

# Successful Removal of a Giant Ovarian Cyst: Case Report

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## INTRODUCTION

Giant ovarian cyst is defined as a cyst >10 cm in diameter from radiological examination or the size of the cyst exceeds the umbilicus <sup>(1)</sup>. Dut to the availability of better imaging modalities, ovarian cysts are diagnosed earlier, and most of them are functional in nature and resolve without treatment. Rarely, ovarian cysts reach large size without causing symptoms. Two main variants of ovarian cyst, Serous and Mucinous, most of them are benign.

Serous cystadenoma of the ovary account for ~60% of ovarian serous tumors <sup>(2)</sup>. They are the commonest type of ovarian epithelial neoplasm. Serous borderline tumors (SBTs) account for one-fourth to one-third of the serous tumors <sup>(3,4)</sup>. They occur commonly in the fourth and fifth decades. Although often asymptomatic, the tumor may sometimes present with abdominal pain and enlargement. We report a rare case of ovarian border serous cystadenoma.

## CASE REPORT

A 48Year old multiparaous women presented to our hospital outpatient department with complaints of gradual distension of abdomen since 3months, associated with on and off abdominal pain, nausea but no vomiting or weight loss. Menstrual history was regular, 8days duration and normal flow. Per abdominal examination revealed mass of height of fundus 34cm, firm, smooth surface, not tender, not freely mobile. Per speculum examination showed normal looking cervix and vagina. per vaginal examination a palpable mass of 34weeks gestational size, not freely mobile and attached to the uterus, bilateral fornices were free with no tenderness. Trans Abdominal ultrasound showed uterus normal in size, both ovaries not clearly seen, minimal pelvic free fluids, evidence of large abdominopelvic thin wall cystic lesion of clear fluid content, no detected definite solid component, no detected color flow signal inside, measures about 17x14 cm (Figure 1). MRI showed a thick walled complex cystic mass with eccentric internal septations in the left ovary, measures 17cmx 15cms (Figure 2), right ovary is atrophic, no other significant abnormality is seen. Laboratory tests including tumor marker CA-125 were within normal limits. Patient underwent exploratory laparotomy, intra operative findings were ascitic fluid present clear straw color-sent for cytology, large left ovarian cyst measuring 17x18cms seen with 2 rounds of torsion (Figure 3), right tube and ovary and uterus no abnormal detected. Left salpingo-Oophorectomy done, omental biopsy taken. Mass of 17x18x10cm size of weight 2.5kg removed. Ascitic fluid, cytology negative for tumor cells. Omentum, biopsy negative for malignancy. The Histopathological investigations revealed Borderline Serous Cystadenoma. Post operative course was uneventful.

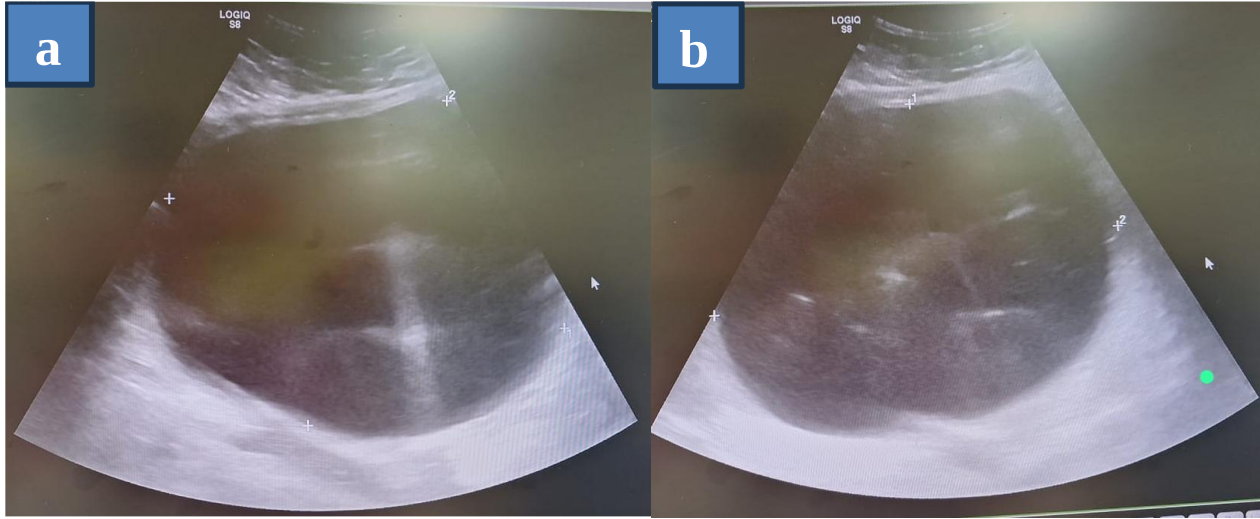


Figure 1. Ultrasound Image

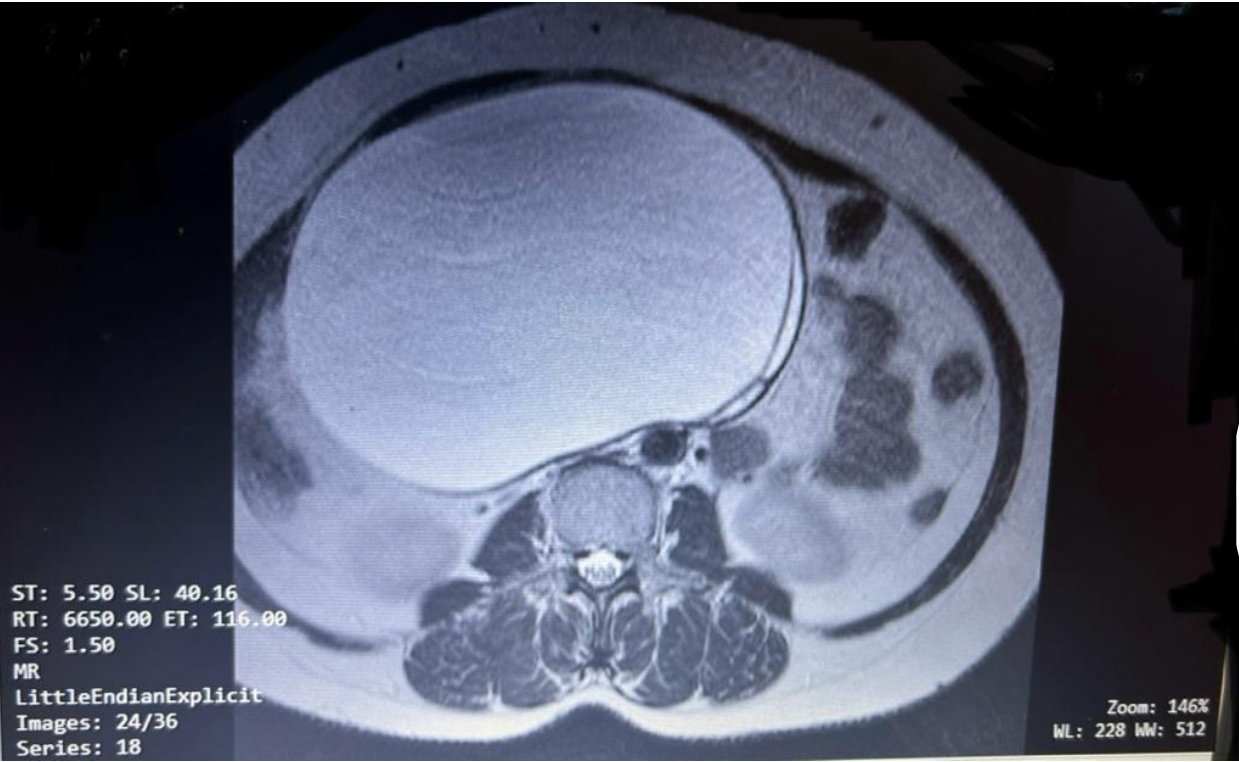


Figure 2. MRI Image

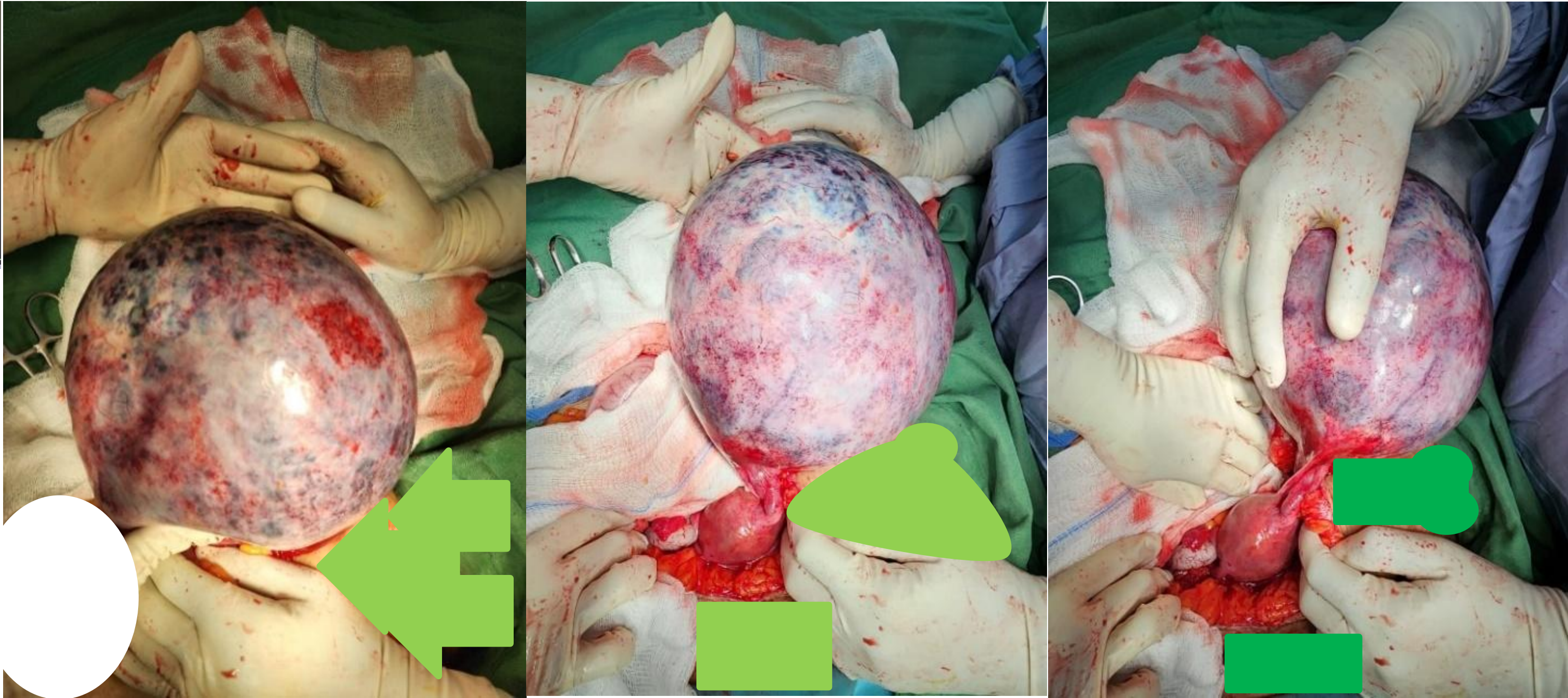


Figure 3. Intra operative view of tumor mass

## DISCUSSION

Pelvic masses may be symptomatic or asymptomatic. Borderline ovarian tumors (BOT) behave as intermediate lesions between benign cystadenomas and invasive carcinoma. With the help of widespread use of modern imaging techniques such as ultrasound and MRI <sup>(5,6)</sup>, detection of ovarian mass has become easier. Two main variants of ovarian cyst, Serous and Mucinous BOT, most of them are benign. Serous tumors are most common cystic neoplasm of the ovary, 60% of which are benign, 25% are malignant, and 15% are borderline cases. The majority of mucinous tumors are benign 75%, 10% borderline, and 15% carcinomas. Serous tumors usually present as large masses, up to 40cm in diameter <sup>(3)</sup>. The management and prognosis of these tumors is dependent on histologic subtype. They rarely spreading beyond the ovaries or having a peritoneal involvement, and therefore displaying a better prognosis as compared to invasive carcinoma <sup>(7,8)</sup>. Another challenge lies in the poor preoperative and surgical diagnostic accuracy for BOT, with often more than one surgical intervention required for complete staging, and diagnosis revealed upon histologic examination <sup>(2)</sup>. Historically, radical surgery was the treatment of choice for BOT; however, there is now a shift towards a more conservative approach given the young age of patients, presentation mostly at an early stage, and low associated mortality rates. However, several studies have reported a higher recurrence rate of the disease with conservative surgical approaches, particularly in the case of unilateral cystectomy. Mortality rates were not significantly increased despite the increased recurrence, especially when patients benefitted from close follow up <sup>(8,9,10,11,12,13)</sup>. In our case, as there is no availability of frozen section in our hospital, and laboratories and imaging modalities favored benign ovarian neoplasm, we decided for unilateral salpingo-oophorectomy. As per the guidelines, regular and intensive follow-up of the patients is essential for the early detection of recurrence in the form of borderline or invasive disease. During the initial 2 years, follow-up evaluation is performed every 3 months. Patients are then evaluated biannually for 3–5 years after surgery, and then annually thereafter <sup>(14)</sup>.

## CONCLUSION

Borderline ovarian tumors have an excellent prognosis. Ovarian cysts more than 10cms are considered as large ovarian cysts. Surgery is recommended for simple cysts larger than 5cm and complex cysts of any size. Based on the MRI findings and tumor marker results, laparotomy and unilateral salpingo-oophorectomy could be the treatment of choice in our case especially when no intra op frozen section facility available. We recommend to make frozen section available in all secondary care center to avoid similar situation.

Written informed consent has been obtained from the patient to publish this paper.

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