Case Report

Ovarian fibrothecoma with minor sex cord elements: a case report

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ABSTRACT

Ovarian fibroma is the most common sex cord stromal tumour of ovary accounting to 1-5% of all ovarian tumours. Minor sex cord elements in ovarian fibroma are a rare entity occupying less than 10% of tumour area. To the best of our knowledge only 20 cases has been reported till date. This case is presented because of its rarity. Authors reported a case of fibrothecoma with minor sex cord elements in a 70yr old postmenopausal women who presented with postmenopausal bleeding with abdominal mass.

Keywords: Fibroma, Minor sex cord elements, Postmenopausal women, Sex cord stromal tumours

INTRODUCTION

Sex cord stromal tumours are group of tumours representing 8% of all ovarian neoplasm and are composed of granulosa cells, sertoli and leydig cells, thecal cells and fibroblasts either singly or in various combinations. Ovarian fibromas are the most common sex cord stromal tumours accounting to 1-5% of all ovarian neoplasms. Young and scully in the year 1983 first described the presence of minor sex cord elements in ovarian fibroma.

It is defined as the tumour with predominantly fibromatous or the comatous area containing scattered minor sex cord elements in less than 10% of tumour area on any slide and individual aggregate should not be more than 0.45mm. These cells form discrete tubules or small nests resembling granulosa cells, sertoli cells or indifferent cells of sex cord type either with or without steroid hormone production in spindled stroma.

CASE REPORT

A 70 yr old woman has come to our gynaecological department with history of postmenopausal bleeding with left adnexal mass. Her routine hematological investigation is normal with CA 125 levels of 39.43IU/ml. CT scan revealed a well defined heterogenous solid lesion measuring 6.5cm x 3.4cm in left adnexa.

She underwent total abdominal hysterecomy with bilateral salpingo opherecomy. Grossly uterus with cervix measured 10x8x6cm with bilateral tubes 4cm in length, left ovary 7x6x4cm with other ovary 2x2x1cm. Cut surface uterus revealed a polyp of size 1m arising from uterine fundus in endometrial cavity.

Left ovary was replaced by a tumour with solid, firm grey white mass. Microscopically the ovarian mass showed benign spindle shaped cells arranged in fascicles and in storiform pattern enclosing small aggregates of sex cord like elements occupying less than 10% of tumour area. These elements are arranged in tubular pattern. There are areas showing luetinization. Endometrium was in proliferative phase with polyp was a benign endometrial polyp. Solid firm homogenous mass with focal yellowish areas (Figure 1). Sheets of benign spindle cells arranged in fascicles and storiform pattern (4x H&E) (Figure 2). Small aggregates of sex cord like elements arranged in
tubular pattern embedded within the fibrothecomatous stroma (45x H&E) (Figure 3).

Figure 3: Sex cord like elements arranged in tubular pattern.

DISCUSSION

Ovarian stromal tumours with minor sex cord elements are a rare neoplasm which was first described by Young and Scully in the year 1983. It is defined as tumour with predominantly fibromatous or the comatous area containing scattered minor sex cord elements in less than 10% of tumour area on any slide and individual aggregate should not be more than 0.45mm. These cells form discrete tubules or small nests resembling granulosa cells, sertoli cells or indifferent cells of sex cord type with or without steroid hormone production in spindled stroma. They are polygonal cells with uniform nuclei and small amount of cytoplasm. The most common clinical symptoms are abdominal pain, bleeding per vaginum and adnexal mass. This case presented with history of postmenopausal bleeding. The average age groups affected are between 16-63yrs with median age of 59yrs.

Table 1: Comparison of ovarian fibroma with other tumours or tumour like conditions.

<table>
<thead>
<tr>
<th>Features</th>
<th>Fibroma with MSCE</th>
<th>Fibromatosis</th>
<th>Brenner tumour</th>
<th>Adenofibroma</th>
<th>Metastatic carcinoid</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spindled cells in fascicles and whorls</td>
<td>+</td>
<td>+</td>
<td>-</td>
<td>-</td>
<td>Extensive stromal proliferation</td>
</tr>
<tr>
<td>Collagen</td>
<td>Variable</td>
<td>Abundant</td>
<td>Variable</td>
<td>Variable</td>
<td>-</td>
</tr>
<tr>
<td>Normal ovarian follicles</td>
<td>Replaced by fibrous stroma</td>
<td>Preserved</td>
<td>-</td>
<td>-</td>
<td>Replaced by tumour cells</td>
</tr>
<tr>
<td>Small nests of undifferentiated sex cord cell type cells</td>
<td>&lt;10% of tumour area</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>Insular, trabecular, rarely solid pattern</td>
</tr>
<tr>
<td>Edema</td>
<td>-</td>
<td>+</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Epithelial nests of transitional/mucinous cells</td>
<td>-</td>
<td>-</td>
<td></td>
<td>-</td>
<td>Uniformly small round cells with clumped chromatin</td>
</tr>
<tr>
<td>IHC</td>
<td>Positive for inhibin, calretinin, CD99, CD56</td>
<td>Negative for inhibin and calretinin</td>
<td>EMA CK+</td>
<td>-</td>
<td>Chromogranin Synaptophysin CD56</td>
</tr>
<tr>
<td>Author</td>
<td>Age in yrs</td>
<td>Clinical features</td>
<td>Endometrial changes</td>
<td>Stromal component</td>
<td>MSC component</td>
</tr>
<tr>
<td>--------------</td>
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<td>-------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Mathur et al</td>
<td>52</td>
<td>Bleeding Per vaginum</td>
<td>Simple endometrial hyperplasia without atypia</td>
<td>Fibrothecomatous component</td>
<td>Poorly defined nests in solid, hollow tubules, cords</td>
</tr>
<tr>
<td>Mandal et al</td>
<td>45</td>
<td>Menorrhagia with incidental finding in normal sized ovary</td>
<td>Proliferative endometrium</td>
<td>Fibromatous component</td>
<td>Small aggregates of undifferentiated sex cord like cells with poorly defined tubular structures</td>
</tr>
<tr>
<td>Sujatha et al</td>
<td>52</td>
<td>Abdominal mass and pain</td>
<td>Simple endometrial hyperplasia with polyp</td>
<td>Fibrothecomatous component</td>
<td>Granulosa cells in micro &amp; macro nodular pattern</td>
</tr>
<tr>
<td>Kawatra et al</td>
<td>65</td>
<td>Postmenopausal bleeding with abdominal pain</td>
<td>Endometroid adenocarcinoma</td>
<td>Fibrothecomatous component</td>
<td>Uniform large cells with inconspicuous nucleoli in poorly defined nests or cords</td>
</tr>
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<td>Kumar et al</td>
<td>79</td>
<td>Postmenopausal bleeding with abdominal mass</td>
<td>Endometroid adenocarcinoma</td>
<td>Fibrothecomatous component</td>
<td>Small well demarcated closely packed aggregates of cells (Granulosa and steroid cells)</td>
</tr>
<tr>
<td>Shilpa et al</td>
<td>55</td>
<td>Postmenopausal bleeding with abdominal mass</td>
<td>Endometroid adenocarcinoma</td>
<td>Fibromatous component</td>
<td>Nests of cells with grooved nuclei and minimal cytoplasm</td>
</tr>
<tr>
<td>Sood et al</td>
<td>13</td>
<td>Masculinizing features with Abdominal mass</td>
<td>-</td>
<td>Fibrothecomatous component</td>
<td>Sertoli like cells arranged in tubular pattern</td>
</tr>
<tr>
<td>Sharma et al</td>
<td>40</td>
<td>Masculinizing features with Abdominal mass</td>
<td>-</td>
<td>Fibrothecomatous component</td>
<td>Sex cord like cells</td>
</tr>
<tr>
<td>Yang et al</td>
<td>58</td>
<td>Abdominal mass</td>
<td>-</td>
<td>Fibromatous component</td>
<td>Uniform large cells in nestas and cords (Unclassified sex cord elements)</td>
</tr>
<tr>
<td>Asavari et al</td>
<td>18</td>
<td>Abdominal mass and Pain</td>
<td>-</td>
<td>Fibrothecomatous component</td>
<td>Few tubules lined by sertoli cells</td>
</tr>
<tr>
<td>Nalini</td>
<td>36</td>
<td>Abdominal mass and Pain</td>
<td>Proliferative endometrium</td>
<td>Fibromatous component</td>
<td>Small tubular cells with round vesicular nuclei &amp; inconspicuous nuclei</td>
</tr>
<tr>
<td>Present study</td>
<td>70</td>
<td>Postmenopausal bleeding with abdominal mass</td>
<td>Proliferative endometrium with polyp</td>
<td>Fibrothecomatous component</td>
<td>Sex cord like cells in tubular pattern</td>
</tr>
</tbody>
</table>

Table 2: Comparison of individual case reports reported in the literature with present study.

Usually these tumours are hormonally inactive but presence of luteinized thecal cells or sertoli like cells leads to hormone production, 50% of tumours have estrogenic effect leading to endometrial hyperplasia, diffuse complex atypical hyperplasia or even adenocarcinoma and 11% of cases have androgenic effect.\(^6,7\) Most of the tumours are unilateral with predominantly solid in appearance and attain maximum size of 1-10cm in
diameter. If the tumour is associated with the comatous component the tumour appear solid whitish to yellow in colour.

Microscopically the tumour cells are spindle shaped arranged in interlacing bundles and fascicles with variable amount of collagen and intermingled sex cord elements. These sex cord elements appear either fully differentiated granulosa cells or indifferent tubular structures resembling sertoli cells. The minor sex cord elements shows variable staining positivity for Inhibin but show specific positive staining for Calretinin. Other immunohistochemical markers that are useful in differentiating these tumours from other tumours are positivity for CD56, CD99, Antikeratin antibody k1, MIC and negative staining for Vimentin, SMA and EMA.3,8

The common differential diagnosis includes ovarian fibromatosis, Brenner tumour, adenofibroma and metastatic carcinoid. The common differentiating features are depicted in Table 1. Young and Scully first reported 7 cases of fibromatosus tumours of ovary in the year 1983. Out of 7 cases, 5 cases had ovarian fibroma with minor sex cord elements. Out of these 5 cases two cases associated with coexisting adenoacarcoma. 2 cases are lutenized thecoma and stromal leydig cell tumours with MSCE.

Out of 50 cases of luteinized thecomas and stromal leydig cell tumours reported by Zhang et al only 2 cases had sexcord elements with granulosa cell morphology.6

The following table 2 demonstrates similar individual case reports reported in the literature.

Endometrial changes related to these tumours are attributable to the hormone production either by thecal cells in stroma or by minor sex cord elements. Five cases reported in literature had endometrial adenoacarcoma secondary to hormone production by these cells.3,9-11 In our case also we had proliferative endometrium with a polyp in a 70 yrs women.

In general, Fibromas are hormonally inactive. But the minor sex cord elements are hormone producing based on the presence of either granulosa cells or sertoli cells. Most of the tumours reported in literature showed estrogenic features but only 2 cases presented with signs of virilization (Sood et al, and Sharma et al.).12,13 This case also showed estrogenic features with postmenopausal bleeding.

Though there are pure fibromas with MSCE, some case reports of fibroma associated with epithelial ovarian tumours have also been reported. Yang et al, in the year 2001, reported a case of mucinous cystadenoma with stromal tumour with minor sex cord elements in 58yr old women.14 In 2014, Aswari et al, reported a case of serous cystadenoma with coexisting stromal tumour with sex cord elements in an 18yr old unmarried girl.15

Two cases of diffuse stromal proliferation with minor sex cord elements in epithelial ovarian tumour have also been reported in literature. Dillon et al, reported in serous cystadenofibroma with stromal sex cord elements whereas Ueda et al, reported in mucinous epithelial ovarian tumour with stromal sex cord elements.16,17

Most of the tumours reported in literature are unilateral tumours except in one literature bilateral ovarian fibroma with minor sex cord elements are reported (Gupta et al).18 Few cases in extraovarian site also reported as fibroma with minor sex cord elements in broad ligament (Omori et al).19

CONCLUSION

This case is being presented for its rarity. Minor sex cord elements in ovarian stromal tumours are prognostically insignificant as these tumours are benign in nature. But extensive histopathological examination is required in these tumours as the potential source for estrogen production can occur from these minor sex cord elements which leads to endometrial changes so that patient may be regularly followed up by the clinician.

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REFERENCES


