

A Case of Bilateral Ovarian Cyst in Primary Hypothyroidism

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Abstract: Ovarian cysts are common cause for gynaecological surgery. Some Ovarian cysts arise due to endocrine disorders and hence don't require any surgical intervention. Hypothyroidism should be considered in the differential diagnosis in females of reproductive age presenting with ovarian cysts/tumours. Adequate Hormone therapy can prevent these patients from undergoing unnecessary ovarian resection and compromised fertility in the future.

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I. Case presentation

An 18 year old unmarried female presented to our OPD in "Sree Balaji Medical college and Hospital" with complaints of irregular menstrual cycles since past 4 months and continuous bleeding per vaginum since past 20 days. Her previous cycles were regular. She further had history of weight gain associated with hair loss. Her family history was nil significant.

On examination she was well nourished, well built with generalised dryness of skin and mild goitre. Her vitals were stable. Mild pallor was present, her abdomen was soft, Non tender. On investigating her, all routine investigations were within normal limits except her TSH levels which were very high about 11 μ Iu/ml. CA-125 levels were normal. USG pelvis revealed Bilateral large ovarian cysts. Right Ovarian cyst of size 8.1 \times 6cm, and Left Ovarian cyst of size 10 \times 7cm, with septations and loculations.

II. Out Come and Follow Up

She was diagnosed as tubo ovarian mass and treated with NSAIDS and IV antibiotics. The bilateral ovarian mass remained the same. Then we planned for Laparoscopic bilateral ovarian cystectomy. As her TSH levels were found to be high, physician opinion was obtained and started her on L-thyroxine 50micrograms. Her S.prolactin levels were also raised 28 ng/ml. Then she was treated her with Cabergolin and she was sent home to be reviewed after 3 weeks.

After 3 weeks her prolactin levels were under control and TSH came down to 6.34 μ IU/ml. Surprisingly USG showed the size of bilateral ovarian cysts to be reduced.

Right ovary cyst - 3.14 \times 2.11 cms.

Left ovary cyst - 3.98 \times 3.10 cms.

Then oral contraceptive pills were advised for 3 months. After few months patient came for follow up. USG showed bilateral ovarian cysts were disappeared.



III. Conclusion

Ovarian cysts have spectrum of presentations. It may be due to various causes. It is our duty to rule out endocrine causes irrespective of size.

Ovarian cysts can be managed medically when associated with endocrine disorders (Hypothyroidism and Hyperprolactinemia), and by doing this, inadvertent oophorectomy can be avoided and thus we can preserve fertility in the women.

Surgical exploration in these cases should be performed only in the emergency cases such as torsion or rupture. Thus endocrine evaluation should be mandatory for all ovarian cysts.



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