

OVARIAN NEOPLASMS COMPLICATING PREGNANCY/ LABOUR / POSTPARTUM

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SUMMARY

Coexistence of pregnancy and ovarian mass is always a perplexing problem for the obstetricians. The presence of cystic ovarian mass may either simply be an exaggerated physiological reaction or it may be a serious life threatening problem like ovarian malignancy. Fortunately, the association of ovarian tumour and pregnancy is not common 1:2334- deliveries (Tachabo et al 1987) 1:2328 (Ashkenazy et al 1988) 1:653 (Yahia et al 1991) 1:1261 (Rathore et al 1995), the overall range is 1:653 to 1:15,000 in various studies. The exact incidence, however, depends on whether one considers, simple cyst noted on ultrasound examination (1/50 livebirths) or pelvic examination (1/80 live births, or those that ultimately require laparotomy (1/1000 to 1/1500 live births). The incidence of ovarian cancer is reported to be between 1/12,000 to 1/50000 live births or 1 to 2% of all ovarian masses with pregnancy (Dudley 1990). In the study by Struyk et al (1984), there was peak incidence of pregnancy with ovarian tumors around 25th year irrespective of parity.

In the present article we present analysis of 20 cases of ovarian neoplasms detected during pregnancy or labour or post partum, who were managed with definitive therapy in the department of Obstetrics and Gynaecology of Mahatma Gandhi Institute of Medical Sciences, Sevagram, Maharashtra, India.

MATERIAL AND METHODS

We have not been doing ultrasonography of all pregnant women and

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as many cases of ovarian neoplasms coexisting with pregnancy remain asymptomatic and are likely to remain unknown, it is not possible to give the exact incidence of pregnancy with ovarian neoplasms. Present study deals with only those cases which were dealt with surgically during pregnancy, post partum or during caesarean section.

OBSERVATIONS

Ninety percent of the women managed were between 20-29 yrs, 5% below 19 yrs, and 5% above 30 yrs. Out of 20 cases studied, 9 (45%) were nullipara and 4 (20%) grand multipara, (Table I). 12 (60%) women were diagnosed in first trimester, 4(20%) in second trimester, intrapartum, 1 other during caesarean section and 2 (8%) post partum. Abdominal pain was the commonest symptom (50%). Presenting complaint was lump in

abdomen in 2. One case was diagnosed during vaginal examination in a woman who came for termination of pregnancy and sterilization, other during caesarean section for some other indication and 1 other post partum during tubectomy operation (Table II). None of those operated during pregnancy aborted or had preterm delivery, however the woman with malignancy was lost to follow up as she went against medical advice. Histopathologically 10 (50%) were simple serous cysts, 5 were (25%) dermoids, and one each were haemorrhagic cyst, mucinous cyst adenoma and papillary cystadenocarcinoma. The woman with malignant disease had conceived after 16 yrs. of infertility.

DISCUSSION

Pregnancies complicated by ovarian tumours do pose considerable problems

Table I
AGE AND PARITY

Parity	Age			Total
	< 19	20-29	> 30	
PO	1	8	-	9
P1	-	3	1	4
P2	-	3	-	3
P3	-	4	-	4
Total	1	18	1	20

Table II
SYMPTOMS OF WOMEN

Symptomatology	1st Trimester	IInd Trimester	Intrapartum	Puerperium	Total
Pain in abdomen	2	-	-	3	5
Lump in abdomen	2	-	-	-	2
Nausea/Vomitting	2	-	-	-	2
Pain in abdomen with Nausea & Vomitting	2	-	-	-	2
Pain in abdomen with Vaginal spotting	-	2	-	-	2
Pain in abdomen with retension of urine	1	-	-	-	1
Vaginal white discharge with itching	1	-	-	-	1
Vaginal spotting	1	-	-	-	1
Acute pain & Vomiting	1	-	-	-	1
Symptomless *	1	-	1	1	3
Total	13	2	1	4	20

* One case was diagnosed accidentally while doing tubectomy, another one during LSCS and third one while doing pelvic examination in a woman with two months amenorrhoca.

of diagnosis and management. In the study by Rathore et al (1995), out of 29 cases around 41% were diagnosed in second trimester; 27.6% were asymptomatic. Vague abdominal pain was the commonest symptom seen (45%). 13% were asymptomatic in the study by Ashkenazy et al (1988); presenting symptom was actually pain with or without bleeding in (81.5%). In Rathor's study (1995) 66% patients were diagnosed

clinically and 5 (17%) were detected by ultrasonography. 17% were incidentally detected at the time of some other surgery like caesarean section / sterilization. In Hess et al's (1988) series 65% were asymptomatic at the time of diagnosis. The most serious complication however is malignancy; fortunately uncommon. Further determinants of nature of tumour, when to perform laparotomy and whether

to give tocolytics, what should be the mode of delivery are difficult decisions to be made. Dudley et al (1994) believed that 30% ovarian masses complicating pregnancy are non-neoplastic and only 1 to 2% are malignant. In the study by Ashkenazy et al (1988) 5.3% out of 38 cases of ovarian tumours coexisting with pregnancy were found to be malignant as was the case in our study also. One patient had infection of the cyst which ruptured in the abdominal cavity causing peritoneal reaction. The most common benign neoplasm of the ovary reported in pregnancy is benign cystic teratoma occurring in 40% (Dudley 1990) and mucinous cystadenoma in 30% (Rathore et al 1995) (present study simple cyst 50%).

The consequences of emergency surgery later in the first trimester are few. However if operation for adnexal masses detected in pregnancy is delayed until the onset of symptoms, the pregnancy prognosis is worsened when compared with that of elective operation (Hess et al 1988). Due to high incidence of abortion during early pregnancy (over all), the safest time to perform laparotomy is early second trimester. In Rathore et al's series (1995) out of 5 patients who underwent emergency laparotomy 1 had abortion (20%) whereas in cases who underwent elective laparotomy, out of 12 patients 1 aborted (8%). Ashkenazy et al (1988) reported 85% abortion rate in women who did not receive tocolytics as against

10% in supported group. We gave tocolytics to all the women, who were operated during pregnancy for removal of tumour. Some believe that in patients whom the asymptomatic mass is noted at or near term, vaginal delivery should be avoided because of dangers of torsion, rupture and haemorrhage during or immediately following labor (Dudley 1990) and it may be best to do an elective caesarean section at term or at the beginning of labor with extirpation of the tumor at the same time (Struyk 1984). However very often this is individualized depending on the situation and in clinical practice women are allowed to deliver vaginally and the tumour managed in post partum period unless possibilities of obstruction are there. Whenever a tumour is discovered in the third trimester operation is deferred because of the risk of preterm labor and technical difficulties of surgery. In our series there was no fetal loss. The possibility of malignancy should always be considered. One woman who presented in puerperium with twisted ovarian tumour, was explored in emergency. She was having torsion of simple cyst with haemorrhage (7-8" in diameter) on left side, and on right side 4"x5" dermoid. So after surgery little bit of ovarian tissue was left, only on right side. She did conceive soon but aborted and later conceived again and had term delivery. Ovarian tumours continue to be a problem

during pregnancy and should always be remembered and managed carefully.

REFERENCES

1. Ashkenazy M, Kessler I, Czernobilsky B, Nahshoni A, Lancet M. *Int. J. Gynec. & Obstet.* 27: 79, 1988.
2. Dudley AG *Telinde's operative gynaecology VII ed* by Thompson JD, Rock JA. J. Lippincott USA 44: 1314, 1990.
3. Hess L.W., Peaceman A, Brien WF, Winkel C A, Cruikshank DP and Morrison JC. *Am. J. Obstet., Gynec.* 158: 1029; 1988.
4. Rathore A, Oumachigui A, Arora P, Raghavan S. *J. of Obstet & Gynec of India*, 45: 465; 1995.
5. Struyk AP, Treffers P.E., *Acta. Obstet. Gynec. Scand.* 63: 421, 1984.
6. Tchabo SG, Stay BJ, Limaye SH *Int. Surg.* 72: 227; 1987.
7. Yahia AR, Rahman S, Rahman MS, Al Suleman SA *Aust. Nz. J. Obstet. Gynec.* 37: 327; 1991.