

SUCCESSFUL MANAGEMENT OF BILATERAL GIANT OVARIAN CYSTADENOMAS IN PREGNANCY : A RARE CASE REPORT

Obstetrics & Gynaecology

Namrata Walke*	Junior Resident, Department of Obstetrics and Gynaecology, Lokmanya Tilak Municipal Medical College and General Hospital, Mumbai *Corresponding Author
Meenal Sarmalkar	Associate Professor and Head of Unit, Department of Obstetrics and Gynaecology, Lokmanya Tilak Municipal Medical College and General Hospital, Mumbai
Madhuri Mehendale	Assistant Professor, Department of Obstetrics and Gynaecology, Lokmanya Tilak Municipal Medical College and General Hospital, Mumbai
Agraj Doshi	Junior Resident, Department of Obstetrics and Gynaecology, Lokmanya Tilak Municipal Medical College and General Hospital, Mumbai
Aishwarya H. B.	Junior Resident, Department of Obstetrics and Gynaecology, Lokmanya Tilak Municipal Medical College and General Hospital, Mumbai

ABSTRACT

23-year-old Gravida 2 Para 1 Living 1 with previous 1 LSCS with 36.1 weeks gestation was referred from the district hospital in view of Ultrasonography suggestive of bilateral serous cystadenoma with no prior medical history in OPD. Measuring about 11.8x10 cm in the right adnexa and 7.9x6.2 cm in the left adnexa. After all routine investigations, tumour markers, and confirmation with MRI, the patient was posted for elective LSCS with bilateral salpingo-oophorectomy at 38 weeks of gestation. Delivered a female child weighing 2.9 kg. Histopathology report suggestive of a mucinous cystadenoma. Patient was there after kept on maintenance of hormone replacement therapy.

KEYWORDS

Cystadenoma, ultrasonography, pregnancy

INTRODUCTION

With the increase in the use and quality of ultrasound during pregnancy, adnexal masses have become more common(1). Most adnexal masses during pregnancy are benign or functional, only about 5% are malignant(2). Fortunately, most of these conditions are benign and resolve on their own. Ovarian cystadenomas are common benign epithelial neoplasms that have an excellent prognosis. The two most frequent types of cystadenomas are serous and mucinous cystadenomas while clear cell cystadenomas and endometriomas are rare(3). Ovarian mucinous cystadenomas are benign epithelial neoplasms that can grow rapidly during pregnancy. The present report describes presence of huge bilateral cystadenomas in term patient with successful management.

Case Report

A 23-year-old married, Gravida 2 Para 1 Living 1 with previous 1 LSCS with 36 weeks gestation was referred from the district hospital to our tertiary care institute in view of ultrasonography suggestive of cystic lesion of approximately 16.5 x 9 cm in the right adnexa and 13.5 x 7 cm in the left adnexa with multiple septa suggestive of bilateral serous cystadenomas incidentally diagnosed. She had spontaneous pregnancy which was diagnosed at 2 months by urine pregnancy test kit following which she registered at district hospital. First and second trimester of her pregnancy was uneventful. At 29 weeks of gestation, her ultrasonography report was suggestive of cystic mass 12x8 cm in right adnexa and 7x4 cm in left adnexa thereafter she followed up in district hospital for routine ANC check-up. She had no active complaints at that time and no significant family history. At 35 weeks of gestation repeat ultrasonography suggestive of increase in size of cystadenoma to 16.5 x 9 cm in the right adnexa and 13.5 x 7 cm in the left adnexa; hence she was referred to tertiary health care institute.

On examination at our institute, her general condition was fair, there were no pallor, edema. She was vitally stable with no complaints. Per abdomen examination revealed, uterine height larger than corresponding gestation, bilateral flanks full with presence of Linea nigra and striae gravidarum, Pfannenstiel scar of previous LSCS present, per vaginal examination cervix OS posterior, with no discharge.

After admission ultrasound done in our institute suggestive of intrauterine pregnancy was consistent with 37-week gestation with normal amniotic fluid index, with cystic multiloculated lesion showing multiple thin septa with in it not showing any vascularity measuring about 17.1x10.2x11.2 cm in the right adnexa and similar morphology in the left adnexa measuring about 7x11 cm, with O-RADS (ovarian-

adnexal imaging reporting data system) score 4 ; provisional diagnosis was ovarian cystadenoma.

All routine investigations were within normal limit. Her tumor markers like serum LDH (432) , and AFP(23358) were raised as shown in table

LDH	432 (raised)
CA 125	104.5 (raised)
CA 19.9	<2 (normal)
CEA	2.66 (normal)
AFP	23358 (raised)

MRI Abdomen + Pelvis confirmed the ultrasonography findings: multiloculated cystic lesion about 19x10x15 cm in the right adnexa, another well-defined lesion 13.8x5x7.3 in the left adnexa, with multiple thin septa, with no evidence of solid component, suggestive of bilateral serous cystadenomas.

She was planned for elective LSCS in view of previous 1 LSCS with huge ovarian mass . Pfannenstiel incision taken over skin, a lower uterine incision taken, delivered a female child of 2.9 kg with an APGAR score of 9/10. Intraoperatively, right ovarian mass of 20x10x15 cm with mucinous content and septa within; similarly mass on left site of 9x13 cm as shown in fig. 1.; Bilateral salpingo - oophorectomy was performed in view of risk of malignancy in future



Fig 1. Intraoperative Image Of Bilateral Cystadenoma

Grossly smooth surfaced cyst with multiloculations containing thick and viscid gelatinous material.; with Septa dividing it into locules, which are thin and translucent shown in fig 2. Histopathology report suggestive of benign mucinous cystadenoma, showing multiloculated cyst filled with gelatinous mucin material, clear to pale yellow in colour, and locules of varying size lined by mucin columnar epithelial cells. Congested wall of locules, thickness up to 2mm shown in fig 3.

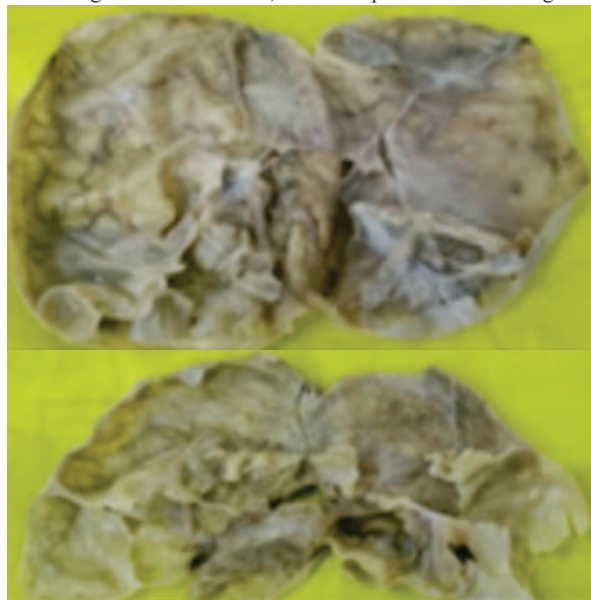


Fig 2. Gross Images Showing Multiloculation.

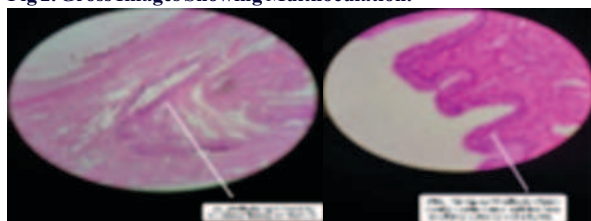


Fig 3. Histopathological Images

Postoperative period was uneventful. Patient discharged on 6th postoperative day. She is on regular follow up; started her on combined oral contraceptive pills as hormone replacement therapy.

DISCUSSION

Adnexal masses are identified in pregnant patients at a rate of 2 to 20 in 1000, about 2 to 20 times more often than in the general population of the same age. About 2% of adnexal masses during pregnancy are malignant (4). The most common types of adnexal masses in pregnancy requiring surgical treatment are dermoid cysts (32%), endometriomas (15%), functional cysts (12%), serous cystadenoma (11%) and mucinous cystadenoma (8%) (4). Cystadenomas represent 40–50% of all benign neoplasms, with serous cystadenoma being the most common (1). Serous cystadenomas are often multilocular and bilateral. While mucinous cystadenomas are bilateral in less than 5% of cases, our case shows a large bilateral mucinous cystadenomas.

Although the majority of attached masses during pregnancy can be observed safely and about 70% resolve spontaneously, a minority of cases require surgical intervention due to symptoms, risk of torsion or suspicion of malignancy. Patients with an asymptomatic cyst of about 5 to 10 cm should be carefully monitored with ultrasound, obstetric colour Doppler and MRI until term. Ultrasound and MRI are safe and can differentiate between benign and malignant lesions. A wait-and-see strategy is recommended for an ovarian cyst with benign characteristics; for an asymptomatic cyst larger than 10 cm, surgical removal is preferred because of the risk of torsion, malignancy, and obstructed labour (5).

Surgical management is encouraged when there is concern that a persistent or larger ovarian mass places the patient at higher risk of acute abdomen, ovarian torsion, or rupture (6). Up to 10% of persistent complex ovarian masses will eventually be diagnosed as malignant,

which means surveillance may not be appropriate; When ovarian cancer is detected, the treatment must be individualized and must take into account the type and stage of the cancer, the woman's desire to continue the pregnancy, and the risk of changing or delaying the treatment.

CONCLUSION

Ovarian cysts or masses during pregnancy should be carefully evaluated to determine the most appropriate treatment option. Serial ultrasound and MRI are used to assess the size of cysts and differentiate between benign and malignant masses. The management plan varies for each patient according to the size of the cystadenoma, the patient's complaints and complications.

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