

HYDRONEPHROSIS MIMICKING OVARIAN CYST

Nazakat Begum,* Gul Mohammad,** and Rashid Ahmed,**

**Department of Obstetrics and Gynaecology, Ayub Medical College.*

***Department of Surgery, Ayub Medical College.*

Introduction

Unilateral hydronephrosis is usually caused by obstruction at the pelvi-ureteric junction or in the ureter caused by various aetiological factors. Most of the time it is symptomatic and confirmed on radiology. But at time hydronephrosis is painless and asymptomatic and presents itself as a mass. If it attains a large size the vessels become elongated and if due to repeated pregnancies the abdominal muscles become lax, then kidney may be pushed down and present as a lower abdominal mass. Here we record a case of giant hydronephrosis which presented as a lower abdominal mass and was confirmed on laparotomy.

Case Report

A thirty-two years old lady who was an Aya at a Dispensary and wife of an orderly at the same Dispensary; a third para; two living children, the third baby born six days ago at home which was a still birth. She never had antenatal care, was admitted via casualty with distension and severe pain in the abdomen. She started developing this distension since the beginning of her last pregnancy, but when it did not disappear after delivery and the pain remained as well and was getting more severe; she started getting worried.

She was first admitted to Medical Ward and they referred her to Gynaecology Ward querring her as a case of ovarian cyst.

Her first two pregnancies had been normal, and she has had normal deliveries; bot babies are alive and healthy. Her bowel habits were normal and there were no urinary symptoms.

A slim lady, afebrile, pulse 120/min. and B.P. 110/70 mm Hg. She was anaemic. Her chest and heart were normal.

The abdomen was uniformly enlarged with fluid thrill present. The abdomen was resonant over the left flank, so it was thought that an ovarian cyst is present on right side which is filling whole of the abdomen except the left flank.

Shifting dullness was confirmed in right flank.

Speculum examination did not reveal any abnormality.

On Pelvic examination Vulva Normal.

There was moderate cystocoele and rectocoele.

Cervix was small and pushed posteriorly. The size of uterus could not be assessed because of huge ascites.

The margins of ovarian cyst could not be palpated.

On two occasions the paracentesis was performed and 500 c.c. and 1000 c.c. of fluid was aspirated on each occasion.

The following investigation were performed:—

1. Blood Picture:	Hb	9.2 Gm %
	TLC	5500/mm ³
	DLC	Polymorphs — 65%
	Lymphocytes	— 30%
	Eosinophils	— 3%
	Monocytes	— 20%
2. Urine Analysis	Sp. Gr.	— 1015
	Albumin & Sugar	— Nil
	RBC	— Nil
	Epithelial cells	— 3-5/Cu mm
	Crystals	— +
3. Blood Urea	45 mg%	
4. Blood Sugar	120 mg%	
5. Liver function tests	Serum bilirubin	0.4 mg%.
	SGPT:	34-14 u/ml.
	Serum Alk Phosp:	8 KAU/l
6. Blood Group & Rh Factor	B, Rh+	
7. Ascitic fluid analysis	PH	7.8
	Sp; Gravity:	1016
8. Microscopy:	Total cell count	125/cu mm
	RBC	++
	Lymphocytes	60%
	Polymorphs	40%
	Gram Stain:	No organism seen
	Zeil Neilson Stain:	No AFB seen
		No malignant cell seen.
9. X-Rays chest	P.A. view	
		No abnormality detected.
10. X-Ray Abdomen		Radiological appearances are suggestive of ascites.

We thought of doing I.V.P. but unluckily hospital's X-Ray plant was out of order at that time.

As ultrasound facilities were also not available at that time at the hospital, a provisional diagnosis of ovarian cyst was made and she was prepared for laparotomy.

Two pints of blood were transfused pre-operatively. On laparotomy it was found that a huge cyst was present filling the whole of abdomen pushing the large gut (the caecum and appendix as well) to the left flank, the small intestine and omentum was pushed higher up in the abdomen. The cyst was formed by the changing of the right kidney into a hydronephrosis, thus the upper pole of the right kidney being the only portion which was not

involved. The right ureter was also dilated. The left ovary and left ureter were normal. The liver and spleen were also normal. About 3000 cc of urine was sucked out from the hydronephrotic kidney. The right ureter was clamped, cut and ligated. Right sided nephrectomy was performed. Appendicectomy was also performed at the same time. Two pints of blood was transfused. The patient was febrile till the fifth day, then she was alright. Stitches were removed on the 8th Postoperative day and she was discharged home on 11th day.

On follow up, a month after operation the patient was alright.

Discussion

Huge abdominal swellings are frequently seen in the clinical practice and offers a medical curiosity.

In our country usually the patients do not come in time and by the time they come, the swellings in the abdomen are of such huge size that it is difficult to diagnose them; and secondly the patients are illiterate and do not give good history which helps the clinician to reach a diagnosis.

This was the second patient in our practice. The previous patient was a young female with a huge big mass occupying the whole of abdomen and diagnosed as ascites by the radiologist.

Hydronephrosis produces no specific clinical syndrome and its presentation tends to differ in children and adults. In children it may be presenting as a Painless Mass.¹ But in adults mostly this loin pain at times may be associated with vomiting and condition may be confused with gastro intestinal disorder.²

Stone formation is common sequela due to stasis and stagnation and if gets infected may lead to pyonephrosis and Pus-formation.³ The patient may ultimately go in to Renal failure. But if the process is very slow then like our cases the only presentation may be just a huge mass without any evidence of Renal failure. Reason being the contralateral kidney is functioning and compensating for the diseased one.⁴

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