Ovarian Fibrothecoma Presenting as a Huge Pelvic Mass – A Case Report

Anishma M.J.¹, Jayanthi R.², Sahitya Meda³

^{1,2,3} Department of Obstetrics and Gynaecology, Meenakshi Medical College and Research Institute, Tamil Nadu, India.

PRESENTATION OF CASE

A 45-year-old para-2, live-2, sterilized woman presented with lower abdominal pain and fever of 10 days duration. She had history of decreased appetite, increased frequency of urination for the last four months. Her menstrual cycles were regular, with average flow, and had congestive dysmenorrhea for the last four months. Her temperature was 99.4 °F and other vitals were within normal limits. Abdominal examination showed a huge stony hard mass of 34 weeks size, margins well defined, nontender, with restricted mobility. Other systemic examination were within normal limits. Speculum examination–cervix was hypertrophied and congested. Vaginal examination–mass felt on all fornices and it was immobile, uterus could not be separately felt from the mass.

USG¹ (Ultra-Sono-Graphy) revealed a hypoechoic mass of size 26.8 x 11.5 x 27.9 cm arising from posterior wall of the uterus, right ovary was not delineated due to overlying mass and left ovary normal, ET (Endometrial Thickness) – 5 mm IVP (Intra-Venous Pyelogram) – showing bilateral hydronephrosis, CA125,² CEA, β HCG, AFP were within normal limits.

DISCUSSION OF MANAGEMENT

Figure 1.
Abdominal Examination Revealing
34 Weeks Size, Well
Defined Stony Hard Mass

Patient underwent staging laparotomy. On opening the abdomen, a huge mass arising from the right ovary extending upward till to the under surface of the diaphragm was seen; pouch of Douglas was filled by the same tumour about 35 x 25 x 20 cm. Mass was not adherent to adjacent structures. No omental thickening. Under surface of diaphragm, paracolic gutter and left ovary was normal. No palpable para-aortic lymph nodes. 50 ml of normal saline was injected into the peritoneal cavity and sent for HPE (Histo-Pathological Examination). Omental and pelvic peritoneal bits sent for HPE. All organs were palpated and appeared normal, no deposits. Ovarian tumour³ along with uterus, both tubes, left ovary was removed into and sent for HPE.

Corresponding Author:

*Dr. M. J. Anishma,
258 Velachery Main Road,
Sembakkam – 600073, Chennai,
Tamil Nadu, India.
E-mail: anishmabright@gmail.com*

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Figure 2.
Post-Operative
Photo Showing
the Total
Hysterectomy
and Bilateral
Salpingo-
Oophorectomy
Specimen

Microscopic Examination

Collection of uniform spread of luteinized theca cells surrounded by spindle ovarian stromal cells with benign nucleus. No evidence of cystic degeneration or necrosis.

Figure 4.
Histopathological
Study with H & E
Stains. Bland Looking
Spindle Stromal Cells
with Oedema and
Hyaline Bands

PATHOLOGICAL DISCUSSION

Figure 3.
Gross Cut Section
and
the Macroscopic
Specimen
Showing
Solid, Lobulated,
Gray White Mass
with Glistening
Surface
Approximately 38
x 25 x 17 cms in
Size

Histopathology Report

Macroscopic Examination

Solid, lobulated, greyish white mass with glistening surface (38 x 25 x 17 cm)

DISCUSSION

Fibrothecomas are the solid primary ovarian tumours and are frequently misdiagnosed as uterine fibroids. Incidence is 3 – 4 % of all ovarian tumours, rarely malignant and in 90 % of the cases are unilateral. Myxoid and cystic degeneration⁴ are common while calcification and haemorrhage are rare. Torsion⁵ is not an uncommon presentation occurring in 8 % of patients. Endocrine manifestation is possible. Early diagnosis⁶ and surgical resection is the treatment⁷ of choice.

CONCLUSIONS

Clinical presentation is often non-specific, patients present with pelvic mass, and pelvic pain. Surgical excision is the preferred treatment for perimenopausal women and is associated with good prognosis.

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