

a matter of judgement

A 29-year-old nulliparous woman, never sexually active, who had had regular 28-day cycles with unremarkable seven-day periods, presented with five months' constant bleeding *per vaginam*. Abdominal examination revealed no abnormality apart from some slight tenderness in the right adnexa on bimanual vaginal examination. In particular, the uterus was normal size and mobile and there were no adnexal masses. Ultrasonography showed no abnormality. Initial blood and cervical cytology results are detailed in Table 1.

Table 1

Initial investigations

Haemoglobin	15.1g/dl
Red cell count	$4.86 \times 10^{12} / l$
White cell count	$6.4 \times 10^9 / l$
T ₄	95nm/l
TSH	1.6mU/l
Cervical cytology	No malignant cells seen

A month later, hysteroscopy and laparoscopy were undertaken to investigate abnormal bleeding and unaccounted for right adnexal tenderness. A normal 8cm uterine cavity was confirmed with no focal lesion. Laparoscopy confirmed the presence of a 4cm left smooth walled ovarian cyst adherent to the pelvic sidewall. There was no other abnormality in the pelvis. The cyst was aspirated of clear fluid, which yielded benign cytology.

- What was the likely nature of the cyst?
- Was it likely to be related to the tenderness noted

on her first visit?

- What is the management of choice?

She did not return for review until four months later, when she came complaining of amenorrhoea since the hysteroscopy and laparoscopy. Blood was taken for a serum hormone profile. (Table 2)

Table 2

Investigations

Luteinising hormone (LH)	11.8iU/l
Follicle stimulating hormone (FSH)	2.5iU/l
Prolactin	440miU/l

- In what way does the hormone profile (Table 2) contradict the history so far?
- What are her management options?

She discontinued the oral contraceptive a year later in order to try for a pregnancy. She had regular cycles for three months and then, once again, developed amenorrhoea. By the time she re-presented she had had two months' amenorrhoea but was also complaining of bloating, frequency and lethargy. Examination confirmed the presence of a 20-week abdominal mass arising from the pelvis. The pregnancy test was negative and a scan confirmed a multicystic mass. The patient was anxious about her fertility. Laparotomy confirmed a 35cm multicystic smooth walled left ovarian cyst. The cyst dissected easily allowing enucleation, and an omental biopsy was taken. Histology revealed a well differentiated Sertoli Leydig tumour with no

malignant cells in either the peritoneal washing or the omental biopsy. Multidisciplinary discussion concluded that the behaviour of this lesion tends to favour local recurrence rather than metastasis. It was agreed to advise second look laparoscopy in three months. This was undertaken. No peritoneal nor other deposits were apparent. The left fallopian tube was adherent to the ovary. Laparoscopic adhesiolysis and ovarian biopsy were undertaken. The biopsy showed a residuum of Sertoli Leydig Tumour but peritoneal washing was again negative.

- f. Bearing in mind her desire for a pregnancy, what are the treatment alternatives?

The patient underwent Left Salpingoöphorectomy and the histology showed no residual tumour. She was followed with scans and check laparoscopy with washings and remained free from recurrence until 17 months later she presented once again with an 18-week pelvic mass. Testosterone was 5.8 nM/l.

- g. What are the treatment options?

It was agreed that, if a conservative approach was undertaken again, she would agree to more aggressive management of her fertility as she had been trying for a pregnancy for two years with no result. The window of reproductive opportunity was closing as more ovarian tissue was being lost with each recurrence. She underwent laparotomy and, a further ovarian cyst enucleation and omental biopsy.

In Vitro Fertilisation was then undertaken with a view to optimising pregnancy rate this cycle but also raising possible frozen embryos for use if/when she lost her ovaries. The first cycle resulted in a pregnancy but no other embryos of suitable quality to cryopreserve.

The pregnancy was uneventful. Regular ultrasound monitoring revealed no cysts. Six months after delivery she presented again with an 18-week mass. She once again hoped for conservative surgery with a view to a future pregnancy in a year or two.

- h. Is conservative surgery again an option?
i. Is radical surgery long overdue?

She opted for Total Abdominal Hysterectomy Right Salpingoöphorectomy and omentectomy, i.e. pelvic clearance. She did not wish for uterine conservation as ovum donation was not acceptable to her. The histology confirmed the same pathology in the removed ovary with no evidence of metastasis.

The remaining questions revolve around reflection:

- Did we all sail too close to the wind? Was the conservative approach too risky for the benefits?
- Were we too eager to undertake the radical surgery at the end?
- Was this a balanced process with consultation at every stage, empowering the patient with a part in the decision-making?

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Laurence Shaw is a Consultant in Obstetrics and Gynaecology at the East Kent Hospitals NHS Trust
lmashaw@aol.com