Incidental Finding of Huge Serous Cystadenoma of Ovary in A Patient With Menorrhagia

Dr. Bansi Popat*, Dr.Rinky Agrawal, Dr. Prerak Modi**, Dr. A.U.Mehta*****

*Second Year Resident, **Assistant Prof., ***Assistant Prof., ***Professor and Head of Department of Obstetrics and Gynecology, B. J. medical college and Civil Hospital, Ahmedabad, India

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ABSTRACT

Ovarian tumors are common in age of 40-60 years. While the most common presentation is pelvic discomfort, we report the case of a 41-year-old female presenting with menorrhagia which is an unusual initial complaint for a large ovarian tumor. Females of 40-50 years of age who present with heavy menstrual bleeding initially undergo assessment to rule out a uterine cause like fibroid, adenomyosis or medical disorder like hypertension all off which can be a common cause leading to menorrhagia at this age. In this case, careful history and physical examination helped in making a quick diagnosis and management. Radiological investigations like Ultrasound of abdomen and MRI abdomen showed a huge cystic mass due to serous cystadenoma of the ovary.

INTRODUCTION

Epithelial neoplasms of ovary accounts for 60%of all ovarian tumors and 40% of benign tumors. Ovarian cystadenomas are common benign epithelial neoplasms which carries excellent prognosis.[1] The most frequent 2 types of it are : serous and mucinous. Benign serous tumors of ovary represents 16% of all ovarian epithelial tumors and majority of ovarian tumors. They occur in adults of all ages but Its Epidemiology prevalence peaks between 40-60years of the human lifespan. It has a very superficial resemblance to the most common type of ovarian cancer (serous carcinoma of the ovary) under the microscope; however, (1) it is virtually impossible to mix-up with its malignant counterpart (serous carcinoma), and (2) does not share genetic traits of indeterminate serous tumors, also called serous borderline tumors , that may transform into serous carcinoma.[2] Serous ovarian cystadenocarcinomas account for ~25% of serous tumors.[3] They are bilateral in 10-20% of cases. Most common presentation is pelvic discomfort and pelvic pain. Chances of malignancy are 40%.

CASE REPORT

A 41 year old P1L1 female patient presented with complaint of menorrhagia since 7years with no compliant of pelvic pain or discomfort. She was having of regular, heavy menses for 7-8days (4-5 pads/d) with passage of clots in every cycle. She had one full term vaginal delivery 24 years back with no significant past, medical, surgical or family history.

On examination per abdomen mass of 26-28weeks size, soft, cystic consistency felt. On per speculum examination : cervix was taken up and deviated to right side. On per vaginum examination : uterus was 26-28week size and not felt separate from mass with both fornices free and clear

On her investigation Hb :10.8gm/dl, Total count : 8300/cumm, Platelets : 2.3 lacs. All other routine investigations were done which were normal. Ovarian tumor marker were also done . All were normal in range including : CA 125 – 23U/ml, LDH – 853.2 U/ML, AFP – 4.0 NG/ML.

On radiological investigations : USG Abdopelvis suggested : Uterus bulky, anteverted with multiple fibroids in fundus and anterior wall pushing endometrial thickness anteriorly, largest measuring 43x38mm in anterior wall. Approx. 21x12cm size cystic lesion with single septation is noted in right adnexal region in abdomen, right ovary not seen separately from it possibility of – serous cystadenoma of right ovarian origin. MRI Abdopelvis shownUterus is bulky with multiple fibroids in anterior and posterior wall, largest measuring35x41x40mm in anterior wall. Approx. 14x21x25mm sized well defined unilocular cystic lesion is noted in pelvis extending to epigastrium, right ovary is not separated from lesion suggestive of-Benign right ovarian cyst, possibility of – Ovarian Serous cystadenoma.

Patient underwent laparotomy under general anesthesia for cyst removal with Total abdominal hysterectomy with bilateral salpingo-oophorectomy.[Fig.1] Per operatively we found cyst was arising from right ovary, right fallopian tube adherent to cyst. Post operatively patient was vitally

Correspondence Address : Dr. Bansi Popat
Room No. B-201, P.G. Hostel, Phase-1, Building in Front of Sahyog MRI Centre, Civil Hospital, Asarwa, Ahmedabad. • E-mail : bansipopat186@gmail.com

stable. Suture was removed on 10th post operative day and patient was discharged.

Histopathological report shown multiple cysts and papillae lined by non stratified or stratified cuboidal to columnar cells resembling to fallopian tube , PSAMMOMA BODIES seen suggestive of - benign serous cystadenoma of ovary. [Fig3]

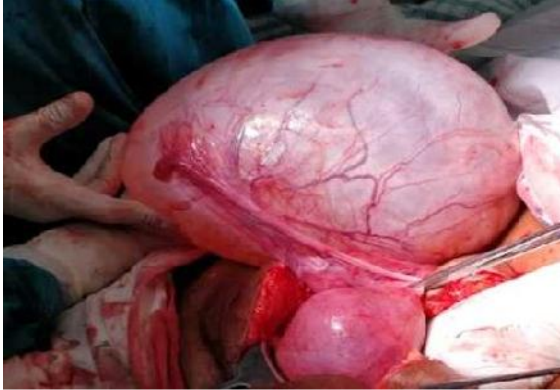

Fig 1 : Per operative photo of ovarian cyst with Fallopian tube adhernt to it.

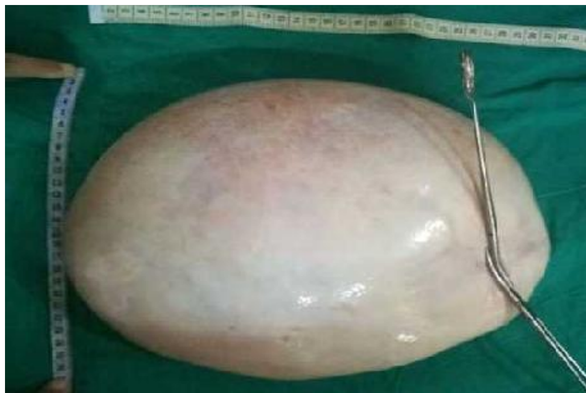

Fig 2 : A huge ovarian cyst measuring 26x28cm and weighing 4.8kg.

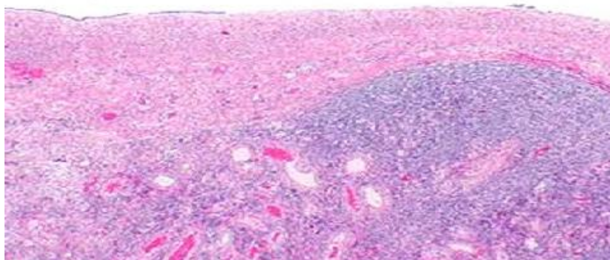

Fig 3 : Benign serous cystadenoma : Simple epitheliallining with underlying fibrous wall, no atypia or invasion is seen.

DISCUSSION

Here we report the case of a 41-year-old female presenting with menorrhagia which is an unusual initial complaint for a large ovarian tumor. Patient with ovarian tumors most commonly present with the complaint of lower pelvic pain or pelvic discomfort, while menorrhagia is unusual presentation of ovarian tumors. Radiological investigation like USG used to diagnose the causes of heavy uterine bleeding.[4]

Here, in this case careful physical examination suggested need for additional radiological intervention like MRI to aid in diagnosis and other investigations like ovarian tumor markers. Huge Ovarian serous cystadenoma can lead to life threatening complication called ovarian torsion if not diagnosed timely . Other complications are rupture of the cyst and malignant transformation.

A study conducted in 1994 mentioned that abdomen and transvaginal ultrasonogram should be part of the initial evaluation of menorrhagia [8] in females, since ovarian cystadenomas have a tendency to grow large. Earlier detection would prevent life-threatening complications such as ovarian torsion. Whether to add abdominal sonogram to the initial evaluation steps is dependent on the physical examination finding and the resources available. Detailed history taking and conducting a thorough physical examination were the keystone in managing this patient, in addition to following guidelines in managing females with menorrhagia.

CONCLUSION

So early detection and intervation can prevent the complication of ovarian tumor like torsion or rupture of cyst or malignant transformation.

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