

An Interesting Case of Large Ovarian Tumor With Term Pregnancy

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Introduction

Benign ovarian tumors are known to complicate one out of 112 deliveries¹. Cystic teratoma is the commonest benign tumor (45%). Pseudomucinomas or serous cystadenomas account for almost 30% of these tumors². Incidence of malignancy in ovarian tumors associated with pregnancy is reported to be less than eight percent³.

Most of the ovarian tumors complicating pregnancy are diagnosed in the first or second trimester; less than 4% of all tumors are detected in the third trimester of pregnancy.

Case Report

Mrs. N. a primigravida aged 24 years, attended antenatal OPD for the first time on 13th Dec, 2000 with a history of seven and a half months of amenorrhea. She was referred from a private hospital because the height of her uterus was more than the period of gestation. Her ultrasonography report at 16 weeks of pregnancy was normal. Her LMP was on 19th May, 2000 and EDD. was 26th Feb, 2001. She was afebrile with pulse rate of 82 per minute and blood pressure of 120/80 mm Hg. On abdominal examination, the uterus was a 32-34 weeks size, deviated to the right side. An ill defined abdominal mass was felt on the left side, extending up to xiphisternum. Her hemogram, liver and kidney functions, and urinalysis were normal.

A sonography revealed a single live fetus of 33 weeks gestation in cephalic presentation. The placenta was anterior in the upper segment and liquor was adequate. A large multicystic lesion (24 x 15 cm) with a solid component (7x5cm) occupied the abdomen, displacing the uterus to the right side. No internal vascularity was seen. There was evidence of bilateral hydronephrosis. Liver, spleen and the retroperitoneum were normal. There was no evidence of free fluid. She was not willing for a preterm delivery, hence she was followed up on an outpatient basis with fortnightly renal function tests

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and biophysical profile. An exploratory laparotomy with lower segment cesarean section for oblique lie was done at 36 weeks of gestation. Peritoneal washings were taken for cytology. A live 2.2 kg male baby was extracted as breech. A large multicystic, mobile, encapsulated mass was seen arising from the left ovary (Photograph 1). The right ovary was normal. Palpation of liver, spleen, omentum and paraaortic lymph nodes showed no evidence of metastasis. Left ovariectomy was done along with omental biopsy. The tumor weighed 5.4 kg and measured 40 x 40 cm (Photograph 2). Histopathological examination showed mucinous cystadenoma with stromal hyperplasia and luteinization. Omental biopsy was unremarkable.



Photograph 1 : Operative photograph showing uterus and ovarian tumor after extraction of baby.



Photograph 2 : Postoperative photograph of the newborn and removed ovarian tumor.

The postoperative period was uneventful. The mother and the baby were discharged in good condition on the tenth post operative day.

Discussion

Cystadenomas account for almost 30% of benign ovarian tumors complicating pregnancy. Dessole et al⁴ have recently described a case of 33 cm mucinous cystadenoma with pregnancy. In our case the giant ovarian tumor complicating late pregnancy was 40 cms in diameter.

Management of an ovarian mass during pregnancy depends on (a) period of gestation of pregnancy, (b) whether torsion, haemorrhage, rupture or infection occur as complications and (c) character of mass i.e. benign or malignant.

Ovarian tumors larger than five cms, complicated benign tumors and those suspected to be malignant ones are managed surgically. Traditional management comprises of exploratory laparotomy at 16-20 weeks of gestation and resection of tumor. This time of gestation is chosen to prevent abortion which is more likely if surgery is done in first trimester. The fetal loss following surgery during pregnancy varies from 10% to 25%. This is increased after emergency surgery, as it may be performed for complications like torsion or rupture of cyst.

The ovarian tumors diagnosed in late pregnancy cause therapeutic dilemma. In most cases, if there is no complication related to the tumor and there is no anticipated risk of it obstructing labour, vaginal delivery is permitted and the tumour removed later.

Van Oppen et al⁶ have managed a case of mucinous cystadenoma in a women with 38 weeks gestation by ultrasound guided puncture of the cyst. However, there is always a risk of intraperitoneal spillage and development of pseudomyxoma peritonei⁷.

We performed cesarean section for an obstetric indication viz. oblique lie of the fetus which was caused by the large tumour shifting the uterus to the right side. The surgery was performed at 36 weeks gestation to ensure fetal lung maturity. A further delay in surgery was avoided in view of progressively increasing maternal discomfort due to excessive abdominal distension.

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