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Laparoscopic management of a bilateral cystadenofibroma in a nulliparous female

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Abstract :
Ovarian cystadenofibromas are uncommon, benign neoplasm-containing epithelial and fibrous stromal components. They account for 1.7% of all benign ovarian tumours and occur in women aged 40-50 years. Because of their solid component and irregular thick septae, on imaging these masses are often misdiagnosed as malignant preoperatively. We present a case of bilateral cystadenofibroma in a nulliparous lady managed laparoscopically

Serous ovarian tumors comprise nearly 25 % of all ovarian tumors and mostly occur in adults. We present a case of b/l ovarian masses which appeared malignant peroperatively. However , microscopy revealed b/l cystadenofibromas. These are benign ovarian tumors often masquerading as malignant both radiologically and on gross appearance. They account for 1.7% of all benign ovarian tumours .[1] With use of frozen section patient was saved from a major surgery with preservation of her fertility.

Case report

A 25 yr old patient came with complains of pain lower abdomen for 3 days. She was married for 4 months and had no menstrual complains. Past history said that she had undergone a laparoscopic ovarian cystectomy 2 years back (Simple cyst-right ovary).Patient was clinically stable. Pervaginum examination revealed a normal sized uterus with a soft, mobile left adnexal mass nearly 6x5 cm in size. There was also some tenderness in the left fornix.A pelvic USG showed a complex 8 cm × 6.8 cm × 4.8 cm mass in the left adnexa with cystic component and thick septations. The left ovary could not be separately identified. Right adnexa looked normal.

Because she had pain, provisional diagnosis of ovarian cyst with torsion was made and she was

posted for a laparoscopy.

On laparoscopy, left ovary was the seat of a growth , 8x7 cm with which showed verrucous appearance and some intervening cystic areas . Similar smaller growth on right ovary was seen. Upper abdomen, bowel, liver surface appeared normal. Straw colored fluid seen in pelvis, sent for cytology. Frozen section taken from the lesions on both the ovaries was sent- it came as benign for both lesions. In view of the grossly malignant appearance of the lesion, frozen section report and the nulliparous status of the patient , it was decided to wait for the histopathology report and post a definitive surgery at a later date, after oncologist opinion. The definitive histopathology report came as benign serous cystadenofibroma of both the ovaries . Hence patient was posted for a laparoscopic resection of the tumor masses . B/L ovarian tumours were resected using harmonic scalpel. Right ovary contained a small simple cyst, cystectomy was done. Specimen was retrieved through a colpotomy. Colpotomy wound was sutured . Peritoneal cavity was cleaned by suction irrigation . Intraperitoneal drain was kept. Histopathology report showed low columnar epithelium with papillae embedded in dense fibrous stroma. , diagnosed as bilateral benign paillary cystadenofibroma, bilateral ovarian tumour resection. Patient was discharged on the second postoperative day.

Discussion

Ovarian cystadenofibromas are uncommon, benign neoplasm-containing epithelial and fibrous stromal components. They account for 1.7% of all benign ovarian tumours and occur in women aged 40-50 years. Because of their solid component and irregular thick septae, on imaging these masses are often misdiagnosed as malignant preoperatively. Even at the time of surgery, a cystadenofibroma may look like a malignant tumour. [2] Usually cystadenomas are lined by a single layer of flattened to cuboidal cells with uniform basal nuclei. However, cells can be pseudostratified and tubal in type with characteristic elongated (secretory cell) or rounded (ciliated cell) nuclei. Mitoses and atypia are absentbut is generally more fibrous.

Oedema is sometimes present. When the stroma is highly cellular and fibrous, the tumour can be designated as “adenofibroma”. However, ovarian

cystadenofibromas may have several macroscopical features of ovarian cancer (vegetation, thick-walled and anarchic vascularisation of the ovarian cortex) as was seen in our case. [3]

This case report also shows the significance of the availability of facility of frozen section in absence of which the gross malignant appearance and the bliaterality of the lesion would have resulted into a major surgery as described by Nisha M et al. [4]

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