

Case Reports

A Ovarian Serous Cyst Adenocarcinoma Presented as Post-Menopausal Bleeding

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Abstract:

The various malignant forms of epithelial tumors of the ovary, in practice, are usually grouped together as ovarian adenocarcinoma. These tumors tends to occur in women aged 45-60 years and are commonly asymptomatic until they are achieved a considerable bulk: most common complaints are of increasing abdominal girth, lower abdominal pain or discomfort and the presence of pelvic mass. Urinary symptoms due to pressure on bladder are quite frequent while disturbance of menstrual cycle or post-menopausal bleeding are unusual. Here we present a case of a 60 years old postmenopausal lady with the complaints of post-menopausal bleeding, and heaviness & lump in the lower abdomen. She was clinically diagnosed as a case of ovarian tumor (ovarian malignancy) & went through laparotomy followed by surgical staging. Then TAH with BSO with infracolicomentectomy with pelvic lymphadenectomy was done. Histopathology revealed serous cyst adenocarcinoma (left ovary) without any metastasis to the opposite ovary or any other organs. In our case one of the most common ovarian neoplasm presented with the rarest symptom made the case interesting to report.

Key words- serous cystadenocarcinoma, postmenopausal bleeding, ovarian tumour.

Introduction:

Epithelial ovarian cancer is the second leading cause of death from gynaecological cancer, and the 5th most common cancer in women overall¹. Malignant serous tumors account for 75% of all epithelial cancers². It is a serious disease, particularly in advanced stages with a course that is punctuated by frequent tumor recurrence, and has a negative impact on quality and length of life. Disease progression typically occurs via loco-regional peritoneal dissemination. Patients commonly develop recurrent ascites and bowel obstruction. Some patients are cured and have high 5 years survival even of advanced ovarian cancer with first-line multimodality therapy.

Case presentation:

A 60 years old postmenopausal lady, presented with the complaints of per vaginal bleeding for 3 episodes

within 2 months. Bleeding was scanty and blackish in colour during 1st two episode, but during 3rd time it was fresh bleeding and persisted for a day but was not heavy. It was not associated with pain, per vaginal discharge, itching & also not related with coitus. She also complains for heaviness in the lower abdomen but no pain. Her heaviness was associated with feeling of abdominal distension & vague discomfort along with some weight loss. She also complaints of dyspepsia, anorexia & flatulence. Her bowel & bladder habit was normal. With all these complaints she consulted with a gynaecologist. On examination the consultant found a mildly tender lump of about 8x6 cm occupying left iliac & hypogastric region. It was dull on percussion with areas of resonance in the flanks. Then she was advised (USG) of whole abdomen. USG revealed partly solid & partly cystic lump. She was referred to our hospital for further

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management. On admission, a partly solid & partly cystic lump about 10x8 cm was found per abdominally which was mobile and mildly tender. On Per speculum examination cervix was healthy. On by manual examination, uterus was bulky (6 weeks) which was deviated to right, a moderate size well defined & freely mobile lump was felt through the left and anterior fornix and a cleft was felt between uterus and the mass. Transvaginalsonography showed bulky uterus with heterogeneous myometrium. Endometrium is ill-defined about 9.6 mm thickened & heterogeneous in echo texture with moderate endometrial fluid collection. For better evaluation MRI was done which revealed a bulky uterus with multiple fluid collection in posterior myometrium with loss of endo-myometrial differentiation. No mass lesion or fluid collection is seen in endometrium. A large lobulated mass (measuring about 12x10 cm) having solid & cystic component in left adnexa of the lower abdomen. No ascites, lymphadenopathy and no sign of metastasis were found in liver or omentum. Endometrial curettage and cervical biopsy was done, which showed atrophic change and chronic cervicitis respectively. Then decision of laparotomy was taken with joint consultation with a general surgeon, anesthetist and oncologist. During laparotomy surgical staging & systemic exploration of abdominal cavity was done, there was no sign of liver, Gastro Intestinal tract (GIT), sub diaphragmatic or omental metastasis. Para aortic lymph nodes were not enlarged & no ascites was present. There was a solid tumor in the left ovary, which was 12x10 cm in size; surface was smooth. Uterus was six weeks in size. Right ovary was atrophied. Then total abdominal hysterectomy with bilateral salpingo-oophorectomy with infracolic omentectomy with pelvic lymphadenectomy was done. There was no metastasis to the opposite ovary & other organs & without any LVSI (Lympho-vascular Space Invasion). Her histopathology report revealed chronic cervicitis, atrophic change in endometrium and myometrium and moderately differentiated high grade serous cyst adenocarcinoma (left ovary). Lymph node showed reactive changes and omentum was free of metastasis. For her further treatment consultation with oncologist was done and the patient was advised for chemotherapy with paclitaxel and carboplatin.

Discussion:

Cystadenocarcinoma is a malignant neoplasm derived from glandular epithelium, in which cystic

accumulations of retained secretions are formed. It is the most common malignant ovarian tumor, usually presents with omental metastases which cause ascites. The current life time risk is 1 per 70 women and the incidence peaking at the age of 67 years³. Repeated ovulation thought to be an important factor which favor ovarian cancer and use of oral contraceptive pill has been linked with 40% reduction in risk in some study⁴. Approximately 5-10% of ovarian cancer are associated with as autosomal dominant syndrome⁵.

Epithelial ovarian cancer (EOC) has often been described as a 'silent killer; with 75% patients being diagnosed with late stage (stage III/IV) disease with a 5 year survival is 30-40%, rather than stage I when survival is 84-94%. This is largely because the symptoms of early stage ovarian cancer are thought to be subtle or absent. However, symptoms of EOC are present in 90% of affected women, even with early stage disease, and that these symptoms are often dismissed, so that for 37% of women with the disease there is a delay of at least 6 months from presentation until a diagnosis is made⁶. A 'symptom index' includes pelvic or abdominal pain, urinary urge or frequency, or difficulty with eating/early satiety present for less than a year, which has been shown to accurately predict the presence of ovarian cancer when used in combination with serum tumor marker⁷. In our case patient present with post-menopausal bleeding and lower abdominal heaviness and during operation surgical staging was found as stage 1A. Histopathology report revealed moderately differentiated high grade serous cyst adenocarcinoma of left ovary. Cervix shows chronic cervicitis with squamous metaplasia. Lymph node shows reactive changes and omentum was free of metastasis. The diagnosis of ovarian cancer is histopathological and it is important to manage the patient rationally. High-grade serous carcinoma is the most aggressive subtype and accounts for the majority of advanced stage cases. Long-term (LT) survival of women with high-grade serous carcinoma (HGSC) is low and often associated with completely resected disease (no gross residue). Other markers such as "oestrogen receptor status" can provide useful information for the later management of the patient. CA-125 is elevated in only 80% of known ovarian cancers and in 50% of those with early-stage disease; In patients whose CA-125 is elevated at diagnosis, serial CA-125 measurement provides a means of assessing response to subsequent chemotherapeutic treatment. The main factors that predict for survival include FIGO stage of disease, tumor grade, surgical

debulking status, histological subtype and sensitivity of disease to platinum-based chemotherapy. In our case surgical staging is stage 1A, debulking surgery included total abdominal hysterectomy with bilateral salpingo-oophorectomy with pelvic lymphadenectomy with infracolicomentectomy, and histopathology showed serous cyst adenocarcinoma of left side. Recent data suggest that in the context of high surgical quality, there is no disadvantage to neo-adjuvant chemotherapy followed by delayed primary surgery⁸. First-line chemotherapy comprises either carboplatin alone or carboplatin in combination with paclitaxel. These standards of care have been defined by international randomized clinical trials [Gynecologic Oncology Group (GOG) 111⁹, OV-10¹⁰, GOG132¹¹ and ICON3¹²]. Ovarian cancer is best managed by centralized integrated multidisciplinary teams. This has been shown to improve outcomes in this disease. In our team, a gynaecologist team, an oncologist, a surgeon, a radiologist and a pathologist were involved. The team decided to go for chemotherapy with paclitaxel and carboplatin after primary healing of surgical wound.

This is a rare condition there are only a few case reports.^{13,14}

Conclusion:

This case is unique in its presentation. Serous cyst adenocarcinoma is one of the commonest epithelial ovarian malignancy with poor prognosis due to its vague symptoms and late diagnosis in advanced stage. But our case patient presented with post-menopausal bleeding with lower abdominal heaviness and we diagnosed her early at surgical staging stage 1A and now she has responded well with chemotherapy.

References:

1. Dewhurst's textbook of Obstetrics & Gynaecology, Eight edition, by d. Keith Edmonds, 760-773.
2. Jeffcoate's Principles of gynaecology, Eight edition by Narendra Malhotra and Protap Kumar, 490-527.
3. Boyle P, Ferlay J. Cancer incidence and mortality in Europe, 2004. *Ann Oncol* 2005;16:481-488.
4. Berchuck A, Schildkraut J. Oral contraceptive pills. Prevention of ovarian cancer and other benefits. *N C Med J* 1997;58: 404-407.
5. Sogaard M, Kjaer SK, Gayther S. Ovarian cancer and genetic susceptibility in relation to the BRCA1 and BRCA2 genes. Occurrence,

clinical importance and intervention. *Acta Obstet Gynecol Scand* 2006;85:93-105.

6. Goff B. Symptoms associated with ovarian cancer. *Clin. Obstet. Gynecol.* 2012;55(1): 36-42.
7. Andersen MR, Goff BA, Lowe KA et al. Use of a Symptom Index, CA125 and HE4 to predict ovarian cancer. *Gynecol Oncol* 2010;116: 378-383.
8. Van Gorp T, Amant F, Neven P, Berteloot P, Leunen K, Vergote I. The position of neoadjuvant chemotherapy within the treatment of ovarian cancer. *Minerva Ginecol* 2006;58:393-403.
9. McGuire WP, Hoskins WJ, Brady MF et al. Cyclophosphamide and cisplatin compared with paclitaxel and cisplatin in patients with stage III and stage IV ovarian cancer. *N Engl J Med* 1996;334:1-6.
10. Piccart MJ, Bertelsen K, James K et al. Randomized intergroup trial of cisplatin-paclitaxel versus cisplatin-cyclophosphamide in women with advanced epithelial ovarian cancer: three-year results. *J Natl Cancer Inst* 2000;92:699-708.
11. Muggia FM, Braly PS, Brady MF et al. Phase III randomized study of cisplatin versus paclitaxel versus cisplatin and paclitaxel in patients with suboptimal stage III or IV ovarian cancer: a Gynecologic Oncology Group study. *J Clin Oncol* 2000;18:106-115.
12. The International Collaborative Ovarian Neoplasm (ICON) Group. Paclitaxel plus carboplatin versus standard chemotherapy with either single-agent carboplatin or cyclophosphamide, doxorubicin, and cisplatin in women with ovarian cancer: the ICON3 randomized trial. *Lancet* 2002;360:505-515.
13. Agdas C, Ahina S, Tayla, Akdemir A, Zekioglu O, Seyidovaa P, Ergenoglu AM. Ovarian serous cystadenoma with ectopic adrenal tissue in a 65-year-old patient: A case Report. *International Journal of Surgery Case Reports* 2017; 33; 89-91.
14. Leelavathi, Roy P, Sree S, Srirama S. Ovarian Serous Cystadenofibroma – A Rare Case Report. *Indian Journal of Obstetrics and Gynaecology Research* 2015;2(4): 297-299.