

Evaluation of Ovarian Tumour Patients: A Retrospective Analysis

B. Ganesh Babu¹, Shobha^{2*}

¹Assistant Professor, ^{2*}Associate Professor,

Department of Obstetrics and Gynaecology, Fathima Institute of Medical Sciences, Kadapa, Andhra Pradesh, India.

ABSTRACT

Background: The present study was undertaken for evaluating patients with ovarian tumour.

Materials & Methods: Data of a total of 100 patients was enrolled. Complete demographic and clinical details of all the patients was obtained from data record files. A Performa was made, and complete medical history was recorded. All the histopathological reports were reviewed, and classification of ovarian tumours was done into benign and malignant.

Results: Out of 100 patients with ovarian tumours, 68 percent of the cases were of benign ovarian pathologies while the remaining 32 percent were of malignant ovarian lesions. Serous cystadenocarcinoma and Endometrioid carcinoma were seen in 13 patients and 16 patients respectively. Non-Hodgkins lymphoma and metastatic cancer were seen in 2 patients and 1 patient respectively. Among being ovarian tumours, Serous cystadenomas was seen in 21 patients while mucinous cystadenomas were seen in 18 patients. Benign fibrous tumours were seen in 10 patients. Thecoma and adenofibroma and Brenner's tumour were seen in 8 patients, 7 patients and 4 patients respectively.

Conclusion: There is great deal of morphologic diversity of ovarian masse which poses many diagnostic and prognostic challenges. A specific diagnosis can usually be made by evaluating routinely stained slides but sometimes immunohistochemistry is required in difficult cases.

Key words: Ovarian Tumour, Cancer.

*Correspondence to:

Dr. Shobha,
Associate Professor,
Department of Obstetrics and Gynaecology,
Fathima Institute of Medical Sciences,
Kadapa, Andhra Pradesh, India.

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INTRODUCTION

Although once considered a single entity, ovarian cancer can be subdivided into different histological subtypes that have different identifiable risk factors, cells of origin, molecular compositions, clinical features and treatments. These histological subtypes include epithelial cancers that account for ~90% of ovarian cancers and include serous, endometrioid, clear-cell and mucinous carcinomas.^{1,2}

Although ovarian cancer may occur at any age, it is more common in patients older than 50 years. Patients often present with nonspecific pelvic or abdominal symptoms. Initial diagnostic tests include transvaginal ultrasonography and serum cancer antigen 125 measurement; however, these tests are not specific for ovarian cancer. Conventional treatment includes surgical debulking followed by chemotherapy.^{3,4}

While there are no symptoms specific to ovarian cancer, most women diagnosed with ovarian cancer do experience such things as bloating, pelvic or abdominal pain, difficulty eating, or urinary symptoms; the problem is that these symptoms are often overlooked until after a diagnosis has already been made.⁵ Hence; under the light of above-mentioned data, the present study was undertaken for evaluating patients with ovarian tumour.

MATERIALS & METHODS

The present study Conducted in the Department of Obstetrics and Gynaecology, Fathima Institute of Medical Sciences, Kadapa, Andhra Pradesh (India) for evaluating patients with ovarian tumour. Data of a total of 100 patients was enrolled. Complete demographic and clinical details of all the patients was obtained from data record files. A Performa was made, and complete medical history was recorded. All the histopathological reports were reviewed, and classification of ovarian tumours was done into benign and malignant. All the results were recorded in Microsoft excel sheet and were subjected to statistical analysis using SPSS software.

RESULTS

A total of 100 patients were enrolled. Mean age of the patients was 41.6 years. Out of 100 patients with ovarian tumours, 68 percent of the cases were of benign ovarian pathologies while the remaining 32 percent were of malignant ovarian lesions. Serous cystadenocarcinoma and Endometrioid carcinoma were seen in 13 patients and 16 patients respectively. Non-Hodgkins lymphoma and metastatic cancer were seen in 2 patients and

1 patient respectively. Among being ovarian tumours, Serous cystadenomas was seen in 21 patients while mucinous cystadenomas were seen in 18 patients. Benign fibrous tumours were seen in 10 patients. Thecoma and adenofibroma and Brenner's tumour were seen in 8 patients, 7 patients and 4 patients respectively.

Table 1: Distribution of patients according to benign and malignant

Tumour	Number	%
Benign	68	68
Malignant	32	32
Total	100	100

Table 2: Distribution of benign tumours

Benign tumours	Number	%
Serous cystadenomas	21	21
Mucinous cystadenomas	18	18
Benign fibrous tumours	10	10
Thecoma	8	8
Adenofibroma	7	7
Brenner's tumour	4	4
Total	68	68

Table 3: Distribution of malignant tumours

Malignant tumours	Number	%
Serous cystadenocarcinoma	13	13
Endometrioid carcinoma	16	16
Non-Hodgkins lymphoma	2	2
Metastatic cancer	1	1
Total	32	32

DISCUSSION

Ovarian cancer is the most lethal gynecologic cancer. Less than one-half of patients survive for more than five years after diagnosis. Ovarian cancer affects women of all ages but is most commonly diagnosed after menopause. More than 75% of affected women are diagnosed at an advanced stage because early-stage disease is usually asymptomatic, and symptoms of late-stage disease are nonspecific. The strongest risk factors are advancing age and family history of ovarian and breast cancer. Women who have symptoms concerning for ovarian cancer should undergo a physical examination, transvaginal ultrasonography, and measurement of biomarkers such as cancer antigen 125.⁶ Hence; under the light of above-mentioned data, the present study was undertaken for evaluating patients with ovarian tumour.

A total of 100 patients were enrolled. Mean age of the patients was 41.6 years. Out of 100 patients with ovarian tumours, 68 percent of the cases were of benign ovarian pathologies while the remaining 32 percent were of malignant ovarian lesions. Serous

cystadenocarcinoma and Endometrioid carcinoma were seen in 13 patients and 16 patients respectively. Non-Hodgkins lymphoma and metastatic cancer were seen in 2 patients and 1 patient respectively. Sharadha, S et al studied the clinical and histopathological presentation of ovarian masses. Incidence of ovarian masses was 6.9 %. Among 205 cases, 68 % were neoplastic. Among the neoplasms, 87.8 % were benign, 10 % malignant, and 2.2 % borderline. Mean ages of malignant and benign neoplasm were 41 and 39 years, respectively. 42.9 % malignant tumors presented with non-specific abdominal and constitutional symptoms. Serous cystadenoma was the commonest benign tumor (67 %) followed by Mucinous (19 %) and Dermoid (11.6 %). Most common malignant ovarian tumor was Serous cystadenocarcinoma (42.9 %). Out of the malignant cases, all were primary except one secondary deposit from Non-Hodgkin's Lymphoma. Only 28.6 % presented at stage I, remaining presented at stage III/IV. Ovarian neoplasms have twice the incidence of non-neoplasms. Mean age of malignant tumors is decreased.¹⁰

Among being ovarian tumours, Serous cystadenomas was seen in 21 patients while mucinous cystadenomas were seen in 18 patients. Benign fibrous tumours were seen in 10 patients. Thecoma and adenofibroma and Brenner's tumour were seen in 8 patients, 7 patients and 4 patients respectively. Zaman S et al, in another study, determined the nature of various ovarian lesions and to ascertain the frequency and distribution of the various non-neoplastic and neoplastic lesions. A total of 498 different non-neoplastic and neoplastic lesions were seen during one calendar year 2008. Non-neoplastic cysts were more common (343, 68.87%) than neoplastic tumours (155, 31.12%). The commonest non-neoplastic cyst was luteal cyst followed by follicular cyst. Among the neoplastic tumours 78.70% were benign and 21.29% were malignant. Benign serous cysts were the commonest benign tumour followed by mature cystic teratoma and mucinous cyst. Serous cystadenocarcinoma was the commonest malignant tumour followed closely by endometrioid carcinoma and granulosa cell tumour. Krukenberg tumour, tumour metastatic to ovaries and non-Hodgkins lymphoma was also diagnosed during this period. Malignant germ cell tumours were seen in much younger age group followed by sex cord stromal tumours. Epithelial tumours were seen in much older age group.¹¹

CONCLUSION

There is great deal of morphologic diversity of ovarian masse which poses many diagnostic and prognostic challenges. A specific diagnosis can usually be made by evaluating routinely stained slides but sometimes immunohistochemistry is required in difficult cases.

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