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Case Report

Laparoscopic Management of a Giant Paratubal Cyst: A Case Report

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ABSTRACT:
We report the laparoscopic management of a giant paratubal cyst in a 17-year-old girl. The patient consulted us because of a significant increase in the size of her abdomen. We chose the laparoscopic approach because of the benign nature of the tumour, thus avoiding a useless and unsightly median laparotomy for this young patient.

Keywords : Giant paratubal cyst, Benign tumour, Laparoscopy, A case report.

INTRODCUTION:

Paratubal cysts are common benign tumours accounting for around 10% of all adnexal masses [1], and are usually no larger than 6 cm [2]. They rarely reach large volumes as described in our patient with dimensions of 29 cm and 10 litres intraoperatively. Most of these formations are benign, but several cases of degeneration to adenocarcinoma have been described [3]. They can cause complications such as adnexal torsion, haemorrhage or rupture.

Patient and Observation:

Patient Information :

- We report the case of a 17 year old female patient with no history of pathology and well adjusted with a giant para ovarian cyst measuring 29 cm.
- Clinical examination revealed a distended abdomen completely filled by a painless renal mass extending below the rib cage.
- Abdominopelvic ultrasound revealed a pure hypoechoic liquid mass with a regular wall without vegetations or partitions, extending from the pelvis to the base of the thorax.
- MRI showed a thin-walled serous unilocular right ovarian cyst classified ORADS 2 measuring 29.5 cm x 29 cm x 14 cm (Figure 1), with normal tumour markers.

Therapeutic Intervention:

The patient was operated on by laparoscopy, under general anaesthetic, using an open laparoscopic trocar under the left rib to gain access to the abdominal cavity, to monitor the cyst and to confirm that there were no intestinal or epiploic adhesions.
The cyst is aspirated by direct introduction of the operating trocar with its nail into the cyst (Figure 2) and aspiration of 10 litres of a citrine yellow liquid. Exploration reveals that it is ultimately a para-ovarian cyst (Figure 3).
A 2 cm suprapubic incision was made (Figure 4) for a transparietal cystectomy in order to perform an extraperitoneal cystectomy (Figure 5).

Follow-up and Results:

The patient progressed well and was discharged the day after the operation.
The anatomopathological study concluded that it was a para-tubal cyst

DISCUSSION:

- Paratubal cysts are common tumours; their embryological origin usually derives from

mesonephrotic or parametonephrotic wolfian remnants or mesothelial inclusions [4].

- Paratubal cysts are often benign tumours. However, in rare cases they may be malignant. [5]. In the form of adenocarcinomas in approximately 2 to 3% of cases [6] [7]. They may be responsible for the usual complications of adnexal masses, i.e. adnexal torsion, haemorrhage or rupture.
- Ultrasonographically, the lesion is generally unilocular, thin-walled, hypoechoic and fluid-filled, with no intra- or exocystic septa or vegetations [8].
- Diagnosis depends on identification of the homolateral ovary, which is not always easy; in our patient, neither ultrasound nor MRI was diagnostic.
- Surgical management of these large cysts by laparoscopy has been the subject of several [9], with initial aspiration of the cyst contents followed by either intraperitoneal or transparietal cystectomy. The parietal incision is essential to extract the cyst.

CONCLUSION:

This case demonstrates that the abdominal cavity can be explored laparoscopically despite the presence of a giant mass, but the first trocar must be under the left rib to avoid invasion of the cyst.

Laparoscopy offers an undeniable advantage: it allows the abdominopelvic cavity to be fully explored, eliminates the risk of malignancy and adhesions, and avoids the need for a midline laparotomy, which allows patients to recover quickly with minimal harm.

Conflicts of Interest:

The authors declare no conflicts of interest.

Authors' Contributions:

- Lounas BENGHANEM: data collection, bibliographic research and writing of the article.
- Bouzid ADDAD: proofreading and supervision of the writing of the article.
- Lydia FAÏD: proofreading and supervision of the writing of the article.
- Kamel HAÏL: proofreading and supervision of the writing of the article.

Figures:

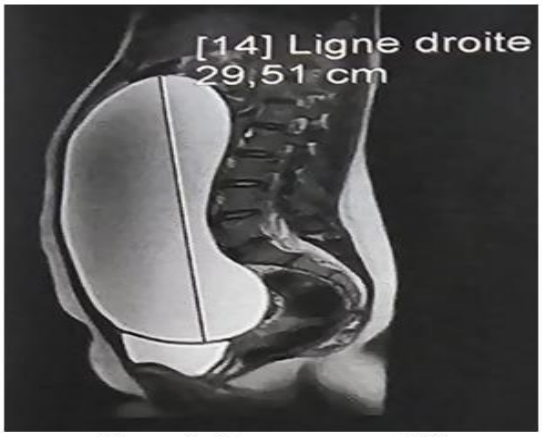

Figure 1 : Appearance on MRI

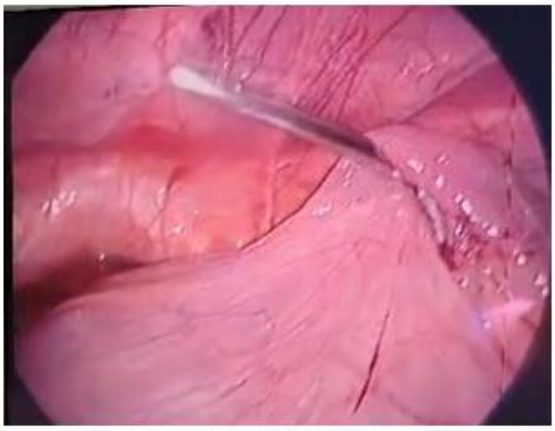

Figure 2 : Aspiration of the cyst

Figure 3 : para-tubal cyst

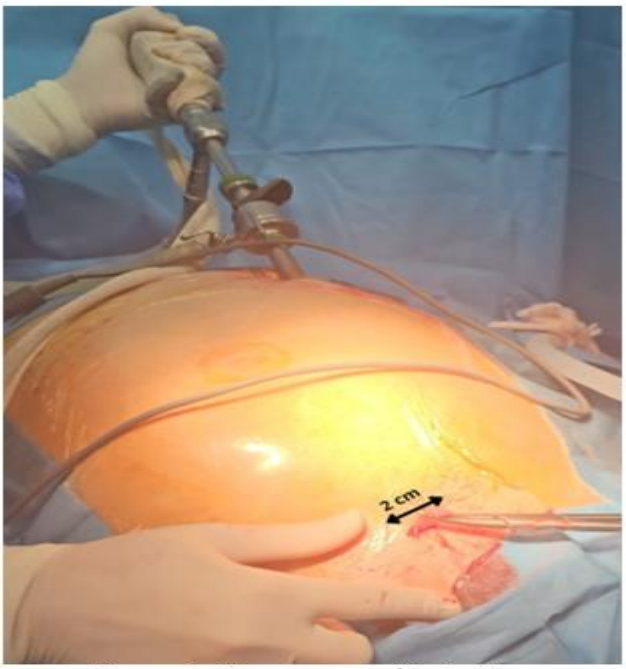

Figure 4 : 2 cm suprapubic incision

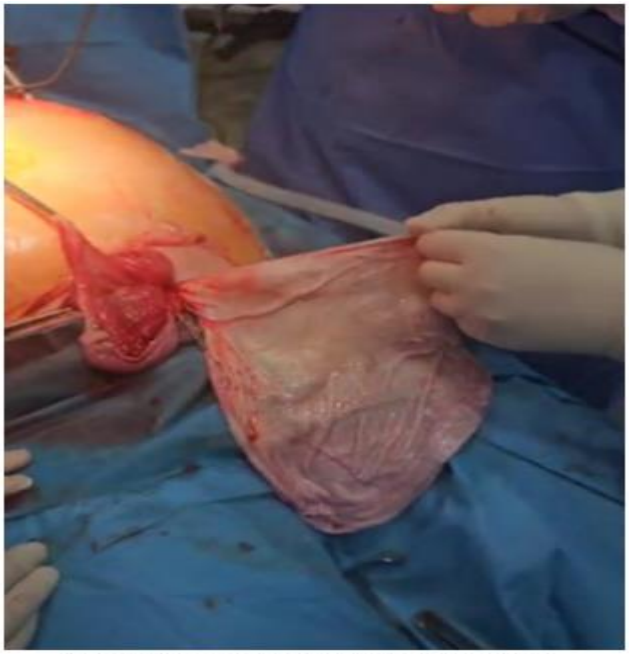

Figure 5 : extra-peritoneal cystectomy

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