E-ISSN: 2708-1508
P-ISSN: 2708-1494
IJCRS 2025; 7(2): 86-92
www.casereportsofsurgery.com
Received: 31-05-2025
Accepted: 03-07-2025

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Giant ovarian cyst and sociocultural factors in disease progression: A case report and review of literature

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DOI: https://www.doi.org/10.22271/27081494.2025.v7.i2b.207

Abstract
Background: Ovarian tumours are reported to be the fifth most common cause of death in the female population, and numerous factors are known to facilitate the development of ovarian tumours. While ovarian cysts/tumours in women especially of reproductive age group is common, giant ovarian cysts/tumours are rare. This study aims to report a case of giant ovarian mass and the contributions of sociocultural factors in disease progression as seen in a private gynaecologic referral centre in Port Harcourt in year 2025.
Case presentation: A 46-year-old Para 1 married but separated, who presented with a 2-year history of progressive abdominal swelling. There was associated oligomenorrhoea and weight loss. Abdominal ultrasound scan was suggestive of ovarian cyst but she doubted the results believing she was pregnant. There was a rapid increase in the size of the mass necessitating her presentation to our facility. The significant examination findings were markedly distended, firm and non-tender, abdomen, with exaggerated abdominal girth that measured 35cm. A multi-specialty team care approach was adopted. The encapsulated tumor was delivered intact without any spillage of its content and weighed 20.5kg, and the outcome was satisfactory.
Conclusion: A complex web of sociocultural and economic challenges contributed to the "giantness" of this tumour, as evidenced by patient's belief system, the quality of the society and its health system. A resetting of systemic factors by way of regulatory roles in the society and its health system is therefore strongly advocated.

Keywords: Case report, giant ovarian cyst, giant ovarian tumour, sociocultural factors, port harcourt, Nigeria

Introduction

Among all female human tissues, the ovary is a highly sensitive, complex and dynamic organ endowed with unique role that need no introduction in the propagation of the human race. While it is the sanctuary of female germ cells and also the primary source of female sex hormones – estrogen and progesterone [1, 2] it is highly regulated by hormones and is a potential site of pathology [3, 4]. Normal ovaries are known to measure 2-3 cm in transverse diameter and 3-5 cm in longitudinal diameter [5, 6] and has a tendency to form cysts. A cyst or tumour of the ovary is considered giant or huge when the size measures more than 10cm or extends from the pelvis above the level of the umbilicus [7, 8]. While ovarian tumours are reported to be the third most common gynaecologic cancer [9, 10], and the fifth most common cause of death in the female population [11], numerous factors are known to facilitate their development [12]. However, the "giantness" of the ovarian cyst or tumor, may provide some useful insight into the paradigm and quality of the individual patient, the society and its health system.

There are some reports globally in which giant ovarian tumours were described. In Moroccan, a 63-year-old postmenopausal woman had ovarian torsion and the size measured 18 × 20 × 22 cm [13]. It was reported in year 2014 that an 85 years old female Indian had an ovarian mass 45cm by 32cm and weighed 27kg, and the histopathology report revealed benign mucinous cyst adenoma [14]. Another study reported a 64-year-old female in Quito-Ecuador with ovarian tumour measuring 32×34×29 cm and weighed 13kg [15]. There are a few other cases of giant ovarian tumours were reported in Europe [16-19], in Asia [17, 20, 21], other Indian studies [22-30] etc. In Africa, huge ovarian cyst in pregnancy was reported in Duala Cameron in year 2024 involving a 32-year-old multiparous married housewife whose cystic mass measured 30cm in largest diameter [31]. Ovarian cyst in 65-year-old grand

multiparous Cameroonian woman measuring 55 × 52 × 24 cm and weighed 10.8 kg, was also reported in year 2017 [32]. There are a few other reports on giant ovarian tumours in Africa [33-35].

Occurrence of ovarian cysts/tumours in women especially of reproductive age group is common [36-38], but giant ovarian cysts/tumours are rare and a few have been severally reported in Nigeria as published from Nnewi in Anambra State [39], Ilorin in Kwara State [40], Yenagoa in Bayelsa State [41], Sokoto in Sokoto State [42, 43], Ilisan-Remo in Ogun State [44], Ibadan in Oyo State [45], Asokoro in Abuja [46], Maiduguri in Bornu State [47], Ikeja in Lagos [48], and others [49-52]. Among the reports, in four cases there was co-existence of giant ovarian tumour with pregnancy [40, 43, 48, 50]. Concern on socioeconomic aspects contributing to delays in treatment and consequent large sizes of tumours have also been reported [53-55]. However, the role or intricate sociocultural/religious factors in the disease propagation has scantily been reported in the literature. This is especially so in a background patriarchal Nigerian society where a lot is culturally expected from the woman before and in marriage. In Port Harcourt City, bilateral huge mature cystic ovarian teratoma was reported in a 23 years old female in year 2020 [56]. Additionally, although accidented ovarian cysts diagnosed at laparotomy had been report [57], there were scanty information on giant ovarian tumours in Port Harcourt [57], hence this report intended to add to the literature. This study aims to report a case of giant ovarian mass and the contributions of sociocultural factors in disease progression as seen in a private gynecologic referral center in Port Harcourt in year 2025.

Case presentation

Clinical history: A 46-year-old Para 1 housewife who presented to the gynecology clinic with a 2-year history of progressive abdominal swelling. There was no abdominal pain, no change in bowel habits, no history of trauma or use of hormonal drugs, but there was associated significant weight loss. At the onset of symptoms, she had presented to various private facilities where a series of investigations were done including abdominal ultrasound scan which was suggestive of ovarian cyst, but she doubted the results believing she was pregnant. In the last 3 months prior to presentation to our health facility, there was a rapid increase in the size of the mass necessitating her presentation to our facility. She had her menarche at 10 years of age. She had a four-day menstrual flow in regular monthly cycle. There was no associated dysmenorrhea or vaginal discharge, but she experienced oligomenorrhoea which prompted her suspicion that she was pregnant as she was desirous of conception. The past medical history had no significant information. Her last confinement was in year 2022 during which she was delivered of a male baby by Caesarean Section following fetal distress. There was no complication during pregnancy which was carried to term. The indication for surgery was fetal distress, and the outcome a live male average sized baby who cried well after birth and was breastfed. Her puerperium was normal. She was married but separated, and has no history of tobacco usage or alcohol consumption.

Clinical examination findings: The findings on examination were a conscious and anxious woman, who was not in respiratory distress, but could not comfortably lie down in the supine position. She was not pale, anicteric, afebrile, and had no pedal edema. The head and neck were normal, and the chest had vesicular breath sounds bilaterally. The pulse rate, blood pressure and heart sounds were normal. The abdomen had a sub-umbilical midline scar, and was markedly distended extending from the xiphisternum to the symphysis pubis, with exaggerated abdominal girth that measured 35cm in circumference. The abdomen was firm and non-tender, the internal organs were not palpable, and the bowel sounds were normoactive. The musculoskeletal system had normal findings.

Investigations: The full blood count; electrolyte, urea and creatinine; liver function test; and retroviral screening were all normal. The clotting profile was normal and international normalize ratio (INR) was normal. Also, the chest radiograph and electrocardiogram were normal. The computerized tomography scan (CT scan) has suggested a mesenteric tumor (dimension was 35.56cm (CC) x 33.53cm (TD) x 25.34cm (AP)); however, cancer antigen 125 (CA 125) assay was borderline high. The result of histopathology analysis revealed serous cystadenoma.

Diagnosis: Giant right ovarian cyst in a married but separated woman with secondary infertility.

Treatment: A multi-specialty team care approach involving gynecologist, general surgeon, anesthetist, and nurses was adopted in the management of the patient. She had an elective exploratory laparotomy under general anesthesia, through a midline incision with adhesiolysis and right giant ovarian cystectomy. The encapsulated tumour was delivered intact without any spillage of its content, and weighed 20.5kg. Post operative care included analgesics, antibiotics, deep vein thrombosis prophylaxis (TED stockinet and subcutaneous low molecular weight heparin (Clexane) injection).

Follow up and outcome: After surgery, the patient's clinical condition was improved, and she was discharged with no complications. The postoperative outpatient follow-up visit was satisfactory.

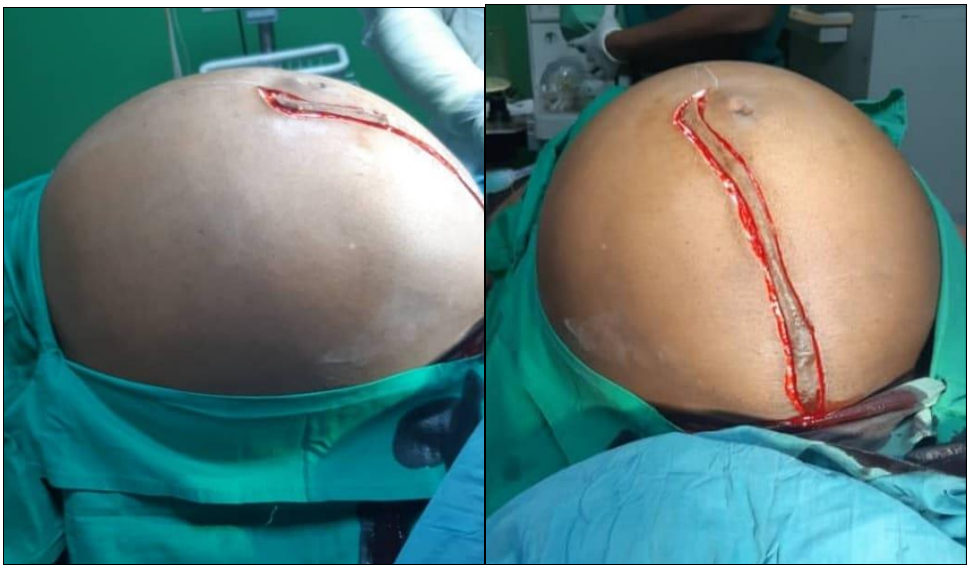

Fig 1: Patient's abdomen before entry into the peritoneal cavity

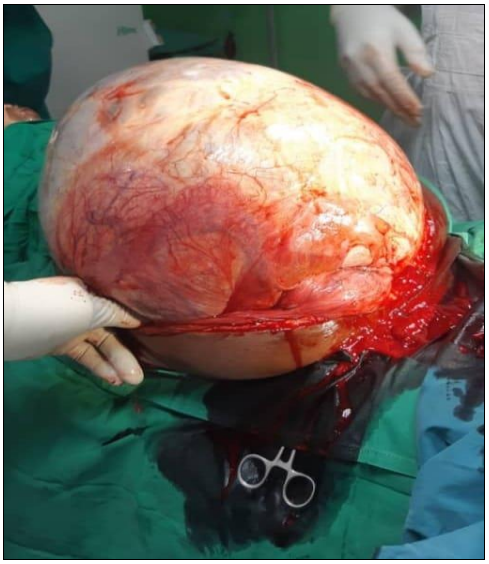

Fig 2: Intraoperative appearance of the mass

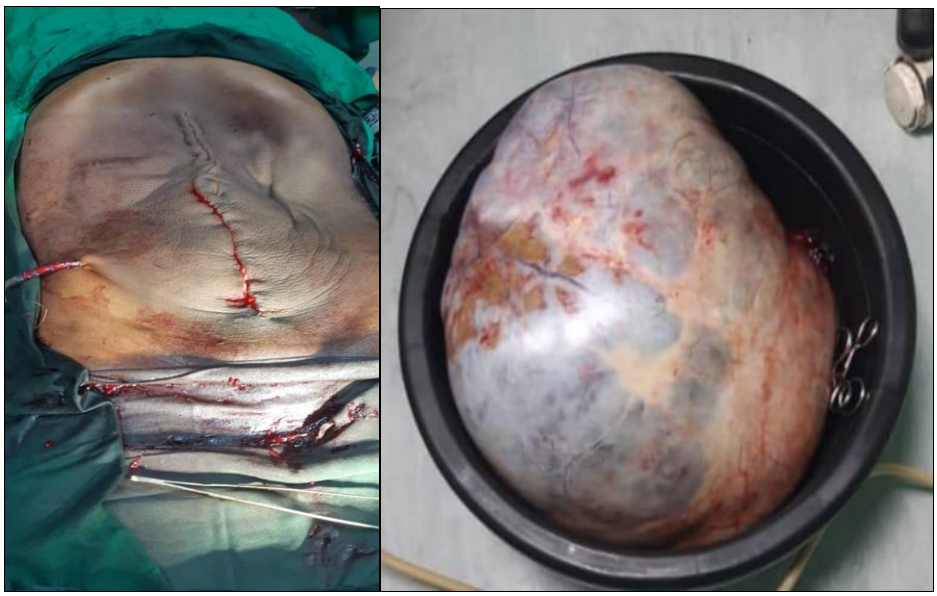

Fig 3: The abdomen in the immediate postoperative period and excised ovarian mass in a plastic basin

Discussion

Medical and surgical practice globally may be the same, however, disease spectrum and scope of practice and experiences of the practitioners may differ. This case report typically highlighted this fact. The case presented was that of a 46 years old Nigerian woman who was married but separated with only one child. In the context of African society, the patient was aware of her age and the risk of impending menopause. The awareness that most Nigerian women reach menopause between 48-52 years of age was an added boost, that attracted some degree of anxiety in marriage, following possible pressure from the in-laws/families for more children, often needed to consolidate her place in the marriage. This tendency has been reported in previous studies that highlighted the unique attributes or relationship between marriage and motherhood in Nigeria [58-61].

The patient's symptoms were progressive abdominal swelling associated with oliguria and some weight loss. There was no urgent discomfort among these symptoms, and therefore may explain the delay in seeking for surgical intervention. It was only when expectation of pregnancy seemed to fail, and rather a recent progression in swelling occurred within three months interfering with her ability to lie down, that she reluctantly let go the paradigm of "hidden pregnancy" to seek for medical help. This is strengthened by the fact that she had doubted the results of abdominal ultrasound scan which had diagnosed ovarian cyst, rather preferred to believe that she was pregnant. This behavior contributed to the increase in size of the tumor, whose dimension extended above the umbilicus – to the epigastrium, has a postoperative intact tumor weight of 20.5kg, and the computerized tomography scan estimated size was 35.56cm (CC) x 33.53cm (TD) x 25.34cm (AP). It therefore qualifies as a giant ovarian tumor. This is similar to the observations in earlier studies in Nigeria [39-52]. The mass was beginning to be symptomatic, as she was comfortable lying down in the supine position. The history of recent increase in size, and cancer antigen 125 (CA 125) assay that was borderline high seemed to suggest likelihood of malignancy. The result of histopathology analysis revealed serous cyst adenoma

A multi-specialty team care approach comprising a gynecologist, general surgeon, anesthetist, and nurses was adopted, and under general anaesthesia with cuffed endotracheal intubation, she had an elective exploratory laparotomy through a midline incision with adhesiolysis and right giant ovarian cystectomy amidst adhesions. Similar general anaesthesia and multidisciplinary team approach were used in previous documented reports [62, 63]. The encapsulated tumour was delivered intact without any spillage of its content. This is similar to the observations in some earlier reported studies [16, 32]. This is a positive achievement for the surgical team amidst challenges of separation of adhesion, as such spillage has been reported to be associated with undesirable short and long-term consequences [64, 65]. The post-operative care and outcome were satisfactory.

Expectations on marriage in a socially dynamic patriarchal Nigerian society may have contributed significantly to the experience of this giant ovarian tumour. Due to her inability to conceive, the patient had been having some marital challenges resulting in separation from her husband, and the fact that she had a male child did not help her situation. Similar unfortunate consequences have been reported as impact of childlessness on marriage by Nigerian authors [66-69]. Constricted family income in the face of diminished purchasing power, may have affected their ability to easily afford healthcare care services. Affordability of cost of healthcare has been reported to negatively health-seeking behaviour and consequently lead to delay in presentation [70], which is seen in this patient. This would probably not be the case in a society of free healthcare or at best available and effective health insurance services. The patient was a Christian with faith-based inclinations. In the same society are reports of crypto-pregnancy stemming from erroneous and deceptive assurances which have been reported by previous researchers [58]. This is different from delusion of pregnancy reported among psychiatric patients [71]. It is therefore understandable and explainable why the abdominal swelling and oligomenorrhoea that she had become a potential lattice that harboured a suspicion of the desired pregnancy. Therefore, while ovarian tumour is a medical illness, the "giantness" of this tumor may have been influenced by a summation of the patient's dominant thoughts pattern, faith and belief system, quality of the patriarchal Nigerian society and its health system.

Study limitations: This is a case report, and therefore bound by the limitations of this type of study. It opens a research opportunity for a prospective original article in the city of Port Harcourt for giant ovarian tumours of similar characteristics.

Conclusion

This patient encountered a complex web of socioeconomic challenges within her marriage as a result of being unable to conceive - infertility, leading ultimately to her separation from her matrimonial home. The fact that she had a male child did not save her from the unfortunate consequences of infertility that women face in marriage, and so passively allowed in the patriarchal Nigerian society. A relatively "cheap belief system" of fake pregnancy came to the rescue, that nurtured and fertilized the growth of this ovarian mass to a giant size. The long period of delay in presentation was encouraged by examples of pseudo or cryptic pregnancy prevalent uncheck in the society. Although the patient was rescued through surgery for advanced ovarian tumour, she is still separated from her matrimonial home. It is apparent therefore that the "giantness" of this tumour was influenced by a complex web of sociocultural/marital challenges, patient's belief system, and the quality of the society and its health system.

Recommendations: A resetting of systemic sociocultural factors by way of regulatory roles in the society and its health system is therefore strongly advocated.

Other information

Acknowledgement: We acknowledge the contributions of Healthbridge Medical Consultants and the patient for granting us their permission to publish this case report for public good.

Research ethics statement: The approval of the Research and Ethics Committee of the Rivers State University Teaching Hospital was obtained and a written consent of the patient was secured.

Source of funding: Self-funded by the researchers.

Conflict of interest: None declared.

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How to Cite This Article
Okagua KE, Ijah RFOA, Oruobu-Nwogu A, Okagua J. Giant ovarian cyst and sociocultural factors in disease progression: a case report and review of literature. International Journal of Case Reports in Surgery. 2025;7(2):86-92