GRANULOSA CELL TUMOUR

(Report of 3 Cases with Review of Literature)

by

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Introduction

Three interesting cases of granulosa cell tumour admitted and treated at Kilpauk Medical College Hospital, Madras, during the period of 6 months in 1984, are presented.

Case Reports

Case 1

A 43 year old female was admitted for vaginal bleeding for 10 days and mass abdomen for 6 months duration. The patient had regular cycles before.

On examination, the patient was anaemic. There was a cystic mass about 20 weeks size palpable per abdomen. On vaginal examination, the uterus was of normal size and firm. A cystic mass felt in the right fornix, freely mobile. After doing routine investigations, dilatation and curettage was done and the histopathology report of the endometrium was: proliferative phase. On opening the abdomen, right ovary was found to be the site of tumour. Left ovary was atrophic and uterus of normal size. No lymph nodes palpable. Liver, spleen and omentum normal. Panhysterectomy with right ovariotomy done. Post-operative period was uneventful.

Case 2

A 40 year old (nulliparous) female was admitted for abdominal pain and mass in the abdomen for 6 months. No history of irregular vaginal bleeding and had regular cycles.

On examination, the patient was anaemic. There was irregular, nodular firm to hard mobile mass about 34 weeks size palpable per abdomen. On vaginal examination, the uterus was about 6 weeks size and firm. A firm irregular mass felt through the fornices.

On exploring the abdomen, right ovary was found to be the site of tumour. Left ovary was atrophic and uterus of 8-10 weeks size. No palpable lymph nodes. Liver and spleen normal. The tumour was nodular, firm to hard in consistency, mobile and the size was about 12″ x 12″, with haemorrhagic areas. The tumour was adherent to bowels and omentum with minimal ascitic fluid. Adhesions were released. Panhysterectomy with right ovariotomy done. Post-operative period was uneventful.

Case 3

A 35 year old female ($P_6 L_6$) was admitted with history of pain and mass in the abdomen for 30 days and dyspnoea for 10 days. No history of vaginal bleeding and her cycles were regular. On examination, the patient was anaemic. Abdomen was distended with ascitic fluid, nodular mass felt in both iliac fossa. On vaginal examination, the uterus was normal size, firm multiple nodular mass felt above the uterus in the lower abdomen. A provisional diagnosis of malignant ovarian tumour was made. Ascitic fluid was tapped, which showed no evidence of malignant cells. Laparotomy, revealed bilateral hard nodular, haemorrhagic ovarian tumours (Right ovary 8 cm x 5 cm, left ovary 6 cm x 4 cm). About 12 litres of straw coloured fluid removed. Uterus and tubes were normal. There was evidence of secondaries over the omentum (caked), intestine, liver and para-aortic node were enlarged. Panhysterectomy with bilateral ovariotomy and salpingectomy was done. Abdomen closed with 400 mgm of endoxan. The patient was on endoxan during the past-operative period.

Sections from the tumours (in all the 3 cases) showed features of granulosa cell tumour. All the 3 patients are undergoing chemotherapy.

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