## Miscellaneous: Poster Abstract

### Case report of vaginal melanoma

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Primary malignant melanoma of vagina is a rare disease with a predilection for local recurrence, distant metastasis and short survival time. Due to the low incidence and lack of reporting in the literature, treatment choices still remain controversial. We describe 2 cases of vaginal malignant melanoma. A 42 yr old female presented with complaints of post coital and per vaginal bleed of 1 month duration. Examination findings shows growth 6 cm x 6 cm on anterior vaginal wall, another 3 x 3 cm lesion on right lateral vagianl wall. Vaginal biopsy showed malignant melanoma, S-100 and HMB-45 positive while negative for CK and LCA. MRI Whole abdomen showed altered lesion [3.8 cm (AP), 6.0 cm (TR) and 4.9 cm (CC)] in upper 2/3rd of vagina extending into vaginal fornices and abutting right lower cervix superiorly, right paravaginal extension and mesorectal fascia. No significant enlarged lymph nodes were seen. In view of localised disease she underwent Type III Radical hysterectomy with bilateral salpingo-ophorectomy with bilateral pelvic lymphnode dissection with total vaginectomy. Histopathology s/o 2 tumour nodules, one located in the anterior vaginal cuff measuring – 5 x 5 x 3.2 cm, another located in right lateral vaginal cuff measuring 2.5 x 3 x 1.5 cm, malignant melanoma with involvement of the cervix with full thickness stromal invasion (2.8/2.8 cm,) invading perivaginal soft tissue, distance of invasive carcinoma from closest stromal margin <0.1 cm (12 O' clock), LVI, PNI – not seen, all pelvic LN free (0/25). In view of positive margin and full thickness stromal involvement, she received radiotherapy to pelvis and Inguinal region to a dose of 45 Gy/25# followed by a boost of 16 Gy/8# to the tumour bed till 01/01/16. Another case is a 40 yrs female, presented with complaints of bloody discharge per vaginum of 4 months duration. On examination, there was a large growth occupying the vagina till introitus. Cervix normal, para free. MRI Pelvis showed altered lesion involving left lateral uterine cervix and upper 2/3rd of vagina with full thickness stromal involvement with mild left parametrial, anterior and posterior paravaginal extension, measuring 2.9 x 4.5 x 5.3 cm. Few subcmlymphnodes were seen in bilateral external and internal iliac regions (L>R). Vaginal Biopsy was suggestive of Malignant Melanoma, expressing S-100, HMB 45 and SDX-10. Metastatic work up was negative. She underwent RH with total vaginectomy with bilateral PLND with RPLND. HPR showed exophytic black growth seen involving all quadrants of vagina, extending upwards into both lips of cervix – 7 x 6 x 2.5 cm, Malignant melanoma, distance of invasive carcinoma from closest margin: <0.1 cm (paravaginal soft tissue), 3/8 right Pelvic LN, ECE +, 01/9 Left pelvic LN , ECE absent, 0/6 Right common iliac LN, 0/1 Reperitoneal LN was seen. She received adjuvant radiotherapy to a dose of 50 Gy/25# to the pelvis and inguinals→ boost of 6 Gy/3# to nodal regions showing ECE & 10Gy/5# to the primary region.

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### Case report of vaginal melanoma

**Inderjit Kaur, Swarupa Mitra, Manoj Kumar Sharma, Upasna Saxena, Parveen Ahlawat, Amit Kumar Choudhary, Sarthak Tandon, Prashant Surkar**

Primary malignant melanoma of vagina is a rare disease with a predilection for local recurrence, distant metastasis and short survival time. Due to the low incidence and lack of reporting in the literature, treatment choices still remain controversial. We describe 2 cases of vaginal malignant melanoma. A 42 yr old female presented with complaints of post coital and per vaginal bleed of 1 month duration. Examination findings show growth 6 cm x 6 cm on anterior vaginal wall, another 3 x 3 cm lesion on right lateral vaginal wall. Vaginal biopsy showed malignant melanoma, S-100 and HMB-45 positive while negative for CK and LCA. MRI Whole abdomen showed altered lesion [3.8cm (AP), 6.0cm (TR) and 4.9cm (CC)] in upper 2/3rd of vagina extending into vaginal fornices and abutting right lower cervix superiorly, right paravaginal extension and mesorectal fascia. No significant enlarged lymph nodes were seen. In view of localised disease she underwent Type III Radical hysterectomy with bilateral salpingo-ophorectomy with bilateral pelvic lymphnode dissection with total vaginectomy. Histopathology s/o 2 tumour nodules, one located in the anterior vaginal cuff measuring – 5 x 5 x 3.2 cm, another located in right lateral vaginal cuff measuring 2.5 x 3 x 1.5 cm, malignant melanoma with involvement of the cervix with full thickness stromal invasion (2.8/2.8 cm,) invading perivaginal soft tissue, distance of invasive carcinoma from closest stromal margin <0.1cm (12 O' clock), LVI, PNI – not seen, all pelvic LN free (0/25). In view of positive margin and full thickness stromal involvement, she received radiotherapy to pelvis and Inguinal region to a dose of 45 Gy/25# followed by a boost of 16 Gy/8# to the tumour bed till 01/01/16. Another case is a 40 yrs female, presented with complaints of bloody discharge per vaginum of 4 months duration. On examination, there was a large growth occupying the vagina till introitus. Cervix normal, para free. MRI Pelvis showed altered lesion involving left lateral uterine cervix and upper 2/3rd of vagina with full thickness stromal involvement with mild left parametrial, anterior and posterior paravaginal extension, measuring 2.9 x 4.5 x 5.3 cm. Few subcmlymphnodes were seen in bilateral external and internal iliac regions (L>R). Vaginal Biopsy was suggestive of Malignant Melanoma, expressing S-100, HMB 45 and SDX-10. Metastatic work up was negative. She underwent RH with total vaginectomy with bilateral PLND with RPLND. HPR showed exophytic black growth seen involving all quadrants of vagina, extending upwards into both lips of cervix – 7 x 6 x 2.5 cm, Malignant melanoma, distance of invasive carcinoma from closest margin: <0.1 cm (paravaginal soft tissue), 3/8 right Pelvic LN, ECE +, 01/9 Left pelvic LN , ECE absent, 0/6 Right common iliac LN, 0/1 Reperitoneal LN was seen. She received adjuvant radiotherapy to a dose of 50 Gy/25# to the pelvis and inguinals→ boost of 6 Gy/3# to nodal regions showing ECE & 10 Gy/5# to the primary region.

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### Extra ovarian adult granulosa cell tumor of omentum: A report of a rare entity

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**Aims:** Extra ovarian granulosa cell tumor (GCT) is extremely rare tumor, assumed to arise from the ectopic gonadal tissue along the embryonal route of the genital ridge. A case of extra ovarian granulosa cell tumor of omentum in a 69 year old female presented here.

**Materials and Methods:** A 69 years old postmenopausal, hypertensive female presented with complaints of pain in right lumber and iliac region of one month duration. Pain was off and on and intermittent. The patient had a history of hysterectomy 12 years ago for fibroid uterus.

**Results:** Ultrasound examination of abdomen showed a hypoechoic lesion of size 78.1 mm x 57.3 mm in right iliac fossa with mild thickening of surrounding omentum. Another hypoechoic lesion of size 36.7 mm x 22.9 mm was seen in retroperitoneal region in supero-medial aspect of right kidney. CECT abdomen showed heterogeneously enhanced nodular lesion of size 6.6 x 6.8 cm in right lumbar region, mild thickening of surrounded omentum also seen however there was no evidence of infiltration to bowel loop seen. Uterus was not visualized. PET CT whole body revealed mildly metabolically active enlarged nodes in the bilateral level ib an ii, metabolically active large lobulated heterogeneously enhancing soft tissue density lesion in right lumbar region with non enhancing areas of necrosis. The lesion is closely abutting the anterior abdominal wall musculature antero laterally and small bowel loop medially surrounding mesenty shows increased vascularity and haziness. Colonoscopy findings were normal. Trucut biopsy of mass right lumbar region was positive for malignancy likely Round cell Sarcoma. A provisional diagnosis of retroperitoneal sarcoma of right lumbar region was made. She underwent exploratory laparotomy with excision of tumor. As per Operative findings there was approximately 8 x 7 cm, firm, omental mass present right to midline, arising from under surface of greater omentum. Ovaries were normal. Gross examination of omental mass showed nodular mass measuring 8 x 5 x 6 cm. External surface was multinodular and cut surface was grey brown to grey yellow with solid cystic areas and areas of necrosis. Microscopic examination of specimen showed Extraovarian Adult granulosa cell tumor/metastasis from occult granulose cell tumor. On IHC Vimentin, CK, SMA, Inhibin were positive, Ki67:15%, ER/PR were also positive and are negative for calretinin, thromobomodulin. Extensive necrosis was seen. After that she underwent rexploration and total omenectomy. HPE showed fat necrosis in omentum.