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Postmenopausal Massive Calcified Ovarian Fibroma – A Rare Case Report

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Abstract

Ovarian fibroma is the most common benign solid tumors of the ovary, commonly misdiagnosed as uterine fibroma or as malignant ovarian tumors. It occurs generally in older perimenopausal women. Large fibromas may undergo torsion causing acute abdominal pain. Doppler ultrasonography imaging is the choice study. CT and MRI are often needed for further characterization and differentiation from other solid ovarian masses. The choice of treatment is surgical removal with intraoperative frozen section. Immuno-histochemical analysis is recommended to rule out the differential diagnosis. Here we present a case of a postmenopausal woman with a large ovarian fibroma reflecting diagnostic difficulties including potential misdiagnosis of the tumor as a malignant ovarian neoplasm that may influence the surgical approach.

Keywords: Ovarian, Fibroma, Postmenopausal.

Introduction

Ovarian fibromas are the most common benign solid tumors of the ovary (1- 4%), typically detected in middle aged women1, often difficult to diagnose preoperatively and commonly misdiagnosed as uterine Fibromas, because of their same pathology, complications, clinical and ultrasonic features[2-3], or sometimes as malignant ovarian tumors because of accompanying ascites and increased serum CA-125 level. Extra uterine fibromas present greater diagnostic challenge. Fibromas are often asymptomatic tumors.

Thus, they can be detected incidentally during routine gynecological examination. The patients with large fibromas can be manifested with nonspecific pressure symptoms such as abdominal pain and distention[4]. The fibromas which might rarely present with massive calcification can be detected incidentally on plain pelvic radiographs[5].

Here we present a case of a 80 year-old postmenopausal with a large ovarian fibroma presented with lump abdomen. This case highlights the diagnostic difficulties that may be encountered in the management of ovarian fibroma including potential misdiagnosis of the tumor as a malignant ovarian neoplasm that may influence the surgical approach.

Case report

A 80-year-old post-menopausal, multiparous woman was presented in with lump abdomen for 20 year which was slowly growing and loss of appetite. In her past medical history there were intermittent episodes of abdominal discomfort and a sensation of abdominal heaviness during the preceding months. Her vital signs were all within

normal limits. Physical examination revealed a palpable abdominal mass in the lower abdomen with sensibility and involuntary guarding. Vaginal examination revealed a normal sized uterus. Pelvic Ultrasonograghy showed a retroperitoneal mass. Pelvic computed tomography revealed a large peripheral calcified soft density solid lesion in abdomen and extending epigastrium to lumbar region. The lesion was present anterior to pancreas. No extension to adnexa is seen. Approximate size of lesion 127×185×207 mm. The CT scan provisional diagnosis was gastrointestinal stromal tumor. Exploratory laparotomy was done and a ovarian mass attached to fallopian tube was removed measuring 25 × 25×20cm. According to histopathological findings, the diagnosis of ovarian fibroma with calcification was confirmed.

Discussion

Ovarian fibromas are the most common neoplasms among benign ovarian sexcord stromal tumours with an incidence of 4%. They are usually unilateral and afew of them contain calcification. The fibromas are generally non-functional but can become hormonal active.

They may be associated with Meigs, Sotos or Gorlin syndromes, which are rare three clinical syndromes [5-7]. The fibromas related with these syndromes can occur in bilateral form and contain calcification in the earlier decades of reproductive age. Concomitant as cites and pleural effusion can be detected about 40-50% of cases with the ovarian fibroma above the diameter about 5 cm. These cases are clinically identified as Meigs' syndrome. Gorlin syndrome is consisted of multiple tissue calcification and nevoid basal cell carcinoma. Approximately 75% of the ovarian fibromas occur in bilateral, calcified and multinodular forms in patients with Gorlin syndrome[8]. Soto's syndrome is another syndrome associated with ovarian fibromas and characterized by congenital anomalies such as microcephaly or dolichocephaly.

Our patient was 80 years old and she had calcified ovarian fibroma. Therefore, she was examined for the presence of any of these syndromes, especially for the Gorlin syndrome. However, there were no pathological findings consistent with these syndromes neither in the preoperative or Peroperative nor in postoperative evaluation. Thus, they cannot be associated with any of these mentioned syndromes.

In another perspective, it is very important to discriminate the ovarian solid lesions from ovarian malignancies in the clinical practice. The evaluation of the content, nature, no dularity, possible papillary projections, and vascularization is difficult for the calcified lesions and as a result of this, CT or MRI has come to the forefront.

The suspicion for malignancy is increased in conditions such as large solid lesions. Indeed, it was observed that in many case reports in the literature, premenarchal patients underwent radical procedures such as oophorectomy for benign fibromas [9]. Besides, a small number of cases reported with ovarian sparing surgery were applied with laparoscopic approach for fibromas[10].

Histopathological verification should be done for these lesions and forexcisional procedures minimally invasive surgical approaches performed with laparoscopy are good alternatives when the fertility desires of young patients are considered.

Conclusion

Ovarian fibromas are uncommon but are the most common benign solid tumor of the ovary. Despite its rarity, it should be preoperatively considered in the differential diagnosis. Its treatment requires surgical removal with intraoperative frozen section and immunohistochemical analysis for definitive diagnosis.

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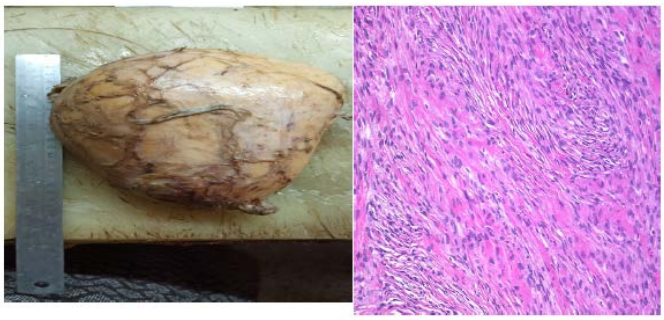
Legends Figure



Fiq.1.(a)Gross examination (b) Histopathological examination