A Case of Bilateral Borderline Ovarian Tumors in Pregnancy

L. McLoughlin, P. Carbiener

INTRODUCTION

With the increased utilization of ultrasound, the finding of an adnexal mass during pregnancy has become more common. While these masses are seldom malignant, such a discovery can leave the patient and physician greatly concerned.

We report the case of a 36-year-old gravida 5 para 4 who was found to have bilateral borderline ovarian tumors (BOTs) during the second trimester.

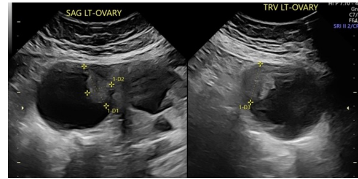
CASE PRESENTATION

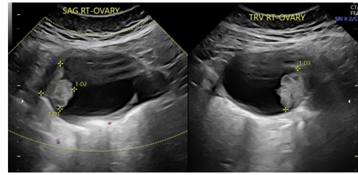
A 36-year-old G5P4 presented at 21 weeks of gestation after a delay in obtaining Medicaid. Ultrasound revealed a singleton pregnancy and bilateral complex ovarian masses measuring 10 and 12 cm. CA-125 was elevated at 176 U/ml.

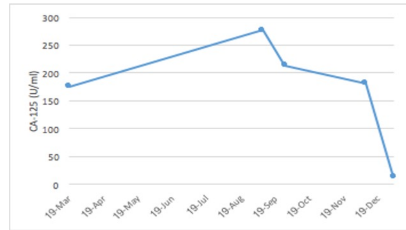
Perinatal and gynecologic oncology co-management required the patient to travel up to 2 ½ hours. Fetal surveillance was reassuring. The patient was induced successfully at 37 weeks.

In the postpartum period, the right adnexal mass increased to 20.06 cm and CA-125 doubled. Two months after delivery, staging surgery was performed. The procedure revealed borderline serous carcinoma in both ovaries with additional low grade serous carcinoma of the right ovary. All lymph nodes were negative for malignancy (Stage 1A LGSOC)

The postoperative period was uneventful. At seven months post staging, her CA-125 was 14 U/ml. She has not required any adjuvant therapy.







REFERENCES

[1] Handbook For Principles And Practice of Gynecologic Oncology, 3rd Edition. (2020).
[2] Marret, H et al. (2010). Guidelines for the management of ovarian cancer during pregnancy. European Journal of Obstetrics & Gynecology and Reproductive Biology, 149(1), 18-21.

DISCUSSION

Borderline ovarian tumors (BOTs) are a semi malignant subclass that account for 10-15% of ovarian epithelial tumors.[1]
They have rarely been reported during pregnancy and there is no consensus on a standardized approach to management.[2]

Tumor characterization is hindered if access to prenatal, maternal fetal, and gynecologic oncology care is delayed by issues of health care access. In this situation, it was not clear how long these masses had existed or how much they had grown in the first half of pregnancy. The potential opportunity to have addressed them in the first and second trimester was not realized. Furthermore, tumor markers in pregnancy were not reliable to identify malignancy or progression.

In this case, the slow growth of the tumors in the latter half of pregnancy, coupled with the lack of ascites or adenopathy, and reassuring fetal surveillance allowed delivery to be postponed to early term, without compromising maternal wellbeing and prognosis. Given the overall good prognosis of these tumors, deferring staging surgery until after delivery seemed prudent in this case and in future cases. Close monitoring by a multidisciplinary team is crucial.

Ultimately the patient and her family had to drive long distances to receive specialty consultation and eventual staging. While the outcome for this patient appears to be unaffected, similar situations could have poor outcomes from what should be avoidable barriers to care access.