Available online at www.sciencedirect.com

SciVerse ScienceDirect

Taiwanese Journal of Obstetrics & Gynecology 51 (2012) 146–147

www.tjog-online.com

Correspondence

Ovarian cancer presenting as an acute abdomen was successfully diagnosed and managed by laparoscopy

A 42-year-old, gravida 2, para 2 woman had suffered from abdominal pain for 1 day. Her history includes two cesarean sections, and a 4-year experience of dysmenorrhea. She was diagnosed accidentally to have a 6-cm ovarian tumor favoring the diagnosis of chocolate cyst (endometrioma) 6 months ago. Her last menstruation date was 29 days ago; therefore, she considered this acute abdominal pain as dysmenorrhea since this attack was accompanied with menstruation.

Transvaginal ultrasound revealed an 80 × 75 × 80 mm cyst with little echogenicity on the right adnexal area. Her urine pregnancy test was negative. Other laboratory examinations were within normal limits, except for leukocytosis of 12,300.

Diagnostic and therapeutic laparoscopy was suggested due to failed response to pain-relieving medication after a 24-hour observation, and clinical diagnosis was the suspicious ruptured or twisted right ovarian chocolate cyst. Laparoscopy showed a dark-red cystic lesion covered by the surrounding omentum. After carefully dissecting the tumor from the surrounding omentum, the diagnosis of tubo-ovarian torsion was made.

Then, laparoscopic salpingo-oophorectomy was performed with complete removal of the intact tumor using a cellulose bag through an enlarged umbilical wound. Frozen pathology favored benign ovarian tumor. However, the final pathology showed mucinous ovarian cancer grade 2. After a careful and thorough discussion and postoperative evaluation, the patient received four-course adjuvant chemotherapy with a combination of paclitaxel and carboplatin, and has been disease-free for 59 months so far.

In this case report, the following interesting issues are raised. First, we completely agree with Dr. Lee's previous comment that great advances in technology offer meticulous options of minimally invasive surgery to empower the gynecologists to manage patients with early ovarian cancer [1], although this issue is still highly debated. Recent studies only suggested that laparoscopic surgery might be used in the management of endometrial cancers, especially type I endometrial cancer (endometrioid carcinoma of the uterus) and/or early-stage cervical cancers, which had better be limited to IB1 and tumor size better be less than 2 cm [2,3]. By contrast, the development of robot-assisted laparoscopy system might overcome the technical limitations in conventional laparoscopy, and provide an opportunity in the management of difficult gynecologic surgeries [4,5], including gynecological cancers [6,7].

Second, is surgical restaging indicated in apparent stage IA epithelial ovarian cancer? To respond to this question is not easy. During primary surgery for advanced-stage epithelial ovarian cancer, all attempts should be made to achieve complete cytoreduction, since women with residual disease <1 cm still do better than women with residual disease >1 cm [8]. When this is not achievable, then the surgical goal should be optimal (<1 cm) residual disease [8]. However, this application might not be appropriate for apparent stage IA epithelial ovarian cancer, since postoperative adjuvant chemotherapy seems to improve the outcome of patients with early-stage epithelial ovarian cancers, even though these patients were treated with fertility-sparing surgery [9].

We conclude that although reoperation is suggested in the majority of patients with accidental diagnosis of ovarian malignancy, for highly selected patients, including those with apparent stage IA epithelial ovarian cancer, removal of the intact tumor without malpractice or overmanipulation, postoperative adjuvant chemotherapy, and good compliance of close follow-up, laparoscopic surgery might not compromise the outcome of these patients.

References

[1] Lee CL, Kay N, Chen HL, Yen CF, Huang KG. The roles of laparoscopy in treating ovarian cancer. Taiwan J Obstet Gynecol 2009;48:9–14.

[2] Lee CL, Huang KG, Chen HL, Yen CF. The roles of endoscopy in endometrial cancer. Taiwan J Obstet Gynecol 2008;47:379–83.

[3] Lee CL, Wu KY, Huang KG, Lee PS, Yen CF. Long-term survival outcomes of laparoscopically assisted radical hysterectomy in treating early-stage cervical cancer. Am J Obstet Gynecol 2010;203:165.e1–7.

[4] Nezhat C, Lavie O, Hsu S, Watson J, Barnett O, Lemyre M. Robotic-assisted laparoscopic myomectomy compared with standard laparoscopic myomectomy—a retrospective matched control study. Fertil Steril 2009;91:556–9.

[5] Lee CL, Han CM, Su H, Wu KY, Wang CJ, Yen CF. Robot-assisted laparoscopic staging surgery for endometrial cancer—a preliminary report. Taiwan J Obstet Gynecol 2010;49:401–6.

doi:10.1016/j.tjog.2012.01.034

[6] Magrina JF, Pawlina W, Kho RM, Magtibay PM. Robotic nerve-sparing radical hysterectomy: feasibility and technique. Gynecol Oncol 2011; 121:605–9.
[7] Magrina JF, Zanagnolo V, Noble BN, Kho RM, Magtibay P. Robotic approach for ovarian cancer: perioperative and survival results and comparison with laparoscopy and laparotomy. Gynecol Oncol 2011;121: 100–5.
[8] Elattar A, Bryant A, Winter-Roach BA, Hatem M, Naik R. Optimal primary surgical treatment for advanced epithelial ovarian cancer. Cochrane Database Syst Rev 2011;8:CD007565.
[9] Satoh T, Hatae M, Watanabe Y, Yaegashi N, Ishiko O, Kodama S, et al. Outcomes of fertility-sparing surgery for stage I epithelial ovarian cancer: a proposal for patient selection. J Clin Oncol 2010;28: 1727–32.

Huann-Cheng Horng
Peng-Hui Wang*
Department of Obstetrics and Gynecology, Taipei Veterans General Hospital, National Yang-Ming University School of Medicine, Taipei, Taiwan

*Corresponding author. Department of Obstetrics and Gynecology, Taipei Veterans General Hospital, 201, Section 2, Shih-Pai Road, Taipei 112, Taiwan.
E-mail addresses: phwang@vghtpe.gov.tw, phwang@ym.edu.tw, pongpongwang@gmail.com (P.-H. Wang)