



Huge Endometrioma Mimicking Ovarian Cancer: A Case Report

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ABSTRACT

Endometrioma (ovarian endometrial cyst) usually occurs in women of reproductive age. We report a rare case of huge ovarian endometrioma that was as large as a watermelon. A 26-year-old woman from Iran complained of abdominal distention over approximately 9 months. Diagnostic imaging revealed a semi solid mass measured about 25 centimeter. After doing laparotomy, an ovarian endometrioma was diagnosed in pathology.

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Introduction

Endometriosis is typically seen during the reproductive years and occurs in 6-10 percent of women. The sites of endometrium implantation include the ovaries, pelvic peritoneum, and other organs. The most common site is ovary (about 60%). Ovarian endometrial cyst is a unique ovarian cyst that has morphologic features and contains chocolate fluid. It rarely exceeds 15 cm in diameter (1). A rare case of endometrioma that was as large as a watermelon (2300 g) is reported in this case study.

Case Report

A 26-year-old married and nulligravida woman complained of abdominal enlargement. She developed irregular menstruation since 3 years ago. Abdominal sonography showed a 7 cm simple cyst in left ovary and a 4 cm simple cyst in right ovary. She used low-dose (LD) oral contraceptive pills (OCP) for 1.5 years having regular menstruation during this time. She stopped using the pills, and had regular menstruation till 9 months ago. But she noted progressive abdominal distension. She had no symptoms of dysmenorrhea, dyspareunia, abdominal

pain, abnormal uterine bleeding, weight loss and difficulty in defecation and urination. During abdominal examination, we found a large and firm mass up to the xiphoid process with regular contours. There was no tenderness or rebound tenderness. In speculum examination, cervix and vagina were normal.

Pelvic examination suggested the same mass that was palpated bimanually through anterior fornix, without adhesion to the uterus. Ultrasonography (US) outlined a large well-defined multilocular mass measured 22.5 x 12 x 10 cm in left adnexa with fine echogenic particles, and a 6.0 x 5.6 cm solid component without septation and thick wall (high morphologic index). In right adnexa, ovary was normal in size with a 36 x 39 mm simple cyst. The uterus was normal in size, and endometrial thickness was 4.3 mm. In posterior wall of the uterus, there was a 36 x 32 mm pedunculated myoma. No ascitic fluid was reported. Serum level of CA 125 was 41 U/ml, and the other tumor markers were normal. With approach to cancer, intestinal preparation was done. In laparotomy with midline incision, we found an abdominopelvic cystic mass measured 25 x 20 x 10 cm with fine borders, solid components and other echogenic particles and chocolate fluid, arising from the left ovary with no remnant ovarian tissue (Figure 1) and left hydrosalpinx, and a 4 cm cystic mass in right ovary. The uterus and the other fallopian tube were normal. There was no ascitic fluid. Peritoneal washing was done.



Figure 1. Gross appearance of the cyst during laparotomy

Then, left salpingo oophorectomy and right ovarian cystectomy were performed. The result of frozen section was a benign tumor. For permanent pathological examination, multiple sections in eleven blocks were submitted. In cutting, cystic structure was full of bloody material. Solid component or papillary vegetation was not identified. The cyst wall was lined by endometrial epithelium with focal hemorrhage, hemosiderin deposition and fibrosis being supported by ovarian tissue. Therefore, the diagnosis of ovarian endometrioma was confirmed and no evidence of endometrioid carcinoma or other malignant epithelial tumor was found (Figures 2 A and 2 B). The cytology of the peritoneal washing was normal.

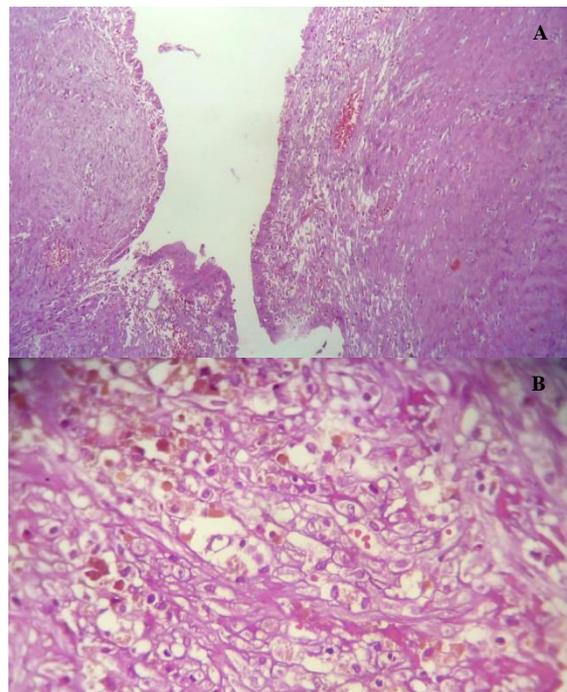


Figure 2. A. Ovarian cyst wall lined by endometrial cells overlying endometrial stroma with hemorrhage and hemosiderin deposition (hematoxylin-eosin, original magnifications $\times 10$). B. Endometrial stroma containing many hemosiderin laden macrophages (hematoxylin-eosin, original magnifications $\times 40$).

Discussion

Ovarian endometrioma is seen in approximately 17-44 percent of women with

endometriosis. While the ovaries remain the commonest site of endometriosis, the size of ovarian endometrioma is typically not large, usually ranging from 1-6 cm. Huge ovarian endometriomas are extremely rare, with only a few case reports being described (2).

When the size of an endometrioma exceeds 15 cm, malignancy must be suspected (1). Several reports indicated that differential diagnosis of endometrioma from other ovarian masses is difficult by US or computed tomography (CT). Andersen et al. reported an unusually large endometrioma measured 20 cm, for which the clinical diagnosis was ovarian endometrioma (1-7). US is the first choice in the diagnosis of adnexal masses, and magnetic resonance imaging (MRI) and CT are the alternative methods. Both CT and MRI are superior to US in the assessment of the nature of adnexal masses, with the highest accuracy for MRI; while US is the cheapest method (3). Therefore, laparotomy should be done in any woman with large adnexal mass. Pathologic diagnosis is important and should be considered.

Clinical features of endometriosis depend on the site of the disease. The common symptoms of the endometriosis are dysmenorrhea, dyspareunia, abnormal uterine bleeding, abdominal pain, infertility, and constant pelvic pain. However, there may not be any symptoms related to it (2, 4, 5). For example in our case, the chief complaint of the patient was only abdominal distension.

Thus, we must always, consider the possibility of endometrial cyst, even if a huge ovarian cyst is detected. Ovarian malignancy

should be excluded.

Conflict of Interests

Authors have no conflict of interests.

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References

1. Ishikawa H, Taga M, Haruki A, Shirasu K, Minaguchi H, Hara M. Huge ovarian endometrial cyst: A case report. *Eur J Obstet Gynecol Reprod Biol* 1997; 74(2): 215-7.
2. Mishra TS, Singh S, Jena SK, Mishra L. Giant endometrioma of the ovary. *J Endometr Pelvic Pain Disord* 2016; 8(2): 71-4.
3. Yasar L, Sönmez AS, Zebitay AG, Neslihan G, Yazicioglu HF, Mehmetoglu G. Huge ovarian endometrioma-a case report. *Gynecol Surg* 2010; 7(4): 365-7.
4. Matsushima T, Asakura H. Huge ovarian endometrioma that grew after menopause: Case report. *J Obstet Gynaecol Res* 2016; 42(3): 350-2.
5. Davis H, Kennrddy S, Prowse AH. Endometrioma-benign endometriotic ovarian cysts. In: Schwab M, Editor. *Encyclopedia of cancer*. Berlin, Germany: Springer Science & Business Media; 2008. p. 973.
6. Andersen O, Giustra P, Leidinger R. Giant endometrioma. *Am J Surg* 2001; 181(3): 272-3.
7. Grandi G, Toss A, Cortesi L, Botticelli L, Volpe A, Cagnacci A. The Association between endometriomas and ovarian cancer: Preventive effect of inhibiting ovulation and menstruation during reproductive life. *Biomed Res Int* 2015; 2015: 751571.