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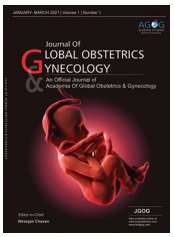
Case Report



Ovarian Fibroma Presenting as a Chronic Torsion

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ABSTRACT

Ovarian fibromas are rare, benign tumours. They constitute around 1% of all ovarian tumors. Diagnosis is a dilemma, as definite diagnosis can only be made on pathological characteristics. While imaging like ultrasonography and magnetic resonance imaging, aided by tumor marker, can be used. We discuss a case of ovarian fibroma, masquerading as chronic torsion in a perimenopausal woman

Key words: Fibroma, rare, ovarian torsion

INTRODUCTION

Ovarian fibroma is the benign solid tumors of the ovary. It can indeed be misdiagnosed due to their similarity to uterine fibroids or malignant ovarian tumors. They usually represent 1% of all ovarian tumors.[1] They are often seen in perimenopausal or post-menopausal women.

Mainstay of diagnosing ovarian tumors is tumor markers, computer tomography, and magnetic resonance imaging. However, a definitive diagnosis can only be ascertained by histopathological examination.

We report a case of an ovarian fibroma with chronic torsion in a perimenopausal woman.

CASE REPORT

A 42-42-year-old woman, P1L1SA1 presented with a complaint of pain in Abdomen, acute in onset, intermittently severe in nature associated with vomiting. On examination, her vitals were within normal limit. On per abdominal examination, a firm, mobile mass was palpated, which was tender. On bimanual examination, the uterus was normal in size; a large 10 cm firm mass felt. It was difficult to establish if the pass was arising from the uterus or adnexa on examination.

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An ultrasound with color Doppler of abdomen and pelvis was done. It was suggestive of 10.8 × 10.5 × 8.8 cm large hypoechoic well solid lesion, showing minimal internal vascularity. The tortuous pedicle was seen adjacent to the lesion on the right side with the preserved flow (RI 0.69) with minimal free fluid in the pelvis likely suggestive of chronic torsion. Computed tomography and magnetic resource imaging revealed an enlarged right ovary with large heterogeneous soft-tissue lesion measuring 10.8 × 10.2 × 1.2 cm with patchy areas if enhancement in post-contrast study without any lymphadenopathy or pelvic effusion. CA 125 level was 63.5 U/mL and all other tumor markers were normal.

An exploratory laparotomy was done and intraoperatively a 10*10 cm solid ovarian mass with an irregular surface arising from the right ovary with a twisted pedicle were seen (Figure 1). The left adnexa and uterus were normal. Subsequently, right salpingo-oophorectomy was performed. The histological findings were confirmatory of ovarian fibroma with 2–3 mitotic figures without signs of necrosis. Gross cross-section of the mass showed a capsule, with tan pale fleshy appearance (Figure 2).

DISCUSSION

Ovarian fibromas are rare entities and have an origin from sex cord-stromal cells. They contain spindle cells or thecal cells or may contain both types.[2] 90% of cases of fibroma are unilateral. Bilaterality is seen in 4–8% of patients while they may be multiple in 10% of patients especially when associated with Gorlin's syndrome.[3]

The association of ovarian fibroma, ascites, and pleural effusion is the classic triad known Meig's syndrome. Most ovarian fibromas are asymptomatic, sometimes present as abdominal

Figure 1: Right adnexa with mass not seen separately from ovary

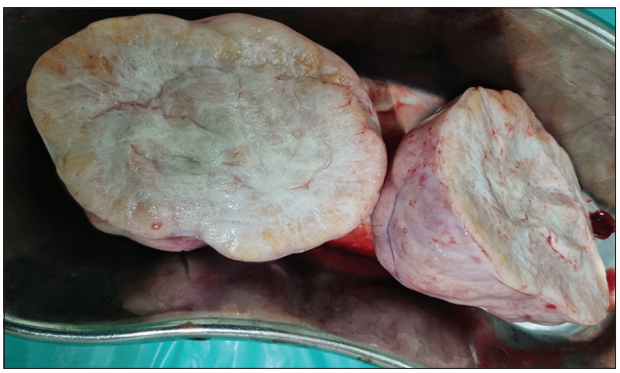

Figure 2: Cross-section of ovarian mass

enlargement, pain, urinary symptoms, and torsion.[4] These can mimic ovarian neoplasms due to solid nature and elevated CA 125 levels, particularly in cases of torsion leading to necrosis and inflammation, which can be indicative of ovarian fibromas.

Ovarian fibromas are stromal tumors characterized by spindle, oval, or round cells that produce collagen. They typically present as solid, firm, spherical masses with a grey-white appearance and often have a lobulated or encapsulated structure, with the ovarian serosa intact. Ultrasonography findings are non-specific but Doppler imaging should be performed where torsion is suspected.

To rule out leiomyosarcoma and sex cord-stromal tumor immunohistochemical analysis and staining is recommended.[5] Surgery is the treatment of choice for ovarian fibromas with intraoperative frozen section by either laparoscopy or laparotomy. Cystectomy can be performed in young women to preserve fertility while total abdominal hysterectomy with bilateral salpingo-ophorectomy is the preferred treatment in elderly patients.

CONCLUSION

Fibromas are relatively uncommon compared to other benign solid ovarian tumor. The diagnosis is confirmed by histopathological examination. Pre-operative diagnosis of ovarian fibromas can indeed be challenging, and surgery followed by histological examination remains the gold standard for definitive diagnosis. Conducting an updated literature review can provide valuable insights into the incidence of these tumors, helping to clarify their existence and aiding in better recognition and management strategies.

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