OVARIAN TUMOURS COMPLICATING PREGNANCY

(Report of 4 Cases)

by

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Introduction

Since January 1981, 4 cases of pregnancy with ovarian tumours were encountered at General Hospital, Solapur (incidence 1 in 1189 deliveries or 0.088%). Two of our patients came with torsion, both being benign serous cystadenomas. Two had malignant tumours and both of these presented with spontaneous rupture of the tumours.

CASE REPORTS

Case 1:

A 20 years old primigravida was admitted on 26-1-82 with 8 months amenorrhoea and dull aching continuous abdominal pain with occasional vomiting for last 15 days. Patient was restless with pulse rate 90/minute, B.P. 100/80 mmHg. Tachycardia went on increasing after admission. Patient was oedematous but not pale. Abdomen was overdistended. There was fullness and tenderness in epigastric region. Uterine contour could not be made out. FHS were doubtful. Flanks were full. Vaginal examination revealed a closed centrally posed cervix with tenderness in fornices. Abdominal paracentesis yielded haemorrhagic fluid. Emergency laparotomy was performed. There was a ruptured solid ovarian tumour on right side with blood in peritoneal caviy. Secondary deposits were present over peritoneum. Right ovariotomy with lower segment caesarean section was done. Baby was fresh still born. Left ovary appeared normal. Histopathological report was endodermal sinus tumour. Post-operatively patient was put on combination chemotherapy—Endoxan, Methotrexate and 5-Flurouracil for 6 months. During this period she developed ascites and lump in abdomen which used to regress temporarily with chemotherapy. Second laparotomy was done 8 months after the first. There was a solid tumour arising from left ovary, adhesions were present. Peritoneal and omental deposits with haemorrhagic ascites were found. Removal of ovarian tumour along with uterus and omentum was done. Patient was discharged against medical advice in moribund condition on 15th post-operative day.

Case 2:

A primigravida was admitted on 27-3-84 with 6 months' amenorrhoea and dull aching pain in right lumbar region for 24 hours. She had vomits, no urinary complaints or bleeding. On examination, there was mild dehydration, pulse and blood pressure were maintained. Uterus was 24 weeks, relaxed, external ballotment was present. A tender mass was palpable in right lumbar region separate from uterus. Routine investigations were normal. With a diagnosis of twisted ovarian tumour with pregnancy laparotomy was performed. A cystic tumour 15 cms. diameter, bluish black due to torsion was arising from right ovary. Left ovary was normal. Right ovariotomy was done. Post-operative period was normal. Patient delivered uneventfully at term.

Case 3:

A 20 years old 3rd gravida was admitted on 13-7-84 with 2 months amenorrhoea, dull aching

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abdominal pain and vomiting for 3 days. She had mild pallor and tachycardia. A tender cystic lump was felt in hypogastrium. The cystic lump was separate from the soft 10 weeks uterus. On laparotomy, bilateral ovarian cysts 15 cms. in diameter were found. Right ovarian cyst had undergone torsion. Uterus was 14 weeks pregnant. Bilateral ovariotomy was done. Cysts were multilocular. Histopathology report was serous cystadenoma. Post-operative period was uneventful.

Case 4:

A 28 years old, gravida—2, para—1 was admitted on 14-7-84 with 8 months amenorrhoea and over distension of abdomen. Patient was moderately pale, unilateral pedal oedema present. Abdomen was tense, overdistended and initial diagnosis of hydramnios was made. Careful palpation showed a groove between a 34 weeks pregnant uterus on left and a huge cyst on right. Fluid thrill was present over the cyst. Flanks were resonant. The groove became prominent in excessive Trendlenberg position (Hingorani's sign). Plane X-ray abdomen showed uterine outline with a well flexed foetus presenting by vertex on left side. On ultrasonography a huge multilocular cyst separate from pregnant uterus was seen. Kidneys were normal. It was decided to wait for foetal maturity and possibly a vaginal delivery followed by laparotomy at term. On 24-7-84 patient developed sudden abdominal pain and tachycardia, abdomen was tense, tender and uterine contour was lost with fluid thrill all over. Immediate laparotomy was done. Peritoneal cavity was full of mucinous material. L.S.C.S. with right ovariotomy was done. Left ovary was normal. The ovarian cyst was 30 cms. in diameter, filled with mucin with solid areas at places. Histopathology report was borderline mucinous cystadenocarcinoma. Post-operative chemotherapy was planned. At follow-up after 2 months, there was no ascites or peritoneal deposit.

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References

1. Buttery, B. W., Beischer, N. A., Fortune, D. W. and Macafee, C. A. J.: Med. J. Aust. 1: 345, 1973.
2. Hertig, A. J. and Gore, H.: Pathology, edited by W. A. D. Anderson, 6th Edition, P. 554, 1971.
3. Ramoso-Jalbuena, A. and Sotto, V.: J. Phillip. Med. Ass. 43: 242, 1967.