RETROPERITONEAL GROWTH SIMULATING OVARIAN TUMOUR

(A Case Report)

by

NIRMAL SEN,* M.B.B.S., D.G.O., M.R.C.O.G.,

PRANATI SINHA,** M.B.B.S.

and

SREEMANTO KUMAR BANERJEE,*** M.O., F.R.C.O.G., Ph.D. (Lond.)

We cannot do better than allow ourselves to be guided by the Cartesian axiom, that we are not bound to accept—indeed, that we are properly bound not to accept—a preposition that is not perfectly clear and distinct "—Nicholson (1935). On one hand is a huge, nodular, lower abdominal tumour with shallow fornices, and on the other non-approachability of the tumour from below, with no definite shifting dullness and radiological enlargement of the stomach leads", not to the perfectly clear and distinct diagnosis of a malignant ovarian tumour, but for some retroperitoneal growth:

Retroperitoneal solid growths may, however, be either lipoma, fibroma, fibromyoma, neuroblastoma, ganglioneuromata, a primary lymphosarcoma or secondary to carcinoma of kidney, or suprarenal. Teratoma, as Nicholson (1934) has pointed out—"a foetus without human form; a body without regions; organs without system, shapes and proportions; impossible absence of some unnatural multiplication of others—in short a light, because it does not shine"—is rather unusual in this case.

We are presenting here an interesting case of retroperitoneal tumour, a fibromyoma of the mesenteric tissue detected histopathologically.

*Ex-Registrar.

**Ex-Senior House Surgeon.

***Reader.

Eden Hospital, Medical College, Calcutta.

Received for publication on 7-12-72.

Case Report

Mrs. G. D., 48 years. Para 4 + 0, last childbirth 12 years, a Hindu housewife of a lower middle class family, was admitted in Eden Hospital in October 1969 with complaints of (a) swelling and occasional pain in the abdomen for 1 year, (b) anorexia and weakness for 1 month.

Menstrual History: Menarche 11 years. Previous cycles — 30 ± 2 days, duration 5-6 days. Menopause 5 years.

Obstetrical History: Para 4 + 0. All terms normal deliveries with uneventful puerperium.

Past History and Family History: Nothing suggestive.

On Examination: The patient had poor general health with anaemia. Pulse 80/min. Respiration 20/min., regular. Blood pressure 120/70 mm. Hg. No other abnormality detected in any other system.

Abdominal Examination: Abdomen was enlarged, more so on the left side. Umbilicus normal. No visible veins or peristalsis or pulsations seen. Skin-healthy. No tenderness, no parietal oedema. The lump occupied the whole abdomen. It did not move with respiration. It was firm and nodular with right and lower borders well defined. Shifting dullness was negative. The lump was dull on percussion and silent on auscultation.

Per Vaginam: Uterus anteverted mobile, small. Lump felt through all fornices.

Routine Investigations: Blood, Hb. 9 gm%. total count 6,500/cmm, (poly 68%.

lympho 30%, eosino 2%) Blood sugar, 78 mg%. Blood urea, 24 mg%, ESR 16 mm. (1 hour), bleeding time 2 min, clotting time 3 minutes. **Urine.** nil abnormal. Chest X-ray revealed no abnormality. I.V.P. Normal functioning kidneys. Barium meal X-ray of stomach showed no abnormality, except enlargement of the stomach.

Management: With the provisional diagnosis of malignant ovarian tumour, laparotomy was done under gas and oxygen anaesthesia. The huge tumour completely obliterated the pelvic cavity. There were multiple big venous channels across the tumour. The tumour had nodular excresences. more marked in the left hypochondrium, left iliac fossa and the umbilical region. Careful dissection was carried out starting from the left iliac fossa and proceeding to the right. A plain of clevage could be made between the tumour and the body of the uterus which was found to be normal. Further exploration was abandoned at this stage due to sudden marked fall of blood pressure and the abdomen had to be closed hurriedly after taking biopsy from the tumour. The biopsy report was fibromyoma.

Investigation done after 4 weeks. Hb. 10 G%, total count 6000/cmm. poly 58%, lympho 40%, eosino 2%. E.C.G. Normal.

Abdomen was again opened under gas and oxygen anaesthesia through an adequate paramedian incision. The plain of clevage was difficult to identify. The greater omentum could be made out at its attachment to the transverse colon and a nick was made on the posterior wall. Through that opening meticulous dissection was carried out with fingers and scissors. The anterior wall of the stomach was found to be adherent to the posterior wall of the tumour. By careful dissection the entire tumour was separated, enucleated and removed. The uterus was removed along with its appendages. Haemostasis was ensured. The anterior stomach wall was plicated and made smaller. Examination of other viscera revealed no abnormality. The greater omentum was sutured after leaving a corrugated rubber drain through the left paracolic gutter. Abdomen was closed in layers. The patient received 2 pints, Group B, Rh +ve blood during operation and postoperative.

Postoperative follow up: There was some blood-stained discharge through the drainage tube for the first 36 hours. The drainage tube was removed after 48 hours. Postoperative period was uneventful. The tumour weighed-7 lbs, was irregular in outline, with heterogenous consistency.

Histopathological report revealed fibromyoma of the mesenteric tissue.

Patient was discharged on the 18th postoperative day.

Follow up after 2 months.—Patient is keeping well with no complaints.

Discussion

On account of its similar symptoms and signs of manifestation many cases of retroperitoneal growths pass on as ovarian tumours unless, laparotomy followed by histopathological examination, reveals its true nature. The commonest symptom of progressively increasing lower abdominal swelling is present in both the cases. The recurrent attacks of abdominal pain in retroperitoneal growth is usually due to temporary impaction of a food bolus in a segment of bowel commonly narrowed by the mesenteric tumour, but such type of pain is also encountered with an ovarian tumour. The shallow fornices in absence of ascites and a firm lump in the pelvis might be clinically either an ovarian tumour or any retroperitoneal mass. One should be on the guard not to mistake a retroperitoneal metastases of small tumours for primary growths nor any malignant retroperitoneal tumour should be accepted as primary unless a thorough investigation is done, though a primary malignant retroperitoneal tumour may occur.

Retroperitoneal tumours are encountered in any age group but are usually seen in the second decade, less commonly between one to ten years of age. But, the abdominal swelling was noticed at birth

in Hosmer's (1880) and Willis's (1935) case. Nicholson's (1929) large retroperitoneal tumour at 4 months and Willis's (1935) at 9 months, stress the fact that age is no bar to such disease. Schonholzer (1907) reported a large tumour present for several years in a eleven year child diagnosed by Lexer (1900). A case reported in a 13 year child by Gale and Wills (1944) consisted of fully mature quiescent tissue accidentally discovered during routine examination. Adult tumour of long standing origin was noticed by Fuller and Jaggers (1927) at 19 years of age.

The common site of retroperitoneal tumours is at the umbilical, left lumbar and left iliac regions. They are usually situated high up close to the superior mesenteric artery, coeliac artery, pancreas and kidneys. A tumour described by Nicholson (1929) was attached to the upper pole of the left kidney and derived its blood supply from renal and upper lumbar arteries. Some tumours arising at the same level extend forward to occupy the root of the mesentery or mesocolon (Lexer, Schonholzer) or even be in the distal parts of the mesentery. Fuller and Jagger described a retroperitoneal teratoma extending laterally and posteriorly deep to the spinal muscles which caused a swelling in the back. Retroperitoneal teratoma of lower lumbar or illio-pelvic regions are rare. A zone of resonance is usually elicited around retroperitoneal mass.

Radiology might help in diagnosing a retroperitoneal growth by demonstrating intestinal obstruction in addition to the opaque tumour, a finding usually not encountered with ovarian tumours. The case discussed had dilatation of the stomach due to pressure.

Summary and conclusion

An unusual case of fibromyoma of the mesenteric tissue is presented. Laparotomy should be attempted in every case. Many inoperable growths not only turn out to be operable, but it also helps to arrive at a diagnosis. Histopathology clinches the diagnosis in those cases where there are severe adhesions and malignancy is doubted, as in the case discussed. The uterus was healthy, both to the naked eye as well as on section. The possibility of Cullen's parasitic fibroid later becoming fibromyoma of the mesentery even in the absence of any pathology in the uterus and its appendages is rather rare.

Acknowledgement

We are thankful to Dr. K. N. Mitra, Director-Professor, Department of Obstetrics & Gynaecology, Eden Hospital, Medical College, Calcutta for his encouragement and to Dr. D. Ray Mahasaya, Principal Superintendent, Medical College Hospital, Calcutta, for his kind permission to publish hospital records.

References

1. Fuller, C. B. and Jagger, F. F.: Brit. J. Radiology. **32**: 176, 1927.
2. Gale. C. W. and Wills, R. A.: J. Path. & Bact. **56**: 403. 1944.
3. Hosmer, A.: Boston Med. Eng. J. **102**: 61, 1880.
4. Lexer, E.: Arch. Klin. Chir. **61**: 648, 1900.
5. Nicholson, G. W.: J. Path. Bael. **32**: 365, 1929.
6. Nicholson, G. W.: Ibid. **84**: 389, 1934.
7. Nicholson, G. W.: Ibid. **85**: 379, 1935.
8. Schonholzer, G.: Beirl. Path. Anat. **40**: 349, 1907.
9. Willis. R. A.: J. Path. Bact. **40**: 1, 1935.
10. Willis, R. A.: J. Path. Bact. **45**: 49, 1937.