RARE OVARIAN TUMOURS

(Report of 4 Cases)

by

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The ovary is one of the common site for neoplasm and approximately thirty different histological types of ovarian tumour have been described. In this paper, 4 different rare type of ovarian tumours have been presented.

CASE REPORT

Case 1

Mesonephroma Ovary

Miss I.K., aged 15 years was admitted in Eden Hospital, Calcutta on 23-9-1978, with abdominal swelling and menorrhagia for 6 months. Menarche at 12 years and cycles were normal. L.M.P. 13-9-1978. Systemic examination was normal, except some degree of pallor (Hb. 8.5 Gm%). Abdominal examination revealed a firm, non-tender, mobile tumour extending 5 fingers breath above symphysis pubis. On rectal examination, uterus was of normal size and tumour was felt separate from the uterus. Provisional diagnosis—"granulosa cell tumour". Routine investigation of blood, urine, stool, X-Ray chest and abdomen were within normal limit. Laparotomy was done on 13-10-1978. A large freely mobile, right sided solid ovarian tumour (15 cm x 10 cm) with irregular surface and capsule broken at places was found. There was no free fluid. Except enlargement of pre and paraaortic lymph glands, all other abdominal organs were normal. Panhysterectomy was done followed by full course of external radiation before discharge from hospital, but the patient did not turn up for follow up.

Pathology report: Mesonephroma ovary (Endodermal sinus tumour).

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Comment

In view of her young age with history of menorrhagia provisional diagnosis was granulosa cell tumour. According to Schiller (1939), mesonephroma—(Endodermal sinus tumour), seldom occurs before 40 years and are endocrinologically inert. But in this case the patient was young and there was history of menorrhagia without any demonstrable pelvic pathology, suggests some endocrinological background and condition may occur in young age. Author fails to explain lymph gland enlargement (nowhere in literature such involvement was mentioned). Biopsy from lymph glands could have given some clue regarding the nature of involvement (malignant or infiammatory). Whatever treatment is done mortality is 50% in unilateral involvement and 100% in bilateral involvement (Novak and Woodruff, 1974).

Case 2

Malignant Teratoma (Immature Teratoma)

Miss S.D., aged 19 years was admitted in Eden Hospital, Calcutta on 28-8-1979 with a diagnosis of twisted ovarian cyst. She attained her menarche at 13 years and till last 3 months was having normal menstruation. For the last 3 months she was having regular but scanty flow. L.M.P. 3-8-1979. She noticed loss of appetite and weight. On the day of admission she had acute pain in abdomen. She had past history of pulmonary tuberculosis 3 years back. Systemic examination revealed, nutrition below average. Pallor (Hb 8 Gm.%); Pulse 110/min. B.P.—110/70 mm. Hg. Temp. 99°F. Per abdomen a firm midline, mobile, slightly tender swelling about 10 cm. x 16 cm. size was detected. Lower pole of the tumour could be felt. Rectal examination proved extrauterine swelling. Routine laparotomy and radiological examination was within normal limit. Right sided ovariotomy was done on 29-8-1979. All other

abdominal and pelvic viscera were normal.

Post-operative period was uneventful and 2 Gm. Endoxan was given intravenously. Patient had full course of external radiation. She was readmitted on 12-12-1979 with severe respiratory distress—(Pulmonary metastasis—X-Ray findings) and died on 3rd day of admission.

Pathological report—Macroscopic: solid tumour. Cut surface—showed

Cystic and solid areas of necrotic brain like material.

Microscopic: Immature teratoma containing both embryonal and extraembryonal elements.

Comment

Teratomas particularly mature type is common in young age but immature variety is very rare (0.2% of all ovarian tumour. During last 6 years, only 1 immature teratoma has been encountered out of 67 ovarian tumours operated on in Eden Hospital, Calcutta. Clinically it is not possible to diagnose the condition—routine histological examination of all ovarian tumours will diagnose more cases of immature teratoma (Novak and Woodruff, 1974) Prognosis is grave. Case reported died within 3 months of therapy. Irradiation and triple therapy has been advocated by many authorities but survival is more directly related to the histopathological findings than to the mode of therapy.

Case 3

Bilateral Dysgerminoma

G.D., 25 years P1 + O, last delivery 8 years back, was admitted in Eden Hospital, Calcutta on 14-5-1977 with an abdomino-pelvic mass and pain in abdomen for last 2 to 3 years. She was having colicky pain in her lower abdomen, associated with nausea and vomiting, acidity at an interval of 2-3 months for last 3 years. She noticed swelling of her lower abdomen for last 2 years. Menstrual history was normal, L.M.P. 4-5-1977. Systemic examination was normal. Abdominal examination revealed an irregular, solid, mobile, nontender, swelling in lower abdomen without any evidence of free fluid. On vaginal examination, uterus was normal in size, anteverted and the mass was extra-uterine. Usual pre-operative investigations were normal. Panhysterectomy was done on 26-5-1977. All abdominal visceras were normal, except some thickening of stomach bed. Clinical and operative diagnosis was Krukenberg's tumour. Post-operative Barium follow through findings—Atropic gastritis. Pathology report: Both ovaries were solid, of smooth surface measuring—right 4″ x 3″; left 6" x 3″. Cut surface varigated. Microscopic picture was of dysgerminoma both ovaries.

She had an uneventful recovery and had full course of external irradiation before discharge. Patient is well without metastasis for 3 years.

Comment

Clinical and operative findings were in favour of Krukenberg's tumour. Dysgerminoma in its early stage may be devoid of any symptoms or may have gastro-intestinal symptoms in its early stage. Case reported was easy for therapy but there is controversy about management of unilateral tumour involvement in young patient, desirous of having further family.

Case 4

Arrhenoblastoma ovary

S.K., 24 years P1 + 0 was admitted in a private clinic on 20-8-1978 with history of amenorrhoea for 2 years (i.e. since last childbirth), excessive hair growth on her cheek and hoarseness of voice for last 6 months. On examination, she was well built with strong biceps and deltoid muscles, with excessive hair on her cheeks and male type of pubic hair growth. Breasts were atrophic, other systemic examination was normal. Per abdomen nothing significant. Per vaginum, there a firm extrauterine tumour about 8 cm. in diameter was well palpated through pouch of Douglas and left fornix. Uterus was anteverted, normal in size. Routine laboratory and radiological investigations were normal. Urinary 17 Ketosteriods 8.6 mgm./24 hours. Prelimenary diagnostic curettage followed by laparotomy with removal of left sided ovariotomy was done on 26-8-1978. Other abdominal viscera and internal genital organs were normal.

Pathology report: Endometrium—atrophic, non-secretory. Ovary-differentiated arrhenoblastoma.

Follow up: Menstruation started within 2 months and muscles became softish. Other signs retrogressed within 9 months but hoarseness persisted till 1½ years.

Comment

Arrhenoblastoma is a rare ovarian tumour, produces at first defemininestation (amenor-

rroea, atrophy of breasts) followed by masculinisation (hirsutism, and hoarseness of voice). In this case, patient was suffering from amenorrhoea since last childbirth which is an usual phenomenoma, due to prolonged lactation. Appearance of virilising signs and pelvic examination clinched the diagnosis. Unilateral removal of the ovary with tumour reverses the clinical condition within a short time and patient may conceive subsequently.

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