AUCTORES
Globalize Your research

Journal of Cancer Research and Cellular Therapeutics
Nattapong Phligbua

Open Article

Short Review

Evaluation of Ovarian Neoplasms concurrent with Contralateral Benign Tumors

Nattapong Phliba*, Tiporn Sirichai, Viwatwongkasem Joe

Department of Medical Nursing, Faculty of Nursing, Thailand.

***Corresponding Author:** **Nattapong Phliba**, Department of Medical Nursing, Faculty of Nursing, **Email:** nattapong@yahoo.net

Received date: May 30,2017;Accepted date : August 11,2017; Published date: August 24,2017.

Citation for this Article: **Nattapong Phliba**. Evaluation of Ovarian Neoplasms concurrent with Contralateral Benign Tumorsd . J Cancer Research and Cellular Therapeutics, **Doi:** 10.31579/2640-1053/011

Abstract

Neoplasm of the ovary may coexist with benign teratoma of the opposite organ. I report from an Ethnic Group in Nigeria the 6 cases which were collected during a period of 30 years at a Reference Pathology Laboratory. As the age range was from 21 to 40 years, the series confirms the uncommonness of teratomas in menopausal females. In contrast, dysgerminoma is shown to feature in younger persons. As bilaterality of neoplasms may occur in the ovaries, attention should be paid during clinical work-up.

Keywords

Ovary; Teratoma; Contralateral Neoplasm; Ethnology.

Introduction

Benign teratoma is a relatively common tumor of the ovary. According to Parrington's associates,[1] it is "formed of fully differentiated mature tissues, often from all three cell layers, and usually comprise a cyst containing sebaceous material, hair, and often teeth." World-wide reports have covered its association with diverse conditions such as pregnancy,[2,3] mimicking malignancy,[4] forming squamous cell carcinoma,[5] superinfection,[6,7] and menopause.[8] It has been associated with primary carcinoma of the fallopian tube.[9] Its ethnological parameters have even been presented in a South African research.[10]

Research on the teratomas of this organ was previously carried out personally.[11] This was based on surgical specimens received at a Reference Pathology Laboratory that serves the Igbos,[12] one of the major ethnological groups in Nigeria. Here, using the personally kept Laboratory Records let me present how certain tumors coexisted with benign teratomas in the contralateral ovary. A review of the literatures is added.

Analysis of Case Reports

Serial No.	Laboratory No.	Age	Symptom	Clinical diagnosis	Histologic diagnosis
1.	B 585/74	28	Mass	Cyst	Cystadenoma
2.	B 1423/74	32	Mass	Tumor	Fibroma
3.	UH 1658/86	21	Mass	Teratoma	Cystadenofibroma
4.	UH 2092/86	28	Mass	Cyst	Dysgerminoma
5.	UH 2430/88	35	Swelling	Cyst	Cystadenocarcinoma
6.	931286	40	Mass	Cystadenoma	Brenner Tumor

Discussion

I have experienced 6 cases of various neoplasms coexisting with a benign cystic teratoma of the other ovary. See Table 1. In all probability, the parameters of these patients are worthy of note.

Note was taken of the age range which was from 21 to 40 years (mean 31 years). These are child-bearing years but no case was associated with pregnancy as in the torsion case from Taiwan,2 and the obstruction case from Ethiopia.3 Therefore, this series confirms the uncommonness of teratoma presentating in menopausal females.8

Females of younger ages are those who suffer from dysgerminoma. The single case in this series is consistent with the New York experience of Barber who stated that it is the most common malignant germ cell tumor found in childhood.[13] The 40 years age limit in this series tallies with Jamaican experience,[14] in the United Kingdom,[15] out of 9 malignant tumors recorded in infancy and childhood, as many as 8 were dysgerminomas. In Yugoslavia,[16] out of 15 such malignant tumors, five showed the dysgerminoma pattern.

Pattern of growths in a community is epidemiologically important. If the benign patterns are considered, namely, cystadenoma, cystadenofibroma, fibroma, and Brenner tumor, each of which occurred once in Table 1, they were precisely those highlighted in a large US report.[17] Incidentally, an Israeli paper devoted attention wholly to cystadenofibroma,[18] remarking that "the characteristic pathologic features of this neoplasm justify its separate listing."

Listing requires that, if neoplastic disease occurs in the one ovary, the state of the contralateral counterpart must be ascertained.[19] Indeed, the frequency of bilaterally of teratoma itself necessitates careful attention.[20] In the US series,[17] out of 103 such cases, [9] (8.7%) were bilateral. It was 10.8% in another US series.[19].

Conclusion

Series have so far been cited from Journals based in the UK,[1,4,15,20] Taiwan,[2] Ethiopia,[3] South Africa,[5,10] USA,[6,8,11,13,17,19] Iran,[7] Korea,[9] Jamaica,[14] Yugoslavia,[16] and Israel.[18] In the present series, the data collected became possible on account of the personal establishment of the histopathology pool recommended by Birmingham, UK, authors,[21].

Who recommended the importance of epidemiological analysis using such pools. It is concluded, therefore, that ovarian neoplasms may coexist with contralateral benign teratomas. Accordingly, when one ovary is involved, its contralateral counterpart should always be examined at operation and, if necessary, biopsied. In other words, whatever the advance in therapy it should take into account the state of the contralateral organ.

References

1. Parrington JM, West LF, Povey S (1984) the origin of ovarian teratomas. J Med Genetics 21: 4-12.
2. Tan KH, Chen KC, Wang TL, Chong CF, Chen CC (2010) ovarian cystic teratoma torsion in pregnancy. Emerg Med J 27: 879-80.
3. Kifle G (1987) ovarian cystic teratoma as a cause of obstructed labour. Ethiop Med J 25: 177-179.
4. Maiti S, Fatima Z, Anjum ZK, Hopkins RE (2008) Ruptured ovarian cystic teratoma in pregnancy with diffuse peritoneal reaction mimicking advanced ovarian malignancy: a case report. J Med Case Rep 2-203.
5. Kaplan E (1977) Squamous cell carcinoma arising in a dermoid cyst of the ovary. S Afr Med J 52:1128-1129.
6. Luk J, Quaas A, Garner E (2007) the superinfection of a dermoid cyst. Infect Dis Obstet Gyneco.
7. Hasanzadeh M, Tabare S, Mlrzaean S (2010) ovarian dermoid cyst. Professional Med J 17:512-5.
8. Gordon A, Rosenshein N, Parmley T, Bhagavan B (1980) Benign cystic teratomas in postmenopausal women. Am J Obstet Gynecol 138:1120-3.
9. Lee YH, Yoo G, Jung HY, Hwang DH, Noh TW, et al. (2000) Primary carcinoma of the fallopian tube coexisting with benign cystic teratoma of the ovary. Yonsei Med J 41:140-3.
10. Bhoola KD, Bhamjee A (1976) a comparative study of ovarian tumours in black and Indian patients. S. Afr Med J 50:1935-1936.
11. Onuigbo WIB (1976) Teratomas in the Igbos of Nigeria. J Natl Cancer Inst 57:1191-2.
12. Basden GT, Niger Ibos, Cass (1966) London.
13. Barber HRK (1982) ovarian cancers in childhood. Int J Radiat Oncol Biol Phys 8:1427-1430.
14. Persaud V (1977) Aspects of primary ovarian cancer in Jamaica. W I Med J 26:90-100.
15. Shawis RN, Gohary AEL, Cook RCM (1985) ovarian cysts and tumors in infancy and childhood. Ann Royal Coll Surg Eng 67:17-9.
16. Jereb B, Golouh R, Havlicek S (1977) ovarian cancer in children and adolescents: a review of 15 cases. Med Pediat Oncol 3:339-343.
17. Katsube Y, Berg JW, Silverbery SG (1982) Epidemiologic pathology of ovarian tumors: A histopathologic review of primary ovarian neoplasms diagnosed in the Denver Standard Metropolitan statistical area. Intl J Gynecol Pathol 1:3-16.
18. Czernobilsky B, Borenstein R, Lancet M (1974) cystadenofibroma of the ovary. Cancer 34:1971-1981.
19. Comerci JT Jr, Licciardi F, Bergh PA, Gregori C, Breen JL (1994) Mature cystic teratoma: a clinicopathologic evaluation of 517 cases and review of the literature. Obstet Gynecol 84:22-8.
20. Bloomfield TH (1987) benign cystic teratomas of the ovary: a review of seventy-two cases. Eur J Obstet Gynecol Reprod Biol 25:231-237.
21. Macartney JC, Rollason TP, Codlins BW (1980) Use of a histopathology data pool for epidemiological analysis. J Clin Pathol 33:351-355.