Squamous Cell Carcinoma In Ovarian Dermoid

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Case

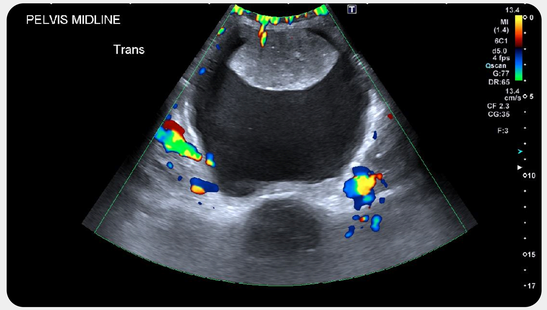
34-year-old woman, P2+1 with one month history of **abdominal pain and progressive distension, along with significant weight loss and reduced appetite.** She had been on the pill for the past four years for contraception.

Surgical history was significant for LLETZ due to CIN III ten years ago. Medical history was significant for anxiety disorder for which she was taking bisoprolol.

General physical examination was normal. Abdominal examination revealed a **palpable, fluctuant mass** measuring approximately **18 cm**, arising from pelvis, **mildly tender** on palpation with **limited mobility.**

Investiation

Baseline labs were normal except mildly raised CRP. CA-125 and CA 19-9 were elevated being 56.2 and 136 U/Ml respectively.



Ultrasound: large cystic mass, 19.3 x 11.6 cm with a solid area of 6.9 x 4.2 cm showing no vascularity

CT scan: a well-defined round mass centrally arising from the pelvis, inseparable from right adnexa/ovary,16.5 x 13.3 x 17.5 cm, largely cystic density with 6.2cm x 4cm x 6.8cm ovoid fat density focus anteriorly, uterus displaced inferiorly towards left, small amount of fluid noted in the pouch of Douglas



Treatment

She was planned for laparotomy and unilateral salpingo-oophorectomy, but intraoperatively, a **large tumor was found adherent to the bowel,** leading to a **total abdominal hysterectomy + bilateral salpingo-oophorectomy + omentectomy + pelvic lymphadenectomy and tumor resection** along with the formation of a **de-functioning loop ileostomy**. Histopathology confirmed **moderately differentiated squamous cell carcinoma (FIGO Stage IIB)**. She is currently postoperative and awaiting **chemotherapy.**

Key Learning Points

MCTs are typically benign but can undergo **malignant transformation**, most commonly into squamous cell carcinoma, occurring in approximately **0.17–2%** of cases.

Presentation may be **non specific** like abdominal pain, distension, and weight loss. Elevated tumor markers like **CA-125 and CA 19-9 can aid in diagnosis, but imaging studies are crucial.**

Treatment involves **surgical resection,** with the extent determined by disease stage and patient factors. **Early-stage disease** may allow for **fertility-sparing** surgery, while advanced stages often require more extensive procedures.

Prognosis depends on factors like tumor stage, grade, and patient age.

A **coordinated approach** involving gynecologists, oncologists, radiologists, and pathologists should be used to ensure accurate diagnosis, effective treatment planning, and optimal patient outcomes.

Regular postoperative monitoring, including clinical evaluations and imaging, is essential to detect recurrences early and manage potential complications, thereby improving long-term survival rates.