OVARIAN FIBROTHECOMA: A CASE REPORT

1, *Richa Chauhan, 2Gyanendra Singh, 3Mala Shrivastava and 4Upendra Prasad Singh

1Consultant Radiation Oncologist, Mahavir Cancer Sansthan, Patna
2Resident Surgeon, Sanjeevani Hospital, Patna
3Consultant Gynaecologist, Sanjeevani Hospital, Patna
4Consultant Surgeon, Sanjeevani Hospital, Patna

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ABSTRACT

Fibrothecoma is a rare type of ovarian sex cord stromal tumor with only a few case reports available in the literature. Histologically, they resemble both fibroma and thecoma. Thecomas are composed of lipid-containing cells that resemble theca interna cells. Fibromas show spindle, oval, or round cells forming variable amounts of collagen. Here we report a case of 52 years old postmenopausal lady who presented with pain abdomen. Clinically, she had a firm lump predominantly in the right flank and her sonographic reports suggested a solid cum cystic mass in right ovary. She was operated with a clinical suspicion of ovarian malignancy but the histopathological examination confirmed it to be a benign fibrothecoma.

INTRODUCTION

Ovarian tumors represent tumors of epithelial, germ cell, and sex cord-stromal origin. Common epithelial tumors are the commonest histological subtype seen accounting for approximately 60% of all ovarian tumors, followed by germ cell tumors. (Kurman et al., 2014) Ovarian sex cord-stromal tumors are uncommon neoplasms that represent approximately 5% of all ovarian tumors. These tumors comprise a heterogeneous group and are formed by diverse cell types that arise from the primitive sex cords or stromal cells. (Haroon et al., 2013) The stromal cells include theca cells, fibroblasts, and Leydig cells whereas the gonadal primitive sex cords include granulosa cells and Sertoli cells (Wilkinson et al., 2008). These cell types may be present separately or admixed and display different degrees of differentiation. Fibrothecoma of ovary is a tumor arising in stroma and containing a mixture of cells comprising of fibroblasts, producing collagen like a fibroma and spindle cells with lipid droplets characterizing a thecoma. (Pratt, 2004) Fibrothecoma of the ovary is very rare as it only accounts for 1.2% of all ovarian cancers. (Quirk et al., 2005). In the present study, we report a case of ovarian fibrothecoma in a postmenopausal lady with a clinical and radiological suspicion of malignancy.

CASE REPORT

A 52yrs old postmenopausal, female presented with pain lower abdomen and gaseous distension for the last 1 month. She had a history of two spontaneous abortion and no live birth. There was a history of irregular treatment for infertility. She was hypertensive and diabetic on oral medication for the last 3 years. On examination, a midline lump about 12 weeks size was found in pelvis which was more towards the right side. Per vaginum examination showed that both the vaginal fornices were full and there was a lump, which was hard, relatively fixed and more towards right adnexa. Uterus could not be palpated separately from the lump. The cervix was normal and there was no vaginal bleeding or discharge.

Complete blood count and routine blood biochemistry was normal. The level of CA-125 was 28.40U/ml. Abdominal and pelvic ultrasound showed a right adnexal solid and cystic lesion of 68mm x 40mm. A cyst of size 42mm x 30mm was seen in left ovary. The uterus was normal in shape and size. There was no ascites or lymphadenopathy. The patient underwent an exploratory laparotomy. A right sided solid mass, with stretched but intact capsule and left ovarian chocolate cyst was found intraoperatively. Bilateral salpingoophorectomy was done as the uterus could not be removed because of the presence of adhesions. The left ovary with the cyst was easily removed, however there was presence of adhesions around the right ovary and it had to be

*Corresponding author: Richa Chauhan,
Consultant Radiation Oncologist, Mahavir Cancer Sansthan, Patna.
It can also be associated with basal cell nevus syndrome, comprising of bilateral ovarian fibromas, multiple basal cell carcinoma of skin and odontogenic keratocysts. (Howell et al., 1990) However, in our case none of the above abnormalities were reported. Grossly, ovarian fibrothecomas are unilateral in about 90% of all cases and are usually solid, spherical or slightly lobulated, encapsulated hard gray white masses covered by an intact ovarian serosa. However, ovarian fibrothecomas of size larger than 10 cm tend to be associated with varying degree of edema, myxoid change and cystic degeneration. Their characteristic sonographic appearance is of a round or oval solid tumor, with regular margins. They may have stripy acoustic shadows, but these are present in just a small percentage of cases. Fibrothecomas can also show cystic areas, due to hemorrhage, edema or necrosis within the stromal tissue. (Paladini et al., 2009).

CA-125 is a tumor marker used for evaluating ovarian tumors. Our patient had a normal value of CA-125. Generally, fibrothecomas are not associated with an increased level of CA125. However, there are reports of thecoma and fibrothecoma associated with Meig’s syndrome and elevated CA-125 values up to 600 IU/ml. Choi K et al in 2006 reported a case of granulosa cell tumor associated with Meig’s syndrome and elevated CA-125 levels of 82.49 IU/ml. (Choi et al., 2006) Macci et al in 2014 reported an ovarian fibroma in association with Meig’s syndrome, hemolytic anemia and raised CA-125. (Macci et al., 2014). The presence of hemorrhagic cyst in the left ovary along with adhesions around the uterus suggests endometriosis as the most probable cause of infertility seen in this patient. Incidentally, a case of secondary amenorrhea and infertility due to Inhibin B producing ovarian fibrothecoma has also been reported by Meyer et al in 2000 and this could be a contributory factor. (Cho et al., 2013) However ashormonal estimation was not done in this case no further comments could be made in this regard. Fibrothecomas have a very good prognosis and the treatment depends primarily on the age of the patient. In case of young patients, laparoscopic tumorectomy can be done, whereas in postmenopausal women radical surgery in terms of bilateral salpingoophorectomy is indicated. (Cho et al., 2013)

Conclusion
Ovarian sex cord-stromal tumors are infrequent tumors, which develop from cells arising from the primitive sex cords or the stroma. They are usually benign and can be treated with simple surgical excision. However, the rarity of sex cord-stromal tumors contributes to a low index of suspicion; and therefore, a thorough knowledge of the clinicopathologic and radiologic findings of these tumors is important to facilitate surgical planning and avoid extensive morbidity surgical procedures.

REFERENCES


