



Case Report

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**Giant abdominal mass originating from the ovary.**

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**ABSTRACT**

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Adnexial masses are commonly seen in gynecologic practice. Distinguishing malign from benign masses should be done for these patients. Mucinous cystadenoma is among the most common benign ovarian neoplasms. It may grow to an enormous size. Here, we report a case of mucinous cystadenoma originating from the right ovary in a 57-year-old woman.

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**1. Introduction**

In women, adnexial mass is a common gynecologic problem. Differential diagnosis is the principal goal of the evaluation of an adnexial mass. For women with a suspicious mass after an initial evaluation, surgical exploration is required. There is no noninvasive techniques for the diagnosis of ovarian cancer (Buys SS, 2005). The most important finding used to determine the presence of malignancy in an adnexial mass is the appearance of the mass by transvaginal ultrasound. Many adnexial masses are asymptomatic and it is discovered as an incidental finding on pelvic imaging. (Myers, 2006). The degree of clinical suspicion of ovarian cancer is significantly higher for postmenopausal compared to premenopausal women; therefore, surgical exploration may be required for many postmenopausal women. The incidence of ovarian cancer increases with age (seer.cancer.gov, 2012).

Size of the mass is an important factor. Surgical exploration is essential for postmenopausal women with a  $\geq 5$  cm mass who also have symptoms suggestive of ovarian cancer (Curtin JP. 1994). Other factors for ovarian cancer, such as menopausal status, elevated tumor marker, symptoms, or risk factors may increase the degree of suspicion. CA 125 is a tumor marker used most commonly for the detection of

epithelial ovarian cancer (CA 125 >35) (Im SS, 2005). referral to a gynecologic oncologist is advised for masses that are highly suspicious for ovarian cancer. Long term Survival in patients with early stage disease, could be possible if an optimal staging could be performed by the surgeon. (ACOG, 2011).

We present a case of delayed development of aggressive, treatment-resistant abdominal mass with unusual gross features.

**2. Case Report**

A 57-year-old woman was admitted to the hospital. The woman was, gravida 6, abortus 0, and parity 6. She had a long-standing history of constipation, and pelvic pain. She was treated with nonsteroidal anti-inflammatory drugs which were ineffective. On pelvic examination her uterus was found to be slightly enlarged. Abdominal examination showed a mass with 200x200 mm in diameters. The rest of her physical examination was unremarkable. Laboratory data revealed white blood cell count as 9700, hemoglobin as 11.4, hematocrit as 33.6, and platelets as 221.000. Serum CA 125 level was elevated (CA-125; 132 IU). Chemistry profile and other serum tumor markers was unremarkable.

BUN, creatinine, and blood sugar were normal. Liver profile was unremarkable. Serum FSH (Follicle stimulating hormone) and LH (Luteinizing hormone) concentrations were increased. (FSH: 30 mIU and LH: 20 mIU) No evidence of gastrointestinal pathology (Intestinal mucinous tumors, etc.) was detected by colonoscopy.

Ultrasonography showed a gross mass arising from the right adnex filling the abdomen. The diameters were 200\*220 mm. Pelvic ultrasound showed the presence of a large solid, rather than cystic, mass with normal endometrial lining. The gross appearance revealed cystic areas. Blood flow was displayed by color Doppler in mass. It was hypervascular at color Power Doppler evaluation. In computed tomography imaging, right adnexial mass with a maximum diameter of 200\*200 mm was detected (cystic right ovarian mass). It was solid with rare cystic spaces. The cyst wall was 2–15 mm in diameters.



**Fig. 1.** The computed tomography imaging showing the mass (Transverse diameter of the mass was 205 mm).



**Fig. 2.** The operation image of the right ovarian mucinous cystadenom. Bunun yirine patolojiye giden hali konulabilir

Midline incision reaching up to xiphoid process in laparotomy was done. The mass was diagnosed in frozen as a right ovarian mucinous cystadenom. Hysterectomy was performed due to symptomatic

uterine adnexial mass. Being a mother at 48 years with menopause, bilateral salpingo-oophorectomy was added to the surgery. Total abdominal hysterectomy with bilateral salpingo-oophorectomy was done. Intraoperative evaluation revealed a mass measuring 210\*240 mm in diameters originating from the right over. (Fig. 2). Uterus, appendix and left over were normal in appearance.

Histopathological examination of hysterectomy specimen revealed a mass measuring 210x240x250 mm attached to the right ovarian. Cut section of the mass showed compatible with mucinous cyst adenoma according to microscopic examination. Evaluation for uterus and left ovary was unremarkable.

### 3. Discussion

The degree of clinical suspicion of ovarian cancer is increased for postmenopausal in comparison to premenopausal women. Therefore, surgical exploration is required for many postmenopausal women with an ovarian mass. Size of the mass must also be considered who proceed to surgical exploration for women with a 5 to 10 cm mass with symptoms suggestive of ovarian cancer (Roman LD, 1997). CA 125 is the tumor marker used most commonly for ovarian cancer. Other serum markers are used to evaluate women for less common histologic types, germ cell and sex cord-stromal tumors. Ovarian mucinous carcinoma generally do not express CA125. (Vang R, 2007)

When all types of mucinous neoplasms are taken into consideration, they account for 10 to 15 percent of all ovarian neoplasms. Approximately 80 percent are benign mucinous cystadenomas. In addition the majority of the rest are (20 percent) mucinous borderline neoplasms (Hart WR, 2005). In addition to this, most mucinous carcinomas originate frequently from the gastrointestinal tract (the most common appendix). The ovarian masses are metastases from these sites (Riopel MA, 1999). Mucinous cystadenomas are among the most common benign ovarian neoplasms. Malignant mucinous tumors may be bilateral in 10% to 20% of cases, benign tumors are rarely bilateral Mucinous cystadenomas occur less frequently which are more likely to be multiloculated, and larger (they can grow to an enormous size). Clinically, mucinous tumors may grow quite large, reaching 30 cm in size and weighing as much as 40 kg (Ozols, 2005). In the differential diagnosis; Other ovarian masses, fallopian tubal cancer, ectopic pregnancy, hydrosalpinx, tuboovarian abscess, paratubal or paraovarian cyst, broad ligament leiomyoma, should always be excluded (Guerriero S, 2002).

Ovarian cysts may cause pain or pressure symptoms. Women who present with acute pain and an ovarian mass should be evaluated without delay and may require urgent intervention. The first step in the evaluation of an adnexal mass is to confirm the presence and anatomic location of the mass with pelvic imaging, usually with ultrasound. Sensitivity of pelvic ultrasound for the diagnosis of ovarian cancer ranges to 86 percent and the specificity ranges to 68 percent in a large meta-analysis (Myers ER, 2006)

In a randomized trial, among 570 women who underwent surgical evaluation for suspected ovarian cancer, 20 cases of malignancy were found. If malignancy is suspected based upon these factors, surgical exploration is required to obtain a specimen for histologic diagnosis. Many women undergo surgical procedures to identify the rare cases of malignancy

who have large adnexial masses (SS, 2005) The objective of this report is to identify distinct features of a giant adnexial mass in a woman. In older patients with giant adnexial mass, laparotomy should be performed. A definitive diagnosis of

ovarian mucinous cystadenom can only be made from histological examination of laparotomy specimens.

Declaration of interest: The authors report no conflicts of interest.

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