

Rare presentation of serous cystadenoma as hemorrhagic cyst

Abstract

Benign ovarian cysts are one of the most common gynecological conditions occurring in the adolescent and reproductive age group. While Serous Cystadenoma is the most common of them all, they rarely grow to large sizes unless. Thus in case of large ovarian cysts, a high index of suspicion must be kept to rule out malignancy. We report a case of a 35 year old multiparous woman who came to us with an abdominal lump arising from the pelvis equivalent to 28 weeks uterus.¹ The patient was taken for exploratory laparotomy and excision of 20x18x15 cm grayish haemorrhagic right sided cyst along with right salpingoophorectomy was done. Frozen section and later on histopathology confirmed the diagnosis of a serous cystadenoma.

Keywords: cystadenomas, salpingoophorectomy, serous, cyst.

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Introduction

Serous cystadenomas constitute about 40% of all ovarian tumours occurring in the reproductive age group. These tumours may be malignant in 40% of the cases. When they do occur, patients usually present with abdominal pain, menstrual disturbances, or at times bladder or bowel pressure symptoms.² Serous cysts rarely grow to large sizes, but if they do, a high index of suspicion must be kept for cystadenocarcinoma. Thus presentation as an abdomen-pelvic mass is very rare.

Case report

A 35 year old, Para 2, Living 2 female, married since 12 years, not tubectomised, came with complains of pain in abdomen and lump in abdomen since 5 days with a ultrasonography report suggestive of a right complex ovarian cyst. She had no menstrual complains and her last menstrual period was 5 days back. Patient had previous two full term Caesarean deliveries, her last childbirth being years back. Patient had history of pulmonary Koch's 7 years back for which she had taken treatment for 6 months. She had no other major medical or surgical illness in the past or had any significant family history. Patient was admitted and thorough examination and investigations were done. Patient was vitally stable and systemic examination was within normal limits. On abdominal examination, there was a mass arising from the pelvis measuring 24x22 cm and equivalent to 26-28 weeks gestation which was cystic in consistency and mobile from side to side. Scar of her previous LSCS was seen. On speculum examination her vagina and cervix was healthy, and vaginal examination revealed a cystic mass equivalent to a 26 weeks uterus arising from the pelvis occupying the right fornix not felt separately from the uterus. The overlying mucosa was free and there was no tenderness in the fornices. Laboratory investigations revealed Haemoglobin of 12.5gm% and Blood group was B positive. Tumour markers were sent and were within normal limits; CA125-13.1U (0-35), AFP-3.7I U (0.5-5.5), CEA-1.5ng/ml (0-2.5). CT scan was done which was suggestive of a right ovarian cystadenoma 10.5x12.8x14.7cm with no internal echoes or septations. There was also a left simple ovarian cyst 4.5x4.1cm with no involvement of pelvic lymphnodes. Uterus and other organs were within normal limits Patient was taken for exploratory

laparotomy for cyst excision with provision for frozen section kept ready. Intraoperatively, there was a large grayish haemorrhagic mass approximately 20x18x15 cm densely adhered to the right ovary and the right fallopian tube was stretched over the mass antero-superiorly which had undergone torsion (Figures 1 & 2). The left sided fallopian tube and ovary as well as the uterus appeared normal. Right salpingoophorectomy with excision of the cyst was done and specimen was sent for frozen section which revealed the mass to be of benign nature most likely to be a serous cystadenoma (Figure 3). Thus, no further exploration was done and the abdomen was closed Post operatively the patient was managed on i.v. antibiotics and analgesics and discharged on day 7 of surgery. Histopathology confirmed the diagnosis of serous cystadenoma of the right ovary (Figure 4).

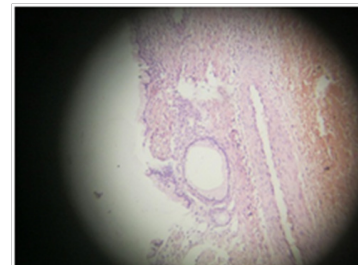


Figure 1 Microscopic cut section of serous cystadenoma with haemorrhage.

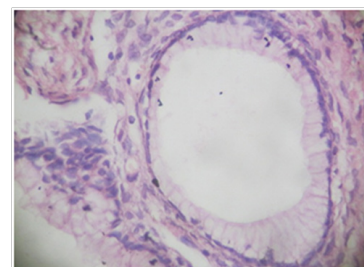


Figure 2 Microscopic cut section of serous cystadenoma of ovary with evidence of haemorrhage.



Figure 3 Inflamed fallopian tube haemorrhagic cyst.



Figure 4 Haemorrhagic cyst of ovary with FT.

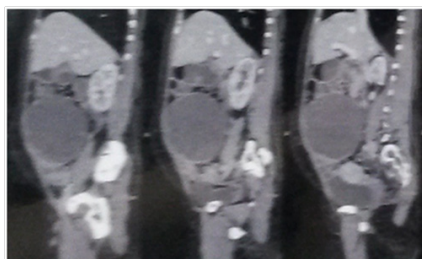


Figure 5 Computed Tomography of serous cystadenoma of ovary.

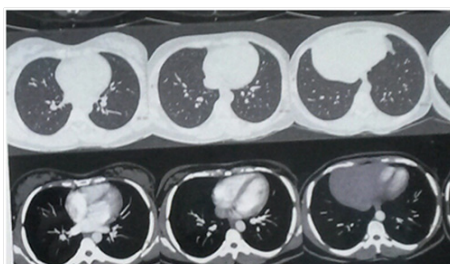


Figure 6 Computed tomography of serous.

Discussion

Surface epithelial stromal tumors, the most common neoplasms of the ovary, encompass five distinct subtypes, namely, serous, mucinous, endometrioid, clear cell and transitional cell along with combination of these types tumors with serous differentiation represent 46% of all surface epithelial stromal ovarian neoplasms of which 50% are benign serous tumors.³ These are usually cystic and tend to have thin walls and lack solid areas. A few papillary excrescences may be present. Serous tumor with a solid, fibrous component is designated as serous cystadenofibroma in which both components are closely intermixed.

In our case the patient presented with severe pain in abdomen with vomiting. Exploratory laprotomy was done. In situ findings were suggestive of huge ovarian mass with torsion with evidence of hemorrhages.

Ovarian torsion accounts for about 3% of gynecologic emergencies. Risk factors include increased length of the ovarian ligaments, pathologically enlarged ovaries (more than 6 cm), tumors, enlarged corpus luteum in pregnancy, and jerky movements. Torsion of the ovary usually occurs with torsion of the fallopian tube as well on their shared vascular pedicle around the broad ligament, although in rare cases the ovary rotates around the mesovarium or the fallopian tube rotates around the mesosalpinx.⁴

Ovarian torsion is twisting of ovary alone or more often along with its salpinx. This twisting initially decreases its venous drainage. This results in increased pressure which on exceeding the arterial pressure will cause necrosis and infarction of the ovary by interrupting the arterial flow. Asymmetrical enlargement of the ovary occurs due to the cyst resulting in a weight imbalance causing the ovary to topple over. This twists its pedicle along the long axis of its salpinx. Ovarian cysts with sizes ranging from 6 to 8 cm have the highest chances of undergoing torsion. However, in our patient a tumor with a diameter of 20 cm rotated on its axis. Our patient had all the typical presentation of an ovarian torsion. She had sudden onset of severe, sharp stabbing, and unilateral lower abdominal pain worsening intermittently over many hours. She had nausea and vomiting. She had history of repeated episode.⁵

Of abdominal pain that can be attributed to torsion. Temperature was also seen. CT and magnetic resonance imaging and colour Doppler are investigation done to diagnose torsion (Figures 5 & 6). Our patient had undergone an exploratory laparotomy for the cyst diagnosed. In situ findings were suggestive of huge ovarian cyst with torsion with hemorrhagic lesions associated with it. It was a rare finding of ovarian serous cystadenoma with hemorrhage.

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Conflicts of interest

The authors declare there is no conflict of interests.

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