Giant Mucinous Cystadenoma of the Ovary Mimicking Ascites: A Case Report

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Abstract
In the present case report we describe a 67 years old woman with clinically apparent ascites and no systemic causes for it and a giant mucinous cystadenoma of the right ovary diagnosed utilizing the CT scan and confirmed by the histological findings.

Keywords
Ascites, Mucinous cystadenoma, Ovary

Introduction
Ascites consists in the accumulation of fluid within the peritoneal cavity and is a common finding with a wide range of causes [1]. Although at least 80% of patients with ascites are found to have liver cirrhosis other pathologies as well as heart failure, peritonitis, nephrotic syndrome, peritoneal neoplasms have also to be considered.

Clinical manifestations of ascites range from complete absence of symptoms to severely distended abdomen with respiratory distress, pyrosis, abdominal pain, nausea, anorexia. On physical examination the flanks are bulged, and a fluid wave can be apparent together with a shifting dullness. Umbilical herniation may further confirm the presence of ascites. Among the different causes of ascites not associated with liver and peritoneal diseases, it is known that ovarian pathologies may determine it although this symptom is not specific and ascites due to ovarian malignant pathology (i.e. ovarian cancer due to metastasization to the peritoneal cavity) may suggest the existence of a disease of the abdominal organs since patients report abdominal fullness, dyspepsia, early satsiety [2].

Here we describe a woman presenting with a giant cystic neoplasm of the ovary mimicking ascites.

Report of the Case
We have recently evaluated a 67 years old woman referred to our hospital for ascites. Her clinical history was negative. She referred a slow progressive increase of the abdominal circumference over the past 4-5 years. On arrival at our hospital the patient showed slight dyspnea, normal arterial pressure and pulse. On physical examination we observed bilateral elevation of pulmonary inferior margins, no signs of cardiocirculatory failure nor peripheral edema, a remarkable ascites with eversion of the umbilicus. No venous reticula, fullness in the flanks, fluid thrill, defense reaction nor shifting dullness were present. Splanchic organs were not palpable, the bowel sounds were muffled. Laboratory investigations were normal with normal liver and kidney function tests, normal albumin plasma concentration and normal plasma ion concentrations. Also plasma osmolarity was in the normal range. The alpha-fetoprotein plasma levels were normal as were other tumoral markers investigated (CA-125, CEA, hCG, CA 19-9). The urine analysis was normal. Chest X-ray did not show any remarkable finding. On abdominal ultrasound examination performed on site upon arrival at the emergency care unit, the liver appeared normal with the description of important ascites. An abdominal CT scan was then performed. The liver, gallbladder, intrahepatic biliary tree, common bile duct, spleen, pancreas, kidneys, large vessels and bladder were all normal. The uterus was homogeneous and hypotrophic. A giant intraperitoneal cystic mass measuring 28.5 × 17.8 × 46.2 cm (with a calculated volume of about 12 liters) was visualized originating from the right ovary with numerous septa displacing the colon, the stomach and pushing up the liver and the spleen with no compression of other abdominal organs (Figure 1). There was no free fluid in the abdomen and nosign of infiltration.

Figure 1: CT scan of the abdomen showing a multiseptated mass originating from the right ovary and occupying the whole abdomen.

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mimicking ascites. Routine laboratory investigations are not of help in case of mucinous cystadenoma of the ovary unless functional ovarian epithelium is present thus possibly leading to elevation of plasma level of oestromarkers such as CA 125 and CA 19-9, although this is not always true [9]. On the contrary, laboratory investigations could be of help in the diagnosis of other causes of ascites such as liver cirrhosis. Ultrasound and CT scan of the abdomen are fundamental for the differential diagnosis, tumour size and extension.

The surgical removal of the mass is the only therapeutic option in case of giant mucinous cystadenoma of the ovary because of symptoms due to mass effect and the above-mentioned risk of malignancy. After surgical removal, the follow up consists in abdominal morphological examination with ultrasound and CT scan together with the analysis of tumour markers if elevated preoperatively. The clinical prognosis of ovarian giant mucinous cystadenomas is usually good since the malignant transformation occurs in less than 10% of cases [9].

In conclusion ovarian neoplasms presenting with very large cystic masses can be mislead with ascites and in these cases morphological examination using ultrasound and CT scan appears fundamental to evaluate their precise origin and relationships with the other abdominal organs.

References