

## Management of Complicated Ovarian Clear Cell Carcinoma

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### Abstract

Epithelial ovarian carcinoma is the most lethal gynaecological malignancy. It consists of different histologic subtypes including high-grade serous, clear cell, endometrioid, low-grade serous, and mucinous. The case represents a huge ovarian clear cell carcinoma in a patient who presented with thromboembolic events (Stroke and pulmonary embolism).

**Keywords:** *Epithelial Ovarian Carcinoma; Stroke; Pulmonary Embolism*

### Introduction

Epithelial ovarian carcinoma is the most lethal gynaecological malignancy.

### Case Reporting

A 52 years old Asian female with background history of fibroid, right ovarian endometrioma and peptic ulcer disease, presented with right arm weakness and paraesthesia for 19 hours. CT scan showed small ill-defined low attenuating area in left high parietal region and MRI scan confirmed multiple acute ischemic infarcts in left parietal lobe and right occipital lobe. The patient tested negative for COVID-19 virus.

The patient was also urgently referred by her GP through the rapid access gynaecological referral for suspected cancer, as she complained of 2 month history of feeling something hard in lower abdomen and unintentional weight loss with decreased appetite. She had an US done which showed large Heterogenous, mostly solid mass superior to uterus measuring 25 x 21 x 11 cm, ovaries not seen separately, minimal fluid and multiple intramural fibroid. At that stage, she was waiting for CT-CAP and CA125.

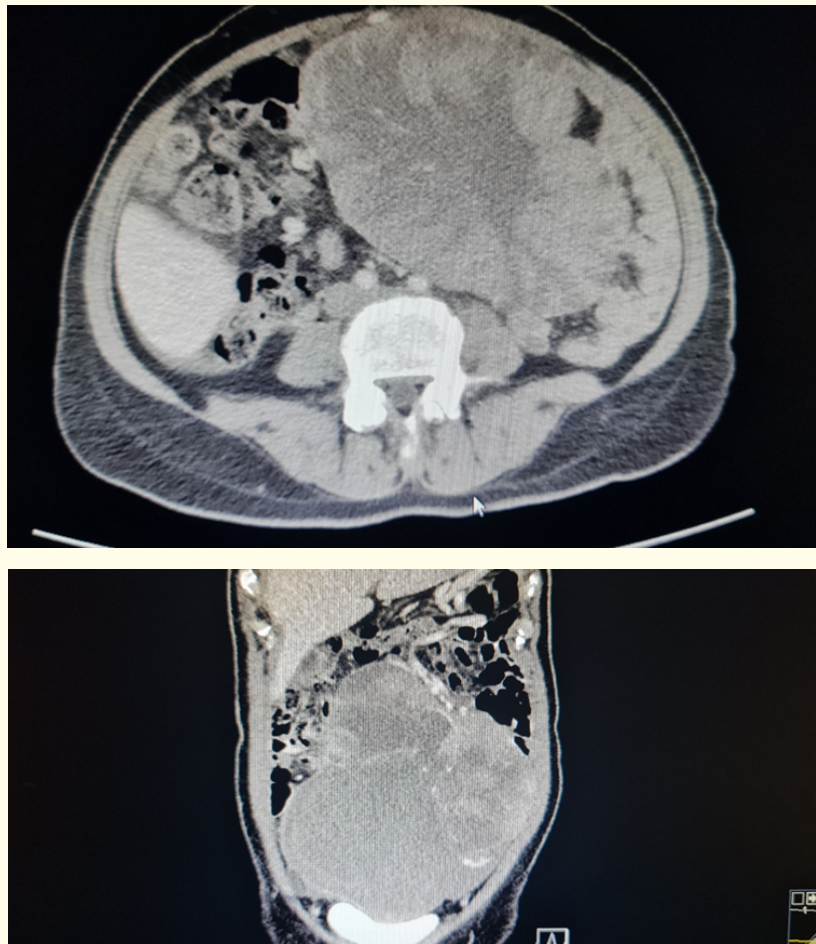
CT-CAP was done during this admission showed:

1. Lt adnexal large heterogenous adnexal mass 18 cm in diameter.
2. Small filling defect in segmental branch of right inferior pulmonary artery representing a pulmonary embolus.
3. Right ovarian cyst measuring 9 cm.

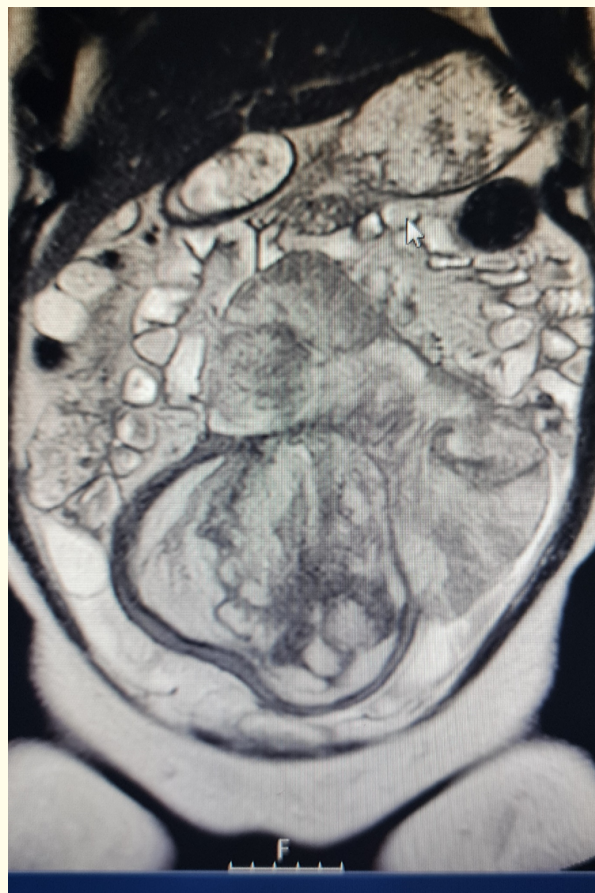
MRI scan showed large intraperitoneal lesion with the apex arising from root of mesentery with haemorrhagic component suggestive of large peritoneal leiomyoma. MDT gynaecological meeting disagreed with radiologists and the patient was scheduled for outpatient ultrasound guided biopsy and CA125.

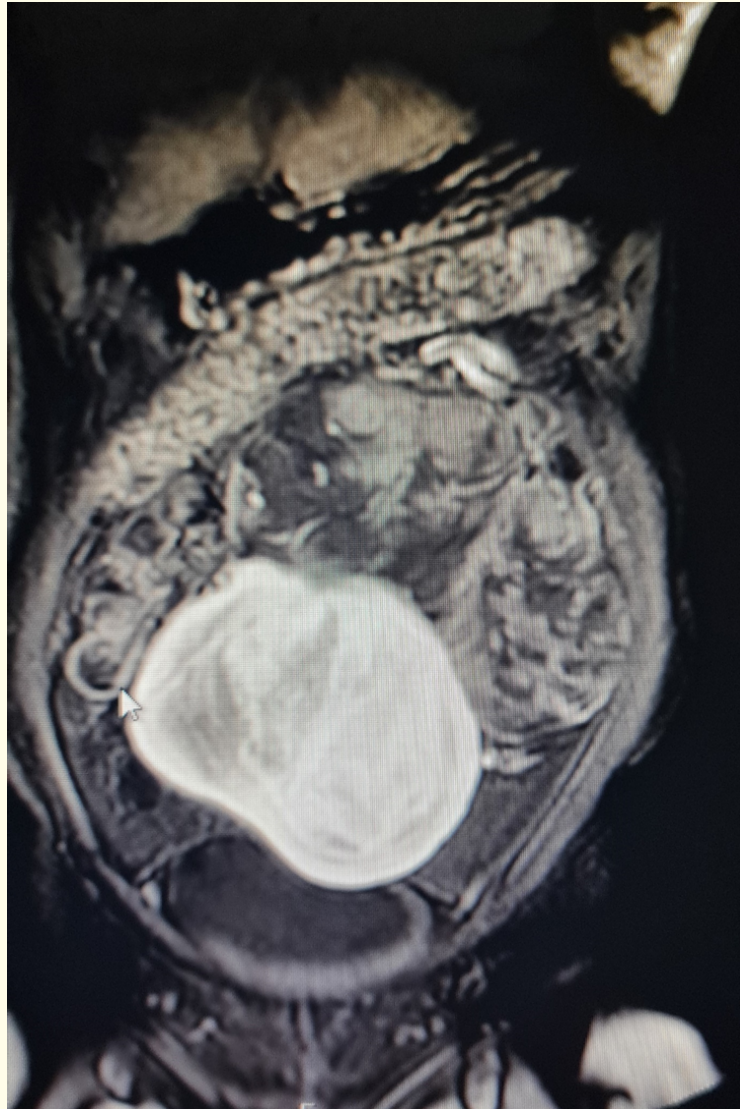
The biopsy results showed clear cell ovarian carcinoma and CA125 result was 273.

The Oncology surgery team were not willing to operate on the patient given her recent Stroke and pulmonary embolism and advised chemotherapy and repeat CT-CAP after 3 months but the patient was concerned that by 3 months the tumor would have metastasize or complicated by rupture and more thromboembolic events. She asked for second opinion. The new team decided to operate even before she completed 3 months of anticoagulation. The tumor was removed completely and staged as grade 1C. The patient was started on chemotherapy after surgery and completed first cycle.



**Figure 1:** CT scan- showing huge intraperitoneal mass.





**Figure 2:** MRI-scan Abdomen showing large left adnexal mass.

### Discussion

Ovarian clear cell carcinoma is the second most common type of epithelial ovarian carcinoma after high grade serous carcinoma. These tumors represented 12.1% of all ovarian cancers. The ages of the patients ranged from 34 to 78 years (mean 51.6 years) and 59% were post-menopausal. There are significant geographical and racial differences in the incidence of clear cell carcinoma, which is higher in



Korea (10.3%), Taiwan (18.6%) and Japan (15% - 25%) [1,2] than in North America and Europe (1% - 12%). Clear cell carcinoma tends to be diagnosed at an earlier stage than serous carcinoma, with 57% - 81% and 19% - 22%, respectively, presenting at stage I or II. The 5-year disease-free survival rates of patients with stage IA and IC1 clear cell carcinoma were 84% - 100% and 86% - 89%, respectively [3].

It shows unique clinical features including:

1. High incidence among Asian women, particularly Japanese women,
2. Low stage at presentation,
3. Association with endometriosis, the presence of endometriosis has been associated with a good prognosis,
4. High incidence of thromboembolic events, and
5. Inherently chemo-resistant.

The main presenting symptoms included a hard, palpable mass (32.6%), and newly developed or an exacerbation of dysmenorrhea (32.6%) and dyspareunia (25.6%). Gastrointestinal symptoms, pelvic pain, and abdominal distension existed in nine (20.9%), eight (18.6%) and one (2.3%) of the patients, respectively [4].

Standard surgical treatment of patients with ovarian clear cell carcinoma is the same as other epithelial ovarian carcinoma. Complete surgical staging is warranted to, at least, detect high-risk relapse patients.

Optimum management depends of epithelial ovarian cancer depends on, disease progression at presentation, metastasis, histological diagnosis, thromboembolic complications and patient's co-morbidities and fitness for surgery.

### Conclusion

Clear cell carcinoma of the ovary usually presents at early stages and FIGO stage 1, 2 have excellent prognosis. Thromboembolic events are common complication but should not be the only determinant of management plan. Tumor stage, metastasis and patient involvement in decision should be taken into account. In case of early stages without metastasis but with thromboembolic events, outweighing the risk of surgical intervention against possible disease progression, metastasis and patient preference should be highly taken into account.

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