

CASE REPORT

A Rare Combination of Omental Cyst, Ovarian Cyst and Leiomyoma of Uterus

¹Shaheen, ²Seema Hakim, ³Veena Maheshwari, ⁴Smriti Bhargava

¹Lecturer, Department of Obstetrics and Gynecology, JN Medical College, Aligarh Muslim University, Aligarh, Uttar Pradesh, India

²Professor, Department of Obstetrics and Gynecology, JN Medical College, Aligarh Muslim University, Aligarh, Uttar Pradesh, India

³Professor, Department of Pathology, JN Medical College, Aligarh Muslim University, Aligarh, Uttar Pradesh, India

⁴Postgraduate Student, Department of Obstetrics and Gynecology, JN Medical College, Aligarh Muslim University, Aligarh Uttar Pradesh, India

Correspondence: Shaheen, Lecturer, Department of Obstetrics and Gynecology, JN Medical College, Aligarh Muslim University D-4, Abdullah Apartment, Civil Lines, Aligarh-202002, Uttar Pradesh, India, e-mail: drshaheen07@hotmail.com

Abstract

Omental cysts are rarer abdominal tumors, with only about 150 cases documented till now. We are reporting an interesting and rarer case of combination of omental cyst with ovarian cyst and leiomyoma of uterus. Cystectomy is indicated even the patient has no symptoms because of possibility of torsion, rupture, bleeding and infection.

Keywords: Omental cyst, ovarian cyst and leiomyoma of uterus.

INTRODUCTION

Mesentric and omental cysts are rare abdominal tumors occurring in approximately one of 105,000 hospitalized patients.¹ Only 2.2% of these cyst are omental cyst.² These cysts are more common in females than males and in white race in comparison to nonwhite race.³ The omental cysts are rarer, with only about 150 cases documented till now and 25% of which presented under 10 years of age.⁴

CASE REPORT

We are reporting an interesting and rarer case of combination of omental cyst with ovarian cyst and leiomyoma of uterus. A 42-year-old nulligravid, married 9 years back, came to JNMCH, AMU with complaints of abdominal lump since 7 years, pain in abdomen off and on 6 years and hypomenorrhea for 6 years. Her menstrual cycles were regular, not associated with pain, or excessive bleeding. On examination, the general condition of the patient was fair. On per abdomen examination, abdomen was distended, tense, nontender. Shifting dullness and fluid thrill was present. Bowel sounds were normal. On bimanual examination, a hard mass felt in right fornix, which was extending up to pouch of Douglas and was freely mobile. It measured 18 × 15 cm approximately, tenderness present over the mass. Uterus was retroverted and could not be felt separately from mass. On ultrasound right heterogeneous adnexal mass 216 × 118 mm with thick septation, a small fibroid seen in anterior wall of uterus, bilateral hydronephrosis was present, right ovary was not visualized. Differential diagnosis: has thought of as

Dermoid, Cystadenocarcinoma. Laparotomy was performed. Peroperative findings—a huge lump 18 × 18 cm weighing approximately 8 kg arising from right adnexa, attached to uterine fundus, omentum and extending up to diaphragm (Figs 1 and 2). Lump was highly vascular and large number of tortuous vein were seen on surface of lump and in omentum. The lump was attached by flimsy adhesion to peritoneum. Lump was excised, myomectomy was done and tissues were sent for histology. On histology—the ovarian mass showed lining of low cuboidal epithelium and had necrotic tissue and hemorrhagic deposits and was filled with serous fluid which was suggestive of cystadenoma of ovary. The histology of omental tissue had multiple cystic tissue of 1 cm each. On section fibro fatty tissue



Fig. 1: Showing peroperative findings as omental cyst and ovarian cyst



Fig. 2: Omental cyst was cut open during surgery

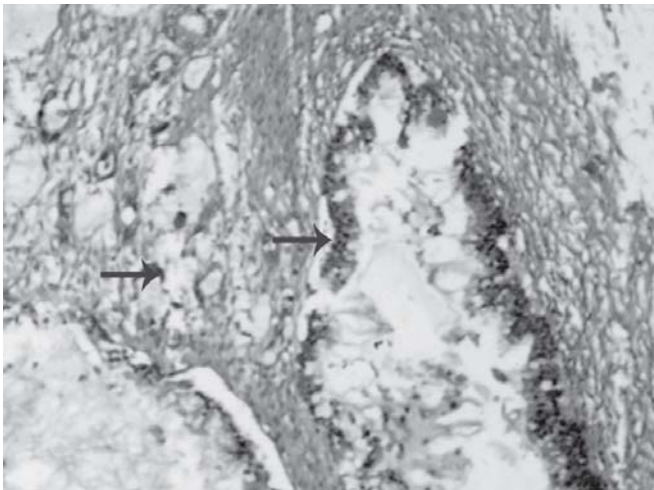


Fig. 3: HPE of omental cyst-fibro fatty tissue of omentum and small cyst lined with tall columnar mucus secreting epithelial tissue

of omentum and small cyst lined with tall columnar mucus secreting epithelial tissue was seen (Fig. 3). Fibroid on section showed smooth muscle arranged in whorls with hemorrhage and hemosiderin deposit suggestive of leiomyoma uterus.

Postoperative period was normal. She was discharged in good condition.

DISCUSSION

Omental cysts are benign uni- or multiloculated endothelial lined cysts. Patients can present with chronic abdominal pain, or a painless abdominal mass, or acute abdomen due to rupture or torsion and respiratory distress due to massive enlargement of cyst.²⁻⁴ The preferred treatment of omental cyst is complete excision. Cystectomy is indicated even the patient has no symptoms because of possibility of torsion, rupture, bleeding and infection.⁵ Malignant degeneration of omental cyst is rare, only few cases of sarcoma and adenocarcinoma have been reported.⁶ Leiomyoma is benign tumor of smooth muscle origin and are the most common neoplasm of the female genital tract. Tumors are estrogen responsive and are located submucosally, intramural (most common), subserosal. Malignant transformation is 0.1 to 0.5%. Ovarian serous cystadenoma is most common of the ovarian tumor. It occurs most commonly in 3rd to 5th decade of life. It has serous fluid filled and usually uniloculated. Combination of all these may be incidental because etiologies differ. Authors have not come across such type of combination in literature.

REFERENCES

1. Richard RR. Mesenteric and omental cyst. In: O'NEILL JA, Rove MI, Grosfeld JL, Fonkalsurd EW, Coran AG (Eds). Pediatric surgery. St Louise: Mosby year book 1998;1269-75.
2. Tamus PS. Mesenteric and omental cyst. In: Donellan WL (Eds) Abdominal surgery of infant and childhood. Luxembourg Harwood Academic Publishers 2001;50:1-8.
3. Moralioglu S, Sonmez K, Turkyilmaz Z, Basaklar AC, Kale N. A child with a giant omental cyst. Acta chir belg 2007;107:724-25.
4. Vanek VW, Phillips AK. Retroperitoneal, mesenteric and omental cysts. Arch surg 1984;119:838-42.
5. Uramatsu M, Saida Y, Nagao J, et al. Omental cyst. Report of a case. Surgery Today 2001;31:1104-06.
6. Hebra A, Brown MF, Mc Geehen KM, Ross III A J. Mesenteric, omental and retroperitoneal cysts in children: A clinical study of 22 cases. South Med J 1993;86:173-76.