

# MSCT of Huge Abdominopelvic Masses in Female: A Pictorial Illustration



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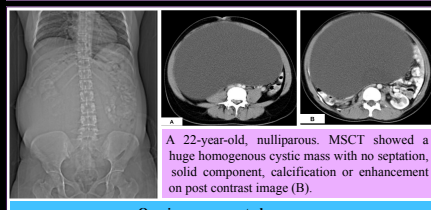
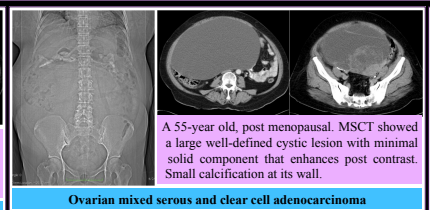
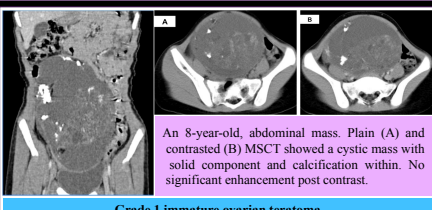
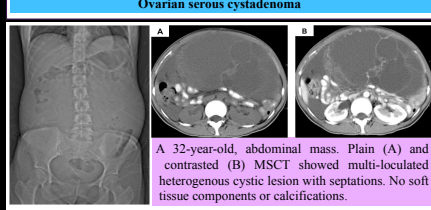
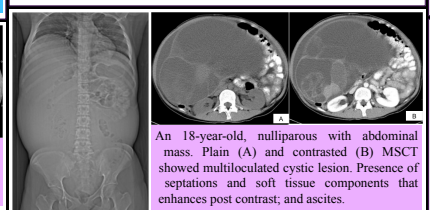
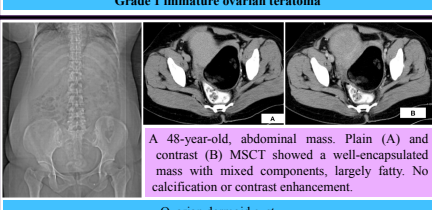
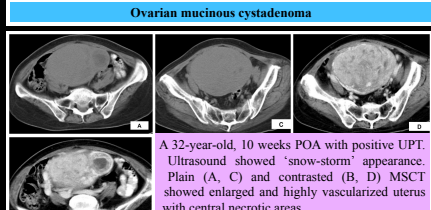
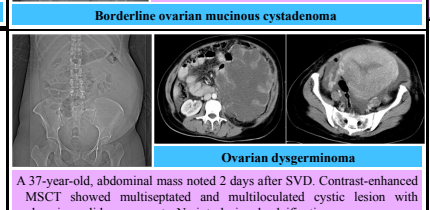
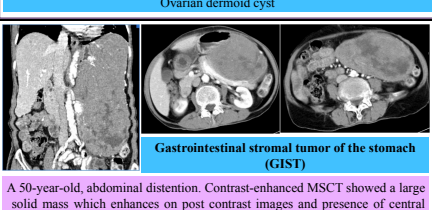
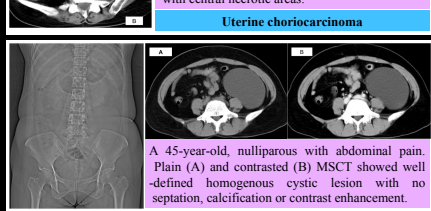
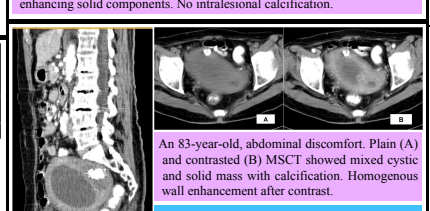
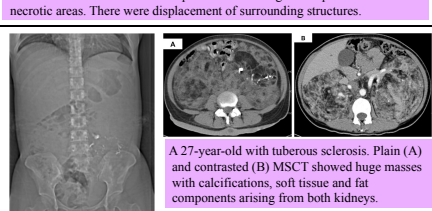
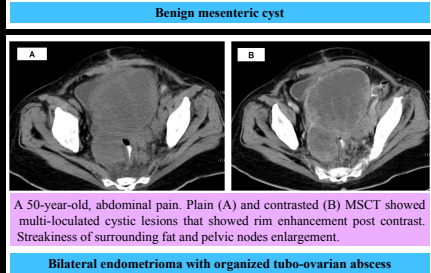
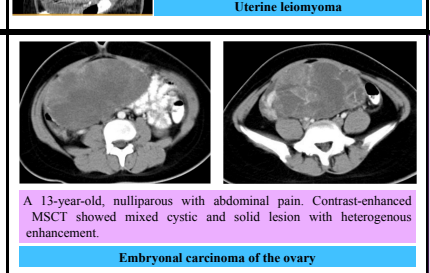
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## Introduction

Large abdominopelvic masses in women may originate from the reproductive system, peritoneum or retroperitoneum and the differential diagnosis are extensive. Often, the diagnosis can be suggested on the basis of tumor location and anatomic landmarks. However, large masses (>5cm) posed a challenge to clinicians and radiologists in determining tumor origin. In these cases, it may not always be possible to differentiate between tumors. Establishing correct diagnosis and accurately staging these tumors are important especially when surgical resection can be an option. We illustrate different entities of huge abdominopelvic masses seen on MSCT to increase familiarity with its differential diagnosis.

 <p>A 22-year-old, nulliparous. MSCT showed a huge homogenous cystic mass with no septation, solid component, calcification or enhancement on post contrast image (B).</p> <p><b>Ovarian serous cystadenoma</b></p>	 <p>A 55-year old, post menopausal. MSCT showed a large well-defined cystic lesion with minimal solid component that enhances post contrast. Small calcification at its wall.</p> <p><b>Ovarian mixed serous and clear cell adenocarcinoma</b></p>	 <p>An 8-year-old, abdominal mass. Plain (A) and contrasted (B) MSCT showed a cystic mass with solid component and calcification within. No significant enhancement post contrast.</p> <p><b>Grade 1 immature ovarian teratoma</b></p>
 <p>A 32-year-old, abdominal mass. Plain (A) and contrasted (B) MSCT showed multi-loculated heterogeneous cystic lesion with septations. No soft tissue components or calcifications.</p> <p><b>Ovarian mucinous cystadenoma</b></p>	 <p>An 18-year-old, nulliparous with abdominal mass. Plain (A) and contrasted (B) MSCT showed multicystic lesion. Presence of septations and soft tissue components that enhances post contrast; and ascites.</p> <p><b>Borderline ovarian mucinous cystadenoma</b></p>	 <p>A 48-year-old, abdominal mass. Plain (A) and contrast (B) MSCT showed a well-encapsulated mass with mixed components, largely fatty. No calcification or contrast enhancement.</p> <p><b>Ovarian dermoid cyst</b></p>
 <p>A 32-year-old, 10 weeks POA with positive UPT. Ultrasound showed 'snow-storm' appearance. Plain (A, C) and contrasted (B, D) MSCT showed enlarged and highly vascularized uterus with central necrotic areas.</p> <p><b>Uterine choriocarcinoma</b></p>	 <p>A 37-year-old, abdominal mass noted 2 days after SVD. Contrast-enhanced MSCT showed multiseptated and multiloculated cystic lesion with enhancing solid components. No intralésional calcification.</p> <p><b>Ovarian dysgerminoma</b></p>	 <p>A 50-year-old, abdominal distention. Contrast-enhanced MSCT showed a large solid mass which enhances on post contrast images and presence of central necrotic areas. There were displacement of surrounding structures.</p> <p><b>Gastrointestinal stromal tumor of the stomach (GIST)</b></p>
 <p>A 45-year-old, nulliparous with abdominal pain. Plain (A) and contrasted (B) MSCT showed well-defined homogenous cystic lesion with no septation, calcification or contrast enhancement.</p> <p><b>Benign mesenteric cyst</b></p>	 <p>An 83-year-old, abdominal discomfort. Plain (A) and contrasted (B) MSCT showed mixed cystic and solid mass with calcification. Homogenous wall enhancement after contrast.</p> <p><b>Uterine leiomyoma</b></p>	 <p>A 27-year-old with tuberous sclerosis. Plain (A) and contrasted (B) MSCT showed huge masses with calcifications, soft tissue and fat components arising from both kidneys.</p> <p><b>Bilateral renal angiomyolipoma</b></p>
 <p>A 50-year-old, abdominal pain. Plain (A) and contrasted (B) MSCT showed multi-loculated cystic lesions that showed rim enhancement post contrast. Streakiness of surrounding fat and pelvic nodes enlargement.</p> <p><b>Bilateral endometrioma with organized tubo-ovarian abscess</b></p>	 <p>A 13-year-old, nulliparous with abdominal pain. Contrast-enhanced MSCT showed mixed cystic and solid lesion with heterogeneous enhancement.</p> <p><b>Embryonal carcinoma of the ovary</b></p>	<h2>Discussion</h2> <p>The majority of large abdominopelvic masses in female patients represent common entities such as ovarian cysts, ovarian cancer, uterine and dermoid tumors. However, uncommon masses may also be encountered and be part of its differential diagnosis.</p> <p>The site of origin, imaging characteristics and clinical history may all help and narrow the differential diagnosis. It is important to note that uncommon presentation of common diseases is more common than the common presentation of rare diseases</p>

## References:

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## Conclusion

Familiarity with clinico-pathologic and imaging features is important and helpful for accurate image interpretation of huge abdominopelvic masses.