

Giant ovarian mucinous cystadenoma misdiagnosed as massive ascites

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ABSTRACT

Introduction: Mucinous cystadenoma is a benign cystic tumour of the ovary that originates from the surface epithelium. It typically presents with non-specific abdominal symptoms, and if not detected early, it can grow to a significant size and lead to complications. This case report aims to illustrate how a giant cystic ovarian tumour can mimic the diagnosis of ascites in a post-menopausal woman, emphasizing the importance of early detection and intervention to achieve a favourable prognosis. **Case Description:** We present a case of a 63-year-old multiparous woman who was referred to our centre with a pronounced abdominal distension, initially mis-diagnosed as massive ascites. A computed tomography scan revealed a cystic lesion measuring 26.5 x 30.2 x 38.1 cm, occupying the abdominal cavity. The patient underwent exploratory laparotomy with salpingo-oophorectomy, and her post-operative recovery was uneventful. Histopathological examination confirmed the diagnosis of mucinous cystadenoma. **Discussion:** Giant cystic ovarian tumours can mimic massive ascites, resulting in a misleading diagnosis and a delay in management, as demonstrated in this case. By reporting this case, we aim to raise awareness and increase suspicion of giant ovarian cysts in all women presenting with significant ascites, thereby facilitating early detection and appropriate management.

Opps! IUCD in my poop!

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ABSTRACT

Introduction: Bowel perforation due to IUD (Intrauterine device) is rare but implies serious complications. It occurs in 1.6 per 1,000 insertions. We encountered a spontaneous expulsion of IUD after laxatives. Our case highlights the conservative management of transmigration of IUD. **Case Description:** Madam A, 30-year-old, G5P4 had a pregnancy with IUD in situ. The patient underwent uncomplicated delivery. However, the IUD was not expelled. A transabdominal scan post-delivery revealed an empty uterus. Abdominal X-ray shows an IUD near the fundus of the uterus. CT pelvis noted the IUD had migrated into the rectosigmoid colon. She was referred to the surgical team and was prescribed oral Foltran in the ward prior to colonoscopy. Sigmoidoscopy revealed an empty colon. Repeated abdominal X-ray post-procedure could not visualise the IUD. **Discussion:** The most common region of perforation of IUD is at the posterior wall of the uterus to the Pouch of Douglas. Transmigration of the IUD into the bowel may be due to the enlarging gravid uterus and contractions. Different methods are practiced for removal of the transmigrated IUD such as colonoscopy, laparoscopic removal or mini-laparotomy. The patient had spontaneous expulsion of the IUD after taking laxatives. This proves that conservative management can be considered for patients before deciding on invasive procedures. **Conclusion:** IUD is a commonly used contraception but the failure rate is still 1-2%. Pregnancy with an IUD in situ possess a clinical challenge and needs meticulous examination in locating the IUD post-delivery.