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A RARE CASE OF OVARIAN CARCINOMA WITH SUSPICION OF ABDOMINAL TUBERCULOSIS PRESENTING AS ACUTE ABDOMEN IN A YOUNG FEMALE

Oncology

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ABSTRACT

Aims And Objectives The differential diagnosis of peritoneal tuberculosis and ovarian carcinoma is difficult at times because of overlapping clinical and lab findings. Also, ovarian carcinoma presenting as torsion ovary is rare. **Methods** A 24yr old female with complains of lower abdominal pain since 10 days, history of weight loss and loss of appetite since 2 months, presented with acute lower abdominal pain and vomiting since 2 days with CECT report showing right adnexal tuboovarian mass of 8*5.4*6.2 cm with ileocaecal thickening. Patient was kept on conservative management for 2 days considering the diagnosis of abdominal tuberculosis. Tumour markers were CA-125- 201.6, CA 19-9-952.5, betaHCG-24.09, Alpha fetoprotein-21.05. As patient continued to have acute pain in abdomen, MRI Pelvis was done to rule out ovarian torsion. MRI Pelvis- Right ovary grossly enlarged and twisted around the pedicle. Exploratory laparotomy was done with detorsion and removal of a solid ovarian mass. Histopathology report- Adenocarcinoma grade III. Management was done further by Chemotherapy. **Results** This was a case of adenocarcinoma ovary grade II in a young female which presented as ovarian torsion and was mimicking abdominal tuberculosis. **Conclusion** This case highlights ovarian cancer in young females with varied clinical presentation which causes delay in diagnosis and management. Ovarian carcinoma much be considered as a differential diagnosis in cases of abdominal tuberculosis and ovarian torsion.

KEYWORDS

INTRODUCTION

Ovarian carcinoma has the poorest prognosis of the gynaecological cancer. Early diagnosis and treatment are important but early stage ovarian CA has non specific symptoms. Peritoneal Tuberculosis (TB) is one of extrapulmonary tuberculosis, which predominantly involves the omentum, intestinal tract, liver, spleen, or female genital tract in addition to the parietal and visceral peritoneum (1). The differential diagnosis of peritoneal tuberculosis and ovarian CA is difficult because of overlapping clinical and lab findings such as ascitis, increased CA 125 level, peritoneal thickening on USG and findings of intra abdominal tumor which confuses the clinicians. Also in an endemic region of tuberculosis, a young female presenting with the above picture is likely to be assumed as a case of tuberculosis.

Treatment and outcome of peritoneal TB and advanced ovarian cancer are poles apart and have a very different approach. peritoneal TB has a medical management with an anti-tuberculosis drug In contrast to advanced ovarian cancer, which must be treated by debulking surgery followed by chemotherapy. Careful examination and diagnosis are needed to differentiate this kind of case to avoid inappropriate treatment.

India is one of the developing countries. The WHO TB statistics for India for 2021 give an estimated incidence figure of 2,590,000 million cases. This is a rate of 188 per 100,000 population. (2) The high incidence of TB should be an awareness for the physician, obstetric gynecologist, and oncology gynecologist to suspect peritoneal TB as a diagnosis for abdominal masses or differential diagnosis for ovarian cancer suspect cases.

Herein we highlight a rare case of advanced stage of ovarian adenocarcinoma in a young female with initial suspicion of tuberculous peritonitis.

Case Report

A 24yr old female, came with a complain of lower abdominal pain since 10 days, history of weight loss and loss of appetite since 3 months. Patient was lean and thin and had tense and tender abdomen with gaurding on examination. Patient was started on ATT empirically in a primary health centre a month back. Patient presented with acute lower abdominal pain with previous USG and CECT report.

Whole abdomen USG showed Mild hepatomegaly with severe degree ascitis present. CECT Abdomen and pelvis- Thickening ileocaecal region with abdominal lymphadenopathy and exudative collection likely tuberculosis. Right adnexal tubo ovarian lesion (Inflammatory).

S. Adenosine deaminase-14. Ascitic fluid CBNAAT- mycobacterium tuberculosis complex not detected. Ascitic fluid cytology- Negative for malignant cells. Tumour markers were CA-125- 201.6, CA 19-9-952.5, beta HCG-24.09, Alpha fetoprotein-21.05.

She was kept on conservative management but as she continued to have acute pain in abdomen, MRI Pelvis was done to rule out ovarian torsion. MRI Pelvis reported as- Right ovary grossly enlarged measuring 8x5x6.4cm appears mostly solid with fee small cystic areas appears twisted around the pedicle. Exploratory laparotomy was done. Intraoperatively moderate ascites was present. A firm mass of size with twisted tuboovarian ligament was noted. Detorsion was done and ovarian mass removed. Metastatic deposits were seen in omentum. Ovarian mass was sent for histopathological reporting. It stated Adenocarcinoma grade II ovary. Patient was transferred to oncology department thereafter for chemotherapy. She received 3 cycles chemotherapy and did not follow up after that.

DISCUSSION

This was a case of adenocarcinoma ovary in a young female which was treated as suspected abdominal tuberculosis but with further workup was found to be a case of ovarian torsion and after exploratory laparotomy it was found to be a Metastatic disease.

Abdominal tuberculosis can occur at any age, but it is predominantly a disease of young adults with the mean age of patients being 30–40 years. Peritoneal tuberculosis mostly presents with non-specific signs and symptoms like pain in abdomen, ascites, and abdomino-pelvic lump, and hence mimics ovarian malignancy (3). Also, many benign as well as malignant conditions other than carcinoma ovary causes rise in CA 125. Ultrasound and CT scan may not help in reaching conclusive diagnosis. However, there are a few studies showing role of CT scan in preoperative diagnosis of tuberculosis. The CT abnormalities that proved to be most useful for distinguishing between the two processes were observed in the parietal peritoneum. The presence of a smooth peritoneum with minimal thickening and pronounced enhancement suggests peritoneal tuberculosis, whereas nodular implants and

irregular peritoneal thickening suggests peritoneal carcinomatosis(4)

The patient also presented with ovarian torsion which is rare in malignant ovarian lesions due to its property to adhere to local structures. Our patient was 24yrs years old and one of the largest reviews conducted found that 52% of torsions occurred in patients between the ages of 9 and 14 years, as a result of increased hormone levels during this period. (5)

CONCLUSION

Patients of any age group can present to the clinicians with a plethora of vague symptoms. Therefore, not just limiting our diagnosis to the endemic region and age group and having a broad spectrum before confirming a diagnosis or treatment is the key. The above case being the eye opener in Indian gynaeoncology cases promoting gynaecologists to suspect CA in an early case and likewise decrease the morbidity of the patients and having favourable outcomes.

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