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Retroperitoneal Serous Cystadenoma

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Abstract: ***Primary Retroperitoneal Serous Cysts PRSCs are rare cystic lesions that often remain asymptomatic until they reach a considerable size. Early recognition and surgical resection are crucial to prevent malignant transformation, rupture, and secondary infection. This report discusses a case involving a 58 - year - old post - menopausal woman presenting with abdominal distension and discomfort. Clinical examination and imaging revealed a large retroperitoneal cystic mass. Surgical intervention led to the successful removal of the mass, and histopathological examination confirmed the diagnosis of a serous cystadenoma. The case highlights the importance of prompt evaluation and appropriate surgical management of PRSCs.***

Keywords: Primary Retroperitoneal Serous Cyst, PRSC, cystic lesions, abdominal distension, serous cystadenoma.

1. Introduction

- PRSCs are rare cystic lesions whose pathogenesis is not well understood.
- They are typically large, unilocular and contain a cyst wall comprised of single layer of cuboidal epithelium. [1]
- Their early recognition and resection are necessary to avoid malignant transformation, rupture, and secondary infection.
- Here we represent a case of abdominal distension and discomfort.

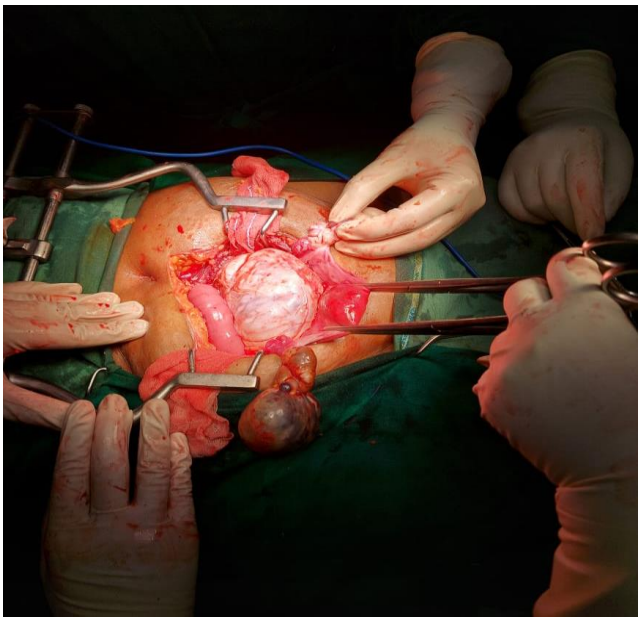
2. Case Report

A 58 - year - old, P3L3 with post - menopausal status, presented with complaints of abdominal distension and discomfort for the past month.

On Examination:
P/A: Palpable mass up to 32 weeks size with restricted mobility with slight tenderness on right side.
P/s: Cervix senile pulled up anteriorly, vagina healthy, PAP smear not taken due to the pulled - up cervix.
P/v: Uterus mobile, pulled up, posterior, forniceal fullness positive, bilateral fornices free, non - tender.
P/R: Cyst located high up.

Investigations:
- Ca125: 13.20, CEA: 1.39
- **USG** - Large multiloculated and septate cystic mass lesion measuring 16x9.8 cm with thick septations noted arising from the pelvis, suggestive of ovarian neoplasm.
- **HPE -** Chronic cervicitis, cystic atrophic changes in the endometrium, congested blood vessels in bilateral fallopian tubes, haemorrhagic cyst, and cystic follicles in the left and right ovaries respectively, peritoneal cyst suggestive of serous cystadenoma, appendix with fibrous obliteration.
- CT abdomen - No evidence of nodularity or septation.

Intraoperative Finding:
- Right ovarian cystic mass adherent to Right lateral pelvic wall
- Left ovary 1x1 cm cystic lesion noted within
- Large cystic mass measuring approximately 15x10 cm arising from the retroperitoneum, extending behind the rectum up to the pelvic floor, occupying the entire sacral and mesentery of the rectum. Adhesions were released, and the mass was removed intact and sent for HPE.
- Bilateral IP ligament identified clamp, cut & ligated, TAH + BSO done by standard procedure.



3. Results

- The retroperitoneal space is bounded anteriorly by the posterior part of the parietal peritoneum, posteriorly by the psoas and quadratus lumborum muscles, as well as the spine, superiorly by the diaphragm, and inferiorly by the muscular wall of the pelvis.
- The large size of this space enables lesions to grow and remain asymptomatic for a long period.
- Primary retroperitoneal cystic lesions are extremely rare because of a lack of epithelial cells in this region. Their incidence is difficult to estimate.
- The pathogenesis of primary RPCs is not well understood.

4. Discussion

- PRSCs should be differentiated from other forms of cystic retroperitoneal lesions based on history and microscopic appearance, as well as their malignant form, cystadenocarcinoma. [2]

- Diagnostic fluid aspiration is discouraged due to concerns about seeding during the procedure if the lesion is malignant. [3]
- The treatment of choice is complete surgical excision, which depends on the location, size, and expertise of the surgeon.

5. Conclusion

Primary Retroperitoneal Serous Cysts PRSCs are extremely rare and often asymptomatic until they reach a large size. This case underscores the importance of prompt evaluation and surgical intervention. [4] Advanced imaging techniques like CT and MRI play a critical role in identifying these lesions, but the definitive diagnosis relies on histopathology. [5] Despite their rarity, awareness and clinical suspicion are vital for timely management, preventing complications, and improving patient outcomes.

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