

Life-threatening Hemoperitoneum and Sepsis with Giant abdominal mass of diagnostic uncertainty

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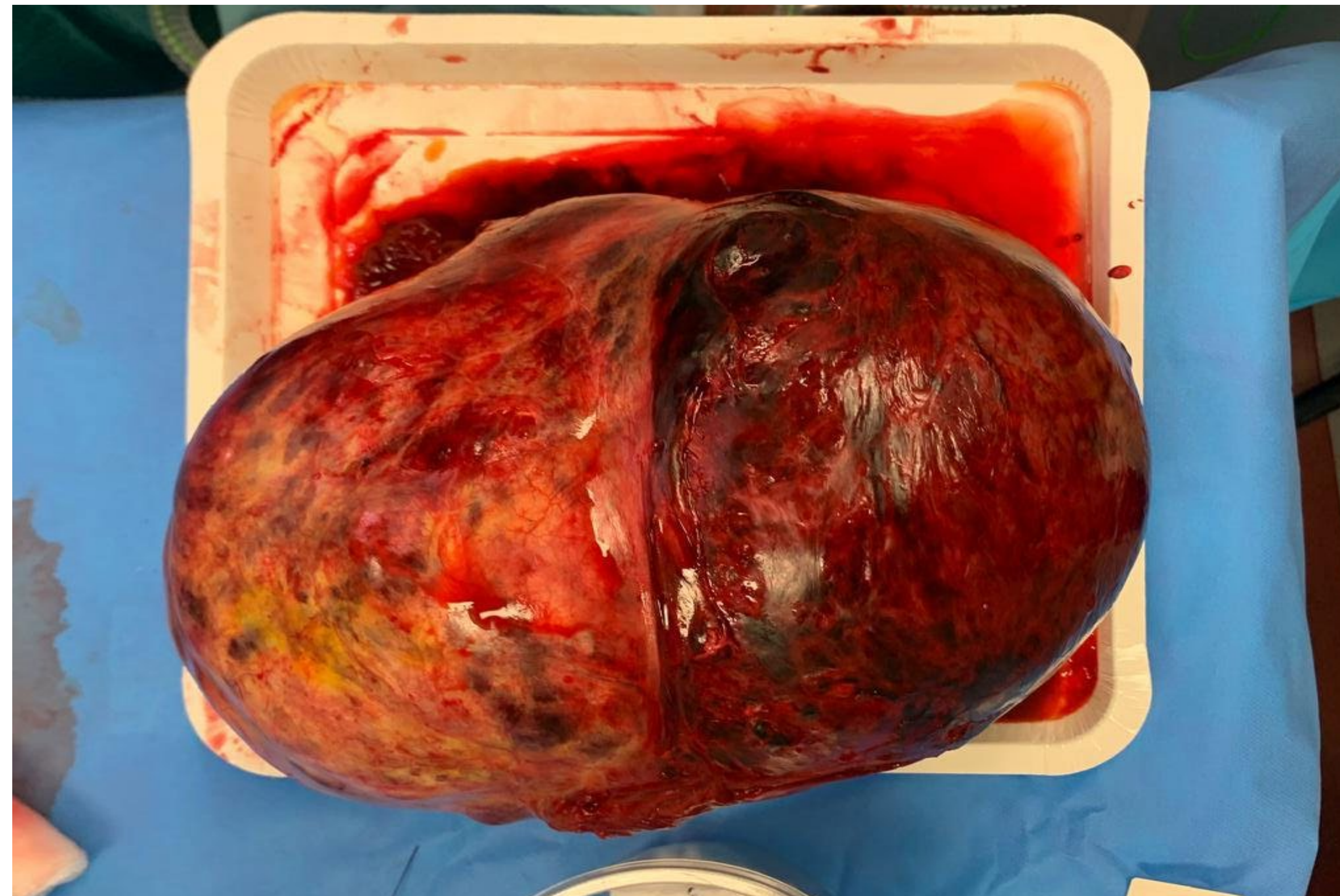
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Objective:

To present a rare case of massive Hemoperitoneum and Sepsis associated with a Giant abdominal mass of diagnostic uncertainty. The challenge was the diagnostic dilemma and the difficulty in management despite multimodal investigations and multidisciplinary team input.

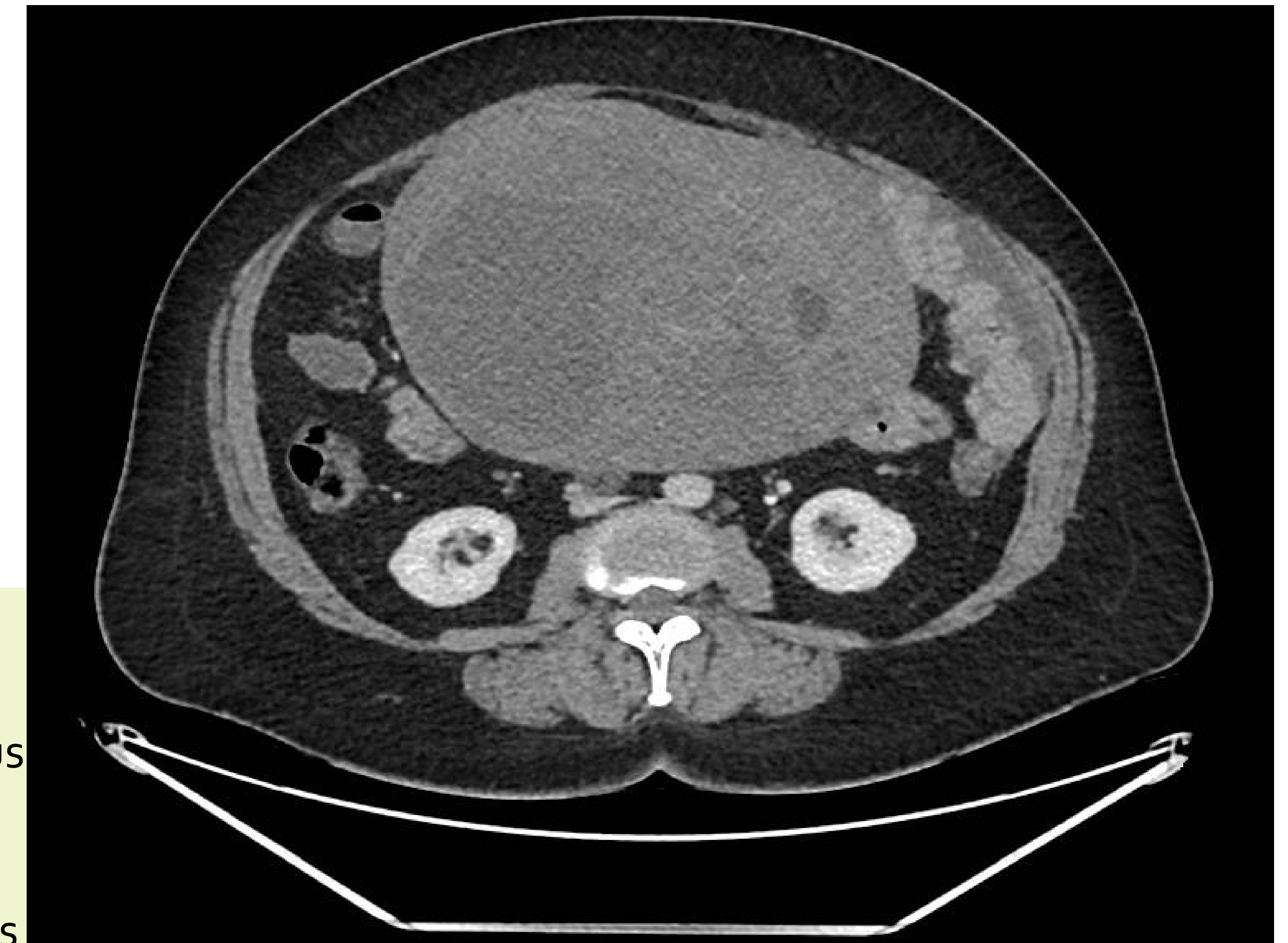
Case Report:

58-years old post-menopausal lady, with history of fibroid presented to the emergency department with acute abdominal pain, distension and vomiting. She was pale, unwell and had a vasovagal syncope. Her CT showed a large mass of 20 x 20 x 15 cm with Omental stranding and Ascites. She became hypotensive overnight with a significant drop of haemoglobin and developed sepsis. Ultrasound showed haemoperitoneum, and a large multilocular solid-cystic complex mass. Uterus was clearly visualised with no fibroid, normal left ovary and right ovary was not visualised. Her CA- 125 was 302. Patient was transfused and received broad spectrum antibiotics. She had an MRI which was reviewed in the joint radiologist- gynaecologist meeting, where it was concluded that the large mass is either a benign fibroid with haemorrhage and degeneration or a right ovarian mass with intermittent torsion. She continued to deteriorate clinically and was counselled for surgery. In view of high suspicion for ovarian malignancy she had a midline laparotomy with full staging procedure. There was a 25 cm malignant looking ovarian mass on the right side with haemorrhagic spillage. There was one litre of haemoperitoneum in the Pelvis. She received further blood transfusion and made a good recovery. Her histology confirms Benign Serous Cystadenofibroma with partial infarction.



Discussion:

Ovarian Cystadenofibromas are relatively rare variants of epithelial tumours of ovary containing epithelial and fibrous stromal components. They account for 1.7% of all benign ovarian tumours. Pre-operative diagnosis is difficult as these tumours mimic characteristics of malignancy such as large cystic mass with septations, papillary projections and solid nodules on ultrasound. The Omental stranding and ascites was also misleading. These tumours can also resemble the gross appearance of malignant tumours peri-operatively. Final histology showed partial infarction and intravascular thrombosis which can reflect torsion. This was possibly the reason for the haemorrhage and was misinterpreted as fibroid degeneration.



Conclusions:

Serous cystadenofibromas can be difficult to diagnose on imaging. Ovarian torsion can be associated with serous cystadenofibromas due to its tendency to grow into large size. This case highlights multidisciplinary approach and utilising multiple imaging modalities. It also emphasize the importance of a detailed discussion with the patient regarding the findings on the scans and the nature of mass. Careful planning, MDT approach and preparation for extensive surgery is also advisable.