

Giant Ovarian Cystadenoma in A Postmenopausal Woman; Diagnosis and Management Challenges. A Case Report in Lindi Southern Tanzania.

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Abstract:

Background:

A giant ovarian cyst is a fluid-containing sac in the ovary which is larger than 10cm, as determined by radiological evaluation or if it extends above the umbilicus during physical examination (1). In current time of medicine, ovarian cysts are diagnosed in early stage due to the improvement of investigations; therefore, it is rare to encounter larger ovarian cysts.

Case Summary:

A 75 years old post-menopausal woman sought care at our center, complaining of abdominal swelling, reduced ability to stand and to walk, accompanied with difficulty in breathing. On examination, the patient was found to have an abdominal-pelvic mass measuring about 32 cm from the symphysis pubis; the patient underwent abdominopelvic ultrasound, which was inconclusive. Therefore, a diagnosis was made after doing an abdominal-pelvic CT scan.

She thereafter underwent open laparotomy, whereby left salpingoophorectomy was done. The ovarian mass, which weighed 10.3 kg, was removed. The biopsy was sent for histopathology at the National Tumor Pathology Center at Ocean Road Cancer Institute. Histopathology results were a benign ovarian cystadenoma of mucinous type with calcifications.

Conclusion:

Abdominal and pelvic mass has several differential diagnoses which can be either gynecologic or non-gynecologic. Giant cysts of ovary are rare and lack distinctive clinical features; therefore, they pose difficulties in making an accurate diagnosis. Thorough history taking, physical examination and radiological evaluation for all women with unspecific symptoms and signs are essential for early diagnosis.

Keywords: pelvic mass; ovarian cyst; giant ovarian cyst

Introduction

A fluid-filled sac within ovarian tissue that is 5 cm or larger in diameter is known as ovarian cyst [1]. Ovarian cysts can occur at any age, but they commonly occur during adolescence. This period represents the time in which women are hormonally at peak due to increased endogenous hormone production [2,3]. Majority of ovarian cysts are benign and most are functional; therefore, they can resolve without medical or surgical treatment. Ovarian cysts after reproductive years can alert an underlying malignant process [1,4].

A cyst of greater than 10cm in diameter within the ovarian tissue during radiological evaluation or when the size goes beyond the umbilicus on physical examination is known as a giant ovarian cyst. Large ovarian cysts are rare to encounter [1,2]. This is because most ovarian cysts are diagnosed early due to the improvement of diagnostic radiological investigations [3,4].

A giant cysts of ovary usually does not have distinctive clinical features; therefore can turn clinician concentration away from other dangerous gynecological and non-gynecologic differential diagnosis of pelvic mass [5,6].

Case report

A 75-year-old woman, Parity 8, Living 5, 20 years post-menopausal, whose last child was 30 years ago, presented with abdominal swelling for 10 years. Abdominal swelling was of gradual onset increase in size with time, which was later accompanied by pelvic heaviness.

She reported having difficulties standing and walking, which started a year ago, and she spends most of her time sitting and needs support while walking. For the past 2 weeks before seeking care to our facility. She presented with difficulties in breathing, more marked during walking.

She occasionally had constipation, but no vomiting or diarrhea. She also reported having abdominal pain, dull aching with a visual analog score of 5. She is a nonsmoker, nonalcoholic.

She was managed as a patient with impression of postmenopausal syndrome, joint disease and ascites without improvement, including attending to traditional medicine before; she sought care at our facility.

On examination, the patient was fully conscious (GCS E4M5V6), afebrile, not jaundiced, not pale, no lower limb edema.

Vital signs were BP- was 138/80 mmhg, RR- 20 cycles per minute, HR-89 beats/minute, regular; axillar temperature 37c; and saturation of oxygen was 98% on room air. The patient's body weight was 78 kg, and height was 160cm; her BMI was 30.5 kg/m².

Per abdominal examination showed a distended abdomen with a pelvic mass extending to abdomen with mixed consistency (firm and cystic), nontender measuring about 32 cm from the symphysis pubis. No remarkable findings on other system (figure1).



Figure 1: Showing distended abdomen with abdominopelvic mass

Complete blood count showed: Hb- 12 g/dl (Normal), Platelet -250/Ul (Normal), serum creatinine was 117 mg/dl(normal), CA 125 was 50 U/ml (mildly elevated), AST, ALT were normal, ECHO, ECG had normal findings. Potassium, sodium, and chloride levels were within normal range.

Abdominal -pelvic USS was done, showing features suggestive of a huge adnexa complex mass with differentials of cystadenoma/cystic adenocarcinoma. There was a limitation to view the whole mass; therefore, a Computed tomography (CT) evaluation was recommended. Abdominal-pelvic CT was done, showing a huge multicystic lesion with thick septations

and low internal echoes occupying the pelvis extending to the abdomen (24.5cm X 22cm X 20cm).

The patient had a diagnosis of a huge ovarian complex cyst, and she the patient underwent left salpingo-oophorectomy. The ovarian tumor was removed successfully with no intraoperative or postoperative complications (Figure 2). Follow-up was done for 6 months of after operation of which all of her preoperative complain was resolved and patient was able to stand, walk, and do her daily activities.

Histopathological assessment results showed benign mucinous cystadenoma (Figure 3).

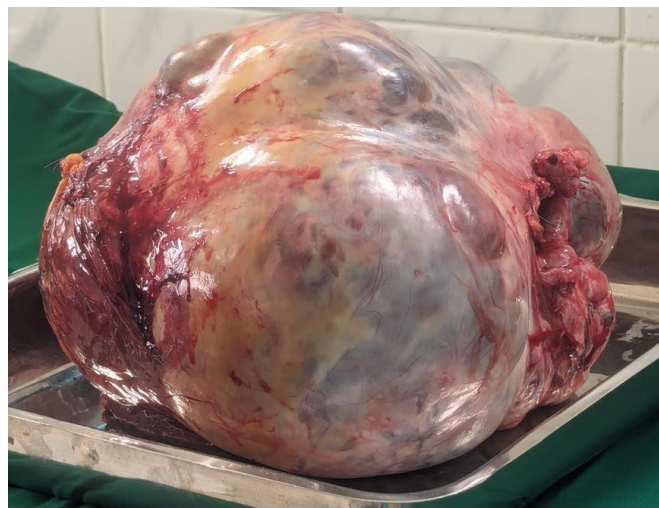


Figure 2: Removed ovarian mass

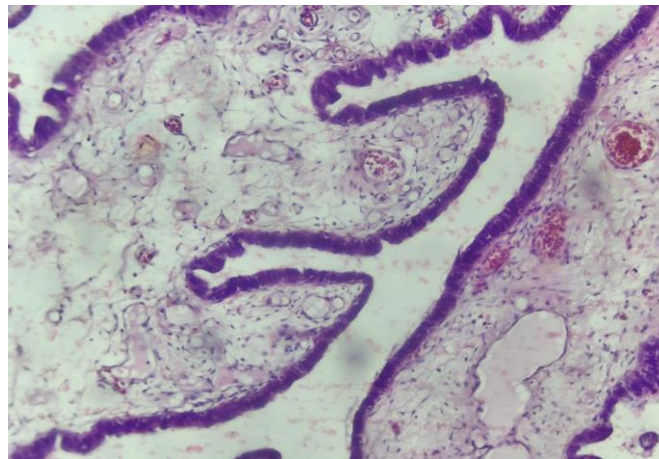


Figure 3: Histopathology section of the removed mass showing mucinous adenoma with calcifications.; H&E staining at 10 x original magnification.

Discussion

We therefore reported, a 75-year-old woman, a 20 years post-menopausal who presented with a giant ovarian cyst which was of mucinous type on histopathological assessment. Large cysts of the ovary are rare and pose difficulties in making a diagnosis and management [7,8]. Ovarian cysts can occur in both pre- and post-menopausal women. However, they are commonly in premenopausal women (20 to 40 years) particularly during adolescence, as this period represents a hormone-active phase of a woman's life [3,7,9].

Prevalence of ovarian cyst is between 3.8%–31.3 percent. Their rate of occurrence raise with age and peaked during adolescence, and decreased thereafter [2]. The peak rate is about 31.3 percent, which occurs at the age of 15 years. Studies have shown that in post-menopausal women, the prevalence is between 5 to 17% [1,4].

Most ovarian cysts have no symptoms and are incidentally diagnosed during radiological examination. Giant ovarian cysts that are rare and might cause discomfort and other pressure symptoms [5,10].

Symptoms and signs of ovarian tumor may involve: abdominal swelling or distension, pain, and menstrual disorders. Other symptom and signs that may occur are due to compression effects, depending on the size of the cyst. Compression of the ureteral tract may cause frequent micturition and retention of urine, which can later result in uronephrosis. The rectum might be compressed, which can lead to constipation and difficult defecation. Other symptoms, like difficulty breathing, and signs of ovarian torsion require emergency assessment and management [1,4,11].

The majority of the worst complications of giant ovarian cysts are associated with surgical care, which includes intestinal malfunction, low blood pressure, shock, cardiac failure, and pulmonary failure [7,9].

Most of the mucinous ovarian tumors are benign mucinous cystadenomas in 85 of 100 cases. These tumors have the potential to develop to a large size. They are often multi cystic tumors composed of fluid and mucus [7,12].

Our patient was a 75-years old post-menopausal woman who presented with abdominal swelling of gradual onset and increase in size with time, which was accompanied by abdominal discomfort and pelvic heaviness. She had clinical features suggestive of compression of adjacent organs, including constipation, and reduced ability to stand and walk due to pressure on venous, lymphatic vessels, and nerve.

On the onset of these symptoms, the patient was attended to at a nearby primary health care where she was repeatedly diagnosed and managed as a patient with postmenopausal syndrome and joint disease.

She thereafter chose to attend to alternative traditional medicine without improvement until she sought care at our facility. She never had a radiological examination before seeking care to our facility. Her relatives brought her to our center after she presented difficult to stand and walk and shortness of breath, more marked during walking, which were not improving with medication. Cultural, social and economic factors were some of the factors that caused our patient to have a late evaluation and definitive management.

Ultrasound is the primary and main radiological examination used for diagnosis. It has an accuracy of about 90% of cases, but it is operator dependent [3,13]. Transvaginal ultrasound has better results over trans abdominal when making radiological diagnosis. However, in some cases, results may be inconclusive, and therefore other investigations may be needed to support the diagnosis, such as tumor markers like CA-125, and radiological evaluation like CT scan), or MRI (magnetic resonance imaging scan)[7,11]. This patient had an ultrasound evaluation, where as an pelvic and abdominal ultrasound were done, followed by a Transvaginal ultrasonography which showed an complex abdominal pelvic mass ,but they had limited view to examine the origin and margin of the whole mass, and therefore, a CT scan was suggested , to be performed to examine further this mass[4,14].

A cyst is benign if it has at least one of benign ultrasonography feature known as b-feature is present which include the cyst is single and unilocular, there is presence of solid components but the largest component is less than 7 mm, there is presence of acoustic shadowing, there is smooth multilocular tumor but the largest diameter less than 100 mm and no blood flow is present, and if there is no ultrasound features of malignancy [3,12,13]. Pelvic and abdominal ultrasonography of our patient was inconclusive and CT scan revealed a huge multi-septated and multi-lobulated cyst (24.5 Cm × 22cm × 20.0 cm), oval-shaped with calcifications occupying the pelvis and extending to the abdominal cavity. In complex, multiloculated cysts, the chance of malignancy raises to 36%. Blood tests should be done to evaluate the likelihood of malignancy. This includes blood tests such as CA-125, LDH, alpha-fetoprotein, and hCG[13,15].

Ultrasound features have high sensitivity and likelihood ratio in estimating the risk of malignancy, even without ca-125 [3,9]. Malignant ovarian cysts make for over 10% of all giant ovarian cysts, and their signs and symptoms, especially in the early stages of the disease, may be vague and non-specific,

which calls for the exclusion of this likelihood in all cases of ovarian cysts [1,11].

The surgical treatment of ovarian cyst must take into account to various factors. The approach is dictated by cyst size, the availability of equipment, and the surgeon skills, and whether the operative goal is to preserve fertility or eliminate the disease in the patient[3,9,13]. Aspiration of the contents of the cyst is not recommended because of complications such as infection, hemorrhage, cyst rupture, and a higher risk of peritoneal adhesion. Vacuum shock is one of rare and dangerous early complication when removing a giant ovarian cyst and it should be prevented by requires a adequate vascular filling [4,8,16].

Open surgery is commonly done for most giant ovarian cysts. Laparoscopy

may also be a option for diagnostic purposes, but in some cases, decompression of the cyst can be done followed by therapeutic removal [9,14]. Laparoscopy can help in the evaluation of the differential diagnoses between ovarian mass and other intra-abdominal tumors, particularly if there is difficult in determining the organ of origin of the mass. In addition, procedure can be changed to an open laparotomy if the need arises. However, laparoscopic surgery in giant ovarian cysts can carry a

likelihood of internal organ injury and perforation during insertion of the trocar[7,17]. In our case, open surgery was done and patient underwent left salpingo-oophorectomy, with no intra-operative and postoperative complications. Follow-up was done for 6 months' post-surgery. All her preoperative complains were resolved and the patient was able to stand and walk and resume her daily activities.

S/N	Author/Year	Age of patient	Imaging results	Procedure done	Histopathology	Country /Citation
1.	Saeed Baradwan (2017)	27	Abdominopelvic CT scan showed a large well-defined cystic lesion originating from the right ovary measuring 15.6 × 26.3 × 31.7 cm.	Lapascop surgery	cystadenoma Serous type	Saudi Arabia (14)
2.	Eugene vernuy yeika (2017)	65	Abdominal ultrasound showed a large multilocular fluid containing sac within right ovary	Laparotomy, cystectomy. The cyst weighed 10.8 kg.	Cystadenoma Mucinous type	Cameroon (16)
3.	Sibraogo kiemtoré (2019)	25	CT scan of the abdomen and pelvis revealed a unilateral cystic mass measuring >10 cm.	Laparotomy, left total oophorectomy. Cyst weight 19.7 kg	Serous cystadenoma	Burkina Faso (5)
4.	Banwari lal bairwal (2020)	16	Abdominal computed tomography (CT) scan revealed a large, multilocal cystic mass measuring 24.3 × 21.5 × 20.2 cm.	Laparotomy, a right adnexectomy	Mucinous cystadenoma	India (10)
5.	Cipta pramana (2021)	40	Abdominal CT scan showed showing a well-defined multilocular cystic mass with regular margins measuring (16 cm× 11.94 cm×19.48 cm).	Laparotomy, a left salpingo-oophorectomy	Mucinous cystadenoma	Indonesia (18)
6.	Cipta pramana (2022)	20	CT scan of abdomen showed a giant septal and lobulated cyst (30.7cm×30.72cm×31.67cm),	Laparotomy, a left salpingo oophorectomy	Mucinous cystadenoma	Indonesia (4)
	John Lugata (2024)	67	CT scan showed huge septated cystic lesion occupying abdominal and pelvic cavities causing mass effect measuring 35.6 cm × 34.8 cm × 32 cm.	Laparotomy, hysterectomy and bilateral salpingoophrectomy.	Mucinous borderline ovarian tumor	Tanzania (11)

Table 1: Case report summary of literature reviewed.

Conclusion

We reported a case of giant ovarian mucinous cystadenoma in a 75 -year-old postmenopausal woman. She presented with abdominal distension, pain, constipation, a reduced ability to stand and walk, and difficulty breathing, which mimicry the impression of postmenopausal syndrome, joint disease and ascites.

Giant ovarian cysts in postmenopausal woman are not common and lack distinctive feature. It therefore poses difficulties in diagnosis and management. Careful history taking, physical examination and radiological evaluation for all women with ambiguous and unspecific symptoms is essential for early diagnosis.

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