TWISTED PARAOVARIAN CYST – A RARE CAUSE OF ACUTE ABDOMINAL PAIN

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Abstract

Torsion of uterine adnexa is an important cause of acute abdominal pain. Torsion of ovarian masses is quite common. However, torsion of paraovarian cyst is very rare. Torsion of fallopian tube and paraovarian cyst are usually seen in the reproductive age group. Physicians need to keep in mind that there is a strong possibility of this uncommon and difficult to diagnose cause of abdominal pain.

Keywords: Torsion; Paraovarian cyst; Acute abdomen; Pain

Introduction

Torsion of uterine adnexa is an important cause of acute abdominal pain.¹² Torsion of ovarian masses is quite common and isolated torsion of fallopian tube has also been reported in literature.²³ However torsion of paraovarian cyst is a very rare event.

Paraovarian cyst/ Paratubal cyst are benign, fluid filled cyst in the adnexa adjacent to ovary and fallopian tube, presumed to be the remnants of the mullerian duct or the wolffian duct.

It is common in the third to fifth decades of life.² Incidence is about 3%. Paraovarian cysts represent approximately 10% of all adnexal masses.⁴⁵ Most are small (1 to 8 cm) and asymptomatic, found at surgery or during imaging examination for another reason.⁴ Large cysts may reach 20 cm or more and become symptomatic exerting pressure and pain symptoms in lower abdomen. It can lead to torsion of the adnexa causing acute pain. We report a rare case of twisted paraovarian cyst which presented as an adnexal mass causing acute abdominal pain.

Case Report

A 42-years-old lady, multiparous with three normal deliveries came to the casualty with complaints of lower abdominal pain which was more over the right iliac fossa—since last two days. Pain was spasmodic in nature radiating to her back associated with nausea and vomiting. Patient was a known hypertensive on treatment. She had regular menstrual cycle but her LMP was 6 weeks ago in this cycle. Her urine pregnancy test and serum beta-HCG were done to rule out pregnancy. The pregnancy test was negative. On general examination-patient was stable with pulse-98/min, blood pressure-140/90 mm Hg, afebrile, but pallor was present, per abdominal examination revealed right iliac fossa tenderness. On per speculum examination cervix and vagina were healthy, on per vaginal examination uterus was anteverted, non tender and mobile. A tense tender cystic mass of 5X6 cm size was felt separate from uterus in right fornix. Blood and urine reports were within normal limits. Her abdominal and pelvic ultrasonography was done which suggested cystic lesion measuring 5.3X6.2X4.2cm adjacent to right ovary with absent vascularity and separated from right ovary. A diagnosis of torsed cyst was suspected.

She was immediately posted for laparoscopic right adnexal cyst excision. Intraoperatively bluish black cyst adjacent to right ovary with one anticlockwise torsion was seen. Bilateral ovaries and left sided fallopian tube were looking normal. Right sided fallopian tube had undergone torsion once along its pedicle(Figure 1&2).

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Figure 2. Twisted paraovarian cyst along with fallopian tube torsion

Torsion was corrected with detorsion of pedicle. Laparoscopic cystectomy was performed and specimen was retrieved using endobag and was sent for histopathology. Histopathology report was suggestive of simple twisted haemorrhagic right paraovarian cyst. Postoperative period was uneventful. She was discharged on 3rd postoperative day.

Discussion
Paraovarian cyst arises from the mesothelium covering the peritoneum and also from the paramesonephric tissue (paramesonephric cyst or mullerian cyst) and rarely from mesonephric remnants of mesonephric cyst or wolffian cyst. They are usually discovered incidentally during surgery and prophylactic excision is performed due to an increased incidence of torsion as well as their propensity to undergo rapid enlargement.

Paraovarian cyst torsion is rare, therefore diagnosis may be delayed. Torsion is three times more common in pregnant women than in the nonpregnant state because the uterus fills the pelvic cavity at the end of 12 weeks and the cyst has more space to undergo torsion. Other complications include haemorrhage, rupture and infection. Malignant neoplasms arising from paratubal cysts are very rare. Physician need to maintain a high index of suspicion for this uncommon and often difficult to diagnose cause of abdominal pain. In sonographic view, they have the same characteristics as ovarian cyst, being differentiated by smaller size, adjacent to ovary and persistence. Colour Doppler sonography may be helpful in detecting viability of adnexal structures by showing blood flow within the twisted vascular pedicle and in the presence of central venous flow. MRI is a useful problem solving tool in the evaluation of adnexal torsion.

Conclusion
Paraovarian cyst torsion should be always considered in the differential diagnosis of acute abdomen in women. Timely diagnosis and treatment of these cysts may prevent the rare complications of torsion and rupture.

Editor’s comments:
Torsion of the paraovarian cyst is a rare cause of acute abdominal pain. Unfortunately, it is not considered initially when a patient presents with abdominal pain.
The lack of specificity of the clinical signs and symptoms often fail to alert the clinician to the condition, making diagnosis difficult. Colour Doppler sonography and MRI are useful problem solving tools in the evaluation of adnexal torsion.

References