Right Ovarian Mucinous Cystadenoma Coexisting with an Incidental Left Ovarian Haemangioma in a Postmenopausal Patient

The Editor,

Sir,

Haemangiomas were first described by Payne in 1869 (1). In the literature, their coexistence with various diseases of the female genital tract has been reported (2–5). Our case differs in that a postmenopausal woman had a mucinous cystadenoma in one ovary and an incidentally discovered cavernous haemangioma with focal positivity for progesterone receptor (PR) in the other ovary.

An 81-year old woman had right lower quadrant pain. Transabdominal sonography revealed a 10 cm right ovarian cystic and septated mass. No left adnexal lesion was reported. There was no sign of ascites. The serum cancer antigen (CA) 125 level of the patient was 144.9 IU/mL (ref 0–35), serum Ca-19-9 level was 24.9 IU/mL (ref 0–39).

Magnetic resonance images revealed a well circumscribed, slightly lobulated contoured, T1 SE hypo-, T2 SE hyperintense, multilocular cystic lesion in the right half of the pelvis (Figs. 1A–D). The left ovary measured 34 x 14 x 35 mm with slight spiculations and was isointense to myometrium on T1 SE and T2 SE weighted sequences (Fig. 1A–B). With injection of contrast material, slightly heterogeneous parenchymal contrast enhancement less than the myometrium was observed (Fig. 1A–D).

The result of the right ovary was reported as a mucinous cystadenoma on frozen section (Fig. 2).

On the cut surface of the left ovary (4 x 3 x 1.5 cm in size), a haemorrhagic nodular lesion, 2.5 x 1.5 cm in size, was noted. Microscopic sections revealed dilated, thin-walled vascular structures, variable in diameter, and the walls of which were comprised a single layer of endothelial cells not showing atypia (Fig. 3).

Fig. 1: Magnetic resonance imaging shows right ovarian lesion to be a multilocular cyst; (A) homogeneous hypo-signal intensity on T1-weighted images and (B) high signal intensity on T2-weighted images. Left ovary has slight spiculations isointense on T1 and T2 weighted images. (C) T2 SPAIR axial image (D) with contrast material; T1-weighted WATS CE axial images show the presence of a slightly heterogeneous enhancement in the left ovary (right lower arrow).

Fig. 2: Histologically, the right ovarian cyst was lined by mucinous epithelium (H&E; x 20).

Fig. 3: Near the ovarian stroma, dilated thin walled vessels were lined by a single layer of endothelial cells, containing red blood cells in their lumen (H&E; x 4).
Based on macroscopic, morphologic and immunohistochemical findings of factor VIII (FVIII), CD 34, smooth muscle actin (SMA) expression, the case was reported as ovarian cavernous haemangioma. Oestrogen receptor (ER) was negative; however, some endothelial cells were positive for PR (Fig. 4).

Some authors have studied immunohistochemical expression of ER and PR, and they have found different results (3, 7). In the present case, luteinization was not observed. Moreover, endothelial cells were negative for ER, but some endothelial cells were positive for PR.

Radiological appearance for the left ovary was inconclusive; the presence of an enlarged ovary (8) and visualization of contrast uptake on preoperative magnetic resonance imaging in a postmenopausal woman supported rich vascular structure. In postmenopausal women, enlarged ovaries with or without contralateral lesions should be evaluated cautiously.

**Keywords:** Magnetic resonance imaging, MRI, mucinous cystadenoma, ovary hemangioma, postmenopausal women, progesteron receptor

*S Altınay¹, MM Naki², M Toksöz³, R Albayrak⁴*

From: ¹Bağcılar Training and Research Hospital, Department of Pathology, Istanbul, Turkey, ²Liv Hospital, Department of Gynecologic Oncology, Istanbul, Turkey and ³Bağcılar Training and Research Hospital, Department of Radiology, Istanbul, Turkey.

**Correspondence:** Dr S Altınay, Bağcılar Eğitim ve Araştırma Hastanesi, Patoloji Laboratuvarı, Merkez Mahallesi Mimar Sinan Caddesi No 6, Bağcılar, İstanbul, Türkiye 34203. Fax: +90 (0) 212 440 42 43, e-mail: drserdara@yahoo.com

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**Table:**

<table>
<thead>
<tr>
<th>Author</th>
<th>Age (years)</th>
<th>Symptom</th>
<th>Size (cm)</th>
<th>Type</th>
<th>Luteinization</th>
<th>Coexisting Lesion</th>
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<tbody>
<tr>
<td>Jurkovic et al, (3) 1999</td>
<td>32</td>
<td>Asymptomatic</td>
<td>NA</td>
<td>Capillary</td>
<td>No ER-PR-</td>
<td>Mucinous cystadenoma</td>
</tr>
<tr>
<td>Akbulut et al, (2) 2008</td>
<td>65</td>
<td>Irregular vaginal bleeding and pelvic pain</td>
<td>0.5</td>
<td>Capillary</td>
<td>No ER-PR-</td>
<td>Serous papillary carcinoma</td>
</tr>
<tr>
<td>Comunoglu et al, (4) 2010</td>
<td>81</td>
<td>Hypertension and hyponatremia</td>
<td>3.5</td>
<td>Cavernous</td>
<td>NA</td>
<td>Mucinous cystadenoma</td>
</tr>
<tr>
<td>Current case, 2013</td>
<td>81</td>
<td>Lower right quadrant pain</td>
<td>2.5</td>
<td>Cavernous</td>
<td>No ER-PR focal+</td>
<td>Mucinous cystadenoma</td>
</tr>
</tbody>
</table>

NA: Not available     ER/PR: oestrogen/progesterone positivity
Can Chronic Consumption of Noni (Morinda citrifolia) Juice Lead to Changes in the Coagulation Profile, Deranged Liver Function and Excessive Intraoperative Haemorrhage?

The Editor,

Sir,

Excessive haemorrhage in orthopaedic surgery can be due to multiple causes. One of the rarer causes is the chronic effect of certain drugs (1). Ascertain preoperative history and stoppage of use of platelet inhibitors, thrombolytics or anticoagulants is imperative (2). Occurrence of excessive bleeding, despite the application of a tourniquet, can be mystifying.

A 68-year old hypertensive female was posted for removal of intra-medullary nail with a discharging sinus from the left tibia, under general anaesthesia. The investigations were normal except for elevated lactate dehydrogenase (LDH) of 401 U/L, prothrombin time (PT) of 16.7 seconds and international normalized ratio (INR) of 1.6.

In spite of tourniquet inflated to 300 mmHg intraoperatively, there was uncontrolled, continuous and profuse bleeding, amounting to nearly 1200 mL. The intra-medullary nail removal had to be abandoned. However, during debridement of the lower tibia, the patient continued to ooze, with the total blood loss estimated to be 1500–1600 mL. The bleeding was assessed as Grade 5, according to Fromme-Boezaart surgical field grading (3). The surgery lasted two hours with the tourniquet time of 77 minutes. Postoperatively, patient informed that she frequently consumed “noni” juice for the last six to seven years. When on noni, she also experienced vaginal bleeding which mimicked menstrual periods and stopped when noni was discontinued. Fifteen days after surgery and discontinuing noni, she also experienced vaginal bleeding which consumed “noni” juice for the last six to seven years. When on noni, assessment of coagulation profile and liver enzymes, stoppage of noni juice and waiting until the PT/INR/liver functions become normal is recommended.

Keywords: Chronic consumption, elevated liver enzyme levels, excessive intraoperative haemorrhage, Morinda citrifolia, noni, noni juice, orthopaedic surgery

MM Panditrao¹, MM Panditrao¹, F Edghill², HF Lockhart²

From: ¹Department of Anesthesiology and Intensive Care and ²Department of Surgery, Public Hospital Authority’s Rand Memorial Hospital, Freeport, Grand Bahama, Commonwealth of Bahamas.

Correspondence: Professor MM Panditrao, Department of Anesthesiology and Intensive Care, Rand Memorial Hospital, Freeport, Grand Bahama, Commonwealth of Bahamas. E-mail: drmmprao@gmail.com

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