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CASE REPORT

Case report of a huge serous ovarian cystadenoma in post hysterectomy woman

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ABSTRACT

A case of large benign serous cystadenoma in 68 year post hysterectomy woman presented with distension and pain in abdomen. Ultrasonography was suggestive of large multinucleated multiseptic cystic lesion extending from right adnexa up to right hypochondriac and epigastric region measuring 28 cm × 20 cm may be a complex ovarian cyst. Computed tomography (CT) showed 25.9 cm × 15cm × 23cm multiloculated cyst with multiple internal septations suggestive of ovarian neoplasm such as serious cystadenoma. Exploratory laparotomy with right ovarian cystectomy was done. Mass of 32 cm × 25cm × 15 cm size of weight 6.2kg was removed and send for frozen section which suggestive of benign serous cystadenoma.

Keywords: Ovarian mass, benign serous cystadenoma, hysterectomy, risk malignancy index (RMI).

The incidence of ovarian tumors is increasing in developing countries [1, 2]. Twenty percent of all ovarian neoplasms are pathologically malignant. Ovarian neoplasms are divided clinically into solid and cystic types. Most common benign cystic neoplasms of ovary are mucinous and serous cystadenomas and cystic teratomas (dermoid). They are thought to largely derive from ovarian epithelial inclusions, which itself is derived from fallopian tube epithelium. Serous cystadenomas account for ~60% of ovarian serous tumors [3]. They can be bilateral in ~15% of cases. Benign cystadenomas may vary in size from 5-20cm in average diameter and are thin walled, ovoid and unilocular. The fluid contained within the neoplasms is usually clear watery and thin to viscous in consistency. The lining of the cyst is flat or may contain small papillary projections. Generally asymptomatic; if symptoms are present, they are usually related to mass effect with displacement of adjacent structures, e.g. loops of bowel, adnexal torsion. Acute pain may occurred due to torsion, cyst rupture or bleeding into cyst.

Case report

A 68 year old woman presented to our hospital with complaints of gradual distension and pain in abdomen since 1 month. On general examination patient was vitally stable. Per abdominal examination revealed large abdominal mass corresponding to 34 to 36 weeks of gestational size of uterus arising from pelvis, smooth surface, cystic in consistency, mobility was restricted, lower border could not be felt. Previous suprapubic

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horizontal scar of hysterectomy was healthy and healed with primary intensions. Per speculum examination revealed healthy vault and vagina. On per vaginal examination mass was felt and on bimanual examination above findings were confirmed. Abdominal ultrasound examination showed evidence of large multiloculated multiseptate cystic lesion extending from right adnexa

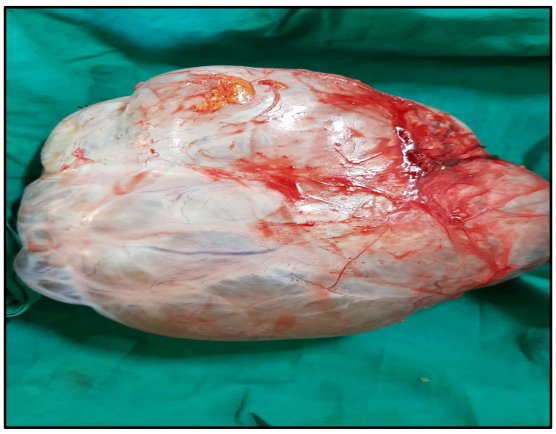

Figure 1: Postoperative view of ovarian mass

up to right hypochondriac and epigastric region measures approx 28 cm x 20 cm in size. So, risk of malignancy index (RMI) calculated and came out to be 402. Computed tomography of abdomen and pelvis demonstrated cystic multiloculated lesion of 25.9cm (cranio-caudal) x 15cm (AP) x 23 cm (transverse) with multiple internal septations. Few of locules showed relative hyperdense components (HU 19). All routine laboratory investigations and tumor marker like CA 125 were within normal limits. Patient underwent exploratory laparotomy. Intra operative findings were large cystic right ovarian mass of 32 x 25x 15cm^3 adherent to omentum and bowel (Figure 1). Mass was separated by blunt dissection and sent for histopathology. Weight of mass was 6.2kg. Histopathology report was suggestive of benign serous cystadenoma. Post-operative course was uneventful.

Discussion

During the postmenopausal years, when ovary should become smaller and quiescent, the presence of palpable ovary must alert the physician to the possibility of underlying malignant neoplasm. The postmenopausal gonad atrophies to a size of 1.5x 1x 0.5cm^3 on average and at that size it should not be palpable on pelvic examination. The majority of neoplasms in this group of patients are benign. Although it is not unrealistic to consider every ovarian neoplasm or ovarian mass potentially malignant, in truth only 20% of all ovarian neoplasms are pathologically malignant. Only occasionally it is possible to differentiate benign from malignant tumors on the basis of history and physical examination findings. In most instances, the diagnosis can be made only after both gross and microscopic examination of the mass. Most ovarian neoplasms of ovary are asymptomatic unless they have been subject to rupture or torsion. A true benign neoplasm of ovary (e.g. serous, mucinous, teratoma) does not resolve spontaneously [4]. The differential diagnosis of ovarian mass varies considerably with the age of patient. In premenarchal and post-menopausal woman, an ovarian mass should be considered highly abnormal and must be immediately investigated. In premenarchal patients, most neoplasms are germ cell in origin while in post-menopausal patients, stromal, germ cells and epithelial ovarian tumors are most common. Women with RMI of less than 200 (low risk of malignancy) are suitable for laparoscopic management [5]. All ovarian cyst that are suspicious of malignancy in post-menopausal woman, as indicated by RMI greater than 200, CT findings and clinical assessment require full laparotomy and staging procedure [5].

Conclusion

CA 125 is only serum tumor marker used for primary evaluation as it allows the risk of malignancy index (RMI) of ovarian mass in post-menopausal woman to be calculated. Now a days, ultrasound examination, CT scans, magnetic resonance imaging (MRI) of the pelvis helps in confirmation of diagnosis.

Conflict of interest: None. **Disclaimer:** Nil.

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