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Large Bilateral Serous Cystadenofibroma Ovaries with Bilateral Torsion with Coincidental Pulmonary Tuberculosis - A Case Report

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Abstract

Background- *serous cystadenofibroma of ovary is a rare, benign epithelial tumour, reported between 15-65 years. It has both epithelial and fibrous stromal components which appears as complex, with solid and cystic components often mimicing malignant tumours.*

A 15 years old female presented with complaints of pain abdomen and distension since 6 months. Per abdominal examination revealed a huge abdomino pelvic mass extending upto xiphisternum, regular and smooth surface, firm in consistency, restricted mobility. Ultrasonography, tumour markers and magnetic resonance imaging revealed a complex bilateral ovarian cyst. A provisional diagnosis of bilateral ovarian cysts was made and on exploratory laparotomy was done. Intra operatively 4 litres of straw colored fluid is drained from larger cyst and bilateral cystectomy done and sent for histopathological examination and it revelead serous cystadenofibroma of ovaries

Key words: *Serous cystadenofibroma, magnetic resonance imaging, histopathological examination.*

Introduction

Benign epithelial tumours are most common neoplasms of ovary including subtypes as serous, mucinous, endometroid, clear cell and transitional cell types along with co-existence of two or more types.

Surface epithelial tumours are 90% out of all ovarian tumours of which serous are 46%. Sex cord stromal tumours account for 8% of ovarian tumours in which fibroma is the commonest accounting to 70%.

Ovarian serous cystadenofibroma is a rare benign epithelial neoplasm containing epithelial and fibrous stromal components and is seen in women of 15-65 years. It is a combination of solid and cystic components and show pappilary projections and these are usually slow growing tumours.

Case Report

A 15 years unmarried girl presented to gynaecological out patient department at mmimsr, mullana, ambala with complaints of pain and distension of abdomen since 6 months, associated with history of constipation since 6 months. No history of loss of appetite and weight. There was history of contact to known case of tuberculosis at home, and her mother had history of paraovarian cyst removal along with caesarean hysterectomy in view of placenta accreta 6 years back.

On examination patient was moderately built with bmi of 23.2kg/m2.age of menarche is 13 years and her menstrual cycle were regular. Her vitals are stable, no history of fever. Per abdomen examination revealed a mass of size corresponding to 32 weeks height of uterus, tense, cystic in consistency, with smooth surface, non-tender, stretching the overlying skin, mobility was restricted. Fluid thrill is present. Pelvic examination not done.

Contrast enhanced magnetic resonance imaging revelead a large well defined unilocular abdomino-pelvic cystic lesion measuring 25.5 x 21 x 19 cm extending inferiorly into hypogastric region, superior to uterus and urinary bladder with indistinct intervening fat planes. However no gross mucosal invasion is seen. Few tiny papillary projections measuring 2-3mm are seen along its walls with some along posterior and lateral walls. Mass is abutting anterior abdominal wall. Gut loops are displaced towars periphery by lesion. Superiorly it is seen extending till epigastic region, posteriorly abutting major retroperitoneal vessels and psoas muscle at places without any evidence of gross invasion.

Another similar cystic lesion measuring 9.4 x 8.1 cm is seen in the cul- de -sac, posterior to uterus. Left ovarian tissue is seen abutting the lesion at its left antero aspect. Few small pappilary projections are also seen along its left anterolateral aspect. It is closely abutting rectum at places without any evidence of mural invasion.

Uterus is normal in size, endometrial thickness measures 13mm with no focal lesions. No free fluid is seen in abdomen with no evidence of significant lymphadenopathy seen a provisional diagnosis as per mri was ? Bilateral exophytic ovarian epithelial tumours.

Routine pre-operative investigations (CBC, RFT, LFT, RBS, PT/INR, HHH, chest X Ray, ECG) and tuberculosis work up was done, as ESR of 80mm and her sputum for CBNAAT is positive later on a provisional diagnosis of bilateral large ovarian tumours was made and she was planned for exploratory laparotomy under general anaesthesia, abdomen opened with midline vertical incision intraoperatively, on naked eye examination on opening the abdomen a large serous cyst with smooth surface bulging

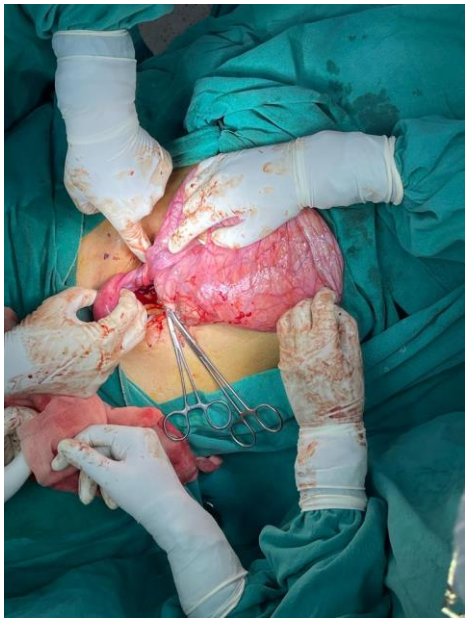
through the incision extending upto diaphragm touching undersurface of liver and spleen, on pelvic pole- uterus is beffy red, congested upto 8 weeks size.

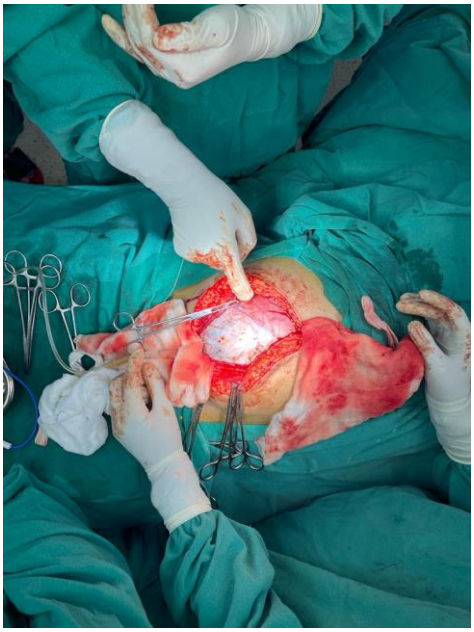
A large cyst of size 25 x 20 x 20 cm arising from the edge of right ovary with smooth vascular surface, stretching the fallopian tube to a length of 25cm on the cyst anteriorly from the right cornua. Fimbrial end is at the level of epigastrium. Cyst wall is 2-5mm thick. Over the anterior surface at cranial pole is an oval shaped area, which is thinned out to 0.2 to 0.5mm, about to rupture. Approx 3.5 litres of straw coloured fluid was aspirated with laproscopy aspiration needle slowly with no expulsion into peritoneal cavity right side cyst pedicle consisting of ovarian ligament, round ligament and fallopian tube and has two loops of torsion, however ovary was healthy torsion undone, right salpingectomy and cystectomy and sent for frozen section.

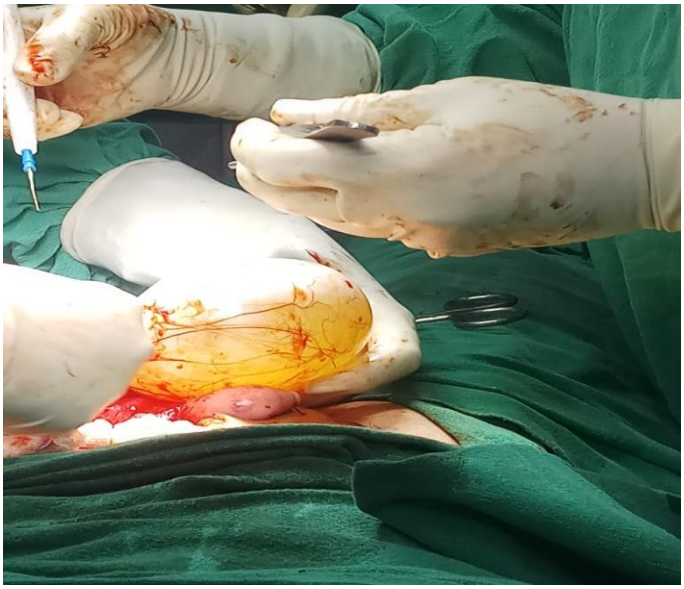
Another cyst of size 10 x 10 cm lying in pouch of douglas arising from mesosalpinx stretching left fallopian tube had one loop of partial torsion, cyst was enucleated bilateral ovaries are normal before abdomen closure, uterus is pinkish in colour, nulliparous size.

The specimen fluid was sent for ADA, cytology and CBNAAT and spicemen frozen section and histopathology shows fibrocollagenous cyst wall lined by columnar epithelium with uniform nuclei, the lining epithelium shows papillary infolding at multiple foci with hyalinized core suggestive of right ovarian and left paraovarian serous cystadenofibroma.

Cystic fluid shows lymphocytes in proteinaceous background. Her post -operative period was uneventful and discharged on anti-tubercular drugs. On her follow up visits, she is doing well with no recurrence and gained 2 kgs weight in 1 month







Discussion

Benign serous cystadenofibroma of ovary is common between age of 15-65 years. It is a rare tumour before 16 years of age characterised by presence of glands with serous epithelial cells and intervening fibrotic stroma. It presents as single mass, rarely as multiple masses within a single ovary or very rarely affecting both the ovaries.

These tumours have unknown etiology but mostly occurs spontaneously and diagnosed on histopathology.

These usually present as painless, regular, well-defined lesions in ovary mimicing serous cystadenoma or malignant neoplasms.

Complications though rarely encountered but dreaded include rupture and torsion.

The treatment is complete surgical removal either by open methods or laproscopy which gives excellent prognosis with almost no recurrence

Conclusion

Serous Cystadenofibroma of Ovary is a benign neoplasm with excellent prognosis after complete surgical removal with low recurrence risk and our interest to publish this case is due to its rare encounter in bilateral ovaries in gynaecological literature in 15 years age old girl.

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