RESEARCH PAPER

Spontaneous Rupture of Ovarian Malignancy: A Case Report

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ABSTRACT
Spontaneous rupture of ovarian malignancy is an uncommon clinical presentation, especially in the absence of predisposing factors. We report a case of a 74-year-old postmenopausal woman who presented with abdominal distension and postmenopausal bleeding, and was diagnosed with a ruptured epithelial ovarian carcinoma. Early recognition and appropriate surgical and adjuvant management are crucial for prognosis.
Keywords: Ovarian cancer, spontaneous rupture, endometrioid carcinoma, FIGO stage IC2.
How to cite this article: Selvaraj S, Rajeswari KS, Spontaneous Rupture of Ovarian Malignancy: A Case Report.Int J Drug Deliv Technol. 2026;16(2s): 557-558; DOI: 10.25258/ijddt.16. 557-558
Source of support:. None
Conflict of interest: None

INTRODUCTION
Epithelial ovarian tumors constitute the majority of ovarian neoplasms. They often present with nonspecific symptoms such as abdominal pain, distension, or may remain asymptomatic until advanced stages. Spontaneous rupture of cystic ovarian malignancies is rare and is associated with upstaging of disease, which adversely affects prognosis.

CASE PRESENTATION
A 74-year-old postmenopausal woman, gravida 3 para 4, presented with complaints of postmenopausal bleeding, abdominal pain, and progressive abdominal distension for two months. On per abdominal examination, tense abdominal distension was noted without guarding or rigidity.
Tumor markers revealed CA-125 levels of 69.51 U/mL and CEA of 2.81 ng/mL. Ultrasonography of the abdomen performed on 13 January demonstrated a large abdominopelvic lesion measuring 27 × 15 cm. Contrast-enhanced computed tomography of the abdomen on 18 January revealed a multiloculated solid cystic mass measuring 12 × 13.8 × 12.4 cm, with a significant reduction in size, irregular cyst wall appearance, and gross ascites, suggestive of cyst wall rupture.

MANAGEMENT
The patient underwent total abdominal hysterectomy with bilateral salpingo-oophorectomy, pelvic lymph node dissection, and omentectomy. Intraoperatively, a ruptured abdominopelvic mass measuring 12 × 15 × 10 cm was identified in the left adnexa. Approximately 3 liters of dark brown fluid were suctioned, and peritoneal fluid was sent for cytological examination.

HISTOPATHOLOGICAL FINDINGS
Histopathological examination revealed a well-differentiated (grade 1) endometrioid carcinoma of the left ovary. There was no involvement of the lymph nodes or endometrium. Peritoneal fluid cytology was negative for malignant cells.
Based on the findings, the tumor was staged as FIGO stage IC2 (T1C2), indicating tumor limited to one ovary with capsule rupture prior to surgery.

DISCUSSION
Spontaneous rupture of ovarian carcinoma is uncommon and may result in peritoneal spill, leading to upstaging of disease. Stage IC disease is considered a high-risk feature for recurrence. Intraoperative or preoperative rupture has been shown to adversely influence long-term prognosis.

CONCLUSION
Patients with FIGO stage IC ovarian carcinoma require adjuvant chemotherapy to reduce the risk of recurrence. The standard recommendation is intravenous chemotherapy with a combination of carboplatin and paclitaxel administered every three weeks for six cycles. Emerging modalities such as intraperitoneal and hyperthermic intraperitoneal chemotherapy are being explored for selected cases.

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