Section of Obstetrics & Gynæcology

President Josephine Barnes FRCOG

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Cases

Ovarian Carcinoma Complicating Pregnancy

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A married woman aged 39 was admitted in the summer of 1970 as an acute abdominal emergency during the twentieth week of her first pregnancy. She gave a history of a sudden onset of severe generalized abdominal pain two hours prior to admission. Until this time the pregnancy had been normal. When admitted to the ward she was in obvious pain. The size of the uterus was consistent with the period of gestation. The patient had guarding and rebound tenderness over the whole abdomen.

At operation, the right ovary was found to be obliterated by a macroscopically malignant cyst which had ruptured, spilling its contents into the abdominal cavity. The enlarged uterus appeared normal as did the remaining ovary. There were no evident secondary deposits. The cyst and involved ovary were removed. The patient made an uneventful postoperative recovery. Microscopic examination showed the cyst to be a papillary serous cystadenocarcinoma with complex reduplication along papillary lines. There were 2–3 mitotic figures per high power field.

The patient's pregnancy continued until thirty-nine weeks when spontaneous delivery of a live male infant occurred. At this time the patient appeared to be free of recurrence. Six weeks after delivery a second exploratory operation showed that there was no residual carcinoma. The patient's recovery has been complete. When last seen in the winter of 1972 she was well.

Discussion

Jubb (1963) reviewed the literature. His figure for the incidence of malignancy in ovarian tumours complicating pregnancy was 2–5% and he found only 24 authentic case reports between 1882 and 1963. He found the characteristic age group to be 30–35 and noted a high incidence of nulliparity. Excessive generalized enlargement of the abdomen and lower abdominal pain were the common presenting symptoms.

Five of Jubb's 24 patients presented with an acute abdomen due to complications of the carcinoma such as rupture, torsion or strangulation. In 21 of his reviewed cases the diagnosis was followed by immediate laparotomy and unilateral oophorectomy. Fourteen of these patients had no further treatment. In the 7 patients who were re-explored no residual carcinoma was evident. Unfortunately there is no record of grading of the carcinoma and follow up was inadequate. Because of this, the figure for the five year survival rate of nearly 60% is unreliable.

Creasman *et al.* (1971) reported a series of 17 patients with ovarian carcinoma which was diagnosed during or within two months of pregnancy. The age range of his patients was 18–34 with a mean of 24 years, and their average parity was 1.4, 9 of them being primigravidæ. Only one of Creasman's patients was treated by unilateral oophorectomy and the remainder had more radical surgery with radiation and/or cytotoxic therapy. All of Creasman's more radically treated patients with stage 1A ovarian carcinoma were well at five years and he claimed that this demonstrated the value of a more radical approach to treatment. It would seem equally likely that the good survival rates reflected early diagnosis at routine antenatal examinations of patients. It is obvious that sacrifice of the pregnancy does not improve the maternal prognosis and that unilateral oopherectomy can be employed.

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REFERENCES

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