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Case Report

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A huge benign ovarian serous adenoma in a 74-year old postmenopausal woman in the Niger-Delta region of Nigeria: a case report

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Abstract

A case of a 74-year old post-menopausal Nigerian woman presenting with a huge benign ovarian serous cystadenoma that weighed 19.5kg. She was referred from surgical outpatient clinic of the same institution. She presented with a 3-year history of progressive abdominal swelling. At laparotomy, there was a huge left ovarian cyst with thin cystic wall containing serous fluid measuring 52 x44 x32cm and weighed 19.5kg. She had TAH +BSO and was discharged home on fifth post-operative day in a stable condition. Histopathological examination revealed simple serous cystadenoma of the ovary. This is the largest benign ovarian cyst report in postmenopausal woman in our institution and one of the largest reported cases from our locality.

Keywords: *Postmenopausal, Huge, Benign, Ovarian, Cystadenoma.*

Introduction

The ovary is one of the components of the female reproductive organs. Tumours can arise from one or both ovaries during a lifetime of the individual, spanning from the pre-pubertal to postmenopausal periods and these tumours could either be benign or malignant.

Huge ovarian tumours are rare in developed countries due to early detection of adnexal masses with the evolution of routine imaging modalities in the recent era of medical practice [1,2]. However, in developing countries ovarian tumour may present as a large mass especially when it is malignant due to late presentation and lack of routine screening.

Huge or giant ovarian tumour refers to a cystic mass measuring more than 10cm diameter in radiological scan or the cyst reaching above the umbilicus [1].

Serous tumours are the commonest form of epithelial ovarian tumours, occurring in women of reproductive ages. Most of the cysts are benign in nature with chance of malignancy being only 7-13% in premenopausal and 8-45% in postmenopausal women [3,4].

Giant benign ovarian serous cystadenoma is rare in elderly postmenopausal women [2,3]. There are scanty reports of huge benign ovarian tumours in the literature, especially in the Niger-Delta region of Nigeria.

We report a 74year old Para 11^{+0} postmenopausal with a giant left ovarian cyst that measured 52 x 44 x 32cm and weighed 19.5kg. Considering her age and the postmenopausal status, we performed total abdominal hysterectomy (TAH) and bilateral salpingo-oopherectomy (BSO) for the patient. Histo-pathological examination revealed a simple serous cystadenoma of the left ovary and a normal right ovary along with fallopian tubes, uterus and cervix.

Case

A 74-year old Para 11^{+0} with 8 living children was referred from surgical outpatient clinic due to huge abdominopelvic mass of 3 years duration. She had thyroidectomy 3months prior to her referral and she was 21years postmenopausal. Abdominopelvic CT-

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Scan with contrast showed features of a huge intra-abdominal unilocular cystic mass of pelvic origin with benign imaging appearances (Figure 1).

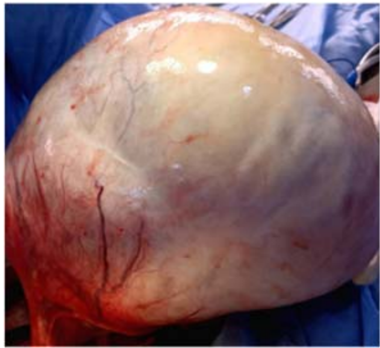

Figure 1: Abdominopelvic CT-Scan with contrast showed features of a huge intra-abdominal unilocular cystic mass of pelvic origin with benign imaging appearances

At presentation, she complained of progressive abdominal swelling of three (3) years duration that was associated with occasional abdominal pains, early satiety, anorexia, and weight loss. She had no history of bleeding per vaginum. Her urinary and bowel habits were normal. She had a thyroidectomy performed 3months prior to her presentation. There was no significant medical history.

On physical examination, she was conscious, alert and well oriented. Her height was 173cm, weighed 79 kilogram and body mass index=26.4kg/m^2. She had 8 cm anterior transverse neck scar that healed with primary intention. Her pulse rate was 82 beats per minute and blood pressure was 120/70 mmHg. The abdomen was grossly distended with presence of dilated superficial abdominal wall vessels. The abdomen was tense on palpation with a non-tender and non-mobile mass. Percussion notes were dull and fluid thrill was positive. There was no bruit heard. The vulva, vagina and the cervix were atrophic but healthy looking.

Laboratory investigations showed haemoglobin concentration of 10.6g/dl, total white blood cell count of 4,400cells/mm^3, neutrophil count of 56%, lymphocytes count of 38%, eosinophils count of 4%. Serum CA-125 was 43.1U/ml, serum electrolytes, urea, creatinine and liver function test were within normal values. Abdominopelvic ultrasound scan done revealed a huge cystic abdominopelvic mass with consideration for ovarian cystadenoma to rule out cystadenocarcinoma while abdominopelvic CT-Scan with contrast showed features of a huge intra-abdominal unilocular cystic mass of pelvic origin with benign imaging appearances, possibly serous cystadenoma of the ovary, with severe mass effect on the urinary bladder, bowel loops and gall bladder. Chest X-ray revealed no significant radiographic features of active lung disease non feature of metastasis.

She was counseled on findings and she gave an informed consent for surgical management. Total abdominal hysterectomy with bilateral salpingo-oophorectomy (TAH+BSO) under general anaesthesia with a midline laparotomy incision was done. Intra-operative findings were thin peritoneal lining without evidence of tumour seedlings, minimal serous ascitic fluid, huge left ovarian cyst with thin cystic wall containing serous fluid, grossly normal left fallopian tube, right ovary and fallopian tube, atrophic but grossly normal 6 weeks sized uterus. The bowel loops were normal and smooth surfaces of intra-abdominal organs. The resected cyst measured 52x44x32cm and weighed 19.5kg (Figure 1). She had uneventful post-operative period. Mrs. BV was subsequently discharged home on 5th post operative day in a stable condition and scheduled for follow-up visits.

A histopathological examination of the cyst specimen (Figure 2) using hematoxylin and eosin stain staining revealed a fibro-collagenous stroma with flattened attenuated epithelial cells. There was no evidence of malignancy. A diagnosis of “benign (simple) serous cystadenoma”

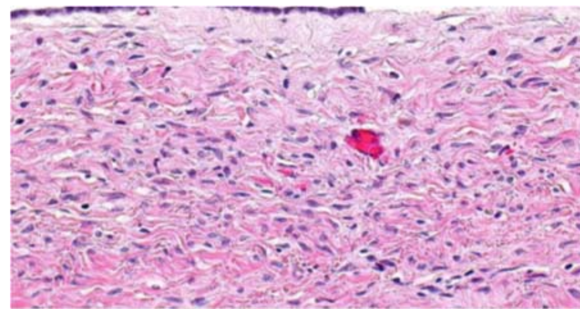

Figure 2: Histopathology image of the cyst specimen

Discussion

Ovarian tumours present in a variety of subtypes and origin of tumour cells. Serous tumours belong to the most common epithelial cell ovarian tumours. They account for 85-90% of all primary ovarian tumours and 70-80% of ovarian cancer deaths from high grade subtype [5].

Serous cystadenoma is a benign growth and can grow to vary sizes. They are usually detected incidentally on imaging studies or during gynaecological examination following complaints. The report of huge ovarian cystadenoma in postmenopausal women is relatively low or unknown in developed world due to advanced imaging modalities. In our environment, finding of such a huge mass is not unusual especially when the tumour has malignant tendency. Reasons attributed for this may range from fear of malignancy, financial constraints, ignorance, lack of health care facility, fear of surgery and superstitious beliefs [6,7]. In some patients, diagnosis can be overlooked because of pronounced obesity or self-neglect [8]. Our patient

delayed in presentation due to her fear of death from resultant surgery.

Majority of these huge ovarian tumours of rapid progression, presenting in the postmenopausal period are often of malignant variant especially in less developed country like ours. Mrs. BV was a 74year old who presented with progressive abdominal swelling associated with occasional abdominal pains, early satiety, anorexia, and weight loss. There was no history of postmenopausal vaginal bleeding, cough and other symptoms suggestive of malignancy. More so, there were no symptoms of severe complications of large ovarian tumour such as torsion, haemorrhage and rupture. Serum CA-125 was minimally elevated.

Postmenopausal woman in her decade is at a higher risk of epithelial ovarian malignancy and any adnexal mass in this group should be approached cautiously [8]. Therefore Mrs BV was offered abdominal hysterectomy and bilateral salpingo-oophorectomy after detailed evaluation and counseling. Though the definitive diagnosis was suspected at laparotomy, confirmation was made through histopathological examination.

Thus, this work does report a rare finding of a huge benign ovarian serous cystadenoma of such size in a postmenopausal woman in a low resource setting.

Conclusion

Benign ovarian serous cystadenoma is a rare disease. This is the largest benign ovarian cyst reported in postmenopausal woman in our institution and one of the largest reported cases from our locality.

List of abbreviations

None provided.

Declarations

Ethical approval

None provided.

Availability of data and materials

The datasets used and/or analyzed during the current study are available from the corresponding author on reasonable request.

Competing interests

No conflict of interest associated with this work.

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Contribution of Authors

We declare that this work was done by the authors named in this article and all liabilities pertaining to claims relating to the content of this article will be borne by the authors.

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