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A Rare Case of Bilateral Ovarian Fibro-thecoma in A Postmenopausal Woman- Case Report

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ABSTRACT

Ovarian fibro-thecoma is a rare benign tumor arising from sex cord stromal cells. It is unilateral and asymptomatic in most cases. It predominantly occurs in postmenopausal women, but it could occur at any age. Surgical resection is the right option to cure this tumor. This report presents a case of a 63-year-old postmenopausal patient complaining of heaviness and asymmetrical swelling in the lower abdomen. Clinically the abdominal mass was diagnosed as a uterine fibroma. It was treated by abdominal total hysterectomy with bilateral adnexectomy. After that the patient was free of symptoms. The histopathological diagnosis was confirmed with a rare ovarian fibro-thecoma.

Keywords

Ovarian-fibro-thecoma, Pelvic-mass, Menopause, Fibroids, Rare benign ovarian tumor.

Introduction

Ovarian tumors are common among postmenopausal women; most of the ovarian tumors in this age group were found to be malignant. There are many kinds of cells in the ovary. There is a possibility of a tumor development from each kind of these cells. There are rare kinds of ovarian tumors. One of the rare cases is stromal sex-cord tumor like fibro-thecoma.

Fibro-thecoma makes up 3-4% of all ovarian neoplasia. Predominantly, it happens in postmenopausal women and presents unilaterally in most cases [1].

Ovarian fibromas are benign tumors arising from the connective tissue of the ovarian cortex, classified into three pathological subtypes: fibroma, thecoma, and fibro-thecoma [2]. These are distinguished by the presence of fibroblastic stromal cells and/or cells resembling luteinized theca cells [3]. Most of the ovarian fibro-thecomas are asymptomatic [4]. Its solid nature and potential association with ascites, pleural effusion, and occasionally increased serum CA-125 levels can complicate differentiation from malignant epithelial ovarian tumors [2]. CA-125-levels rarely elevate in these tumors which can lead to a misdiagnosis as ovarian malignancy. Fibro-thecoma can also accompany Meigs syndrome [5] The diagnosis is essentially dependent on histological examination [3].

It is crucial to diagnose the tumor early. Surgery is the preferred treatment option using minimally invasive and fertility-sparing techniques on young patients and total abdominal hysterectomy with bilateral adnexectomy on elderly and postmenopausal patients [2,3,6].

This case study presents a rare case of a bilateral ovarian fibro-thecoma in a 63-year-old woman who complained from a sensation of heaviness and swelling of the lower abdomen, treated surgically by abdominal total hysterectomy with bilateral adnexectomy eight months ago. Now, the patient is healthy and free of complaints since the operation was successfully performed.

Case Presentation

The patient is a 63 years old postmenopausal female; her last menstrual period was 10 years ago. She had previous three vaginal deliveries, and hypothyroidism following subtotal thyroidectomy 25 years ago. She is under the treatment with thyroxine 100 mg on an empty stomach daily, her clinically and laboratory findings are stable. The patient is a heavy smoker and a thin person, her body mass index is of 17 kg\m^2. She complained from heaviness and an asymmetrical swelling in the lower abdomen in a protruding outward manner, which was noticeable for three to four months prior. There were no abnormal vaginal discharges or bleeding. She had no urinary or gastrointestinal complaints or weight loss. There is no history of malignant tumors in the family.

The gynecological examination shows atrophic cervix uteri and vaginal epithelium; on bimanual examination there were two palpable pelvic masses to identify. The first mass was in the right abdominal lower quadrant extended to the level of the umbilicus. It was very hard and solid, regular, mobile, and painless. The second mass was on the left side, smaller, well separated from the previous one, also hard, solid, painless and mobile. It was not possible to distinguish the origin of the masses whether they were from the uterus or from the ovaries. It was also difficult to palpate a separated uterus. But the first suspicion was that the masses were fibroids that originated from the uterus, the second suspicion was that they belonged to the ovaries and are ovarian tumors.

The pelvic transabdominal and transvaginal ultrasound revealed the presence of inhomogeneous masses possibly due to uterine fibroids (enlarged uterus 130 × 70 mm, many inhomogeneous masses of 85 and 67 mm in diameter developed intramural). There was another sub-serosal fibroid with a diameter of 55mm in the left adnexal region, another similar structure of 80 mm in diameter was found in the retro-uterine space (Figure 1).

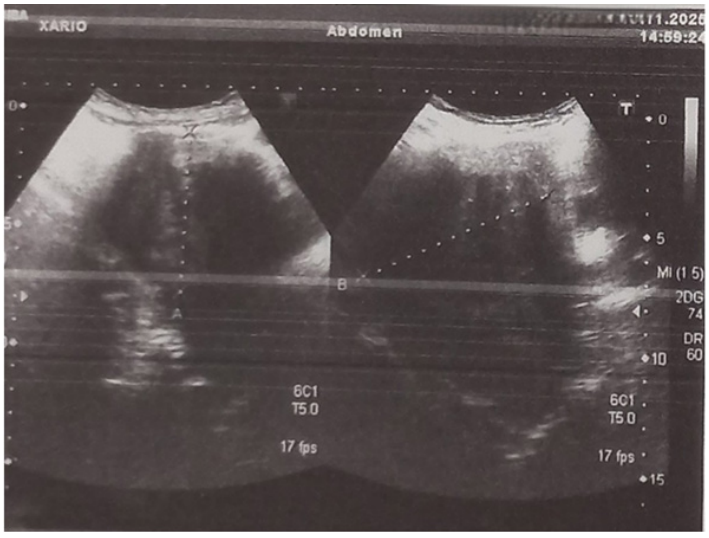

Figure 1: Appearance of the pelvic mass by ultrasound.

The CT-scan for the chest, abdomen and pelvis showed normal lungs and heart. The bladder was full at the time of examination. There were signs of pressure on its fundus without full abnormality. The retroperitoneal region was normal with no para-aortal or pelvic lymph nodes enlargement, the echo of the liver was normal and no dilation of the urinary tract was found.

In the pelvis, the CT-scan found a huge enlarged uterus with several subserous and intramural leiomyomas. One of them is 60 mm in diameter displacing the left ovary. Anteriorly, there was a huge mass measuring 130 mm in diameter. The uterus was very enlarged; measuring 165 × 130 × 180 mm. The rectum and the bladder were pushed and pressed due to uterine fibroids. Kidneys and urinary tract were not affected. There were no lymph nodes enlargement, no ascites and no thickness of the peritoneum or omentum were found (Figure 2).

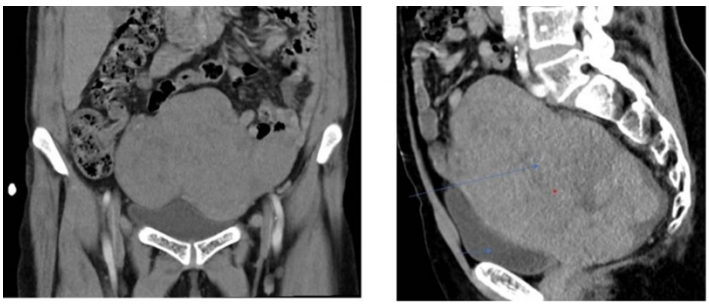

Figure 2: Preoperative pelvic computer tomography long arrow shows the big mass and the short arrow shows the compressed bladder (sagittal and cross-sectional views).

The patient's hemoglobin was 12.6 g\dl, Liver and kidney's profile and glucose were within normal limits. CA-125 was 42.1 IU\ml, which is double the normal limits approved in the laboratory.

Cystoscopy shows normal cavity of the bladder but the left ureter orifice positioned higher than normal. The patient strongly refused the recto-colonoscopy.

A written consent has been obtained for surgery. A suprapubic transverse incision (Pfannenstiel) under general anesthesia was done. There was a little amount of yellowish fluid in the pelvic cavity, 5 ml has been taken for cytology. The uterus was in fact atrophic, regular, mobile and placed between two large masses. There were no adhesions, the left ovary was enlarged (60 × 60 mm in diameter), hard, mobile and with an intact and smooth capsule. The right ovary was also enlarged (160 × 160 mm in diameter) solid, hard, mobile, and with an intact and smooth surface as no cystic patterns or adhesions were found. The appendix, bowel, liver and omentum were macroscopically free of pathological features. An abdominal total hysterectomy with bilateral adnexectomy were performed (Figures 3,4,5).

Postoperative period was smooth and the patient was discharged home in a good condition without encountering complications.

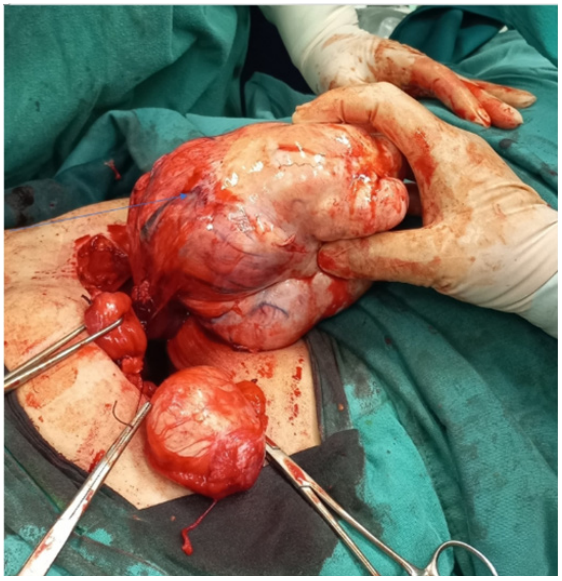

Figure 3: Intraoperative image of bilateral enlarged ovaries (a big right ovarian tumor) and a normal seized uterus in the middle and left smaller ovarian tumor. (The arrow shows the right ovary).

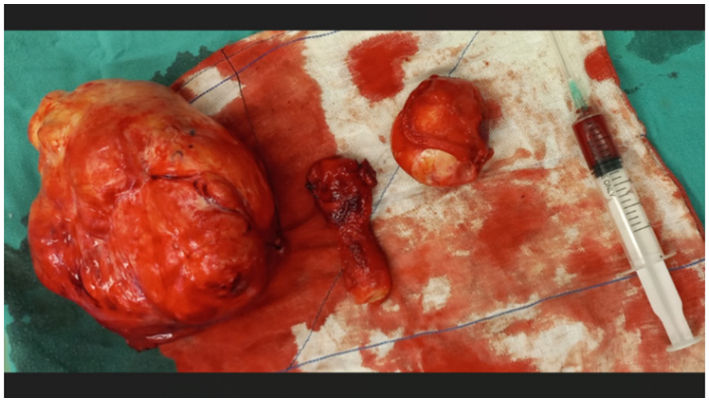

Figure 4: Post operative specimen. Large right ovarian mass, uterus, left ovarian mass and peritoneal fluid.

The histopathological findings were confirmed with bilateral fibro-thecoma of the ovaries, the largest mass measured 150 mm in diameter. CIN1 of the cervix was a coincidental finding. There were no malignancies. The peritoneal fluid was free of any cells suspected of malignancy (Figure 6).

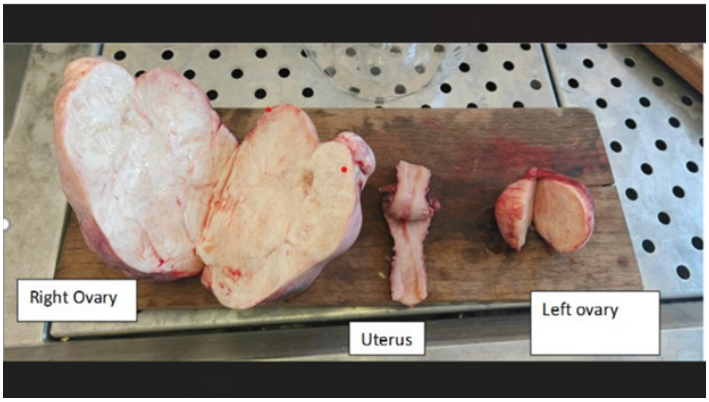

Figure 5: Post operative cutting surface of the specimen. (A large right ovarian mass, uterus and left ovarian mass).

After eight months, the patient is doing well and free of any compliance.

Discussion

Ovarian fibro-thecomas are a subtype of ovarian sex-cord stromal tumors. These tumors are composed of thecomas which is formed by stromal cells that resemble the theca cells and fibromas that are structured of the spindled stromal cells that form collagen [7,8]. Fibro-thecomas are mostly found unilaterally in postmenopausal women [1]. The youngest affected patient is 14 years old [6]. The mean age to occur is 47,73 years, but the tumor size in postmenopausal women was significantly bigger than that in premenopausal women [9]. The clinical manifestations of the ovarian fibro-thecomas are ambiguous [10], approximately 60% of the patients had no symptoms [4], frequently encountered symptoms include pelvic pain and metrorrhagia [3] . In the current case there were no metrorrhagia and no obvious pelvic pain, however, pressure and asymmetrical enlargement in the lower abdomen were noticed. The diagnosis of this kind of tumors is often difficult and may be confused with malignant tumors due to its solid nature, and its association with ascites, and pleural effusion [6]. Elevated CA-125 levels, and the fact that some cases present an atypical appearance on ultrasound imaging may indicate the presence of malignant tumor or some other kinds of benign tumors [4]. Ultrasound examination shows hypoechoic masses with clear border, on doppler ultrasound blood flow signals are low [11]. On imaging, fibro-thecomas shows mild enhancement in both CT and MRI [7]. An elevation in CA-125 is infrequently

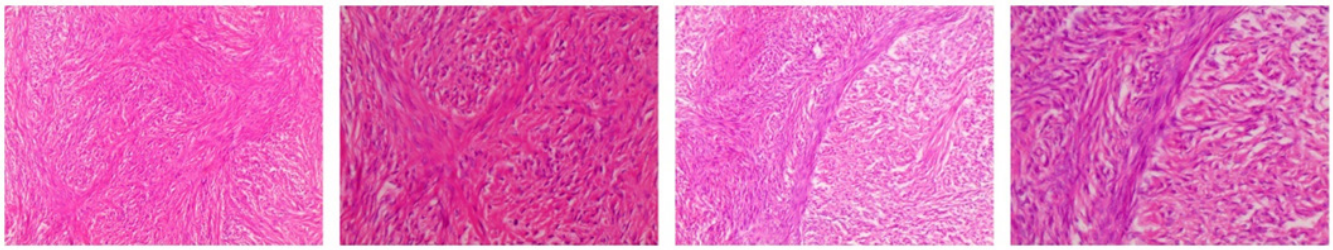

Figure 6: Histological sections showing the appearance of a fibrothecoma.

Microscopic images of the histopathological analysis of the bilateral ovarian masses via hematoxylin-eosin staining. They demonstrate a morphologic appearance between fibroma and thecoma. The cells showing ovoid to round nuclei and pale gray cytoplasm, there is also spindle nuclei reflecting the overlap between fibroma and thecoma.

observed in fibro-thecomas. Elevated serum CA-125 levels were detected in 11.3% of patients with ovarian fibroma/fibro-thecoma. A positive correlation was observed between CA-125 elevation and the size of a tumor [2,12]. In this case the patient exhibited a nearly two-fold increase in serum CA-125 levels. Ovarian fibro-thecoma is rarely accompanied by torsion in approximately 5,88% of cases and is less common in premenopausal women [9]. The optimal strategy to diagnose at present is clinical examination, and ultrasound imaging, yet final confirmation of the diagnosis is histological examination [13]. It is necessary to distinguish between this kind of masses and the uterine fibroids [14]. In this case, histopathological examination was performed to overcome the limitation of radiographic modalities in characterizing ovarian fibro-thecoma. As a result, it is important to recognize it as a benign tumor early, in order to prevent unnecessary extensive surgical interventions, especially in women of reproductive age [6].

Total abdominal hysterectomy with bilateral salpingectomy, as a surgical approach is recommended for postmenopausal women, whereas premenopausal women occasionally underwent laparoscopic approach. The expected outcome of the ovarian fibro-thecoma is positive [13].

In the following table, there is a comparison between the characteristics of this case and three cases which were reported in different countries.

A Table to compare characteristics of this case and another cases.

Variable/ characteristics	Current case	Case 1	Case 2	Case 3
Reference	This case	[16]	[15]	[1]
Age\years	63	35	54	54
Chief complaint	heaviness and an asymmetrical swelling in the lower abdomen	Abdominopelvic pain and abdominal mass	Metrorrhagia, large pelvic mass and dull lower abdominal pain	Gradual and painful increase in the abdominal contour, dyspnea
Tumor size post-surgery	Right mass: 15*15 cm Left mass: 6*6 cm	Right mass: 40*30 cm Left mass: 20*15 cm	Right mass: 16*12*7.5 cm Left mass: 2*3cm	Large left mass, multiple uterine masses and a smaller right mass
Tumor marker (CA-125)	42.1 IU\ml	1835 IU/ml	normal	197 IU/ml
Surgical approach	Total abdominal hysterectomy with bilateral salpingo-oophorectomy	Total hysterectomy with bilateral salpingo-oophorectomy	Total hysterectomy with bilateral salpingo-oophorectomy	Total hysterectomy with bilateral salpingo-oophorectomy
Accompanies	non	Meigs syndrome -Left adnexal in subtorsion, ascites [2.5l]	non	Ascites [3l]
Outcome/follow-up	8 months	3 months	8 months	8 months

Conclusion

Fibro-thecoma is a rare ovarian tumor with ambiguous symptoms, which is most common in the postmenopausal women. It is a benign tumor that can resemble uterine fibroids by radiographical investigations. It is diagnosed histo-pathologically, and treated Surgically. It has in general a favorable prognosis.

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