

Fibroma of the Ovary



Medical Science

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ABSTRACT

An ovarian fibroma is a benign ovarian tumour of sex cord-stromal (mesenchymal) origin. Although fibroma accounts for 4% [1-2] of all ovarian neoplasms, they are the most common sex-cord ovarian tumour. These tumours generally occur in older women. Preoperative accurate diagnosis offers difficulties, since there is no specific characteristic symptoms. The ultrasonographic finding can not easily distinguish ovarian fibroma from uterine myoma. Being its solid nature and some time associated with ascites, confused with ovarian malignancy. Here is the 55 years old patient presented with lower abdominal mass with discomfort is treated with hysterectomy and bilateral salpingo-oophorectomy.

Introduction:

Fibroma of ovary is most common benign ovarian tumour encountered in gynaecology practice. They tend to occur mostly during perimenopausae and post menopause, the median age having been reported to be about 52 years and are rare in children.[3] Ovarian fibroma are reported to be unilateral in 90% of cases.[4] Preoperative accurate diagnosis is often difficult and are commonly misdiagnosed as uterine myoma, because of solid nature shown in the ultrasonographic findings. Sometimes elevated serum CA-125 level, presence of ascites may lead to the mistaken diagnosis as a malignant tumour of ovary.[5, 6] Recurrence of ovarian fibroma has rarely been reported in the literature. Management is guided by the benign nature of the lesion and consist of surgical removal of the ovarian fibroma. Bilateral Salpingo- oophorectomy can be considered in perimenopausal or post menopausal women. However preservation of normal ovarian tissue is recommended even though there is risk of recurrence of the fibroma.

Case report:

A 55 years old post menopausal woman reported to our outpatient department with complaints of mass abdomen. The mass was gradually increasing in size, but there is no history of pain in any form. She is known case of diabetes mellitus and on insulin for last three months. Prior to that she was on oral hypoglycemic agents. On examination, she has moderate body built. Perabdomen examination there is a mass of 14wks uterus size arising from the pelvis. Mass is solid in consistency, regular smooth margins and side to side mobility is restricted. Per-speculum examination revealed no abnormalities. Pelvic examination is suggestive of ovarian mass. Ultrasound and C.T. Confirmed large well defined homogenous ovarian mass of size around 10.5x8.8 cms in midline of lower abdomen. However the size of the uterus is normal. Endometrial thickness is 5mm. There was small amount of free fluid in the pouch of Douglas.

Considering her age and nature of the ovarian mass, laparotomy was planned after controlling blood sugar. On laparotomy, there is large pearly white solid ovarian mass of about 10x8 cms size on left side, the uterus is normal in size. There was small amount of free fluid in the peritoneal cavity, and is sent for cytology examination. On palpation lymph node are not palpable and no visible or palpable mass on omentum. Since the patient is post menopausal age Total abdominal hysterectomy, and bilateral salpingo-oophorectomy with partial omentectomy was performed. Intraoperative and post operative period was uneventful and patient

was discharged after a usual hospital stay. Cut section of specimen shows solid gray-white mass with whorling appearance.

Microscopic picture of cervix shows, chronic cervicitis with nabothian cyst, endometrium is atrophic. Multiple sections from the tumour studied show features of fibroma of ovary. Rt ovary and tube are unremarkable, left fallopian tube and remnant ovary appear normal. Omental tissue is normal.

Discussion:

Ovarian fibroma, which belong to the group of sex-cord-stromal cell tumour, are the most common benign solid tumour of the ovary. In almost all cases, they are benign and curable by surgical excision. The tumour generally occur in older women.

Since there are no characteristic symptoms and the ultrasonographic findings can not easily distinguish ovarian fibromas from the uterine myomas. Ovarian fibroma are often difficult to diagnose before surgery. One of the study reported only 21.7% were diagnosed accurately as ovarian fibroma, and some were misdiagnosed preoperatively as uterine myoma.

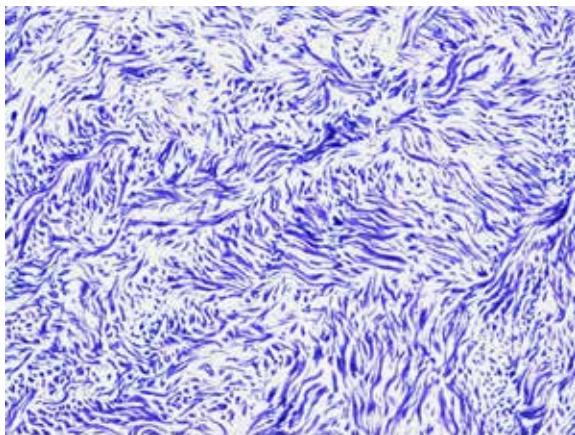
Microscopically, ovarian fibromas are solid tumour comprising spindle fibroblastic cells. Cellular fibroma, which is a rare form of ovarian fibroma, can also occur. A tumour comprising cells with closely packed nuclei with absent or minimal nuclear atypia and 1 to 3 mitoses/10 high power field is classified as cellular fibroma. A tumour showing moderate nuclear atypia and >3 mitoses/10 high-power field has a malignant potential and is designated as a fibrosarcoma.[7]

Surgery is the recommended treatment for ovarian fibroma. Salpingo-oophorectomy can be considered in perimenopausal and post menopausal women and only cystectomy may be performed in younger women, preferably those who have not completed family. Some comparative analysis of the outcomes between the laparoscopy group and the laparotomy group showed that laparoscopic surgery has the advantage. With the advances in operative instruments, and the techniques, laparoscopic surgery has become more popular, and it is being used frequently by many gynaecologists. The fibroma after morcellating can safely be removed through 12-mm trocar site.

Conclusion:

Ovarian fibroma are uncommon but are the most common benign solid tumour of the ovary. Treating doctors should be aware of this type of tumour because of the difficulties in preop-

erative dignosis This tumour is often misdiagnosed as a uterine myoma in ultrasonographic findings and is some time mistaken for a malignant tumour of the ovary, because of its solid nature, increased tumour marker levels, and ascites. However ovarian tumour are benign in nature and can be treated completly by surgical removal.



(Figure-1) Cut section of ovarian fibroma



(Figure-2) Microscopic picture of ovarian fibroma

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