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Case Report

Borderline Ovarian Tumour with Atypical Clinical Presentation: A Case Report

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Abstract

Borderline ovarian tumours are epithelial ovarian tumour group that takes position between clearly evident benign and malignant tumours. These tumours are usually properly diagnosed in earlier stages of the disease, rarely give relapses and have a long period of survival. The primary treatment is surgery and it requires careful exploration.

73-year-old patient was admitted to the Clinic for Gynaecology and obstetrics due to the existence of large tumour mass in the pelvis. She denied any subjective complaints, there was no data of gynaecological cancer in her family history and in her personal history, she had a cerebrovascular insult and gallbladder calculosis. Values of tumour markers CA 125, CEA иHE4 were in normal range, while CA 19-9 was elevated.

The patient underwent surgery with increased operational risk. Intraoperative findings confirmed the existence of a large cystic tumour mass with origin from right ovary, over 500ml serous fluid in the abdominal cavity and cystic change in the lower half of the liver. After consultation with pathologist, classical hysterectomy with bilateral adnexectomy, partial omentectomy and right pelvic lymphadenectomy was performed.

Postoperative course was complicated with progressive increase in transaminase values and the hepathologist was consulted who suspected that primary biliar cirrhosis of the liver may be the cause. Immunological analyses were taken. Histopathological finding was mucinous multicystic tumour of the right ovary, with no stromal invasion, punching capsules or presence of tumour tissue in opposite adnexa, uterus, perimetrium, lymph nodes and omentum. Tumour board decided that specific oncological treatment is finished.

Diagnosis and treatment of Borderline ovarian tumours are the challenge both for the surgeon and pathologist, but by early and detailed histological analyses and adequate surgical treatment, the disease can be completely cured.

Keywords: *Borderline tumour; Surgery; Diagnostic; Treatment*

Introduction

Borderline ovarian tumours are epithelial ovarian tumour group which, according to histological and biological characteristics takes position between clearly evident benign and malignant tumours. These tumours are usually properly diagnosed in earlier stages of the disease, rarely give relapses and have a long period of survival. According to FIGO classification from1971. They are classified as cystadenomas of low malignant potential-borderline tumours or proliferative cystadenomas. Borderline tumours of the ovary account for 15% of all epithelial carcinoma and include different histological types: serous (around 60%), mucinous (around 30%) and extremely rare endometrioid and tumours with mixed histological origin [1,2].

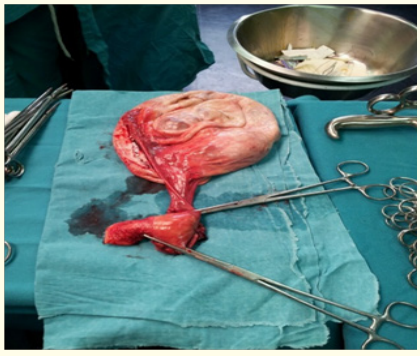
The primary treatment is surgery; if the tumour is diagnosed at earlier stage, depending on the menopausal status, ovariectomy, adnexectomy or hysterectomy with bilateral adnexectomy is required. In addition, it requires careful exploration, abdominal resection of

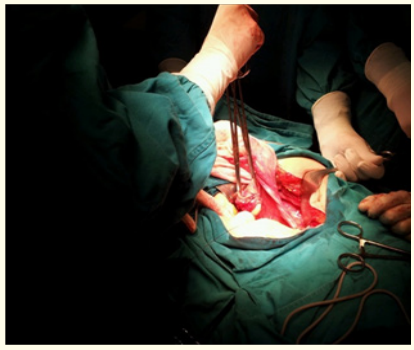
peritoneal implants, peritoneal cytology, total omentectomy and in certain cases of serous tumours, pelvic and para aortal lymphadenectomy [3,4].

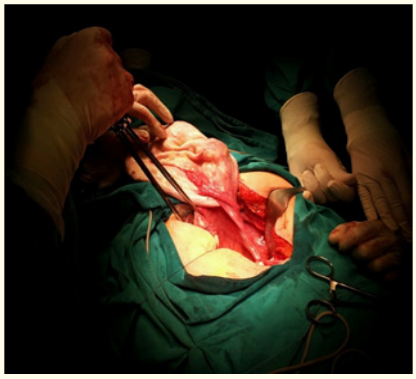
Case Report

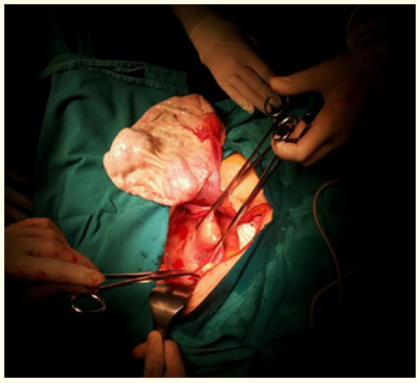
73-year-old patient was admitted to the Clinic for Gynaecology and obstetricsdue to the existence of large tumour mass in the pelvis. She was examined gynaecologically last time seven years ago, denied any subjective complaints, except for the occasional "swelling abdomen". There was no data of gynaecological cancer in her family history, she was in menopause for 18 years, with two vaginal delivery and few miscarriages. In her personal history, she had a cerebrovascular insult three years ago and gallbladder calculosis.By ultrasound examination of pelvis and abdomen a cystic tumefact with 150x200mm diameter was diagnosed, with multilocular excrescence, probably originated from right ovary. Also, gallbladder calculosis and focal blur, not clearly margined in dimensions 25x20mm in liver on the border of VI and VII segment were mentioned. Values of tumour markers CA 125, CEA иHE4 were in normal range, while CA 19-9 was elevated (360). During preoperative preparations Colour duplex scan of carotid and vertebral arteries, NMR, as well as puncture of ascites were performed. It was not possible to exclude malignant ovarian tumourwith certainty.

The patient underwent surgery with increased operational risk. Intraoperative findings confirmed the existence of a large tumour mass with origin from right ovary, dimensions 230x180x160 mm, light, wrinkled surfacewith numerous cystic prominences on the inner board surface. There was over 500ml serous fluid in the abdominal cavity. Left adnexa, uterus, pelvic peritoneum and other pelvic organs were without pathological changes. Liver with smooth surface and cystic change in the lower half. After consultation with pathologist, classical hysterectomy with bilateral adnexectomy, partial omentectomy and right pelvic lymphadenectomy was performed. Ascites was aspirated and sent to cytological examination.









Postoperative course was complicated with progressive increase in transaminase values and the hepathologist was consulted who suspected that primary biliar cirrhosis of the liver may be the cause. Immunological analyses were taken.

The patient was discharged in a good general condition, recovered, with normal laboratory tests. Histopathological finding was mucinous multicystic tumour of the right ovary, mostly coated with one-level mucinous epithelium without atypical findings. In a few focuses were formations of papillary structures with discrete nuclear atypia. There was no stromal invasion, punching capsules or presence of tumour tissue in opposite adnexa, uterus, perimetrium, lymph nodes and omentum. Cytological findings showed many reactive-modified mesothelial cells.

PHDg: Atypicalproliferating-borderlinemucinoustumorovariidextri, FIGO Ia.

This case was presented to Tumour board specialist group who decided that there is no need for further oncological treatment.

Discussion

Classification of mucinous Borderline ovarian tumours includes two main histological types: mainly intestinal and rare endocervical. Exceptionally, mucinous Borderline ovarian tumourscan be intraepithelial or micro invasive carcinomas.

They are typically multilocular, with possible solid structures, areas of necrosis and haemorrhage, but the presence of ascites is very unusual. Mucinous tumours of the intestinal histological type are usually bilateral and show mixed mucinous-epithelial components[5].

In this case unilateral tumour was diagnosed with large amount of ascites, suspected tumour change in liver, followed with minimal subjective complaints, so it was difficult to set preoperative diagnosis. It was decided to make midline laparotomy, and after exclusion of malignancy by pathologist adequate surgical procedure was performed. During postoperative period, hepathologist was consulted and suggested that described changes in liver were most likely primary biliar cirrhosis and not a malignant change. Diagnosis and treatment of Borderline ovarian tumours are the challenge both for the surgeon and pathologist, but by early and detailed histological analyses and adequate surgical treatment, the disease can be completely cured.

Conclusion

Classification of mucinous Borderline ovarian tumours includes two main histological types: mainly intestinal and rare endocervical. Exceptionally, mucinous Borderline ovarian tumours can be intraepithelial or micro invasive carcinomas.

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