OVARIAN CYST IN HOMOEOPATHIC PRACTICE

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OVARIAN CYST

Introduction

- The ovary is a pair of glands either side of the uterus Produce hormones including the main female hormone, known as oestrogen and small amounts of androgens, such as testosterone. Ovaries *produce* ova (eggs) *from a small swelling called follicle* which then released into the uterus once a month, during the menstrual cycle. **Menstrual cycle**.
- During **follicular phase** water starts accumulating around the egg cell.
- An **ovarian cyst** is any collection of fluid, surrounded by a very thin wall, within an ovary. Any ovarian follicle that is larger than about two centimeters is termed an ovarian cyst. An ovarian cyst can be as small as a pea, or larger than an orange.[1]
- Most ovarian cysts are functional in nature, and harmless (benign) In the US, ovarian cysts are found in nearly all premenopausal women, and in up to 14.8% of postmenopausal women.[1]
- Ovarian cysts affect women of all ages. They occur most often, however, during a woman's childbearing years.[1]
- Some ovarian cysts cause problems, such as bleeding and pain. Surgery may be required to remove cysts larger than 5 centimeters in diameter.[1]
- Ovarian cysts are small fluid-filled sacs that develop in a woman's ovaries. Most cysts are harmless, but some may cause problems such as rupturing, bleeding, or pain; and surgery may be required to remove the cyst(s). It is important to understand the function of the ovaries and how these cysts may form.[2]
- Women normally have two ovaries that store and release eggs. Each ovary is about the size of a walnut, and one ovary is located on each side of the uterus. One ovary produces one egg each month, and this process starts a woman's monthly menstrual cycle. The egg is enclosed in a sac called a follicle. An egg grows inside the ovary until estrogen (a hormone), signals the uterus to prepare itself for the egg. In turn, the lining of the uterus begins to thicken and prepare for implantation of a fertilized egg resulting in pregnancy. This cycle occurs each month and usually

ends when the egg is not fertilized. All contents of the uterus are then expelled if the egg is not fertilized. This is called a menstrual period.[2]

- In an ultrasound image, ovarian cysts resemble bubbles. The cyst contains only fluid and is surrounded by a very thin wall. This kind of cyst is also called a functional cyst, or simple cyst. If a follicle fails to rupture and release the egg, the fluid remains and can form a cyst in the ovary. This usually affects one of the ovaries. Small cysts (smaller than one-half inch) may be present in a normal ovary while follicles are being formed.[2]
- Ovarian cysts affect women of all ages. The vast majority of ovarian cysts are considered functional (or physiologic). This means they occur normally and are not part of a disease process. Most ovarian cysts are benign, meaning they are not cancerous, and many disappear on their own in a matter of weeks without treatment. While cysts may be found in ovarian cancer, ovarian cysts typically represent a harmless (benign) condition or a normal process. Ovarian cysts occur most often during a woman's childbearing years.[2]

Classification[1]

A. Non-functional ovarian cysts

1. Serous Cystadenoma
2. Mucinous Cystadenoma
3. Dermoid cyst
4. Benign endometrioma or Chocolate cyst
5. Para ovarian cyst
6. Polycystic-appearing ovary

B. Functional ovarian cysts[1]

7. Follicular cyst
8. Corpus luteum cyst
9. Theca Lutein cyst

Non-functional cysts

There are several other conditions affecting the ovary that are described as types of cysts, but are not usually grouped with the functional cysts. (Some of these are more commonly or more properly known by other names.) These includes:[1]

Functional ovarian cysts:

- A functional ovarian cyst is a sac that forms on the surface of a woman's ovary during ovulation. It holds a maturing egg. Usually the sac goes away after the egg is released. If an egg is not released, or if the sac closes up after the egg is released, the sac can swell up with fluid.[2]

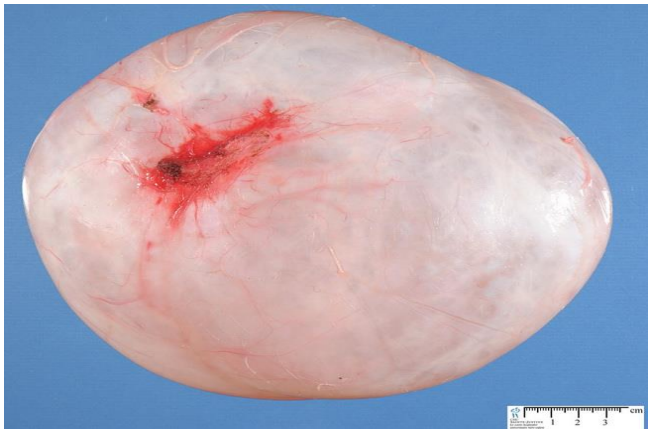
- Functional ovarian cysts are different than ovarian growths caused by other problems, such as cancer. Most of these cysts are harmless. They do not cause symptoms, and they go away without treatment. But if a cyst becomes large, it can twist, rupture, or bleed and can be very painful.[2]

- The development of a functional ovarian cyst depends on hormonal stimulation of the ovary. A woman is more likely to develop a cyst if she is still menstruating and her body is producing the hormone estrogen. Postmenopausal women have a lower risk for developing ovarian cysts since they are no longer having menstrual periods. For this reason, many doctors recommend removal or biopsy of ovarian cysts in postmenopausal women, particularly if the cysts are larger than 1-2 inches in diameter.[2]

- The size of the ovarian cyst relates directly to the rate at which they shrink. As a rule, functional cysts are 2 inches in diameter or smaller and usually have one fluid-filled area or bubble.[2]

- The cyst wall is usually thin, and the inner side of the wall is smooth. An endovaginal ultrasound can reveal these features. Most cysts smaller than 2 inches in diameter are functional cysts. Surgery is recommended to remove any cyst larger than 4 inches in diameter.[2]

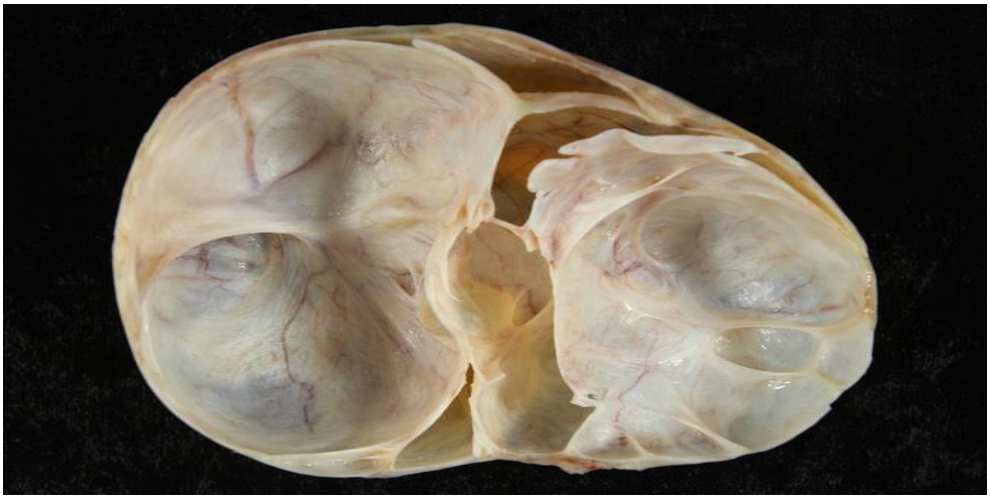
1. Serous Cystadenoma-[3]



- These are cystic benign neoplastic tumour with adenomatous and papillary proliferations.
- This is the most common benign neoplasm (20-40%).
- Bilateral in about 20%.
- **Size** is variable; on an average, moderate size.
- **Shape** is round.

- **Surface** is smooth; it may be with warty growths on the surface and inside the cyst.
- **Colour** Bluish white with translucent wall.
- **Consistency** is cystic or solid papillomatous.
- **Contents** – Watery fluid containing serum proteins-albumin and globulin.
- **Microscopical appearance** – Cystic cavities with single layer of low columnar epithelium which may be ciliated. Papillae-connective tissue core with epithelial lining. Connective tissue stroma. In potentially malignant, epithelia are many layered.
- **Complication** – Ascites due to infiltration of papillary growth on the peritoneum. Rupture-spontaneous due to perforation of the papilla. Malignancy- in about 25% cases.

2. Mucinous Cystadenoma-[3]



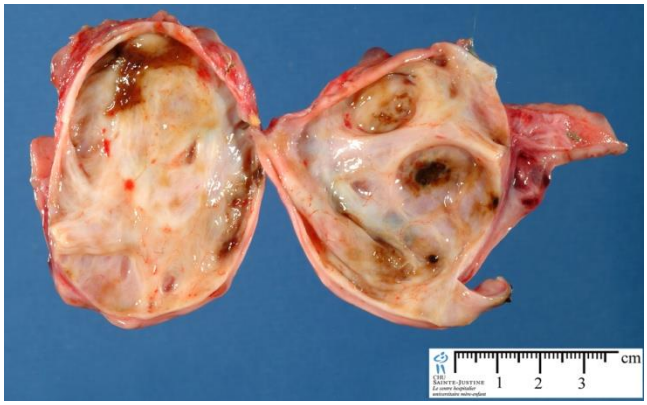
- These are cystic benign neoplastic tumour with mucinous adenomatous proliferation. It is the second commonest of all benign ovarian neoplasm.
- It is unilateral in 85%.
- **Size** - Variable from small to that filling up the abdomen.
- **Shape** – Round.
- **Shape** – Smooth or bossed
- **Colour** – Bluish white
- **Consistency** – Partly cystic and partly solid or cystic.

- **Contents** – Clear or glairy, viscid, straw or chocolate coloured fluid containing mucin.
- **Microscopical appearance** – Cystic cavities lined by a single layer of tall mucus secreting columnar epithelium with basal nuclei. Interlocular connective tissue septa
- **Complication** – Torsion, Rupture, Pseudomyxoma peritonei, Malignancy

3. Dermoid cyst- [3]

- This is benign c any age, common during the reproductive period, especially in young virgins.
- **Incidence** – 10 % of all ovarian neoplasms.
- **Histogenesis** – This arises from totipotent cells (Unfertilised primordial germ cell) capable of producing epiblastic, mesoblastic and hypoblastic structures.
- **Pathology** – Usually unilateral, bilateral in less than 10%.
- **Size** – Varies small to modrate, round or oval shaped, smooth surfaced, whitish opaque colour, tensely cystic, long pedicle.
- **Cut surface** – Unilocular cystic cavity with a small knoby area-mamilla or foetal rudiment
- **Content** – Sebaceous material, tuft of hair, teeth.
- **Microscopic** – all the structures of primitive three embryonic layers but mainly ectodermal. The mamilla is covered with stratified squamous epithelium and contains hair follicles, sebaceous glands, cartilage, muscle tissue, glands. The rest of the cyst is usually lined by granulation tissue.
- **Complication** – 1. Torsion, 2. Adhesions and infection from bowel, 3. Impaction in the pouch of douglas or uterovesical pouch causing obstruction in labour, 4. Autoimmune hemolytic anemia.

4. Benign endometrioma or Chocolate cyst



- Chocolate *cyst* is caused by endometriosis, and formed when a tiny patch of endometrial tissue (the mucous membrane that makes up the inner layer of the uterine wall) bleeds, sloughs off, becomes transplanted, and grows and enlarges inside the ovaries.[1]

- It is the commonest form of endometriosis develops in ovary which may be unilateral or bilateral (50%). They are of chocolate coloured cysts usually about 8-14 cm diameter but get always adherent with the surrounding structure.
- The content is tarry menstrual blood. Microscopically, there are cystic cavities lined with endometrium like tissue.
- In some cysts, there may not be lining of endometrium but there is connective tissue with macrophage cells having ingested haemosiderin-blood pigment.
- **Age and Parity** – In Reproductive age commonly at 30-50 years.[3]

Clinical Feature

Symptoms – [3]

- Secondary progressive cyclical severe dysmenorrhoea, Pain starts 5-7 days before menses, becoming maximal at the height of bleeding and persists during menses and thereafter.
- Pelvic pain
- Dyspareunia
- Infertility
- Backache
- Rectal pain and bleeding during menstruation
- Dysuria

Signs – [3]

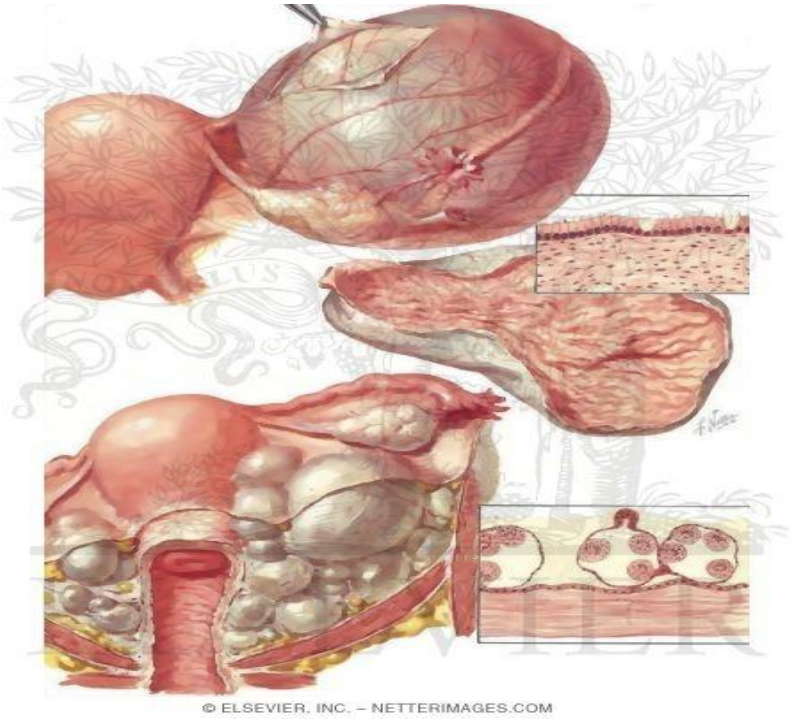
Bimanual vaginal examination –

- In ovarian endometrial cyst, tender fixed cystic bilateral or unilateral swelling of large lemon to orange size is felt on the posterior fornix.
- In endometriosis of the Douglas pouch, there are tender fixed nodules felt in the pouch through the posterior vaginal fornix especially at the uterosacral ligament.
- In rectovaginal septal lesions, the latter are felt at lower position than that of Douglas pouch. [3]

Complication –

- Infertility
- Rupture of endometrial cyst and chemical peritonitis caused by cyst content.
- Small intestinal obstruction and sigmoid colon obstruction.
- Adenocarcinoma [3]

5. Para ovarian cyst



- Paraovarian cysts are not actually ovarian, they are usually located along side the ovaries or on the fallopian tubes but they are often hard to distinguish from the ovarian cyst.
- The paramesonephric duct (or Mullerian duct) forms the fallopian tube at about 9 weeks of gestation. Multiple invaginations near the ostium of the tube become the fimbriae. Any

secondary invagination that does not connect may form a blind sac and enlarge to form a paraovanan cyst.

- Paraovarian cysts account for 10-20% of all adnexal masses and are relatively uncommon in children. They are more common in women 30 to 40 years of age.
- Paraovarian cysts arise from the tissues of the broad ligament, predominantly from mesothelium covering the peritoneum (mesothelial cysts) but also from paramesonephric (paramesonephric cysts or Mullerian cyst) and rarely mesonephric remnants (mesonephric cyst or Wolffian cyst).
- They are usually incidentally discovered during surgery and prophylactic excision is performed due to the increased incidence of torsion as well as their propensity to undergo rapid enlargement.
- These cysts represent remnants of of the Wolfiaan duct that lies parallel to the upper third of the vagina, uterus, and fallopian tubes. The cysts can grow to be very big and even extend to the upper abdomen. Their size and symptoms do not correspond to the hormonal cycle like other ovarian cysts do. [4]

Types: [4]

- Paramesonephric cyst
- Hydatid cyst of Morgagni
- Wolffian cyst
- Kobelt cyst
- Cyst of the organ of Rosenmuller
- Paramesonephric cysts

Complications: [4]

- paraovarian cyst torsion (2-16%)
- Haemorrhage
- Rupture
- Secondary infection
- Neoplasatic transformation (2.9%)

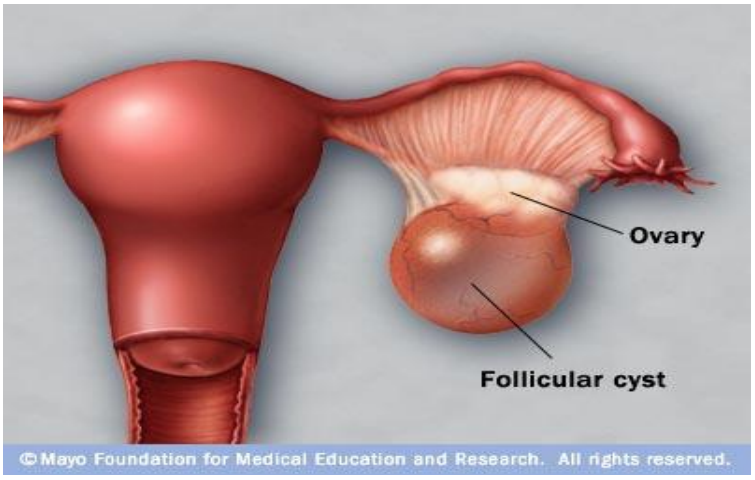
6. <u>Polycystic-appearing ovary</u>-

- Polycystic-appearing ovary is diagnosed based on its enlarged size - usually twice that of normal - with small cysts present around the outside of the ovary. [1]

- This condition can be found in healthy women and in women with hormonal (endocrine) disorders. An ultrasound is used to view the ovary in diagnosing this condition. [1]
- Polycystic-appearing ovary is different from the polycystic ovarian syndrome (PCOS), which includes other symptoms and physiological abnormalities in addition to the presence of ovarian cysts. Polycystic ovarian syndrome involves metabolic and cardiovascular risks linked to insulin resistance. These risks include increased glucose tolerance, type 2 diabetes, and high blood pressure.[1]

    i. Polycystic ovarian syndrome is associated with infertility, abnormal bleeding, increased incidences of miscarriage, and pregnancy-related complications.
    ii.
    iii. Polycystic ovarian syndrome is extremely common and is thought to occur in 4%-7% of women of reproductive age and is associated with an increased risk for endometrial cancer. [1]
    iv. The tests other than an ultrasound alone are required to diagnose polycystic ovarian syndrome. [1]

7. Follicular cyst [2]



- **The follicular ovarian cyst** is the most common kind of ovarian cyst.
- It is basically a sac inside the ovary filled with fluids.
- In the normal procedure a follicle that contains the egg is in fact a fluid filled cyst, when due to some unusual reason the follicle doesn't release the egg and continues to grow, then it forms a cyst. Generally, the cysts resolve with little or no treatment during a few months time.

- *The follicular ovarian cyst* generally occurs during the time ovulation and it can grow up to 2 to 3 inches.
- **Causes**: The **follicular ovarian cyst** is caused when the follicle fails to release the egg and fills up with fluid.[2]

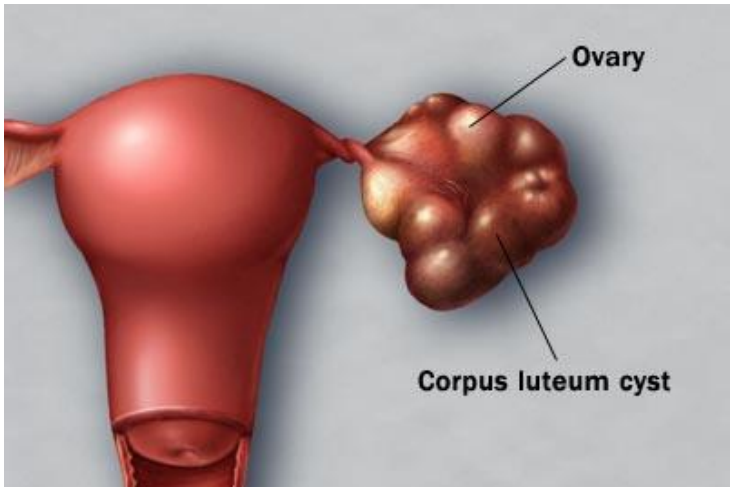
Symptoms -

- Pain in the lower abdomen during the monthly period
- Monthly cycle is delayed.
- Vagina might bleed when monthly cycle is not going on.
- The most common form of symptom caused by a cyst is pain. The pain occurs when a cyst ruptures or twists on its self. Such a situation can lead to severe pain and lots of discomfort.
- The pain caused by follicular cysts is called mittelschmerz and is it occurs during the middle of the monthly cycle.
- Only about ¼ of women who suffer from follicular ovarian cyst have to face this pain.
- In most cases the presence of cysts goes unnoticed. The reason being; the cysts generally don't cause any kind of symptom. If the cysts don't have any symptoms then their detection is generally accidental. They are found during routine pelvic check up or during an ultra sound examination. Once the diagnosis is confirmed, based on the size and condition of the cyst treatment is started. In most cases cysts are benign in nature and rarely cause much trouble. But there might be discomfort, pain, irregular periods and pain during intercourse.
- But sometimes the cyst might cause severe excruciating pain. In such cases it is important to opt for surgery. Once the surgery is done the cyst is generally sent to the lab to detect the nature of the cyst, just in case it might be malignant. But generally in the case of follicular ovarian cysts they are benign in nature. However do remember that ovarian cyst surgeries may come with complications. So always consider this before opting for surgery. [2]

Complication –

- **Twists**: Severe pain accompanied with vomiting and cyst
- **Ruptures**: Severe pain after or during sex [2]

8. Corpus luteum cyst



- A collection of fluid or small fluid-filled sacs within a woman's ovary that is surrounded by a thin wall is called an ovarian cyst.
- Corpus luteum cyst is a type of ovarian cyst that occurs after the release of an egg from a follicle. After the release of egg follicle, it becomes a corpus luteum. [5]
- The corpus luteum releases progesterone and estrogen to prepare the uterus for pregnancy. If no pregnancy occurs, the corpus luteum normally breaks down and disappears on its own.
- Corpus luteum cysts are one of the two most common types of ovarian cysts. They happen frequently in pregnant women, as well as many women of childbearing age. Most corpus luteum cysts are harmless, cause no pain, and will dissolve on their own. In some circumstances, they can cause complications. However, most can be treated through simple dietary changes. [6]
- Corpus luteum cysts are usually observed during ultrasound or during a routine pelvic exam.
- The corpus luteum breaks down and disappears if the pregnancy does not take place. However, it may form a cyst and become filled with blood or fluid.
- The condition is generally asymptomatic and usually found on one side only.
- These cysts may become 3 to 4 cm in size.
- Women who are on birth control pills usually won't form corpus luteum cysts, as birth control pills prevent ovulation. Certain fertility drugs that induce ovulation increase the chance of having these types of cysts.
- If a woman gets pregnant with corpus luteum cysts, the pregnancy is unlikely to suffer any ill effects. This type of ovarian cyst tends to diminish over time; if a cyst is present at the beginning of pregnancy, it may not disappear until the second trimester.[7]

Pathophysiology -

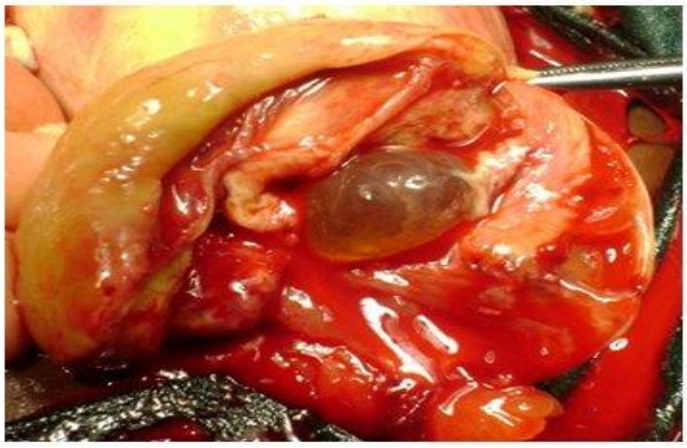
- Corpus Luteum cysts are believed to be formed with small changes occur within the ovary or the menstrual cycle. In a normal menstrual cycle, the egg is brought to maturity within a small sac called a follicle. About fourteen days after the start of the last period, the body will signal to the ovary to release the egg. The follicle will burst, releasing the egg to travel down

to the uterus. The follicle then dissolves. In the case of corpus luteum cysts, the follicle does not dissolve. Instead, it reseals itself and fills up with fluid, creating the cyst.[7]

Symptoms –

- Most of these types of ovarian cyst produce no symptoms. However, if the cyst grows large, it can cause pain in the lower abdomen. This pain can either be sharp from time to time, especially after use the bathroom or have intercourse. It can also be a steady low ache. For some women, the pain is felt in the lower back.
- If there is a sudden sharp pain in the lower abdomen, particularly during or after intercourse, There is a chance that the cyst has burst. When this happens, there is always the possibility of internal bleeding.
- Corpus luteum cysts may also cause the ovary to twist around the ovarian ligament. This condition is called ovarian torsion, and can cut off the blood flow to the ovary. Pain and nausea are the most common symptoms of ovarian torsion.
- Corpus luteum cysts also have the potential to rupture, causing sudden, sharp pain and some internal bleeding.
- Women with corpus luteum cysts shouldn't be concerned, unless extreme pain or bleeding occurs.
- With most corpus luteum cysts, everyday activities can still be maintained and the woman's life will not be affected. Some medical professionals may recommend avoiding sex until these types of cysts have been resolved, since the physical nature of intercourse may cause the ovarian cyst to rupture.
- In the case of malignant ovarian cysts, cancer may occur. However, this rarely results with corpus luteum cysts. [8]

9. Theca Lutein cyst



- Theca-lutein cyst a cyst of the ovary in which the cystic cavity is lined with theca cells.
- These are usually bilateral cysts arise as a result of excess of chorionic gonadotrophin in hydatidform mole or choriocarcinoma.
- In these, multiple cysts appear in both ovaries and are lined with granulosa lutein or theca lutein cells.
- This type of cysts is also produced iatrogenically as a result of ovarian overstimulation by human pituitary gonadotrophin and clomiphene therapy in infertility. [3]

Ovarian Cysts Causes [2]

The following are possible risk factors for developing ovarian cysts:

- History of previous ovarian cysts
- Irregular menstrual cycles
- Increased upper body fat distribution
- Early menstruation (11 years or younger)
- Infertility
- Hypothyroidism or hormonal imbalance
- Tamoxifen (Soltamox) therapy for breast cancer [2]

Signs and symptoms: [2]

Usually ovarian cysts do not produce symptoms and are found during a routine physical exam or are seen by chance on an ultrasound performed for other reasons. However, the following symptoms may be present:

- Dull aching, or severe, sudden, and sharp pain or discomfort in the lower abdomen (one or both sides), pelvis, vagina, lower back, or thighs; pain may be constant or intermittent—this is the most common symptom
- Feeling of fullness, heaviness, pressure, swelling, or bloating in the lower abdomen.
- Breast tenderness.
- Pain during or shortly after beginning or end of menstrual period.
- Long-term pelvic pain during menstrual period that may also be felt in the lower back
- Pelvic pain after strenuous exercise or sexual intercourse

- Pain or pressure with urination or bowel movements
- Nausea and vomiting
- Headaches
- Strange pains in ribs, which feel muscular
- Vaginal pain or spotty bleeding from the vagina
- Infertility
- Fever
- Abnormal pain or tenderness in the abdominal or pelvic area
- Weakness, dizziness, or fainting
- Pallor or anemia (possibly from loss of blood)
- Abnormally heavy or irregular menstruation
- Abdominal swelling or unusual increased abdominal girth
- Increased facial hair similar to a male pattern
- High or low blood pressure unrelated to medications
- Excessive thirst or urination
- Unexplained weight loss
- A noticeable abdominal or pelvic mass
- Strange nodules that feel like bruises under the layer of skin [2]

Ovarian Cysts Diagnosis [2]

A health care practitioner may perform the following tests to determine if a woman has an ovarian cyst or to help characterize the type of cyst that is present:

- **Endovaginal ultrasound:**

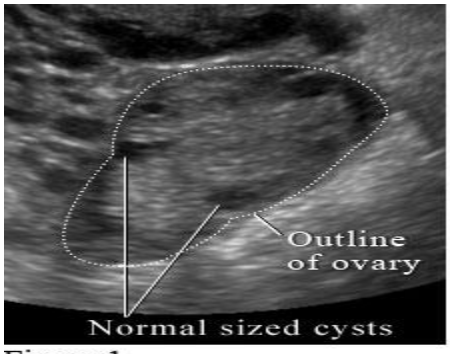


Figure 1

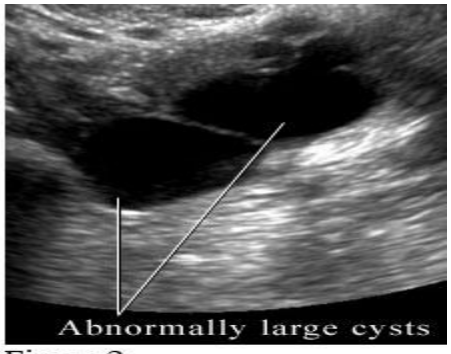
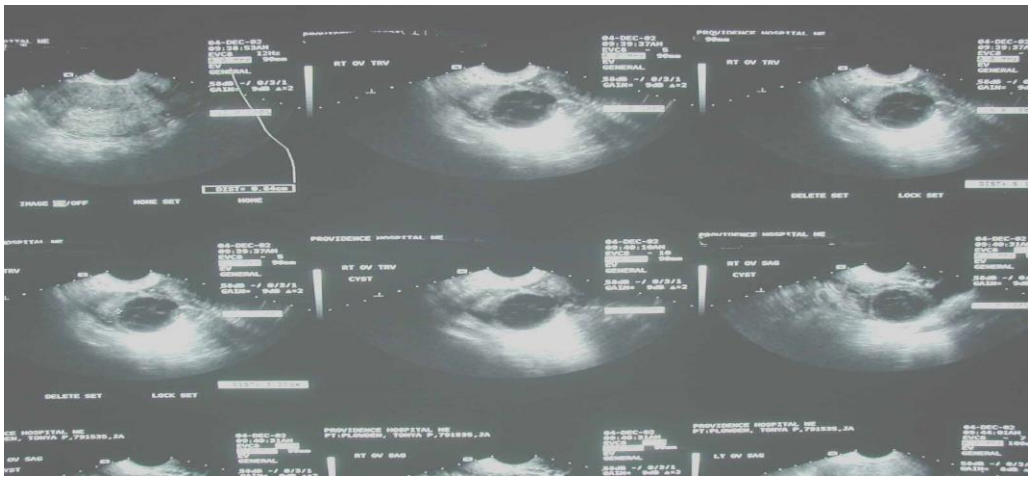


Figure 2

This type of imaging test is a special form of ultrasound developed to examine the pelvic organs and is the best test for diagnosing an ovarian cyst. A cyst can be diagnosed based on its appearance on the ultrasound.

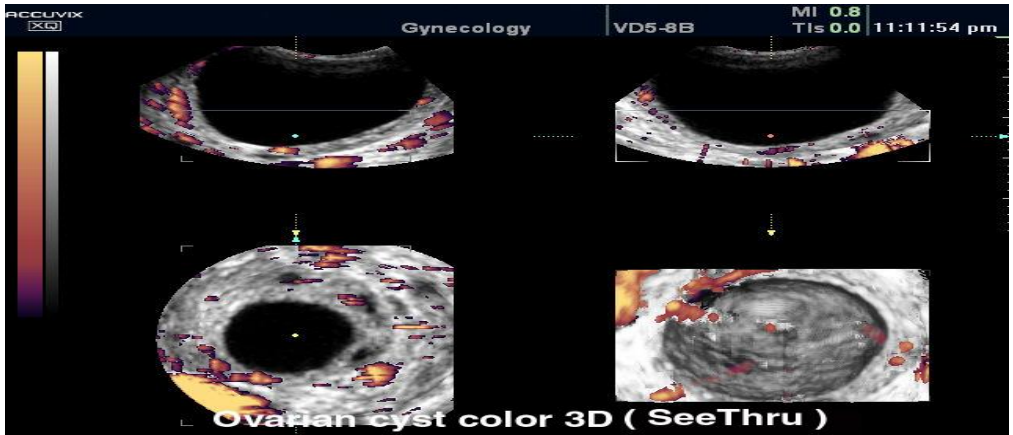
- An endovaginal ultrasound is a painless procedure that resembles a pelvic exam. A thin, covered wand or probe is placed into the vagina, and the examiner directs the probe toward the uterus and ovaries.
- This type of ultrasound produces a better image than a scan through the abdominal wall can because the probe can be positioned closer to the ovaries.
- Using an endovaginal ultrasound, the internal cystic structure may be categorized as simple (just fluid filled), complex (with areas of fluid mixed with solid material), or completely solid (with no obvious fluid). [2]

- **Other imaging:**



An Axial CT demonstrating a large hemorrhagic ovarian cyst. The cyst is delineated by the yellow bars with blood seen anteriorly. CT scanning aids in assessing the extent of the condition.[2]

- MRI scanning may also be used to clarify results of an ultrasound. [2]



- **Laparoscopic surgery:** In this procedure the surgeon makes small incisions through which a thin scope (laparoscope) can pass into the abdomen. The surgeon identifies the cyst through the scope and may remove the cyst or take a biopsy from it. [2]

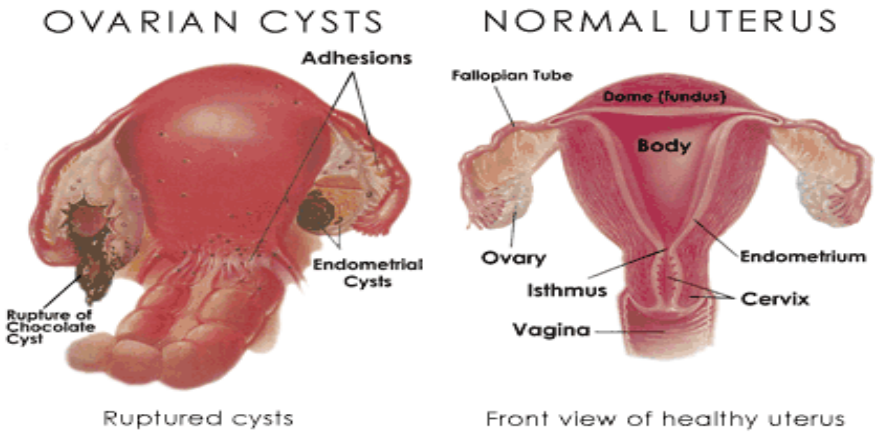
- **Serum CA-125 assay:** This blood test checks for a substance called CA-125, which is associated with ovarian cancer (the CA stands for cancer antigen). This test is used in the assessment of epithelial ovarian cancer and may help determine if an ovarian mass is harmless or cancerous. However, sometimes benign conditions such as endometriosis or uterine fibroids may result in the elevated levels of CA-125 in the blood, so the test does not positively establish the diagnosis of ovarian cancer. [2]

- **Hormone levels:** A blood test to check LH, FSH, estradiol, and testosterone levels may indicate potential problems concerning these hormone levels. [2]

- **Pregnancy testing:** The treatment of ovarian cysts is different for a pregnant woman than it is for a nonpregnant woman. An ectopic pregnancy (pregnancy outside the uterus) must be ruled out because some of the symptoms of ectopic pregnancy may be similar to those of ovarian cysts. [2]

- **Culdocentesis:** This test involves taking a fluid sample from the pelvis with a needle inserted through the vaginal wall behind the uterine cervix. [2]

Complication:



Ruptured cysts

Front view of healthy uterus

- Torsion of the pedicle
- Adhesions
- Rupture

- Infection and suppuration
- Ascites
- Pseudomyxoma peritonei
- Malignant changes

Ovarian Cysts Treatment [1]

About 95% of ovarian cysts are benign, meaning they are not cancerous. Functional ovarian cysts are the most common type of ovarian cyst. They usually disappear by themselves and seldom require treatment.

Treatment for cysts depends on the size of the cyst and symptoms.

Pain caused by ovarian cysts may be treated with:

- A warm bath, or heating pad, or hot water bottle applied to the lower abdomen near the ovaries can relax tense muscles and relieve cramping, lessen discomfort, and stimulate circulation and healing in the ovaries. Bags of ice covered with towels can be used alternately as cold treatments to increase local circulation. [1]
- Combined methods of hormonal contraception such as the combined oral contraceptive pill – the hormones in the pills may regulate the menstrual cycle, prevent the formation of follicles that can turn into cysts, and possibly shrink an existing cyst. [1]
- Limiting strenuous activity may reduce the risk of cyst rupture or torsion. [1]
- Oral contraceptive/birth control pill use decreases the risk of developing ovarian cysts because they prevent the ovaries from producing eggs during ovulation. [1]

Initial treatment

- Functional ovarian cysts typically go away without treatment within 1 to 2 menstrual cycles, so, patient should be on observation without treatment (watchful waiting) to see whether the ovarian cyst gets better or goes away on its own. Another pelvic exam should be done in 1 to 2 months to see whether the cyst has changed in size. [2]
- If an ovarian cyst doesn't improve in 1 to 2 menstrual cycles, your doctor may want to do more tests to be sure that your symptoms are not caused by another type of ovarian growth. Home treatment with heat and pain-relieving medicine can often provide relief of bothersome symptoms during this time. [2]

Ongoing treatment

A functional ovarian cyst that persists through 2 to 3 menstrual cycles, has an unusual appearance on ultrasound, or causes symptoms may require treatment with either medicines or surgery.

- Surgical removal of the cyst (cystectomy) through a small incision (laparoscopy) may be needed if a painful functional ovarian cyst does not go away despite medical treatment. If a cyst has an unusual appearance on ultrasound or there is risk factors for ovarian cancer, surgical removal through a larger abdominal incision (laparotomy) instead of by using laparoscopy may be needed. [2]

Home Treatment

Home treatment can help relieve the discomfort of functional ovarian cysts.

- Empty the bladder as soon as there is urging to urinate.
- Constipation should be avoided, though constipation does not cause ovarian cysts but may further increase the pelvic discomfort. [2]

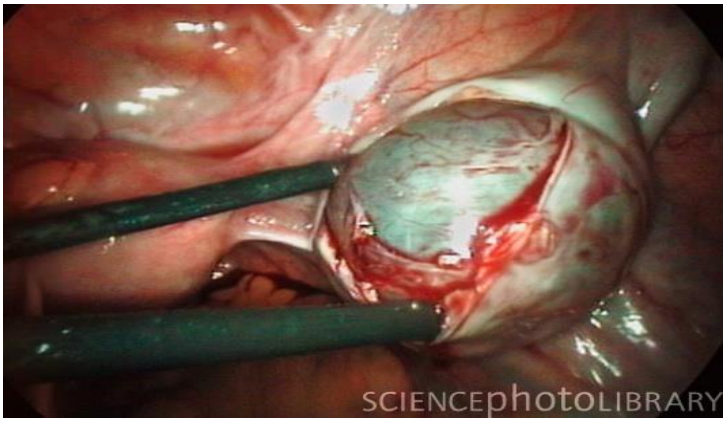
Surgery Choices

- Surgery for an ovarian cyst or growth can be done through a small incision using laparoscopy or through a larger incision (laparotomy). [2]

- Laparoscopy may be used to confirm the diagnosis of an ovarian cyst in a woman of childbearing age. Persistent, large, or painful ovarian cysts that have no signs of cancer risk can be removed during laparoscopy, leaving the ovary intact. [2]

- Laparotomy is used when an ovarian cyst is very large, ovarian cancer is suspected, or other problems with the abdominal or pelvic organs are present. If cancer is found, the larger incision lets the surgeon closely examine the entire area and more safely remove all cancerous growth. [2]

Ovarian Cysts Surgery



- **Laparoscopic surgery:** The surgeon makes small incisions through which a thin scope (laparoscope) can pass into the abdomen. The surgeon identifies the cyst through the scope and may remove the cyst or take a sample from it. [2]

- **Laparotomy:** This is a more invasive surgery in which an incision is made through the abdominal wall in order to remove a cyst. [2]

- **Surgery for ovarian torsion:** An ovarian cyst may twist and cause severe abdominal pain as well as nausea and vomiting. This is an emergency, surgery is necessary to correct it. [2]

Goals of surgical treatment for an ovarian cyst are to:

- Confirm a diagnosis of an ovarian cyst.
- Rule out the diagnosis of ovarian cancer.
- Remove cysts that are causing pain.
- Relieve the pressure that cysts larger than 3 in. may cause on the bladder and other pelvic organs. [2]

Homoeopathic concept of Ovarian cyst

- Homoeopathy got a **generalized concept** of disease **irrespective of name and organ** involved.
- According to **Dr. Kent**, it is the **man that is sick** and to be restored to health, **not his body, not the tissue.**
- **Ovarian cyst** is not a disease itself rather it **is product of some internal disease.**
- There is no definite cause of formation of ovarian cyst, probably it is because of some hormonal imbalance of the ovary. That means ovarian cyst is **true natural chronic disease with** definite involvement of **Miasm**.
- On the basis of symptoms produced by ovarian cyst is mixed miasmatic disease. i.e. **Psora-sycotic.**

Symptoms of **Ovarian cyst** found in different Repertories are

Complete Repertory (Version 2003)

- **FEMALE - TUMORS - general - cysts - ovaries**
- **FEMALE - TUMORS - general - cysts - ovaries - par-ovarian**
- **ABDOMEN - FULLNESS - hypogastrium**
- **ABDOMEN - SWELLING - general - hypogastrium**
- **ABDOMEN - PAIN - dull - hypogastrium**
- **FEMALE - PAIN - vagina**
- **EXTREMITIES - PAIN - lower limbs - hips**
- **EXTREMITIES - PAIN - lower limbs - hips - coition agg. - during**
- **EXTREMITIES - PAIN - lower limbs - hips - exertion, after**
- **URETHRA - PAIN - urination - during**
- **RECTUM - PAIN - stool - during**
- **STOMACH - VOMITING - general - nausea - during**
- **HEAD - PAIN**
- **CHEST - PAIN - muscles - intercostal**
- **GENERALITIES - WEAKNESS, enervation, exhaustion, prostration, infirmity**

- **GENERALITIES - FAINTNESS, fainting**
- **CLINICAL - ANEMIA - blood, from loss of - metrorrhagia, menorrhagia, menstrual derangements, from**

Kents Repertory

- **[Kent] [Genitalia female]Tumours:Ovaries:Cysts:**
- **[Kent] [Abdomen]Pain:Aching,dull pain (see Boring,Gnawing,etc.):Hip,region of:**
- **[Kent] [Abdomen]Pain:Aching,dull pain (see Boring,Gnawing,etc.):Hypogastrium:**
- **[Kent] [Back]Pain:Lumbo-sacral region:**
- **[Kent] [Abdomen]Fullness,sensation of:**
- **[Kent] [Abdomen]Heaviness,as from a load,etc.:**
- **[Kent] [Chest]Pain:Sore,bruised:Mammae:**
- **[Kent] [Genitalia female]Pain:Vagina:**
- **[Kent] [Extremities pain]Pain:Hip:Exertion,after:**
- **[Kent] [Urethra]Pain:Urination:During:**
- **[Kent] [Rectum]Pain:Stool:During:**
- **[Kent] [Head]Pain,headache in general:**
- **[Kent] [Chest]Pain:Sore,bruised:Costal cartilages:**
- **[Kent] [Stomach]Vomiting:**
- **[Kent] [Stomach]Nausea:**
- **[Kent] [Generalities]Anaemia:**

The Important Homoeopathic drugs indicated for Ovarian cysts are

- Bovista
- Apis mellifica
- Platina
- Lycopodium
- Thuja
- Lachesis mutus
- Bufo
- Iodine
- Lilium Tig.
- Conium Mac.
- Colocynthis
- Kali Bromatum

BOVISTA

- **Mind** -Enlarged sensation. [Arg.n.] Awkward; everything falls from hands.Sensitive.
- **Diarrhoea before and during menses.**
- **Menses too early and profuse; worse at night. Voluptuous sensation. Leucorrhoea acrid, thick, tough, greenish, follows** menses. Soreness of pubes during menses. Metrorrhagia; Parovarian cysts.

APIS MELLIFICA

- **Mind** -Apathy and indifference. Awkward; **drops things readily.** Listless; cannot think clearly. Jealous, fidgety, hard to please. Sudden shrill, piercing screams. Whining.
- **Tearfulness. Jealously, fright, rage, vexation, grief. Cannot** concentrate mind when attempting to read or study.
- **Ovaritis; worse in right ovary. Menses suppressed, with cerebral and head symptoms, especially in** young girls. Dysmenorrhoea, with severe ovarian pains.

Platina

- **Parts hypersensitive**
- **Ovaries** sensitive and burn; vaginismus, nymphomania, pruritus **vulva, ovaritis with sterility**
- Menses too early, too profuse, dark clotted with spasms and painful **bearing down and sensitiveness of the parts**
- **Mental troubles associated with suppressed menses**
- **Self exaltation**

Lyco

- Vagina dry, painful coition
- Varicose veins of pudenda
- Leucorrhoea acrid with burning in vagina
- Discharge of blood from vagina during stool
- Melancholy; afraid to be alone

THUJA

- **Left-sided and chilly Pt**
- Mind.-Fixed ideas, **Emotional sensitiveness; music causes weeping and trembling**
- Female.-Vagina very sensitive. [Berb.; Kreos.; Lyssin.]
- Warty excrescences on vulva and perineum. Profuse leucorrhoea; **thick, greenish.**
- **Severe pain in left ovary and left inguinal** region. Menses scanty, retarded. Polypi;
- Ovaritis; worse left side, at every menstrual period.
- **Profuse perspiration before menses.**

LACHESIS

- Menses too short, too feeble; pains all relieved by the flow. [Eupion.]

- **Left ovary very painful and swollen, indurated. Acts especially well** at beginning and close of menstruation.
- Ill effects of suppressed discharges.
- Mind.-**Great loquacity**. **Jealous. [Hyos.] Mental labor best performed at** night.
- **Suspicious**; nightly delusion of fire.

Other Rare drugs indicated for Ovarian cyst

- Oophorinum
- Aur. Iod.
- Xantoxylum

Case Study

- A lady age of 41, having of **polymenorrhoea** with **pain in abdomen** reported us on **21/09/10,**
- She had complained of

  Heartburn < empty stomach,

  Fullness of abdomen < after food.

Physical generals:-

RHC - Hot patient

Desire - Sweet, Bitter, Warm food

Aversion - Sour, Spicy, Milk

Thirst- increased

Sleep - disturbed

Mental generals:-

Avarice

Irritable

Compulsive disorders

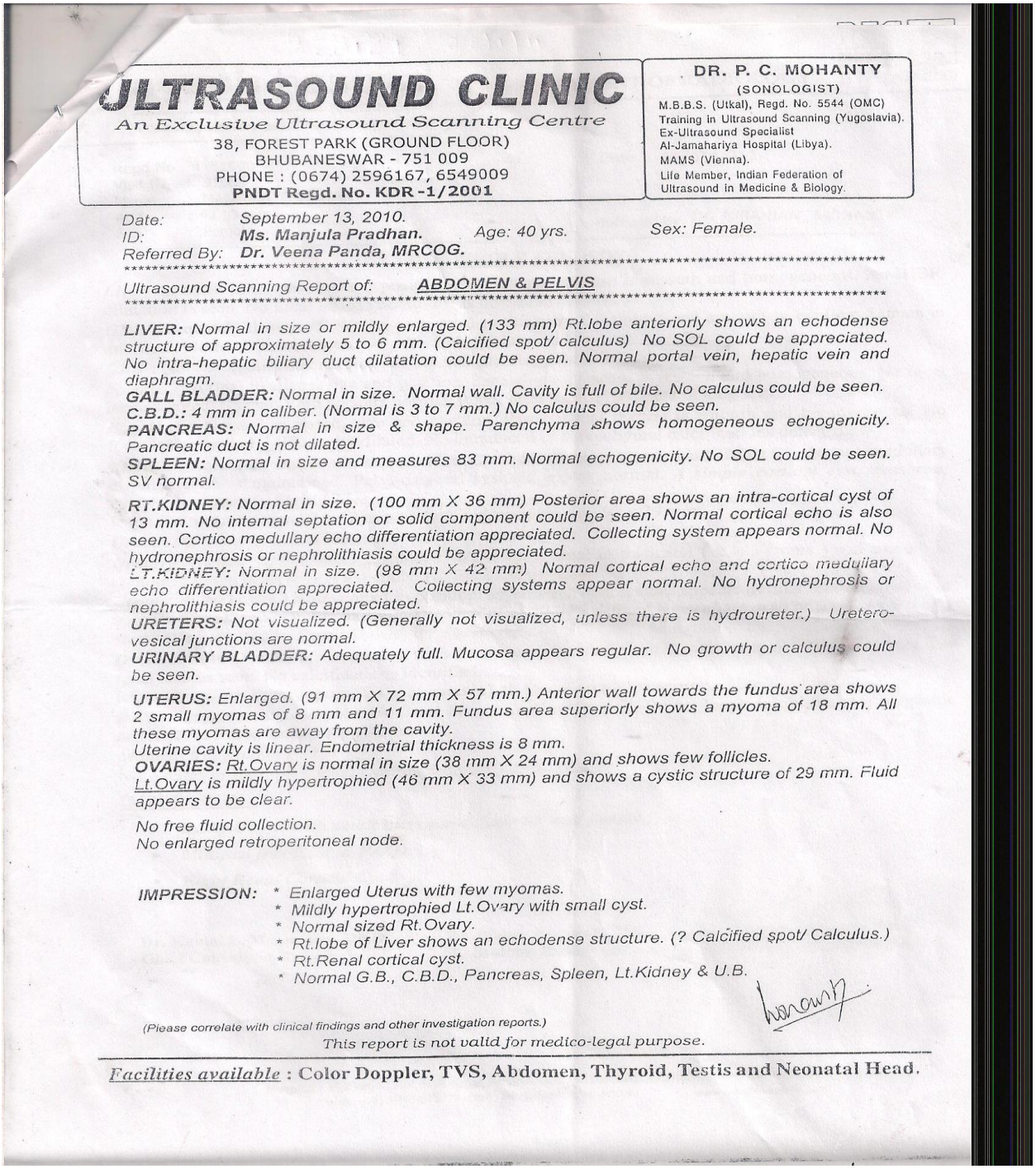
Sympathetic

Hurry/Haste in doing work

Ultrasound Report findings:-

- **Enlarged uterus with few myomas.**

- **Middle hypertrophied with small cyst.**
- Normal sized Rt. Ovary.
- Rt. Lobe of liver shows echodense structure.
- **Rt. Renal cortical cyst.**
- Normal Gall bladder, C.B.D., Pancreas, Spleen, Lt. Kidney & Urinary bladder.



ULTRASOUND CLINIC
An Exclusive Ultrasound Scanning Centre
38, FOREST PARK (GROUND FLOOR)
BHUBANESWAR - 751 009
PHONE : (0674) 2596167, 6549009
PNDT Regd. No. KDR -1/2001

DR. P. C. MOHANTY
(SONOLOGIST)
M.B.B.S. (Utkal), Regd. No. 5544 (OMC)
Training in Ultrasound Scanning (Yugoslavia).
Ex-Ultrasound Specialist
Al-Jamahariya Hospital (Libya).
MAMS (Vienna).
Life Member, Indian Federation of Ultrasound in Medicine & Biology.

Date: September 13, 2010.
ID: Ms. Manjula Pradhan. Age: 40 yrs. Sex: Female.
Referred By: Dr. Veena Panda, MRCOG.

Ultrasound Scanning Report of: ABDOMEN & PELVIS

LIVER: Normal in size or mildly enlarged. (133 mm) Rt.lobe anteriorly shows an echodense structure of approximately 5 to 6 mm. (Calcified spot/ calculus) No SOL could be appreciated. No intra-hepatic biliary duct dilatation could be seen. Normal portal vein, hepatic vein and diaphragm.
GALL BLADDER: Normal in size. Normal wall. Cavity is full of bile. No calculus could be seen.
C.B.D.: 4 mm in caliber. (Normal is 3 to 7 mm.) No calculus could be seen.
PANCREAS: Normal in size & shape. Parenchyma shows homogeneous echogenicity. Pancreatic duct is not dilated.
SPLEEN: Normal in size and measures 83 mm. Normal echogenicity. No SOL could be seen. SV normal.

RT.KIDNEY: Normal in size. (100 mm X 36 mm) Posterior area shows an intra-cortical cyst of 13 mm. No internal septation or solid component could be seen. Normal cortical echo is also seen. Cortico medullary echo differentiation appreciated. Collecting system appears normal. No hydronephrosis or nephrolithiasis could be appreciated.
LT.KIDNEY: Normal in size. (98 mm X 42 mm) Normal cortical echo and cortico medullary echo differentiation appreciated. Collecting systems appear normal. No hydronephrosis or nephrolithiasis could be appreciated.
URETERS: Not visualized. (Generally not visualized, unless there is hydroureter.) Uretero-vesical junctions are normal.
URINARY BLADDER: Adequately full. Mucosa appears regular. No growth or calculus could be seen.

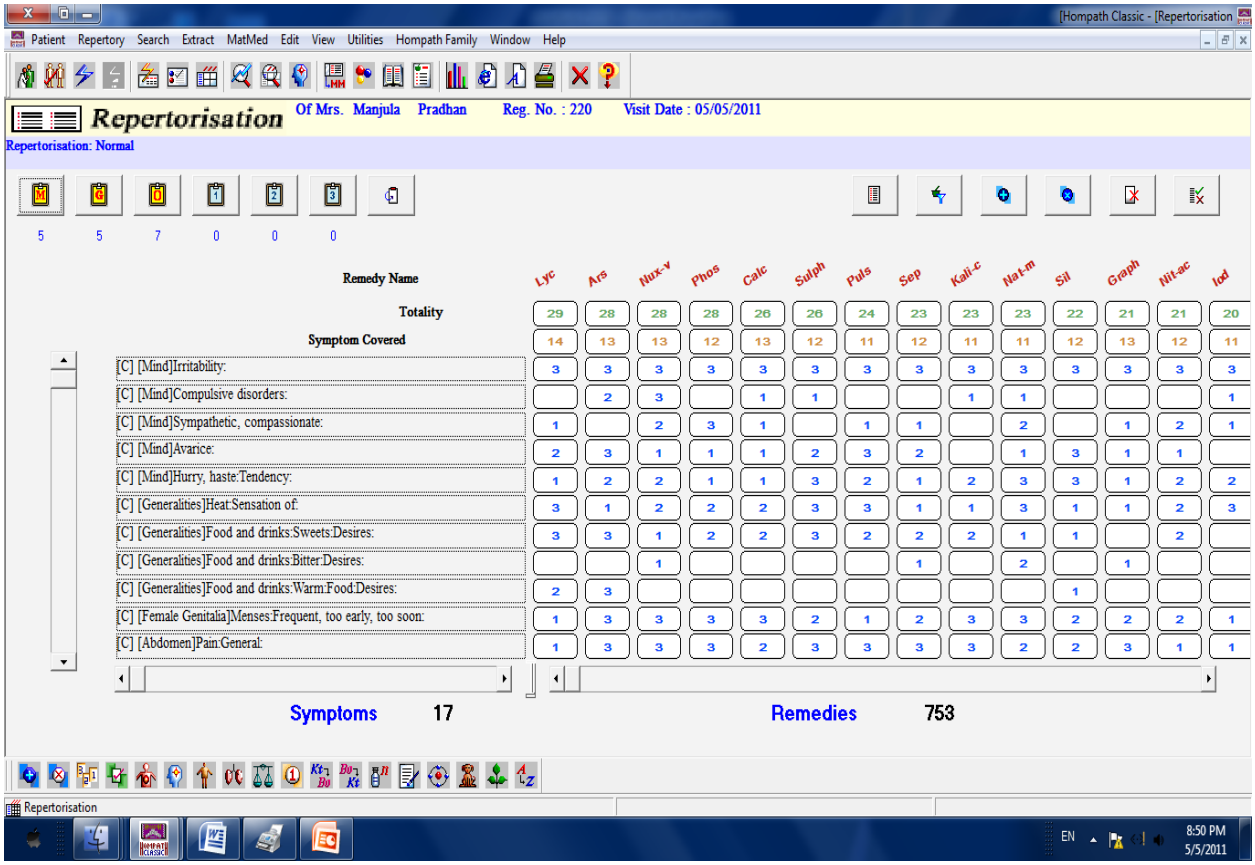
UTERUS: Enlarged. (91 mm X 72 mm X 57 mm.) Anterior wall towards the fundus area shows 2 small myomas of 8 mm and 11 mm. Fundus area superiorly shows a myoma of 18 mm. All these myomas are away from the cavity.
Uterine cavity is linear. Endometrial thickness is 8 mm.
OVARIES: Rt.Ovary is normal in size (38 mm X 24 mm) and shows few follicles.
Lt.Ovary is mildly hypertrophied (46 mm X 33 mm) and shows a cystic structure of 29 mm. Fluid appears to be clear.

No free fluid collection.
No enlarged retroperitoneal node.

IMPRESSION:
* Enlarged Uterus with few myomas.
* Mildly hypertrophied Lt.Ovary with small cyst.
* Normal sized Rt.Ovary.
* Rt.lobe of Liver shows an echodense structure. (? Calcified spot/ Calculus.)
* Rt.Renal cortical cyst.
* Normal G.B., C.B.D., Pancreas, Spleen, Lt.Kidney & U.B.

(Please correlate with clinical findings and other investigation reports.)
This report is not valid for medico-legal purpose.

Facilities available : Color Doppler, TVS, Abdomen, Thyroid, Testis and Neonatal Head.



Basis of Prescription

- Through Repertorisation, Lycopodium has evolved as No. 1 drug among the panel of remedies.
- As patient is Hot, desiring for warm food is peculiar symptoms, so Lycopodium was prescribed.

Prescription –

R_x

Lyco 0/1, 0/2, 0/3, 0/4

2 oz, 16 doses, BD.

2nd visit – 20/10/10

- Menstrual History – Normal
- Pain in abdomen – decreased
- Heartburn remained
- Fullness of abdomen is slightly decreased
- Soreness of both soles < exertion

P/G – Thirst – Normal

Appetite – Normal

Stool – Normal

Urine – Normal

Prescription –

R_x

Lyco 0/5, 0/6, 0/7, 0/8

2 oz, 16 doses, BD.

3rd Visit:- 23/11/10

- Regular menstrual cycle
- Heartburn 50% decreased
- Soreness of both the soles 70% decreased

P/G – Appetite – N

Thirst – N

Stool – N

Urine – N

Prescription:-

R_x

Lyco 0/9, 0/10, 0/11, 0/12

2 oz, 16 doses, BD.

4th Visit:- 17/12/10

- No Heartburn
- Menstrual cycle regular (24 days interval)
- No pain in sole

P/G – Thirst – N

Appetite – N

Stool – N

Urine – N

Prescription:-

R_x

Lyco 0/13, 0/14, 0/15, 0/16

2 oz, 16 doses, BD.

5th Visit:- 28/01/11

- Soreness of abdomen <during menses
- Heaviness of abdomen
- Backache (++)
- Regular menses (25 days interval)

R_x

Lyco 0/17, 0/18, 0/19, 0/20

2 oz, 16 doses, BD.

6th Visit:- 26/02/11

- Menstrual cycle (28 days interval)
- Backache 60% decreased
- Sole and knee soreness 90% decreased
- Heaviness of abdomen decreased

- Soreness of lower abdomen decreased

P/G – Thirst – N
Appetite – N
Stool – N
Urine – N

R_x

Lyco 0/21, 0/22, 0/23, 0/24

2 oz, 16 doses, BD.

7th Visit:- 28/03/11

- Menstrual cycle (30 days interval)
- Bleeding – N
- Weak digestion
- Pain in chest < empty stomach
- Appetite diminished

U.S. REPORT

ayush hospital
BHUBANESWAR
A Unit of Ayush Hospital & Trauma Care (P) Limited

DEPARTMENT OF RADIOLOGY

Regd No : 31688
Visit ID : 31688
Name : MANJULA PRADHAN
Age : 41 Years
Sex : Female

Date : 03/03/2011

Referred By Dr. NIRANJAN MOHANTY

USG WHOLE ABDOMEN

Liver : Normal in shape, size and position. Parenchymal texture is smooth and homogeneous. No IHBR dilatation is seen. No focal lesions noted. PV is normal in dimension.

GB : Adequately distended. Walls are normal in thickness (2 mms) and smooth in contour. Lumen is anechoic. No focal lesions seen. No peri-cholecystic collection seen.

CBD : Normal in dimensions. No intraluminal pathology detected.

Spleen : Normal in shape, size and position. Parenchymal texture is smooth and homogeneous. No focal lesions noted. Splenic Vein appears normal. It measures approx. 97 mms in long span.

Pancreas : Normal in shape, size and position. Parenchymal texture is smooth and homogeneous. No focal lesions noted. MPD is not dilated. No intraductal or parenchymal calcifications detected.

Kidneys : Normal in shape, size and position. Cortical echo appears normal (Grade 0). Cortico-medullary differentiation is maintained. Pelvi-calyceal systems appear normal. *A simple cortical cyst measuring 13 x 15 mms seen in Right Kidney.*

Right Kidney measures 97 x 32 mms ; Left Kidney measures 92 x 39 mms.

Ureters : Not visualized . (Normal).

Urinary Bladder : Adequately distended. Walls are normal in thickness (2 – 3 mms) and smooth in contour. Lumen is uniformly anechoic. No focal lesions seen.

Uterus: *Bulky in size.*. Antevereted in position. Myometrial echotexture appears normal. Endometrial echo appears normal and is in the midline. *Evidence of small well defined hypoechoic area of size 1.1 x 0.9 cms seen in Anterior wall – Small fibroid.* It measures approx. 99 x 49 x 66 mms.

Ovaries: Both Ovaries are normal in shape, size and position. Multiple sub-centimetric follicles seen. No focal lesions seen. No calcifications identified.

Right Ovary measures approx. 31 x 25 mms ; Left Ovary measures approx. 32 x 23 mms.

R.I.F. : appears unremarkable. No focal lump or collection seen. Bowel loops exhibit normal peristaltic activity. No Probe tenderness elicited.

Minimal free fluid in P.O.D.

No Ascites or Retroperitoneal Lymphadenopathy detected.

IMPRESSION :

- ***Bulky Uterus with small Intramural Anterior wall fibroid.***
- ***Minimal free fluid in P.O.D.***
- ***Right Renal Cortical Cyst.*** ✓

Dr. Kamal L. Mohapatra. DNB
Chief Consultant Radiologist.

Dr. Bikash Agrawala, MD
Consultant Radiologist.

Dr. Surai Murmu, MD
Consultant Radiologist.

- **No Ovarian cyst, Small fibroid uterus, Rt. Renal cortical cyst, Minimal free fluid in P.O.D.**

R_x

Lyco 0/25, 0/26, 0/27, 0/28

2 oz, 16 doses, BD.

Case study 2

1st visit- 09/01/10

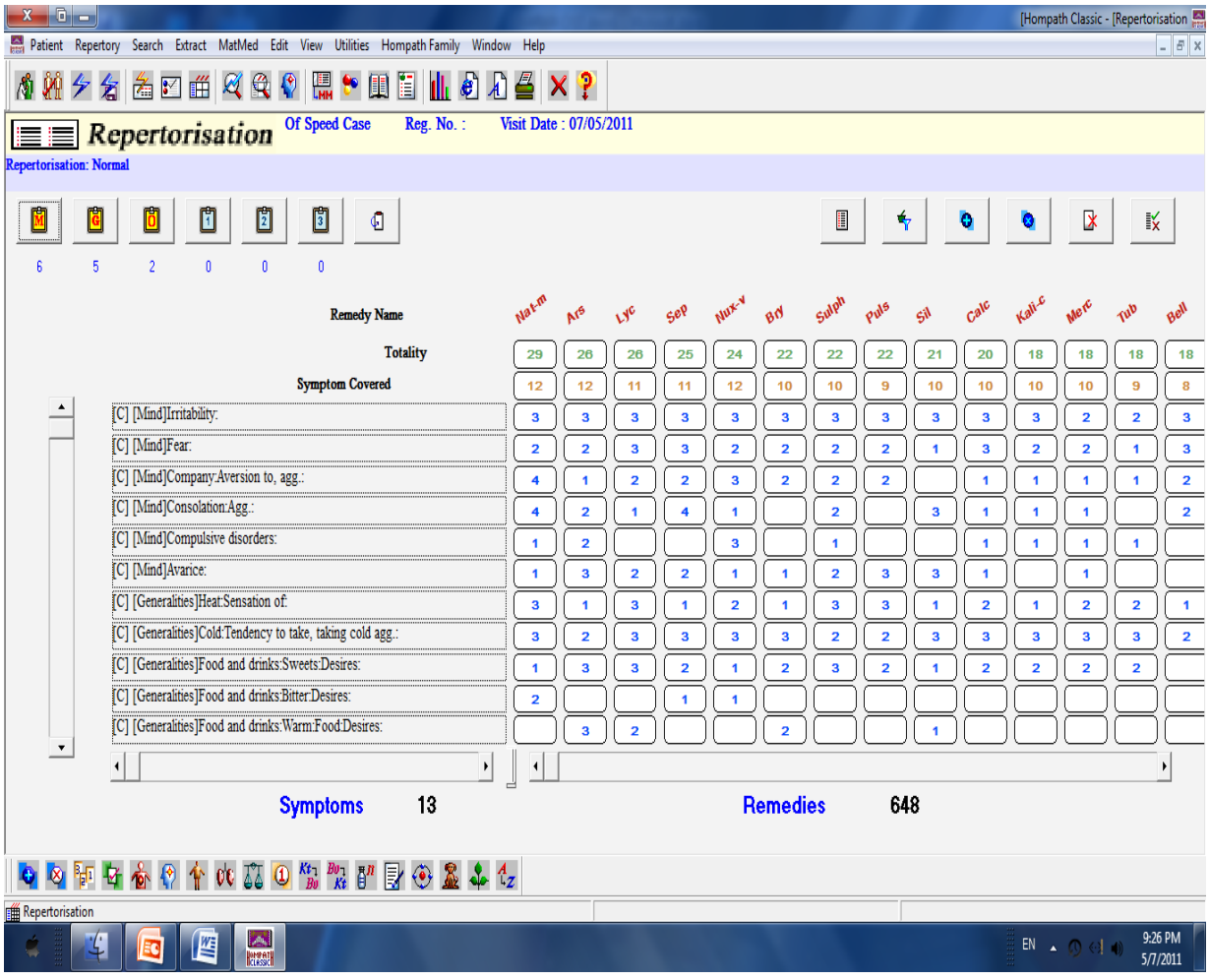
Miss Priyanka Pradhan aged about 24 years HF, was suffering from pain in lower abdomen, Irregular menstrual disorder, Flatulence abdomen and backache in lumbosacral region.

Physical general-

- Hot patient,
- Easily catches cold,
- Desire for sweets, bitter, warm food;
- Perspiration- profuse
- Thirst- decreased with dry tongue.

Mental generals-

- Irritability
- Fearfulness
- Company aversion
- Consolation aggravates
- Compulsive disorders
- Avarice


[Hompath Classic - [Repertorisation
Patient Repertory Search Extract MatMed Edit View Utilities Hompath Family Window Help
Repertorisation
Of Speed Case
Reg. No. :
Visit Date : 07/05/2011
Repertorisation: Normal
6 5 2 0 0 0
Remedy Name
Totality
Symptom Covered
Nat-m Ars Lyc Sep Nux-v Bry Sulph Puls Sil Calc Kali-c Merc Tub Bell
29 26 26 25 24 22 22 22 21 20 18 18 18 18
12 12 11 11 12 10 10 9 10 10 10 10 9 8
[C] [Mind]Irritability: 3 3 3 3 3 3 3 3 3 3 3 2 2 3
[C] [Mind]Fear: 2 2 3 3 2 2 2 2 1 3 2 2 1 3
[C] [Mind]Company:Aversion to, agg.: 4 1 2 2 3 2 2 2 1 1 1 1 2
[C] [Mind]Consolation:Agg.: 4 2 1 4 1 2 3 1 1 1 2
[C] [Mind]Compulsive disorders: 1 2 3 1 1 1 1 1
[C] [Mind]Avarice: 1 3 2 2 1 1 2 3 3 1 1
[C] [Generalities]Heat:Sensation of: 3 1 3 1 2 1 3 3 1 2 1 2 2 1
[C] [Generalities]Cold:Tendency to take, taking cold agg.: 3 2 3 3 3 3 2 2 3 3 3 3 3 2
[C] [Generalities]Food and drinks:Sweets:Desires: 1 3 3 2 1 2 3 2 1 2 2 2 2
[C] [Generalities]Food and drinks:Bitter:Desires: 2 1 1
[C] [Generalities]Food and drinks:Warm:Food:Desires: 3 2 2 1
Symptoms 13
Remedies 648
Repertorisation
EN
9:26 PM
5/7/2011

Basis of Prescription

- Through Repertorisation, Lycopodium has evolved as No. 3 drug among the panel of remedies.
- As patient is Hot, desiring for warm food is peculiar symptoms, so Lycopodium was prescribed.

Making totality the medicine prescribed

R_x

Lycopodium 10m, 1 dose

Placebo

2nd visit: 10/02/10

- Irregular menses was reduced upto 50%
- Backache in lumbosacral region also reduced to 40%
- Pain in lower abdomen completely reduced .
- Flatulency also reduced to 40%
- Functional history normal

R_X

Placebo

3rd visit - 28/04/10

- Irregular menses again reappeared as before was with late for 1 month
- Back pain reduced to 50%
- Flatulence reduced to 80%
- Functional history normal

R_X

Placebo

- Patient was advised for USG of abdomen

4th visit - 03/06/10

USG report was suggesting right ovarian cyst of size 38×31 mm

GLOBAL DIAGNOSTIC CENTRE
Cuttack Road, Opp. Pattnaik Petrol Pump
Bhubaneswar- 751006, Orissa, Ph. 0674 - 2314888
Regd. No. 523 / 06

1st Report

Name: MS. PRIYANKA PRADHAN
Ref By: DR. NIRANJAN MOHANTY

Age : 21 Sex : F
Date: 16.05. 2010

ULTRASOUND OF WHOLE ABDOMEN

LIVER:- Is normal in size, shape and position. Liver measures 118 mm. Hepatic parenchyma is homogenous and uniform. No focal or diffuse lesion seen. Hepatic vessels are normal. Portal vein is normal. PV measures10 mm. No evidence of fluid collection seen in morrison's pouch.

GALL BLADDER:- Normal in size and position. Folded in shape. Wall thickness is normal. Lumen is clear. No calculus or growth seen.
CBD:- Is normal in caliber. CBD measures 5 mm. Lumen is clear.

SPLEEN:- Is normal in size, shape and position. Spleen measures 95 mm. Normal echopattern. No focal lesion seen. Splenic vein is normal.

PANCREAS:- Is normal in size, position and echotexture. No SOL seen. Pancreatic duct is normal.

KIDNEYS:- Both kidneys are normal in size, shape and position. Renal cortex is normal on both sides. Cortico-medullary differentiation is maintained on both sides. No calculus or hydronephrosis seen on both sides. RK :- 95 x 42 mm. LK :- 98 x 45 mm.

URINARY BLADDER:- Is normal in size and position. Margins are regular. No calculus or mass seen. Wall thickness is normal. Post void residual urine is 9 ml.

UTERUS:- Is normal in size, anteverted in shape. Uterus measures 91 x 38 x 54 mm. Myometrial echos are normal. Endometrium is normal and measures 9 mm. Cervix is normal. No fluid in pouch of Douglas.

OVARIES:- **Right ovary** is enlarged in size and measures 49 x 42 mm. Normal in shape and position. Evidence of a cyst measuring 38 x 31 mm is noted in right ovary. No calcification or septae is noted within the cyst. **Left ovary** is normal in size, shape and position. Left adnexa is free from any mass. Left ovary measures 29 x 23 mm.

PERITONEUM:- No free fluid is seen in the peritoneal and pelvic cavity. Aorta and IVC are normal. Bowel loops are normal.

IMPRESSION: FEATURES ARE SUGGESTIVE OF ? RIGHT OVARIAN CYST.

SUGGESTED: CLINICAL CORRELATION

DR. BISHNU BAJORIA, DNB
CONSULTANT RADIOLOGIST

- Menses irregular with late 3 months.
- Burning pain sole was there <heat of sun.
- Backache reduced to 80%

Physical general:

- **Thirst –** decreased with dry tongue
- **Stool -** undigested
- **Appetite -** normal

Mentally she was extremely busy for her study.

Mother reported, she is not taking medicine.

R_X

Apis mel. 0/1, 0/2, 0/3, 0/4

2oz 16 doses BD

5th visit - 09/07/10

- Menses was normal
- Other complains were reduced to normal.
- Functional history normal

R_X

Apis mel. 0/5, 0/6, 0/7, 0/8

2oz 16 doses BD

6th visit - 13/08/10

- Menses was regular but scanty for 2 days with **black, clotted blood**.
- Functional history normal

R_X

Apis mel. 0/9, 0/10, 0/11, 0/12

2oz 16 doses BD

7th visit - 10/09/10

The patient was completely better with regular menses, cycle continues for 4-5 days and again advised to go for USG of abdomen and pelvis.

R_X

Apis mel. 0/13, 0/14, 0/15, 0/16

2oz 16 doses BD

8th visit - 28/10/10

- The complaint was better in all respect.
- The USG report was suggested that the **size of the ovarian cyst was reduced.**
- **Size - 31×24 mm**

GLOBAL DIAGNOSTIC CENTRE
Cuttack Road, Opp. Pattnaik Petrol Pump
Bhubaneswar - 751006, Orissa, Ph. 0674 - 2314888
Regd. No. 523 / 06

Name : MS. PRIYANKA PRADHAN
Ref By: DR. NIRANJAN MOHANTY

2nd Report

Age : 21 Sex : F
Date: 29.08. 2010

ULTRASOUND OF WHOLE ABDOMEN

LIVER:- Is normal in size, shape and position. Liver measures 121 mm. Hepatic parenchyma is homogenous and uniform. Hepatic vessels are normal. Portal vein is normal. PV measures 10 mm. No evidence of fluid collection seen in morrison's pouch.

GALL BLADDER:- Normal in size and position. Folded in shape. Wall thickness is normal. Lumen is clear. No calculus or growth seen.

CBD:- Is normal in caliber. CBD measures 5 mm. Lumen is clear.

SPLEEN:- Is normal in size, shape and position. Spleen measures 105 mm. Normal echopattern. No focal lesion seen. Splenic vein is normal.

PANCREAS:- Is normal in size, position and echotexture. No SOL seen. Pancreatic duct is normal.

KIDNEYS:- Both kidneys are normal in size, shape and position. Renal cortex is normal on both sides. Cortico-medullary differentiation is maintained on both sides. No calculus or hydronephrosis seen on both sides. RK :- 92 x 43 mm. LK :- 94 x 45 mm.

URINARY BLADDER:- Is normal in size and position. Margins are regular. No calculus or mass seen. Wall thickness is normal. Post void residual urine is 9 ml.

UTERUS:- Is normal in size, anteverted in shape. Uterus measures 91 x 36 x 54 mm. Myometrial echotexture is homogenous and uniform. Endometrium is normal and measures 6 mm. Cervix is normal. No fluid in pouch of Douglas

OVARIES:- Right ovary is enlarged in size and measures 36 x 31 mm. Normal in shape and position. Evidence of a cyst measuring 31 x 24 mm is noted in right ovary. No calcification or septae is noted within the cyst. Left ovary is normal in size, shape and position. Left adnexa is free from any mass. Left ovary measures 29 x 26 mm.

PERITONEUM:- No free fluid is seen in the peritoneal and pelvic cavity. Aorta and IVC are normal. Bowel loops are normal.

IMPRESSION: FEATURES ARE SUGGESTIVE OF RIGHT OVARIAN CYST.

SUGGESTED: CLINICAL CORRELATION.

Bajoria
DR. BISHNU BAJORIA, DNB
CONSULTANT RADIOLOGIST
29/08/2010

Facilities Available : Colour Doppler, TVS, TRUS, USG of Neonatal Brain, Orbit, Thyroid, Breast & Scrotum

(This report is an opinion not the final diagnosis. Please correlate with clinical findings and other investigation report.)
This report is not valid for medico - legal purpose.

9th visit - 08/11/10

- Cycle regular
- Other complaints were better
- Functional history normal

R_X

Apis mel. 0/21, 0/22, 0/23, 0/24

2oz 16 doses BD

10th visit - 01/12/10

- Right ovarian cyst was there.
- Menses was regular.
- Functional history normal

R_X

Apis mel. 0/25, 0/26, 0/27, 0/28

2oz 16 doses BD

11th visit - 08/01/11

- Menses delayed 15 days.
- Right ovarian cyst.

R_X

Apis mel. 0/29, 0/30, 0/31, 0/32

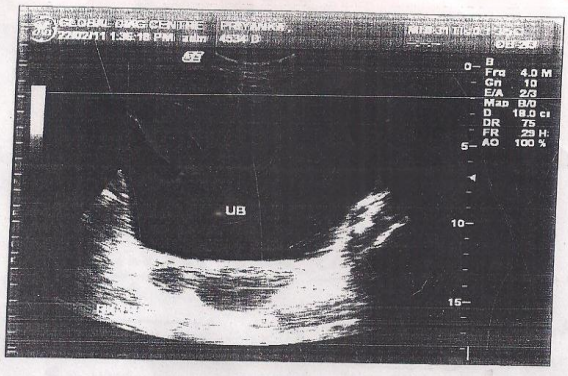
2oz 16 doses BD

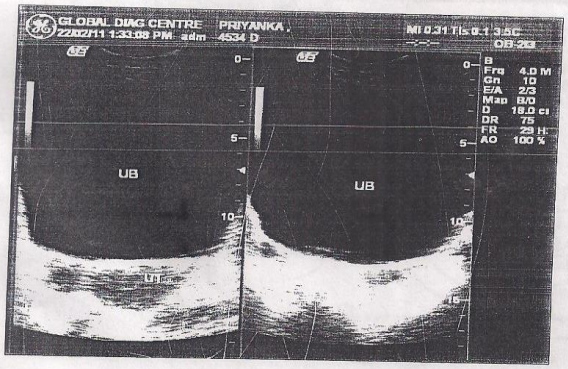
Again patient was advised to go for USG of abdomen and pelvis.

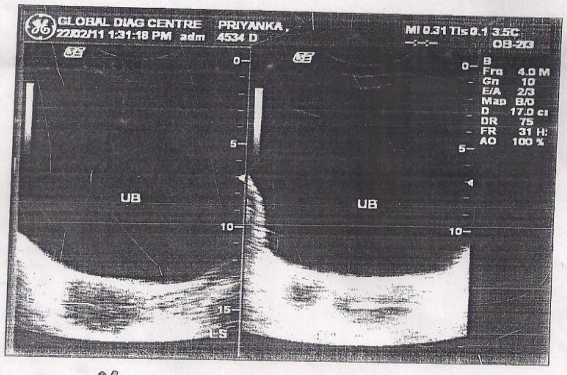
12th visit - 22/02/11

USG report suggesting No Right ovarian cyst.

3rd Report







Miss. Priyanka pradhan

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Regd. No. 523 / 06

Name : MS. PRIYANKA PRADHAN 3rd Report **Age : 21 Sex : F**
Ref By: DR. NIRANJAN MOHANTY **Date: 22.02. 2011**

ULTRASOUND OF WHOLE ABDOMEN

4th day of cycle

LIVER:- Is normal in size, shape and position. Liver measures 118 mm. Hepatic parenchyma is homogenous and uniform. Hepatic vessels are normal. Portal vein is normal. PV measures 10 mm. No evidence of fluid collection seen in morrison's pouch.

GALL BLADDER:- Normal in size and position. Folded in shape. Wall thickness is normal. Lumen is clear. No calculus or growth seen.
CBD:- Is normal in caliber. CBD measures 5 mm. Lumen is clear.

SPLEEN:- Is normal in size, shape and position. Spleen measures 110 mm. Normal echopattern. No focal lesion seen. Splenic vein is normal.

PANCREAS:- Is normal in size, position and echotexture. No SOL seen. Pancreatic duct is normal.

KIDNEYS:- Both kidneys are normal in size, shape and position. Renal cortex is normal on both sides. Cortico-medullary differentiation is maintained on both sides. No calculus or hydronephrosis seen on both sides. RK :- 94 x 43 mm. LK :- 97 x 45 mm.

URINARY BLADDER:- Is normal in size and position. Margins are regular. No calculus or mass seen. Wall thickness is normal. Post void residual urine is 15 ml.

UTERUS:- Is normal in size, anteverted in shape. Uterus measures 92 x 38 x 56 mm. Myometrial echotexture is homogenous and uniform. Endometrium is normal and measures 5 mm. Cervix is normal. No fluid in pouch of Douglas.

OVARIES:- Both ovaries are normal in size, shape and position. Both adnexa are free from any mass. Right ovary measures 34 x 27 mm. Left ovary measures 29 x 24 mm. Both ovaries shows multiple follicles, the largest one measuring 12 x 10 mm in right ovary and 8 x 6 mm in left ovary.

PERITONEUM:- No free fluid is seen in the peritoneal and pelvic cavity. Aorta and IVC are normal. Bowel loops are normal.

IMPRESSION: NORMAL STUDY.

Bajoria
DR. BISHNU BAJORIA, DNB
CONSULTANT RADIOLOGIST
22/02/20

Facilities Available : Colour Doppler, TVS, TRUS, USG of Neonatal Brain, Orbit, Thyroid, Breast & Scrotum

(This report is an opinion not the final diagnosis. Please correlate with clinical findings and other investigation report.)
This report is not valid for medico - legal purpose.

Menses regular.

R_X

Apis mel. 0/29, 0/30, 0/31, 0/32

2oz 16 doses BD

Now, she is also under our treatment.

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