ORIGINAL RESEARCH PAPER

Gynaecology

KEY WORDS: Post menopausal age, theco-fibroma.

A RARE CASE OF THECO-FIBROMA

Bijan Kumar Mukhopadhyay* Asst.Prof, Department of Obstetrics and Gynaecology, Sri Ramakrishna Institute of Medical Sciences, Durgapur, West Bengal, India. *Corresponding Author

Saswati Mukhopadhyay M.SC, B.ED

ABSTRACT

A patient of 70 years age came with complaint of retention of urine on and off and lower abdominal pain for 2 years. Pain abdomen was intermittent and dragging type. Attained menopause 20 years back, P4L2D2 - all are FTND at home. LCB - 45Years. General condition fair, pallor present. No Cyanosis, icterus, clubbing. PR -78 /mint, BP-140/80mm of Hg, Chest – Bilateral air entry clear, CVS—S1 and S2 audible . Further, per abdomen examination indicated a mass corresponding to the size of 22-24 week of gravid uterus, solid and stony hard in consistency, fixed, not mobile from side to side as well as above downwards. Lower margin could not be felt. Flank was full, no fluid thrill or shifting dullness. Per vagina examination revealed that atrophied, small polyp coming out from cervix and a stony hard mass corresponding 22-24 week size of gravid uterus. USG report showed a large mass of size 9.6x8.4x6.5cm arising from pelvis. Right hydronephrosis is seen due to mass compression, it was reported to be large fibroid with hydronephrosis. X-ray revealed soft tissue shadowing in pelvic cavity extending in to the abdomen and diagnosed as - pelvic soft tissue mass? Fibroid?? Ovarian Mass??. Based on these it was planned for total abdominal hysterectomy. During operation it was found that it was a solid ovarian tumour of weight 900gm, stony hard in consistency, benign in nature. Mass sent for histopathological examination on histopathology it was confirmed as Theco-fibroma.

Introduction:

Thecoma of the ovary is a stromal tumor composed of lipid-containing cells with a variable component of fibroblasts [1]. It arises from the ovarian stroma and exhibits a spectrum of histological appearances which includes, simple fibromas and the other end, tumors showing distinct differentiation to specialized perifollicular or follicular theca cells or their luteinized equivalents[2]. These tumors exhibit a much lower frequency of associated endometrial pathology and evidence of endocrine disturbance than the pure thecoma. Theco-fibromas appear unilateral, solid, spherical or slightly lobulated, encapsulated, hard, gray-white masses covered by glistening intact ovarian serosa[3]. They rarely appear bigger than the size of an orange[4]. In present case we are reporting an unusually big thecofibroma.

Case report:

A patient of 70 year age came with complaint of retention of urine on and off and pain lower abdomen for 2 years. Patient was asymptomatic for 2 years. Gradually she developed retention of urine. Pain abdomen was intermittent and dragging type. Patient attained menopause 20 years back. Obstetrics history**-** P4L2D2. All are FTND at home. LCB 45Years. No history of DM, HTN, EPILEPSY, BA. Family history is of no significance. Patient had good appetite of mixed diet, good sleep and bowel and bladder were normal. General condition fair**.** Pallor present**.** No Cyanosis, icterus, clubbing. PR -78 /mint, BP-140/80mm of Hg, Chest –Trachea centrally placed, Bilateral air entry clear, CVS**—**S1 and S2 audible, No murmur. Per abdomen a mass corresponding the size of 22 - 24 week of gravid uterus, solid and stony hard in consistency, fixed , not mobile from side to side and above downward, lower margin could not be felt, flank was full, no fluid thrill or shifting dullness was noticed. Per vagina examination revealed that cervix and vagina atrophied, small polyp coming out from cervix, a stony hard mass corresponding 22-24 week size of gravid uterus felt, cervical movement not tender, uterus could not be made out separately. Her investigation report showed that Hb-10gm, TLC-9200, N60L36M4B0E0, Platelet-1.5lac, ESR-08 in 1st hour, P/S—Dimorphic anemia, HbSAg ,HIV, VDRL non-reactive, Blood urea-22mg/dl, S. creatinine-0.8mg/dl, S.uric acid-4.2mg/dl, CUE-normal.

USG showed a large hard mass of size 9.6x8.4x6.5cm seen arising from pelvis (Fig:1). The details could not be seen on USG due to poor transmission of sound signals. Right hydronephrosis is seen due to mass compression. Impression of USG was given as large fibroid with hydronephrosis. MRI Pelvis was suggested. X-ray report showing the soft tissue shadowing in pelvic cavity extending in to the abdomen. With above findings it was diagnosed with a query as pelvic soft tissue mass or Fibroid or Ovarian Mass**.** Surgery was performed and a mass of 900 grams was removed (Fig 2a &2b).

Discussion:

Ovarian tumour is not a single entity but a very complex one. Among all the ovarian neoplasms sex cord- stromal tumors of the ovary comprises of about 8%[5]. The fibroma, thecoma and theco fibroma of ovary grow from the connective tissue of the ovarian cortex and are a rare benign tumors[6]. Thecofibroma is seen rarely, less than 1% of all ovarian tumours[7]. The thecofibromas are usually of small size. The tumor itself is a rare that to bigger tumors is of more rarity. The cystic fibrothecoma of the ovary weighing 10kgs and 2.8kgs are reported from different parts of the world[8,9]. But in the Indian literature thecofibroma of 900 grams is the first of its kind and therefore this case becomes more unique, gains all the importance. Due to the rarity of the tumor incidence and size it was diagnosed as pelvic soft tissue mass or fibroid or ovarian mass by USG. The histopathological study revealed that the cut section of the ovarian mass showing compressed ovarian stroma at the periphery. Tumour shows spindle shaped cells arranged in interlacing bundles (Fig 3a,3b,3c). No hyperchromasia or pleumorphism. Focal area shows hyalinization of stroma. No evidence of malignancy. This led to the diagnosis as thecofibroma. The atrophy or compression of the cortical area is considered as significant for the diagnosis of thecofibroma[10]. Genetically the chromosomal aberration is considered as the factor responsible for thecofibroma, more so the trisomy and /or tetrasomy 12 was the most common culprit[5]. The ovarian thecoma presents various and nonspecific imaging manifestations. Less enhancement of fibromas and thecofibromas than fibroids and myometrium on MRI imaging should help in differentiating these tumors.

Fig 1(a ,b). Showing the USG of the patient.

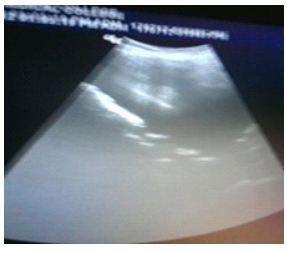

Fig-1a

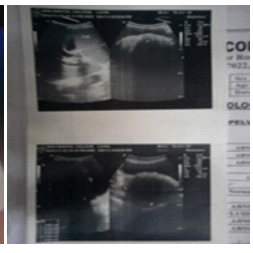

Fig-1b

Fig2a:Showing thecofibroma mass.

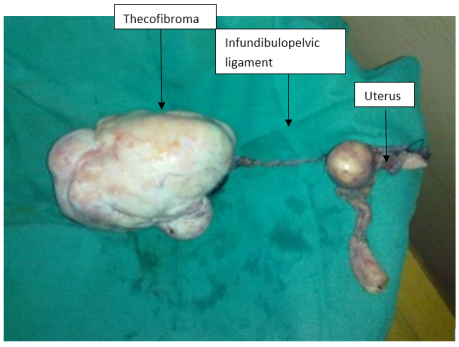

Fig 2b: Showing cut section of the thecofibroma.

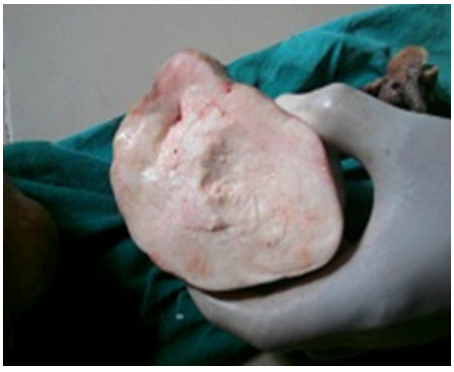

Fig 3(a,b,c): Showing the histopathological features of the mass as the cofibroma.

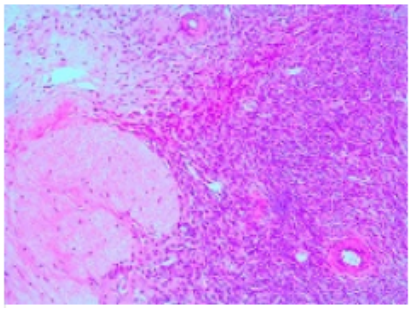

Fig-3a

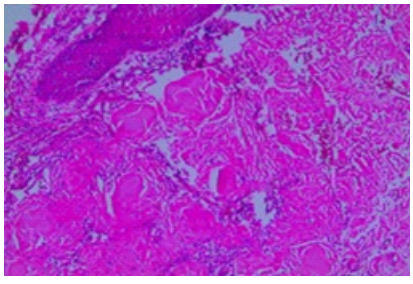

Fig-3b

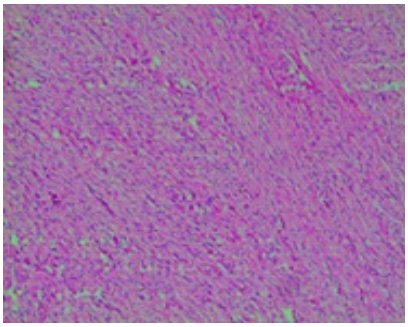

Fig-3c

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