An unusual case of large ovarian thecoma with no hormonal symptoms

M. Madhavi • Kavitha Chenthil
Tirunelveli Medical College Hospital, Tirunelveli, Tamil Nadu-627011

Mrs. Valliammal, a 49-year-old female of low socioeconomic status presented with intermittent lower abdominal pain for 2 years. She had attained menopause 10 years back. Before that her periods were regular. She had no postmenopausal bleeding. She had no fullness of her breasts. She was a known diabetic, on treatment. There was no family history of similar tumour. She was a P5 L5.

On examination she was found to be a hypertensive with grade I hypertensive changes in the fundus. On per abdominal examination, there was a mass arising from the lower abdomen about 10 cm above the pubic symphysis which was not tender. On PV a mass was felt through the right fornix. The size of the uterus could not be made out.

Ultrasonogram revealed a large fluid collection in both iliac fossae. The mass was not separate from the uterus. Both ovaries could not be identified.

CT Scan also revealed a solid mass of mixed density with irregular margins filling in the suprapubic region, arising from the uterus. Left ovary was seen. Right ovary was not visualised.

She was posted for surgery. On opening under spinal anaesthesia with a large RPM incision there was about 500 ml of fluid in the peritoneal cavity (not blood stained). There was a large pedunculated tumour 20 cm X 20 cm, stony hard arising from the right ovary. Left ovary was normal. On cut section it was a solid tumour with white streaks.

Histopathology revealed a thecoma and the uterus showed atrophic endometrium.