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Giant serous adenofibroma of fallopian tube: A case report

Nurul Amirah Shaik Farid, Nur Azwin Hamran

Department of Obstetrics & Gynaecology, Hospital Sultanah Bahiyah, Alor Setar, Kedah

ABSTRACT

Introduction: Serous adenofibroma of the fallopian tube is rare. It is abenign tumour with few reported cases worldwide. Most are asymptomatic, small in size, and would be an incidental finding during surgery for other gynaecological indications. **Case Description:** A 19-year-old girl presented with abdominal distension for the past 3 years which gradually increased in size but with a normal menstrual cycle. Clinical examination revealed a mobile, non-tender mass equivalent to 24 weeks gestational size uterus. A pelvic ultrasound scan revealed a cystic, anechoic, unilocular, and thin-walled mass arising from the pelvis and reaching up to the xiphisternum measuring 20 x 10 cm with no sinister features. Tumour markers were within the normal range. She underwent laparotomy and decompression of the cystic mass which drained 2.3 litre of straw-coloured fluid. Right salpingectomy was performed in view of the difficulty to identify the normal fallopian tube structure. The liquid cytology was compatible with a benign cyst. The histopathology of the specimen was reported as serous adenofibroma of the fallopian tube. **Discussion:** In view of the large size of the tumour, it will be a challenge to diagnose a tubal pathology pre-operatively as it mimics other gynaecological pathology, most commonly that of ovarian origin. The diagnosis will be distinguished during the surgical intervention and requires histopathology confirmation.

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Angular pregnancies: Different clinical courses and management

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Department of Obstetrics and Gynaecology, Sultan Ahmad Shah Medical Centre @IIUM, Pahang, Malaysia

ABSTRACT

Introduction: Angular pregnancy is a rare type of pregnancy with associated life-threatening complications. However, it is largely under reported and under diagnosed. We hereby report four cases of angular pregnancies, managed in our centre since 2019. We aim to share our clinical experience of the diagnosis and management of the condition. **Case Description:** All four cases presented in the first trimester with symptoms of vaginal bleeding and lower abdominal pain. Case A: initial B-HCG level was 19,752 IU/L, diagnosed with 3-dimensional transvaginal ultrasound (3D TVS) and pregnancy was spontaneously aborted. Case B: initial B-HCG levels were also suspiciously high at 22,710 IU/L. Pregnancy was terminated with a single dose of intramuscular Methotrexate after pregnancy monitoring by 3D TVS deemed to be at high risk of rupture. MRI Pelvis reported a similar finding. Case C: The diagnosis was confirmed by 3D TVS and the gestational sac remained the same despite a significant reduction in serial B-HCG. Thus, ultrasound-guided suction and curettage was done. Case D did not benefit from 3D TVS and no B-HCG was sent. The actual diagnosis was missed until 36+4 weeks. She delivered via emergency caesarean section, allowing spontaneous resolution of the angular region to be observed following fetal delivery. None of the cases were complicated by any uterine rupture or major bleeding episode. **Discussion:** A high index of suspicion and the usage of appropriate diagnostic tools are important to reach an accurate diagnosis. Individualized management options should be discussed either for conservative or termination of pregnancy.