

A RARE CASE OF MUCINOUS OVARIAN ADENOCARCINOMA TUMOR IN ADULT FERTILE FEMALE.

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Abstract

Mucinous ovarian tumor are rare and mostly benign, but some may be malignant. The main challenge in the diagnosis of these tumours is its atypical presentation. Even if the patient presents early with some symptoms, the diagnosis is not reached always. This delays the treatment and leads to poor prognosis. Though the prognosis of this tumour is very good if detected in early stage. The final outcome depends on the stage and histology. Here, we present a rare case of mucinous ovarian adenocarcinoma in a 40 years old female who presented to us with complaints of pain in abdomen and enlarging abdominal mass.

Keywords: mucinous, ovarian, adenocarcinoma, tumor & fertile female.

Introduction

Mucinous ovarian tumors may be benign or malignant and are seen in upto 10-15% of all ovarian neoplasms. Majority of these are benign. These tumours do not have any specific presentation and may be seen as benign mucous cystadenoma, pseudomyxoma peritonei, mucinous tumors of low malignant potential and invasive mucinous ovarian carcinoma.

Each of them differ from the other clinically, histologically and at molecular level.[1] It is a type of epithelial gland tumor and constitutes 5% of all epithelial ovarian malignancies.[2]

Compared to other epithelial ovarian cancers, prognosis of mucinous ovarian malignancy is poor. These tumours can attain weight as much as 5-10 kilograms. Here we present a case of clinical interest of a 40 years old married woman who

was diagnosed as a case of Mucinous ovarian adenocarcinoma[3].

Material & Method

A 40 years old married female, presented to us with complaints of pain in lower abdomen and feeling of mass in lower abdomen. She complained of increase in size of mass since last 4 months. She also had complaints of dysmenorrhea, fatigue, constipation and white discharge since last 5 months. She was para 4 with 3 live children and had 1 abortion. On history taking, she told that her menstrual cycles were regular (4-5 days / 28+5 days) with average flow. She used to have pains during menstrual cycles with passage of pea sized clots. She is a known case of hypothyroidism and was on Tab. Thyroxine 50 mcg, once a daily and with no other relevant past history.

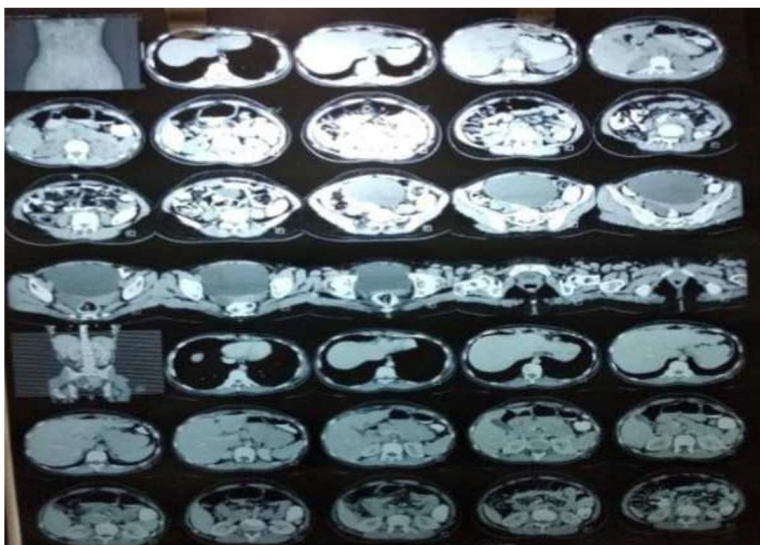


Figure 1: CT with B/L Ovary

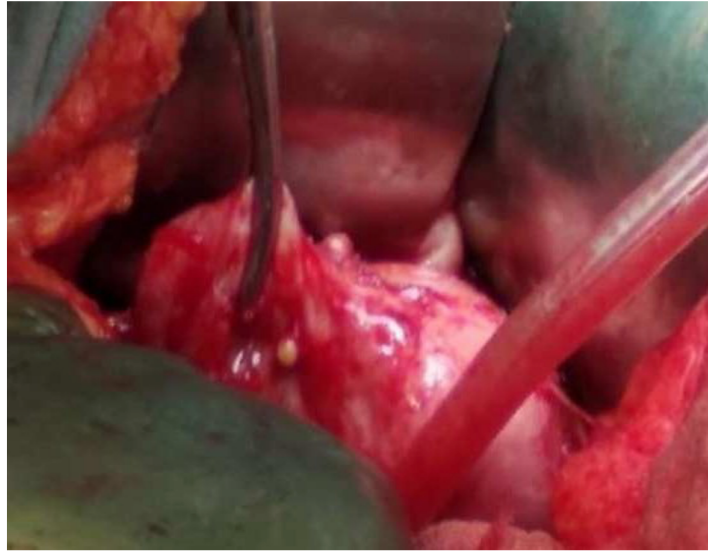


Figure 2: Uterus with Metastatic Deposit



Figure 3: Omentectomy



Figure 4: TAH + BSO Specimen

Discussion

On per abdomen examination, a large, firm, fixed mass of size of about 14-16 weeks with fullness in lower abdomen with flank fullness on both the sides was seen. There was no shifting dullness. Vaginal examination done showed immobile uterus with mass attached to it. Cervical lymph node, infraclavicular lymph node, inguinal lymph node were not palpable[4].

On haematological investigations, her Hb was 12.3 g/dL, WBC count 4000/cumm, blood urea 20 mg/dL, serum creatinine 0.95 mg/dL, SGOT 34 μ /L, SGPT 19 μ /L, total protein 7.5 gm/dL, serum albumin 3.9 gm/dL and serum globulin 3.62 gm/dL. Her CA-125 was found to be raised (1670 μ /ml). She underwent ultrasound of the whole abdomen which revealed bulky ovaries with tubo-ovarian mass with ascites[5]. Her cervical biopsy showed chronic cervicitis with LSIL which was also confirmed on PAP smear test. Further, CT pelvis done which was suggestive of bulky ovary with fat stranding enhancing lymph node in right para-colic gutter right adnexa with metastatic calcified deposits all over the omentum. Minimal ascitic fluid was seen in pelvic cavity[6].

Peritoneal fluid cytology was suggestive of metastatic adenocarcinoma of the ovary. Based on the findings, the patient was counselled about exploratory laparotomy with total abdominal hysterectomy with bilateral salpingo-oophorectomy with omentectomy with bilateral pelvic lymph node and para-aortic lymph node excision under general anesthesia. But prior to undergoing this major surgery, the patient underwent 5 cycles of chemotherapy with Inj. Cisplatin 50 mg in 50 ml of normal saline given via peritoneal drain[7].

Patient underwent successful chemotherapy cycles and then total abdominal hysterectomy. Her hospital stay was uneventful and was discharged in hemodynamically stable condition. She was followed-up after 3 months. Her repeat CA-125 was 7.28 μ /ml, a substantial decrease compared to the preoperative state. Her CEA was 0.89. No abnormalities were seen on ultrasound of abdomen and pelvis.

Mucinous ovarian adenocarcinoma has a low incidence amongst all squamous ovarian epithelial cancer. Majority of these are benign, while malignancy has been reported in 10-15%. Primary ovarian mucinous tumour has a bilateral presentation. The presentation of this tumour is atypical, hence, even though the patient may present early but the diagnosis may not be reached. This is a challenge for the treating physician. An elevated CA-125 level is more frequently seen in epithelial ovarian tumors. In the present study, CA-125 was highly raised preoperatively and postoperatively it reduced significantly. Radiographic evaluation is recommended along with tumor markers. A clinical suspicion of malignancy should always be kept. Benign cysts of size less than 8 cm are managed conservatively, while large size cysts require laparotomy

which helps in prevention of perforation and spillage of the cyst fluid into the cavity.[8]

The prognosis depends on histological subtype of cancer with well more than 90% recovery in early stage. Our patient had received 5 cycles of chemotherapy followed by exploratory laparotomy, which she stood successfully and at present is asymptomatic and healthy.

Conclusion

Mucinous ovarian Adenocarcinoma is rare type squamous ovarian epithelial cancer. Mainly they are benign 80-90%, 10-15% are malignant mainly U/L But primary ovarian mucinous tumor is mostly B/L, Tumor shows mucin laden cells scattered in ovarian stroma. T/T in advance cancer Taxane-platinum chemotherapy \rightarrow f/b - TAH + BSO & lymphadenectomy (pelvic, paraaortic)+ omentectomy. Prognosis is dependant on histological subtype of cancer. Generally prognosis is well more then 90% recovery in early stage.

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