Huge Ovarian Mass

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Abstract :

Ovarian masses are commonly found in gynaecology and may acquire huge sizes. Presentation of huge ovarian masses has become rare in the modern world due to early diagnosis, increased awareness and availability of better imaging modalities. Still we get reports of patients with large ovarian masses that are mostly benign but needs to be differentiated meticulously from malignancy. Diagnosis can be made by clinical examination and diagnostic studies like ultrasonography, CECT abdomen and pelvis and biochemical markers. Although final diagnosis is only possible at laparotomy. Herein we present a case of huge ovarian mass where patient presented with sudden onset huge abdominal distension preceded by generalised weakness. The patient underwent laparotomy with total hysterectomy with bilateral salpingoophorectomy with partial omentectomy. Her postoperative course was unremarkable.

Introduction : In the modern era of medicine, huge ovarian tumours have become rare, as most of the cases are diagnosed early during routine gynaecological examinations or as incidental finding on the ultrasound examination of the pelvis and abdomen.[1] Ovarian tumour is not a single entity but a complex wide spectrum of neoplasms involving a variety of histological tissues.[2] The commonest tumour of ovary is epithelial tumour. They may originate from the tube, endocervix, endometrium or bladder epithelium. Its reported to occur in middle aged women between 3rd and 5th decade. They may reach enormous size filling the entire abdominal cavity.[3] Sometimes they may get complicated by torsion, haemorrhage, rupture, etc. Hence early diagnosis and prompt treatment is the key for successful management.[4] Management of ovarian cysts depends on the patients age, the size of the cyst and its histopathological nature.[5]

We report a case of a postmenopausal women with sudden onset abdominal distension with radiological aspects suggestive of neoplastic ovarian mass.

Case report : A 50 year old, P5L5, postmenopausal since 12 years came to outpatient department of OBGY, at Tertiary Care Hospital in December 2017 with complaints of sudden onset abdominal distension since 8 days preceded by generalised weakness since 15 days. She had sensation of fullness in abdomen leading to discomfort and decreased appetite. There was no history of bowel and bladder complaints or abdominal pain. She had regular menstrual cycles. All 5 of her issues were full term normal home deliveries.

On examination, her general condition was fair. She was thin built. Her vitals were stable. Respiratory and cardiovascular system examination findings were normal. In per abdominal examination, on inspection her abdomen was distended and tense. On palpation, the tumour was 34 weeks size, firm in consistency, mobile, with smooth surface, irregular margins, however lower margin was not reached.

Her haematological investigations were within normal limits. Her renal, liver functions were also normal. Her serum CA125 level was 54.5 IU/ml. Ultrasound examination was suggestive of large well defined abdomino-pelvic lesion measuring around 30x20x15 cm, showing multiple septae and internal echoes within lesion. Doppler showed no vascularity. Both ovaries were not seen seperatly from liver, features suggestive of neoplastic ovarian mass. There was also bilateral hydronephrosis, proximal hydroureter, mid and distal ureter not visualised due to lesion. CECT abdomen and pelvis (Image no.-1) showed evidence of large cyst of size 302x279x208mm seen in the right adnexa, pelvis and abdomen, reaching upto the epigastric region. The lesion shows multiple peripheral septae with no evidence of calcification. Small bowel is displaced superiorly and

uterus is displaced to left side. Bilateral mild to moderate hydronephrosis and hydroueter is seen due to pressure on pelvic ureters. Findings are suggestive of large right ovarian cyst/ cystadenoma.

Exploratory Laparotomy was done. A huge multilobulated cystic tumour arising from left ovary measuring approximately 35x25x15cm, occupying the abdomen from pelvis to xiphisternum was excised through a midline vertical incision extending from pubic symphysis to supraumblical region. Decompression of the cyst was not done to avoid spillage into peritoneal cavity. The mass weighed 6 kg was. There was evidence of minimal ascites. Ascitic fluid was taken and sent for histopatholofical examination. Gross evidence of malignancy was ruled out. There was no evidence of metastasis in the abdomen or undersurface of liver. Right ovary seemed to be normal. Total abdominal hysterectomy with bilateral salpingoophorectomy with partial omentectomy was done. Specimen was sent for histopathological examination. Lymph nodes were not seen to be involved. The postoperative period was uneventful. On histopathological examination it was brought up to be mucinous cystadenoma of the ovary.

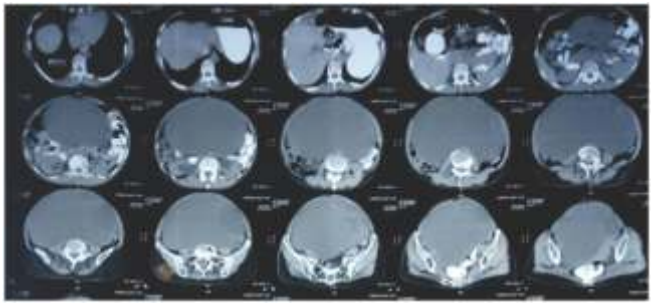

Image 1- CECT abdomen and pelvis showing ovarian mass completely filling the abdominal cavity

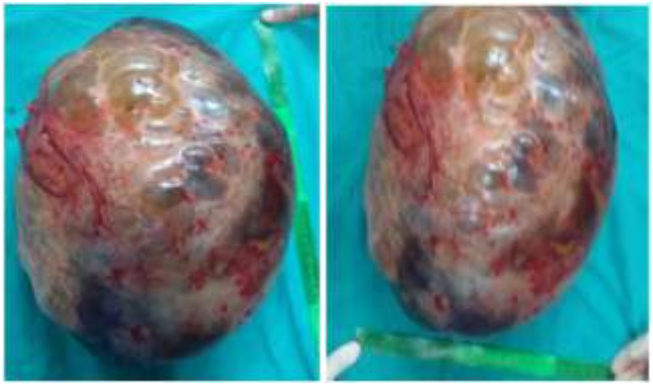

Image no 2 and 3- Excised specimen of Ovarian mass measuring approximately 35x25x15 cm

Discussion : Detection of ovarian cysts cause considerable worry in women because of the fear of malignancy, but it is a established fact that many ovarian tumours present as cysts, but all cysts are not tumours.[6] On the basis of cell of origin, ovarian neoplasms are divided into epithelial, sex cord stromal and germ cell neoplasms.[7] Ovarian epithetlial tumours constitute about half of all the ovarian tumours. Serous tumours are most common cystic neoplasm of the ovary, 60% of which are benign, 25% are malignant and 15% are borderline cases. The vast majority of mucinous tumours are benign (75%) 10% borderline and 15% carcinomas.[6] The definition of huge ovarian cysts varies from those measuring more than 10cm in diameter in preoperative scans to those reaching above the umbilicus.[8] Mucinous cystadenoma is a benign ovarian tumour. It is reported to occur in middle aged women. It is rare among adolscents or in association with pregnancy or in postmenopausal women, as seen in our case who is postmenopausal since 12 years. On gross appearance these are characterised by cyst of variable sizes without surface invasion. Only 10 % of primary mucinous cystadenoma is bilateral. Cyst is filled with sticky gelatinous fluid rich in glycoprotein. Histologically, mucinous cystadenoma is lined by tall columnar non ciliated cells with apical mucin and basal nucei.[9] Most important investigation for diagnosis of ovarian cyst is abdominal ultrasound. It confirms ovarian origin of mass and provides information on cystic nature and its wall structure. Ultrasound helps to distinguish benign and malignant tumours. Other than ultrasound, CT and MRI is useful for larger masses and examining the abdomen for metastasis.[8] CA 125 helps in identifying and following malignant epithelial tumours of the ovary.[10] Management of ovarian cysts depends on the patient's age, the size of the cyst and its histopathological nature. Conservative surgery as ovarian cystectomy and salpinoophorectomy is adequate for benign lesion.[9] Traditionally giant cysts have been managed by a full midline laparotomy. In recent years, with availability of modern advanced techniques and expertise in minimally invasive surgery, laparoscopic excision is preferred in management of giant ovarian cyst that exceed to the umbilicus mainly due to its least invasiveness, better cosmesis and short hospital stay. Giant cyst limits working space. The most potential hazard

of drainage is the possibility of cell spillage into abdominal cavity or drainage site with the potential of subsequent seeding.[10] Hunter et al. reported that rupture of the cyst capsule and greater dissemination can be prevented by gradual decompression. Repeated paracentesis have been associated with tumour seeding of the peritoneal cavity, bleeding, infection, and increased adhesions resulting in difficult cyst removal.[11]

Conclusion : Despite uncommon presentation and unexpected diagnosis mucinous cystadenoma was removed intact, successfully without any spillage or spread. Our present study gives evidence of unsuspected giant abdominal tumour in a women. Reporting such cases helps to increase the suspicion of its possibility and avoid any misdiagnosis or improper treatment and its complications.

References :

1. Katke R. D. Huge mucinous cystadenoma of ovary with massive third degree uterovaginal prolapsed in postmenopausal woman: rare case report and review of literature. Int J Reprod, Contracept, Obstet Gynecol. 2015;4:255-8.
2. Kamel R M. A Massive Ovarian Mucinous Cystadenoma. A case report. ReprodBiolEndocrinol 2010;8-24.
3. N Wobodo EI (20100 Giant Mucinous Cystadenoma: case report. Niger J Clin Pract 13: 13-228.
4. Scully R E, Young R H, Clement P B (1998) Tumours of the ovary, maldeveloped gonads, fallopian tube and broad ligament. In atlas of tumour pathology. Armed Forces Institute of Pathology, fascicle 23, 3rd series, Washington DC, USA.
5. Katke R D, Kiran U, Sarogi M, Sarode S, Thawal R. Giant borderline mucinous cystadenoma with previous 3 caesareans. J Postgraduate Gynaecol Obstet. 2014;1:1-4
6. Bhasin S K, Kumar V, Kumar R. Giant Ovarian Cyst: A Case Report, vol 16 no. 3, july-sept 2014.
7. Sujatha VV, Babu SC. Giant ovarian serous cystadenoma in a postmenopausal women: a case report. Cases J 2009;2:7875.
8. Singla D K, Kansal R, Bansal I, Thami G, Agrawal N. Case report: Laparoscopic management of a giant ovarian cyst. Asian Pac J Health Sci 2014;1:43-6.
9. Khoiwal S, Hasija S. Huge Mucinous Cystadenoma of Ovary- A case report. IOSR Journal of Dental and Medical Sciences. 2015;14(10);38-39.
10. De Lima SH, Dos Santos VM, Darma, Vitorino Modestodesto FR. A 57 year old Brazalian women with a giant mucinous cystadenocarcinoma of the ovary. A case Report. J Med Case Rep 2014;8:82.
11. Hunter DJ. Management of a massive ovarian cyst. Obstet Gynaecol 1980;56:254-255.