

Huge Ovarian Mucinous Cystadenoma Complicating Term Pregnancy: A Case Report

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Abstract: *Huge ovarian cyst are found in less than 1% of all ovarian cyst in pregnancy and are associated with poor foeto - maternal outcome. A 28 years old G2P1L1/post caesarean pregnancy was referred from her PHC/ with complains of intermittent pain abdomen at 29 weeks. Her scan showed huge ovarian cyst of 30×18 cm with multiple thick septations. Woman was conservatively managed till term and elective repeat surgery was planned however she was post caesarean patient. Elective lower segment caesarean section along with left sided salpingo-oophorectomy was done along with delivery of 2.4 kg healthy female baby. Histopathology was suggestive of mucinouscystadenoma of ovary. Although antepartum removal of ovarian cyst has been recommended to ensure good pregnancy outcome, expectant management and timed intervention can be adopted for pregnancy with huge ovarian cysts.*

Keywords: mucinouscystadenoma; ovarian cyst; pregnancy

1. Introduction

Detection of ovarian cyst during pregnancy has become more common due to routine use of ultrasonography in antenatal care. The reported incidence of pelvic mass varies from 0.5 to 2.2 percent. Out of this occurrence of giant ovarian tumour is less than 1% of the ovarian cyst during pregnancy. About 60% of total adnexal mass during pregnancy constitutes of dermoid and mucinous cyst. Huge cyst increases maternal morbidity due to abdominal pain, torsion, rupture and secondary infection of the cyst. It may cause wrong calculation of gestational age, malpresentation, obstructed labour and may affect fetal growth as well as can cause IUGR. No specific protocol has been developed till date hence the case management varies from case to case. Main stay of management include tumour size, type, origin, gestational age, presenting symptoms and medical condition of these women.³ The present case report describes a rare occurrence of huge ovarian cyst in term pregnancy associated with malpresentation and its successful management.

2. Case Report

A 28 year old woman was referred from a primary health centre with history of amenorrhea for 7 months and history of intermittent pain abdomen. The woman was G2P1L1/post caesarean pregnancy / last child birth since 3 years. She was asymptomatic and had taken routine supplementation of iron and calcium along with two doses of tetanus toxoid

from her primary health centre. On calculation with her LMP she was 29 weeks 5days of gestation. She had not done any blood investigation and however she had an ultrasound scan done at 17 weeks which was suggestive of large abdomino pelvic was suggestive of large abdominal mass of size 25× 15 cm extending to left hypochondrium and left lumber region and pushing the uterus towards right side. The finding of ovarian cyst with pregnancy was diagnosed at her primary health centre and she was advised for speciality care. shedidnot turned up. She was asymptomatic till 29 weeks and developed intermittent pain abdomen of varying severity. she was referred to our hospital for further management.

On examination her vital signs were stable, per abdominal examination suggested fundal height of almost 34 weeks with regular fetal heartrate. Abdomen seemed to be tense and vague tenderness was present. There was no bleeding or discharge pervaginum. All routine blood investigations done and were within normal range. Ultrasonography showed a single live fetus of 29 weeks with a large multi septatedmulticystic abdominopelvic mass in left side extending superiorly above umbilicus measuring 25×15 cm having thick internal septations showing presence of internal vascularity and multiple tiny internal echoes. The lesion causing marked mass effect on gravid uterus displacing it to the right side and on the urinary bladder. MRI showed abdomino pelvic mass with thin septa suggestive of left ovarian cyst.



The women and her relatives were counselled about the condition and all the management options were discussed. After discussion conservative management approach was adopted and she was kept on regular follow up. She was given medications for pain relief and was advised to report immediately if pain increased or any complication occurred. She came for regular follow up till 34 weeks and was planned for an elective Caesarean section at 38 completed weeks. She was taken up for elective caesarean section under spinal anaesthesia and she delivered a male baby of 2.9 kg weight with an APGAR 7/10, 9/10. Left sided salpingoophorectomy was done at the same sitting. There was a huge left sided ovarian tumor of 30× 18cm and weighed 2.9 Kg. Ovarian mass was sent for histopathological examination. Woman recovered fully and was discharged on 8th post operative day after suture removal. The histopathology of mass was suggestive of benign mucinouscystadenoma of ovary.

3. Discussion

Most of the ovarian masses are asymptomatic and are diagnosed incidentally during pregnancy due to routine use of ultrasound. Cysts more than 3 centimeters are detectable on sonography and usually decline spontaneously after 10 weeks of gestation. Lesions persisting beyond 12 weeks associated with complex sonological features are neoplasm and are usually benign. The most common symptom of ovarian masses is pain which may be mild to severe if torsion or rupture takes place and warrants immediate surgery. Normal physiological and anatomical changes during pregnancy may cause some pain so the pathological conditions like ovarian tumor gets ignored in absence of routine scan as in the present case. The mainstay of diagnosis is ultrasound which is 96.8% sensitive and 77% specific for diagnosing ovarian masses however MRI can be suggested in equivocal cases if available. Advantage of MRI over sonography is that it can visualize the more posterior and lateral area of the pelvis which may be obscured by fetal bones. It is safe as it does not involve harmful ionizing radiation and has accuracy rate of 100%. The role of tumor makers in pregnancy is equivocal as all the markers CA 125,

CEA, alpha fetoprotein are usually elevated during pregnancy and varies in each trimester so are difficult to conclude if used alone and without imaging modalities.

Management is primarily surgical. Tumor size, gestational age and primary presenting complain are the most important factors affecting the surgical removal. The risk of spontaneous abortion in first trimester and preterm labour and IUGR in third trimester should always be kept in mind. Second trimester is the best time for surgery for the removal of ovarian masses as the risk is low compared to first and third trimester. Laparoscopic management of the cyst may be considered due to the advantage of short hospital stay and lesser blood loss however this approach requires expertise and may not be possible in women with large tumors and with advanced gestation. Considering watchful management and reserving surgery in case of onset of symptoms and emergencies can be considered. There are many case reports that considered watchful expectancy as the best management approach for huge ovarian cyst presenting in third trimester and removed the cyst at the time of elective caesarean section.

In our case we discussed all the possibilities and complication of this huge tumour on pregnancy and immediate removal. Expectant management was chosen and woman was carefully monitored and elective surgery was planned at 38 completed weeks and elective repeat lower segment caesarean section was done as planned along with left sided salpingoophorectomy with optimal fetomaternal outcome.

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