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Case Report

Intestinal malignancy masquerading as primary ovarian carcinoma

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ABSTRACT

About 4-5 % of ovarian tumours are metastatic from other organs, most frequently from the female genital tract, the breast, or the gastrointestinal tract. Ovarian metastases constitute 76% of genital tract metastases from extragenital primary tumours, of which 78% arise in the gastrointestinal tract. Metastatic ovarian tumours, often mistaken as primary ovarian carcinomas. A 37 year old P2+0 presented with c/o - Abdominal distension since last 6 months. It was associated with anorexia, constipation and generalised weakness. Not having any menstrual complaint. P/A: moderate ascitis was there. A mass of 8x10 cm felt through right fornix extending up to right iliac fossa. Mass was firm in consistency with restricted mobility. Uterus felt separately from the mass. Left fornix clear. A right sided ovarian mass of approx. 10x15 cm of variegated consistency identified. Bladder wall was thickened. Small nodules of approximately 1 cm present over dome of bladder under visceral peritoneum. Omentum, ascending colon, transverse colon, descending colon, caecum, greater curvature and lesser curvature were thickened. Liver and spleen were normal. Total abdominal hysterectomy with bilateral Salpingo oophorectomy with partial omentectomy was done. Histopathology Revealed metastatic adenocarcinoma of the genital tract and B/L ovaries. So it was concluded that secondaries from intestinal malignancy can present as primary ovarian malignancy.

Keywords: Primary ovarian carcinoma, Intestinal malignancy, Metastases

INTRODUCTION

About 4-5 % of ovarian tumours are metastatic from other organs, most frequently from the female genital tract, the breast, or the gastrointestinal tract.[1] Ovarian metastases constitute 76% of genital tract metastases from extragenital primary tumours, of which 78% arise in the gastrointestinal tract.[2] Metastatic ovarian tumours, often mistaken as Primary ovarian carcinomas.

CASE REPORT

A 37 year old P2+0 presented with c/o - Abdominal distension since last 6 months. It was associated with anorexia, constipation and generalised weakness. She was not having any menstrual complaint. On abdominal examination moderate ascitis was there. Omentum felt as firm to hard omental cake. A vague mass of approximately 8x10 cm felt in the right iliac fossa extending to hypogastrium. Lower end of the mass not reachable. On per vaginal examination uterus parous size, anteverted. A mass of 8x10 cm felt through right fornix extending up to right iliac fossa. Mass was firm in consistency with restricted mobility. Uterus felt separately from the mass. Left fornix clear. Her blood investigation revealed Hb = 8.5 gm% and all other investigation (CBC, LFT, KFT, S. electrolytes, chest X-ray PA view) were within normal limit. CA 125 = 14.7 IU.

MRI and CECT abdomen - Moderate sized , well defined space occupying lesion, displaying mixed signal

intensities s/o mixed solid & cystic component, of approx. 11x10 cm noted involving both adnexa in the pelvic region reaching up to umbilicus with omental caking , and thickened coecal wall - Findings are likely suggestive of Malignant ovarian tumour with Uterine fibroids. With the help of clinical examination and radiological investigation, a diagnosis of right sided ovarian tumour most likely malignant with uterine fibroids was made.

Patient prepared for laparotomy. One unit blood was transfused preoperatively and one unit in the post-operative period. 3.5-4 literes of haemorrhagic fluid was drained. A right sided ovarian mass of approx. 10x15 cm of variegated consistency identified. Bladder wall was thickened. Small nodules of approximately 1 cm present over dome of bladder under visceral peritoneum. Omentum, ascending colon, transverse colon, descending colon, caecum, greater curvature and lesser curvature were thickened. Liver and spleen were normal. Total abdominal hysterectomy with bilateral Salpingo oophorectomy with partial omentectomy was done. Tissues were sent for histopathology. Histopathology Revealed metastatic adenocarcinoma of the genital tract and B/L ovaries. The enlarged right ovary revealed ovarian oedema. After HPE reporting a diagnosis of metastatic adenocarcinoma of most probably large intestine was made.

The patient was planned for further workup and chemotherapy but unfortunately she expired within 20 days of the surgery.

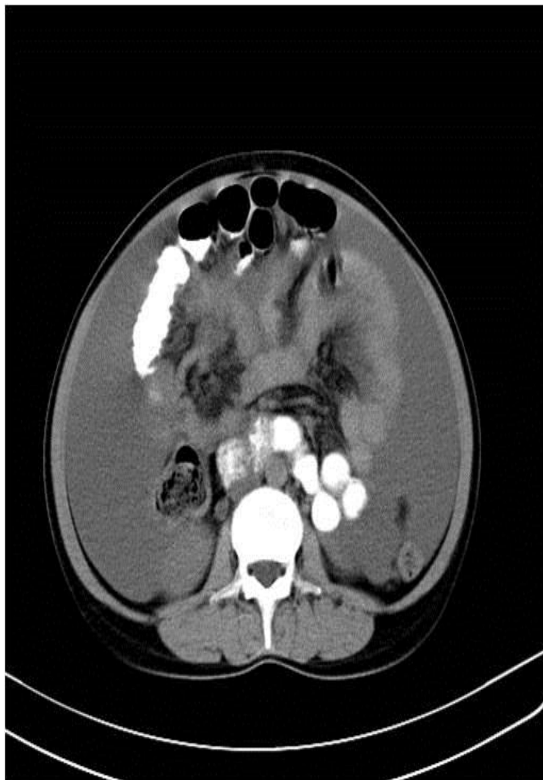

Figure 1: MRI showing caecal wall thickening.

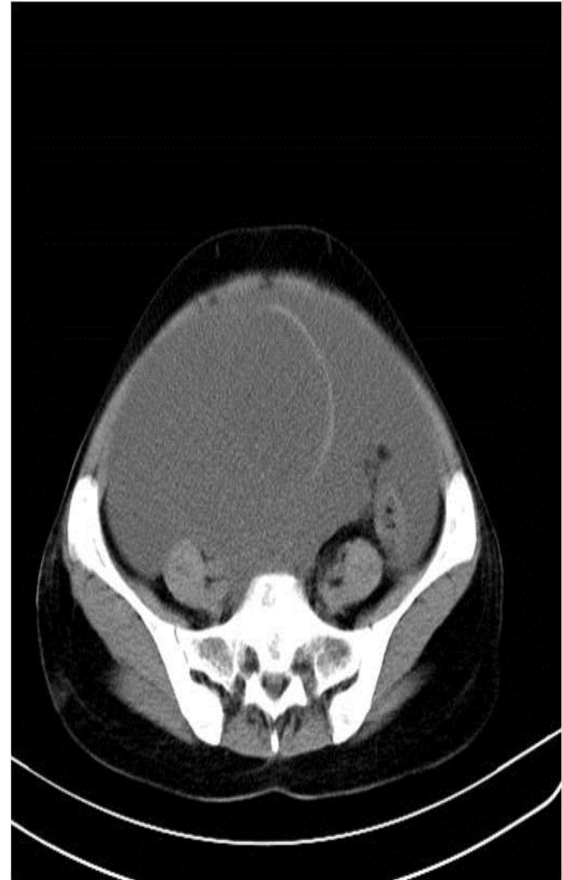

Figure 2: MRI showing adnexal mass.

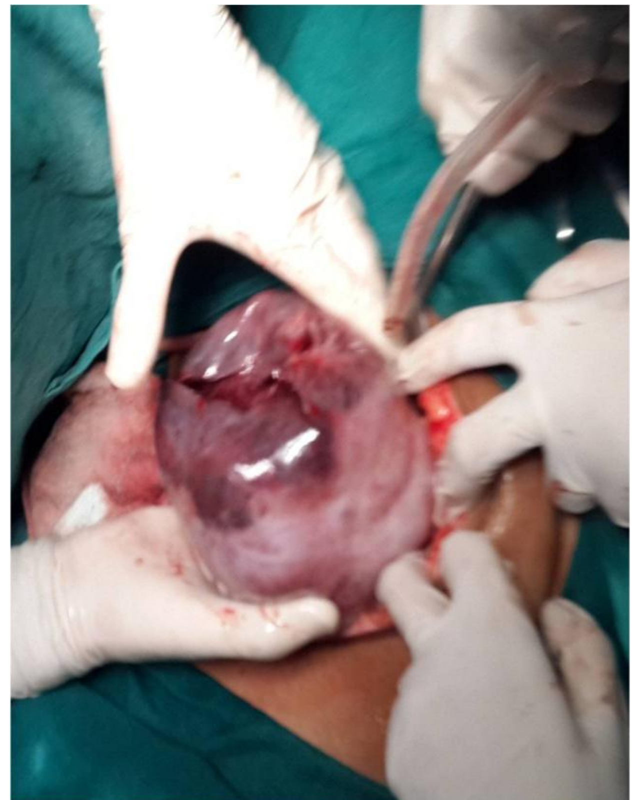

Figure 3: Right ovarian mass.

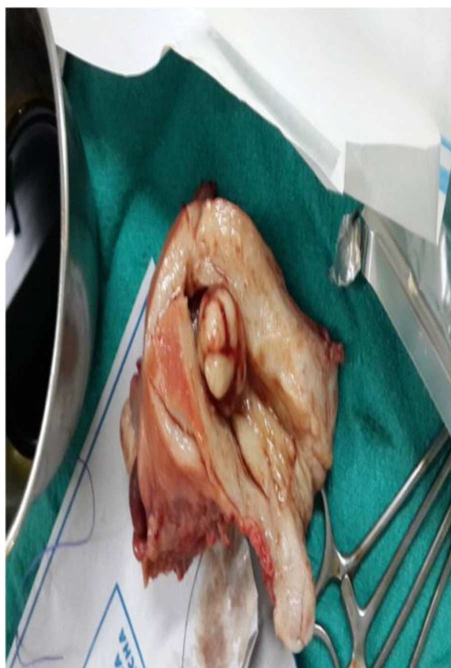

Figure 4: Intramural fibroid.

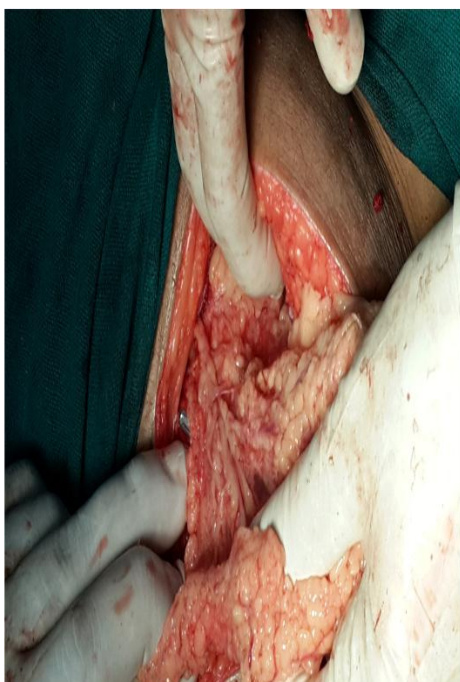

Figure 5: Omental thickening.

DISCUSSION

Intestinal malignancies, mainly from the rectum or sigmoid colon (77%) spread to the ovary.[1] Clinical presentation may be of intestinal carcinoma antedating ovarian tumour (50-75%of cases) or of an ovarian tumour (3-20% of cases).[3] The distinction of metastatic ovarian carcinoma from a primary malignant ovarian neoplasm is crucial to its subsequent management.[4] In our case the patient presented as a case of primary ovarian malignancy. Up to 45% metastases from the large intestine are clinically interpreted as primary ovarian carcinomas, because of large size and predominantly cystic. On microscopic examination also they closely mimics primary ovarian adenocarcinoma.

In our case we get an unusual finding of diffuse massive oedema of right ovary. Massive ovarian oedema due to permeation of the ovarian lymphatics by metastatic carcinoma is rare, with a few cases reported to date.[4] Few studies have addressed the more common problem of accurate diagnosis of metastatic colonic adenocarcinoma.[5] A thorough history facilitates the diagnosis, but occasionally, a complete clinical history is not available or the ovarian tumour may be the first indication of an unsuspected primary carcinoma of the colon. Integration of clinicopathologic, immunohistochemical and cytogenetic features is helpful for the differential diagnosis of metastases of colorectal carcinomas from primary ovarian carcinomas.[5] In case of an ovarian tumour, metastatic disease should always be considered to avoid pitfalls in diagnosis and therapy. The gastrointestinal tract is the most likely location of primary tumour, followed by breast and endometrium.

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