Original Research Paper

Volume - 15 | Issue - 09 | September - 2025 | PRINT ISSN No. 2249 - 555X | DOI : 10.36106/ijar

Obstetrics & Gynaecology

# A CASE REPORT OF MUCINOUS CYSTADENOMA OF OVARY

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**ABSTRACT** Ovarian mucinous cystadenoma is a benign tumour, that arises from the surface epithelium of the ovary. Of all ovarian tumors, mucionous tumors comprises of 15-20%. Benign mucinous ovarian tumors are rare at extremes of age, before puberty and after menopause, they are common between 3rd and 5th decade. About 85% mucinous tumors are benign, 10 % are borderline and 15% are malignant. This report describes a 50 year old female patient with complaints of mass per abdomen and pain abdomen since 1 year. Ultrasonography features suggestive of mucinous cystadenoma of Right ovary, further adviced for MRI pelvis and CA125. With informed consent Laparotomy and proceed was done. It showed that even in large abdominal masses a carefull decision is neccessary to avoid complications and to improve patients prognosis. Malignant features to be ruled out for further surgical staging. All ovarian tumours with pain abdomen should not be suspected for Rupture and torsion.

**KEYWORDS :** Mucinous Cystadenoma, Benign Tumors, Cell Print Cytology, Mass Per Abdomen

## INTRODUCTION

Among benign ovarian neoplasms, Serous and mucinous cystadenoma and mature cystic teratoma are the most common. Ovarian mucinous cystadenoma arises from the surface epithelium of the ovary. It appears as rounded, ovoid, irregularly lobulated growth with smooth outer and inner surfaces. They are bilateral in upto 20 percent of cases. They are typically thicker walled, mucoid-containing tumors that may be small but can often attain large diameters. They may be unilocular or multilocular.[1]

Of all ovarian tumors, mucinous tumors comprises of 15-20 %. About 85% mucinous tumors are benign, 10 % are borderline and 15% are malignant. Histologically mucinous cystadenoma are composed of multiple cysts and glands lined by simple nonstratified tall columnar epithelium with basal nuclei-secreting mucin.[2]

Although benign ovarian mucinous tumors are rare at extremes of age, before puberty and after menopause, they are common between the third and fifth decade. The most common complications of benign ovarian cysts are torsion, haemorrhage and rupture.[3]

Huge ovarian tumors have become extremely rare in the current medical practice, as the majority of cases are diagnosed early during routine gynecological examinations or as incidental findings.[4]

## Case Report

A 50 year old female of para 4, living 4, tubectomised 28 years back, resident of agasnoor, manthralayam, presented to OBG out patient department and admitted on 8th July 2023 with complaints of mass per abdomen since 1 year, insidious in onset and gradually progressed to present size, associated with lower abdominal pain since 1 year, pricking type, on and off, radiating to iliac fossa, aggravates on exertion and relieved on taking medications. Not associated with weight loss. General examination and systemic examination was uneventful.

Abdominal inspection - No engorged veins, 18 weeks suprapubic bulge seen, all quadrants moves equally with respiration. Palpation - No local rise of temperature, mass felt in suprapubic region ,18 weeks size, smooth surface, soft and cystic in consistency , non-tender, freely mobile in all directions with all borders made out . Percussion - Tympanic note heard. Per speculum examination - vagina and cervix is healthy, no white discharge per vagina. Bimanual examination - Mass size corresponds to 16 to 18 weeks size, right fornix fullness noted, left fornix is free, Groove sign positive and No cervical motion tenderness, cervical mobility not transferred to mass, Mass is freely mobile.

## Investigations

Haemoglobin – 10.6 gm%
Blood group and Rh typing – O POSITIVE
Pap Smear – Negative for intraepithelial lesion or malignancy
LFT- Normal
RFT- Normal
Coagulation profile - Normal
ECG - Normal
2D-Echo- Normal, EF=60%
CA-125 – 21.20 u/ml

Ultrasonography (Fig.1): Revealed an anechoic cystic lesion measuring 11 × 8.5 cm with few internal septations and echoes seen in right ovary.

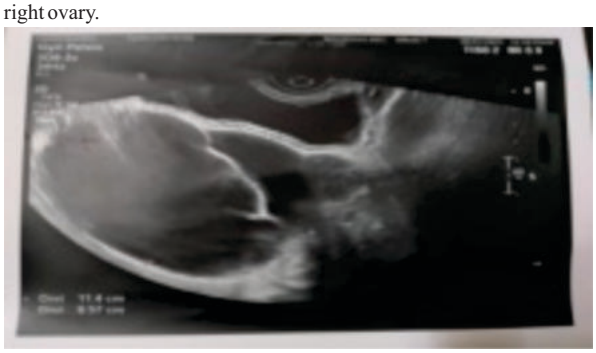

**Fig.1 Ultrasonography Showing Anechoic Cystic Lesion Measuring 11 × 8.5 Cm with Few Internal Septations and Echoes in Right Ovary.**

MRI pelvis showed a large well defined thin walled multiloculated cystic lesion measuring 6.6×10.3×10.6 cms showing T1 hypointense and T2/STIR hyperintense signal is seen in right adnexa. Lesion is seen indenting dome of bladder, Features suggestive of mucinous cystadenoma of right ovary.

## Management

Patient was explained about the condition, consent was taken prior to surgery. Laparotomy and Proceed was done, Peritoneal fluid was collected and sent for histopathological examination & it showed negative for malignant cells followed by Total abdominal hysterectomy with Right salphingo-ovariotomy and left Salgingo-oophorectomy with omentectomy was done and cell print cytology of right side cyst of size 10×10 cm (Fig.2) was done, which showed benign epithelial cells, 1 locule of cyst shows mucin content, other locules are serous, suggestive of benign ovarian cyst and sent for histopathological examination. Anticlockwise palpation is performed starting from right hemi-diaphragm and liver, then moved across to the stomach, lesser omentum, left hemi-diaphragm and spleen. Palpation continued down the left paracolic gutter into the pelvis , then up the right paracolic gutter. Finally small bowel and mesentery were palpated for any secondary metastases. No metastasis seen. Lymph nodes were palpated in pelvis and para-aortic area. No enlarged lymph nodes seen. The post operative period of the patient was uneventful. Patient was discharged in good condition.

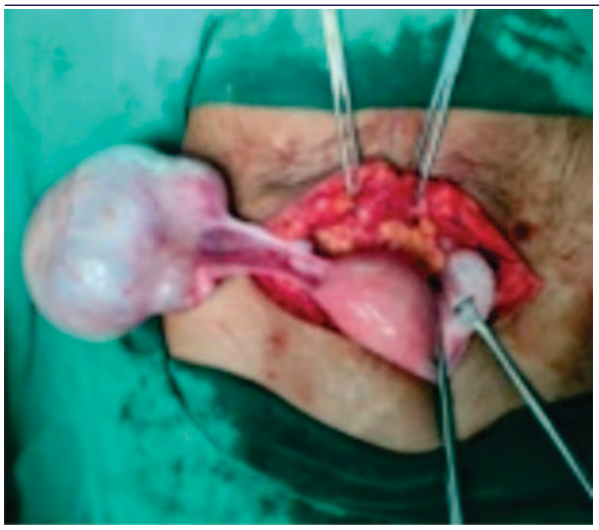

**Fig.2 Ovarian Cyst of Size 10×10 cm Noted on Right Side**

Pathology reported a ovarian cyst measuring 10×6×3cm (Fig.3) With multiloculated cyst measuring 5× 2 cm. Multiloculated cyst had thin cyst wall with no papillary projections, solid areas or areas of haemorrhages or necrosis. The cyst contains thin mucinous fluid.

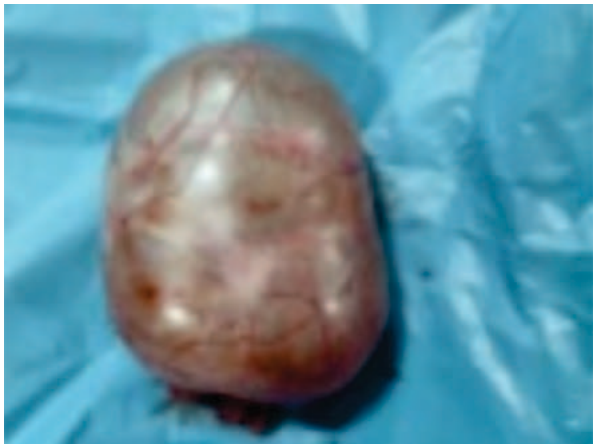

**Fig.3 Ovarian Cyst Measuring 10×6×3 cm**

Microscopy showed ovarian tissue with multiple cyst of varying sizes lined by single layer of tall columnar mucin secretary epithelium and contains mucinous matter. There is no evidence of atypia.(Fig.4 )

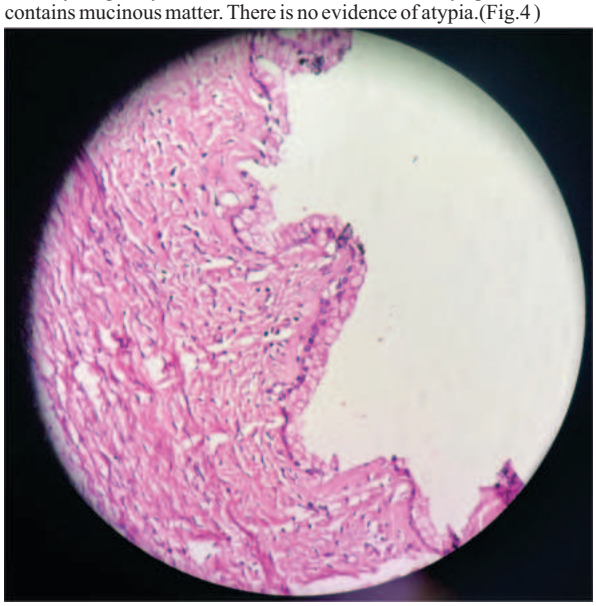

**Fig.4 Cyst Lined by Single Layer of Tall Columnar Mucin Secretary Epithelium and Contains Mucinous Matter.**

## DISCUSSION

Mucinous cystadenoma of ovary is reported to occur in middle aged woman between 3rd and 5th decade. In this patient the age of woman was 50 years. It is rare among adolescents in association with pregnancy.[5]

Only 20% of primary mucinous cystadenoma is bilateral. In this patient, tumor was unilateral and affecting right ovary. USG, MRI can provide detailed information and CA 125 elevated in >80% of patients with epithelial ovarian cystadenoma. In this patient CA 125 is 21.20 u/ml which is normal.

Management of ovarian cysts depends on the patients age, the size of the cyst and its histopathological nature. Conservative surgery is adequate for benign lesions.[6]

In this patient, laparotomy and Proceed followed by total abdominal hysterectomy with right salphingo-ovariotomy with left salphingo-oophorectomy with omentectomy was done without complications as the age of the patient was 50 years in menopausal age group and size of the cystadenoma of right ovary was 10 × 6 × 3 cm. The rate of torsion in benign ovarian cyst is 3-12% and the rate of rupture of benign ovarian cyst is 1-2%

## CONCLUSION

Cystadenoma of ovary will continue to be a risk factor for women as the majority of the patients will be diagnosed at later stage. This can prove that adequate healthcare services along with a high clinical awareness by all physicians are vital when approaching an ovarian mass.

It showed that even in large abdominal masses a careful decision is necessary to avoid complications and to improve patients prognosis. Malignancy features to be ruled out. All ovarian tumors with pain abdomen should not be suspected for rupture and torsion.

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