Giant fibrothecoma - an interesting case

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Summary

A 45-year-old woman came for specialized medical attention due to intraabdominal pathology that began in 2003. Studies indicated the presence of a cyst in the right ovary, for which she was referred for surgery. She did not undergo the surgery and for a period of two years she suffered from an excessively enlarged abdomin. Posterior ultrasound studies indicated the presence of fibromatosis and she was again referred for surgery. Laparatomy was carried out and a giant cyst was found in the right ovary attached to the omentum, intestine, appendix, posterior side of the abdominal wall and to the uterus. We proceeded to remove the cyst and successively total abdominal hysterectomy and bilateral salpingo-oophorectomy were performed. Post surgery, the patient progressed well taking pertinent prophylatic measures. The histopathology report diagnosed a giant fibrothecoma weighing 30 pounds, together with endometrial hyperplasia and leiomyomas. The international literature reports that the incidence of these tumors is low, 5% of ovarian tumors, and even lower for functioning tumors as in this case.

Key words: Giant fibrothecoma; Diagnosis; Management; Evolution.

Introduction

Fibrothecomas are benign neoplasias which belong to the estrogenic group of sex cord tumors with differentiation in fibroblastic or Theca cells. The incidence is low and represents less than 5% of all ovarian tumors.

These tumors were first described in 1982 and as non lobular diffuse androblastomas. Young and collagues reported 36 cases of these tumors. Keitoky *et al.* in 1997 published nine cases of these tumors [1].

The World Health Organization (WHO) recognized these tumors and classified them as fibrothecomas [2, 3].

Case Report

Clinical history

A 45-year-old female patient, gravida 3, para 3, from Panama City came under our care. She had a history of cardiac antecedents in early childhood but had a normal adolescence. She smoked, did not have allergies but a secondary pulmonary pathology due to smoking. She experienced menarche at the age of 16, and her menstrual cycle lasted seven to 15 days with frequent irregular bleeding.

After her last pregnancy in 1980 an intrauterine device (Copper T) was inserted and soon afterwards (the same year), she had a partial bilateral salpingo-oophorectomy.

She had had check-ups in health centers, with annual cervical smears but had never had an ultrasound. Her last menses were in February 2005 and she was in menopause.

Recent clinical history

The patient was seen at Chemsa Foundation on March 17, 2005 with a record of progressive and significant abdominal girth initiating in 2003, after staying in a rehabilitation center for narcotic consumption. There, she gained weight, which she lost when she left the institution because she started to use drugs again. Despite the weight loss, she still had a large abdomenal girth which continued to increase as if she was pregnant but without any other symptoms or pain. She went to a health center where the doctor requested an ultrasound study. The study was performed at Santo Tomás Hospital and revealed an ovarian tumor. The patient was then referred to the preoperative clinic of Santo Tomás Hospital but she did not go.

In 2004 she went to another health center because of the constant asymptomatic abdominal increase. She underwent a new ultrasonographic study which showed diagnostic ovarian fibroma but she once again refused treatment.

In March 2005, she was admitted to a private hospital/clinic because she had difficulty breathing and even walking. She was again referred to Santo Tomás Hospital, where she was evaluated. In spite of the dysnea and her 8-month pregnancy-compatible abdomen, she was scheduled for a hysterectomy on July 20, 2005, three months later.

She returned to the hospital/clinic on March 17, 2005 to undergo general exams:

– Pelvic ultrasound indicated a large solid abdominopelvic mass with a heterogenic pattern considered as diffuse uterine fibromatosis.

– Thoracic radiography showed atelectasis in the base of the right pulmonary lobe with decreased right pulmonary volume. She did not present pneumothorax or hypertension and the left pulmonary space was normal.

– Electroencephalogram revealed nonspecific abnormality in the anterolateral area. Cardiologic consultation indicated that she did not have any contraindications for surgery.

– Laboratory results showed: hemoglobin 11.1 g, hematocytes 35.5%, leucocytes 7,970 and normal differentials, negative VDRL, type and Rh A negative, TPT 32/31 sec and TP 14/13 sec.

The abdomen contained a 20-cm mass, and after reviewing the laboratory and other exams, we agreed to perform the surgery, Hysterectomy together with total abdominal hysterectomy with bilateral salpingo-oophorectomy was scheduled for March 21, 2005.

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Fig. 1

Fig. 2

Fig. 3

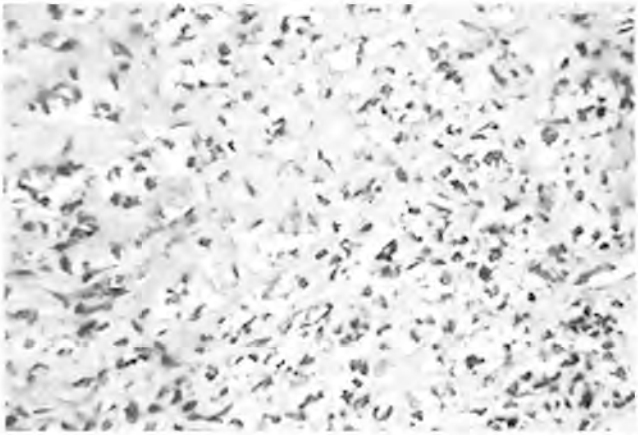

Fig. 4

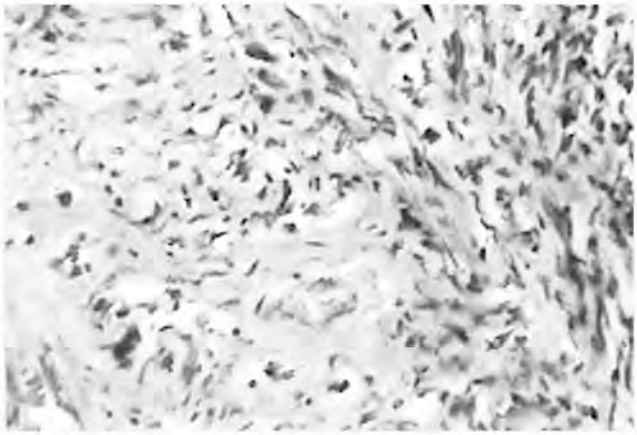

Figure 1. — Well defined encapsulated ovoid mass (25 x 23 x 13 cm - 13.9 kg).
Figure 2. — The sectioned mass shows a yellowish white cut surface intermixed with cystic and hemorragic areas.
Figures 3 and 4. — The sections show zones with fascicles of spindle cells with centrally placed nuclei and a moderate amount of pale cytoplasm. They are interchanged with closely packed spindle stromal cells arranged in a "feather-stitched" or storiform pattern. Mysoid changes and cystic degeneration are also noted.

Hospital admission

The patient was admitted on March 21, 2005 at 8:00 a.m. and surgery was initiated. The patient was submitted to epidural anesthesia and the abdomen was incised with a medial cut going a little further than the umbilical scar. Immediately the cut was extended until the mesogastrium because of the dimensions of the mass, which turned out to be a giant ovarian tumor adhering to the uterus, internal abdominal wall, small intestine, appendix and peritoneum.

As a consequence of the finding we decided to proceed with surgical intervention to free the mass from the peritoneal wall (visualizing both ureters in its route), the peritoneum, and the intestine. Hemostasis was performed because of excessive multiple blood vessels connected to the ovarian mass.

In order to carry out the hysterectomy, we proceeded with the extraction of the ovarian tumor in its total and integral form, and thus hysterectomy was successfully achieved without any complications. We closed the cupule and the Penrose drain was left in the cavity and then the incision was closed in planes. We left the Foley catheter and the Levin tube was not placed until later. The surgery lasted about two hours and 45 minutes. Antibiotic treatment was started 1 g keflin of and dicynone IM; blood (500 cc) was transfused. Demerol (75 mg) every four hours and primperan IV every eight hours were prescribed for nausea or vomiting. Post transfusion hemoglobin resulted to be 10.8 g five hours after surgery.

Arterial pressure was between 130/70 and 100/60 and post surgical urination was good (between 1,000 and 1,400 cc). The patient had no febrile temperature at any time after surgery.

The second day the Foley catheter was removed but the intravenous tube was maintained because the patient could not have any food orally. The antibiotic was replaced with 80 mg of garamycin every 12 hours.

The third day the patient started liquid feeding and she tolerated it very well. The Penrose was removed and the patient progressed well.

On March 24, the fourth day after surgery, she was released from hospital.

Postoperative course

The stitches were removed seven days after surgery and the surgical scar was in a good state as was the patient's general condition.

On July 13, 2005 the patient returned to the hospital in a healthy state and good mood. Her blood pressure was 130/80 and she weighed: 53.5 kg, which in comparison to her weight before the surgery, shed had regained about 13 kg. The patient indicated to us that she had a normal appetite and food tolerance with normal intestinal habits. Physical examination that her condition was satisfactory. Follow-up was recommended to the patient.

Histopathology

She histopathology report confirmed endometrial hyperplasia with simple atypia and residual hyperplasia of the stroma, intramural leiomiomas, and the right ovary with a fibrothecoma weighing 13.9 kg and 25 x 23 x 13 cm. An immunohistochemical study was recommended for verification of the diagnosis but after consultations with other pathologists, this recommendation was discarded.

Discussion and Conclusion

Fibrothecoma is a low-incidence tumor, accounting for less than 5% of all ovarian tumors [4, 5].

Appears in middle age, has unilateral characteristics and is usually benign with a good prognosis after surgery. This case was a typical fibrothecoma which we considered it as giant because of the dimensions and weight. Fortunately, due to the capsule's integrity, no serious complications occurred in the intestinal and pulmonary apparatus [6].

This case is interesting because the international literature does not report any other case of fibroma like this one- with these dimensions and weight. Thus, we consider this case to be a very useful contribution to the literature.

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