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Research Article

OVARIAN GIANT SEROUS CYSTADENOMA: A CASE IN A 16-YEARS-OLD GIRL

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ABSTRACT

The authors report a case of giant serous cystadenoma of the right ovary in a 16-years-old girl. They recall the diagnostic procedure by indicating that there is no specific symptomatology. Some signs are nevertheless frequently found and are related to the increase in the volume of the mass. But, a careful physical examination of the abdomen associated with transabdominal ultrasound makes it possible to make the diagnosis. The benign or malignant nature must be confirmed by biopsy. The treatment of choice is surgical and must take into account the age and desire for maternity of the patient.

Key Words:

Serous cystadenoma-giant ovarian tumor-
ovarian cyst- Kisangani

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INTRODUCTION

The most frequent ovarian tumors are epithelial, almost always cystic and serous. They may be benign (60-70%), malignant (20-25%) or borderline (10-15%) [1,2]. Giant forms have become rare due to the development of high-performance technologies that enable early diagnosis. However, they have not entirely disappeared for several reasons: Call signs are for a long time discrete and not very specific; ultrasound (examination of choice) requires to be performed by an experienced practitioner not to be confused with ascites. The diagnosis can be delayed, leaving time for the cyst to become large and lead to mechanical complications [3]. We report the case of a giant serous cystadenoma observed in a girl of 16 years, in order to demonstrate the difficulties encountered by the clinician to arrive at the diagnosis of certainty.

Patient and Observation

A16-years-old adolescent, nulligest, with no specific pathological history, consulted us in 2015 for increased abdominal volume and recurrent spaniomenorrhea having evolved for more than a year. It was followed in several medical centers of the place where the diagnosis of ascites and

the immaturity of the hypothalamic-pituitary-ovarian axis were posed. Spironolactone-based treatment and low-sodium diet were initiated without improvement. On the contrary, the abdomen continued to increase in volume and the patient became dyspneic due to its transfer to a pediatric center where the diagnosis of peritoneal tuberculosis was based on the appearance of the peritoneal fluid which, unfortunately, was not analyzed in the laboratory. A therapeutic peritoneal aspiration had evacuated 500 ml of the serous fluid and an anti-tuberculosis treatment instituted for 6 months without any improvement.

The patient reported anorexia and exaggerated pelvic heaviness at the standing station. She weighed 63 Kgs (weight gain of 7kgs); Secondary sexual characteristics were present. The abdomen was increased in volume [Fig. 1], entirely matt with superior convexity. The sign of Fourester and the sign of Moiroud were present. The liver was not palpated; No anomaly of the cardio-respiratory system was objectified, the hymen was intact. The abdominal ultrasound showed an anechoic image with a thin partition close to the lower pole and centered of a slightly echogenic zone, with posterior reinforcement of the echoes. The image extended far beyond the monitor screen [Fig. 2a]. The liver, spleen and intestinal loops were pushed

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back towards the flanks and not surrounded by liquid. The uterus was pushed back [Fig. 2b], homogeneous with virtual cavity and measured 60mm x30mm x25mm. The cross section had made it possible to distinguish the mass of the bladder [Fig. 2c].



Fig 1 increase in abdominal volume

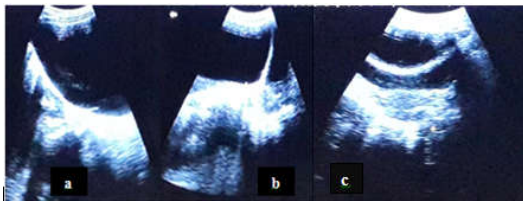


Fig 2 Anechoic image in longitudinal section.

a. image overflowing the monitor screen; b. uterus pushed back; c. cross-section showing the bladder, cystic mass and uterus from top to bottom

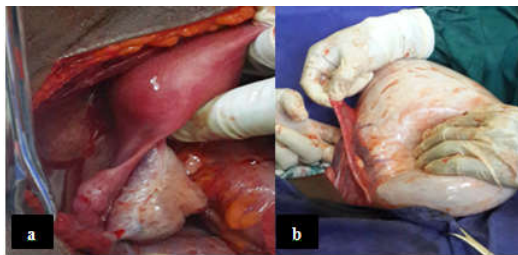


Fig 3 Macroscopic images of the uterus and appendages.

a. uterus, trunk and left ovary of normal appearance; b. straight horn adhering to the mass

The left ovary was normal in appearance, the right ovary not seen. Douglas fir was free. The diagnosis was that of a giant cyst of the right ovary. A surgical exploration by median laparotomy was performed. In per operating, the uterus and the left appendages were of normal appearance [Fig. 3a]. The right ovary was occupied by a voluminous cystic mass. The right tube had adhered to the surface of the mass [Fig. 3b]. After adhesiolysis of the right tube, we performed the right ovariectomy. The mass had a weight of 7000g. The contents were serous and quantified at 6700ml. The operative sequences were simple; the patient had left on the 5th day. Anatomopathological examination had found a serous cystadenoma. Surveillance in the following year was without particularity.

DISCUSSION

The serous cystadenoma accounts for 40% of the total ovarian mass [2]. The detection of the giant and unilateral form arouses

much concern for the physician and the patient because of the fear of malignancy.

There is no specific symptomatology of giant ovarian cysts. In the literature, the most frequent sign is the increase in the volume of the abdomen, as in the case of our patient. But the patient may also report pelvic pain due to gravity; menstrual disorders or signs of mechanical complications related to the size of the tumor. At a later stage, the mass can compress the diaphragm and interfere with the expansion of the rib cage, causing dyspnea. These signs were also noted in our patient.

Abdominal palpation can regain a renitent mass of regular contours. It will also seek classical supraspinal and sub-pubic voids [4,5]. The percussion notes dullness with higher convexity. It can also find signs of Flot, Fourestier (lumbar sound in a sitting or crouching position due to the backflow of the intestines in the lumbar fossa) and Moiroud (ascending wave sign). In front of all these signs, the problem of differential diagnosis with ascites can not arise. But in the case of a very large cyst, or in an obese patient, all these distinctive signs disappear and it is not uncommon for these cysts to be punctured as an ascites.

The gynecological examination is often difficult and does not provide much information. The main complementary examination which allows to suspect the ovarian origin of the tumor, to inform about its structure (content, wall and dimensions) and to eliminate the diagnosis of ascites is transabdominal ultrasound. Often the size of the tumor does not make it possible to obtain a complete transverse or sagittal section. This was the case with our patient. Some other examinations are only necessary in case of uncertainty diagnosis. Some are useful for the assessment of the extent of cancer (IRM, Scanner) [3,4,5]; to monitor postoperative progression of a malignant cyst (ACE, CA 125 and CA 19-9) [6]. However, IRM is also essential in the case of a large cyst (> 7 cm in diameter) because ultrasound cannot provide complete exploration [7].

The treatment of a giant ovarian cyst is surgical too. A large medial incision under and supra-umbilical makes it possible to extract the tumor whole and to avoid the risk of dissemination in case of carcinoma [3]

The surgical procedure must take into account age and parity. In young women wishing to maintain their fertility, the treatment must be conservative, as was the case with our patient. In older patients, adnexectomy or total non-conservative hysterectomy is preferable, protecting against possible errors and recurrences [3,7].

CONCLUSION

Large ovarian tumors are not uncommon in developing countries. The delay in diagnosis is most often related to the patients themselves who consult late, but also to the limited diagnosis means not -always allowing detection in first intention. However, a good physical examination of the abdomen can bring elements of suspicion.

Competing interest

The authors declare that they have no competing interests

Author's is contributions

Modia O'yandjo A. and Bosenge Nguma JD Participated in the management of patient. Modia O'yandjo wrote the first draft. All authors contributed to writing and revising of drafts; performed critical reviews of manuscript for intellectual content and approved the final manuscript.

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