Pelvic Spleen Masquerading as an Ovarian Neoplasm

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Abstract

A case of a 53-year-old perimenopausal woman who presented with an 18-month history of irregular vaginal bleeding is reported. Vaginal ultrasonography revealed a 10 x 7 cm pelvic mass with an increased blood flow. Her serum CA125 was within the normal range. At laparotomy a normal spleen was found within the pelvic cavity.

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Case Report

A 53-year-old Caucasian woman, a receptionist in a general practice, was referred to the gynaecology outpatient clinic with an 18-month history of heavy, irregular menses and a pelvic mass on an abdominal ultrasound arranged by her General Practitioner (GP). She was otherwise asymptomatic. There was no family history of breast or ovarian cancer.

Vaginal examination revealed a mobile, non-tender 12-week sized pelvi-abdominal mass. Vaginal ultrasound showed a well-defined mass with low echogenicity and increased vascularity measuring 106 x 71 x 69 mm in the Pouch of Douglas. The uterus was of normal size with an endometrial thickness of 8.8 mm. The right ovary was normal but the left could not be visualised. Liver and renal functions were normal. Her platelet count was 95 x 10^9 / L. Her serum CA125 was 16 U / ml.

In view of her age, symptoms and ultrasound findings, the patient was advised to undergo laparotomy with a likely hysterectomy and bilateral salpingo-oophorectomy. She declined a pre-laparotomy laparoscopy.

At laparotomy there was no free peritoneal fluid so saline washings were sent for cytological examination. The uterus and both ovaries were of normal size, but in the Pouch of Douglas there was a normal looking spleen measuring 130 x 80 x 20 mm on an elongated vascular pedicle. A surgical opinion was sought—the consensus being not to attempt to relocate or remove it. Postoperative recovery was normal. Peritoneal fluid cytology was negative.

Discussion

This finding of a pelvic spleen masquerading as a possible malignant ovarian tumour is, to our knowledge, unique. The poor overall prognosis for ovarian cancer relates mainly to the fact that 70% of patients present with advanced disease. Screening programmes which aim to detect disease at an early, curable stage, usually use a combination of serum CA125 levels and pelvic ultrasound to differentiate between benign and malignant ovarian masses. CA125 alone can only detect about 50% of cases of stage I disease.[1]

Ultrasonographic characteristics of a malignant tumour include a combination of cystic and solid elements within the mass, bilaterality and an increase in blood flow to the mass.[2]

Whilst small ovarian tumours, in premenopausal women may be managed, at least in the short term by observation only, plus or minus suppression of ovulation, exploratory surgery is recommended if the mass is greater than 8 cm in diameter and is predominantly solid, or if the woman is postmenopausal with an adnexal mass.[3]

This patient, therefore, fulfilled many of the criteria more likely to be associated with a malignant ovarian tumour. It was felt that despite the normal serum CA125 level, exploratory (and debulking) surgery was indicated in view of the size of the mass and the tumour blood flow characteristics. Due to the complex and suspicious nature of the mass in this case and the patient's age and symptomatology, it was felt that

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open laparotomy was the surgical treatment of choice.

It could be argued that laparoscopic examination of the mass would have spared the patient an open procedure, but we believe that the nature of the mass would not have been ascertained laparoscopically (it had the appearances of an haemorrhagic ovarian tumour) and laparotomy would have been inevitable.

The patient's menstrual problem has been well controlled with a prostaglandin synthetase inhibitor. Her mild thrombocytopaenia persists but all investigations relating to bone marrow function have been normal.

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