



Case Report

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Management of a Large Mucinous Cystadenoma of Ovary in a Young Unmarried Woman: A Case Report.

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Abstract

Large ovarian tumors are rare in modern times. Majority of cases are diagnosed when small because patients seek early medical attention and more so as ultrasound is a widely and easily available diagnostic modality. We present the case of a 24 year old unmarried woman who presented with gross abdominal distension resembling a full term pregnancy. Trans abdominal ultrasound revealed a huge cystic mass occupying the entire abdomen. CT Scan revealed a large multi-septate cystic mass of possible ovarian origin with no features suggestive of malignancy. The tumor markers were normal. A provisional diagnosis of benign cyst was reached and a laparotomy was undertaken. During surgery, A large right sided ovarian cyst was found and unilateral salpingo-oophorectomy was performed. The post-op histopathology report confirmed the diagnosis of a benign mucinous cystadenoma of the ovary. The cyst weighed 16 kgs. The patient made an uneventful recovery. This case is unique for the large size of the tumor, young age of patient and the fact that the patient did not seek any medical attention till the mass had grown to a huge size.

Introduction

A 24-year-old unmarried woman presented with profound abdominal distension associated with mild abdominal pain. The distension gradually increased over two years. The patient had not sought any medical help prior to the visit to our hospital. She gave history of only mild abdominal pain on and off and no had other associated symptoms. She attained menarche at 15 years and had regular menses.

On examination, the abdomen was enlarged like a full term pregnancy. A huge mass was found arising from the pelvis and occupying the entire abdomen superiorly up to the xiphisternum and laterally to both flanks. The lower border of the mass could not be reached. The mass was smooth, regular, cystic, non-tender and non-ballotable with fluid thrill.

Trans abdominal ultrasound revealed a huge cystic mass with thin internal septations occupying the entire abdomen. Uterus & both ovaries could not be visualized.

CT abdomen revealed a multi septate cystic lesion measuring 37.6 x 31.0 x 36.3 cms in size. The lesion appeared to be extending from epigastrium to pelvic region causing displacement of contrast filled stomach superiorly and bowel loops laterally and inferiorly. There was no evidence of intra-tumor hemorrhage, calcification or thickening of adjacent wall. There was no ascites, fluid in the pelvis and no abdominal or pelvic lymphadenopathy. Uterus was normal. Both lungs were normal. Differential Diagnosis-Large Ovarian Cyst / Mesentric Cyst.

Investigations

All pre-operative blood tests, hormone profile and tumor markers were normal.

TUMOR MARKER	RESULT	NORMAL RANGE
Lactate Dehydrogenase (LDH)	161 IU/L	135-214 IU/L
Alfa Fetoprotein (AFP)	0.836 IU/ML	0-5.8 IU/ML
Serum Beta Human Chorionic Gonadotropin (HCG)	0.1 IU/L	<5 IU/L
Carcinoembryonic antigen (CEA)	1.02 NG/ML	0-4.7 NG/ML
Cancer Antigen 125 (CA 125)	8.4 U/ML	0-35 U/ML

After discussion with the multi-disciplinary team including radiologists, surgeons and anesthetists, with a provisional diagnosis of benign cyst and informed consent, the patient posted was for laparotomy.

The abdomen was opened by midline vertical incision and the cyst was identified to be arising from the right ovary. The cyst was smooth with no capsular invasion and was filled with yellowish brown sero-sanguinous fluid. More than 12 liters of fluid was aspirated to decompress the cyst after which the mass was delivered out of the incision. Left tube and ovary were normal. Right tube was stretched over the cyst and right ovary could not be identified separate from the mass hence, right salpingo-oophorectomy was performed. The patient made an uneventful recovery and was discharged on 4th post-op day. 02 weeks and 06 weeks post-op visits were unremarkable.

The intact cyst weighed grossly 16 kgs as the patient weighed 58 kgs before and 42 kgs after surgery. Post-op, the mass weighed 5.6 kgs, was multi-septate with daughter cysts and contained yellowish brown fluid. The cut section revealed one large cyst with four daughter cysts containing clear to jelly like fluid.

Histopathology report revealed a multi-cystic neoplasm lined by single layer of mucinous columnar epithelium with no atypia. The intervening stroma showed fibrosis with hyalinization and no evidence of borderline mucinous tumor, intra-mucosal carcinoma or invasive malignancy. Impression-Low grade mucinous cyst-adenoma of ovary. Fluid cytology was negative for malignancy.



Image-1-Supine view of patient's abdomen



Image 2-CT scan Sagittal View

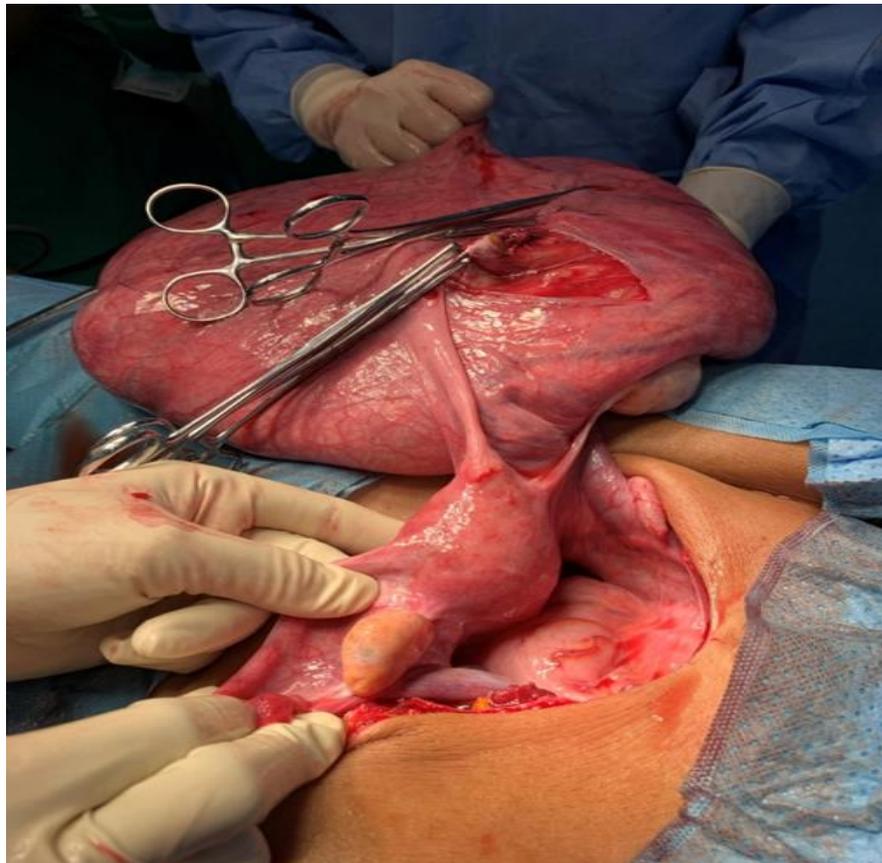


Image 3-Intra-op photo

Discussion

Ovarian cystadenomas are common benign epithelial neoplasms having excellent prognosis. The two most frequent types are serous and mucinous cystadenomas. Benign mucinous cystadenomas account for 80% of ovarian mucinous tumors. They occur mainly in the third to sixth decades, but may occur in younger women. [1]. They are unilateral in 95% of the cases and rare among adolescent girls or pregnant women. Mucinous cystadenomas may be associated with Dermoid cysts indicating germ cell origin and with Brenner tumors indicating epithelial origin. [2]. Mucinous cystadenomas consists of cysts of various size, maybe multi-septate with smooth surface and no capsular invasion. Microscopically it consists of columnar epithelium with basal nuclei and mucin contained in the apices. The symptoms associated with large tumors are nonspecific and generally include abdominal and pelvic pain and bloating. [3]. The initial imaging study recommended in the evaluation of adnexal masses is pelvic ultrasound. Transabdominal ultrasound or endo-vaginal ultrasound is the study of choice. [4]. The management of ovarian cystadenomas depends on the symptoms, size and age of the patient. [5]. A conservative approach is sufficient in benign cases. The best treatment is unilateral salpingo-oophorectomy or ovarian cystectomy with the removal of the adnexal mass. [6]. Clinical recurrence is uncommon and reflects either incomplete resection or a new primary tumor. In our case, a unilateral salpingo-oophorectomy was performed.

Consent- A written informed consent was taken from the patient for publication of this case report and its accompanying photos, images and reports.

Competing interest -The author does not have any competing interests.

Author's contribution -This work was done exclusively by the author and there is no contribution by any other authors.

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