Case Report
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Ovarian fibroma in a postmenopausal woman: A case report

Abstract

Ovarian fibromas are uncommon, accounting for 4% of ovarian tumors. The clinical examination, ultrasonographic, and tumor marker data remain the best preoperative approach currently available for ovarian tumors. However, the diagnosis remains histological. We hereby present the uncommon case of unilateral ovarian fibroma in a 55-year-old woman who presented with pelvic chronic pain the past 2 years. Underwent a bilateral adnexectomy through laparotomy and pathologic examination confirmed the diagnostic of ovarian fibroma. Our case is to illuminate the diagnosis of ovarian fibroma as a rare diagnosis and it should be considered in the differential diagnosis of solid ovarian masses.

Keywords: ovarian mass, ovarian fibroma, spindle cells

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Introduction

ovarian fibroma is one of the rarest solid tumors of the ovary. is definite as solid stromal tumor of the ovarian sex cord representing 1 to 4% of benign ovarian tumors.[1] It is difficult to diagnose in the preoperative step and generally taken for a uterine fibroid. MRI imaging is more effective than ultrasound in asserting the uterine or ovarian nature of a lateral solid uterine mass. The surgical excision and the histology examination is necessary for confirmation diagnosis. Adnexectomy is the choice treatment for young patients, however a radical treatment is indicated for perimenopausal and menopausal patients. Here; we present a rare case of unilateral ovarian fibroma in a 55-year-old woman who presented with pelvic chronic pain the past 2 years. She underwent a bilateral adnexectomy through laparotomy and pathologic examination confirmed the diagnostic of ovarian fibroma.

Case presentation

A 55-year-old patient with no medical or surgical history and no family history of neoplasia, 6 gravidity 4 parity, 2 spontaneous abortions, menopausal for 4 years, who consults for increased abdominal volume associated with pelvic pain type heaviness evolving for more than 2 years, associated with urinary signs type pollakiuria without digestive signs all evolving in a context of conservation of the general state.

The clinical examination finds a Abdomin-pelvic mass lateralized on the left side, painless arriving halfway to the umbilicus. The abdominopelvic ultrasound combined with the transvaginal ultrasound objective the presence of a solid, movable, and non-homogenous echoic mass (7 × 8 cm) in the left side of the uterus most probably subserous uterine leiomyoma. No pathologic findings within the right ovary were found. Low effusion in the Douglas was detected. Pelvic MRI showed a large, well-limited mass with polylobed contours in the median and left latero-uterine area, in heterogeneous T1 and T2 hyposignal with discrete diffusion hypersignal, enhancing heterogeneously after injection of gadolinium. It measured 70×66×10 mm, a small pelvic effusion was associated.

Chest X-ray did not objectivize a pleurisy. Laboratory tests including carcinoembryonic antigen and α-fetoprotein were normal.

The patient underwent an exploratory laparotomy objecting a voluminous left mass of about 10 centimeters depending to the left ovary associated with low abundance ascites, exploration shows the contralateral ovary without abnormalities. omentum, intestinal surface, peritoneum, and other pelvic and abdominal viscera were free of tumor deposits. Retroperitoneal lymph nodes were not enlarged the patient benefited of a bilateral adnexectomy.

A pathological examination showed that the tumor was macroscopically nearly white, but there were no obvious necrotic lesions (Figure 1). Microscopically, the tumor was composed of thin spindle cells in a whorled arrangement, but nuclear atypia and mitosis were not observed, and the fibroma diagnosis was confirmed (Figures 2-4). the study of the peritoneal fluid does not show any suspicious cells. Post-operative recovery was uneventful and the woman was discharged on the 3th post-operative day. She is now on follow-up and doing well for the past 3 months post-surgery.

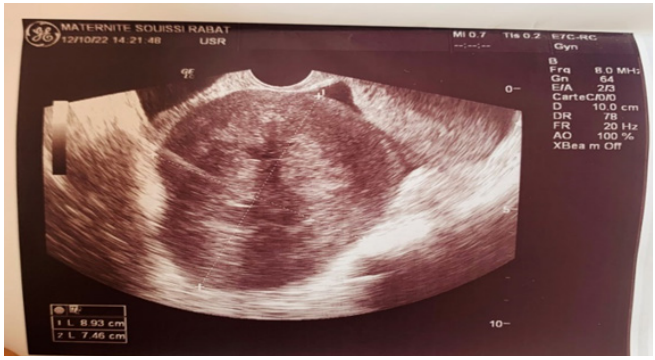

Figure 1 Hypoechogenic latero uterine mass with echogenic zones of 7*8 cm.

Discussion

Ovarian fibroids represent 4% of all ovarian tumors.[2] It develops from muscle fibers and connective cells; macroscopically, they are

well-defined, encapsulated, partly hyalinized. microscopically, there are 2 pathological varieties: fibroids or fibroblast cells arranged in a whirlwind and producing collagen and fibro thecomas that are distinguished by a rich lipid content.[3] They are most commonly unilateral, except when they are part of a Gorlin-Goltz syndrome. These tumors occur generally in postmenopausal or perimenopausal women,[2] they are reported that 75% of the patients were 40 years old and 50% were menopausal.[3,4]

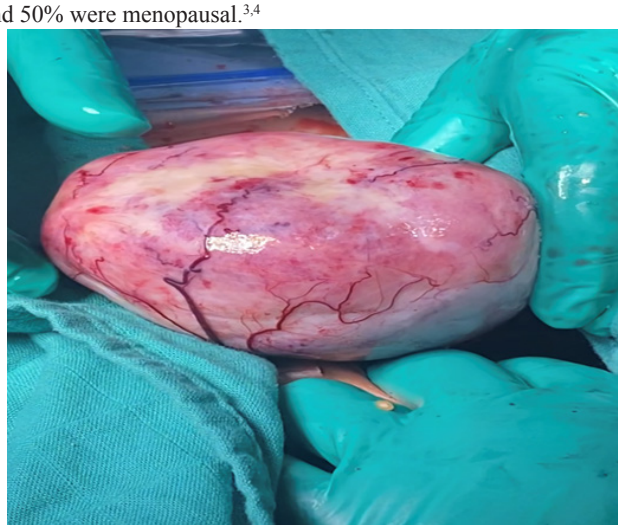

Figure 2 Surgical exploration showing a left ovary with a mass of about 10 cm.

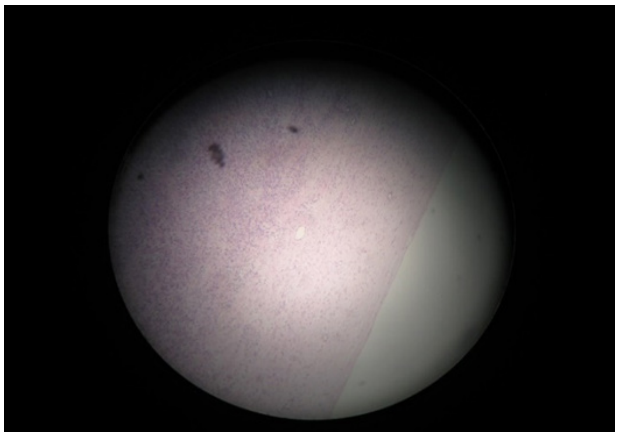

Figure 3 Tumor limited by a capsule.

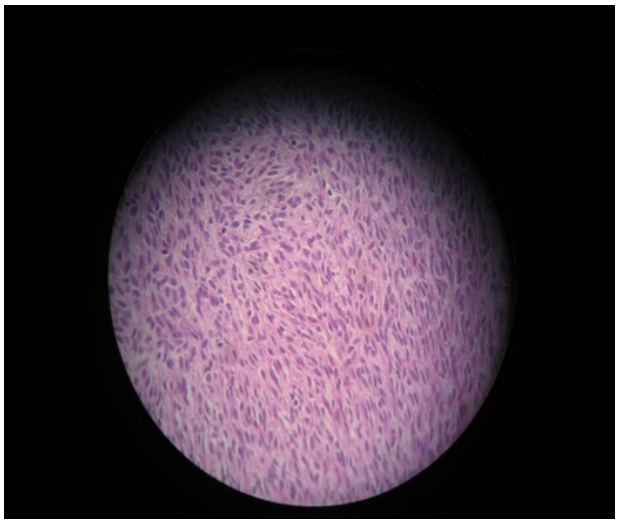

Figure 4 Regular nuclei without atypia.

The circumstances of discovery are very variables: fortuitous, during an assessment exploration of a pelvic mass or in front of non-specific symptoms: pelvic pain chronic or acute, impact on the urinary tract, digestive, vascular or nervous.[5] Clinically, ovarian fibroid present as a solid, mobile mass with a regular surface that varies greatly in size.[6] The major difficulty is to differentiate between ovarian fibroma and other solid ovarian tumors. This benign tumor may be associated with an ascites and pleurisy in the context of the syndrome of Meigs demons in almost 1% of cases; who will disappear after his excision.[6,7]

In our patient associated with the tumor; there was a low abundance effusion the Douglas; but the chest X-ray did not objectivize pleurisy allowing to eliminate the syndrome of Meigs demons.

ovarian fibroma on ultrasound presents as a solid, homogeneous and hypoechoic mass with posterior acoustic shadowing, similar to a pedunculated subserosal uterine leiomyoma.[8] In MRI, there are two essential signs allowing to make the diagnosis of ovarian fibroid: the mass appears with a weak signal in T2 and in MRI angiography, there is no vascularization in the arterial phase nor any contrast to the parenchymal time. whereas there is a small enhancement in the late phase. It may be the site of hemorrhage, edema, cystic transformation or calcifications.[6,9,10]

The treatment of ovarian fibroid is surgical, Salpingo-oophorectomy can be considered in perimenopausal or postmenopausal women, and cystectomy can be performed only in young women.[6,11]

Conclusion

Ovarian fibroids are benign tumors rare; their diagnosis is based primarily on clinical and radiological explorations including ultrasound is the first-line examination completed in some cases by resonance imaging magnetic. However, the definitive diagnosis is histological. Surgical removal of these solid ovarian tumors is recommended because of the low probability of malignancy.

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Availability of data and materials

Supporting material is available if further analysis is needed.

Competing interests

The authors declare that they have no competing interests.

Consent for publication

Written informed consent was obtained from the patient for publication of this case report and any accompanying images. A copy of the written consent is available for review by the Editor-in-Chief of this journal.

Ethics approval and consent to participate

Ethics approval has been obtained to proceed with the current study. Written informed consent was obtained from the patient for participation in this publication.

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