

## Correspondence

## A challenge in the management of a patient with ovarian cancer associated with extensive endometriosis

Epithelial ovarian cancer (EOC) is the second most common gynecologic malignancy and most common cause of death among women with gynecologic cancers [1]. The initial management of women with EOC is surgery [2,3], followed by chemotherapy; however, chemo-resistance often occurs, resulting in therapeutic failure [4]. Studies have consistently shown that the volume of residual diseases related to EOC that remains after cytoreductive surgery inversely correlates with survival [5]; therefore, every strategy is tried to complete ultraradical cytoreductive surgery. A recent Cochrane study has suggested that definite optimal cytoreduction for advanced EOC can significantly improve survival of patients rendered microscopically disease-free [6].

Sometimes, some benign situations, such as extensive endometriosis and infection, might mimic tumor invasion, with resultant over-treatment and the possible occurrence of complications [7–9], especially when accompanied by EOC. Among these, endometriosis is one of the most common benign disorders accompanying EOC [10]. Endometriosis is a medical illness [11], although the occurrence of complications, such as intestinal obstruction, sometimes requires surgical intervention. Therefore, the management of cases with ovarian cancer accompanied with endometriosis might face this troubling situation, as presented in the following case.

A 32-year-old asymptomatic female, gravida 0, para 0, was diagnosed accidentally with a right pelvic mass during routine annual physical examination. Her other history was unremarkable. Tumor survey revealed a 12-cm cystic complex mass at the right lateral pelvic wall, elevated cancer antigen 125 (163 U/ml), and negative upper gastrointestinal endoscopy, but external compression of the lower gastrointestinal endoscopy. Under the impression of malignant ovarian cancer, she underwent exploratory laparotomy. After washing cytology, the operation revealed a right ovarian mass, which was removed completely. The frozen biopsy showed clear cell carcinoma. The right pelvic lymph nodes had also been invaded by cancer. The patient then underwent complete cytoreductive surgery, including total hysterectomy, retroperitoneal lymph node dissection, appendectomy, random sampling, and infracolic omentectomy. However, a 0.5 × 0.5 cm ulcer was found at the anterior wall of the upper rectum; the lesion was palpable and about 2 cm in size.

Microscopic residual tumor seemed to be achievable in this patient if the rectal lesion was removed. After careful and thorough consideration and discussion, a rectal-sigmoid colon junction wedge resection with primary repair was performed. Pathology revealed clear cell carcinoma accompanied with endometriosis of the right ovary, metastatic carcinoma of the left ovary, bladder wall, and right pelvic lymph nodes, but only endometriosis without malignant tumors on the rectal-sigmoid wedge resection specimen. Postoperatively, a standard chemotherapy, including paclitaxel, and carboplatin was prescribed with a smooth clinical course.

The volume of residual disease remaining after cytoreductive surgery for EOC inversely correlates with survival; this volume is within the surgeon's control. A growing body of published reports has confirmed the relationship between complete cytoreduction to nearly invisible disease and better outcome [6]. Sometimes, these patients with EOC might need ultraradical cytoreductive surgery, including wedge resection or segmentectomy of the small or large intestines (complex or multiple bowel resections), splenectomy and complete peritonectomy. However, many complications may arise from these procedures, such as infection of the incision site, damage to neighboring organs, and scar tissue formation, which may cause future obstruction and incisional hernia. In addition, short bowel syndrome may also occur when a large portion of the small intestine is removed.

Ultraradical cytoreductive surgery is associated with morbidity and potentially significant mortality. Therefore, accurate diagnosis of the tumor lesions preoperatively or even intraoperatively is of great importance. Unfortunately, the differential diagnosis of colon-rectal metastasis from EOC or endometriosis and other benign diseases, such as inflammatory bowel disease, is difficult and sometimes impossible because of the very similar colonoscopic and radiologic findings.

### References

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Chun-Yu Shih

*Department of Obstetrics and Gynecology,  
Taipei Veterans General Hospital, Taipei, Taiwan*

*Department of Obstetrics and Gynecology,  
National Yang-Ming University, Taipei, Taiwan  
Department of Pathology, National Yang-Ming University,  
Taipei, Taiwan*

Chiung-Ru Lai

*Department of Obstetrics and Gynecology,  
National Yang-Ming University, Taipei, Taiwan  
Department of Pathology, Taipei Veterans General Hospital,  
Taipei, Taiwan  
Department of Pathology, National Yang-Ming University,  
Taipei, Taiwan*

Chen-Yu Huang

Nae-Fang Twu

Kuan-Chong Chao

Peng-Hui Wang\*

*Department of Obstetrics and Gynecology, Taipei Veterans  
General Hospital, Taipei, Taiwan  
Department of Obstetrics and Gynecology, National Yang-  
Ming University, Taipei, Taiwan*

\*Corresponding author. Department of Obstetrics and Gynecology, Taipei Veterans General Hospital, Taipei, Taiwan.

*E-mail addresses:* [phwang@vghtpe.gov.tw](mailto:phwang@vghtpe.gov.tw),  
[phwang@ym.edu.tw](mailto:phwang@ym.edu.tw) (P.-H. Wang)