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A RARE CASE OF SYNCHRONOUS OVARIAN FIBROMA AND SPONTANEOUS JEJUNAL PERFORATION IN A POSTMENOPAUSAL WOMAN

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ABSTRACT **Background:** Ovarian fibromas are rare benign ovarian tumors typically occurring in postmenopausal women. Their presentation may be nonspecific, occasionally mimicking malignancy. Coexisting gastrointestinal complications such as spontaneous jejunal perforation are rare and often diagnosed intraoperatively. **Case Presentation:** A 66-year-old postmenopausal woman presented with a five-year history of intermittent lower abdominal pain. Imaging revealed a right adnexal mass. Exploratory laparotomy revealed a 10×10 cm right ovarian fibroma and a chronic spontaneous jejunal perforation secondary to tuberculosis. The perforation was repaired, and a total abdominal hysterectomy with bilateral salpingo-oophorectomy was performed. Histopathology confirmed ovarian fibroma. Recovery was uneventful. **Conclusion:** This case underscores the importance of a thorough intraoperative survey in postmenopausal women with adnexal masses and chronic abdominal symptoms, especially in settings where gastrointestinal pathology may be clinically silent.

KEYWORDS : Ovarian fibroma, Jejunal perforation, Chronic abdominal pain, Postmenopausal, Sex cord-stromal tumor

INTRODUCTION

Ovarian fibromas are benign sex cord-stromal tumors, representing approximately 1–4% of all ovarian neoplasms [1]. These tumors usually occur in the fifth to seventh decades of life and are typically unilateral and solid [2]. While most fibromas are asymptomatic, they can present with lower abdominal pain, ascites, or a palpable mass [3]. Due to their firm consistency, they may resemble malignant ovarian tumors on imaging [4].

Jejunal perforation is an uncommon surgical finding, especially when asymptomatic. Chronic perforations can occur secondary to infections such as tuberculosis, ischemia, or previous inflammation [5]. Asymptomatic cases are rare and often diagnosed intraoperatively during unrelated procedures.

This case illustrates the unusual coexistence of a benign ovarian fibroma and a spontaneous jejunal perforation secondary to tuberculosis in a postmenopausal woman.

Case Presentation

A 66-year-old multiparous postmenopausal woman presented to casualty with complaints of intermittent lower abdominal pain persisting for five years, which worsened over the previous 24 hours. She denied gastrointestinal disturbances, weight loss, or vaginal bleeding. Her medical history was notable for pulmonary tuberculosis treated in the last 3 years. There were no prior abdominal surgeries.

On examination, she was afebrile with stable vital signs. Abdominal palpation was non-tender. Pelvic examination revealed palpable right adnexal mass. Transvaginal ultrasonography revealed a 10 cm solid right adnexal mass. She was scheduled for staging laparotomy due to the suspicion of a neoplasm.

Intraoperative Findings

During laparotomy, approximately 10–15 cc of yellowish peritoneal fluid was noted. A bilobed, 10×10 cm solid mass arising from the right ovary was observed, pushing the uterus posteriorly. The left ovary and fallopian tube were grossly normal. Dense adhesions were present between the bowel and left adnexa. The bladder was adherent to the lower uterine segment.

Careful dissection revealed a 2×2 cm spontaneous jejunal perforation with fibrosed, rolled-out margins and no active bleeding, suggesting chronicity. The defect was repaired in two layers using polydioxanone sutures. Frozen section of the ovarian mass revealed benign fibroma. Total abdominal hysterectomy with bilateral salpingo-oophorectomy was completed.

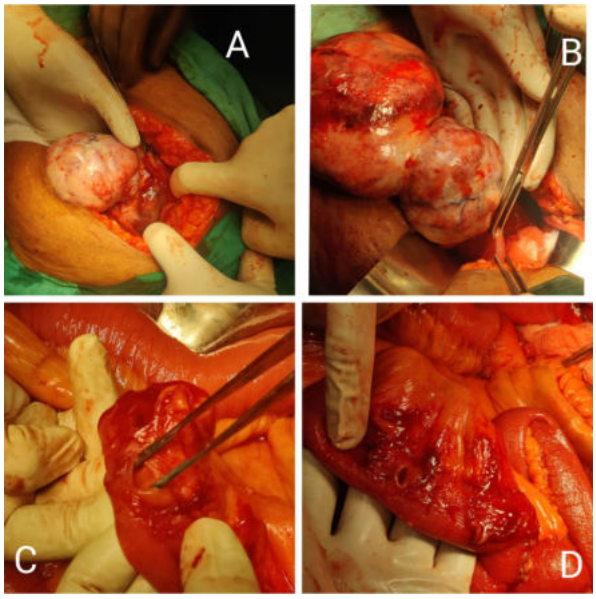

Figure 1. Intraoperative sequence of findings during staging laparotomy. (A) Identification of a solid, firm right ovarian mass with smooth surface, suggestive of fibroma. (B)) Exposure of the bilobed, solid ovarian mass arising from the right ovary. (C) & (D) A sealed jejunal perforation with rolled edges, consistent with an old, asymptomatic perforation.

Postoperative Course

The patient received intravenous antibiotics and analgesics. Postoperatively, a minor serosanguinous wound discharge was noted, which resolved with local care and escalation of antibiotics. She was discharged on the seventh postoperative day in stable condition.

Histopathology

Grossly, the right ovarian mass was firm, white, and fibrous. Microscopy revealed interlacing bundles of spindle cells embedded in a collagen-rich stroma without atypia or mitotic figures, consistent with ovarian fibroma .The jejunal sample showed evidence of chronic inflammatory changes and fibrosis, confirming a chronic perforation. No granulomas or malignancy was found.

DISCUSSION

Ovarian fibromas, though rare, are the most common benign solid ovarian tumors. They typically present in the perimenopausal and postmenopausal age group [1,2]. Their imaging features can mimic malignant tumors due to their size and solid consistency [4,6]. Intraoperative frozen section is useful for diagnosis and surgical planning [7].

Jejunal perforation is most commonly acute and symptomatic, resulting from trauma, infections like tuberculosis, or ischemia [5,8].

Chronic, silent perforations due to tuberculosis are exceedingly rare and can remain clinically occult [9]. In this patient, the spontaneous jejunal perforation was likely a sequela of subclinical tubercular enteritis, supported by her history of pulmonary tuberculosis and the fibrosed appearance of the perforation site[9]. Adhesions, chronic inflammation, and perforation likely resulted from a subclinical tubercular enteritis [9].Similar cases have been documented where tuberculous enteritis caused small bowel perforations that were incidentally found during unrelated procedures [10].

This case emphasizes the importance of systematic intraoperative evaluation. Surgeons should be aware of the possibility of silent gastrointestinal lesions in patients with a history of abdominal tuberculosis or unexplained abdominal pain, even in the absence of acute symptoms.

CONCLUSION

Ovarian fibromas, though benign, may clinically mimic malignancy. Coexisting gastrointestinal pathologies such as jejunal perforation, although rare, should be suspected in patients with chronic abdominal symptoms and a history of tuberculosis. Intraoperative vigilance is crucial for detecting and appropriately managing such coexisting lesions, thereby preventing potential complications.

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