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A RARE CASE OF LARGE OVARIAN FIBROMA IN A POSTMENOPAUSAL WOMAN

Rucha Sanap Changale[1], Maureen Prativa Tigga*[2], Ravindra Manohar Thawal[3], Ganesh G. Gowda[4]

[1]Niramay Hospital, Utkhana Medical College Road, Nagpur, Maharashtra.
[2]Department of Obstetrics & Gynaecology, Farookh Academy of Medical Education, Mysore Karnataka. 571103
[3]Mauli Super-specialty Hospital, Gangapur, Maharashtra.
[4]Department of Vascular Surgery, JSS Medical College & Hospital, Mysore, Karnataka.

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***Corresponding Author: Maureen Prativa Tigga**
Department of Obstetrics & Gynaecology, Farookh Academy of Medical Education, Mysore Karnataka, 571103.
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ABSTRACT

Ovarian fibromas a very rare and constitute only 1% of organic ovarian neoplasms. The definitive diagnosis is made by histopathological examination of the surgically excised specimen. Presented here is a case of large ovarian fibroma in a postmenopausal woman.

KEYWORDS: Ovarian fibroma, leiomyoma, postmenopausal.

1. INTRODUCTION

Uterine leiomyoma or fibroid is a benign tumour of the smooth muscle tissue of the uterus and their occurrence in ectopic sites are rare. Ovarian fibromas are scarce and constitute only 1% of organic ovarian neoplasms.[1] Clinical examination, sonographic imaging and tumour markers remain the best diagnostic workup that is currently available for ovarian tumours. Ovarian fibromas occur mostly in elderly postmenopausal age group and are benign. The definitive diagnosis is established by the histopathological examination.[2]

Presented here is a case of an ovarian fibroma in a postmenopausal patient who presented with abdominal mass and pelvic pain.

2. CASE PRESENTATION

A 62-year-old P4L4 patient with hypertension and on treatment, presented with chronic pelvic pain for past 2 years. She also complained of progressive abdominal heaviness and a lump in in the abdomen for the same duration. Initially,

the patient felt that a lump was reaching just above the pubic bone, however she noticed a gradual increase in size of the same. In the past 1 year she experienced a rapid growth in the mass and the current size of the mass reached up to 2 finger above her umbilicus. She also reported generalized pain in the abdomen for past 20 days. There was no history of weight loss, gastrointestinal disturbance, breathing difficulties, or abnormal vaginal bleeding. She was postmenopausal for 12 years and had not experienced any postmenopausal bleeding. There was no history of breast, ovarian, or endometrial cancer in the family. The clinical examination revealed a patient in good general condition with a pelvic mass 4 cm above the umbilicus on abdominal examination. The abdomino-pelvic CT scan showed a solid tissue mass measuring 22 ×17x 15 cm in close contact with the uterine wall and taking contrast homogeneously without infiltration of the surrounding organs.

The CA125 level was 29 IU/ml. Surgical exploration with a midline abdominal incision revealed a large solid mass arising from the left ovary and adherent to the uterus. (Figure 1) . Gross examination of the surgical specimen revealed a multilobulated nodular formation measuring 22x14x12.5 cm (Figure 2). A total hysterectomy with bilateral salpingo-ophrectomy was performed (Fig. 3). The postoperative course was without any complications. Histological examination revealed a proliferation of spindle cells in fascicles and arranged in intersecting bundles with abundant collagen. The mitotic activity was low and cellularity was low to moderate without signs of marked atypia. There were areas of oedema and cystic degeneration and all these pointed in favour of an ovarian fibroma.

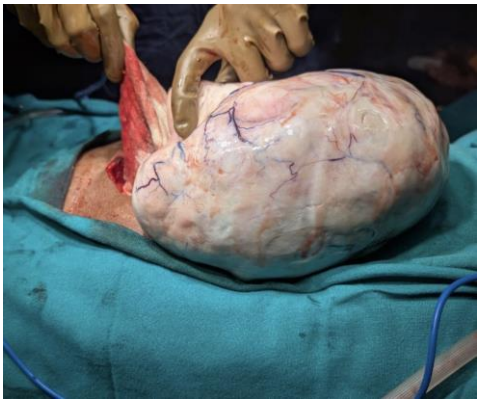

Figure 1: A 22x14x12.5 cm large solid fibroma arising from the left ovary.

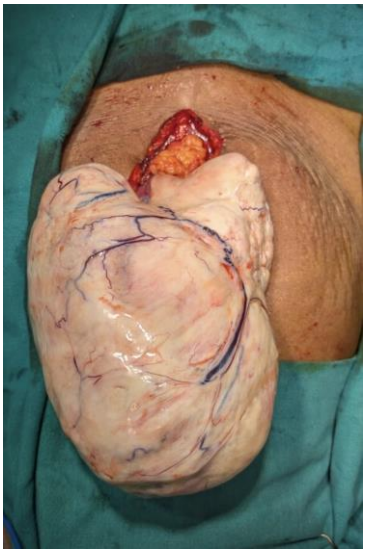

Figure 2: The solid fibroma showing vascularity, multilobulated and nodular pattern.

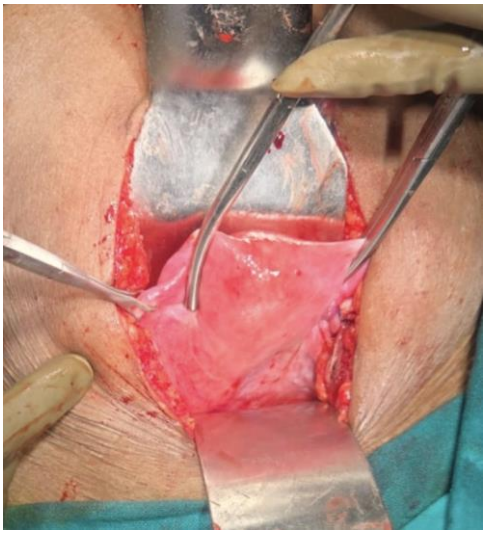

Figure 3: A total hysterectomy with bilateral salpingo-ophrectomy being performed as a definitive treatment.

3. DISCUSSION

Uterine myoma or leiomyoma is a benign tumour of the smooth muscle tissue of the uterus.[3] The extrauterine localization is rare, unusual and pathogenesis is poorly understood thereby posing a diagnostic conundrum.[4]

The ovarian fibromas are rare benign tumours representing only 1% of all ovarian tumours.[1] They are a type of fibrothecal tumours of the ovary, containing spindle-shaped connective cells, thecal cells or both types of cells.[5]

Ovarian fibromas can occur between 20 and 65 years of age. The average age is in the fifth and sixth decades.[6] Bilaterality is seen in 4–8% of patients and can be multiple tumours in 10% of cases,[7] particularly in Gorlin's syndrome,[8] or associated with pleural effusion and ascites in Meigs' syndrome.[9]

The symptoms include pelvic pain and abdominal fullness due to presence of a mass, as seen in our patient.[10,11] The diagnosis may be serendipitous, or during evaluation of a pelvic mass.[12] The major difficulty is to differentiate between ovarian fibroma and other solid ovarian tumours.[13] Cystic degeneration and haemorrhage are common, but calcification in ovarian fibromas is rare.

Bilateral ovarian leiomyomya is encountered in the pediatric age group and young females and are usually not associated with uterine leiomyoma. On the contrary a coexistent leiomyoma along with ovarian fibroma is more consistent in the perimenopausal age group. Radiological imaging is often insufficient to give a precise diagnosis. The sonographic appearance often reflects an echogenic mass associated with multiple shadow cones that are not due to calcifications but because of the attenuation of the ultrasound beam produced by the fibrous tissues.[14] Ultrasound is not conclusive, and a magnetic resonance imaging (MRI) is a better diagnostic modality. Ovarian fibroma is described to typically show low signal intensity on T1-weighted MR images, and marked hypo-intensity on T2-weighted images; the contrast medium enhancement of fibromas is heterogeneous and mild-to moderate.[12] The definitive diagnosis of an ovarian fibroma requires identification of the smooth muscles arranged in fascicles within the tumour.

Ovarian leiomyomas must also be differentiated from leiomyosarcomas which demonstrate cytologic atypia, increased mitotic activity and tumour necrosis.[6] In our case, none of were detected and it was a benign fibroma.

The treatment of choice is a definitive surgery. Salpingo-oophorectomy must be considered in perimenopausal or postmenopausal women, and cystectomy can be considered only in young women.[15]

4. CONCLUSION

Ovarian fibromas are an uncommon clinical entity and their, preoperative diagnosis is challenging. Surgery along with histological study is used to establish the definitive diagnosis.

Consent

Written informed consent for publication of their clinical details and/or clinical images was obtained from the patient.

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