



## A CASE REPORT ON BILATERAL OVARIAN CARCINOMA IN YOUNG WOMAN

Supriti Kumari<sup>1</sup>, Nitin Tyagi\*<sup>2</sup> and Gaurav Anand<sup>3</sup>

<sup>1</sup>MBBS, MS (Obstetrics & Gynae), Senior Resident, Department of Obstetrics & Gynae, Vardhman Mahavir Medical College & Safdarjung Hospital, New Delhi-110029.

<sup>2</sup>MBBS, MD (Post Graduate Student), Department of Biochemistry, Vardhman Mahavir Medical College & Safdarjung Hospital, New Delhi-110029.

<sup>3</sup>MBBS, Government Vellore Medical College.

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### \*Corresponding Author

**Nitin Tyagi**

MBBS, MD (Post Graduate Student), Department of Biochemistry, Vardhman Mahavir Medical College & Safdarjung Hospital, New Delhi-110029.

### INTRODUCTION

In the current era of medical practice, giant ovarian tumours have become rare due to early discovery on routine check-ups. Detection of ovarian tumours causes panic amongst patients because of the fear of malignancy leading to psycho-somatic stress disorders. In addition to this, large size of these tumours causes mechanical pressure symptoms on the gastrointestinal, respiratory and urinary tract. Large ovarian tumours in young woman are mostly benign. Epithelial ovarian cancer is seen in 4.1% in women less than 30 years and the cases which present as bilateral are of 0-17%.<sup>[1]</sup> We present a rare case of bilateral ovarian carcinoma in a 27year old woman.

### CASE SUMMARY

A 27 years old para-2 woman presented in our gynaecology outpatients department with c/o rapidly growing abdominal mass since 2 months associated with pain abdomen. The mass was detected on investigation for severe anaemia. Patient underwent multiple blood transfusion followed by jaundice. She had h/o tuberculosis 4years back. On general examination, she was thin built, not pallor, not icteric, no odema and no significant lymphadenopath noted. Respiratory and cardiovascular system were normal On palpation- a cystic mass corresponding to 36 weeks of uterine size palpated which was mobile from side to side. Lower margin could be reached with difficulty, firm in consistency. Mobile side by side, margins were ill defined and extending till xiphisternum and reaching iliac fossa both

sides. On pelvic examination uterus was normal in size and all fornices were full. Rectal mucosa was free.

Her investigations showed haemoglobin of 7.2 gm followed by patient received two units of blood transfusion. Her peripheral smear showed was microcytic hypochromic anaemia with all other investigation were normal. S.LDH=553 & S.CA125=219; all other tumour markers are normal. USG whole abdomen showed liver normal in size with echo pattern and showed focal lesions. Bilateral kidneys appeared normal. The entire abdomen and pelvis is occupied by a multicystic lesion / mass which shown septae within it.

Bilateral ovaries could not be visualised separately. In view of past history of tuberculosis, the differential diagnosis of encysted tubercular ascites or large ovarian cyst was made.

### **Cect Whole Abdomen**

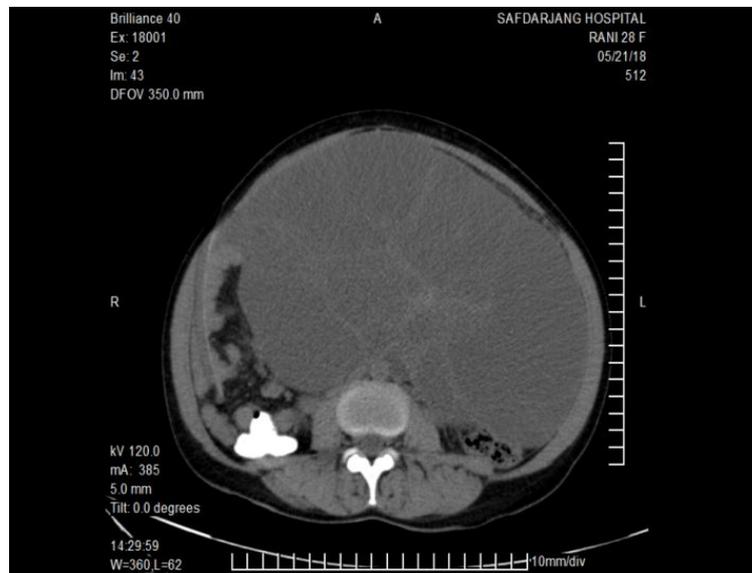
A CECT whole abdomen was done which showed a large multi septated cystic lesion of size ~19.8\*10.5\*21.8cm is seen in the abdomino-pelvic region with few thick enhancing septae and internal vascularity (Figure 2.1.1). The lesion appeared to be originating from the right adnexa and causing superior displacement of the bowel loops. Another small solid cystic lesion of size 86\*40\*85mm was seen in left adnexa with enhancing solid component and thickened septae with internal vascularity within (Figure 2.1.2). Uterus was seen separately and appeared normal. Minimal free fluid was seen in abdomen. No evidence of significant lymphadenopathy is seen. A provisional report of bilateral malignant ovarian tumour was made and patient planned for laprotom with a consent for hysterectomy and bilateral salphingo-oophorectomy if scrape cytology was positive for malignancy.

A comprehensive staging laprotomy was performed by midline incision. About 200ml of haemorrhagic ascetic fluid was taken and sent for cytology. There was a large cystic mass of 30\*25\*25 cm arising from the right ovary. Right salphingo-oophorectomy was performed. On cut-section, there was multiloculated cystic with solid areas. Scrape cytology revealed sheets, papillae and individual scattered cells with moderate pleomorphism and focally high m:c ration suggestive of a malignant epithelial tumour of ovary possibly mucinous. There was another mobile solid-cystic mass with a solid nodule on the surface of size 10\*15\*15 cm arising from the left ovary. In view of suspicion of malignancy in this mass as well, a decision for hysterectomy was taken. Total abdominal hysterectomy with left salphingo-

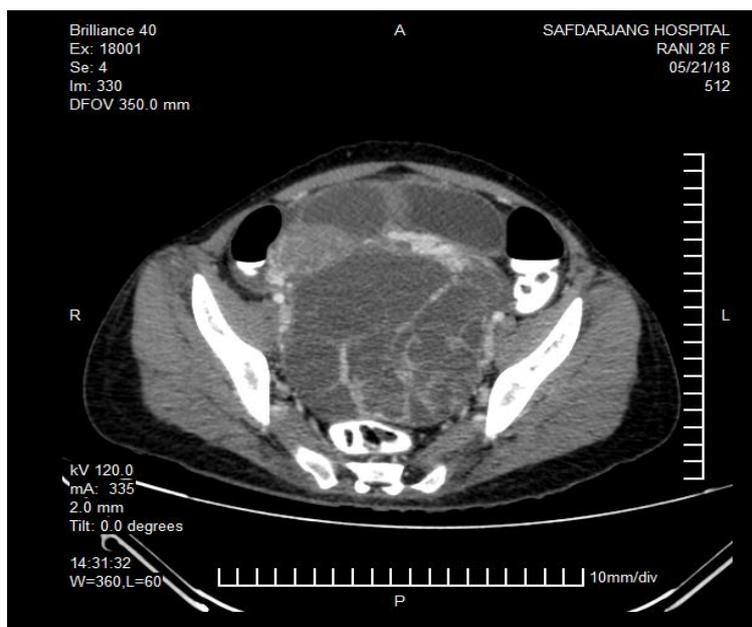
oophorectomy, peritoneal biopsies, supra-colic omentectomy, pelvis and para-aortic lymphadenectomy and appendicectomy was performed in view of mucinous origin.

Her histopathology report revealed as B/L mucinous cystadenocarcinoma of ovary with negative lymph nodes as shown in (Figure 2.1.7,2.1.8). Hence she was stage Ib

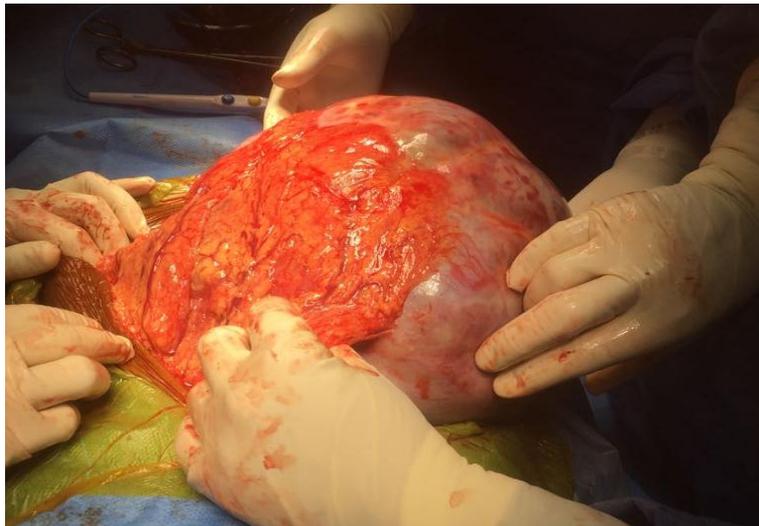
Proper consent is taken.



**Figure 2.1.1: Cect Whole Abdomen Shows Right Sided Ovarian Mass.**



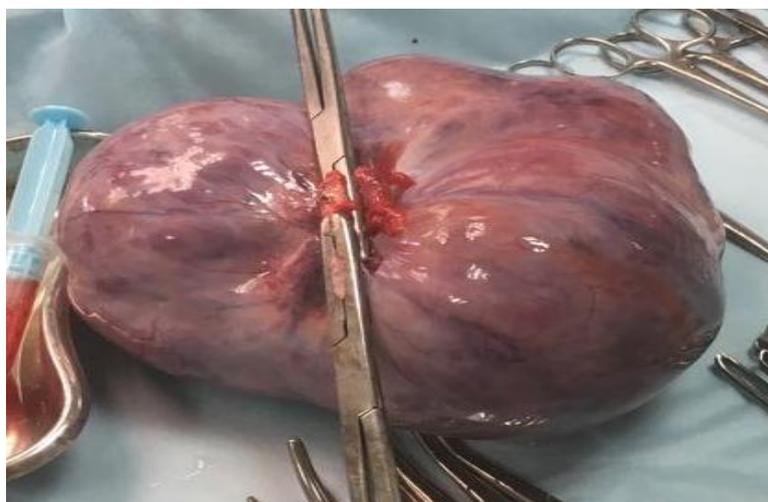
**Figure 2.1.2: Cect Whole Abdomen Shows Left Ovarian Mass.**



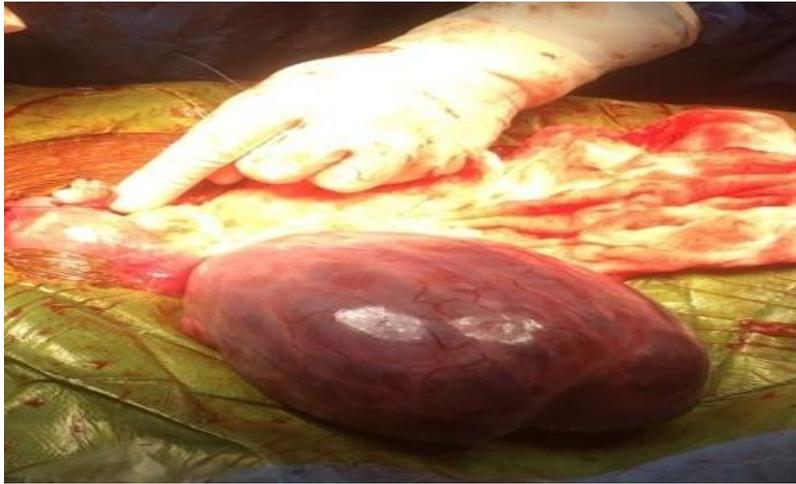
**Figure 2.1.3: Intraoperative Picture Showing Omental Attachment With The Mass.**



**Figure 2.1.4: Intraoperative Picture Showing Tubal Attachment.**

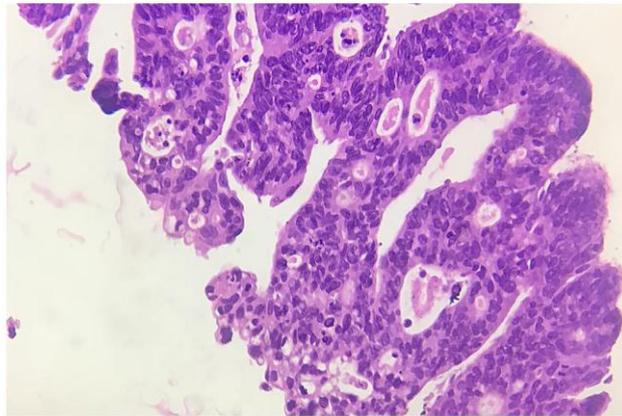


**Figure 2.1.5: Complete Unruptured Right Ovarian Mass.**



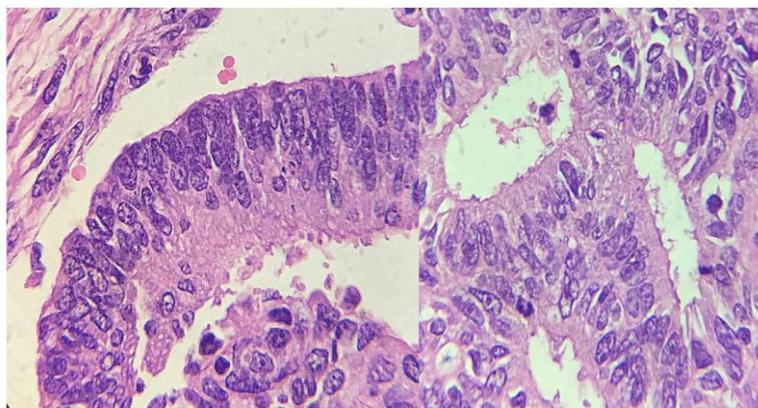
**Figure 2.1.6: Left Sided Ovarian Mass.**

**MICROSCOPY**



**Figure 2.1.7: Right Ovary: 10x H&E Image With Infiltrative Invasion; Small Clusters Of Cells Float In Irregular Cleft-Like Spaces.**

**MICROSCOPY**



**Figure 2.1.8: Left Ovary: H&E Image With Higher Power View Showing Prominent Nucleoli, Coarse Chromatin And Atypia.**

**Abbreviations**

S. CA 125 = Serum Cancer Antigen

S. LDH = Serum Lactate Dehydrogenase

S. CEA= Serum Carcinoembryogenic Antigen

Beta HCG= Beta Human Chorionic Gonadotrophin

OPD= Outpatients Department

PHC= Primary Health Centre

**DISCUSSION**

The most common types of epithelial neoplasm are encountered as 80% benign 10% borderline malignant and 10% malignant.<sup>[2]</sup> Mucinous tumours represent about 8-10% of epithelial tumours, while mucinous cystadenoma themselves are not infrequent, majority of them (80%) are benign while only 10% of them are borderline and another 10% are malignant. Mucinous tumours of ovary accounts for 36% of all ovarian tumours.<sup>[3]</sup> Giant mucinous cystadenocarcinoma of ovary with bilateralism with huge abdominal mass is very rare. The epithelium of the cyst is usually cylindrical and mono or multi- stratified cuboidal epithelium is due to the pressure inside the cyst, the classical cells show clear cytoplasm and a hyper-chromatic nucleus at the base.<sup>[4]</sup>

Young patient with huge abdominal mass with sudden progression and bilateralism is very rare in mucinous cystadenocarcinoma of ovary. My objective of case report is to give attention to ovarian epithelial tumours in OPD and PHC services to decrease incidence in any undiagnosed or mis-diagnosed cases.

Various imaging modalities are used in making diagnosis of ovarian tumours. Ultrasonography is used to diagnose and infer about possible malignancy. Computed tomography and magnetic resonance imaging scans can be used for larger masses and metastatic involvement. Serial measurements of the biomarker CA-125 can be of great help.<sup>[5]</sup> Surgery is inevitable for larger tumours even if it's benign. The contralateral ovary should also be examined. Hunter et al reported that rupture of the cyst capsule and greater dissemination can be prevented by gradual decompression. Repeated paracentesis have been associated with tumour seeding of peritoneal cavity, bleeding, infection, and increased adhesions resulting in difficult cyst removal.<sup>[6]</sup> In a study of it is observed that satisfactory diagnostic accuracy of the intraoperative imprint cytology (95.60%) in their study. The

sensitivity, specificity, positive predictive value, negative predictive value, and diagnostic accuracy were 97.7, 91.37, 95.56, 95.65, and 95.60% respectively.<sup>[7]</sup>

Differential diagnoses of ovarian masses include mesenchymal hamartoma, choledochal cyst, hydrops of the gallbladder, congenital splenic cyst, pancreatic pseudocyst, pancreatic cystadenoma, hydronephrosis, multicystic dysplastic kidney, multilocular cystic nephroma, adrenal haemorrhage, mesenteric and omental cysts, gastrointestinal duplication cyst, meconium pseudocyst, ovarian cysts and cystic neoplasm, hematocolpos, urachal cysts, appendiceal abscess, and abdominal and sacrococcygeal teratoma. Giant ovarian tumours can cause abdominal compartment syndrome. Timely and aggressive resuscitation, prompt surgical decompression, and intensive perioperative hemodynamic management are required for patients with ovarian mucinous cystadenoma complicated by abdominal compartment syndrome

## CONCLUSION

In developing countries, patients having ovarian tumours seek medical help usually during advanced stages of the disease. Fortunately, in our case, the tumours were removed successfully without any dissemination despite a delay in diagnosis. Reporting such cases with unusual presentations helps in suspicion of its possibility and avoid any misdiagnosis or improper treatment and its complications.

## REFERENCES

1. Jubilee B, Michael F. Mucinous tumors of the ovary: current thoughts on diagnosis and management. *Curr Oncol Rep*, 2014; 16: 389.
2. Sebastin A, Thomas A, Regi A. Giant benign mucinous cystadenoma: A case report. *Open J Obstet Gynaecol*, 2012; 2: 220-2.
3. Katke RD, Huge Mucinous Cystadenocarcinoma with Mucocoele of Appendix in a Postmenopausal Women: Extremely Rare Case Report with Review of Literature. *Gynaecol Obstet (Sunnyvale)*, 2015; 5: 279. doi:10.4172/2161-0932.1000279
4. A 9-kg ovarian mucinous cystadenoma in a 14-year old premenarchal girl. *Am J Case Rep*, 2014; 15: 326-329
5. Kotis A, Karatapani S, Papamargaritis V, Lisgos P, Sisamotos G. A Case of a large ovarian tumour. *BMJ Case Rep*, 2011; 2011.
6. Hunter DJS. Management of a massive ovarian cyst. *Obstet Gynaecol*, 1980; 56: 254-255.

7. Jain R, Jain V, Dutta S, Awasthi S, Jain SK. Role of Intra-operative Cytology in the Diagnosis of Ovarian Neoplasm's. *Int J Sci Stud*, 2015; 3(5): 72-75.