

CASE REPORT

RARE CASE OF FIBROTHERCOMA OF OVARY

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ABSTRACT

Ovarian fibrothecomas are uncommon tumors of gonadal stromal cell origin. They account for 3 to 4% of all ovarian tumors and in 90% of cases are unilateral. Here we present case of 19 yrs old nulligravida with right sided adnexal mass with chronic abdominal pain.

Keywords: fibrothecoma, ovarian tumors

INTRODUCTION

A nineteen year old nulligravida presented with dull aching pain in right iliac fossa since six months. She also reported that the pain increased during menses and she had menorrhagia during that three cycle. She also complained of polymenorrhoea. General physical and systemic examination was normal. Local examination of abdomen was not significant. Pelvic examination revealed a small adnexal mass on right side of around 4cmx4cm, freely mobile, non-tender, cystic to firm in consistency was present.

Complete hemogram and routine blood biochemistry of patient were within normal limit. CA-125 was 16.5mIU/ml. Pelvicsonography revealed a round to oval well defined, lobulated mass of mixed echogenicity measuring 5.1x4.1x4cm. Right ovary was not seen separately from this mass. There was increased vascularity. The finding suggestive of fibrothecoma. MRI showed the findings of a solid ovarian mass arising out of right adnexa which was not separated from right ovary. Size of mass was 4x4.4x4.2cm with well defined margins and few necrotic areas. These findings corresponded with fibroma or dysgerminoma of ovary.

Patient underwent laparoscopic tumorectomy. 4x4x4cm right adnexal mass arising from ovary was present. The cyst wall was dissected and mass was retrieved along with capsule. The mass was lobulated, irregular and yellowish in appearance. The left sided ovary was normal and no any ascites. Post-operative course of patient was uneventful. On histopathological examination, the tumour tissue was composed of nest of oval to poly-

hedral cells with uniform round nuclei and clear to eosinophilic cytoplasm. These nests were surrounded by fibroblastic proliferation without any atypia. Thus diagnosis of fibrothecoma was confirmed. Postoperative ultrasonography was normal.



Figure 1: Laparoscopic Cystectomy



Figure 2: Gross Appearance

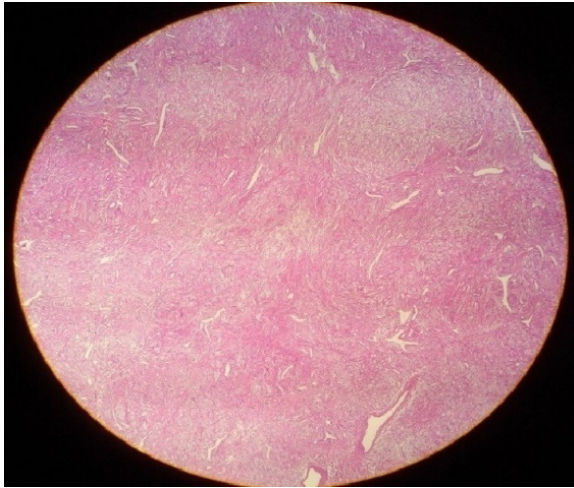


Figure 3: Histopathological View

DISCUSSION

The fibrothecomas are mesenchymal tumors deriving from ovarian stroma and consisting of theca like elements and fibrous tissue. The term fibrothecoma has been used for neoplasms which are intermediate between theca cell tumour and fibroma. The vast majority of fibrothecoma behave in a benign fashion and malignant variants are exceedingly rare¹. These tumours occur generally in postmenopausal women. However, these are two peaks of frequency the first peak of onset is in between 20 and 40 yrs and second peak is after menopause. The occurrence of tumour before age of 20yrs is extremely rare². The tumour is unilateral in 90% cases with average diameter of 6cm. In 4-5% of cases it may be more than 20cm³. The clinical presentation of ovarian fibrothecoma is relatively non specific such as pelvic and abdominal pain. Some ovarian thecomas are associated with estrogenic manifestations such as irregular bleeding, menorrhagia, endometrial hyperplasia. Grossly, fibrothecomas are usually solid, spherical or slightly lobulated, encapsulated hard gray white masses covered by glistening and intact ovarian serosa. Histologically, these tumors are characterized by presence of spindle, oval or round cells

forming various amount of collagen and a smaller population of theca cells⁴. Differential diagnosis of fibrothecoma includes other solid ovarian masses such as Brenner tumours, granulosa cell tumour and dysgerminomas. In presence of extensive cystic degeneration fibrothecoma can be easily mistaken for malignant ovarian tumour. In our case, diagnosis of MRI favoured a benign fibrothecoma. Absence of ascites and normal CA-125 levels further strengthened the diagnosis. In case of young patients, laparoscopic tumorectomy is recommended over laparotomy. Whereas in postmenopausal women radical surgery in terms of bilateral salpingo-oophorectomy is indicated.⁵

CONCLUSION

Ovarian fibrothecomas represent an ovarian stromal tumor developing in a wide spectrum of clinical settings. Stress should be laid on diagnosing the tumour based on imaging studies either as benign or malignant. In cases of benign tumours in young women fertility conserving surgeries should be choice of treatment rather than overtreatment with radical surgery. Close follow up is indicated in all cases.

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