

Giant Musinous Cystadenoma Monitored Until The Term Pregnancy Without Ending Pregnancy: Case Report

Gebeliği Komplike Etmeden Miyada Kadar Takip Edilen Dev Ovaryan Müsinöz Kistadenom: Olgu Sunumu

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Abstract

There is no certain consensus on approach towards the adnexal mass in pregnancy. A wide spectrum treatment from conservative monitor to the complicated operations may be needed. Many of these adnexal masses are benign and disappear itself. Adnexal masses which have become persistent in the later weeks of pregnancy may force the physician and patient in the monitoring and treatment processes. This study, based on a case having an adnexal mass which was accidentally determined in the 29th week of the pregnancy, aims to contribute to the diagnosis, follow-up and treatment of the adnexal masses in pregnancy by using the datum of the literature.

Key words: Adnexal mass, cyst, pregnancy.

Özet

Gebelikte adneksiyel kitlelere yaklaşımda belirlenmiş bir konsesusu yoktur. Konservatif takipten komplike operasyonlara kadar geniş spektrumda tedavi gerekebilir. Bu adneksiyel kitlelerin büyük çoğunluğu benign olup, çoğu rezoluse olabilir. İlerleyen gebelik haftalarında persiste olan adneksiyel kitleler hekimi ve hastayı takip ve tedavide zorlayabilir. Biz bu yazıda 29. gebelik haftasında tesadüfen tespit edilmiş adneksiyel kitlesi olan bu vakadan yola çıkarak gebelikte adneksiyel kitlelerin tanı, takip ve tedavisine literatur verileriyle katkıda bulunmak istedik.

Anahtar kelimeler: Adneksiyel kitle, kist, gebelik, müsinöz kistadenom.

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Introduction

Mucinous tumors form one-third of(%36) the tumors in general. Most parts of mucinous tumors are benign, so they are mucinous cystadenoma(%81). Borderline tumors constitute fourteen percent and malign tumors do five percent. The average age having mucinous cystadenoma is 44. They are one of the main tumors that can reach the biggest size. Their range can reach 30 centimeter and more, and their weight can be as much as 30-40 kilograms. Bilateralite is rare and %98 is unilateral(1,2).

During pregnancy, the incidence of adnexal mass index changes between 1/18 and 1/8000. They are usually asymptomatic(3). Although they are rarely seen, there is no a certain consensus on the approach of adnexal mass index in pregnancy that requires broad spectrum treatment from conservative follow-up to complicated operation. This situation forces clinicians to treat and monitor the patient. We want to examine recognition, diagnosis and monitoring of adnexal mass with the case that was accidentally diagnosed in third trimester.

Case

A 29 aged pregnant woman applied the clinic in the 29th week of her pregnancy with two gravida, one parite. In ultrasonography, one living fetus compatible with 29 week was detected along with intense cystic lesion with multiseptas which is approximately 314*172mm that starts from epigastric region to left lateral abdomen in it. Ca 125 level of patient was 15. Low resistance blood flow was not seen in doppler ultrasonography. There was not a specific feature of clinical complaint of patient. All other diagnoses were also normal. Patient and her relatives were informed about the current situation. Patient who was informed about malignite did not approve the operation with the risk of preterm labor. Information paper was signed by patient and then she was monitored spontaneously. The patient was taken for caesarean section in her 36th week pregnancy electively. After the operation, the mass which was in intra-abdominal excised with left oophorectomy without rupturing. The result of pathology was recorded as benign musinous cystadenoma that weighed 2500gr and its size was 23*18cm(Picture 1,2). There weren't any complications of the patient in post-operation monitoring.



Picture 1&2: The pictures of adnexal mass after the sectio

Discussion

Thanks to ultrasonography used in routines of adnexal mass, the mass can be diagnosed in the early stages. However, masses can be complicated with rupture, cyst bleeding, infection and torsion. The ultrasonography can distinguish the masses which is simple, complicated or solid(4).

Small adnexal masses that are seen as accidentally in ultrasonography are not risk group. Moreover, Bernard and his friends found that big and ultrasonographically complicated masses get well spontaneously. In this study, 18391 ultrasonography was used and applied to 432 women. Adnexal mass incidence was found as %2.3 and percentage of over torsion was determined as %1(5).

The best time for elective surgery is second trimester. The patient should be informed about preterm labor risk. In our case, the patient was in her 29th week. The fact that 3rd trimester has more risk of complication of surgery for the patient, preterm delivery is risky and the patient suspected for malignency risk cysts were told to the patient and her relatives. However, the patient and their relatives agreed on the operation by taking all risks when it is need.

The best interventional method should be discussed(laparoscopy or laparotomy). In the most of the studies, It is shown that the 1st trimester laparoscopy is more reliable and suitable than 2nd trimester laparoscopy.

While discriminating the benign malign of adnexal masses, ultrasonography, doppler ultrasonography and tumor markers can be used. Many characteristic features were defined in discrimination of benign and malign mass in ultrasonography studies. According to studies that were used for diagnosis malignite, average positiveness of ultrasonography is %74 and average sensitivity is %88.

Weiner et al. have studied on blood flow resistance in women with adnexal masses with pre-exploratory surgery transvaginal color flow imaging technique. Intramural blood flow continuously shows low resistance in patients with malign tumor and flow index is below 1/16. While the sensitivity of preoperative flow index in malign ovarian tumor screenings are %94, its specificity is %97. These criteria are used in making distinction between malign and benign ovarian masses: number of veins in each mass, vein localization(central or peripheral), peak pulse rate, lowest resistance index, average resistance index. Color doppler signals are detected to be %100 in malign, %75 in benign masses. It is reported by Alcazar et al. that this difference is statistically meaningful(6,7).

Tumor indicators can be also clue in about the ma-

lign and benign distinction. Ca 125 tumor related antigen is an antibody used on %80 of patients with epithelial ovarian cancer. Malignite too, increases in acidic benign cases(8).

In our case, it was not considered as malign when it was observed that the patient was diagnosed during the 29th week of pregnancy, Ca 125 turned out normal, number and localization of veins in ultrasonography were evaluated and the flow index in doppler ultrasonography were looked. They decided to postpone the operation until a complication is developed after the patient and her relatives were informed. Therefore, the patient with an estimated fetal weight of 2850gr was taken into cesarean section. Mass of the patient who went through cesarean section was taken by oophorectomy without being ruptured.

Consequently, according to clinical and radiological symptoms of the patient, conservative or surgery approach options are evaluated during the gestational week that the mass is identified, even though the growth of the mass is vital when diagnosed. Adnexal masses that are considered to be asymptomatic, benign should primarily be treated with conservative approach. However, if it is necessary to interfere, elective operation at the beginning of the 2nd trimester is an ideal period for both mother and fetus.

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