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CASE REPORT

Huge fimbrial cyst causing bilateral hydroureteronephrosis - a rare case report

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ABSTRACT

Small fimbrial cysts are most commonly seen, sometimes become larger and presents with symptoms. Here we presents a case of huge fimbrial cyst detected incidentally in a 20 year nulligravida came to out patient department with abdominal distention. Examination and imaging revealed large abdominopelvic cystic mass with no solid areas or septations. Minilaparotomy done, right fimbrial cyst was evident, cyst wall removed intoto. Histopathology confirmed fimbrial origin. Paraovarian cyst should be included in the differential diagnosis of a cystic mass visualized on ultrasound.

Keywords: Paraovarian cysts, fimbrial cyst, adenexal mass.

Fimbrial cyst represents approximately 10% of adnexal masses.[1] In most of cases they are very small, but very few cases are reported in literature where they exceed 15 cm in diameter. It is very difficult to differentiate it from ovarian cyst on ultrasonography. Such huge cyst may present with discomfort like pain, torsion or rupture and sometimes totally asymptomatic.

Case report

A 20 years old girl married, nulligravida came to out patient department with complains of distention of abdomen since 3months. Otherwise patient was comfortable. She had history of 3 months of amenorrhea followed by menses. On abdominal examination cystic tense mass up to 34 weeks size felt. On vaginal examination uterus was difficult to palpate.

On ultrasound large cystic lesion in abdomen and pelvis was seen. Right ovary was not visualized separately. Left adnexa was normal. In CT abdomen and pelvis a large 12x 20x 21 (APXMLXSI) cm sized, well defined thin walled cystic lesion showing mild heterogenous enhancement of wall arising from right adnexa and its extension to abdomen. Mass effect was seen on the urinary bladder, adjacent bowel loops, spleen, pancreas and kidney. Mass effect was seen on bilateral ureter at the level of illial vessel crossing with bilateral mild proximal hydronephrosis and hydroureter. The level of CA-125 and LDH (Lactate Dehydrogenase) was 32.6U/ml and 642 U/L respectively. Rest lab reports were within normal limits.

Minilaparotomy was done with 3cm infraumbilical midline vertical incision. An aproximately 2.5 liter of clear fluid was aspirated from cyst. Cyst found to be arising from terminal portion of right fallopian tube and fimbria (Figure 1). Right ovary was normal. Cystectomy

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was done. Cyst wall sent for histopathology. Left ovary and tube was normal. Uterus was normal size.

Postoperatively patient recovered well. Histopathology report suggestive of fibrocollagenous cyst wall lined by

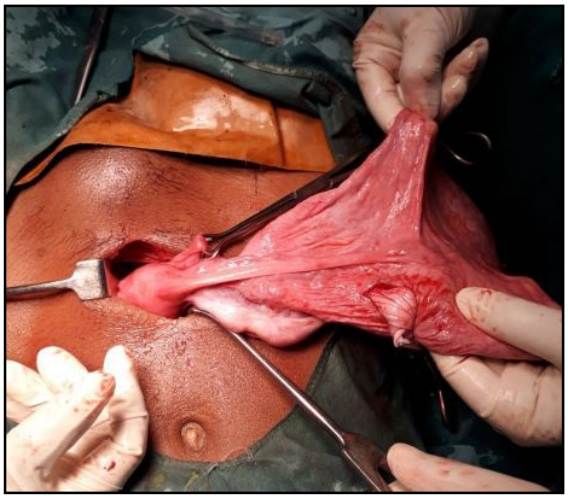

Figure 1: Laparotomy showing fimbrial cyst

fallopian tube like epithelium of low columnar to cuboidal epithelium, noncilliated and surrounded by prominent layer of smooth muscle. Features were consistent with fimbrial cyst.

Discussion

Paraovarian cyst are usually small, they rarely large enough to be clinically significant. Majority have been reported in young women.[2] Most of patients are asymptomatic. Symptoms are because of pressure effects of huge cyst, rupture or torsion, lower abdominal pain, discomfort, abdominal distension and menstrual irregularities. In our case though the fimbrial cyst was so huge, she was asymptomatic and was detected as an incidental finding.

Paraovarian cysts can show a wide range of sonographic features.[3] Sonographycally they are usually thin walled, smoothly marginated, unilocular cysts. Their risk of malignancy is low if no papillary projections are detected at transvaginal sonography, but when mural proliferations are present, a borderline tumor can be found at pathological examination. MRI might be useful in making a preoperative diagnosis.[4]

Paraovarian cyst should be included in the differential diagnosis of a cystic mass visualized on ultrasound.

Conflict of interest: None. **Disclaimer:** Nil.

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