

Evaluation of an Adnexal Mass

Nicki Webb, MSN, WHNP-BC

Case Study

Mrs. D is a 50-year-old woman who presents with intermittent left-lower-quadrant pain over the past three to four months. She has been married for the past 26 years, has a 22-year-old son, and lives in a growing college community located between three large metropolitan cities with a population of approximately 190,000.

Review of Systems

Mrs. D was in her usual state of health until she developed the intermittent left-lower-quadrant pain. Her ear, nose, and throat; respiratory; and cardiovascular examinations are negative; her appetite is good; and her weight is stable. Mrs. D is not experiencing nausea, vomiting, or diarrhea but notes increased constipation over the past three weeks with intermittent abdominal bloating. She denies hematochezia. She has had mild stress incontinence since the delivery of her child and is otherwise unchanged. She does not have hematuria or dysuria. Mrs. D has regular menstrual cycles that last three to four days and are light flow with mild to moderate dysmenorrhea. She uses condoms for birth control. She has mild cramping-type pain to the left lower quadrant during and after sexual intercourse, which has occurred approximately in the past three to four months. Mrs. D has had two episodes of intramenstrual spotting. She has noticed some increased hot flashes and occasional night sweats. Her last pelvic examination, Pap smear, and mammogram eight months ago were negative. Mrs. D has had one pregnancy and one child, and her extremities are without pain or edema.

Personal: Mrs. D is active and walks daily. She recently joined Weight Watchers to improve her diet and “lose extra pounds.”

Social: Mrs. D consumes two to three glasses of wine weekly. She denies tobacco or drug use.

Physical examination: Her head is atraumatic and normocephalic and the results of her head, eyes, ears, nose, and throat examinations are within normal limits. Mrs. D's neck examination is negative for lymphadenopathy or thyromegaly, and no palpable supraclavicular lymph nodes are present. Her chest is clear to auscultation bilaterally, and her heart rate and rhythm are regular with no audible murmurs. Mrs. D's abdomen is soft, mildly distended, and tympanic to percussion; has active bowel sounds; and has mild tenderness to the left lower quadrant, without palpable masses or hepatosplenomegaly. Her groins are without palpable adenopathy. Mrs. D's pelvic examination reveals normal external genitalia with pink, moist vaginal mucosa and no visible lesions. The cervix is grossly normal appearing. On bimanual and rectovaginal examination, the cervix is soft, mobile, and nontender. The uterus is approximately 8 cm and anteverted. Right adnexa is nonpalpable. The left adnexa has a palpable fullness approximately 4–5 cm and is slightly tender. No additional palpable masses or nodularity are noted in the cul-de-sac.

Differential Diagnosis

Mrs. D has an adnexal mass. Determining the type and cause of the mass can be difficult because of a number of conditions can result in the development of adnexal masses. The determination will be dependent on the patient's age, her

menopausal state, the size of the mass, ultrasonographic findings, whether the patient is symptomatic, whether there are unilateral or bilateral findings, and laboratory results.

Risk Factors

Age and menopausal status are the two risk factors to be considered in a woman presenting with an adnexal mass.

Age: A patient's age is a very important factor when determining the potential cause of an adnexal mass. An adnexal mass found in premenarchal girls or postmenopausal women is abnormal, warrants an immediate investigation, and should be considered malignant until proven otherwise (Drake, 1998). Neoplasms found in the premenarchal patient usually are of germ cell origin and warrant immediate surgical exploration (Drake).

After menarche, adnexal masses are most likely because of follicular and corpus luteal cysts of the ovary formed during the normal menstrual cycle. Patients of childbearing age who are still menstruating can have malignant and benign lesions; however, most of these are benign processes (DiSaia & Creasman, 2002). Other benign causes for adnexal and pelvic masses include endometrioma, polycystic ovaries, tubo-ovarian abscess, hydrosalpinx, fibroid tumor, ectopic pregnancy, and ovarian torsion. Malignant adnexal masses in a premenopausal patient usually include the low-malignant or borderline type (Drake).

Nicki Webb, MSN, WHNP-BC, is a women's healthcare nurse practitioner in the Department of Gynecologic Oncology at the University of Texas M.D. Anderson Cancer Center in Houston.

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