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SEROUS OVARIAN CYSTADENOFIBROMA AND REVIEW OF THE LITERATURE: REPORT OF A CASE

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ABSTRACT

Ovarian cystadenofibroma is a relatively rare benign ovarian tumor[1] that arises from germ lines and ovarian stroma. This tumor can be solid, cystic or semi-solid, depending on the fraction of epithelium and stroma it contains and the secretory activity of the epithelium that composes it. We report the case of a 66-year-old multiparous patient consulted for pelvic pain where an MRI was requested, objectifying the presence of a mass of ovarian origin. The postmenopausal patient since the age of 55, not taking hormone replacement therapy. She presented as comorbid arterial hypertension for 6 years under treatment. The preoperative ultrasound showed a left solidocystic mass of ovarian appearance, finely echogenic, site of endocystic vegetation, measuring 7.58 mm x 6.20 mm long axis.

INTRODUCTION

Ovarian cystadenofibroma is a relatively rare benign ovarian tumor[1] that arises from germ lines and ovarian stroma. This tumor can be solid, cystic or semi-solid, depending on the fraction of epithelium and stroma it contains and the secretory activity of the epithelium that composes it.[2] Ovarian cystadenofibromas can present as malignant tumors, posing the

problem of adjusting surgical treatment. We present a case of cystadenofibroma in a 65-year-old patient with no particular pathological history.

OBSERVATION

A 66-year-old multiparous patient consulted for pelvic pain where an MRI was ordered, objecting to the presence of a mass of ovarian origin. The postmenopausal patient since the age of 55, not taking hormone replacement therapy. She presented as comorbid arterial hypertension for 6 years under treatment. The preoperative ultrasound showed a left solidocystic mass of ovarian appearance, finely echogenic, site of endocystic vegetation, measuring 7.58 mm x 6.20 mm long axis. With the presence of low-abundance effusion, the mass was non-vascular on Doppler, the contralateral ovary was without abnormalities (Fig. 1-2). Preoperative pelvic MRI supported the hypothesis of a unilateral primary ovarian tumor without visible lymphadenopathy in contact with the iliac and lumbo-aortic vessels. Pelvic MRI described a well-limited left latero-uterine mass measuring 77x45x61mm, solido-cystic, with the presence of endocystic vegetation, enhanced after injection of gadolinium, and effusion blade at the level of the Douglas-fir sac. Laparoscopic examination revealed a firm solid left ovarian mass, associating a cystic component. The right dinghy was normal in appearance and free from grip. A low abundance effusion was visualized. In the abdominal area, no sign of dissemination was seen. Faced with this aspect which seemed to allow exhaustive resection of the lesions and given the very probable diagnosis of ovarian cancer, a laparoconversion was undertaken. It made it possible to perform non-conservative extrafacial hysterectomy, submesocolic omentectomy, multiple peritoneal biopsies. The latter were performed without the need for the extemporaneous examination because of the body of arguments pointing to the malignancy leading to the wrong fear of the diagnosis of cancer. Pathological examination made the diagnosis of unilateral simple serous papillary cystadenofibroma. The examination of the other specimens intended for pathology was free from tumor or tumor cell.

Comments

The exact incidence of ovarian cystadenofibromas is poorly determined. However, it seems higher than that historically accepted.[1,3] Thus, Fatum et al. found this entity in nearly 8% of the 302 cystectomies or adnexectomies performed between 1995 and 2000.[4] Ovarian cystadenofibromas are most often of the serous type as in our patient, but they can also be of the endometrioid type, clear cell or mucinous.[2,5] They frequently appear in women aged 40

to 50 years, but they can affect younger women, especially when they have been exposed in utero to disthylbene.[6] These tumors are most often asymptomatic. When they are large, they are likely to cause pelvic pain, rectal emptying disorders, increased abdominal circumference or dysuria.[3,6-9] They can sometimes manifest as metrorrhagia or feminization which is believed to be secondary to the hyperestrogenia induced by the tumor.[8,10]

The mechanism underlying this hyperestrogenia is thought to be hypersecretion of the hormone by the tumor itself. For our observation, there were reasons to fear the hypothesis of cancer before the operation, both on the pelvic imaging data and on the history. Ovarian cystadenofibromas may exhibit several macroscopic features usually associated with ovarian cancer (thickened adenoids, septa and wall, suspicious intracystic fluid, anarchic vasculature of the ovarian cortex). It is therefore important for surgeons not to ignore the falsely worrying morphological aspect of these ultimately benign tumors. In such a context, we must therefore recall the value of an extemporaneous examination the management of an ovarian tumor suspected of malignancy. This should be asked if the tumor presents worrying macroscopic characteristics (adenoids, thick septa, suspicious intracystic fluid) and if the results of this examination are likely to modify the operating strategy. If this request for an extemporaneous examination is anticipated before the operation, the patient must be informed of any changes that her conclusions are likely to cause concerning the operating strategy (laparoconversion, bilateral hysterosalpingo-oophorectomy, lumboaortic and pelvic lymphadenectomies). In the case where the extemporaneous examination shows a border tumor of the ovary, maintaining the laparoscopic approach to complete the staging procedures seems sufficient.[10] However, in the event that the extemporaneous examination is not feasible or uncertain, the laparoscopic aspect described in this article should encourage the surgeon to postpone extensive first-line surgical treatment.

Conflict of interest

The authors declare no conflict of interest.

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Consent

Written informed consent was obtained from the patient for publication of this research study. A copy of the written consent of each patient is available for review by the Editor-in-Chief of this journal on request.

Figures

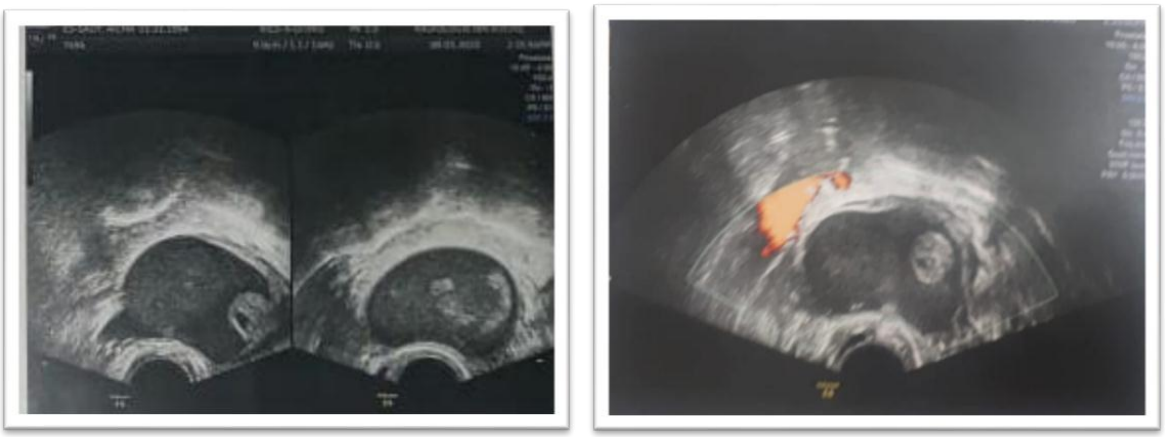

Figure 1-2: Left solido-cystic ovarian mass, not vascularized on Doppler.

Figure 3: Left solido-cystic ovarian mass on pelvic MRI, measuring 7 cm.

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