CPC DEPT OF GENERAL SURGERY

ABDOMEN, STILL A PANDORA`S BOX

A 53-year-old female, presented to the Surgery OPD with complaints of abdominal swelling and intermittent dull aching pain in the lower abdomen for the past 3 months. The swelling was insidious in onset and gradually progressed to the current size. The pain was non-radiating, non-migratory, and relieved with medication.

She also reported associated symptoms including loss of appetite, nausea without vomiting, postprandial abdominal discomfort, stress and urge urinary incontinence, burning micturition, increased frequency of urination, and constipation. There was no history of fever, weight loss or gain, or trauma.

She had undergone hysterectomy and appendicectomy 25 years ago. There is no history of similar complaints in the past or any comorbidities. She follows a mixed diet and reports adequate sleep but decreased appetite and irregular bowel and bladder habits. There is no history of addictions or drug allergies. Family history was not contributory.

General examination, she was conscious, coherent, and oriented, with no pallor, icterus, cyanosis, clubbing, lymphadenopathy, or pedal edema.

Her vital signs were stable: temperature 98.6°F, pulse 86 bpm, blood pressure 110/70 mmHg, respiratory rate 16/min, and SpO_2 99% on room air.

Abdominal examination -the abdomen was distended with fullness predominantly in the lower abdomen, left flank, left hypochondrium, and epigastric region. A sub-umbilical midline scar was noted. A solitary, vertically oval mass approximately 22x18 cm was palpable, extending from 6 cm above the umbilicus to the pubic symphysis and laterally into both lumbar regions. The mass was firm, smooth, non-tender, had well-defined borders, restricted mobility, and was dull to percussion with surrounding resonance. There was no cough impulse or pulsations, and the mass became less prominent with leg raise and head raise. The mass does not fall forward on knee elbow position. No free fluid noted.

Bowel sounds were present on auscultation. Per rectal and per vaginal examinations were unremarkable.

INVESTIGATIONS - Hb-11.1 gm/dl ,Total WBC count13,000cells/ml ,Pcv-31.3%,

Platelets- 4,19,000 Cells/microliter,PT-13.5 Sec, INR-1.2,aPTT-33.5 Sec.

ULTRASONOGRAPHY OF ABDOMEN AND PELVIS:-

Large well defined cystic lesion approx 22 x18.4 x 10.5cms noted extending from pelvis more towards right side till epigastric region in abdomen.Multiple internal septations with free floating internal echoes noted. Few cystic areas noted in periphery of cyst- possible loculations

CT ABDOMEN AND PELVIS