



Ovarian fibroma with cervical cancer in same patient: A case report

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Abstract:

Ovarian Fibroma is the commonest benign tumor of the ovarian sex-cord stromal (mesenchymal). These tumors are usually solid tumors and are usually seen in middle aged women and diagnosed by ultrasound or CT scan and confirmed by pathological findings. According to FIGO staging of cervical carcinoma, for IA2-IB-IIA2, are usually treated by surgical methods like Primary radical hysterectomy with bilateral salphingo-oophorectomy with or without pelvic node dissection and followed by chemo or radiation depending on the histopathological findings, if nodes are positive for malignancy.

Key words: Cervical cancer; Fibroid; Ovarian fibroma; Post menopausal bleeding; Radical hysterectomy

Introduction

Cervical cancer is the second most common cancer in women worldwide. The early stages of cervical cancer has been detected increasingly due to cytological screening programs. The main surgical intervention for these cases is by modified radical. Hysterectomy with pelvic node dissection according to clinical staging of the disease [2,3]. Ovarian Fibroma represents 4% of all ovarian neoplasm's, occurring mostly during peri and post menopausal women[1,4]. The degree of mitotic activity is the main parameter for cellular fibroma from Fibro

sarcoma[5]. Macroscopically, ovarian fibromas have whitish appearance resembling uterine leiomyomas.

Case report

A 46 year postmenopausal women came with history of bleeding per vaginum since 2 months. She attained menopause 6 years back. The bleeding was mild to moderate in flow, foul smelling. She changed about 2-3 pads per day. There is history of passage of clots and is associated with pain abdomen localized to lower abdomen; not radiating. Patient also has history of post coital bleeding since 3

months. There was no history of loss of weight, loss of appetite. Her past history and family history were not significant. Obstetric history – P3L3, last child was 22 years back. She is tubectomised. The General Examination was within normal limits, her height being 151 cm, weighing 57 kgs; with BMI of 24.9.kg/m² No pallor was present. On Abdominal examination, a midline mass was seen, palpable up to 14-16 weeks size, mild tenderness was present; hard in consistency, irregular surface, lower border could not be felt, mobility was restricted (vertical). No presence of free fluid; Bowel sounds were heard.

On speculum examination, bleeding per vaginum was present. A growth was seen arising from the cervical lips. Per vaginum examination showed, mass is arising from the cervical lips, hard in consistency, bleeds on touch, cervical movement is continuous with the abdominal mass, which was about 14-16 weeks in size. Per Rectal examination shows rectal mucosa and parametrium are free. The provisional diagnosis with the above history suggests fibroid uterus with carcinoma cervix IIA. Ultrasound examination reveals uterus is anteverted, bulky in size, 96x56x65mm. Endometrium is ill defined with ET 10mm. A large densely calcified globular mass of 15x13cm is noted occupying umbilical region arising from the fundus. Both ovaries appear normal. There is no evidence of ascites or pleural effusion seen. In view of postmenopausal bleeding with cervical growth, patient was posted for examination under anesthesia followed by cervical biopsy with fractional curettage. Finding of Examination under anesthesia; Per Abdomen- Mass was upto 14-16 weeks, hard in consistency, irregular surface, lower border well made out, mobile in all directions, uterus is about 8-10 weeks, felt separately from the mass. P/S- Bleeding present with clots, hard mass felt throughout the cervical lips which bleeds on touch, thickness is approximately about 2 to 3 cm. Cervical biopsy was done, uterine sound couldn't be passed for endometrial sampling to rule out endometrial involvement. Histopathology report showed stratified squamous epithelium with moderately differentiated squamous carcinoma of cervix

(Fig-1&2).Diagnosis at the moment suggests carcinoma cervix IIA1 with left ovarian tumor. With this histopathology report, type III radical hysterectomy with pelvic node dissection was planned. On opening the abdomen, a solid tumor about 12x10x8 cm, projecting from the left side of ovary and the right ovary was normal. Radical hysterectomy was done and no lymph node were involved (Fig-3). Post operatively patient did fine and well. Macroscopic findings: Left ovarian mass,

solid mass with 13x9x7 cms, external surface is nodular with solid grey-white to mucoid areas (fig-4). Uterus measure about 10x8x6 cms with proliferative growth 4x3 cm, involving both the cervical lips extending upto internal os (Fig-5). Uterus and the cavity were normal. The right ovary and both the fallopian tubes were normal. Microscopic findings: Cervix shows features of moderately differentiated squamous cell carcinoma; stroma shows dense lymphocytic infiltration involving full thickness of cervix. Ovary shows features of fibroma(Fig-6&7).

Discussion:

Ovarian fibromas constitute about 4% of all ovarian tumors [4]. Usually they are asymptomatic, when smaller in size, but larger tumors can cause symptoms ranging from vague discomfort to acute abdominal pain when associated with torsion. Fibromas are always benign, and when complicated with ascites and right sided hydrothorax, it is known as Meig's syndrome. The treatment for fibromas is excision, and the prognosis is good. In this case, the histopathology report confirmed carcinoma cervix and ultrasound showed big fibroid uterus, so surgery was planned. On opening the abdomen, the ovarian pathology was diagnosed and confirmed by histopathology as ovarian fibroma with carcinoma of cervix, which is rare. Cervical carcinoma incidence vary in women between 15-49 years can be as high as 60.6% [3]. The treatment of carcinoma cervix can be radical surgery, radiation therapy and chemotherapy or a combination of all the above methods. In young females, who have undergone surgery for carcinoma cervix where ovaries can be spared, but in older patient and patients who have completed their family, removal of the ovaries is advised.

Consent was taken from the patient regarding the publication of her case study.

Conclusion

In spite of early diagnosis of cervical cancer, CT&MRI has its own benefit in pre operative assessment of the disease. If the oncologist know about the extension of the disease, better decision can be made during the surgery.

Conflict of interest:

The authors declare that there are no conflict of interest

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Figure 1: Stroma shows dense lymphocytic infiltration along with necrosis

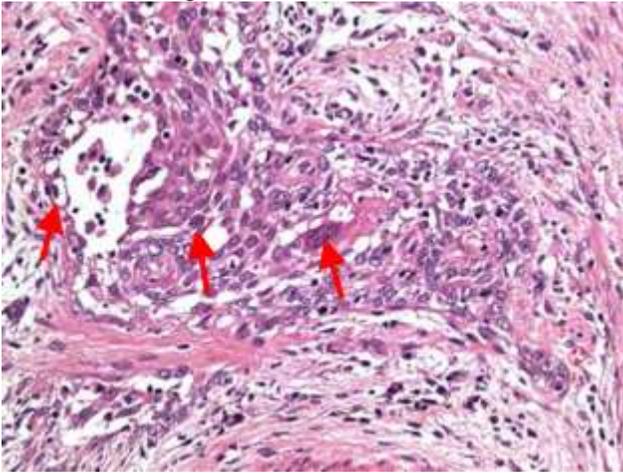


Figure 2: Tumor shows vascular emboli along with squamous cell carcinoma

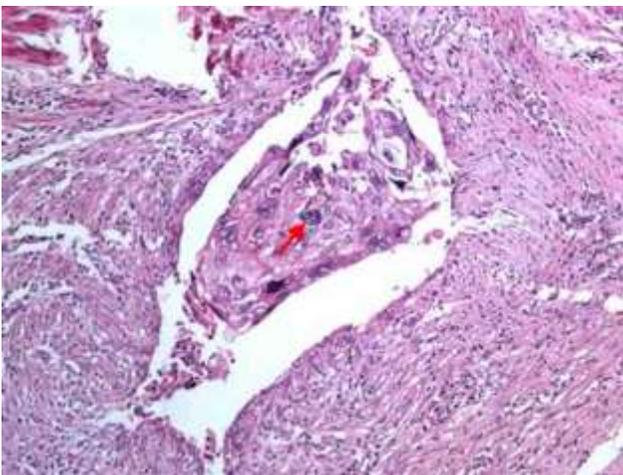


Figure 3: Uterus along with right and left ovary



Figure 4: Left ovarian mass shows solid white, irregular surface



Figure 5: Shows (A) cervical growth and (B) ovarian fibroma



Figure 6: Hypocellular tumor consisting of bundles of collagen fibres

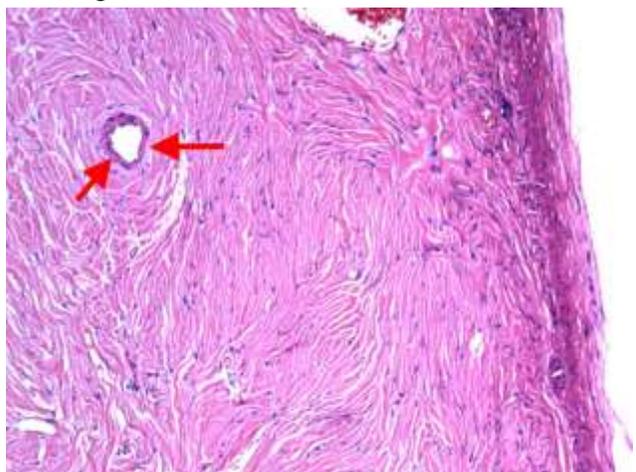
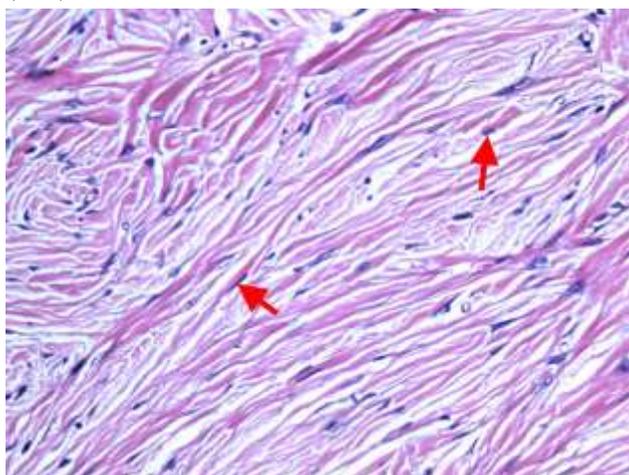


Figure 7: Spindle cells in between collagen fibres (40x)



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