Keywords: Endometrioma, Dermoid cyst, Imaging, Case report

Introduction

e quantity and calibre of follicles within the ovary are referred to as ovarian reserve, and endometrioma itself might have a detrimental e ect on it [1]. To assist prevent any harmful e ects on ovarian pathophysiology, it is essential to remove this benign cyst as soon as possible [2]. e most prevalent teratoma and the cause of 20% of all ovarian tumours is the mature ovarian cyst teratoma, also known as the ovarian dermoid cyst [3]. e removal of a dermoid cyst must be done carefully in order to preserve the ovarian reserve even though it has no e ect on fertility [4]. Dermoid cyst complications can also include rupture, torsion, and malignant transformation. It is highly uncommon for two benign diseases to coexist [5]. e preferred course of therapy will be decided with the support of the endometrioma and dermoid cyst diagnoses [6]. Presentation of a Case a 41-year-old lady with bilateral pelvic masses was referred [7]. e main complaint was severe le pelvic pain. Her bilateral pelvic pain had substantially increased. And for pain relief, she took ibuprofen [8]. On a scale of 1 to 10, the patient described the pain as acute and indicated that it was worse on the le than the right [9]. e patient exhibited normal vital signs and was attentive and afebrile [10]. e pelvic pain wasn't accompanied by any other signs or symptoms. Without guarding or rebound, bilateral adnexal pain was felt upon probing. As the rst screening method, transvaginal ultrasonography revealed a bilateral adnexal mass measuring 3.75 4.79 cm and related to ovarian cysts. While the le ovarian cyst displayed some peripheral calci cation with solid components, the right ovarian cyst was compatible with hemorrhagic cysts. Ovarian dermoid cysts on both sides were thought to exist. Pelvic magnetic resonance imaging MRI was performed because of abnormal ultrasound results and a worry about malignancy. It revealed a le dermoid cyst and what might be an endometrioma or hemorrhagic cyst on the right. e right ovary was 3.9 cm in diameter and showed precontrast T1 hyper intensity, intermediate to low T2 signal, and no discernible contrast enhancement, all of which were most likely signs of endometrioma. A dermoid cyst-like 3.8 cm fat tumour was visible in the le ovary. Yet, only a histological study could de nitively determine whether the pathology was benign or malignant.

e patient was encouraged to proceed with bilateral laparoscopic cystectomy a er examining his or her treatment choices. She was aware of the dangers associated with surgery and gave her approval. She didn't have any other health or surgical issues. She had two healthy vaginal deliveries and was monogamous. She denied using alcohol or cigarettes. ere was no history of colon, ovarian, or breast cancer in

followed by the removal of the le dermoid cyst in its entirety from the ovary during a procedure known as a bilateral ovarian cystectomy. e person had no problems with the operation and tolerated it. is instance of Endometrioma and dermoid cyst coexistence in each ovary, which was con rmed by MRI as a result of unusual ultrasound ndings, emphasises how important it is to e ectively remove both cysts. e most frequent cause of chronic pelvic pain in women who are fertile is endometriosis, which is also closely related to painful ovulation, menstruation, and infertility. Almost 10% of women globally who are of reproductive age are thought to have endometriosis. Ovarian Endometrioma is the clinical manifestation of endometriosis and is present in up to 44% of people with endometriosis several ndings imply that adhesions between the peritoneum and ovarian surface implants may be the source of endometrium's. e quantity and calibre of follicles in the ovary, which is characterised by Endometrioma, can be negatively impacted. Inside of an ovary. To assist prevent any adverse e ects on ovarian pathophysiology, it is essential to remove this benign cyst as soon as possible. e most prevalent Teratoma and the cause of 20% of all ovarian tumours is the mature ovarian cyst Teratoma, also known as the ovarian dermoid cyst. e removal of a dermoid cyst must be done carefully in order to preserve the ovarian reserve even though it has no e ect on fertility. Dermoid cyst complications can also include rupture, torsion, and malignant transformation. It is highly uncommon for two benign diseases to coexist. e preferred course of therapy will be decided with the support of the Endometrioma and dermoid cyst diagnoses. A 41-year-old lady with bilateral pelvic masses was referred. e main complaint was severe le pelvic pain. Her pelvic pain had intensi ed considerably. She took ibuprofen for the ache she was experiencing bilaterally. On a scale of 1 to 10, the patient gave the pain a 5 severity rating, describing it as severe and worse on the le than the right. e patient exhibited normal vital signs and was attentive and afebrile. e pelvic pain wasn't accompanied by any other signs or symptoms. Without guarding or rebound, bilateral adnexal

cyst from the ovary and remove it intact, with minimal bleeding. In attempting to remove the e right ovary's Endometrioma burst as a chocolate cyst and was vigorously irrigated without noticeably bleeding. In an End pouch, the cystic wall of the right ovary was removed. e le ovary's dermoid cyst was also excised and placed in an End pouch. During the treatment, a few pelvic adhesions were discovered and lysed. Little blood loss was necessary to achieve haemostasis. Even a er the bilateral cysts were removed, the ovaries were unharmed. Samples were delivered to the pathology section. It is highly unusual for dermoid tumour and Endometrioma to coexist in the ovaries. is is the rst instance that has been documented of an Endometrioma in