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Clinical, radiological and pathological features in patients with ovarian masses

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Abstract

Background: Ovarian masses may occur in various demographics. Most masses are diagnosed late due to ambiguity of the clinical presentation. The most common symptom is pain abdomen which is nonspecific. Pelvic ultrasonography is used to aid clinical examination to come to an early diagnosis and treatment. Final diagnosis is given by histopathological examination of ovarian mass tissue which is obtained through various surgical methods. In this study the correlation of clinical, radiological and histopathological correlation is studied.

Aim: to study the clinical and histopathological correlation in patients with ovarian masses in various demographics

Methods: 40 women who had ovarian masses from July 2023 to December 2024 were chosen for the study after fulfilling the inclusion criteria. Patient's history, examination findings, ultrasonography findings along with the histopathological report were noted for the study.

Results: In the present study majority of the patients were in the age group 21 - 30 years old (35%). Majority of the patients were married at the ages between 18-25 years (47.5%). 62.5% of the patients with ovarian masses had their first child between the ages of 18-25 years. Majority of the patients with ovarian masses are parous women. 45% of the cases with ovarian masses had two children. In the present study majority of the patients with ovarian masses were pre-menopausal (87.5%). Patients who presented with ovarian masses were more likely to be overweight constituting 27.5% of the total study group. The most common symptom the patients showed was pain abdomen (42%). It was observed that most of the patients had symptoms for less than 6 months (73%). On examination it was observed that 55% of palpable masses were cystic and 45% were solid. It was noted that majority of the patients in the study had CA-125 levels less than 35 IU/ml constituting 57% of the total study group. Based on ultrasound findings it was observed that majority of the ovarian masses were <7cm, constituting 60%. 92.5% were unilateral, 70% did not have internal echoes, 62.5% were unilocular, 70% did not have septations, and 97.5% did not have ascites. The commonly done surgery was unilateral cystectomy constituting 37.5%. On histopathological examination the most common finding was luteal cyst.

Conclusion: In the current study with 40 cases of ovarian masses which match the inclusion criterion were taken into the study and analyzed. The patient history, clinical examination, tumor markers, ultrasound findings and histopathological examination findings were considered for the present study. Prevalence of ovarian masses in various demographics observed. Patients were classified according to their history, clinical findings, radiological findings and histopathological findings, correlation and comparison noted.

Keywords: Ovarian mass, ovary, ovarian tumour, ovarian cancer, ovarian cyst

Introduction

The ovary is complex in its embryology, histology, steroidogenesis. It can develop functional and inflammatory changes but also has the potential to develop malignancy. Ovarian masses may occur at any age. Benign masses arise during reproductive years and malignant ones are seen in young adults and post-menopausal females^[1].

Most masses produce few or only mild, non-specific symptoms. The most common symptoms include abdominal distension, abdominal pain, discomfort, lower abdomen pressure sensation, and urinary or gastrointestinal symptoms.

Acute pain may occur with adnexal torsion, cyst rupture, or bleeding due to a cyst rupture, bleeding into a cyst. Masses that are unilateral, cystic, mobile, and smooth are most likely to be benign, whereas those that are bilateral, solid, fixed, irregular, and associated with ascites, cul-de-sac nodules, and a rapid rate of growth are more likely to be malignant. The most commonly indicated study is pelvic ultrasonography, which will help document the origin of the mass. The ultrasonographic examination provides information about the size of the mass, the consistency-

unilocular cyst, mixed echogenicity, multiloculated cyst, or solid mass-which can help determine management^[2]. As ovaries are not clinically assessable like the cervix, vagina and uterus hence there are no readily available screening tests.

Due to this any ovarian pathology are easily missed in an early stages of the disease.

In India, ovarian cancer is the second most common gynaecological cancer among women with incidence being 4.5-5.5 per 100,000 women in India.

Worldwide every year about 2,25,000 women are diagnosed with ovarian cancer out of which 1,40,000 face mortality. It is due to late presentation of the disease (most women, 70% present in stage III or IV) and lack of availability of effective screening methods for early detection of ovarian cancer^[3].

Aim

The aim is to assess the clinical and pathological features of ovarian masses and its prevalence in various demographics.

Objectives

The following are the objectives of the study-

1. To assess the prevalence of ovarian masses.
2. To classify the ovarian masses based on their clinical and pathological features.
3. To correlate clinical findings with radiological and pathological findings of ovarian masses.

Materials

This is a prospective observational study conducted in the Department of Obstetrics and Gynaecology at Kamineni Institute of Medical Sciences (KIMS) Narketpally from August 2023 to October 2025. This study group includes patients who

come to Kamineni institute of Medical Sciences OPD with an ovarian mass. It only includes patients who have signed the written consent, patients who will undergo the necessary investigations such as USG and other investigations that were included in the study. Patients who have any other pelvic mass other than ovarian mass, patients who are pregnant and Patients who do not give consent to the study and patients who are not willing to undergo the necessary investigations for the study are not included in the study.

Methods

After getting approval from the Institutional Ethics Committee and the patients diagnosed with Ovarian masses who consented to participate in the study after fulfilling the inclusion and exclusion criteria will be enrolled in the study. Detailed history like demographic characteristics, and other relevant details are recorded. Thorough clinical examination including general examination, systemic examination and gynaecological examination to assess the cervix, external genitalia, adnexa and uterus will be performed for each and every patient included in the study. Ultrasonography (USG) of the pelvis is carried out to locate and know the characteristics of the ovarian mass. Baseline and necessary indicated investigations are carried out for the study subjects. WHO classification for ovarian masses is used to classify the different types of ovarian masses. Histopathology findings and radiological findings are used to correlate with the clinical diagnosis of the ovarian mass. Statistical tools were used to know the statistical significance of various factors to ovarian masses. The results from the present study was then compared to other similar studies done in the past.

Results

Table 1: Distribution of patients according to age

Age group	Benign	Benign %	Malignant	Malignant %	Total n=40	Total %	Chi-square test
<20 years	4	100	0	0	4	10	0.010 (significant)
21-30 years	13	93	1	7	14	35	
31-40	10	100	0	0	10	25	
41-50	8	100	0	0	8	20	
>50	3	75	1	25	4	10	

Table 2: Distribution according to age at marriage of the patient

Age group	Benign	Benign %	Malignant	Malignant %	Total n=40	Total %	Chi-square test
<18	14	93	1	7	15	37.5	0.313 (insignificant)
18-25	18	95	1	5	19	47.5	
26-30	0	0	0	0	0	0	
Unmarried	6	100	0	0	6	15	

Table 3: Distribution according to age at first child of patient

Age group	Benign	Benign %	Malignant	Malignant %	Total n=40	Total %	Chi-square test
<18	6	100	0	0	6	15	0.132 (insignificant)
18-25	24	96	1	4	25	62.5	
26-30	1	100	0	0	1	2.5	
Nulligravida	7	87.5	1	12.5	8	20	

Table 4: Distribution based on parity

Parity	Benign	Benign %	Malignant	Malignant %	Total n=40	Total %	Chi square test
Nulligravida	7	87.5	1	12.5	8	20	0.001 (significant)
1 child	2	100	0	0	2	5	
Two children	18	100	0	0	18	45	
Three children	8	100	0	0	8	20	
>three children	3	75	1	25	4	10	

Table 5: Distribution according to age of menarche of patient

Age	Benign	Benign %	Malignant	Malignant %	Total n=40	Total %	Chi-square test
<9	0	0	0	0	0	0	0.372
9-16	38	95	2	5	40	100	
>16	0	0	0	0	0	0	

Table 6: Distribution according to menopause status

Menopause status	Benign	Benign %	Malignant	Malignant %	Total n=40	Total %	Chi-square test
Pre menopausal	34	97	1	3	35	87.5	0.063
Post menopausal	4	80	1	20	5	12.5	

Table 7: Distribution based on menstrual cycle frequency

Frequency	Benign	Benign %	Malignant	Malignant %	Total n=40	Total %	Chi-square test
Normal	36	95	2	5	38	95	0.739 (insignificant)
Infrequent	1	100	0	0	1	2.5	
Frequent	1	100	0	0	1	2.5	

Table 8: Distribution according to duration of menstrual cycle

Duration	Benign	Benign %	Malignant	Malignant %	Total n=40	Total %	Chi-square test
Normal	32	94	2	6	34	85	0.884 (insignificant)
Prolonged >7	3	100	0	0	3	7.5	
Reduced <2	3	100	0	0	3	7.5	

Table 9: Distribution according to comorbidities

Comorbidity	Benign	Benign %	Malignant	Malignant %	Total n=40	Total %	Chi-square test
No comorbidity	35	95	2	5	37	92.5	0.679
Hypothyroid	1	100	0	0	1	2.5	0.816
Diabetes mellitus	0	0	0	0	0	0	-
Hypertension	1	100	0	0	1	2.5	0.816
Other	1	100	0	0	1	2.5	0.816

Table 10: Distribution according to family history

History	Benign	Benign %	Malignant	Malignant %	Total n=40	Total%	Chi-square test
Htn	4	100	0	0	4	10	0.402 (insignificant)
Dm	4	100	0	0	4	10	
Ba	1	100	0	0	1	2.5	
Breast lump	1	100	0	0	1	2.5	
Fibroid uterus	2	100	0	0	2	5	
Cancer	0	0	0	0	0	0	
Nil	28	93	2	7	30	70	

Table 11: Distribution according to BMI

Bmi	Benign	Benign %	Malignant	Malignant %	Total n=40	Total %	Chi-square test
Underweight(<18.5)	6	86	1	14	7	17.5	0.884(insignificant)
Normal (18.5-24.9)	17	94	1	6	18	45	
Overweight (25.0-29.9)	11	100	0	0	11	27.5	
Obesity class i (30.0-34.9)	2	100	0	0	2	5	
Obesity class ii (35.0-39.9)	2	100	0	0	2	5	
Obesity class iii (>40)	0	0	0	0	0	0	

Table 12: Distribution according to symptoms

Symptom	Benign	Benign %	Malignant	Malignant %	Total n=40	Total %	Chi-square test
Pain abdomen	20	91	2	9	22	42	0.202
Mass abdomen	1	100	0	0	1	2	0.816
Menstrual symptoms	7	100	0	0	7	13.4	0.504
Urinary symptoms	4	67	2	33	6	11.5	0.001
Constitutional	1	50	1	50	2	4	0.003
Asymptomatic	9	100	0	0	9	17	0.434
Infertility	0	0	0	0	0	0	-
Vomiting	5	100	0	0	5	9.6	0.583

Table 13: Distribution according to duration of symptoms

Duration	Benign	Benign %	Malignant	Malignant %	Total n=40	Total %	Chi-square test
<6months	20	91	2	9	22	73	0.127 (insignificant)
6months-1year	7	100	0	0	7	23	
>1year	1	100	0	0	1	3	

Table 14: Distribution according to examination findings

Examination findings	Finding	Benign	Benign %	Malignant	Malignant %	Total n=40	Total %	Chi-square test
Consistency	Cystic	6	100	0	0	6	55	0.001
	Solid	3	60	2	40	5	45	
Mobility	Mobile	8	100	0	0	8	72	0.000
	Fixed	1	33	2	67	3	28	

Table 15: Distribution according to ca-125 levels

Ca 125 levels(u/ml)	Benign	Benign %	Malignant	Malignant %	Total n=40	Total %	Chi-square test
<35 u/ml	8	100	0	0	8	57	0.000
35-200 u/ml	2	67	1	33	3	21	
>200 u/ml	2	67	1	33	3	21	

Table 16: Distribution based on size of mass (USG findings)

Size	Benign	Benign %	Malignant	Malignant %	Total n=40	Total %	Chi-square test
<7cm	24	100	0	0	25	60	0.109 (insignificant)
>7cm	13	87	2	13	15	40	

Table 17: Distribution according to ultrasound findings

Usg findings		Benign	Benign %	Malignant	Malignant %	Total n=40	Total %	Chi-square test
Laterality	Unilateral	36	97	1	3	37	92.5	0.079
	Bilateral	2	67	1	33	3	7.5	
Echogenicity	Present	11	92	1	8	12	30	0.370
	Absent	27	96	1	4	28	70	
Locularity	Unilocular	25	100	0	0	25	62.5	0.850
	Multilocular	13	87	2	13	15	37.5	
Septations	Present	10	83	2	17	12	30	0.588
	Absent	28	100	0	0	28	70	
Ascites	Present	0	0	1	100	1	2.5	0.000
	Absent	38	97	1	3	39	97.5	

Table 18: Distribution according to type of surgery

Surgery	Benign	Benign %	Malignant	Malignant %	Total n=40	Total %
Usg guided biopsy	0	0	2	100	2	5
Bso	3	100	0	0	3	7.5
Unilateral oophorectomy	10	100	0	0	10	25
Unilateral cystectomy	15	100	0	0	15	37.5
Debulking	0		0	0	0	0
Tah+ uso	2	100	0	0	2	5
Tah+ bs+uo	6	100	0	0	6	15
Tah+bso	2	100	0	0	2	5

Table 19: Distribution according to type of tumour

Histopathological findings	Number of cases n=40	No of cases %
Simple serous ovarian cyst	9	21
Seromucinous cystadenoma	1	2
Serous cystic adenoma	5	11
Mucinous cystic adenoma	5	11
Endometriotic cyst	3	7
Corpus luteal cyst	9	21
Dermoid cyst	4	2
Follicular cyst	4	9
Mature cystic teratoma	1	9
Squamous cell carcinoma	1	2
Malignant surface epithelial tumour	1	2

Table 20: Distribution of clinical symptoms, examination findings and radiological (USG) findings

		Benign	Benign %	Malignant	Malignant %	Total n=40	Total %
Symptoms	Pain abdomen	20	91	2	9	22	42
	Mass abdomen	1	100	0	0	1	2
	Menstrual symptoms	7	100	0	0	7	13.4
	Urinary symptoms	4	67	2	33	6	11.5
	Constitutional	1	50	1	50	2	4
	Asymptomatic	9	100	0	0	9	17
	Infertility	0	0	0	0	0	0
	Vomiting	5	100	0	0	5	9.6
Examination	Consistency	Cystic	6	100	0	6	55
		Mix	0	0	0	0	
		Solid	3	60	2	5	45
	Mobility	Mobile	8	100	0	8	72
		Fixed	1	33	2	3	28
Usg	Size	<8cm	24	100	0	24	60
		>8cm	13	87	2	15	37.5
		Not visualized	1	100	0	1	2.5
	Laterality	Unilateral	36	97	1	37	92.5
		Bilateral	2	67	1	3	7.5
	Echogenicity	Present	11	92	1	12	30
		Absent	27	96	1	28	70
	Locularity	Unilocular	25	100	0	25	62.5
		Multilocular	13	87	2	15	37.5
	Septations	Present	10	83	2	12	30
		Absent	28	100	0	28	70
	Ascites	Present	0	0	1	1	2.5
		Absent	38	97	1	39	97.5

Discussion

Ovarian masses can present with various clinical, radiological and histological features. Ovarian masses may manifest in a wide range leading to difficulty in diagnosis. In this study we have compiled and analysed 40 ovarian masses in detail over a period of 2 years to understand the correlation between the various features and relation to various demographics.

In the present study the peak incidence of ovarian masses was between age group 21 to 30 years with 35.4% of the total. Similar observations were made by Aishwarya *et al* between age group 20-29 years with 42.5% [4]. Chi Square test, p value was 0.010 which denotes significance between age of the patient and type of ovarian mass.

Based on the present study the maximum incidence of ovarian masses was in patients whose age of marriage 18-25 years constituting 47.5%. 85% of them were married.

P value is 0.313 which is statistically proven to be insignificant. Similar observations were made by Pei Luo in 2019. Maximum incidence of 57.8% was seen in patients who were married and showed statistical insignificance [5]. Similar to the above observations study done by Wang X *et al* shows 54.28% were married. Contrary to the above two studies it statistically proves significance [6]. Ovarian masses were seen in in patients with 2 or more children constituting 35.4%. P value is 0.001 hence statistically significant. A similar study done by Camilla Skold *et al* in 2021 proved statistical significance between parous women and incidence of ovarian cancer [7]. The peak incidence of ovarian masses was seen in patients who attained menarche between the ages 9 to 16 out of which 93.5% were benign and 6.5% were malignant. P value is 0.063 hence it was statistically insignificant. Ting-Ting Gong *et al* in 2012 which showed that age of menarche was inversely associated with risk of ovarian tumours [8]. Maximum incidence of ovarian masses were seen in pre-menopausal women constituting 87% and 14% of the women with ovarian tumours were post-menopausal. P value is 0.063, hence statistically insignificant. Chingis Mustafin *et al*

study in 2022 showed similar results with 67% pre-menopausal and 33% were post-menopausal women [9]. 92% of the total study group had normal frequency of cycle and 96% of the study population had normal duration of cycle. The p value was found to be 0.739 hence it is statistically insignificant. Similar study was done by L Titus-Ernstoff *et al* and it was observed that menstrual cycle characteristics and symptoms were unrelated to the to the risk ovarian cancers [10]. In the present study 93.5% of patients with ovarian masses did not have any comorbidities. P values were >0.050 hence it is proved to be insignificant. Similar study was done by Maas HA *et al* it was observed that patient comorbidities did not have a significant effect on ovarian tumours [11]. 76% of the total patients did not have any relevant family history. P value is 0.402 hence it is insignificant. Similar study was done in 2018 by Zheng G *et al*. Contrary to the present study it was observed that relative risk of ovarian cancer increases with the presence of family history. The study statistically proved significance [12]. According to the present study 45% of patients had a normal BMI (18.5 to 24.9) out of which 93% were benign and 7% were malignant. P value was 0.850 hence it is statistically insignificant. Similar study was done by Jason D *et al* in 2005. Contrary to the present study BMI was proved to be statistically significant with P value was 0.049 [13]. 42% of the total patients presented with pain abdomen. Out of which 91% were benign and 9% were malignant. According to study done by Sharma *et al* 93.16% of the cases presented with mass abdomen followed by abdominal pain constituting of 64.9% contrary to the present study. Jagan *et al* in 2020, shows that the most common complaint was pain abdomen constituting 83.1%. Bhattacharya MM *et al* and Shahin Rashid *et al* shows pain abdomen to be the most common complaint constituting 78.1% and 81.3% respectively [14, 15, 16, 17]. In the present study majority of the patients with ovarian masses have CA-125 levels less than 35U/ml, constituting 85% and all of them were found to be benign ovarian masses. 15% had CA-125 levels greater than 35IU/ml which were malignant. P value

is 0.000 which proves statistical significance. In a study done by Sharma *et al* in 2020, contrary to the present study statistical insignificance was proved as p value is 0.680^[16]. 60% of the patients had mass of <7cms out of which 100% of the ovarian masses were benign. 40% had masses >7cms out of which 87% were benign and 13% were malignant. It is statistically insignificant as the p value was 0.109. Bailey CL *et al* shows that ovarian masses with <7cm in diameter are associated with minimal risk for ovarian cancer and masses with size >7cm were found to have an increased chance of being malignant^[17]. Based on laterality of the mass, it was observed that 92.5% were unilateral and 7.5% were bilateral. P value is 0.070, hence it was proved to be statistically insignificant. Jagan *et al* in 2020, showed majority of the cases were unilateral constituting 80.9% and 19.1% bilateral masses^[18]. 55% of the masses were cystic and 45% were hard masses. P value is 0.001 hence statistically significant. Similar study was done by Jagan *et al* in 2020 showing majority of the palpable ovarian masses were cystic constituting 81.3%^[18].

Conclusion

In this study 40 cases of ovarian masses which match the inclusion criteria were taken into the study and analysed. The patient history, clinical examination, tumour markers, ultrasound findings and histopathological examination findings were considered for the present study.

Prevalence of ovarian masses in various demographics observed. Patients were classified according to their history, clinical features, radiological findings and histopathological features. Correlation and comparison of the above mentioned features noted.

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Conflict of Interest

Not available.

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