Mrs. S. 57yr old, postmenopausal lady

from Palakkad.

Stupied upto · XII^th Standard

Homemaker

Married to Mr M. 60yr ·, accompanied by Daughter

Belonging to upper middle class (Modified Kuppuswamy scale).

Presenting Complaint

Abdominal discomfort x 3months.

Mass abdomen x 2weeks.

HOPI :-

57yr old postmenopausal lady presented c complaints of vague abdominal discomfort in the past 3months, a dull dragging ~~pa~~ sensation in the lower abdomen, which was insidio in onset and intermittent in nature, increased on bending and raveling back to normal posture.

Patient also complaints of a mass in the lower abdon that she noticed 3weeks back, no associated pain, no. variat in size c position / straining.

No. Bystanders claims to have noticed a drastic weight loss in the last 3months.

No h/o. loss of apetite / feeling of satisfy

No h/o urinary symptoms.

No h/o constipation / bleeding PR / diarrhoea.

No h/o post menopausal bleeding.

No h/o mass. P/V.

No h/o long standing fever / cough.

Menstrual history

Menarche at 12yrs.
Regular cycles.
Menopause at 49yrs.
No h/o of PMB.

(Menstrual cycles. ↓ ~~[illegible]~~)

No HMB.
~~Gives h/o USG [illegible]~~

Marital & Obstetric h/o

Married at age of 22yrs.
Multiparous, P_2L_2 - Both vaginal delivery
Not sterilized.

Past h/o:

HTN on medications × 8yrs.
~~[illegible]~~ → No surgical history
→ No h/o. use of OCP.
→ No h/o use of HRT

→ Gives h/o having a cyst (?Endometriotic) in 2004-5 ~~[illegible] at the~~ age of incidentally detected ↓ & was on a daily ~~[illegible]~~ drug ~~[illegible]~~ ↓ Stoped later in f/u scan size ↓ed.

Personal h/o:-

(N) Sleep and apetite
Mixed diet
Regular bowel & bladder habbits.
No addictions. /No passive smoking

Family h/o:-

No h/o. Breast, ovarian, endometrium or colon cancer in family.

Socioeconomic :-

Upper middle class.

General Physical Examination

Cooperative patient
Ht - 147cm Wt - 49 BMI - 19.6

Pallor (+), No lymphadenopathy / edema.
No clubbing, cyanosis.

PR - 84/min, Reg. .... (R) char, volum.
Perpheral pulse - (N)

BP - 130/70. (R) arm sitting

RR - 12/min regular.

SpO_2 - 98% RA. Afebrile

B/L breast - no lumps / masses
axilla - no lymphnodes / masses.

Thyroid - normal
Spine & Gait - normal

System

- Resp :- AEBE, No adventitious sound.
No evidence of pleural effusion

- CVS - PR - 84/min .... S_1S_2 heard - in all areas
BP - 130/70 ..
~~A systolic murmur in the Aortic area~~
~~Asystolic murmur in Aortic area~~ ~~no radiation~~ (probably - ~~sclerotic~~

- CNS - No FND

GI System:- Oral cavity normal

P/A:-
Patient examined after obtaining consent, emptying the bladder and exposed from xiphisternum to pubic symphysis in the presence of a chaperone.

- Abdomen - fullness in the lower abdomen
Umbilicus central, inverted.
Skin appear normal, no scars, dilated vessels / visible peristalsis / pulsation
- All quadrants moving equally with inspiration
- ~~No increase in size of swelling on cough~~.
- Normal orifices appear intact

The ~~scalp~~ becomes less prominent on leg raising
fullness.
Fullness of (L) flank (+)

Palpation: - tense.
A ~~from~~ large mass ~ 12 x 10 cm palpable in the lower abdomen arising from LIF and extending to (L) lumbar, umbilical, hypogastrium and crossing over to right side, ∃ well defined borders, all borders palpable. not tender to touch, ∃ mobility (no restriction in either axis / no differential mobility).

No hepatomegaly
No splenomegaly (R)
No fullness in flanks. No Inguinal LN

Percussion:-
Tidal percussion (N).
Traube space → Tympanitic sound.
Dull note over the mass.
No evidence of free fluid.

Auscultation: - Bowel sounds (+)
No bruit over mass

Pelvic & Urogenital Exam.

Ext genetalia: - Sparse pubic hair.
Vulva atrophic.
~~Vagina pale~~, ~~no discharge~~.

P/S: - ~~No discharge~~ (Pt. bladder emptied before exam).
Vagina pale; No descent / cystocele / rectocele even on straining
~~No bleeding~~ Cervix not visualized, ~~No~~

P/V: - Cervix pulled up, Uterine size could not be made out
mass felt in the (L) fossa and high the anterior fornix, same felt

per abdomen extending uptill umbilicus.

Nontender, Mobility (+)(F).

(R) fornix free.

No nodularity in POD.

Rectovaginal Exam :- RV septum - normal.
No ?ed thickness/ induration

P/R :- Rectal mucosa normal
Parametrium free.
Fecal stain (+).

Summary :-
57yr old, post menopausal multiparous lady c̄ h/o abdominal discomfort and mass per abdomen. c̄ probable history of endometriosis. (endometriotic cyst) and no other significant medical/ family history.

O/E :- Asthenic patient c̄ BMI of 19, anemic, c̄ (N) systemic examination c̄ an intraabdominal, 10×12cm tense, non tender mass from LIF - extending to (L) lumbar, umbilicus, hypogastrium c̄ regular, defined borders, mobile c̄ no ascites and on P/V exam same mass felt thgh the (L) and anterior fornix, Uterus not separately made out and no nodularity in POD

Δsis :- 57yr old post menopausal multiparous lady c̄ a (L) adnexal mass most probably an ovarian tumor for further evaluation and management.