Vol. 3, No. 2, Jul-Dec 2019

ANDALAS OBSTETRICS AND GYNECOLOGY JOURNAL

Alamat Korespondensi:
Ruang Redaksi Andalas Obstetrics and Gynecology Journal, Lantai 3 PPDS Obstetri dan Ginekologi Universitas Andalas, RSUP DR. M. Djamil Padang, Jl. Perintis Kemerdekaan Padang, Sumatera Barat 25127

Website:
http://jurnalobgin.fk.unand.ac.id/index.php/JOE

eISSN : 2579-8324 pISSN : 2579-8323

CASE REPORT

Metastasis of Residive Mucinous Ovarian Carcinoma to Umbilicus, Peritoneum, And Ascites Fluid With No Malignancy Marker Found in The Previous Post-Operative Histopathological Examination

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Abstract

Background *: Malignant ovarian tumor are still the number one cause of death and the second most of incidents for gynecological malignant tumors. The principles of management of ovarian cancer are the same as the principles of handling other malignant diseases, for the treatment of primary lesions operatively and the handling of potential sites of tumor metastases with chemotherapy. Histopathological examination is still considered a gold standard for diagnosis and definitive treatment of malignant ovarian tumors. If histopathologic results are obtained, then the patient will be planned to undergo postoperative chemotherapy. The mismatch between the preoperative and intraoperative clinical features, and the results of postoperative histopathological examination is a problem in managing cases of ovarian malignant tumors.*

Objective *: Report a case of residive ovarian carcinoma with no appearance of malignancy marker in the previous postoperative histopathological examination.*

Method : Case report

Case *: We report the case of a 45-year-old woman with a history of two previous laparotomy. The first operation was carried out in February 2014 on the indication of an extra ovarian cyst, resulting in the impression of a "Follicular Cysts" based on histopathological examination. The second operation was performed in March 2015, performed surgical staging tumors with an indication of malignant ovarian tumors with clinical metastases, but from histopathological examination it was found that "Cystadenoma Ovarii Muscinosum Multiloculare" and "no visible signs of malignancy", so the patient was not managed with postoperative chemotherapy. In April 2019 patients came with complaints of new mass growth, from CT-Scan and USG investigations there was a suspicious impression of a residive ovarian tumor with metastases into the omentum and massive ascites. On May 16, 2019 an optimal debulking was performed with the findings of residive mass, ascites, and mass metastases in the intra operative peritoneum. From the results of histopathological examination, it was found that "Muscinous Carcinoma with metastases to the umbilicus, peritoneum, and ascitic fluid*

Keywords: *Malignant residive ovarian tumor, mucinous ovarian carcinoma*

Received June 2nd, 2019
Accepted June 30th, 2019
Correspondence: Arif Fadillah, email : dr.ariffadillah@gmail.com

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INTRODUCTION

Malignant ovarian tumors are the second most common case of all gynecologic malignancies and are the number one cause of death from all gynecological cancer mortality. In general, patients are diagnosed late because there is no accurate early detection method for ovarian cancer, so that only 25-30% are diagnosed at an early stage. Ovarian cancer is the fifth most common cancer that causes the mortality of women in the United States after lung, colorectal, breast and pancreatic cancer. The incidence in women under 50 years is 5.3 over 100,000 and increased to 41.4 over 100,000 women over 50 years.[1,2]

In Indonesia, malignant ovarian tumors are the sixth highest number of malignancies in women after uterine, breast, colorectal, skin and lymphoma cervical carcinoma. In general, ovarian malignancies are found at an advanced stage. The tumor enlarges and spreads to the surrounding organs without complaint. That is why this tumor is known as a silent killer disease. Ovarian cancer only causes complaints when it has spread to the peritoneal cavity and in this situation, surgery and adjuvant therapy are often not helpful. Malignant ovarian tumors have the highest mortality in women on productive age compared to other cancers. The efficiency of management in patients with ovarian cancer can be improved by standardizing preoperative and postoperative evaluations.[1,3]

The principles of management of ovarian malignancy are the same as the principles of handling other malignant diseases; the treatment of primary lesions operatively and the handling of potential sites of tumor metastases with chemotherapy. Anatomical Pathology Examination is still the gold standard for definitive diagnosis in cases of malignant ovarian tumors and is a requirement for adjuvant therapy. The mismatched between the results of the pathology anatomy examination with the clinical manifestation in cases of ovarian tumors suspected of malignancy often causes problems in the management of patients, especially in administering chemotherapy adjuvant.

MATERIAL AND METHOD

This article describes a case report of a 45-year-old woman, with a diagnosis of P3H3 + malignant residive ovarian tumor with umbilical metastasis and omentum + ascites + 2x laparatomy history. The patient came to the Gineco-Oncology Polyclinic of RSUP Dr. M. Djamil Padang. The ultrasound examination gives the impression of an ovarian malignant tumor. Laparotomy performed with a reddish mass with uneven surface, adhesions with umbilical and peritoneum, ascites (+). Visible thickening of the omentum, peritoneum covered with a grayish white, fragile mass. Ectopic pregnancy in the right ovary without bleeding, the left ovary is within normal limits. Impression of advanced stage ovaries. Optimal debulking is performed with ± 1000 cc of bleeding during the operation. Transfusion of 2 units PRC intraoperative. Then the tissue sample is inspected in PA examination.[10,11]

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CASE REPORT

A 45-year-old woman, with a diagnosis of P3H3 + residive malignant ovarian tumor with umbilical metastases and omentum + ascites + 2x laparatomy history. The patient came to the Gyneco-oncology Polyclinic of RSUP Dr. M. Djamil Padang. Patients present with the chief complaint that the abdomen feels increasingly enlarged since 6 months ago, felt a lump around the umbilicus. The patient had previously undergone laparotomy surgery twice for indications of an ovarian tumor. The first operation was carried out in February 2014 at Elizabeth Batam Hospital on the indication of right ovarian tumor. The second operation was carried out in March 2015 in RSUP DR. Dr. Djamil Padang, performed a complete surgical staging tumor with an indication of clinical suspicion of malignant ovarian tumors (RMI = 384). Multiloculare "and" no visible signs of malignancy ". The patient did not undergo postoperative chemotherapy, but was still asked to re-control every 6 months, but the patient did not come because she felt healed. Weight loss > 10 kg in the past 6 months. Physical examination found that the abdomen appeared bulging, palpable mass around the umbilicus with uneven surface, and fixed.

In laboratory tests, the impression is within normal limits. On ultrasound examination, an inhomogenous hypoechoic mass with size > 6.55 x 2.96 cm was seen. Solid part (+) size > 2cm, septum (+) > 4mm, papile (+) > 4, ascites (+), vascularity (+), Omental cake (+). Left and right kidney no abnormalities. Obtained an impression of a malignant ovarian tumor. CT scan shows that the uterus is unclear. Inhomogenous hypodens mass appears in the posterior vesica urinaria, indistinct border, irregular edges. Obtained an impression of a residive ovarian tumor with metastases in the peritoneum and omentum, massive ascites + suspected metastasis to spleen.

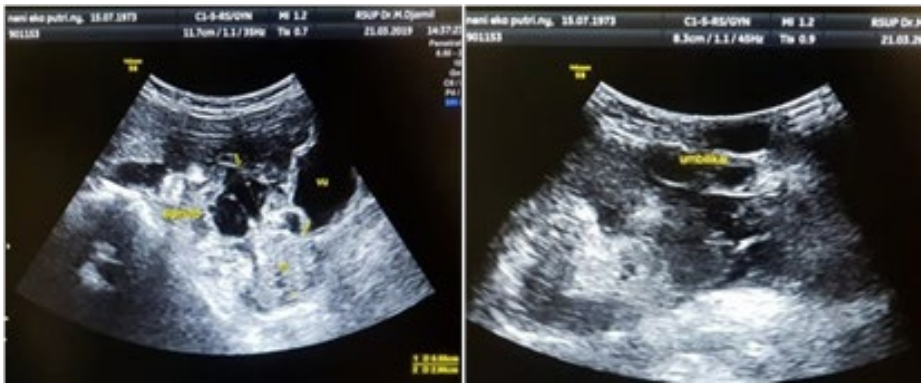

Figure 1. Overview of Transvaginal Gynecological Ultrasound results

Laparotomy is performed under general anesthesia. After the peritoneum opens, a reddish mass with an uneven surface appears, adhesion to umbilical and peritoneum, ascites (+). Thickening of the omentum appears, the peritoneum is enveloped with a grayish, fragile white mass. The impression obtained is advanced stage ovarian cancer. Patients are planned

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for optimal debulking. The patient then consulted intraoperatively to Digestive Surgery. Bleeding during were about 1000 cc, 2 units transfusion intraoperatively was performed. The tissue is examined for anatomic pathology.

Figure 2. Intraoperative Findings

RESULTS AND DISCUSSION

A case of a 45-year-old woman has been reported, a referral from the Gineco-oncology Polyclinic RSUP DR.M.Djamil Padang with diagnosis of P3H3 + a residive malignant ovarian tumor + metastases in the umbilicus and peritoneum + ascites + 2x laparatomy history. The first operation was carried out in February 2014 on the indication of the right ovarian cyst, resulting in the impression of a "Follicular Cysts" on anatomical pathology examination. The second operation was carried out in March 2015, complete surgical staging of the tumor with an indication of clinically suspicious ovarian tumors clinically (RMI 384). However, from postoperative Anatomical Pathology examination, it was found that "Cystadenoma Ovarii Muscinosum Multiloculare" and "no sign of malignancy". Patients did not get chemotherapy and did not carry out advice for control every 6 months because she felt healed.

In April 2019 patients returned with complaints of suspicion of new mass growth, from CT-Scan and USG investigations there was a suspicious impression of a residual ovarian tumor with metastases into the omentum and massive ascites. On May 16, 2019 an optimal debulking operation was performed with the findings of mass residuals, ascites, and mass

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metastases on the intra operative peritoneum. From the results of the anatomical pathology examination then obtained the results of "Mucinous Carcinoma with metastases to the umblycus, peritoneum, and ascitic fluid.

The diagnosis in this patient is made from history, physical examination and supporting examination. From the history it was found that the abdomen felt progressively enlarged since 6 months ago, and felt a mass lump in the umbilic region. In addition, there were also complaints of praneoplastic syndrome such as weight dropped significantly as much as 10 kg during the last 6 months. Also on physical examination, there is a fixed mass with uneven surface and fixed or immovable, on the ultrasound examination there is a hypoechoic inhomogenous mass with size > 6.55x2.96 cm, with a solid part (+) size > 2cm, septum (+) > 4mm, papil (+) > 4, ascites (+), vascularization (+), omental cake (+). From the IOTA rule regarding the diagnosis of ovarian tumors obtained the impression of malignancy, in addition to the CT scan obtained an impression of residive ovarian tumor suspects with metastases on the peritoneum and omentum, accompanied by massive ascites + suspected metastases on the spleen. Intraoperative clinical findings and confirmed from anatomic pathology examination according to advanced stage ovarian cancer. It can be concluded that the process of establishing the diagnosis in this patient has been appropriate.

The principles of management of ovarian malignant tumors are the same as the principles of handling other malignant diseases; the treatment of primary lesions operatively and the handling of potential sites of tumor metastases with chemotherapy. Anatomical Pathology Examination is still the gold standard for definitive diagnosis in cases of malignant ovarian tumors and is a requirement for adjuvant therapy. Mismatch between the clinical manifestations and the results of the anatomic pathology examination, or the presence of borderline anatomic pathology results become a problem in the management of ovarian tumor cases, especially in the case of chemotherapy as a postoperative adjuvant therapy.

According to the Gyneco-Oncology National Reference Book and Clinical Practice Guidelines for Malignant Ovarian Tumors, Anatomical Pathology examination is still a major requirement for conducting chemotherapy, this means that the role of the Anatomical Pathology examination is vital in determining the outcome of an ovarian tumor case.

In this case the patient was found in an advanced clinical stage according to FIGO criteria with metastases to the umbilicus, peritoneum and ascites fluid, then in this patient the optimal procedure was debulking the tumor. After being confirmed with the results of postoperative Anatomical Pathology examination stating the impression of "Muscinous Carcinoma with metastases in the umbilical and omentum and ascites fluid", then the treatment will be continued with chemotherapy as neoadjuvant. Based on the literature, the prognosis of advanced ovarian carcinoma cases is relatively poor. The overall five-year

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survival rate is 20% for patients with epithelial ovarian cancer (80% - 95% for stage I, 40% - 70% stage II, 30% stage III and <10% in stage IV).

In this case it is considered important to review the anatomical pathology diagnosis on slide number PJ-697-15. On June 26, 2019, a diagnosis review was given by the Anatomy Pathology Department, conclusions obtained in slides III, IV, and V of Cystadenoma Ovarii Muscinous Multiloculare in the presence of several atypical cells. Whereas on slide V, it was concluded: Non-Invasive Cystadenoma Ovarii Muscinosum Implantation with some atypical cells in the peritoneum. From the perspective of Gyneco Oncology, the diagnosis review of pathology anatomy is still leaves the question whether if it already appropriate with the histopathological criteria of borderline ovarian tumors that have been widely used or not. On the other hand, the Pathology Anatomy section has not included atypical ovarian tumors with atypical cells in the classification of a malignancy, so that it will make a bias in determining the classification and possible appropriate management. Proper terminology should add the term tumor with a low malignant potential (of low malignant potential), following the nomenclature that reported by FIGO. The decision in the impression of an Anatomical Pathology examination results determines the outcome of an ovarian tumor case.

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