

## Giant Ovarian Cyst Adenoma in a Postmenopausal Woman: A Case Report with Literature review

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### Abstract

Giant ovarian cysts are benign in most cases and histopathologically they are either serous or mucinous. A case of large ovarian cyst (20 × 18 × 10cm) is reported here. She presented at our OPD clinic with complaints of gradual distension of abdomen and a palpable mass for 6 months. At laparotomy a giant, cystic, smooth, vascularized mass adherent with fallopian tube was encountered. Considering age and premenopausal status we performed Total Abdominal Hysterectomy with Bilateral Salphingo-oophorectomy. Histopathology revealed serous cystadenoma of ovary. Post-operative recovery was excellent and patient was discharged at 5th post-operative day in a good health status.

**Keywords:** Serous cystadenoma; Bilateral salphingo-oophorectomy; Tumour marker

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### Introduction

With the advantage of routine Imaging modalities Giant (>10 cm) ovarian cyst has become rare now [1-3]. Among the serous tumours cystadenoma, adenofibroma, and surface papillomas are the benign serous tumours. These occur in about 25% of all benign and 58% of all ovarian serous tumours [2]. Serous tumours are common during reproductive periods and 50% occurs before the age of 40. The chance of malignancy is only 7%-13% in premenopausal and 8%-45% in postmenopausal women [3,4]. Serous cystadenoma is cystic in nature containing serous fluid and cystic component. In previous studies large/giant ovarian cysts were described as cysts measuring more than 10 cm size in diameter in radiological scan or clinically above the level of umbilicus [5-10].

### Case Report

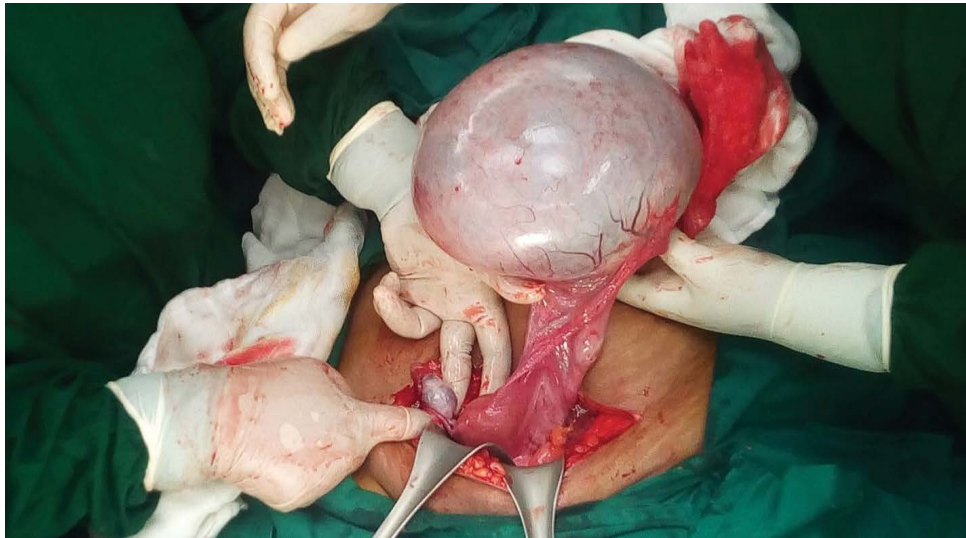
A 52 years postmenopausal women P3 ALB 12 years came for OPD consultation with complaints of gradually increasing abdominal mass for last 6 months. She had no history of weight loss, anorexia, nausea, vomiting. Her bowel and bladder habit was normal. Her menstrual cycle was regular. She had no major medical disorders or surgical interference before. She had no Family history of ovarian malignancies.

On general examination it was observed that her body built and nutritional status was average, weighing 60 kg, vital parameters within normal limit. Abdominal examination revealed a large mass extending beyond the umbilicus corresponding with 28 weeks of

gravid uterus. The mass was mobile, smooth surfaced, firm to hard in consistency, slightly tender on palpation. On per vaginal examination cervix found normal, both fornices were full. Laboratory tests were unremarkable. Tumour markers were within normal limit CA-125:16 U/ml, LDH 179 u/L. Paps smear showed no evidence of malignancy. Ultrasonography revealed uterus was normal in size with endometrial thickness 6 mm. Large left ovarian cyst was seen (14 cm × 10 cm × 10 cm, L × T × AP) which was bilocular, smooth walled with clear anechoic contents. The calculated RMI (Risk of Malignancy Index) was  $1 \times 3 \times 16 = 48$ .

Considering age and postmenopausal status we planned for Total Abdominal Hysterectomy with Bilateral Salphingo-oophorectomy. Abdomen was opened by transverse incision. Intraoperative left ovarian (20 cm × 14 cm × 10 cm) sized mass seen. Left Fallopian tube was adherent and stretched over the cyst (**Figure 1**). No healthy ovarian tissue seen. Right fallopian tube, ovary, uterus found healthy. Intraoperative complications and blood loss was minimum.

On histopathology examination cyst was bilocular with smooth thin walled lined by single layer of flattened epithelium. The cyst was filled with clear serous fluid. No malignant cells were seen. Her post-operative period was uneventful. Early ambulation and oral feeding started. Patient was discharged in 5<sup>th</sup> post-operative day in a sound health status.



**Figure 1** Left ovarian tumor (20 cm × 14 cm × 10 cm), fallopian tube is stretched on.

**Table 1** Giant ovarian tumours: Literature review.

Study Year	Age of Patient	Common Symptoms	Site of Tumors	Size	Tumour Marker	Operation Done	Histopathology Report
2011 (Dey M, et al. [4])	28	Gradual swelling of abdomen 6 m	Right ovary	20 cm × 19 cm	51.2 iu/ml	Rt salphingo-ophorectomy	Papillary cystadenoma
2018 (Fatema N, et al. [5])	57	Palpable pelvic mass for 6 m	Left ovary	43 cm × 15 cm × 9 cm	36 iu/ml	TAH+BSO	Benign serous cystadenoma
2005 (Mulayim B, et al. [8])	36	Large abdominal mass	Right ovary	35 cm × 20 cm × 16 cm	.....	Ophorectomy	Serous cystadenoma
2013 (Madhu YC, et al. [9])	55	Abdominal distension for 13 yrs	Left ovary	50 cm × 39 cm × 47 cm	.....	TAH+BSO	Mucinous cyst adenoma
2019 (Bhadoria S [10])	58	Gradual distension of abdomen for 3 months	Right ovary	32 cm × 26 cm × 24 cm	.....	TAH+Rt sided cystectomy +left sided salphingo-ophprectomy	Benign serous cystadenoma

## Discussion and Conclusion

Serous tumors secrete serous fluid and are originated by the invagination of surface epithelium of ovary. Serous tumors are commonly benign and (70%); 5%-10% have borderline malignant potential; and 20%-25% are malignant [3]. Only 10% cases of serous tumors are bilateral [4]. To distinguish between benign, borderline malignant and malignant serous tumors frozen section is necessary because this distinction cannot be made on gross examination. In some previous studies they mentioned that patient had some significant complaints besides a palpable lump (**Table 1**). In this context our patient had no such complaints. In another study Madhu YC, et al. [9] menstrual history was regular as in our case. Size of the tumor was variable in different studies. Sujatha VV, et al. [2] described the maximum size (60 cm × 47 cm × 30 cm). CA -125 was normal in limit in most of the cases.

For diagnosing ovarian tumors Pelvic ultrasonography, Computed Tomography (CT), Magnetic Resonance Imaging (MRI) and Tumor marker CA-125 are most helpful diagnostic tool. Besides RMI (Risk of Malignancy Index) is done to exclude malignancy. RMI scoring system is described as Ultrasonography characteristics with Menopausal status and CA-125 value in an attempt to predict the risk of malignancy of ovarian mass [6].

**Total score:** USG score × menopausal score × CA-125 (u/ML).

**USG score:** 0 no risk factors, 1 one risk factor, 3 2-5 risk factors.

**High risk factors in USG:** Multiloculated, solid, bilateral, ascites, evidence of metastasis.

**Menopausal status:** 1 premenopausal, 3 postmenopausal.

**Score >200:** High risk for malignancy (Risk of malignancy is 42 times).

Excision of large ovarian cyst in women of reproductive age may damage ovarian reserve. In a literature review the authors mentioned the role of bilateral cystectomy compared to unilateral [7].

In case of large ovarian tumor many intraoperative complications reported like sudden hypotension due to decreased venous return, pulmonary edema due to sudden re-expansion of chronically collapsed lung, venous pooling after sudden removal of intra-abdominal mass [1,3]. To avoid these unwanted complications and for proper management of these types of cases multidisciplinary approach is appreciated.

## Conflicts of Interest

The authors declare that they have no conflicts of interest.

## Consent

Written informed consent was obtained from the patient for publication of this case report.

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