MANAGEMENT OF OVARIAN CYSTS IN PRIMARY CARE

Ovarian cysts are common in women of all ages, and are benign in most cases. It is estimated that pelvic ultrasound will reveal abnormal ovarian morphology in 21% of asymptomatic postmenopauasal women, with this number being even higher for younger women. There are many different causes and types of ovarian cysts including: *Functional* (ovulatory), *pregnancy-related* (corpus luteal), *dermoid, endometriomas, PCOS, malignancy*. It is obviously important to be vigilant and maintain a high index of suspicion for ovarian cancer in all women, but it should be highlighted that **less than 1%** of ovarian cysts are malignant. Longitudinal studies have consistently shown that small, simple ovarian cysts with no suspicious sonographic features are usually benign. Conversely, there are specific clinical features that would warrant prompt referral to a gynaecologist.

Ovarian cysts will be managed differently depending on many factors, specifically:

- Age and menopausal status
- Personal and family medical history
- Ultrasound appearance of the cyst
- +/- tumour markers (specifically CA-125 in post-menopausal women)

Ovarian cysts in young women

The majority of ovarian masses found in women of reproductive age will be functional (benign), and the overall risk of malignancy in this group is low. In a pre-menopausal woman, an ultrasound finding of a simple cyst, <10cm diameter, with no features of malignancy, is consistent with a benign ovarian cyst. Most of these (70%) will resolve spontaneously and thus are best managed by repeating the ultrasound, usually in 6-12 weeks, to ensure resolution. Cysts or masses that continue to enlarge, become symptomatic, or attain a more worrisome sonographic appearance would justify referral to a gynaecologist. Note that CA-125 levels are not helpful in the general pre-menopausal population due to the high false positive rate and should only be obtained in the presence of a very large or suspicious mass. It is important to discuss the possible complications of ovarian cysts such as haemorrhage, rupture and ovarian torsion.

Ovarian cysts in pregnant women

Many ovarian cysts are found incidentally on routine antenatal USS. The vast majority of these will be benign (often corpus luteal cysts) and can be managed expectantly as they are likely to resolve. Referral to a gynaecologist would be warranted in the case of suspected malignancy, acute complication such as torsion or if the size of the cyst is sufficient to cause obstetric complication.

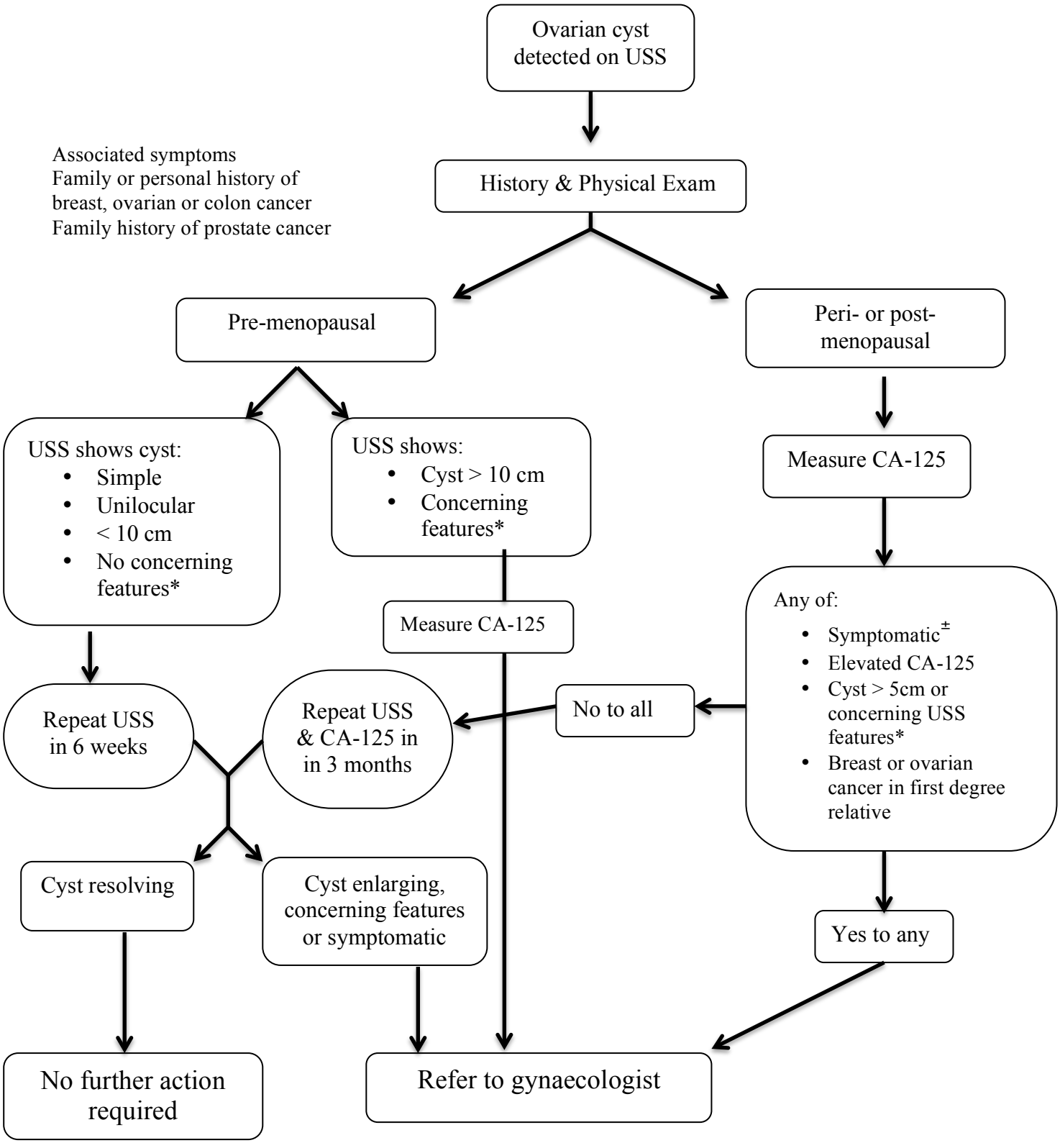
Ovarian cysts in the peri- or post-menopausal woman

The risk of malignancy is higher in this group, but it is important to remember that the majority of these cysts will be benign. The management of ovarian cysts in this age group will depend on the individual risk of malignancy, which is determined by a thorough history, physical exam, CA-125 concentration and the sonographic appearance of the cyst. Large studies in this population have shown that an asymptomatic woman with a simple, small (<5cm), unilateral, unilocular cyst and a normal CA-125, has a very low risk of malignancy. These cysts would be best managed expectantly by repeating the USS at 3, 6 and 12 months as most will resolve spontaneously in 12-24 months. Conversely, if there is a clinical or sonographic suspicion of malignancy, strong family history of breast or ovarian cancer, or an elevated CA-125 (>35U/mL), referral to a gynaecologist would be most appropriate.

Further information may be found at the following sites:

- RCOG guideline (UK), Ovarian cysts in postmenopausal women (2003). http://www.rcog.org.uk/files/rcog-corp/GTG3411022011.pdf
- Parker, W (2006). Ovaries make cysts for a living: When to do no harm. *OBG Management.* http://www.jfponline.com/Pages.asp?AID=3830

A GUIDE TO MANAGING ASYMPTOMATIC OVARIAN CYSTS IN PRIMARY CARE



*** Concerning USS features associated with increased risk of malignancy**

- Complex
- Multilocular
- Solid Components
- Papillary extensions

± Symptoms of early ovarian cancer:

- Bloating, increased abdominal size
- Urinary urgency or frequency
- Difficulty eating or feeling full
- Abdominal or pelvic pain

*If new within the past year and recurrent (occur > 12 times per month)