



EP02.46 Decidualized Endometrioma and Fibrothecoma with Atypical Sonologic Features Confounding the Diagnosis of Malignancy

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Case Presentation

A 25-year-old nulligravid consulted because of debilitating and progressive dysmenorrhea. Transrectal ultrasound showed an 84.8 x 79.2 x 48.5 mm (volume 171 ml) multilocular, thick-walled ovarian new growth. It contained homogenous low-level echoes and an avascular echogenic structure with irregular margins. The impression was an endometrioma but because of some atypical features, the IOTA ADNEX Model was calculated. There was a 96.1% chance of benignity and a 3.9% risk of malignancy.

The patient was started on Dienogest 2 mg tablet once daily. After 2 months, the patient still experienced dysmenorrhea. A repeat transrectal ultrasound showed that the right ovary enlarged to 93.2 x 77.7 x 76.5 mm (volume 290 ml). It was a multilocular solid cyst with minimal intra-tumoral vascularity. The solid component measured 41.5 x 43.8 x 26.5 mm. The cystic component measured 75.3 x 59.4 x 65.8 mm and was filled with low level echoes. There were four papillary projections seen.

The patient underwent an exploratory laparotomy. There was a 7.2 x 6.8 x 6.0 cm pedunculated irregular cystic lesion attached to the superior portion of the right ovary. This was excised and was sent for frozen section that showed a sex cord stromal tumor, to consider a granulosa cell tumor. Referral to gynecologic oncology service was done. A right salpingo-oophorectomy, bilateral pelvic lymph node dissection, and omentectomy were done. Final histopathology showed a fibrothecoma and an endometrioma of the right ovary.

Conclusion

Endometriomas are described as unilocular cysts with ground-glass echogenicity and are typically classified under IOTA Modified Benign Simple Descriptors (BD1). Exogenous and endogenous progesterone may alter the sonologic features of endometriomas to appear malignant, warranting an aggressive approach that involves removal of the entire ovary. Rare cases such as collision tumors wherein two histologically distinct tumors coexist in one ovarian mass may also confound the diagnosis such as in this case. Prompt referral and a clear dialogue with a gynecologic oncologist upon recognition of possible malignancy on ultrasound can help prevent performing extensive surgery.

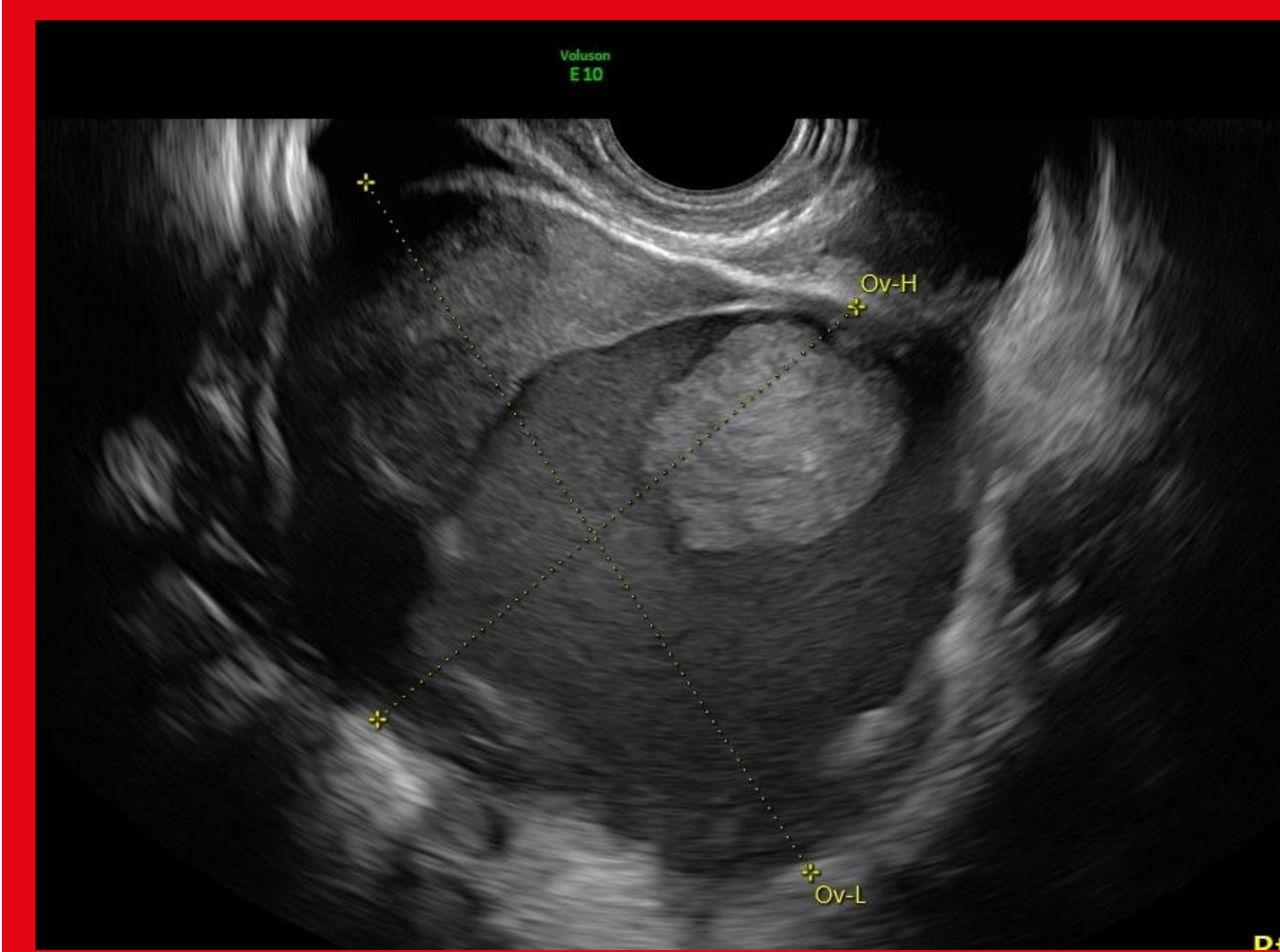


Figure 1. Right ovary prior to Dienogest treatment

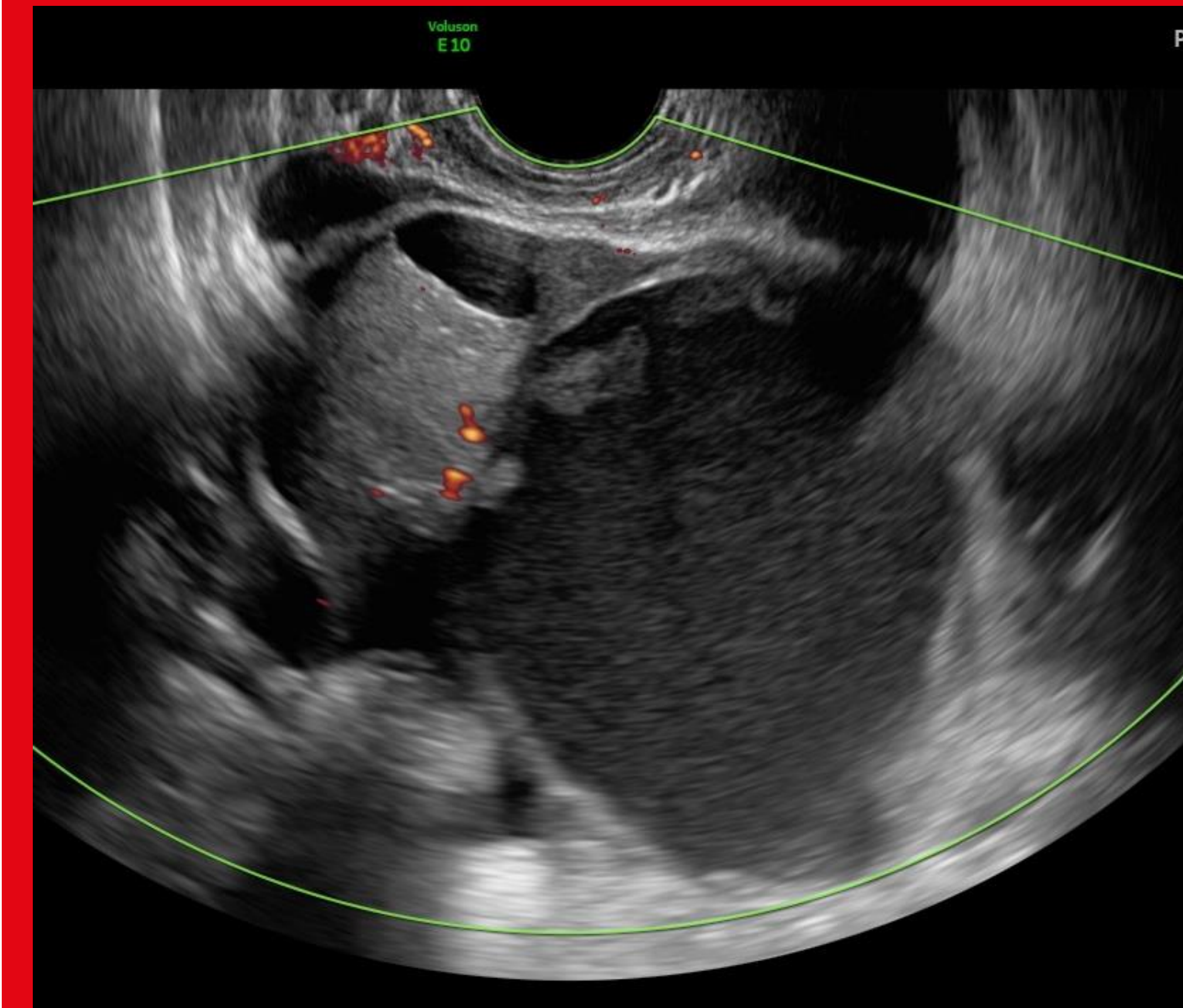


Figure 2. Right ovary after 2 months of Dienogest

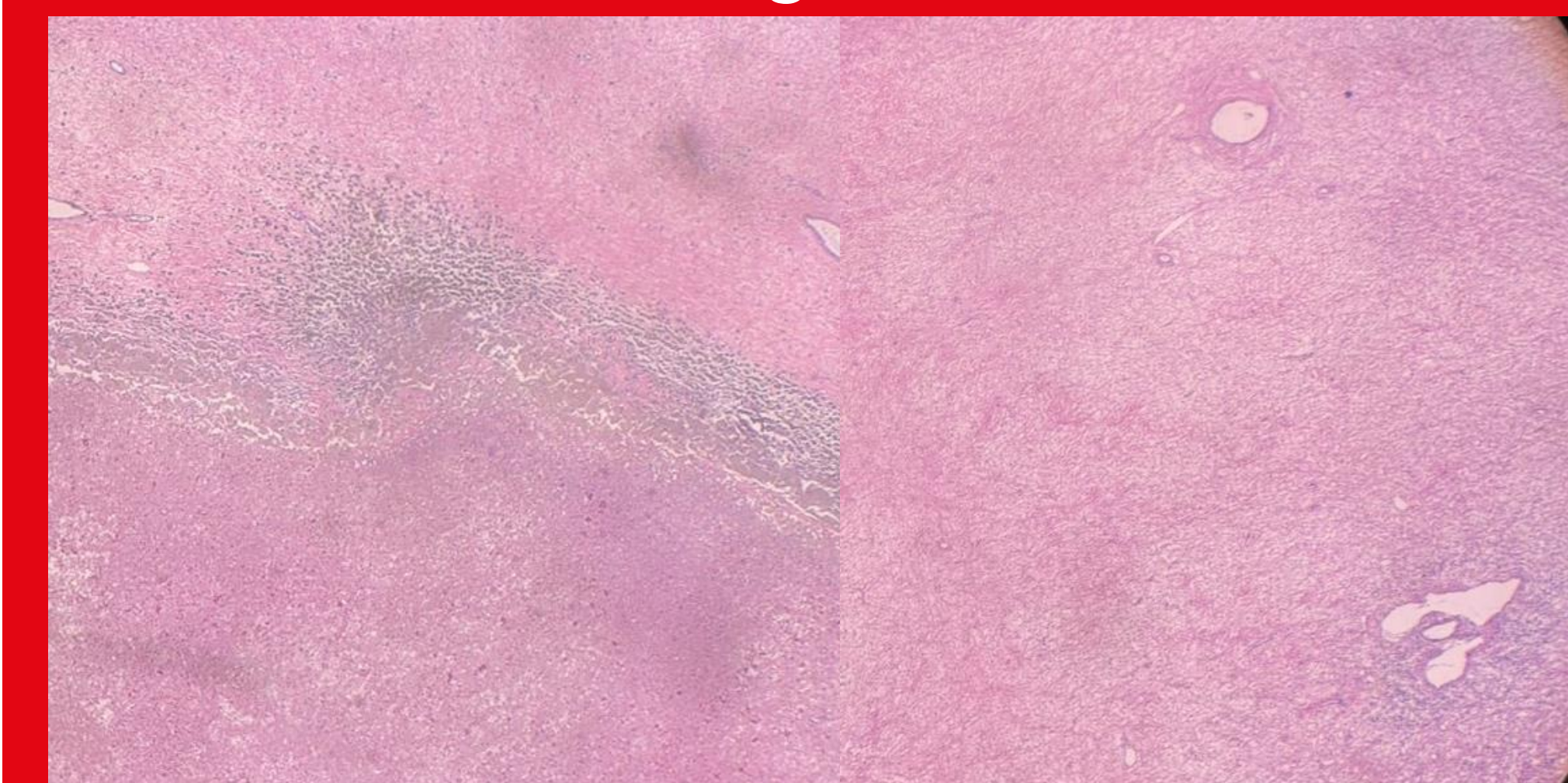


Figure 3. (left) Endometrioma (right) Fibrothecoma