Gynecol Surg (2010) 7:365–367
DOI 10.1007/s10397-009-0482-6

COMMUNICATION

Huge ovarian endometrioma—a case report

Levent Yaşar · A. Süha Sönmez · Ali Galip Zebitay · Gezer Neslihan · H. Fehmi Yazıcıoğlu · Gülseven Mehmetoğlu

Received: 10 February 2009 / Accepted: 11 March 2009 / Published online: 25 March 2009

Abstract A 33-years-old woman referred to our hospital with a huge abdominopelvic mass. Ultrasonographically, a septated cyst 24.3 × 17.6 × 16.6 cm in dimension without neovascularization was diagnosed. Serum CA125 and CA19-9 levels were 70.4 and 383,1 U/ml, respectively. Right salpingooopherectomy was performed through laparotomy and pathologic examination revealed an endometrioma. The cyst was 5 kg in weight, 26 × 18 × 17 cm in dimension, and contains 3,250 ml of chocolate brown fluid.

Keywords Adnexal mass · CA-125 · Endometrioma

Introduction

Pelvic endometriosis commonly involve the ovaries, and bilateral involvement occurs in one third to one half of cases [1, 2]. Ovarian endometrioma rarely exceeds 10–15 cm in diameter [1, 2]. Approximately 0.7% to 1.0% of patients with endometriosis have lesions that undergo malignant transformation [5]. When the diameter of ovarian cyst exceeds 10 cm, malignancy must be suspected [3–5]. The larger endometriomas that exceed 15 cm in diameter are more likely to harbor a neoplasm, but this is not a rule [1]. Generally, endometriomas are diagnosed by ultrasonograpic examination, but sometimes it is difficult to make a differential diagnosis preoperatively. We present a rare case of huge ovarian endometrioma which is 26 cm in largest diameter and even we did not suspect endometrioma preoperatively, and the diagnosis of endometrioma was determined by postoperative pathologic examination.

Case

A 33-year-old, 105 kg in weight, 1.75 cm in height, gravida 3, para 2 woman had been referred to our hospital with a pelvic mass. She was suffering from right lumbar pain, nausea, and abdominal distension. Symptoms first begun 2 months ago, and she had not experienced dysmenorrhea, dyspareunia, or pelvic pain ever before. A mobile, abdominopelvic cystic mass with regular surface was palpated on bimanual examination that extends to the xiphoid. In ultrasonographic examination, there was a septated cystic mass that is 24.3 × 17.6 × 16.6 cm in dimension (Fig. 1), and neovascularization was not determined by Doppler. The serum tumor markers were as follows: CA125, 70.4 U/ml; CA19-9, 383.1 U/ml; CA15-3, 19.7 U/ml; βHCG, 0.29 mIU/ml; AFP, 1.6 ng/ml; CEA, 3.5 ng/ml. Guaiac test was negative and erythrocyte sedimentation rate was 30 mm/h. Benign cellular changes were found in cervical smear and proliferative endometrium was established in the histologic examination of endome-

This case report had been presented as a poster in "Vl. International Congress of the Turkish–German Gynecological Association, 18–22 May 2005".

L. Yaşar (✉)
Bakirkoy Dr Sadi Konuk Research and Teaching Hospital,
Ayazaga Oyak Sitesi 12. Blok no: 3,
80670 Sisli Istanbul, Turkey
e-mail: leventderya@gmail.com

A. Süha Sönmez
Medicana Hospital IVFUnit,
Istanbul, Turkey

A. Galip Zebitay · G. Neslihan · H. F. Yazıcıoğlu · G. Mehmetoğlu
Süleymaniye Maternity and Women's Disease Research and Teaching Hospital,
Istanbul, Turkey

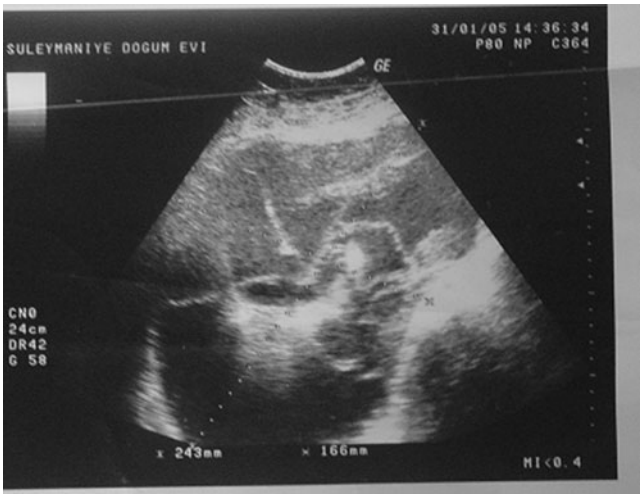

Fig. 1 Ultrasonographic appearance of endometrioma

trial sampling. An explorative laparotomy through a midline vertical incision was planned.

A cystic mass with a smooth surface and dirty white in color was diagnosed at laparotomy, which originates from the right ovary and fills almost the whole abdomen (Fig. 2). Peritoneal washings were negative in cytologic examination. The uterus, left ovary, and left tuba were normal in appearance, and right salpingo-oophorectomy was performed. It was reported as benign by frozen section and the operation was completed without any complication. The patient was discharged with full recovery on the sixth postoperative day.

In gross pathologic examination, cystic mass was 5 kg in weight and 26 × 18 × 17 cm in dimension. There was 3250 ml of chocolate brown fluid in cystic mass. The pathologic examination revealed a benign cyst with hemorrhagic necrotic endometrial tissue inside it that was well adjusted with endometrioma.

Discussion

The biggest endometrioma in literature was reported by Ishikawa and Taga [4] from Japan in 1997. This endometrioma was 25 × 18 × 12 cm in size, arising from right ovary and containing approximately 2500 ml of chocolate brown fluid. In our case, the endometrioma was 26 × 18 × 17cm in size and contained 3250 ml of chocolate brown fluid.

Primary complaints of patients with endometrioma are dysmenorrhea, dyspareunia, infertility, and constant pelvic pain [2], but interestingly, these symptoms were not present at the time of diagnosis or ever before in our patient. In our case, ultrasonographic examination showed a thick septated cystic mass resembling ovarian cancer. But the color Doppler evaluation was in normal range. Whereas serum CA 125 level was elevated slightly, increase in serum CA 19-9 level was evident. This was an interesting finding because increase in CA 125 is usually greater than increase in CA 19-9 in cases with endometrioma [2]. Especially in young women in the reproductive period, serum CA 125 values that are greater than classic 35 U/ml threshold value are not indicative of a malignancy [6].

Ultrasonography is the first choice in the diagnosis of adnexal masses and magnetic resonance imaging (MRI) and computed tomography (CT) are the alternative methods. Both CT and MRI are superior to ultrasonography in the assessment of the nature of adnexal masses, with the highest accuracy for MRI [7]. But ultrasonography is the cheapest and easiest method. In our case, we decided to perform a laparotomy because of the presence a huge adnexal mass reaching the xiphoid and multiple thick internal septations inside it. She was also morbidly obese (34.3 kg/m^2) and did not accept the possibility of malignant tumor spillage that will lead to chemotherapy during laparoscopic surgery. It is clear that there is no method making definitive differential diagnosis of adnexal masses. Therefore, when laparotomy was the modality chosen for the therapy in our case who was not willing to preserve her future fertility, it was not necessary to perform further radiologic imaging methods.

We presented this case because of its rarity. An endometrioma as huge as this one has not been published before. It may be the biggest endometrioma in the literature, but interestingly, we could not diagnose it preoperatively. Endometrioma must be kept in mind during differential diagnosis even in cases with huge adnexal masses.

Fig. 2 Appearance of the cyst during laparotomy

References

1. Clement PB (1994) Diseases of the peritoneum. In: Kurman RJ (ed) Blaustein's pathology of the female genital tract, 4th edn. Springer, New York, pp 664–667
2. Fedele L, Bianchi S, Bocciolone L et al (1992) Pain symptoms associated with endometriosis. Obstet Gynecol 79:767
3. Hesla JS, Rock JA (2003) Endometriosis. In: Rock JA, Jones HW (eds) Te Linde's operative gynecology, 9th edn. Lipincott-Raven, Philadelphia, pp 599–603
4. Ishikawa H, Taga M (1997) Huge ovarian endometrial cyst: case report. Eur J Obstet Gynecol Reprod Biol 74:215–217
5. Reuter KL, Davidoff A, Cooney JV, Hunter RE (1988) An unusually large endometrioma simulating an ovarian malignancy. Am J Radiol 151:834–835
6. Kitawaki J, Ishihara H, Koshiba H et al (2005) Usefulness and limits of CA-125 in diagnosis of endometriosis without associated ovarian endometriomas. Hum Reprod 20(7):1999–2003
7. Spencer JA (2005) A multidisciplinary approach to ovarian cancer at diagnosis. Br J Radiol 78(Special Isssue 2):S94–102