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Case Report of A Huge Ovarian Mucinous Cystadenoma

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ABSTRACT

Large benign ovarian tumors are rare in modern world due to increased awareness and better imaging techniques. We report a case of a 40 year old woman presenting with vague abdominal pain and severe abdominal distension since 6 months. The diagnosis was made by history taking, clinical examination, lab investigations, abdominal ultrasound and by histopathological study of excised surgical specimen. The patient underwent laparotomy and total hysterectomy with unilateral salpingo-opherectomy with uneventful postoperativecourse. With this case we would like to emphasize the significance of thorough evaluation of all women who present with vague abdominal pain. These conditions if diagnosed and managed early can thereby reduce the possibility of complications associated with huge tumors like pressure symptoms, psychological trauma and stress of the possibility of malignancy. Summary: Huge ovarian cystic masses treated with laprotomy give excellent results.

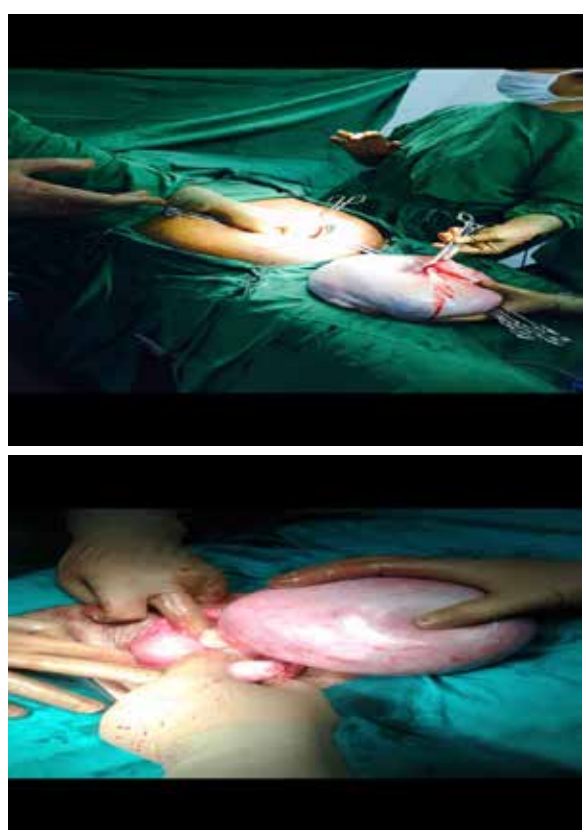
KEYWORDS : Ovarian cyst, abdominalmasses,abdominaldistension,mucinouscystadenoma.

INTRODUCTION:

Mucinous cystadenomas make up 15% - 20% of all ovarian tumors. They often become very large and can extend up into the abdomen [1,2]. About 80% of mucinous tumors are benign, 10% are border-line and 10% are malignant. Although benign ovarian mucinous tumors are rare at the extremities of age, before puberty and after menopause [3], they are common between the third and the fifth decades [4]. The most frequent complications of benign ovarian cysts, in general, are torsion, hemorrhage and rupture. Pseudomyxoma peritonei can result if the tumor ruptures and spills its contents into the peritoneal cavity. We report a case of large benign mucinous cystadenoma in a 40 year old woman.

CASE PRESENTATION:

A 40 year old female, married since 21 years, P7L7A1 , presented to our department with a gradually increasing abdominal swelling, first noticed 6 months ago. The swelling was accompanied by vague abdominal pain since one month more in the right iliac fossa. Pain was dull aching and continuous in nature. No history of fainting attacks, vomiting or other gastrointestinal symptoms. No history of fever, cold, cough, breathlessness, weight loss, diarrhea, constipation, trauma, per vaginal, per rectal bleeding. She had normal regular menstrual cycles. No history of any major illness, operation or allergies. No significant personal or family history. On general examination she was moderately nourished and weighed 60 kg. Vitals were normal. There was no pallor, icterus, oedema or lymphadenopathy. Abdominal examination showed uniform distension, striae seen, umbilicus everted, no scars, sinuses or dilated viens. The liver and spleen were not palpable. Mass was firm, tender, ballotable, no guarding, rigidity. Percussion note was dull all over the abdomen with positive fluid thrill. Bowel sounds were heard normally. On examination generalized distension of abdomen was evident. Abdominal ultrasonography was suggestive of a large heteroechoilesion noted in whole of abdomen with septations. Differential diagnosis given was mesenteric cyst, ovarian cyst. Uterus was normal and separate from the mass. Abdominal organs were compressed by the mass. Abdominopelvic computerized tomography(CT) findings were25*20 cm well defined multiseptate cystic lesion in abdomen s/o mucinous cystadenoma of right ovary. Tumour markers CA-125 was 30 U/ml. B HCG, AFP were in normal range. Intraoperative findings showed a large tense, smooth surfaced cystic mass extending from the pelvis upto paraumbilical region . The mass was so large that it could not be excised without a large abdominal incision, so, 2.5 liters of intracystic fluid was drained, until the cyst could be excised with its remaining fluid . The fluid was dark brown in colour and sticky in consistency. The mass originated from the right ovary with the right fallopian tube adherent to the surface. So ,a right sided salpingooophorectomy was done . There was no free fluid in the abdomen. The cyst wall measured 35 × 30 × 20 cm, , and totally weighed 5 kg after the partial fluid aspiration. Frozen section showed that the mass was benign in nature. Total abdominal hysterectomy was done. Pathology confirmed mucinous cystadenoma of the ovary.



Intraoperative images of the tomor.

DISCUSSION:

Mucinous cystadenomas (MCAs) of the ovary are known for their potential to grow to massive proportions and are often incidentally diagnosed. They are typically benign tumors accounting for 15% of ovarian neoplasms and up to 80% of all mucinous tumors. Ovarian MCAs are characteristically unilateral, only 5% presenting bilaterally, and the peak incidence occurs among women who are between 30 and 50 years of age. Mucinous tumors of the ovary occur principally in middle adult life and are extremely rare prior to menarche. The histopathological groups of mucinous tumors are described as follows: (1) MCA (2) mucinous tumor of uncertain malignant potential (borderline), and (3) mucinous carcinoma . MCA appears as a large cystic mass, is often multiloculated, and contains sticky gelatinous fluid. Microscopically, the tumor consists of cystic spaces lined by tall columnar epithelium with mucinous differentiation. In general, ovarian MCAs tend to present with abdominal distention. The vast majority of mucinous tumors are benign (75%), 10% borderline, and 15% carcinomas . Complications include torsion of the ovary, rupture of the cyst within the abdomen, haemorrhage, pseudomyxoma peritonei. Pseudomyxoma peritonei is a condition of mucinous ascites usually secondary to mucinous tumour of intra abdominal origin most often associated with mucinous cystadenoma of the ovary, mucocele of the appendix and gall bladder and intestinal malignancy. Spontaneous perforation of mucinous cyst may lead to implantation of the cells on the peritoneum. Or else, the mesothelium of the peritoneum is converted to high columnar epithelium with secretory activity. The cell type is similar to mucinous cystadenoma. Even after removal of tumour, these cells continue to secrete mucin. There is tendency of recurrence. Treatment includes surgical excision of the tumour (debulking surgery) with intraperitoneal chemotherapy.

CONCLUSION:

Huge ovarian cystic masses treated with laprotomy give excellent results. Recurrence rate is very low if the tumour is excised completely. Chances of recurrences are high if there is intraoperative cyst rupture or if cystectomy is done instead of adnexectomy. Chances of malignant transformation is about 5-10%.. Hence these conditions if diagnosed and managed early can reduce the possibility of complications associated with huge tumours like pressure symptoms, psychological trauma and stress arising from the possibility of malignancy. To achieve this goal there has to be increased awareness and annual checkups for all women.

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