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Abstract

Ovarian cystadenofibroma is a rare benign tumor comprised of both epithelial and stromal components. It is one the unique tumors which is usually mistaken for malignancy on imaging because of partly solid and partly cystic appearance. Frozen section and subsequent histopathological examinations play a vital role in arriving at definite diagnosis and thus avoiding unnecessary extensive surgical procedure. We described a case of bilateral ovarian cystadenofibroma in a 64 years old female with the clinical impression of malignancy and posted for radical surgical procedure.

Keywords: cystadenofibroma, bilateral, malignant, ovary

Introduction or Background:

Ovarian cystadenofibromas are uncommon tumor of admixture of mullerian epithelium and stroma, both benign in nature. Unlike cystadenomas which are a common ovarian tumor, cystadenofibromas are rare with an overall incidence of 1.7 % of all ovarian tumor. On imaging modalities like Ultrasonography, Computed tomography and Magnetic resonance imaging, it has posed diagnostic challenges by mimicking malignancy due to complex solid cystic components.

Case Presentation:

A 64 years old postmenopausal female, known case of hypertension, diabetes, dyslipidemia, peripheral vascular disease presented with vague abdominal pain and discomfort since 6 months on and off and aggravated since 1 month. Her family history was negative for any malignancy. On examination, her vitals were normal. Her blood sugar level and lipid profile were controlled. Serum concentration of Cancer antigen 125 (CA 125), was slightly raised i.e 41 units/ml. (The reference range 0–35 units/mL). On Ultrasonography, the left ovary shows a well-defined solid cystic mass with turbid contents and thickened wall, measuring 4.5 x 3.5 cm. The right ovary shows a well-defined solid cystic multi-loculated thickening. The left ovary measuring 6 x 5 cm.

Figure 1: Ultrasonography of Pelvis showing (a) Right ovary showing multi-loculated cystic lesion with thick wall (White arrow) measuring 6 x 5 cm, (b) Left ovary showing well-defined cystic lesion with thickened wall and turbid content (Black arrow) measuring: 4.5 x 3.5 cm.

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walled mass measuring 6.0 x 5.0 cm (Figure 1). Uterus was normal and there was no ascites. No evidence of metastatic disease in pelvis or abdomen. Computed Tomography reveals both ovaries appearing bulky with bilateral ovarian complex cyst, largest seen on the right side measuring about 6.0 x 5.0 cm. (Figure 2) Provisional diagnosis of invasive malignancy was rendered because of solid cystic appearance on imaging. Also intraoperative impression was of malignancy. Frozen section was done to solve this diagnostic dilemma and further modify the course of surgery. It confirmed bilateral ovarian serous cystadenofibroma. Subsequently bilateral salpingo-oopherectomy was performed. Peritoneal washing was also done which was negative for atypical cells. Gross examination reveals bilateral ovarian cystectomy specimen, measuring right side 6 x 5 x 3 cm, and left side 4.5 x 3.5 cm, partly cystic and partly solid, weighing 51 gm and 48 gm respectively. External surface shows focal area of congestion and focal nodular appearance with intact capsule. (Figure 3) Cut section reveals a multiloculated cyst with septations, drains hemorrhagic fluid with focal solid area. (Figure 4) Microscopic examination shows benign endometrial-type epithelium covering broad papillary fronds of stroma; at places papillae are cleft-like and project intraluminally (Figure 5). Also small tubular glands embedded in fibrous stroma were seen (Figure 6). A diagnosis of bilateral ovarian cystadenofibroma was rendered. The patient tolerated the procedure well and is regularly followed up.
of bilaterality. Tumor markers like CA-125 are usually normal or mildly elevated.\(^{1,2,3}\) On USG and CT Scan, it reveals multiloculated solid cystic component appearance with increased vascularity in 50% of cases.\(^{3,4}\) MRI shows low signal intensity on T2 weighted sequence and black sponge effect. Nevertheless, the distinction between benign and malignant tumor remains difficult even after the above described imaging modalities as quoted in literature by Cho. \textit{et al} in his study of 16 cases.\(^{3,4}\) Frozen section plays pivotal role in arriving at the diagnosis before radical surgery is performed.\(^{1,2,3,4,5,6}\) On gross examination, the ovaries are enlarged with size from 1 cm to 20 cms with a mean of 9 cms. It is usually partly solid and partly cystic, however only solid component has been also reported in literature.\(^{1,2,7}\)

Microscopic examination reveal either small tubular glands embedded in fibrous stroma or benign low cuboidal endometrioid type lining epithelium covering broad papillary fonds of stroma. The mesenchymal component shows benign appearing cells with an endometrial stromal or fibroblastic morphology. No atypia or mitosis is documented.\(^{1,2,5,6}\) When compared with cystadenoma, the latter have slender, delicate papillae and rarely shows hyalinization\(^{1}\) On histopathology the differential to be considered is low grade endometrial sarcoma which show increased stromal cellularity with periglandular stromal cuffing, stromal atypia and mitotic figures \(>2 \text{MF/10 hpf}.)\(^7\)

Rarely, it presents with unusual clinical scenario. Complications like torsion or haemorrhage may developed in the cyst which may present as acute abdomen. Mechera R \textit{et al}., reported a case of large bowel obstruction due to a large benign ovarian cystadenofibroma in a 60–year–old lady with Klippel Feil syndrome.\(^8\)

The Mullerian origin of cystadenomas is quite discernable as it has both ovarian surface epithelium and cortical stromal components.\(^2\) The treatment of choice is complete surgical excision as was achieved in index case. The prognosis is excellent.\(^{1,2,3,4,5,6,7}\) This tumor is invariably benign with no metastatic potential.\(^7\) Therefore it is utmost importance for clinicians to be cognizant of this unique tumor as it mimicked malignancy preoperatively as well as intra operatively and hence can avoid unnecessary radical surgery.

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References


