نحوه اپروچ به خانم ۶۶ ساله به شکایت نفخ شکم در درمانگاه پزشکی خانواده

ارایه دهنده: دکتر علی مهران زاده کارورز پزشکی خانواده

استاد راهنما: استاد تفرشی عضو هیئت علمی گروه زنان

CHIEF COMPLAINT

خانم ۶۶ ساله با شکایت بزرگ شدن شکم و نفخ شکمی

PRESENT ILLNESS

خانم ۶۶ ساله با شکایت نفخ شکمی و بزرگ شدن شکم از دو ماه قبل بدون علایم همراه که چندین مرتبه به پزشک‌های مختلف مراجعه کرده است و درمان علامتی دریافت کرده است ولی بهبودی در علایم حاصل نشده است.
شرح‌حالی از علایم ادراری مانند سوزش ادرار، تکرر ادرار و تغییر رنگ ادرار نمی‌دهد.
علایم گوارشی اعم از اسهال، یبوست و خونریزی گوارشی ندارد.
علایم واژینال مانند احساس خشکی، ترشح غیرطبیعی و خونریزی ندارد.

PMH: هیپوتیرووییدی

PSH: Neg

DH: Levothyroxine 100 mg Daily

AH: Neg

FH: Neg

PHYSICAL EXAMINATION

V/S: BP= 124/70
Ht= 167 cm / Wt= 83 kg / BMI= 29.76

بیمار هوشیار و اورینته بود. در ظاهر ILL و TOXIC نبود.
ملتحمه Pale نبود و اسکلرا Icteric نبود.
سمع ریه‌ها قرینه و Clear بود. دیسترس تنفسی نداشت و ویز و رال سمع نشد.
معاینه قلب نرمال بود.
نبض اندام‌ها پر و قرینه بود.
در معاینه شکم اسکار جراحی مشاهده نمیشد، تندرنس، ریباند تندرنس و گاردینگ نداشت. واضحا Distend بود. در لمس در به طور جنرالیزه توده لمس میشد.

دانشگاه علوم پزشکی و خدمات بهداشتی درمانی تهران

بیمارستان ضیائیان

گزارش سونوگرافی

نام و نام خانوادگی بیمار:	بخش درخواست کننده: سونوگرافی
کد پذیرش: سن بیمار: ٦٦	نام پزشک ارجاع دهنده: عبادتی نخجیری نسیم - نسیم
تاریخ پذیرش: ۰۸:۳۸ - ۱٤۰٤/۰٤/۱۸	تاریخ جوابدهی:
کد برگه:	کد ملی بیمار:

شرح حال درد

در سونوگرافی شکم و لگن انجام شده:

کبد با اندازه و شکل طبیعی رویت شد و ضایعات Cystic و یا Solid در آن رویت نشد.

اکوژنیسیته پارانشیم کبد به صورت منتشر افزایش یافته می باشد. (کبد چرب گرید۱).

تطابق با LFT توصیه می شود.

مجاری صفراوی داخل و خارج کبدی و ورید پورت دیامتر نرمال دارند.

کیسه صفرا با ضخامت جداری نرمال رویت شد. سنگ و اسلاج در داخل آن رویت نشد.

اندازه، اکوژنیسیته پارانشیمال و شکل طحال طبیعی می باشد.

در سونوگرافی از پانکراس و پاراآئورت در حد قابل بررسی ضایعه مشخصی رویت نگردید.

ابعاد، حدود و پاترن هر دو کلیه طبیعی است. اکوژنیسته پارانشیم هر دو کلیه نرمال رویت می شود.

سنگ و هیدرونفروز و ضایعه فضاگیر Solid و Cystic در کلیه ها مشاهده نشد.

حجم و شکل مثانه طبیعی مشاهده شد. ضخامت جداری مثانه نرمال می باشد. مثانه فاقد سنگ مشاهده شد.

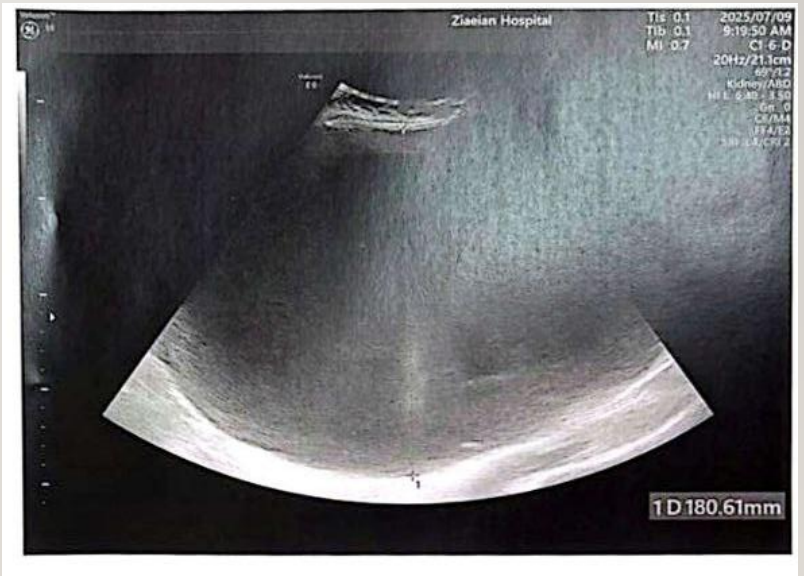
ابعاد رحم۴۲*۷۹ م.م است. **اکوپترن میومتر هتروژن است.**

ضخامت دو لایه اندومتر۱۰ م.م رویت شد.(افزایش یافته)

تخمدان راست با ابعاد نرمال رویت شد.

مایع آزاد مختصر در حفره لگن مشاهده شد.

تصویر ضایعه کیستیک بزرگ با امتداد از لگن تا اپی گاستر به ابعاد ۱۰۴*۱۸۰*۲۳۸ م.م دارای چند سپتای مختصر پریفرال داخلی دیده می شود که به نظر دارای منشا ادنکسال (به احتمال زیاد منشا از ادنکس چپ) می باشد.



Hematology CBC WBCs - Whole Blood

Test	Result	Method	Reference Intervals(Sex & Age adjusted)
W B C	6.0 x10*3/µL		4-10
Eosinophil#	0.4 x10*3/µL	.	0-0.8
Neutrophil#	2.8 x10*3/µL	.	1.5-8
Lymphocyte#	2.4 x10*3/µL	.	0.8-4.8
Monocyte#	0.4 x10*3/µL	.	0.2-1
Basophil#	0.0 x10*3/µL	.	0-0.2
Eosinophil	**6.1 %**	.	0-5
Neutrophils	47.2 %	.	38-80
Lymphocyte	39.4 %	.	18-50
Monocyte	6.5 %	.	2-10
Basophil	0.9 %	.	0-2

Hematology CBC - RBCs - Whole Blood

Test	Result	Method	Reference Intervals(Sex & Age adjusted)
R B C.	5.07 x10*6/µL	.	3.8-5.4
Hemoglobin.	14.3 g/dL		11.9-15.9
Hematocrite	43.5 %		35-47
M C V	86 fL		80-100
M C H	28.2 pg		27-33
M C H C	32.8 g/dL		32-36
RDW %	13.6 %	.	11.5-14.5

Hematology CBC - Platelets - Whole Blood

Test	Result	Method	Reference Intervals(Sex & Age adjusted)
Platelets	238 x10*3/µL		140-450
PCT	0.23 %		0.16 - 0.33
MPV	9.5 fL	.	7.2-12
PDW	19.0 %		9-20

Biochemistry - Serum

Test	Result	Method	Reference Intervals(Sex & Age adjusted)
Fasting blood sugar	115 mg/dl	Enzymatic-Col	82-115
Creatinine	0.9 mg/dl	Calorimetry	0.6 - 1.3
SGOT (AST)	**85 U/l**	Enzymatic	0-35 units/L
SGPT (ALT)	**47 U/l**	Enzymatic	Adult/child: 4-36 Elderly: may be slightly higher than adult Infant: may be twice as high as adult
Alkaline phosphatase	244 U/l	Kinetic	64 - 306

Immunoassays - Serum

Test	Result	Method	Reference Intervals(Sex & Age adjusted)
AFP	0.7 IU/ml		
CEA	**20.8 ng/ml**	ELISA	Non-smokers: < 5 Smokers < 10
CA 19-9	7.2 U/ml	ECL	< 27 U/ml
CA 125	4.9 U/ml	ELISA	<35
Human epididymis protein 4	84.2 pmol/l	ELISA	UP To 120
Ferritin	23 ng/ml	ELISA	10 - 124

Endocrinology - Serum

Test	Result	Method	Reference Intervals(Sex & Age adjusted)
TSH	3.5 mIu/l	ELISA	0.3-4.2 mIU
Beta-hCG	**0.7 mIU/ml**	ECL	Non-pregnant: <5 Indeterminate: 5-25 Probable pregnancy:: >25

دانشگاه علوم پزشکی و خدمات بهداشتی درمانی تهران

بیمارستان ضیائیان

گزارش سی تی اسکن

نام و نام خانوادگی بیمار:	بخش درخواست کننده: سی تی اسکن
کد پذیرش: سن بیمار: ٦٦	نام پزشک ارجاع دهنده: عبادتی نخجیری نسیم - نسیم
تاریخ پذیرش: ۰۸:۰۸ - ۱٤۰٤/۰٤/۲٤	تاریخ جوابدهی: ۱۷:٤۷-۱٤۰٤/۰٤/۲٤
کد برگه:	کد ملی بیمار:

شرح حال درد

Spiral CT of Chest with and without contrast media

Findings :

Cardiomegaly is seen.

Mild pericardial effusion is noted.

Both pulmonary parenchymas are normally aerated.

No mass lesion or abnormality is seen.

Bronchovascular patterns of both lungs are normal.

Pleural effusion is not seen.

In mediastinal window, normally enhanced vessels are seen.

There is no evidence of abnormal lymphadenopathy or pathologic enhancement after contrast medium injection .

Vertebral bodies are unremarkable.

دانشگاه علوم پزشکی و خدمات بهداشتی درمانی تهران
مرکز تحقیقات توسعه آموزش در علوم پزشکی ضیائیان (پرتو نگار ضیائیان)
دکتر سید علی محمد صالح
متخصص رادیولوژی و سونوگرافی
تمام وقت جغرافیایی و مسئول فنی ن ۱۲۷۹۴۱

نام استاد: دکترمحمد صالح - سید علی

کد پذیرش: سن بیمار: ٦٦	نام پزشک ارجاع دهنده: عبادتی نخجیری نسیم - نسیم
تاریخ پذیرش: ۰۸:۰۸ - ۱٤۰٤/۰٤/۲٤	تاریخ جوابدهی: ۱۷:٤۷-۱٤۰٤/۰٤/۲٤
کد برگه:	کد ملی بیمار:

شرح حال درد

سی تی اسکن اسپیرال شکم و لگن - با و بدون تزریق

سی تی اسکن ریه و مدیاستن با و بدون تزریق

سایر سرنگ انژکتور

بازسازی هر ناحیه (اضافه بر هزینه سی تی اسکن اصلی)

Spiral CT-Scan of Abdominopelvic Cavity with and without contrast media (IV & Oral)

Findings :

The liver is normal in size and enhanced homogeneously. .

*Tiny **hypodensity lesion measuring 5mm in segment V of liver is seen. that is not characteristic because of small size however regards to its density tiny cystic lesion could be in first DDX.***

Follow up is recommended.

The gallbladder is fluid-filled .

The portal and splenic veins are patent .

The spleen is normal in size and density .

No pancreatic or adrenal mass is noted .

The kidneys excrete contrast symmetrically, without evidence of hydronephrosis.

Scattered small cyst in both kidneys with largest diameter 13mm are seen.

There is no significant retroperitoneal adenopathy .

Imaged bowel structures, specially the cecum and rectum , show no abnormality .

The perirectal fat and ischiorecal fossa are unremarkable .

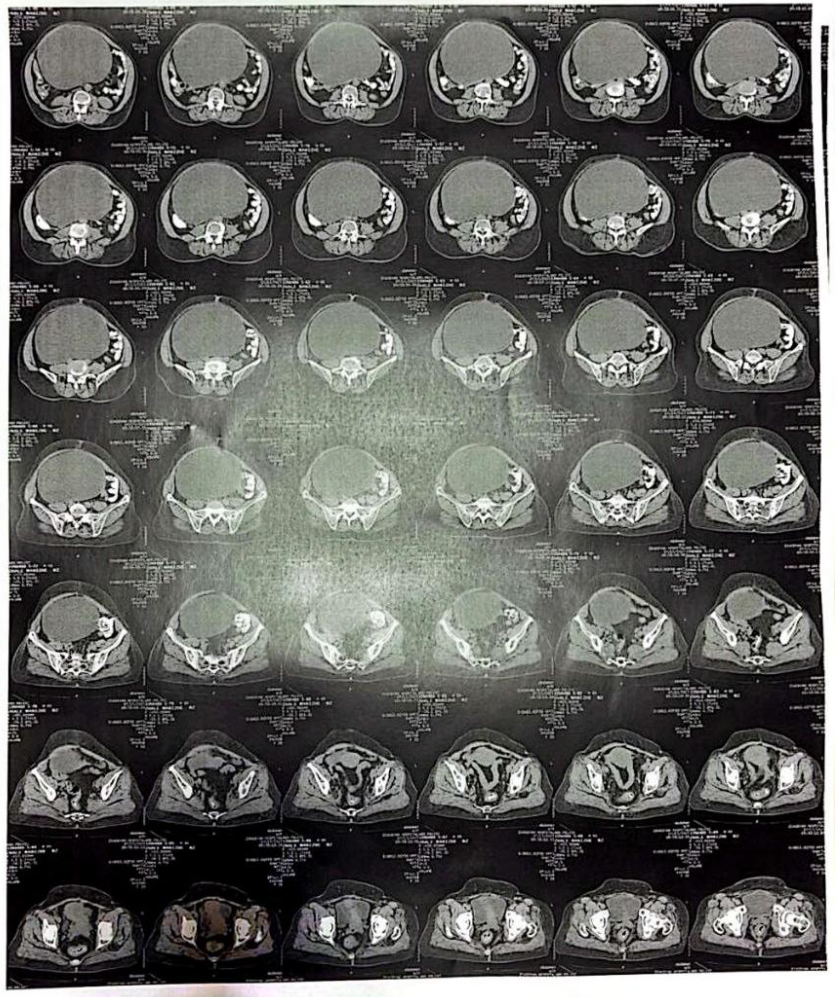
The urinary bladder is normal .

Pelvic organs: normal.

Large cystic lesion with extension from right side of pelvic in to abdominal cavity up to epigastric measured 261*164*223mm is noted . that is accompanied with mild internal thin enhancing septa

Adnexal lesion specially from right ovary is in DDX

ZIAEIAN HOSPITAL



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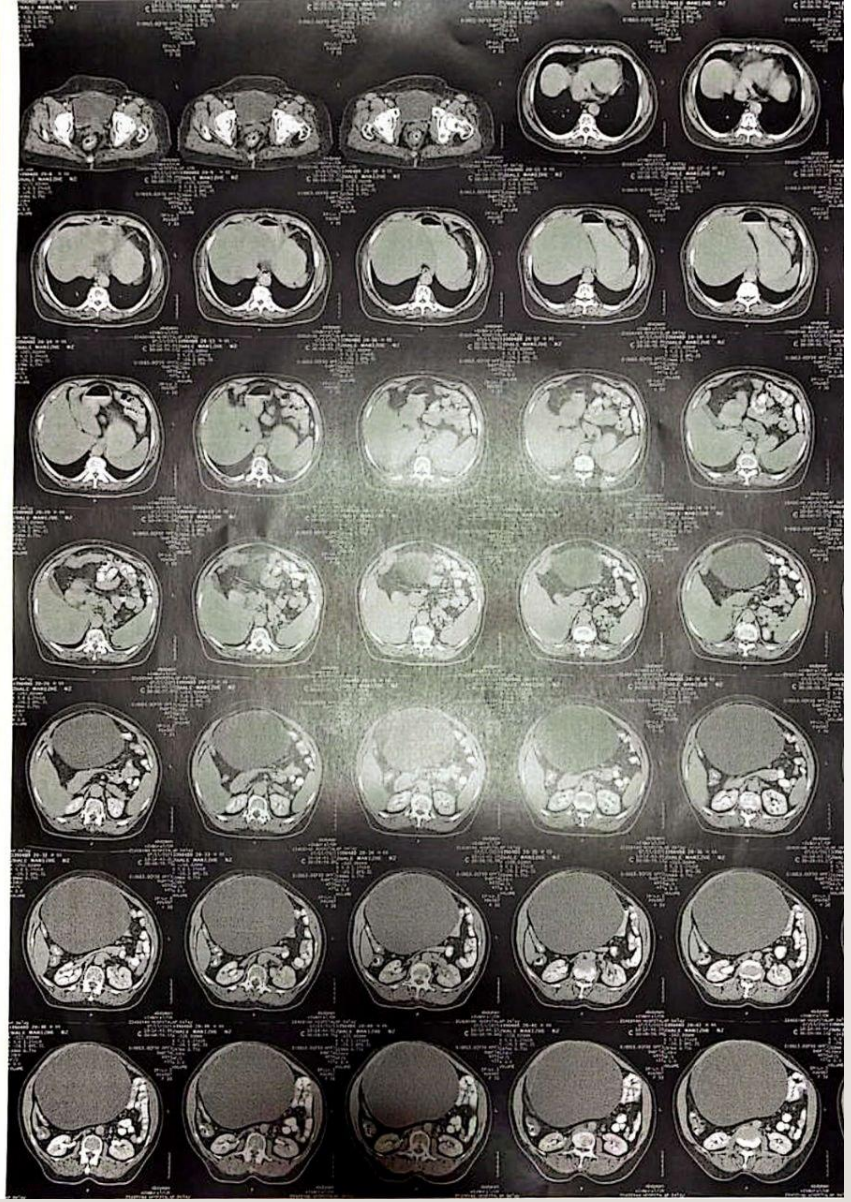
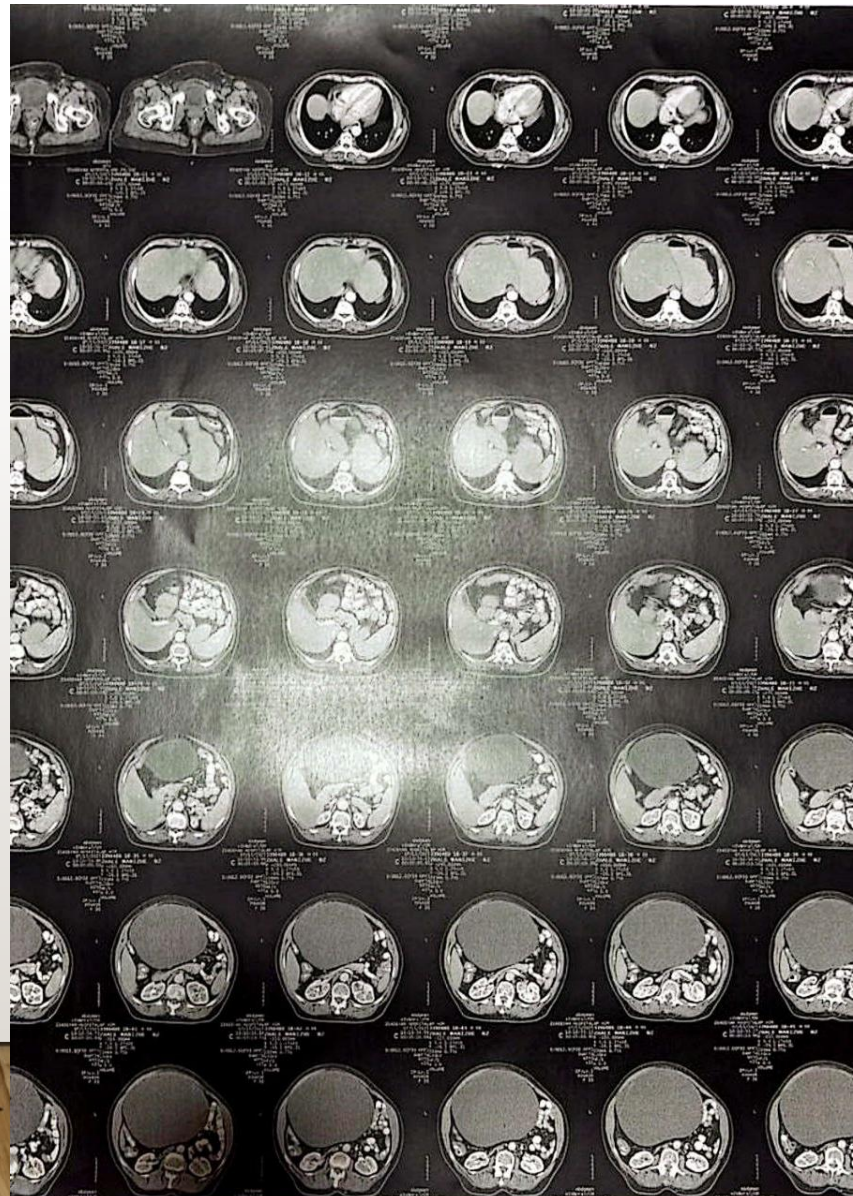




Adnexal masses

An adnexal is a common gynecologic issue. Adnexal masses may be found in females of all ages and have many etiologies

The principal goals of the evaluation of an adnexal mass are to determine whether the mass is "almost certainly benign," has a "reasonable chance of being malignant," and whether there is an urgent condition that requires prompt medical or surgical treatment.

Management of nonurgent conditions may involve:

- Expectant management
- Surveillance
- Surgery

Clinical presentation

Patients with an adnexal mass may be asymptomatic or present with one or more of the following symptoms. Frequency of symptoms vary widely depending on the etiology of the mass and population studied:

- **Pelvic pain or pressure** – Pelvic pain or pressure is the most common symptom associated with an adnexal mass. When present, it is often unilateral and can be of variable severity, acute or gradual onset, sharp or dull, and constant or intermittent.
- **Abdominal fullness or pressure**
- **Gastrointestinal discomfort:** nausea, vomiting, constipation, bloating
- **Difficult or frequent urination**
- **Dysmenorrhea**
- **Dyspareunia**
- **Fever**
- **Abnormal uterine bleeding**

DIAGNOSTIC EVALUATION

Patients with an adnexal mass and acute and/or severe pain or hemodynamic instability should be evaluated and stabilized in the emergency department. Patients in whom a potentially urgent condition is not suspect are typically evaluated in an outpatient setting.

History and Physical examination

The medical history should include the following:

- **Menstrual history (including last menstrual period and presence/severity of dysmenorrhea)**
- **Characteristics of the pain (if present)**
- **Presence/absence of fever**
- **Sexual history**
- **Presence/absence of infertility**
- **Risk factors or symptoms of ovarian cancer**

Physical examination:

- **Pelvic examination**
- **Findings such as pain with palpation; abdominal distention, ascites, or bloating**
- **Signs of a hormonally active mass, such as virilization**
- **Basic laboratory evaluation includes a pregnancy test and complete blood count.**

Frequency of symptom categories in women with ovarian cancer

Type of symptom	Percent
Abdominal	77
Gastrointestinal	70
Pain	58
Constitutional	50
Urinary	34
Pelvic	26

Risk factors for ovarian cancer

	Relative risk	Lifetime probability (%)[1]
General population	1.0	1.3[1]
***BRCA1* gene mutation**		35 to 46[2,3]
***BRCA2* gene mutation**		13 to 23[2,3]
Lynch syndrome (hereditary nonpolyposis colon cancer)		3 to 14[4,5]
Other gene mutations		
BRIP1		5.8[6]
RAD51C		5.2[7]
RAD51D		12[7]
Family history of ovarian or fallopian tube cancer (with negative testing for a familial ovarian cancer syndrome)	Uncertain[8]	
Infertility	2.67[9]	
Endometriosis (increase in risk of clear cell, endometrioid, or low-grade serous carcinomas)	2.04 to 3.05[10]	
Cigarette smoking (increase in risk of mucinous carcinoma)	2.1[11]	
Intrauterine device	0.68[12]	
Past use of oral contraceptives	0.73[13]	
Past breastfeeding (for >12 months)	0.72[14]	
Tubal ligation	0.69[15]	
Previous pregnancy	0.71[16]	

Diagnosis

The diagnosis of an adnexal mass may be suspected on pelvic examination and confirmed with pelvic imaging; a definitive diagnosis of the etiology of an adnexal mass is made by characteristic histologic findings following surgery. a presumptive diagnosis of the etiology of an adnexal mass can often be made based on the classic sonographic appearance of the mass and can be further supported with clinical findings.

Role of additional imaging — For most patients, the diagnosis of an adnexal mass is made by ultrasound. For masses with indeterminate features on ultrasound, or images that are suboptimal, further characterization of the mass can be achieved by obtaining MRI or referral to an ultrasound specialist

MANAGEMENT

Patients requiring prompt intervention — Adnexal masses that require prompt intervention because of their potential for causing serious morbidity (hemorrhagic shock, sepsis) and/or loss of ovarian function include:

- **Ectopic pregnancy**
- **Adnexal torsion**
- **Tubo-ovarian abscess**
- **Ruptured or hemorrhagic ovarian cyst**

Sonography assessment categories:

- **Normal ovary** (O-RADS 1)
- **Almost certainly benign** (O-RADS 2; risk of malignancy <1 percent)
- **Low-risk** (O-RADS 3; risk of malignancy 1 to <10 percent)
- **Intermediate-risk** (O-RADS 4; risk of malignancy 10 to <50 percent)
- **High-risk** (O-RADS 5; risk of malignancy ≥50 percent)

Serum tumor markers:

Cancer antigen 125 (CA 125) is the most common tumor marker evaluated in patients with adnexal masses

When to refer to a gynecologic oncologist

Referral of women with a pelvic mass to a gynecologic oncologist: ACOG guidelines

Premenopausal women (refer if any are present)
Very elevated CA 125 level*
Ascites
Evidence of abdominal or distant metastases
Postmenopausal women (refer if any are present)
Elevated CA 125 level*
Ascites
Nodular or fixed pelvic mass
Evidence of abdominal or distant metastases

ACOG: American College of Obstetricians and Gynecologists; CA 125: cancer antigen 125.

Candidates for surgical evaluation

- Patients with a high-risk mass on imaging
- Elevated tumor marker; CA 125 level >35 units/mL
- Large mass size – A mass ≥10 cm in diameter is typically an indication for surgical exploration
- Intermediate-risk mass plus symptoms or risk factors
- Intermediate-risk mass plus elevated CA 125
- An adnexal mass suspicious for a germ cell or sex cord-stromal tumor

surveillance

Surveillance typically includes one or more pelvic ultrasounds and/or measurement of serum tumor markers; however, there is no consensus regarding the best approach and various surveillance frequencies have been described . In general, on repeat imaging, neoplastic cysts enlarge, non-physiologic benign cysts remain unchanged or enlarge slowly, and physiologic cysts resolve.

Surveillance frequency

- **Patients with an intermediate-risk mass on imaging**
  - **Postmenopausal patients**

    repeat a transvaginal ultrasound and cancer antigen 125 (CA 125) level in 6 weeks, 12 weeks, and then every three to six months for one year; a final ultrasound and CA 125 level are performed after one additional year.

  - **Premenopausal patients**

    repeat a transvaginal ultrasound in six weeks. This allows visualization of the mass at a different point in the menstrual cycle. We then repeat an ultrasound in three months and then in six months; a final ultrasound is performed after one additional year.

- **Patients with a low-risk mass on imaging**

  repeat a transvaginal ultrasound in three months and then in six months

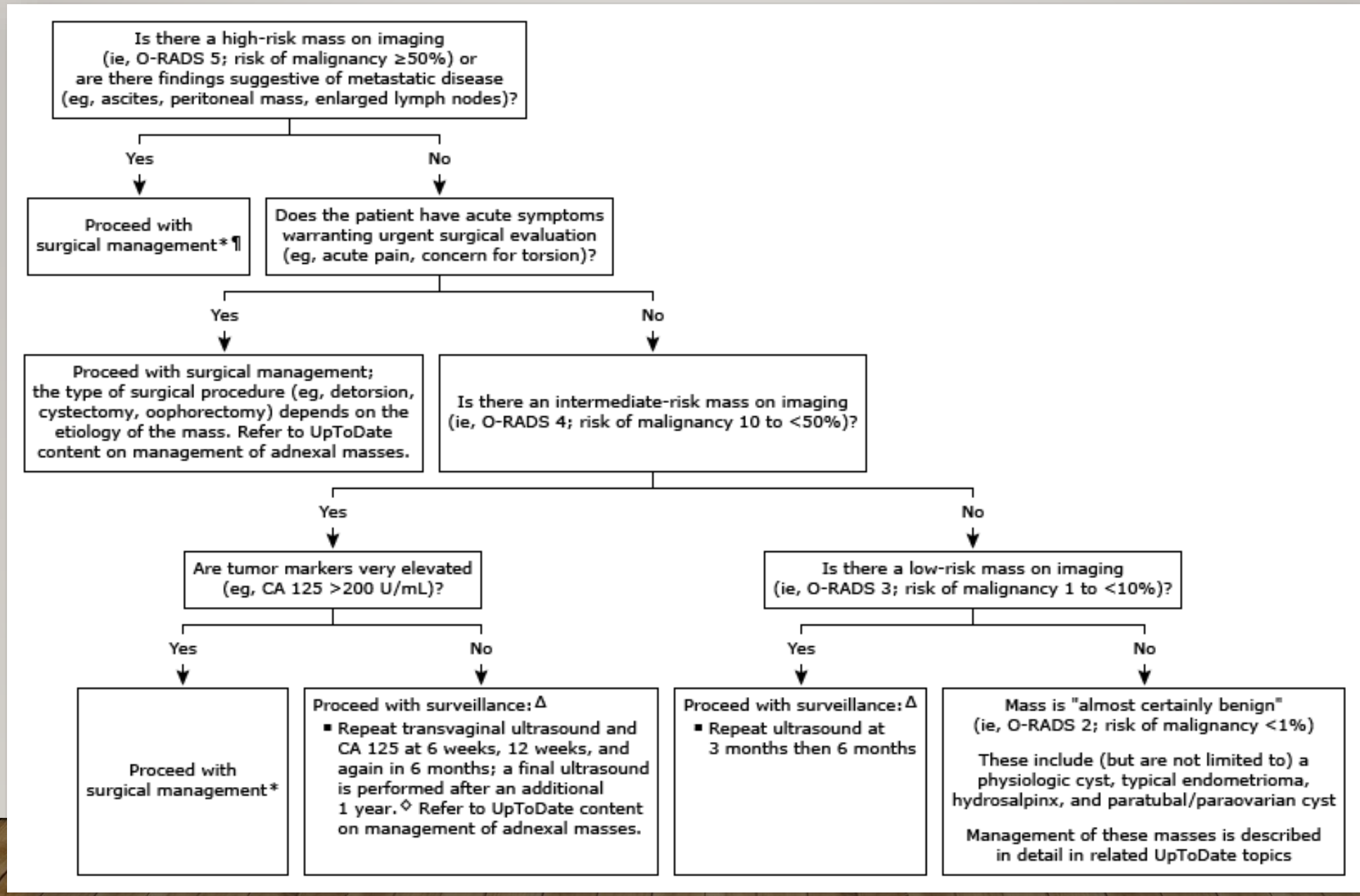
Surveillance frequency

A CA 125 level is not routinely repeated in all premenopausal patients. If the initial CA 125 level was <35 units/mL, we do not repeat the test. If the initial level was moderately elevated (≥35 to ≤200 units/mL), we repeat the test with each ultrasound until a pattern emerges. If the level is consistently low or moderately elevated, we discontinue CA 125 testing.

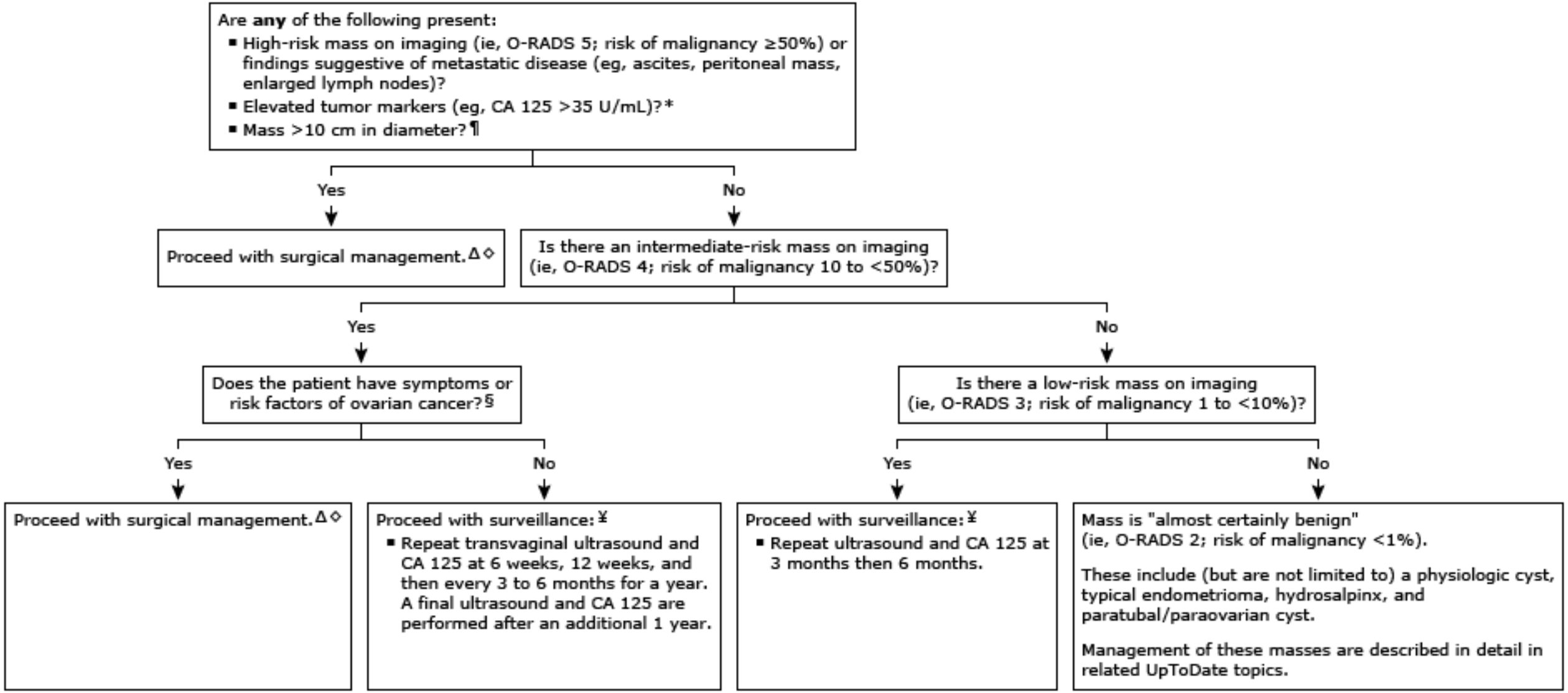
During surveillance, we proceed with surgery if any of the following occur:

- **The mass develops high-risk features of malignancy** (or there are new findings suggestive of metastatic disease)
- **The mass is increasing in size or is ≥10 cm**
- **Tumor markers become elevated** (eg, CA 125 level >35 units/mL in postmenopausal patients or >200 units/mL in premenopausal patients**) or trend upward**

Nonpregnant, premenopausal patient



Postmenopausal patient



سطوح پیشگیری

Primordial Prevention

Primary Prevention

Secondary Prevention

Tertiary Prevention

Quaternary Prevention

Primordial Prevention

- Promoting healthy lifestyles to reduce obesity, a risk factor for some ovarian tumors
- Encouraging balanced diets and physical activity
- Public health campaigns to reduce smoking, as smoking is linked to certain ovarian cancers
- Reduce exposure to environmental carcinogens (e.g. asbestos)

Primary Prevention

- Counseling on oral contraceptive use, which reduces the risk of epithelial ovarian cancer by suppressing ovulation (ACOG supports long-term use for risk reduction in high-risk women).

- Genetic counseling and testing for BRCA1/BRCA2 mutations in women with a family history of ovarian or breast cancer, followed by risk-reducing salpingo-oophorectomy (RRSO) in high-risk individuals.

- Education on avoiding unnecessary hormone replacement therapy (HRT) in postmenopausal women, as prolonged HRT use may increase ovarian cancer risk.

Secondary Prevention

- Transvaginal ultrasound or CA-125 testing in women with symptoms suggestive of adnexal masses (e.g., pelvic pain, bloating), though routine screening is not recommended for the general population (per USPSTF and ACOG, due to low specificity and risk of overdiagnosis).

- Risk of Malignancy Index (RMI) or OVA1 testing to stratify the likelihood of malignancy in women with detected adnexal masses, guiding further management.

- Monitoring asymptomatic benign adnexal masses (e.g., functional cysts) with serial ultrasounds to detect changes early, avoiding unnecessary surgery.

Tertiary Prevention

- Surgical management (e.g., cystectomy or oophorectomy) for benign or malignant adnexal masses, followed by rehabilitation to restore pelvic function or quality of life.
- Adjuvant chemotherapy or targeted therapies (e.g., PARP inhibitors for BRCA-mutated ovarian cancer) to prevent recurrence in women with malignant adnexal masses.
- Regular follow-up with imaging or tumor markers (e.g., CA-125) in women with a history of ovarian cancer to detect recurrence early and manage symptoms.

Quaternary Prevention

- Avoiding routine pelvic imaging or CA-125 screening in asymptomatic, low-risk women, as recommended by USPSTF and ACOG, to prevent overdiagnosis of benign masses and unnecessary surgeries.

- Counseling against immediate surgery for small, simple ovarian cysts (<5 cm) in premenopausal women, as many resolve spontaneously (per UpToDate 2025 guidelines).

- Deprescribing or avoiding non-evidence-based treatments (e.g., unproven herbal therapies for ovarian cysts) to reduce patient harm and costs.

نقش پزشک خانواده