CASE REPORT PROF-1440

TREACHEROUS OVARIAN TUMOURS

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ABSTRACT ... A 47 years old P7 A0 presented with history of gradually increasing abdominal mass and menorrhagia for the last six months. Pelvic ultrasound showed enlarged uterus with multiple fibroids of varying sizes with bilateral, large ovarian tumours with solid elements and hypoehoic thick fluid with septations. CT scan also confirmed same findings. Staging Laparotomy was performed which confirmed the findings of ultrasound and CT scan. Total abdominal hysterectomy with bilateral salpingo-oophorectomy was done along with peritoneal washings for cytology. Histopathology showed uterine fibroids, simple endometrial hyperplasia and Bilateral Mucinous cyst Adenomas of ovary with no evidence of malignancy.

Key words: Treacherous Ovarian Tumour, Mucinous Cyst adenoma, Adnexal Mass

INTRODUCTION

Ovarian tumours can be divided into three main groups, functional, benign and malignant[1]. Ovarian cysts arising in the normal process of ovulation are called functional cysts and are always benign. Any of the ovary's many tissue types may become neoplastic. By far, the most frequent are those arising from the surface epithelium (mesothelium), and most of these are partially cystic lesions. In relative frequency, functional cysts account for about 24% of all ovarian cysts, benign cysts 70% and malignant 6%[2]. Functional ovarian cysts occur at any age (including in utero), but are much more common in reproductive-aged women. They are rare after menopause. Most benign neoplastic cysts occur during the reproductive years, but the age range is wide and they may occur in persons of any age. Mucinous cystadenoma are commonest, large ovarian tumours and may become enormous. They may be multilocular. They are commonest in the 30-50 age group. About 5% will be malignant. We present a case report in which a 47 years old patient presented with menorrhagia and abdominal mass. Ultrasound showed multiple uterine fibroids and bilateral ovarian masses. She was managed surgically. Histopathology showed ovarian tumours to be Mucinous cyst adenomas with no evidence of malignancy.

CASE REPORT

The patient was a 47 years old lady who was married for the last 27 years. She was P7 A0 with all previous normal vaginal deliveries. She had 7 alive issues, 4 males and 3 females and the last child born was 10 years old. She presented with the history of heavy, regular menstrual flow along with gradual, painless distention of abdomen for the last six months.

Her age of menarche was 13 years. Her cycle previously was 5/30, regular with average flow. She used to soak 3 pads per day. Now, for the last 6 months, her cycle was 10-12/30. She soaked 5-6 pads/day. Bleeding was associated with the passage of clots. There was no history of dysmenorrhea, intermenstrual, post coital bleeding or vaginal discharge. She also complained of painless, gradual abdominal distension for the last 6 months. There were no bowel or urinary complaints. Rest

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of the systemic review was unremarkable. The couple months. There were no bowel or urinary complaints. Rest of the systemic review was unremarkable. The couple practiced with drawl method of contraception. Her pap smear was never taken. Her past surgical, medical and family history was unremarkable. There were no known drug allergies.

Her general physical and systemic examination was unremarkable. Abdominal examination showed an irregular mass in the lower abdomen extending to both the right and left iliac fossae. It was firm in consistency, mobile, non-tender. It was not possible to go below the mass. It was dull to percussion. There was no visceromegaly. Bimanual examination revealed an enlarged, 16-18 weeks sized uterus, irregular in outline with multiple sized fibroids. There were large adnexal masses about 12x15 com bilaterally filling whole of the pelvis and restricting the mobility of the uterus.

Her baseline investigations were all within normal limits. CA 125 was raised but carcinoembryonic antigen (CEA) levels were within normal range. Abdominal and pelvic ultrasound revealed that uterus was 12 x 9 x 7cms in size with multiple fibroids of varying sizes, the largest one being 5x6 cms. Bilaterally, large adnexal masses were present , left one was 16x14 cms and right was 12x14 cms in size. These adnexal masses were of mixed echogenicity having solid and cystic elements. The rest of the abdominal and pelvic ultrasound was unremarkable. CT scan was advised to know the extent of the tumour and involvement of abdominal organs. It also confirmed the findings of ultrasound and the rest of the scan was unremarkable.

Her laparotomy was planned after thorough counseling of the family. Per-operative findings included enlarged uterus about 12x10 cms in size. It was irregular having multiple fibroids of varying sizes. Large bilateral ovarian tumours were present, partly solid and partly cystic, about 14x16 cms in size (Fig 1). Omentum was normal and no peritoneal fluid was present. Undersurface of the liver was smooth and no enlarged pelvic or abdominal lymph nodes were present. Total abdominal hysterectomy was done along with the complete removal of bilateral ovarian tumours. Peritoneal washings and omental biopsies were also taken. Cut surface of the uterus also confirmed ultrasonic findings.

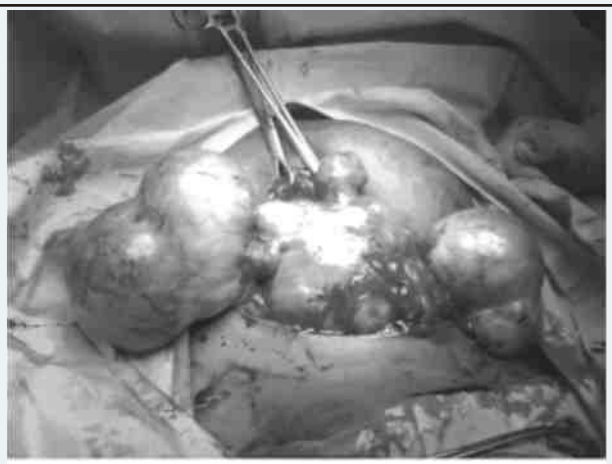

Fig-1. Bilateral Ovarian tumours and uterus showing Multiple fibroids.

Fig-2. Cut section of Uterus showing multiple Fibroids of varying sizes

Her post operative recovery was very smooth. She was discharged on 4th post-operative day in satisfactory condition. Histopathology report showed fibroid uterus, simple cystic hyperplasia of the endometrium and bilateral, mucinous cyst adenomas of the ovary with no evidence of malignancy in any of the specimens. It was a surprise for everyone involved in the management of this patient. Her stitches were removed on 8th post-operative day. Till her last follow-up, one year after surgery, she has no reoccurrence of the tumour.

DISCUSSION

Mucinous cystadenomas can be located in the ovaries, pancreas, and in the retroperitoneum[3]. According to the literature, symptoms are nonspecific, and most patients complained of an abdominal distension or mass with or without pain[4]. Bilateral mucinous cystadenoma of the ovary are extremely rare[5]. Mucinous cystadenomas were relatively large, varying from 10 to greater than 20 cm in diameter, which is large enough to cause symptoms like abdominal fullness[4]. Mucinous cystadenomas may cause a relentless collection of mucinous fluid within the abdomen, known as pseudomyxoma peritonei, which frequently is fatal. Preoperative diagnosis is very difficult, not because the tumors are often overlooked in the differential diagnosis but also because no sensitive methods or reliable markers are available[6]. The finding of an elevated CA125 level is most useful when combined with an ultrasonographic investigation while assessing a postmenopausal woman with an ovarian cyst[7]. Other tumor marker values may be elevated in patients with neoplastic ovarian cysts. These markers include serum inhibin in granulosa cell tumors, alpha-fetoprotein in endodermal sinus tumors, lactic dehydrogenase in dysgerminomas, and alpha-fetoprotein and beta-hCG in embryonal carcinomas. Ultrasonography is the primary imaging tool for a patient considered to have an ovarian cyst. Findings can help define morphologic characteristics of ovarian cyst. CT scanning is inferior to ultrasonography and MRI for helping define ovarian cysts and pelvic masses. MRI images have better soft tissue contrast compared to CT scan images, particularly for identifying fat and blood products, and can give a better idea of the organ of origin of gynecologic masses. Persistent simple ovarian cysts larger than 5-10 cm and complex ovarian cysts should be removed surgically. Excision of the cyst alone, with conservation of the ovary, may be performed in patients who desire retention of their ovaries for future fertility or other reasons[8]. Included are endometrioma, dermoid, and functional cysts. If the ovarian cyst is benign, removal of the opposite ovary should be considered in postmenopausal women, in perimenopausal women, and in premenopausal women older than 35 years who have completed their family and are considered at increased risk for subsequent development of ovarian carcinoma. These issues should be discussed with the patient preoperatively. Total tumor excision is necessary because the heterogeneous composition may require careful examination by pathologists to rule out borderline tumors and non-invasive carcinomas. A gynecologic cancer specialist should be available to help with any patient who undergoes surgery for a potentially malignant ovarian cyst. This allows the appropriate surgery to be performed on patients found to have cancer. Whenever possible, the patient should have consulted with the specialist prior to the surgery to allow all issues to be addressed. The prognosis for benign cysts is excellent. All such cysts may occur in residual ovarian tissue or in the contralateral ovary.

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