

## CME

ST LUKE`S HOSPITAL ANGAL

### Case presentation

- 47 year old female presented with main c/o persistent umbilical pain x 2 months.
- Inability to pass urine well for same period of time.
- Past history of exploratory laparotomy for an unknown abdominal mass in Mahagi Hospital, DRC.

## Conti....

- Physical examination revealed a middle aged female with some degree of wasting. No lymphadenopathy or pallor.
- Sister Joseph nodules.
- Slightly distended abdomen. Pfannenstiel incision scar. Suprapubic mass, immobile, non tender, 8x7x5 in size.



picture



Conti...

- **Initial Impression**: Urine Retention secondary to Intra-abdominal Mass.
- Infected umbilical wound.
- Uterine fibroids

## Conti...

- Ultrasound done twice: echocomplex mass in the pelvis with cystic and solid components. Gross ascitis.
- Hb: 12.2g/dl
- Diagnostic serology: NR
- What further investigations could we have done ?

## Conti...

- FBC
- RFT/LFT
- CA 125
- CXR
- Cytology of ascitic fluid

## Conti..

- We subsequently decided on exploratory laparotomy.
- At laparotomy we found massive ascitis. Huge right ovarian mass, 9x7x6cm in size. Metastasis to small bowels, bladder and pelvic walls.
- Took specimens from above sites for biopsy and closed abdomen.

## Conti..

- Good post operative recovery.
- Patient counselled about the provisional Dx.
- Discharged on 6<sup>th</sup> POD.
- Advised to return x 1/12 when biopsy results available to consider referral for chemo/radiotherapy.

## Conti....

- By this time we had a clue of an underlying ovarian malignancy basing on her age, presentation with vague abdominal symptoms, pelvic mass, ascitis and the findings at laparotomy

## ***Ovarian Carcinoma***

- This is rare, but more women die from it than from carcinoma of the cervix and uterine body combined because in up to 80% it causes few symptoms until it has metastasized, often to the pelvis with omental and peritoneal seedlings.
- In the western world it's the 4<sup>th</sup> commonest cause of cancer-related death. Statistics from uganda are hard to come by.

## Cont..

- 80% of ovarian malignant tumours are cystadenocarcinomas.
- The remaining 20% are a group of rare germ cell or sex cord malignancies or secondaries e.g from the G.I tract (*krukenberg tumours*)

## Incidence/risk factors

- 1 in 2500 women >55years
- 1 in 3800 if >25yrs
- Family history; if 2 close relatives affected lifetime ovarian cancer risk is 40%
- Carriers of mutations in *BRCA1* or *BRCA2* genes stand an increase risk too. 40% for women with mutations in *BRCA1* and 25% for *BRCA2*.

## Cont..

- It is commoner in those with many ovulations (early menarche, nullipara)
- Combined oral contraceptive pill use reduces risk.

## Clinical findings

- Symptoms are often vague and insidious and include abdominal pain, discomfort, and distension.
- Pelvic mass.

## Screening

- There`s really no good screening test.
- The aim is for early detection of disease
- Plasma levels of cancer associated antigen (CA-125) lack sufficient sensitivity or specificity for population screening.
- Worldwide no professional body has started screening yet.

## Diagnosis

- Starts with a thorough history and physical exam- a solid, irregular, fixed pelvic mass is highly suggestive of an ovarian malignancy particularly in combination with ascitis.
- Ultrasound/CT
- Cytology
- Serum tumour markers, CA-125
- Histology taken at surgery gives the definitive diagnosis.

## Staging at laparotomy is by FIGO

- **Stage I**: Disease limited to 1 or both ovaries.
- **Stage II**: Growth extends beyond the ovaries but confined to the pelvis.
- **Stage III**: Growth involving ovary and peritoneal implants outside pelvis (eg superficial liver), or +ve retroperitoneal/inguinal nodes.
- **Stage IV**: Distant metastases-liver parenchyma

## Treatment

- Surgery and Chemotherapy
- Surgery aims to remove as much tumour as possible for effective chemotherapy
- In very advanced disease “debulking surgery” is preferred.
- In a young woman with early disease, the uterus and other ovary may be left for fertility; if the tumour involves both ovaries, uterus and omentum are removed.

## Treatment

- Chemotherapy usually for up to 6 months.
- Carboplatin with Paclitaxel: produce higher response rates and longer survival compared to use of carboplatin alone.
- **Intraperitoneal(IP)** chemotherapy: a recent clinical trial indicated that median survival time is longer for patients with stage III epithelial ovarian adenocarcinoma receiving IP chemotherapy

## Prevention

- Pregnancy before the age of 25 as well as breastfeeding provides some reduction in risk.
- Tubal ligation and hysterectomy reduce the risk.
- Bilateral salpingo-oophorectomy greatly reduces the risk of not only ovarian cancer but breast cancer also.
- Oral contraceptives for 5yrs or more reduces risk by 50% in later life.

## Prognosis

- Very poor

## Reference

- Oxford handbook of clinical specialties 7<sup>th</sup> edition by J. Collier, M. Longmore, M. Brinsden
- Current surgical diagnosis and treatment 12<sup>th</sup> edition by Gerard M. Doherty
- NICE – under formulation
- [www.wikipedia.com](http://www.wikipedia.com)
- UCG – no data available.