



Research Journal of Pharmaceutical, Biological and Chemical Sciences

Pregnancy Associated with Ovarian Mucinous Cystadenoma: A Case Report.

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ABSTRACT

To report the occurrence of a rare case of pregnancy associated benign ovarian tumour (mucinous cystadenoma). Our reported case was a middle aged women booked and immunised outside came for safe confinement. The data were collected by history-taking, clinical examination, laboratory investigations, transabdominal ultra-sonographic examination, and by histo-pathological study of the excised surgical specimen. The case was reported as a rare pregnancy associated ovarian mucinous cystadenoma. This case report emphasizes the significance of thorough evaluation of all pregnant women. Although the condition is extremely rare, it is a potentially dangerous if not timely diagnosed and managed properly.

Keywords: ovary, cystadenoma, tumour

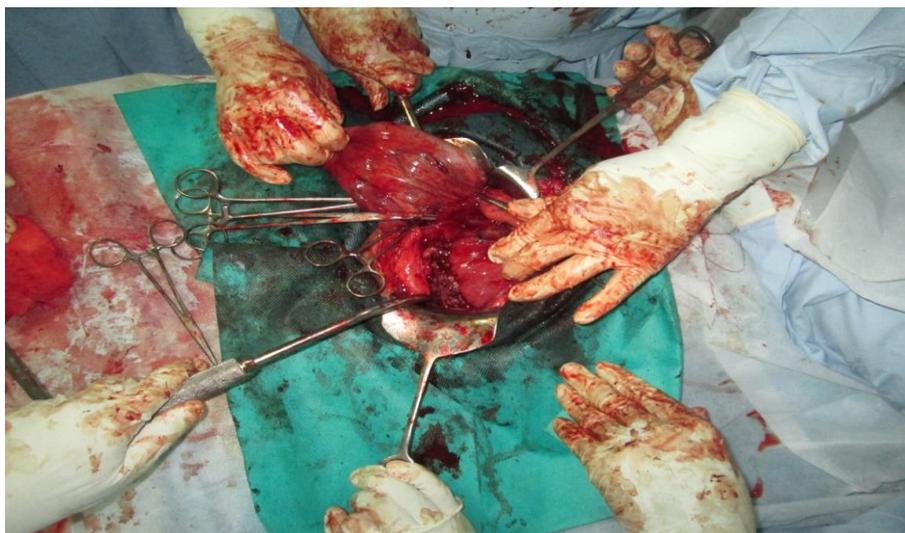
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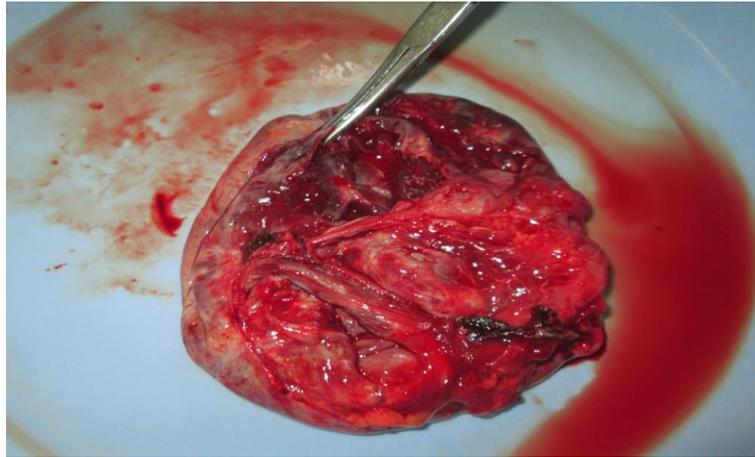
INTRODUCTION

Mucinous cystadenomas are benign epithelial tumours that are typically multilocular, thin walled cysts with smooth external surface containing mucinous fluid. These are amongst the largest tumours of ovary, may reach enormous dimensions. Of all ovarian tumours, mucinous tumours comprise 12% to 15% and 75% of all mucinous tumours are benign, 10% borderline, 15% are invasive carcinoma [1]. The incidence of ovarian cysts during pregnancy is less than 5%, and most of them are benign in nature. Giant cysts are found in less than 1% of the cases of ovarian cysts with pregnancy [2]. Torsion is the most common and serious complication of benign ovarian cysts during pregnancy followed by haemorrhage and rupture. If the cyst ruptures it leads to the formation of pseudomyxoma peritonei and the viscera show extensive adhesions. Appendectomy at the time of primary surgery prevents pseudomyxoma peritonei, as often mucocele of appendix is known to cause this complication [3].

Case Report

27 years old Gradiva 2 Para 1 previous caesarean delivery came to our antenatal clinic for the first time with 9 months of amenorrhoea. Her menstrual cycles were regular. She had been married for 4 years and had a 3 years old girl baby via caesarean section done for cephalopelvic disproportion. She was booked and immunised outside but she came to our hospital for elective repeat caesarean delivery as hernioplasty was done here for incisional hernia 2 years back. She had only one Ultrasonography report done at 26 weeks of gestation showing a single live intrauterine fetus of 26 weeks of gestation, together with a huge cystic mass arising from the right adnexa. General survey and systemic examination showed no abnormality. Abdominal examination revealed distended abdomen which made it impossible to perform Leopold manoeuvres. Sonographic evaluation demonstrated single live intrauterine foetus corresponding to 37 weeks gestation in cephalic presentation, the placenta was anterior with grade 3 lacunae pattern and liquor was adequate and estimated fetal body weight was 2500 g. Sonographic examination also demonstrated a huge multiloculated, smooth surfaced cystic mass with no solid component or papillary projections at the right side of the uterus extending to subhepatic area. Obstetric color Doppler sonographic findings were evaluated in normal ranges. A reassuring fetal status was determined by electrocardiotocography. All the preoperative investigations were within normal limits. Caesarean section was performed under general anaesthesia through a midline skin incision and lower uterine segment incision, a healthy female infant weighing 2500 g delivered. A huge, right ovarian multiloculated, smooth surfaced cystic mass of about 14 cm×12 cm in size was exposed and ovarian cystectomy was performed. Frozen section examination revealed a benign cyst that might be compatible with a mucinous cystadenoma. Sterilisation done by modified pomeroys technique (as per patient and her husband's consent). The surgery has been completed successfully. The patient has been discharged at postoperative day 4 without any problem. In subsequent follow-up, no abnormality was detected.





DISCUSSION

The most common benign adnexal masses during pregnancy are cystic teratomas (36%), followed by cystadenomas (15%). Several cases of ovarian mucinous cystadenomas in pregnancy have been reported in the literature [2,4-8]. Yenicesu GI et al. [1] and Qublan HS et al. [6] both described removal of right ovarian mucinous cystadenomas weighing around 6 kg after Caesarean section. The cysts in both cases were very similar to that in our patient. Noreen H et al [5] reported term vaginal delivery of a grand multipara (aged 30 years) after the removal of a huge left ovarian mass (42 cm×40 cm×20 cm) at 30 weeks of gestation. Balat O et al [7] also reported an unthreatened late pregnancy with a huge mucinous cystadenoma of the left ovary, diagnosed sonographically at 26 weeks of pregnancy.

Any adnexal mass smaller than 5 cm in size during pregnancy rarely causes symptoms. Therefore, the size of the tumour as well as its ultrasound characteristics, colour Doppler flow, and symptoms is important in determining the management of pregnant patients with adnexal masses. Symptomatic, solid, bilateral, and complex lesions should be subjected to surgery whenever discovered. Moreover, unilateral simple ovarian cysts, 5-8 cm in size, should be evaluated sonologically up to 16-18 weeks and if they fail to regress or if they increase in size, surgical intervention should be undertaken. It is also advisable that any surgical intervention in the first trimester be avoided if possible because of the high rate of spontaneous abortion. The optimum time for surgical intervention is 16-18 weeks of gestation.

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