Journal Homepage: -www.journalijar.com

INTERNATIONAL JOURNAL OF ADVANCED RESEARCH (IJAR)

Article DOI:10.21474/IJAR01/18328
DOI URL: http://dx.doi.org/10.21474/IJAR01/18328

RESEARCH ARTICLE

FIBROTHECOMA: CLINICAL, RADIOLOGICAL AND IMMUNOHISTOCHEMICAL DATA ABOUT AN OBSERVATION

I. Traoré, S. Boudhas, K. Saoud, N. Mamouni, S. Errarhay, C. Bouchikhi and A. Banani
Service de Gynécologie Obstétrique I CHU Hassan II, Faculté de Médecine, de Pharmacie et de Médecine Dentaire, Université sidi Mohammed Ben Abdellah, FES.

Manuscript Info

Manuscript History
Received: 26 December 2023
Final Accepted: 28 January 2024
Published: February 2024

Key words:-
Fibrothecoma, Rare Tumor, Ovary

Abstract

Fbrothecomais a benigntumor of the sexcords of the ovary, from the fibrothecal group. These are rare tumorsthatgenerallyoccur in postmenopausewith a good prognosis and rare cases of fibrothecoma cancer have been reported. We report a case of fibrothecoma in a patient in genitalactivitywithouthistory in the obstetrics and gynecologydepartment CHU Hassa II Fez Morocco. The interest of this case isits occurrence in a patient withgenitalactivity.

Introduction:-

Ovarianfibrothecomais a rare and benignneoplasm of the sexualcords and stroma of the ovary, usually ocatedunilaterally in the ovary. It has mixed features of fibroma and thecoma. Patients maybeasymptomatic, or presentwithpelvic abdominal pain and/or distension, and sometimesbleedingaftermenopause [1].

Thesesexcordstromaltumors are classifiedintothreecategories, namely pure stromaltumors, pure sexcordtumors and mixed sexcord-stromaltumors. Among pure stromaltumors, fibroids and thecomas have both been defined. An additionalsubtype, fibrothecoma, containselements of bothpreviouslymentionedsubtypes to varyingdegrees. Becausethissubtypelacks strict identifiers and objective measures for classification, the fibrothecomasubtype has not been officiallynamed by the WHO [2].

The vastmajority of documented fibrothecomas have been observed in elderlyperi-menopausal patients withtwo case reports of fibrothecomasoccurring in adolescents [3].

Patient and Observation:-

Patient information:
This is Mrs. I. B. Patient, 38 yearsold, withoutany notable surgicalmedicalhistory, barelypared, still in good health. Presentingchronic abdominal pain promptinghis consultation associatedwith an increase in abdominal volume.

In whom the clinicalexaminationfinds a conscious patient stable on the HD and afebrilerespiratorylevel, and in whom the gynecologicalexaminationfinds a right lateraluterine mass slightly tender to palpation.

Clinicalresults:
Conscious patient, hemodynamically and respiratory stable, afebrile.

Corresponding Author:- I. Traoré
Address:- Service de Gynécologie Obstétrique I CHU Hassan II, Faculté de Médecine, de Pharmacie et de Médecine Dentaire, Université sidi Mohammed Ben Abdellah, FES.

Gynecologicalexamination:
Speculum:
Macroscopically normal cervix, no externalbleeding, no pathologicalleukorrhea.

Vaginal examination:
Cervix of normal consistency, uterusdifficult to assess, slightlateraluterinesensitivitybilaterally.

Abdominal examination:
Abdomen enlarged, palpation of a slightly hard mass, appearance of pain on palpation.

Therapeutic intervention and follow-up: wecarried out:
- Pelvicsubpubic and endovaginalultrasound
Normal sizeduterus, no myoma or signs of adenomyosis.
Presence of a leftovarian mass with double solidocystic component measuring 17x10 cm not takingcolor Doppler encoding.
Right ovarywithoutparticularity.
Absence of effusion.
- Thorax abdomen pelvis scanner
Large pelvicsolid-cystic mass, requiringcomparisonwithpelvic MRI data for bettercharacterization.
- Pelvic MRI
Large pelvic mass, inter utero-rectallyappearing to beat the expense of the leftovary, initiallysuggesting a reworkedovarianfibrothecoma.
Wedecided to perform a laparotomywith exploration.
• Presence of lowabundance ascites aspirated for cytologicalstudy
• Presence of a solidpolylobedleftovarian mass withsmoothwallmeasuringapproximately 20*10 cm withoutanarchicvascularization or exocystbuds.
• Normal sizeduterus
• Unremarkable right appendix
Carrying out a leftadnexectomy, biopsy of the colonicparietalgutters and the omentum.

Anapathpost surgery
- LEFT ANNEXECTOMY
Spindlecelltumorproliferationinitially suggestive of a stromaltumor.
An immune histochemicalstudyisnecessary to support the diagnosis.
- LEFT GPC
Substantially normal fibrofatty tissue.
- RIGHT GPC
Substantially normal fibrofatty tissue.
- OMENTOMECTOMY
Substantially normal fatty tissue.

IHC complement
Histological and immune histochemicalappearance of a fibrothecoma.

Monitoring and results
Clinical and ultrasoundfollow-up of the patient wascarried out at 3 monthsthenat 6 months and 12 months. Unremarkableclinicalexaminationwith absence of functionalsigns.

Discussion:-
Of variable size, mostoften 5 to 10 cm in diameter, itisgenerally a solid, yellowishtumor, rarelypresentingfoci of necrosis or hemorrhage, bilateralin 3 to 5% of cases [4].

They are responsible for hyperestrogenism in at least 60% of cases [5], exceptionallyvirilization.

The treatment of thecaltumorsisbased on simple oophorectomy, given the lowmalignantpotential, but withsystematic biopsies of the endometrium in order to eliminateneoplasia [4].

Thecomapresentsaftermenopausein 65% of patients. It isusually one-sided and varies greatly in size. It has awell-defined capsule and a firmconsistency. The cut surface islargely or entirelysolid, but cystsmaybepresent. It has a yellowcolor, an important feature in the differentialdiagnosiswithfibroma (Fig.1). Microscopically, it is composed of bundles of spindle-shapedcellswithpoorlydefinededges, centrallyplacednuclei, and a moderateamount of pale grayish-pinkcytoplasm.

The intervening tissue may show considerablecollagendeposition and focal hyaline plaque formation. The degree of cellularity varies considerably. Sometumors in youngwomen are heavilycalcified [6.].

WithOilRed O, thecomacells show abundantintracytoplasmicneutral fat, and silver spots typically show reticulinfiberssurroundingindividualcells (as opposed to granulosa celltumor, in whichreticulinsurroundsclumps of cells). The differentialdiagnostic iswith a luteinizedadult granulosa tumorcanbedifficult; FOXL2 mutationalanalysismaybeuseful in such cases, with the presence of a mutation supporting the diagnosis of adult granulosa celltumor [7].

Ovarian immune histochemicalanalys is evealsthat 17 betahydroxysteroiddehydrogenase (HSD) type 5 and 17-alpha-hydroxylase (OH) are expressed in thecalcellsexplainingtestosteronesynthesis. Aromataseisveryweaklyexpressed in a few cells [8].

Of variable size, mostoften 5 to 10 cm in diameter, itisgenerally a solid, yellowishtumor, rarelypresentingfoci of necrosis or hemorrhage, bilateralin 3 to 5% of cases [4].

They are responsible for hyperestrogenism in at least 60% of cases [5], exceptionally for virilization. The treatment of thecaltumorsisbased on simple oophorectomy, given the lowmalignantpotential, but withsystematic biopsies of the endometrium in order to eliminateneoplasia [4].

The intervening tissue may show considerablecollagendeposition and focal hyaline plaque formation. The degree of cellularity varies considerably. Sometumors in youngwomen are heavilycalcified [6].

Conclusion:-

Fbrothecomais a rare benigntumorgenerallyencounteredaftermenopause. Our study has justshownthat cases of fibrothecomascanbefound in patients withgenitalactivitywithclinical, radiological and immune histochemicalspecificities. The latter do not interferewith the treatmentwhichremains the surgicalresection of the tumortaking over the ovary.

Conflict of interest

The authorsdeclare no conflict of interest.

Author contributions

All authorsread and approved the final version of the manuscript.

Références:-

1. https://www.orpha.net/consor/cgi-bin/OC_Exp.php?lng=FR&Expert=314478 consulté le 11/06/2023
2. Chen H., Liu Y., Shen L.F., Jiang M.J., Yang Z.F., Fang G.P.: Ovarianthecoma-fibroma groups: clinical and sonographic features with pathological comparison. J OvarianRes2016; 9: pp. 81
3. Chechia A., Attia L., Temime R.B., Makhlouf T., KoubaaA.: Incidence, clinicalanalysis, and management of ovarianfibromas and fibrothecomas. Am J ObstetGynecol2008; 199: pp. 473. e1-4Schoolmeester J.K., Erickson L.A.: Ovarianfibrothecoma. Mayo Clin Proc 2019; 94: pp. 1652-1653
4. Aiman J. Virilizingovariantumors. ClinObstetGynecol1991 ; 34 : 835-847
5. Young RH, Scully RE. Endocrine tumors of ovary. Curr Top Pathol1992 ; 85 : 113-164
6. Young RH, Clement PB, Scully RE. Calcifiedthecomas in youngwomen. A report of four cases. Int J GynecolPathol. 1988;7:343-350
7. Kommoss S, Gilks CB, Penzel R, et al. A current perspective on the pathologicalassessment of FOXL2 in adult-type granulosacelltumours of the ovary. Histopathology. 2014 ;64 :380-388

8. A.Bontouxa et al; Fibrothécome ovarien bilatéral et sécrétant responsable d'une hyperandrogénie post-ménopausique : données cliniques, hormonales, radiologiques et immunohistochimiques à propos d'une observation; Annales d'Endocrinologie 79 (2018) 250–259.