# Vaginal ovarian cystectomy during vaginal hysterectomy

## *A case report*

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A 27 year old patient had four children by normal delivery and was admitted for hysterectomy because of heavy periods that did not respond to medical treatment. Examination under anaesthesia (EUA) revealed an anteverted, mobile, normal size uterus. There was no genital prolapse. The right ovary felt slightly enlarged to about 4 cm in diameter but it was freely mobile. No abnormality was detected in the left adnexum. It was decided to perform the hysterectomy vaginally.

Following removal of the uterus both ovaries were inspected and palpated.

The left one was normal. The right ovary was enlarged ($5 \times 4 \times 4$ cm), with what appeared to be a benign dermoid cyst (mobile, smooth capsule, no ascites).

While the right ovary was outside the pelvic cavity, a large abdominal pack was threaded into the pelvis. This limited the mobility of the right ovary and also kept the bowel out of the may. Standard ovarian cystectomy was performed with due care not to rupture the cyst wall. The ovary was then reconstructed. Good haemostasis was achieved before closure of both the pelvic peritoneum and the vaginal vault. The total estimated blood loss was 150 mls and the total operative time was 55 minutes. The patient made a very good recovery and was discharged home on the fourth post operative day. Histological examination confirmed a benign dermoid cyst.

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## DISCUSSION

Laparotomy is the traditional route to perform ovarian cystectomy. Wood *et al.* ([1]) reported five cases of laparoscopic ovarian cystectomy. They described two techniques to remove dermoid cysts from the peritoneal cavity: (1) the cyst can be placed over a hole in the Pouch of Douglas and a needle inserted from the vagina to drain and deflate it, prior to removal; or (2) a plastic bag can be placed in the peritoneal cavity and the cyst placed in the bag which is then closed and removed from the pelvis.

Gynaecologists have become more aware of the surgical potential of the vagina

in pelvic surgery. Sheth and Malpani ([2]) reported 150 cases of routine oophorectomy at the time of vaginal hysterectomy. Magos *et al.* ([3]) reported three cases of myomectomy through the vaginal approach. To my knowledge no one has reported a vaginal approach as the primary access for ovarian cystectomy.

In the presented case the ovarian cyst was discovered accidentally during vaginal hysterectomy. If the presence of this cyst had been known beforehand the patient would have a pelvic ultrasound and CA 125 estimated prior to surgery. Besides EUA, diagnostic laparoscopy should have been performed to allow direct assessment of the size, mobility and capsule of the cyst, exclude pelvic adhesions, ascites or any other pelvic pathology before the start of vaginal hysterectomy and ovarian cystectomy.

In conclusion, in relatively young patients who suffer from a benign condition that requires hysterectomy but coincidentally are found to have an ovarian cyst, the vaginal approach for the hysterectomy and ovarian cystectomy is a safe option. The operative time and hospital stay are shorter compared to laparoscopic or laparotomy access respectively. It is very advisable to insure the benign nature of the cyst by pelvic ultrasound, serum CA 125 and intraoperative diagnostic laparoscopy.

REFERENCES

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