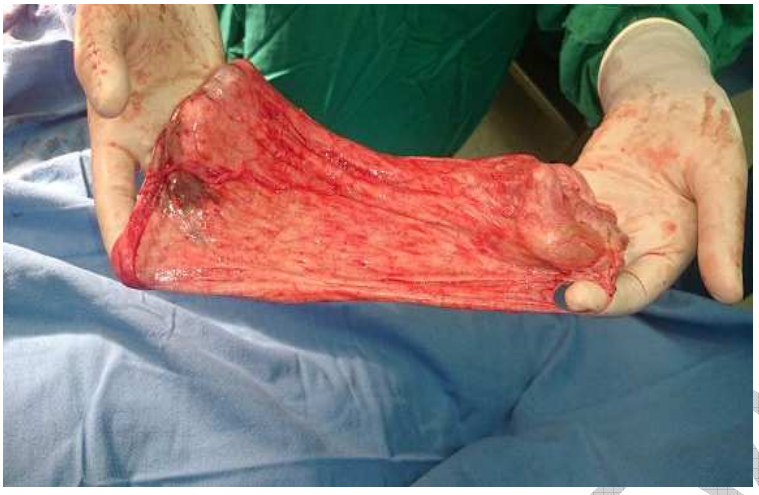


Figure 4: Fluid Aspirated



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