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Case Report

Mucinous cystadenoma of ovary with third degree uterovaginal prolapse in postmenopausal woman: a rare case report

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ABSTRACT

Mucinous tumours of the ovary represent a spectrum of neoplastic disorders, including benign mucinous cystadenoma, pseudomyxoma peritonei, mucinous tumors of low malignant potential (borderline), and invasive mucinous ovarian carcinoma. These tumors are related closely to each other and are distinct from other histologic subtypes of epithelial ovarian neoplasms from a clinical, histologic, and molecular standpoint. Mucinous cystadenoma of ovary presenting with 3rd degree uterovaginal prolapse is extremely rare. This case highlights the importance of choosing the appropriate route of approach and about maintaining the gynae oncological safety. In our case, total abdominal hysterectomy with bilateral salpingo oophorectomy with anterior colporrhaphy with McCalls Culdoplasty with Moschowitz repair and posterior perineorrhaphy was performed.

Keywords: Mucinous cystadenoma of ovary, Uterovaginal prolapse, Mc Calls Culdoplasty, Moschowitz repair

INTRODUCTION

Mucinous cystadenomas make up 15-20% of all ovarian tumours. Benign ovarian mucinous tumours are rare at the extremities of age, before puberty and after menopause. They are common between the third and the fifth decades.[1] Total hysterectomy with bilateral salpingoophorectomy remains the treatment of choice in such benign cases (where the family is complete).[2]

Here, we would like to present a case of ovarian tumour with third degree utero-vaginal prolapse in a 52 years old, post-menopausal female where the patient presented with abdominal discomfort and pressure symptoms and responded remarkably to surgical treatment. The patient could go back to her normal life following the treatment.

CASE REPORT

52 years old, post-menopausal multiparous woman presented with the complaints of some mass coming out of vagina for 2 years and a lump in the abdomen for 6 months. On per abdomen examination, mass corresponds to 24 weeks size of gravid uterus, hard, irregular and non-tender. Per vaginal examination revealed a 3rd degree UV prolapse with huge cystocele and rectocele (Figure 1).

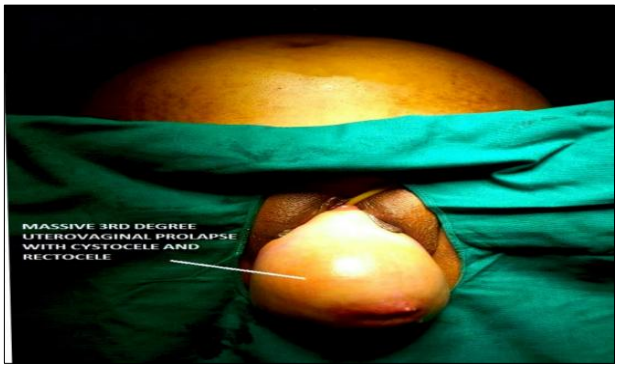

Figure 1: Massive 3rd degree uterovaginal prolapse with cystocele and rectocele.

No demonstrable stress incontinence. Ultrasonography whole abdomen revealed a large well defined cystic mass lesion with enhancing internal septations, on right adnexa

(10.9×13.6×10.4 cm) with no evidence of mural nodule/ calcification within the lesion (Figure 2).

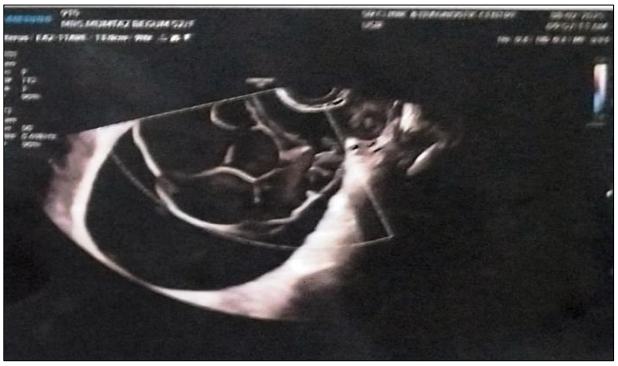

Figure 2: USG whole abdomen showing a large well defined cystic mass lesion with enhancing internal septations, on right adnexa (10.9×13.6×10.4 cm).

Her Pap smear showed NILM, metaplastic squamous cells. Tumor markers CA 125 was 18.7, CA 19-9 was 1, CEA was 1.5. Laparotomy under general anesthesia was performed taking frozen section of the ovarian tumor. Frozen section suggests benign ovarian tumor. So total abdominal hysterectomy with bilateral salpingoophorectomy with anterior colporrhaphy with McCalls Culdoplasty with Moschowitz repair and posterior perineorrhaphy performed was performed (Figures 3 and 4).

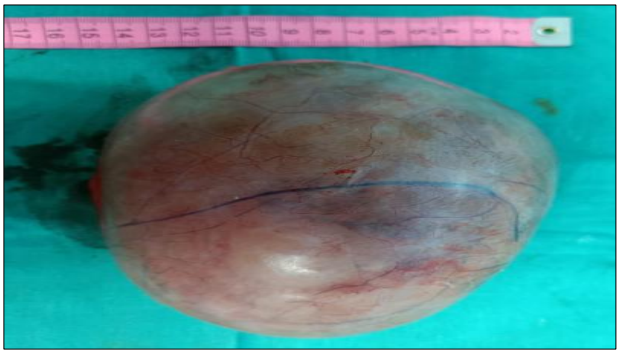

Figure 3: Specimen of right ovarian tumor.

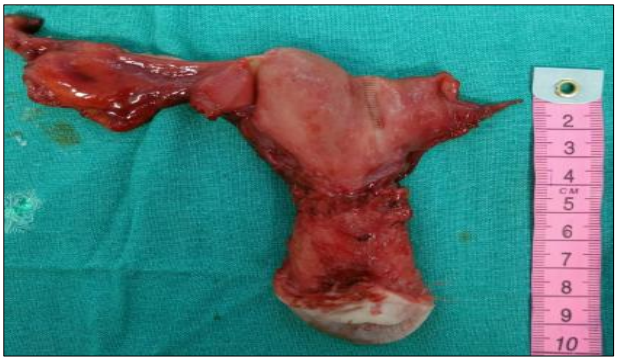

Figure 4: Specimen of hysterectomy.

Final histopathological report confirmed mucinous cystadenoma of ovary with no atypia or malignancy.

DISCUSSION

The study presented a case of mucinous cystadenoma of ovary with third degree UV prolapse.

There are four major categories of ovarian tumours: epithelial tumour (65-75%) - serous or mucinous cystadenoma/carcinoma, clear cell carcinoma, Brenner tumour; germ cell tumours (15%) - dysgerminoma, embryonal cell cancer, choriocarcinoma, teratoma; sex-chord-stromal tumours (5-10%) - granulosa cell tumour, thecoma, fibroma; metastatic tumours (10%) - uterine, stomach, colon, breast, lymphoma.[3]

Mucinous cystadenoma is a benign ovarian tumour. It is reported to occur in middle-aged women. It is rare among adolescents or in association with pregnancy.[4]

Only 10% of primary mucinous cystadenoma is bilateral.

Management of ovarian cysts depends on the patient's age, the size of the cyst and its histopathological nature. Conservative surgery as ovarian cystectomy and salpingo-oophorectomy is adequate for benign lesions.

CONCLUSION

In our case, the tumour was large unilateral, affecting the right ovary and was associated utero-vaginal prolapse which is an exceptionally rare presentation, and this poses a real challenge for surgeon to plan the route and surgical management of both at same setting. In our case the surgical procedures were performed with the intention of not to compromise the oncological safety and to tailored the need of the utero vaginal prolapse repair.

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Ethical approval: Not required

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