

Mass Per Abdomen: A Diagnostic Dilemma

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ABSTRACT

A P2L2 postmenopausal lady came with a history of mass PV with difficulty to walk and pain in the left hip. She also had a scan report showing a left complex adnexal mass suggesting ovarian malignancy. GPE showed a vague mass in the LIF which on CT scan was diagnosed as a retroperitoneal neoplasm measuring 100 × 70 × 80 mm. Core needle biopsy of the mass came as poorly differentiated metastatic carcinoma. No primary found. Palliative chemotherapy for 6 cycles with Paclitaxel and Cisplatin was given and the mass completely regressed in size.

Keywords: Retroperitoneal mass, Metastatic carcinoma, Psoas muscle spasm.

How to cite this article: Jyothi GS, Sundari N, Prabhu VMD, Swarup A. Mass Per Abdomen: A Diagnostic Dilemma. J South Asian Feder Obst Gynae 2012;4(3):161-163.

Source of support: Nil

Conflict of interest: None declared

INTRODUCTION

Retroperitoneal tumors are rare and present insidiously. It is not unusual for retroperitoneal sarcoma to present to a gynecologist as a first point of specialist reference usually with an ultrasound diagnosis suggesting ovarian malignancy. We need to be aware of the possibility of retroperitoneal sarcomas in the assessment of a pelvic mass.^{1,2} The importance of computed tomography in the differential diagnosis and appropriate management of retroperitoneal tumor is emphasized here.³ Laparotomy by surgeons inexperienced with retroperitoneal tumors should be avoided as it prejudices the chances of a long, disease free interval and possibly adversely affects the chances of cure.⁴ This paper reviews the above problems and makes a number of suggestions.

CASE REPORT

Mrs V aged 45 years; a postmenopausal lady from low socioeconomic status, P2L2, came to the Casualty of MS Ramaiah Medical Teaching Hospital, Bengaluru on 30-12-2007 with history of pain in the left hip since 6 months, low back pain since 2 months and inability to walk since 15 days. She also gave history of mass per vagina since 2 years. With the above complaints, she was admitted to the orthopedics department. GPE was normal. Orthopedic examination showed left sided fixed flexion deformity of 30° at the hip and 20° flexion of the left knee. Painful but full range of movements was present. Routine investigations were normal. X-ray hip was normal. Patient had a pelvic scan report dated 17-11-2007 showing a left adnexal complex mass of 6.1 × 4.2 cm with left-sided hydronephrosis. Uterus and right ovary normal. Patient was shifted to OBG department with skin traction for 1 week.

Evaluation at OBG department showed a vague mass with ill defined margins in the left iliac fossa with evidence of guarding. Pelvic examination showed a III degree UV prolapse with grade II cystocele and rectocele. Cervix hypertrophied and cervical lips everted. PV examination revealed the uterus to be retroverted and normal size, mobile, with fullness/vague mass in the left fornix. Right fornix was free. Repeat pelvic scan done confirmed the presence of left adnexal complex cyst measuring 80 × 68 × 75 mm with thick wall internal septations and mural nodule suggesting ovarian malignancy. Uterus and right ovary was normal. Left-sided hydronephrosis present. Minimal free fluid in the pouch of Douglas present.

Further evaluation showed CA 125 and CEA to be within normal limits. Pap smear showed no evidence of malignancy. ECC done did not yield any material. Colposcopy and guided biopsy confirmed to chronic nonspecific cervicitis. Upper and lower GI endoscopy was normal. Orthopedic review, opined as arthritis of the left hip with flexion deformity. Surgical opinion conferred to an ovarian mass with no other pathology detected.

EUA done revealed a hard fixed immobile mass on the left side of the abdomen, as psoas muscle spasm was eliminated under GA, the flexion deformity of the left hip and knee joints disappeared and the abdomen relaxed. Surgical oncologist opined it as a mass arising from the bone/organized tubercular mass. Further evaluation needed. CT scan done revealed upper abdomen to be normal. No evidence of lymphadenopathy or ascitis. A cystic retroperitoneal mass in the left pelvic region measuring 100 × 70 × 80 mm encasing the external iliac vessels splayed medially (Fig. 1). Left ureter infiltrated and occluded with significant hydronephrosis (Figs 2 to 4). Mass adherent to iliacus and psoas muscle, uterus normal. Ovaries not identified. So, a diagnosis of a retroperitoneal mass as described was made along with possibilities of left ovarian neoplasm with adjacent retroperitoneal infiltration/? Primary retroperitoneal neoplasm made. Core needle biopsy of the mass done under LA. The report came as poorly differentiated carcinoma-metastatic, immunohistochemistry advised.

Search for primary made. ENT examination normal. FNAC thyroid showed no evidence of malignancy. Thyroid and breast scans normal. Endometrial biopsy showed no malignancy. No primary found. So, a diagnosis of occult primary with retroperitoneal secondaries made. Consultations done with radiotherapist and medical oncologist. Final decision was palliative CT for 6 cycles. Patient presented with left lower limb DVT after the first cycle of chemotherapy with paclitaxel and cisplatin. Managed appropriately. Continued chemotherapy for 5 cycles. Re-evaluation done after the third course of chemotherapy. Flexion deformity of the hip was resolved completely. Abdominal mass not palpable. Repeat ultrasound of the abdomen and pelvis showed the lesion to be much reduced measuring 57 × 19 mm with iliac vessels seen



Fig. 1: Cystic mass in the left retroperitoneal region measuring 70 × 80 mm with a craniocaudal span of 100 mm with a thin enhancing irregular wall with encasement of the left external iliac artery and vein. There is obstruction of the left ureter with the dilated proximal ureter seen medial to the mass

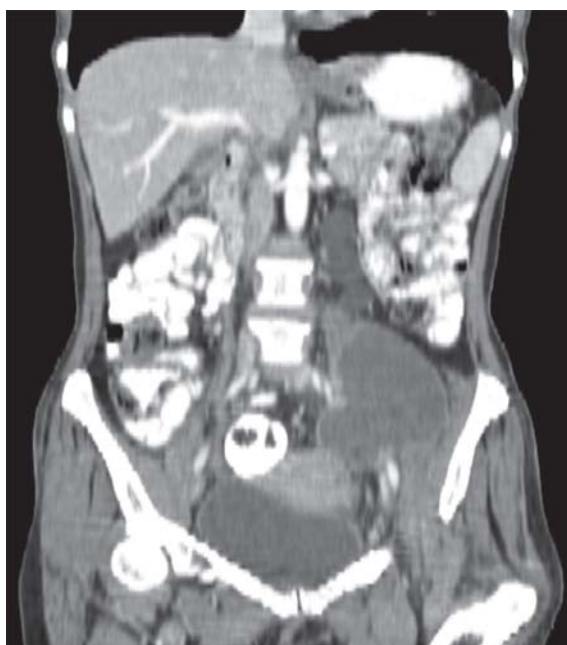


Fig. 2: Coronal image showing the dilated proximal ureter and the mass in the retroperitoneum on the left side



Fig. 3: Left parasagittal image showing the dilated renal pelvis and the mass in the retroperitoneum on the left side

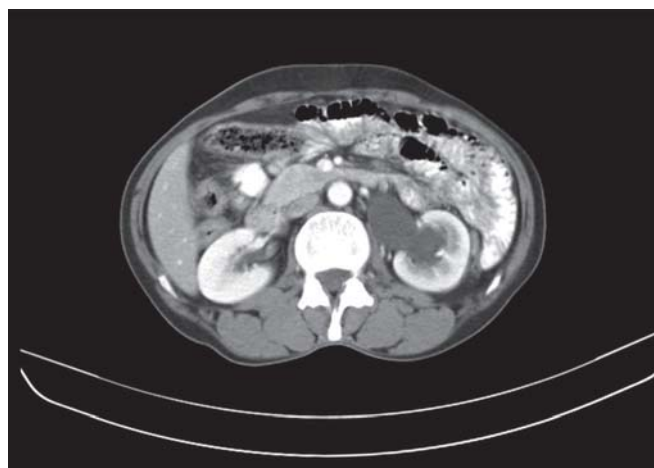


Fig. 4: Image showing the dilated collecting system of the left kidney

adjacent. Mild left hydroureteronephrosis, uterus normal. ET—2 mm and both ovaries normal. No free fluid in the abdomen or pelvis. Upper abdomen normal.

DISCUSSION

The lessons learnt from this case are that any vague mass felt per abdomen—think beyond an ovarian mass. Evidence of obstruction like hydroureteronephrosis with a predominant solid tumor showing clinical signs of vascular or rectal displacements, we should consider other less common d/d of pelvic mass.⁵ Fixed flexion deformity of the hip (Psoas spasm) with mass per abdomen may not be ovarian cyst alone.⁶ Misinterpretation of the clinical signs with overemphasis on ultrasound can lead to a wrong diagnosis and may result in unnecessary laparotomy.¹ Poorly differentiated types have few lipoma-like tissues with increasing internal bleeding or necrosis making a precise diagnosis on imaging alone difficult. Because, these tumors response to treatment and prognosis varies depending on the level of differentiation, biopsy as a

final diagnosis is important.⁷ Patients with advanced poorly differentiated carcinoma should be considered for cisplatin-based combination chemotherapy, especially if tumor occurs predominantly in the mediastinum, retroperitoneum or lymph nodes.⁸

Patient came walking to the OBG department for review and was comfortable. No mass felt per abdomen. Ring pessary was inserted as a conservative treatment for uterovaginal prolapse. Repeat abdominopelvic scan showed complete regression of the mass and the patient is on regular medical oncology and OBG follow-up.

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