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Case Report

A huge benign ovarian mucinous cystadenoma in post-menopausal woman

Kamala Verma*

Department of Obstetrics & Gynaecology, S.P. Medical College and Associate Group of P.B.M. Hospital, Bikaner Rajasthan, India

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***Correspondence:**
Dr. Kamala Verma,
E-mail: girishdrbaniya@gmail.com

ABSTRACT

Mucinous cystadenomas are the second most common type of epithelial tumor of ovary. Most of these tumors are benign. However some tumor can grow to enormous size. In modern world giant benign tumor of ovary are rare because of improved diagnostic technologies and general awareness of public.
This report presents the case of 50 year old post-menopausal, grand multiparous woman having a very large mucinous cystadenoma. She had laparotomy followed by total hysterectomy with bilateral salpingo- oophorectomy. Her post-operative course was uneventful. She came for follow up in healthy condition.

Keywords: Giant, Ovarian tumour, Benign, Mucinous Cystadenoma

INTRODUCTION

Mucinous cystadenomas are benign epithelial ovarian tumors that are characterized by multilocularity, smooth outer and inner surface. They tend to be large reaching 20 to 30 cm in size containing mucinous fluid.[1] Mucinous cystadenoma comprises 15 – 20 % of all ovarian tumors and 80 % of these are benign, 10 % are borderline and 10 % are malignant.[2,3] Benign mucinous tumors are most common between the third and fifth decades. They are rarely seen before puberty and after menopause. It is unilateral in 90 % and bilateral in 10 % of cases.[4]

Usually benign ovarian tumors are asymptomatic. However symptomatic patients tend to present with abdominal swelling, discomfort, dyspepsia or weight loss. The most frequent complication of benign ovarian cyst is torsion, hemorrhage and rupture.[5]

In this report we present a case of huge benign ovarian mucinous cystadenoma in post-menopausal HIV positive Indian woman. She managed with surgical treatment and had good recovery.

CASE REPORT

A 50 year old postmenopausal lady P10 L8 presented to our gynae outdoor with four year history of abdominal swelling. Initially swelling was small in size and located in supra pubic region then it gradually increased in size and extended up to the epigastrium. It was associated with abdominal discomfort, dyspepsia, reduced appetite and weight loss. She had no history of fever, cough, vomiting or constipation. She also had no urinary complaints. She had stopped her menstrual periods since last 2 year. Her past medical and surgical history was insignificant.

On clinical examination patient was emaciated and pale. Her pulse, blood pressure and temperature were normal. Abdominal examination revealed grossly distended abdomen. On per vaginal examination cervix and vagina appeared normal. A large mass felt anterior to uterus. Exact size of uterus and adnexa was not made out. Her ultrasound revealed a pelvic mass of 22 × 15 cm in size, thick walled cystic lesion with dense internal echoes extending up to epigastrium region. MRI showed a large

cystic lesion in pelvis extending into supra umbilical region approximately size of lesion was 132 × 234 × 290 mm with thin internal septation. Uterus showed normal signal intensity. No pelvic lymphadenopathy seen. Liver spleen was normal. There was no evidence of pleural effusion. Her investigations including liver and kidney function, blood sugar, electrolytes, complete blood count and urine analysis were normal. Her CA – 125 and CEA marker was in normal range. She was diagnosed as HIV positive for that anti-retroviral therapy started. She was planned for laparotomy and operative findings were a large left ovarian cystic multiloculated mass measuring 28 × 23 × 15 cm with smooth surface, and capsule of cyst was intact. Uterus and right ovary, fallopian tube was normal. Left fallopian tube was stretched along with tumor. There was no ascites, liver, spleen and intestine was normal. She had total hysterectomy with bilateral salpingo- oophorectomy. Intra operative one unit blood transfused. Her post-operative recovery was uneventful. Histopathology report of the mass revealed benign mucinous cystadenoma. She was discharge on 9th post-operative day. She came in follow up in healthy condition after 6 weeks of surgery.

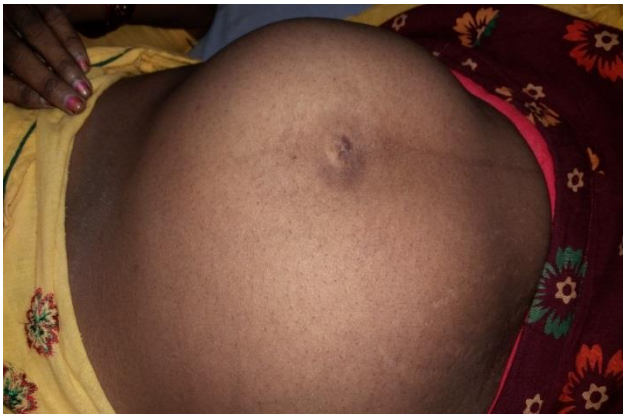

Figure 1: Showing over distended abdomen of patient.

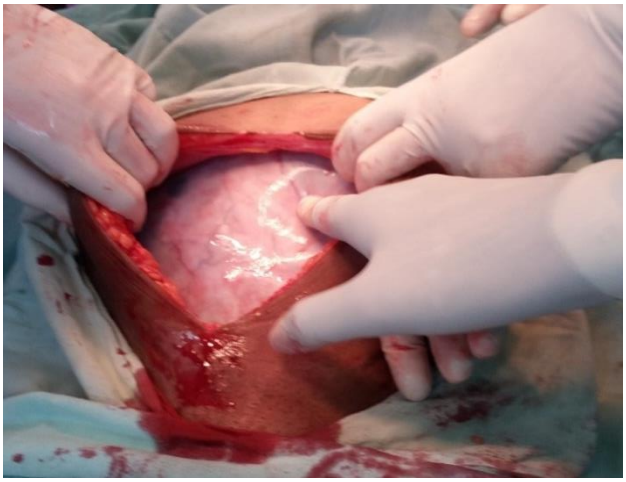

Figure 2: After incision showing intact cyst.

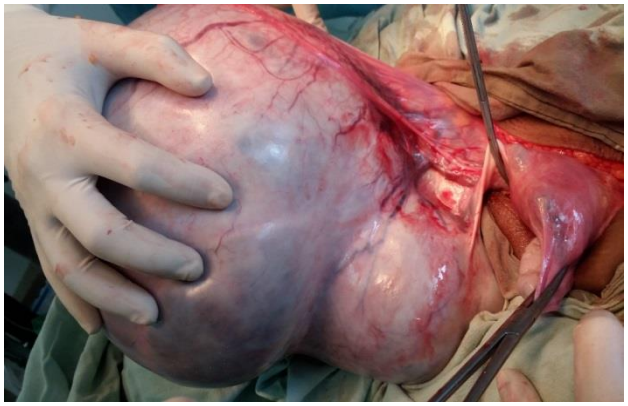

Figure 3: Intraoperative picture showing large tumour with uterus and adenexa.

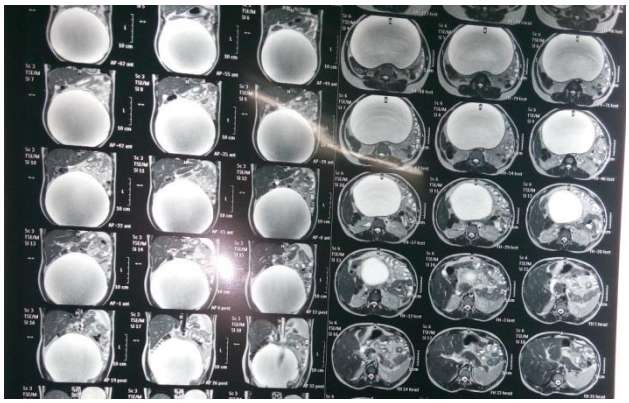

Figure 4: MRI finding.

DISCUSSION

Giant ovarian tumor rarely seen in modern world, because of improved diagnostic technologies and general awareness but in developing countries like India where scarcity of health facilities in remote area is a well-known problem, also female literacy rate is very low as well as no one in family is concerned for women health. This is the reason why some patient land up in advanced and critical stage of disease.

Fortunately majority of ovarian cysts are benign and have good surgical response. Mucinous cystadenoma arise from ovarian surface epithelium and comprises 10 – 20 % of ovarian epithelial tumors. Mucinous cystadenomas are divided into three categories benign, borderline and malignant.[6] Benign mucinous tumor tend to present earlier while malignant tumor are often seen later in life. The peak incidence occurs between 30 – 50 years of age, it is rare among adolescent and after menopause.[7]

Most of the benign ovarian tumors are asymptomatic. However giant tumors present with abdominal swelling, abdominal discomfort, and urinary tract changes, respiratory embarrassment due to pressure effect. Presence of acute abdominal pain should raise the

suspicion of torsion, rupture, infection or hemorrhage into the tumor.

Clinical examination is mainly directed towards differentiation of benign from malignant tumor. Apart from general examination the size, shape, consistency, mobility, tenderness, presence of ascites should be assessed. Investigation like ultrasonography, chest x-ray, intravenous urography, tumor markers and CT scan should be done to rule out malignancy. On gross appearance mucinous tumors have multiloculated cystic areas with smooth surface. They contain gelatin like sticky fluid. Histopathologically mucinous cystadenoma is lined by tall columnar epithelial cells with apical mucin and basal nuclei.

Management of ovarian cyst depends on patient's age, size of tumor and its histopathological nature. Conservative surgery as ovarian cystectomy and salpingo-oophorectomy is adequate for benign tumors. In our case patient was 50 year old and post-menopausal, so total hysterectomy with bilateral salpingo oophorectomy was performed.

This case has demonstrated that not all giant ovarian tumor are malignant in postmenopausal age group. Still every effort should be made to exclude malignancy.

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Conflict of interest: None
Ethical approval: The study was approved by the institutional research review board & ethics committee and written consent was taken from patient.

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