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A Study of Benign Ovarian Tumours in Patients Attending GYNEA OPD of Skims Soura

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Abstract

Ovarian tumours are commonly encountered in gynaecology. The major challenge to a Gynecologist is to distinguish between benign and malignant tumours. The commonly done investigation for this purpose include USG and tumour markers. There are certain USG features of malignancy which helps to arrive at a definite diagnosis. Methodology and results: This study was carried over a period of one year, 100 patients were included in this study presented in gynaecology OPD of Skims Soura with USG documented Ovarian tumours and complaints of vague abdominal pain, menstrual irregularities, heaviness in lower abdomen. Diagnosis being made USG and CA -125, CEA, LDH, HCG. USG was used as diagnosis to differentiate benign from malignant tumours including tumour markers. Those with functional ovarian cysts <6 cm, unilocular, non septate were given medical management while those with ovarian cysts >6cm, multilocular, multiseptate were subjected for surgical management. Based on histopathological finding majority of tumours in our study were serous cystadenoma (75%) followed by mucinous cyst adenoma (15%) followed by endometrioid, clear cell, borderline tumours, hemorrhagic, paraovarian cysts and mature cystic teratoma, there were 2 cases of serous cystadenocarcinoma. Major presenting symptom in our study was abdominal pain (75%). Most common age group in our study was 25-35 years. Conclusion:USG and tumour markers help us to distinguish between benign and malignant ovarian tumours. Based on diagnosis management can be conservative or surgical.

Keywords: Tumours, tumour markers, ultrasound, doppler, cystadenoma

Introduction

Ovarian tumours are seen in women throughout their lifespan. They are divided into three major groups; Benign, Border line and malignant. In majority of cases tumours are benign and can be managed conservatively. Symptoms associated with malignancy include abdominal distension, early satiety, urinary urgency. Diagnosis of ovarian tumours is done mainly on ultrasonography and tumour Markers like CA-125, Carcinoembryonic antigen (CEA), lactate dehydrogenase (LDH) Alphafetoprotein, human chorionic gonadotrophin(HCG). RMI uses USG + CA-125 to assess the risk of malignancy $RMI = U \times M \times CA-125$ U = ultrasound assigned score 1 for each solid area, multilocular, metastasis M= 3 for postmenopausal patients. Functional ovarian cysts can be distinguished from neoplastic cysts as they are usually 6-7 cms Unilocular contains clear fluid and lining epithelium is functional epithelium of unit from which it arises (1). They are mostly asymptomatic but sometimes they manifest as menstrual irregularities, pain abdomen, heaviness in lower abdomen. Diagnosis being made by USG and Doppler supplemented by tumour markers. Benign Ovarian cysts sometimes manifest with complications like rupture, hemorrhage and torsion.

Methodology

Our study was carried over a period of one year from August 2017-june 2018. 100 patients were included in the study presenting in the gynaecology OPD of Skims Soura with USG documented. Ovarian tumours. These patients presented with symptoms of vague abdominal pain, menstrual irregularities, heaviness in lower abdomen. Diagnosis being made by USG and CA- 125, carcinoembryonic antigen CEA, lactate dehydrogenase LDH, and HCG.

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Patients with ovarian cysts upto 6 cm, Unilocular cysts, non-septate cysts were given a trail of oral contraceptive pills for 3 months. Candidates for surgical treatment include ovarian cysts with size >6 cm, septate, multilocular, those with solid components and those where ovarian cysts persisted even after 3 months of oral contraceptive intake. Surgery was done either laproscopically or by laprotomy depending on parity, previous surgical history. All necessary investigations were done along with tumour markers and pre anesthetic checkup. Valid consent Was taken from patients regarding procedure and it's complications. Decision for ovariectomy/cystectomy was taken on table. All tissues retrieved by laparoscopy or laprotomy were sent for histopathological examination, which was analysed by department of pathology in skims soura.

Results

Distribution of patients according to histopathological examination:

TYPE of report	No. of Patients	Percentage
1.serous cyst adenoma	25	25%
2.Mucinous cyst adenoma	15	15%
3.Endometroid tumours	10	10%
4.Clear cell tumours	10	10%
5.Borderline serous	4	4%
6.Borderline mucinous	4	4%
7.Serous cystadenocarcinoma	2	2%
8.Hemorrhagic cyst	10	10%
9.paraovarian cyst	5	5%
10.Mature cystic teratoma	15	15%

Distribution of Patients According to Symptoms.

Symptom	No. of Patients	Percentage
1.Abdominal pain	75	75%
2.menstrual abnormalities	10	10%
3.Retension of urine	3	3%
4.Dysmennoria	7	7%
6.Infertility	10	10%

Age Wise Distribution of Patients.

Age Group	No. of Patients	Percentage
15-25 YR	20	20%
25-35 YR	50	50%
35-40 YR	30	30%

Discussion:

Ovarian tumours are commonly encountered in gynecological practice. They can be functional cysts, benign or malignant tumours. Diagnosis of a ovarian tumour is made by imaging studies(3-5) and tumour markers. USG is safe and reliable modality and classify these tumours into benign or malignant according to morphological index (unilocular, unilocular -solid, multilocular, multilocular-solid or solid). Colour Doppler and MRI can also be used for diagnosis. However final diagnosis is made by histopathology (6). Functional ovarian cysts are common in young age and resolve spontaneously within 6-8 weeks however chances of malignancy increase as age advances (7). In our study which was aimed to study ovarian tumours in 100 patients attending gynea Opd of skims soura. The most common tumour in our study was serous cyst adenoma (25%) followed by mucinous cyst adenoma (15%). There were 2

cases of serous cyst adenocarcinoma in our study (2%). Endometroid tumours were (10%). clear cell tumours (10%), borderline serous 4% and borderline mucinous 4% hemorrhagic cysts (10%), paraovarian cyst (5%) and mature cystic teratoma (15%). The most common symptom in our study was abdominal pain 75%. This is similar to study done by kayastha(8)

Incidence of Ovarian Tumours in Different Studies

Studies	Serous Cystadenoma	Mucinous Cyst Adenoma	Mature Cystic Teratoma
1.Mondal etal 9	29.9%	11.1%	15.9%
2.Maliheh etal 10	38%	22%	30%

Conclusion

Ovarian tumours are commonly encountered in gynecological practice. Patients common symptoms are pain, menstrual irregularities, heaviness in lower abdomen or sometimes they can be asymptomatic. Being Gynecologists, we should be able to distinguish between different types of ovarian tumours. Functional cysts generally regress of their own or by trail of 3-month oral contraceptive pill. Diagnosis being made by USG and tumour markers, based on the diagnosis subsequent management can be carried out.

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