

Ovarian Mucinous Cystadenoma in an Adolescent

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Disclosure

Dr. Smith has no relevant financial relationships or commercial interests to disclose. This presentation will not include discussion of commercial products and or services.

Thank you!



Case

A 12-year-old Caucasian female presents to the pediatric emergency department following a 4-week history of non-tender abdominal distention.

Past medical history is significant for generalized anxiety disorder, chronic constipation and anal fissures



Review of Systems

Constitutional symptoms: No fever, no decreased activity, no decreased appetite, no weight change.

Skin symptoms: No jaundice, no rash.

Eye symptoms: No pain.

ENMT symptoms: No ear pain.

Respiratory symptoms: No shortness of breath.

Cardiovascular symptoms: No chest pain.

Gastrointestinal symptoms: Constipation, no pain, no nausea, no vomiting, no rectal bleeding.

Genitourinary symptoms: No dysuria.

Musculoskeletal symptoms: No back pain.

Neurologic symptoms: No headache.

Additional review of systems information: All other systems reviewed and otherwise negative.



Physical Exam

VITAL SIGNS: Temp 98.2 F, HR 72, BP 119/79, RR 20, 100% on RA.

Weight 43.4 kg (47%), Height 151 cm (32%), BMI 19 (58%)

GENERAL: No acute distress. Well nourished.

HEENT: Oral mucosa is moist. Ears, Nose, Mouth & Throat WNL.

CHEST: Normal heart and lung exam.

ABDOMEN: Soft. Moderate diffuse distension. No tenderness. No guarding. No rebound. No organomegaly. No mass. Normal bowel sounds.

NEUROLOGIC: Alert, oriented x3. No facial asymmetry. Clear speech. Responded appropriately to questions.



Initial Abdominal X-ray

IMPRESSION:

No evidence of bowel obstruction, gross mass, organomegaly, or pathologic calcification.

Nonspecific bowel gas pattern.

Moderate stool in the colon.



Initial Management

She was discharged home with stool softeners for constipation.

Plan for PCP follow-up in 2-3 days



Second Hospital Encounter

Re-evaluated by her pediatrician three days later.

Noted to have increased abdominal distension despite multiple bowel movements.

Admitted to the children's hospital for further evaluation.

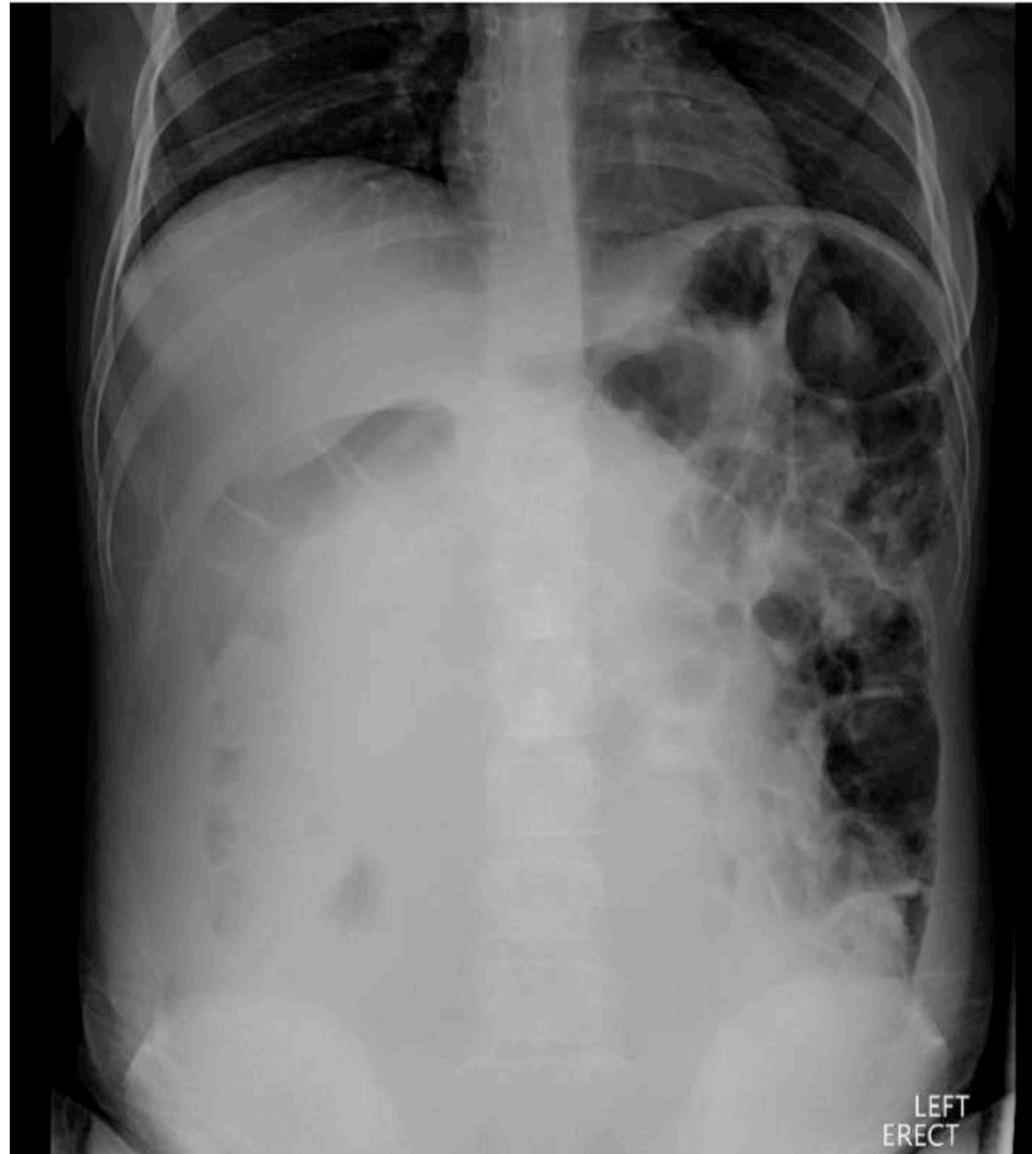


Repeat Abdominal X-ray

IMPRESSION:

No evidence of bowel obstruction, gross mass, organomegaly, or pathologic calcification

Possible ileus/constipation.



IMPRESSION:

22.0 x 14.4 x 31.0 cm cystic mass concerning for a neoplasm possibly of ovarian in origin.

The kidneys demonstrate mild hydronephrosis.

The uterus and bladder are grossly unremarkable.



Lab Workup

CBC, BMP, LFTs - within normal limits

UDS - negative

Tumor Markers AFP, CA 125, HCG - within normal limits



Interventions

Exploratory laparotomy revealed a 4 kilogram right-sided ovarian mass.

Patient was observed post-op and discharged after 3 days.

She is being followed by Pediatric Hematology-Oncology. No additional interventions have been needed to date.



Discussion

Ovarian mucinous cystadenomas arise from the ovarian surface epithelium.

Overall, these tumors account for 20-25% of all benign ovarian tumors.

While the majority of mucinous cystadenomas are benign, there is a 10% risk of co-existing ovarian malignancies.

Peak incidence occurs between the third and fifth decades.

- Less than one percent occurs in patients under the age of twenty



Discussion

Increased abdominal girth in an adolescent female is typically gastrointestinal in origin but gynecologic causes must also be considered.

The most common presenting symptoms include:

- Abdominal pain
- Increased abdominal girth
- Persistent abdominal bloating

Most ovarian masses are physiologic; however, neoplasms do occur.



Discussion

Primary imaging studies may include transabdominal or transvaginal ultrasonography. MRI or CT with PO and IV contrast can provide further clarification for indeterminate lesions.

Observation is the preferred treatment for functional ovarian cyst while neoplasms are treated with resection.

For mucinous cystadenoma, resection is curative and does not increase the risk of future ovarian malignancy in the unaffected ovary.



Discussion

Anchoring Bias - a cognitive bias that describes the common human tendency to rely too heavily on the first piece of information offered when making decisions



References

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