PREGNANCY WITH LARGE OVARIAN TUMOUR – A CASE REPORT

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Abstract :

Ovarian tumour occur at any age group. So pregnancy with ovarian cyst is not very uncommon. But pregnancy with large tumour is uncommon. A 25 years old lady was admitted in BSMMU with 3rd gravida 28 weeks pregnancy with large ovarian tumor with ascites with H/O previous two caesarean section. Ovarian tumour was diagnosed at her 24 weeks pregnancy by ultrasonography. FNAC was done by the advice of her clinician which reveal dysgermenoma. She was referred to BSMMU from cancer Institute, Mohakhali for termination of pregnancy.

Key word: *Dysgerminoma.*

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Introduction :

Germ cell tumours are derived from the primordial germ cells of the ovary. Their incidence is only approximately one tenth the incidence of malignant germ cell tumour of the testis, so most of the advances in the management of these tumours have been extrapolations from experience with the corresponding testicular tumours.[1] Although malignant germ cell tumours can arise in the extragonadal sites such as mediastinum and the retroperitoneum, most germ cell tumours arise in the gonad from the undifferentiated germ cells. The variation in the site of these cancers is explained by the embryonic migration of the germ cells from the caudal part of the yolk sac to the dorsal mesentry before their incorporation into the sex cords of the developing gonads. Although 20-25% of all benign and malignant ovarian neoplasms are of germ cell origin, only approx. 3% of these tumours are malignant.[2] A woman has a life time risk of ovarian cancer of around 1.5%, which makes it the second most common gynaecologic malignancy.[3]

Case Report:

A 26 year old lady of 3rd gravida with H/O previous 2 caesarean section got admitted with 28 weeks pregnancy with large ovarian tumour on 21st December'08. She was on irregular antenatal check up. When her abdomen become unusually enlarged at her 24 weeks pregnancy USG was done and reveals 24 weeks pregnancy with large ovarian tumour. FNAC was done in Kushtia and it reveals dysgerminoma. At that time decision was taken for continuation of pregnancy. But patient distress was increased because of tumour and ascites. Then they referred the case to Cancer Institute, Mohakhali, from where they transferred the patient for termination of pregnancy to fetomaternal medicine unit, BSMMU. After admission patient was cachectic, severely distressed and anaemic. On perabdominal examination abdomen was hugely distended upto 36 weeks pregnancy size, abdominal girth was 110cm, fluid thrill was present and there was a cleavage found between fundus of uterus and ovarian tumour. An opinion from gynaecological oncologist was taken and decision for caesarean hysterectomy was taken. On 21st December'08 laparatomy was done by lower midline incision. Ascitic fluid was drawn and send for cytology. Caesarean section was done. A female baby of 600gm was delivered. Approach to lower segment of uterus was very difficult. Exploration was done for surgical staging. Whole tumour was brought out with difficulty. The consistency was jelly like and most of the places the capsule was broken. The tumour was free from adhesion. The opposite ovary seems to be healthy. Total abdominal hysterectomy with bilateral salpingo oophorectomy was done and tissue sent for histopathology. There were no macroscopic metastatic deposit over omentum, peritoneum, gut, liver and gallbladder. Abdomen was closed keeping a drain tube. Three units of blood was

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transfused. Histopathology report reveal dysgerminoma. The patient was discharged on 8th POD with the advice to attend oncology unit for further treatment.

Discussion:

Of all the gynaecologic cancers ovarian malignancies represent the greatest clinical challange. A women's risk at birth of having ovarian cancer sometimes in her life is nearly 1.5% and that of dying from ovarian cancer is almost 1%. Germ cell tumour generally occur prior to puberty or in early adult life. It account for about 15% of all ovarian tumours at all ages.[4] However it accounts for 60-70 percent of tumours in women under the age of 20.[4] In contrast to the relatively slow growing epithelial ovarian tumours, germ cell malignancies grow rapidly and often are characterized by subacute pelvic pain related to capsular distention, haemorrhage or necrosis. The rapidly enlarging pelvic mass may produce pressure symptoms on the bladder or rectum and menstrual irregularities also may occur in menarchal patients. As these malignancies occur in young women, 20% to 30% of all ovarian malignancies associated with pregnancy are dysgerminoma.[1] Approximately 75% of dysgerminoma are stage I (i.e confined to one or both ovaries) at diagnosis.[5] In patient whose contralateral ovary has been preserved, disease can develop in 5% to 10% of the retained gonads over the next 2 years. In the 25% of patients who present with metastatic disease, the tumour most commonly spreads through lymphatics. It can also spread hematogeneously or by direct extension through the capsule of the ovary with exfoliation and dissemination of cells through out peritoneal surfaces. The treatment of patient with early dysgerminoma is primarily surgical, including resection of primary lesion and proper surgical staging. Chemotherapy and/or radiation is administered to patients with metastatic disease. Because the disease principally affects girls or young women, special consideration must be given to the preservation of fertility whenever possible. The minimum operation for ovarian dysgerminoma is a unilateral salpingo oophorectomy if there is desire to preserve fertility.[5]If fertility need not be preserved it may be appropriate to perform a total abdominal hysterectomy and bilateral salpingo oophorectomy in patients with advanced disease.

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