PRIMARY OVARIAN CARCINOID OF ONE OVARY WITH STRUMA CARCINOID IN THE OTHER OVARY

(Report of A Rare Case)

by

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Carcinoid tumours are neoplasms of either the enterochromaffin cells of the intestinal tract or their equivalents in other organs; 65% of all cases, occur in the appendix and 25% in the terminal ileum. Other rare sites are colon, rectum, pancreas, testis and ovary. The primary ovarian carcinoids most often arise from the respiratory or gastrointestinal epithelium in a dermoid cyst or within a solid teratoma, mucinous cystic tumour; it may occur in a pure form.

A rare case of primary carcinoid tumour of the left ovary with struma carcinoid of the right ovary and extensive secondaries is reported. Review of literature revealed that such a case has not been so far reported.

CASE REPORT

Mrs. B, 48 years old para 6 got admitted on 30-6-79 for pain and distension of abdomen of one month duration and vaginal bleeding for 3 days. She attained menopause 5 years back.

On examination she looked pale with average build. Facial hirsutism was present. There were three small discrete, firm left supraclavicular nodes palpable.

Examination under anaesthesia showed uterus was of normal size and deflected to the left. There was an irregular mass in the left side closely adherent to the uterus and 2 inches x 2 inches size. There was an oval, solid, mobile mass 5 inches x 4 inches with irregular surface felt in the right fornix. Hard multiple nodules were felt in the pouch of Douglas. Length of uterine cavity was about 3 inches. Curettage was done; scrappings were scanty and sent for histopathological examination.

During the one month waiting period after admission, patient developed ascitis and definite palpable hard left supraclavicular nodes. Ascitic fluid was tapped and found to be haemorrhagic. Forty five days after admission pelvic mass turned out to be an abdominal mass (of about 20 weeks pregnancy) encroaching the right iliac fossa.

Laparotomy was done on 20-7-79. Both ovaries were found to be the seat of friable papillary growth. Peritoneum over the pouch of Douglas, Rectal wall, omentum, bladder peritoneum, parietal peritoneum and serosa of bowels were found to be studded with yellow secondary deposits. Multiple hepatic secondaries and omental cakes were present. Pancreas was spared. The diagnosis was revised on the table as malignant, bilateral papillary cystadenocar-

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cinoma and total abdominal hysterectomy with bilateral salpingo-oophorectomy proceeded with. Immediate post operative period was uneventful.

Pathologist reported it as a bilateral ovarian primary tumours, one of them was primary ovarian carcinoid. The other one was predominantly one of struma ovari containing amber coloured colloid and with carcinoid metastases, (Figures 1 and 2). Urinary five hydroxy indole acetic acid was found to be negative.

Chemotherapy with cyclophosphamide was started. However, two weeks following surgery she developed hepatomegaly the liver reaching about 2 inches below the costal margin. As she was found to be hypersensitive to endoxan, methotrexate was started with close monitoring over the marrow function. Mean time she also developed a new mass of about 2 inches x 2 inches (which was hard and irregular) in the right iliac fossa.

One month after laparotomy the right iliac region mass started regressing but hepatomegaly persisted. Because of her husband's illhealth, she was discharged against advice. She did not return and later we were informed about her demise at home i.e. about ten months following her laparotomy, due to spread of malignant disease.

During the five year period 1977-1981 among 210 ovarian tumours which had been sent for histopathologic examination following surgery in our hospital, there were three carcinoid tumours giving an incidence of 1.4%.

This case did not have the features of carcinoid syndrome.

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See Fig. on Art Paper IV