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Original Research Article

To study the incidence of palpable abdominal mass in Gynaecological patients

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Abstract:

Background & Method: The aim of this study is to study the incidence of palpable abdominal mass in Gynaecological patients. All the patient coming with palpable abdominal and pelvic adnexal mass in the gynecologic OPD were included in the study irrespective of age, parity, symptomatology, marital status, etc.

Result: The incidence of malignant tumor was 16.66%. The maximum age group being > 40 years. The incidence of abdominal mass associated with pregnancy was 5.76%.

Conclusion: As patients usually come from low socioeconomic status in our hospital, majority of them were illiterate. Patients usually present late when they have symptoms or have any complication. Hence proper screening of the patient is important. Ultrasound is effective in detecting the abdominal mass, size and type of abdominal mass, so that early diagnosis can be done and treatment can be given as soon as possible. With proper selection, the size of an ovarian cyst does not necessarily constitute a contraindication for laparascopic surgery.

Keywords: incidence, palpable, abdominal mass & Gynaecological.

Study Designed: Observational Study.

1. INTRODUCTION

Among the abdominal masses, uterine fibroids are the most widely recognized pelvic cancers of ladies. Being a significant reason for unusual uterine draining they are the most ordinarily refered to reason for hysterectomy. They have various gamble elements, signs and side effects and various modalities for treatment. Strategies for treating myomas fluctuate in light of area, size, and introducing symptoms[1].

Development and area are the fundamental factors that decide whether a fibroid prompts side effects and issues. A little injury can be suggestive in the event that situated inside the uterine pit while a huge sore outwardly of the uterus might go unnoticed[2].
Intramural Fibroids are situated inside the mass of the uterus and are the most widely recognized type; except if huge, they might be asymptomatic. Intramural fibroids start as little knobs in the strong mass of the uterus. With time, intramural fibroids might extend inwards, causing mutilation and prolongation of the uterine cavity[3].
Subserosal fibroids are situated under the mucosal (peritoneal) surface of the uterus and can turn out to be extremely huge. They can likewise fill out in a papillary way to become pedunculated fibroids. These pedunculated developments can really disengage from the uterus to turn into a parasitic fibroid[4].
Submucosal fibroids are situated in the muscle underneath the endometrium of the uterus and twist the uterine cavity; even little sore in this area might prompt draining and fruitlessness. A pedunculated injury inside the cavity is named an intracavitary fibroid and can be gone through the cervix.
Cervical fibroids are situated in the mass of the cervix (neck of the uterus). Seldom fibroids are tracked down in the supporting designs (round tendon, wide tendon, or uterosacral tendon) of the uterus that likewise contain smooth muscle tissue[5].
Fibroids might be single or various. Most fibroids start in an intramural area, which is the layer of the muscle of the uterus. With additional development, a few injuries might create towards the beyond the uterus or towards the inner hole. Auxiliary changes that might create inside fibroids are drain, rot, calcification, and cystic changes.

2. MATERIAL & METHOD

This study is a prospective study of all cases of large abdominal mass presenting during June 2020 to May 2021 at Amaltas Institute of Medical Sciences, Dewas, M.P.
Study population

- Includes Women (all ages) and the relevant population of women with treatment for fibroids and ovarian mass.

Inclusion Criteria:
Patients admitted in Gynecological ward in Department of Obstetrics and Gynecology, diagnosed with uterine fibroid and ovarian mass was selected for the study.
The Criteria for diagnosis either by clinical features, USG findings and hysterectomy or confirmed by histopathological examination. Through clinical examination including per abdominal, per speculum, per vaginal and per rectal examination was done.
All the patient coming with palpable abdominal and pelvic adnexal mass in the gynecologic OPD were included in the study irrespective of age, parity, symptomatology, marital status, etc.
A detailed history of each case was recorded with reference of age, religion, parity, socioeconomic status, symptomatology, marital status, menstrual history, obstetric history, family history, history of contraceptive methods, method adopted and history of present and past medical and surgical illness.

3. RESULTS

Table 1: Distribution of palpable abdominal mass in different age group

		16-20 yrs	21-25 yrs	26-30 yrs	31-35 yrs	36-40 yrs	>40 yrs	Total
Ovarian	**Benign**	03	08	01	03	07	15	55
	Malignant	00	03	03	04	00	06	
Fibroid		01	10	12	10	07	05	46
Others				03				03
Total								104

Table 2: Educational Status

Educational Status	Total no. of cases	Incidence (%)
Illiterate	94	90.3%
Primary	06	5.76%
Middle	04	3.84%

Majority of patients were illiterate.

Table 3: Distribution of palpable abdominal mass in relation to histopathology (Ovarian)

Histopathology	Total No. of cases	%
Serous cyst adenoma	11	24.44%
Mucinous cyst adenoma	03	6.66%
Papillary adenocarcinoma	03	6.66%
Papillary cyst adenoma	02	4.44%
Mucinous cyst adenoma-Carcinoma	01	2.22%
Functional Ovarian cyst	20	44.44%
Dermoid cyst	09	20%
Dysgerminoma	01	2.22%
Clear cell carcinoma	01	2.22%
Yolk sac tumor	01	2.22%
LAMA	01	2.22%
Tubercular Abscess	02	4.44%
Hydronephrotic mass of kidney	01	2.22%

4. DISCUSSION

In the current review the occurrence of harmless cancer is 83.33% and that of dangerous growths is 16.66%. Comparative finding was found in study done by Jha et al.[6] were 83.9% of ovarian growths were harmless and 16.1% of ovarian cancers were dangerous. In any case, in a review done by Ahmed et al.[7], the frequency of harmless growths was 59.2% and danger was 40.8%. As per JPMA (2009), there were 72% harmless cancers and 28% were dangerous.

In our review, the scope old enough was 15-70 years. This corresponds well with many examinations done in various region of the planet. Patients with ovarian growths went from 6-98 years. In one more review done by Bhattacharya et al[8] the most youthful patient was 10 years of age young lady and advanced age was 73 years of age. Our review showed the pinnacle rate of ovarian growths in age bunch over long term in the middle of between 21-25 years which was similar with study done by Kayasth et al. were top occurrence of ovarian growths was between 21-40 years. Greatest number of threat was seen in more seasoned age bunch. Comparable finding was found in our review were 10.91% instance of danger were found in patients more than 40 years. However, in a review done by Kayasth et al.[9] 66.7% instances of threat were found in patients north of 40 years.

Out of all out instances of ovarian growth (both harmless and dangerous), reciprocal association was found in 21.81% and right side contribution was seen as in 52.72%. Comparable finding was found in a review done by Kayasth et al[9].

In our review, the commonest kind of ovarian cancer as per What classification's identity was surface epithelial growths (50.5%) which was tantamount to a few examinations and among the surface epithelial cancers, serous pimple adenoma was the remarks one (24.44%) trailed by mucinous blister adenoma (6.66%). Second most normal cancer found in our review was microbe cell growth (22.2%).

5. CONCLUSION

As patients usually come from low socioeconomic status in our hospital, majority of them were illiterate. Patients usually present late when they have symptoms or have any complication. Hence proper screening of the patient is important. Ultrasound is effective in detecting the abdominal mass, size and type of abdominal mass, so that early diagnosis can be done and treatment can be given as soon as possible. With proper selection, the size of an ovarian cyst does not necessarily constitute a contraindication for laparascopic surgery.

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