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A RARE CASE OF GIANT FIBROTHECOMA OF OVARY PRESENTING AS A MALIGNANT OVARIAN TUMOUR

Gynaecology

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ABSTRACT

Ovarian fibrothecomas are uncommon tumours of gonadal stromal origin which account for 3-4% of all ovarian tumours and in 90% cases are unilateral1,2,3. Ovarian fibrothecoma are composed of an admixture of fibrous and thecomatous elements. Histologically these tumours are characterized by the presence of spindle and round cells forming various amounts of collagen and contain population of theca cells containing intracellular lipid. Here we describe a large unilateral ovarian tumour in a 60 year old female with gross ascites, bilateral pleural effusion and with elevated ca 125 tumour marker. A diagnosis of malignant ovarian tumour was made on the grounds of preoperative investigations and radical surgery was planned. Histo-pathological examination however revealed an ovarian fibrothecoma reinforcing the non-specificity of ca-125 as a marker of ovarian malignancy and establishing the importance of proper histopathological examination even in the most obvious of cases.

KEYWORDS

Fibrothecoma, Ca-125, Malignancy

INTRODUCTION

Ovarian fibrothecoma is a rare type of ovarian sex cord stromal tumour 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. Fibroma shows spindle, oval or round cells forming variable amount of collagen. Here we report a case of 60yr old post menopausal female who presented with abdominal pain, abdominal fullness and loss of appetite. Clinically she had a firm lump in the lower abdomen and her ultrasonography report suggested retroperitoneal ovarian mass and contrast enhanced computed tomography of abdomen and pelvis was suggestive of bilateral ovarian neoplastic masses. She was operated with a clinical suspicion of malignancy but the histopathological examination confirmed it to be a benign fibrothecoma

fig 1. Cut surface of a fibrothecoma

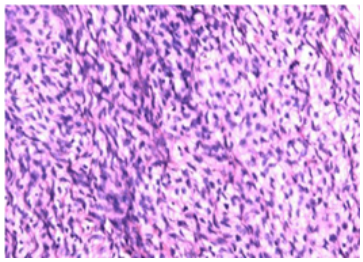


fig 2. H&E staining: fibrothecoma
Source: Internet

CASE REPORT

A 60 yr old postmenopausal female presented with pain in abdomen, abdominal fullness and loss of appetite for the last 2 months. She had a history of hysterectomy done due to menorrhagia.She was a diabetic and was on oral hypoglycaemics for the same since last 10 years. On examination, a midline lump in the lower abdomen about 15x10cm in dimensions was found. On pervaginal examination, it was found that both the vaginal fornices were full and the fullness was more towards the left adnexa. The cervix was normal and there was no vaginal bleeding or discharge. Haemogram and routine biochemistry were normal. The level of ca-125 however was 783u/ml (n: 0—35iu/ml). The abdominal and pelvic ultrasonography was suggestive of a retroperitoneal/ovarian mass with moderate ascites. The cect abdomen and pelvis showed large lobulated solid two mass lesions. One lesion measuring 16x12x11cm (cc x tr x ap) noted in right abdominopelvic region and second lesion measuring 8.8x9.8x11.4cm (cc x tr x ap) noted in left lower abdominopelvic region and left adnexa. Left side moderate pleural effusion was found with mild right sided pleural effusion and gross ascites.

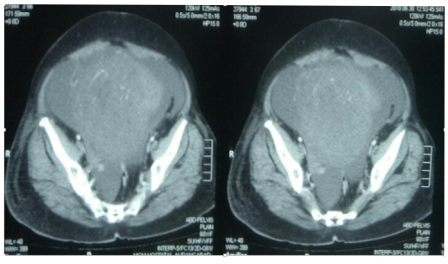


fig 1.

The patient underwent an exploratory laparatomy which showed e/o around 3 litres of ascitic fluic and 15x20cm left ovarian tumour, with multiple adhesions between ovary and ureter and cecum on the right side, and posteriorly to the posterior abdominal wall. Adhesiolysis was done and the mass was excised in toto. Bilateral pelvic lymph node dissection was done and bilateral salpingo-oopherectomy was done. Intraoperatively the dissected mass was sent for frozen section examination, which was negative for malignancy.

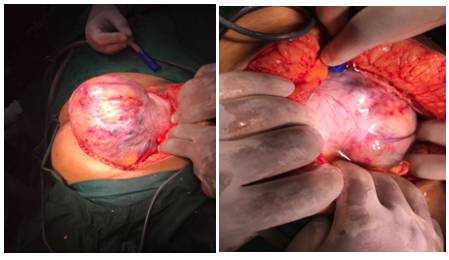
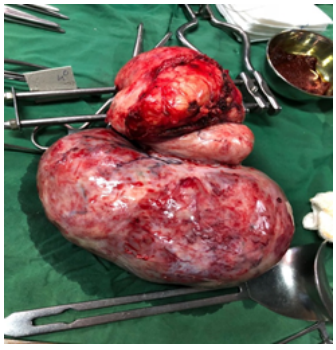


fig 2

The histopathological examination of the mass on gross examination showed left ovarian solid mass measuring 20x16x9cm, externally bossellated with intact capsule. On serial slicing of the tumour , the tumour was found to be entirely solid with homogenous yellowish to whitish, firm and trabeculated cut surface. There was no cystic or haemorrhagic/necrotic or calcified areas in the gross and cut section of the specimen. On microscopic examination the tumour showed features of a benign, cellular neoplasm which was composed of

fibroma and thecoma components. The fibroma component comprises of spindle shaped cells arranged in fascicles and storiform pattern and the thecoma component comprised of poorly defined nodules of medium to large rounded cells with abundant pale cytoplasm. The right ovary and fallopian tube were essentially normal.



CONCLUSIONS:

Fibrothecoma are uncommon benign ovarian tumours seen in the 5th decade of life. It accounts for only 3-4% of all ovarian tumours and are rarely malignant. [1,2,3]

Fibrothecomas occur predominantly in older postmenopausal women. They may be associated with meigs syndrome[9] characterized by the presence of hydrothorax, ascites and elevated ca 125 levels.[4,8] Clinical presentation is often nonspecific while patients most commonly present with pelvic pain, pelvic mass and metrorrhagia. the clinical examination generally finds a solid, mobile tumour with regular surface and of a variable size.

Hormonally active tumours and the associated endocrine manifestations are rare. On ct scan ovarian fibrothecomas may appear as a homogenous solid tumour with varying degrees of enhancement.[5] In 79% of cases the tumour appears as a solid mass with delayed accumulation of contrast medium, while in 21% of cases the tumour is partly or mainly cystic thus making differential diagnosis from the ovarian masses such as serous cystadenofibromas or even malignant tumours difficult.[5]

Although the definitive diagnosis of fibrothecoma is histologic, conte et al[7]have described the presence of characteristic sonographic patterns of fibrothecoma.

Treatment of these ovarian tumours is predominantly surgical.[3,6] the surgical intention is always that of complete resection of the mass or even en bloc resection with adjacent or infiltrated organs and structures. For all patients with a potentially resectable tumours the surgical access preferred is a long vertical midline incision with the patients in supine position. Factors influencing survival outcome of tumourous mass include location, tumour size, adjacent involvement, mitotic index. However it is generally agreed that the most important factor for survival outcome of such tumours is the surgeons skill in resecting the tumour. Considering the difficulty in achieving complete resection with clear margins in giant tumours, especially those with involvement of critical abdominal vessesls as vena cava, aorta and mesenteric vessels, a larger tumour size is found to be a negative prognostic factor. If the surgeon is able to achieve safe tumour resection without microscopic residual disease, the patient may expect long term survival, regardless of tumour size. In fact, it has been shown that the status of the gross surgical margins is the most importan factor influencing prognosis. When neoplastic infiltration of adjacent organs is suspected, en bloc resection with the involved organs is preferable.in conclusion we have experienced a rare case of a giant fibrothecoma presenting as a malignant ovarian tumour. We report this case with a brief review of literature.

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