INTRODUCTION

The incidence of adnexal masses in pregnancy is 0.5 – 2/1000 pregnancies. More than 90% of cysts are benign. Physiological cysts are common before 12 weeks, Organic cysts like dermoid are common after 16 weeks. Dermoid and cystadenomas comprise 60% of the total adnexal masses removed during pregnancy. Symptoms are variable. One third of adnexal masses are found incidentally during routine ultrasound in early pregnancy. Pain is the most frequent symptom in case of cyst accident (torsion, rupture, hemorrhage). Mucinous cystadenomas are benign epithelial tumours that are typically multilocular, thin walled cysts with smooth external surface containing mucinous fluid. These are amongst the largest tumours of ovary, may reach enormous dimensions. Of all ovarian tumours, mucinous tumours comprise 12% to 15% and 75% of all mucinous tumours are benign, 10% borderline, 15% are invasive carcinoma. The most frequent and serious complication of a benign cyst during pregnancy is torsion. The incidence is reported to be 5%. Torsion is common in the first trimester or puerperium leading to even rupture of the cyst into the peritoneal cavity. Patients, undergoing emergency surgery because of torsion or hemorrhage are at the greatest risk of spontaneous abortion or premature delivery compared to elective surgery, which must be delayed till 2nd trimester.

The present report describes the rare occurrence of a huge ovarian cyst in a pregnant patient.

CASE REPORT

A grand multipara lady, aged 30 years, presented with gestational amenorrhea of about 07 months with abdominal discomfort and breathlessness for last 15 days. Sonographic examination demonstrated a huge, unilocular ovarian cyst and an alive fetus of about 30 weeks gestation. Intraoperative findings were huge left ovarian cyst (42x40x20 cm) with straw coloured mucinous fluid. Left salpingo-oophorectomy was performed followed by peritoneal washings and omental biopsy. Histopathology revealed mucinous cystadenomas with inflammatory changes in omentum and no malignant cells in peritoneal washings. She delivered vaginally a female baby of 3.5 kg at 38 weeks with good Apgar score.
Histopathology revealed mucinous cystadenoma and inflammatory changes in omentum; peritoneal washings were clear. She was discharged with regular antenatal follow-up. She delivered vaginally a female baby of 3.5 kg at 38 weeks with good Apgar score.

**DISCUSSION**

Most of the adnexal masses are discovered incidentally during pregnancy because of the routine use of ultrasound. Tumour markers are unhelpful in normal pregnancy.

Management depends upon the symptoms, gestational age, size and characteristics of the cysts. If the mass is unilateral, unilocular and < 6 cm, observation is recommended. If mass is larger than 6 cm, solid, bilateral, persist into the second trimester or become symptomatic then the surgical intervention is required.1

Elective surgery should be delayed until second trimester. Simple cystectomy should be attempted as primary therapy. Contralateral adnexa should be examined for pathology. Once mass is removed it must be opened and examined. If there is any suspicion of malignancy frozen sections should be obtained and acted on accordingly. Most masses in pregnancy are benign in character and malignancy rate is low.1

Mucinous cystadenomas are benign epithelial ovarian tumours that are characterized by multilocularity, smooth outer and inner surface and tend to be large reaching 20-30 cm containing mucinous fluid. Mucinous cystadenomas are one of the largest tumours known.2 There are several case reports in literature showing huge mucinous cystadenomas complicating the pregnancy and need emergency surgical intervention as in this case.3-5

Qublan et al. described a 6300 g multiloculated right ovarian cystadenoma measuring 33x24x20 cm at 38 weeks of pregnancy associated with IUGR and malpresentation.6 This was not seen in this case despite the larger size of mass.

There are some reports of mucinous cystadenomas causing virilization during pregnancy.7,8 In these mucinous adenomas the stromal cells resemble lutein or Leydig cells and responsible for production of androgen and so after the removal of ovarian neoplasm virilizing manifestations disappeared. In addition, there have been several reported huge mucinous cystadenoma found in pancreas, mesentery and omentum during pregnancy.9,10

It is concluded that ovarian cyst in pregnancy must be followed-up properly. Early diagnosis and appropriate intervention is associated with best fetomaternal outcome.

**REFERENCES**

6. Qublan HS, Al-Ghoweri AS, Al-Kaisi NS, Abu-Khait SA. Benign mucinous cystadenoma with stromal luteinization during pregnancy: a hormonally responsive tumor and a rare cause of

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**Figure 1:** Cyst could be seen through the abdominal incision; a small incision is given on the cyst and mucinous fluid was aspirated.

**Figure 2:** Cyst was delivered out of abdomen after aspiration of 4 liters of mucinous fluid.


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