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Multiple Peritoneal Inclusion Cysts in Post Operative Case of Ectopic Pregnancy.

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ABSTRACT
MULTIPLE PERITONEAL INCLUSION CYSTS, ALSO KNOWN AS PERITONEAL PSEUDOCYSTS, MULTICYSTIC MESOTHELIOMA, AND BENIGN CYSTIC MESOTHELIOMAS, ARE A TYPE OF CYST-LIKE STRUCTURES THAT APPEARS IN RELATION TO THE PERITONEAL SURFACES AND RESULTS FROM A NON-NEOPLASTIC REACTIVE MESOTHELIAL PROLIFERATION. PERITONEALINCLUSIONCYSTSAREUNCOMMONABDOMINOPELVICCYSTSSEENINPERIMENOPAUSAL WOMEN.ITISOFTEN MISDIAGNOSEDCLINICALLYASANOVARIANTUMORDUETOSIMILARPRESENTATIONANDMIMICKING FINDINGSONRADIOLOGY.WE DESCRIBEAPERIMENOPAUSALWOMANPRESENTINGWITHPELVICMASS.HERCLINICALFINDINGONRADI OLOGYSUGGESTEDANOVARIAN TUMOR;HOWEVER,BIOPSYREVEALEDITASPERITONEALINCLUSIONCYSTS WITH CHRONIC INFLAMMATORY CHANGES.WEDISCUSSTHEPOSSIBLEWAYSTOAVOIDSUCHMISTAKES.

KEY WORDS*: MUCINOUS CYSTADENOMA OF OVARIES, PERIMENOPAUSAL WOMEN, PERITONEAL INCLUSION CYSTS*

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I. INTRODUCTION

PERITONEAL INCLUSION CYSTS, ALSO KNOWN AS PERITONEAL PSEUDOCYSTS, MULTICYSTIC MESOTHELIOMA, AND BENIGN CYSTIC MESOTHELIOMAS, ARE A TYPE OF CYST-LIKE STRUCTURES THAT APPEARS IN RELATION TO THE PERITONEAL SURFACES AND RESULTS FROM A NON-NEOPLASTIC REACTIVE MESOTHELIAL PROLIFERATION. PERITONEALINCLUSIONCYSTS (PIC)AREUNCOMMONMESOTHELIUM-LINEDABDOMINOPELVICCYSTSSEENINPERI MENOPAUSALWOMEN. IT PRESENTS AS PELVIC MASS OR WITH PELVIC PAIN AND MAY BE MISDIAGNOSEDASANOVARIANTUMOR.

II. CASE REPORT

A 29 YEAR MULTIPAROUS WOMAN CAME TO SURGERY OPD WITH CHIEF COMPLAINT OF BILATERAL FLANK PAIN SINCE 10DAYS ASSOCIATED WITH NAUSEA AND PAIN IN LOWER ABDOMEN. NO ANYOTHER COMPLAINTS LIKE BURNING MICTURITION, WEIGHT LOSS AND IRREGULAR MENSES, PER VAGINAL DISCHARGE WITH ADEQUATE SLEEP AND APPETITE AND NORMAL BOWEL BLADDER ACTIVITIES WERE THERE. PATIENT WAS OPERATED FOR ECTOPIC PREGNANCY BEFORE 1 YEAR AT GOVT. HOSPITAL JAMNAGAR THROUGH PFANNENSTIEL INCISION. ON PER ABDOMEN EXAMINATION ABDOMEN WAS SOFT NON TENDER WITH A PALPABLE BALLOTABLE MASS IN THE LOWER ABDOMEN WITH DISTINCT SMOOTH MARGINS. PERSPECULUM EXAMINATION SHOWED FEATURES OF MIXED VAGINITIS. RESULTS OFROUTINEBLOODINVESTIGATIONAND CA 17.7 &CA-125WEREFOUND WITHINNORMALLIMITS. ON USG EXAMINATION AN ILL DEFINED IRREGULAR SHAPED MARGINATED ANECHOIC LESION MORE THAN PROBE SIZE WITH LACK OF LIMITING WALL IS NOTED IN PELVIC CAVITY. BILATERAL OVARIES SHOWS MULTIPLE FOLLICLES AND ENCASEMENT OF THEM BY THE LEISON IS NOTED. WITH ANTERIOR DISPLACMENT OF UTERUS SUGGESTIVE OF PERITONEAL INCUSION CYST. CECT ABDOMEN WAS DONE AND IT WAS SUGGESTING LARGE WELL DEFINED NON ENHANCING MULTI LOCULATED CYSTIC LESION WITH IMPERCEPTIBLE WALL OF APPROXIMATE SIZE OF 11*16*18 CM WITHIN PELVIS WITH LACK OF LIMITING WALL. IT SHOWS ENCASEMENT OF BOTH OVARIES.

PATIENTUNDERWENTELECTIVELAPAROTOMYINVIEWOF THE LARGE OVARIAN MASS. INTRAOPERATIVE FINDINGS**(IMAGE 1A 1B 1C)**CONFIRMED PERITONEAL INCUSION CYSTWITH HEALTHYOVARIES. 4DISCRETE TRANSPARET THINWALLED,SMOOTHSURFACED,CLEARFLUIDFILLED ANDVARIABLYSIZEDCYSTS(5-12CM)STUDDEDUTERO-VESICAL FOLD,BROADLIGAMENT,PELVISANDRETROPERITONEALSPACES . THE LARGEST CYST OF SIZE 10*8 OVAL SHAPED CYST WAS FOUND ADHERED WITH THE RIGHT OVARY AND UPPER BORDER OF THE UTERUS WHICH WERE SEPARETED WITH THE HELP OF BLUNT DISSECTION. OTHER CYST WHICH WERE ADHERED TO THE UTERUS AND LEFT OVARY WERE DISSECTED OUT WITH HELP OF BLUNT DISSECTION. BOWELS APPEAR UNREMARKABLE WITHOUT ANT PATHOLOGY. PATIENT UNDERWNT UNEVENTFUL LAPAROTOMY FOR CYST REMOVAL AND DISCHARGED ON 5^{TH} DAY. HISTOPATHOLOGY **(IMAGE 2A 2B)**SUGGESTED PERITONEAL INCLUSION CYST WITH CHRONIC INFLAMMTORY PROCESS.

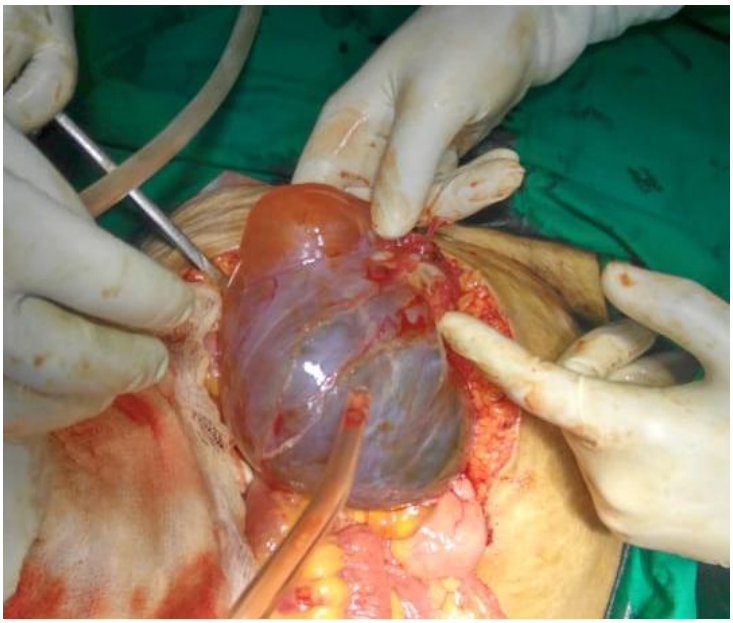

IMAGE 1A(THE LARGEST CYST).IMAGE 1B()

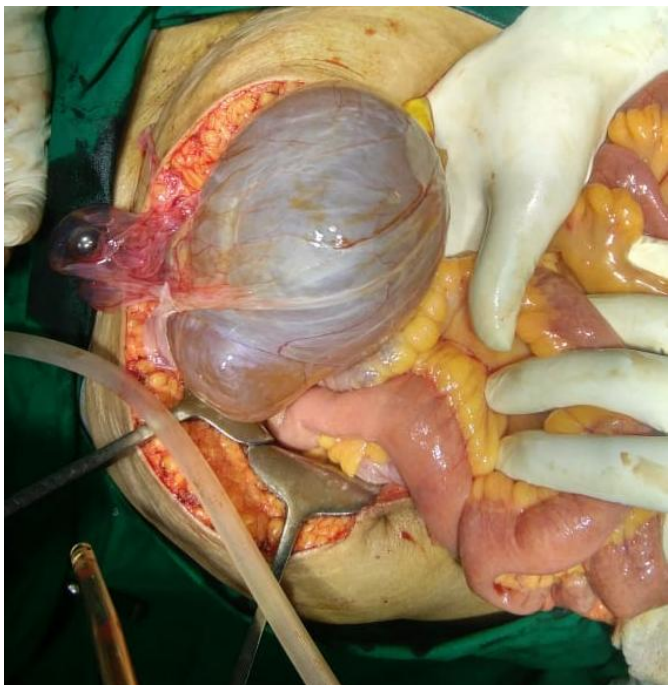

IMAGE 1B()

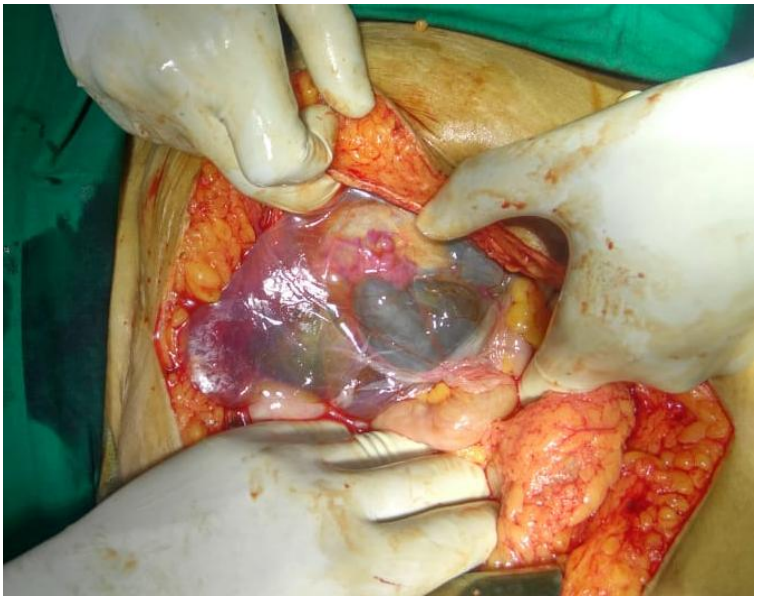

IMAGE 1C(MULTIPLE SMALL CYSTS)

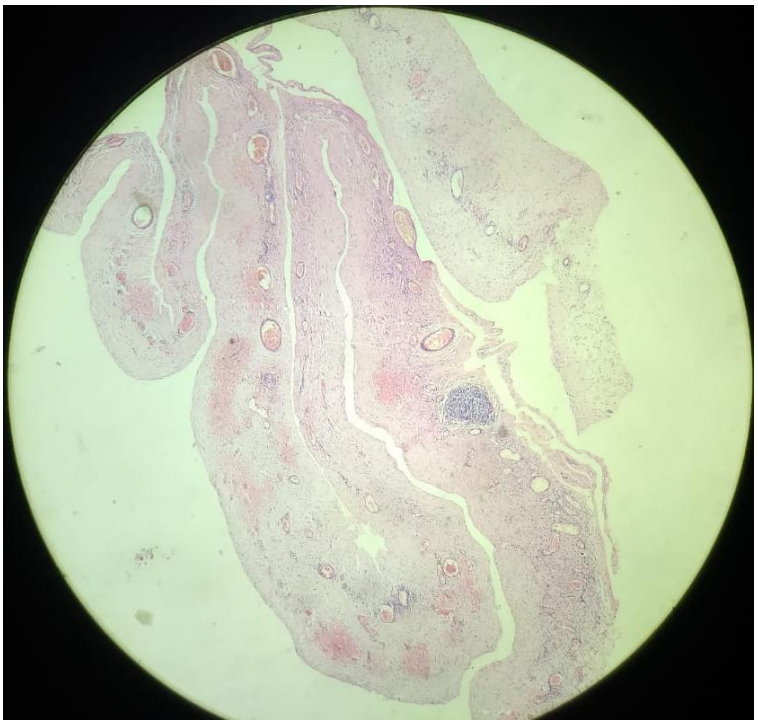

IMAGE 2A (10X POWER)CYSTIC ARCITECTURE SEEN WITH CONGETION AND INFLAMMATION. CYSTIC WALL FORMED BY PERITONEAL TISSUE.

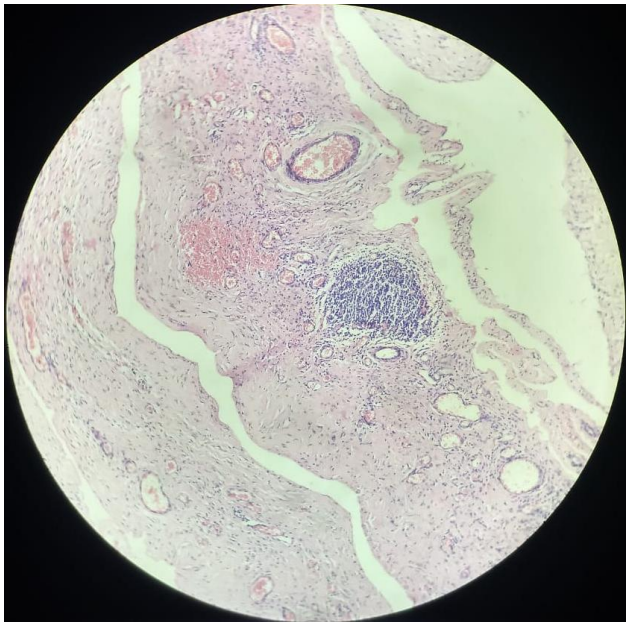

IMAGE 2B(4X POWER)

III. DISCUSSION

USUAL PRESENTATION IS PROGRESSIVE ABDOMINAL OR PELVIC PAIN OR PALPABLE MASS ASPRESENTINOURPATIENT.RARELYTHERECANBEBACKACHE, DYSPAREUNIA,CONSTIPATION,TENESMUS,URINARYFREQUENCY OR INCONTINENCE, ANOREXIA, DYSFUNCTIONAL UTERINE BLEEDING, OR INFERTILITY. PULMONARY EMBOLISM AND VENOUS STASIS MAY ALSOOCCURSECONDARYTOCOMPRESSION.RISKFACTORSINCLUDE PREVIOUSINTRAPERITONEALSURGERIESPERFORMED6MONTHSTO 20YEARSEARLIERBYANYROUTE,INTRAPERITONEALINFLAMMATION, PELVICINFLAMMATORYDISEASE,PERITONEALTUBERCULOSIS, LEIOMYOMA,TUBO-OVARIANABSCESS,ETC.OURPATIENTHAD TUBALLIGATION,LEIOMYOMAANDPELVICINFLAMMATORYDISEASE.

PIC MAY BE MISDIAGNOSED AS MUCINOUS CYSTADENOMA OF OVARIES FOR SIMILAR PRESENTATION AND SLIGHTLY RAISED CA125 DERIVEDFROMCOELOMICEPITHELIUMINBOTHCONDITIONS. USGFEATURESARENON-SPECIFIC,WITHSMOOTHTHIN WALLEDMULTISEPTATECYSTSCONTAININGLIQUIDOF DIFFERENT ATTENUATION.[2] CT SCAN SIMILARLY GIVE COBWEB APPEARANCE OF LOCULATED FLUID WITH SEPTATIONS WITHIN, CONFORMING TO THE PERITONEAL SPACE WITH IPSILATERAL OVARY WITHIN IT OR IN THEWALL.INTRAOPERATIVEPICTYPICALLYPRESENTSASCONFLUENT MASSORDISCONTINUOUSCYSTSSTUDDEDTOGETHER.

POSTULATEDPATHOLOGYFORPICINCLUDESINABILITY TOABSORBPHYSIOLOGICALSECRETIONSOF ACTIVEOVARIESBY DISEASED, INFLAMED OR FIBROSED PERITONEUM FORMING CYSTS WITHINPERITONEALADHESIONS.[3]WEMISSEDTHEDIAGNOSISOF THISUNCOMMONENTITYPOSSIBLYBECAUSEOF SIMILARAGE, SYMPTOMS,SIGNSANDUSGFEATURESMIMICKINGBENIGN MUCINOUS CYSTADENOMA OF OVARY.

CONSERVATIVE TREATMENT (USE OF GNRH ANALOGS, ORAL CONTRACEPTIVES TO SUPPRESS OVULATION, PAIN MEDICATION) IS THE FIRST LINE OF TREATMENT. IMAGE-GUIDED TRANSVAGINAL FLUID ASPIRATION AND SCLEROTHERAPY HAVE BEEN ATTEMPTED WITH PARTIAL SUCCESS.

SURGICAL RESECTION OF ADHESIONS IS NECESSARY ONLY IN SELECTED CASES. AFTER SURGICAL RESECTION, THE RISK OF RECURRENCE IS 30-50%. PERITONEAL INCLUSION CYSTS HAVE NO MALIGNANT POTENTIAL DESPITE THE OCCASIONAL OCCURRENCE OF METAPLASIA.

HORMONESINCLUDEORALCONTRACEPTIVES, TAMOXIFEN,LEUPROLIDE, ETC.ASPIRATIONWITHORALCONTRACEPTIVE

COMBINATIONGIVESGOODRESULT.USG/FLUOROSCOPY-GUIDED SCLEROTHERAPYWITH10% IODINEORABSOLUTEETHANOLREPORTED90%SUCCESSRATE.
THEGOLDSTANDARDTREATMENTISCOMPLETERESECTIONLAPAROS COPICALLYORBYLAPAROTOMY.

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