Ovary: Poster Abstract

Unusually high serum Ca 19-9 in a benign ovarian tumor

Divya Pandey, Neha Pruthi, Sudha Salhan
VMMC and Safdarjung Hospital, New Delhi, India

Introduction: Ovarian tumors have a varied spectrum of presentation. Tumors which look malignant clinico-biochemically can ultimately turn out to be benign. Tumor markers help in diagnosing various malignancies. Carbohydrate antigen 19-9 is one such marker seen to be elevated in some ovarian tumors.
Case: A 55 year old, lean and thin postmenopausal female presented to Gynae OPD with abdominal mass, anorexia and weight loss developing over last 6 months. During workup, she was found to have unusually high Ca 19-9 along with MRI findings suggestive of ovarian tumor. Staging laparotomy followed by total abdominal hysterectomy with bilateral salpingoophorectomy was performed. Per operative findings were suggestive of benign nature of ovarian tumor of size 18× 20 cm. Patient was kept under follow up. Histopathology report showed benign mucinous cystadenoma. The serum levels of Ca19-9 returned to normal 8 weeks following surgery. This case report shows a rare and significant elevation of Ca19-9 levels with benign mucinous cystadenoma of the ovary, thus showing that women with unusually elevated tumor markers and even symptoms suggesting malignancy may actually harbour a benign disease.
Conclusion: Unusually high Ca 19-9 may be associated with benign mucinous cystadenoma but thorough workup to rule out malignancy is a must in every case.

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Immature teratoma

Introduction: Immature teratoma represents 3% of all teratomas, 1 % of all ovarian cancers and 20% of malignant ovarian germ cell tumors. It is found either in pure form or as a component of a mixed germ cell tumor. It occurs essentially during the first two decades of life. According to WHO, immature teratoma is defined as a teratoma containing a variable amount of immature embryonal type neuroectodermal tissue
Case: We present here a report of 23 years old unmarried female who presented with complaint of abdominal pain since 1 month and her CT scan done outside, showed fibroid uterus. She had history of typhoid fever 1 month back for which USG was done which suggested large uterine fibroid. On examination she was hemodynamically stable. On abdominal examination a non-tender supra-pubic mass of 24 weeks size with firm consistency, irregular margin was felt. On investigation CA 125 was 64.90 IU/L, LD- 223, beta HCG- 1.14. On MRI a large abdomino-pelvic lesion, likely left adnexal lesion with multiple cystic areas, with hemorrhage, with ascites and enlarged retroperitoneal lymph nodes with omental infiltration suggestive of a possibility of malignant germ cell tumor. In view of large ovarian tumor, possibly malignant decision for staging laparotomy was taken. Intra-operatively a large irregular vascular solid mass of 20 x 20 cms with bosselated appearance with few cystic lesions over it was seen, arising from left ovary and was sent for frozen section which reported malignant mature teratoma with components of immature teratoma. She underwent laparotomy with left salpingo-oophorectomy with right ovarian biopsy, omentectomy, appendectomy with B/L pelvic lymphadenectomy. Histopathology was suggestive of grade III immature teratoma. In view of grade III immature teratoma, she received chemotherapy (BEP regimen) post-operatively and is currently under follow up.
Conclusion: This case reflects the importance of early diagnosis in cases of pelvic masses in young females. Fertility preservation should be considered in young women with germ cell tumors. Patients with grade II or III tumors or a mere advanced stage disease should be treated with adjuvant chemotherapy (BEP) in addition to surgery.

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Inguinal lymphadenopathy as a presentation for ovarian cancer

Swati Shah, Shveta Giri, Rupinder Sekhon, Sudhir Rawal

Ovarian carcinoma usually presents at an advanced stage with diffuse intra abdominal manifestations. Inguinal lymph node metastasis is rare event in ovarian cancer. We report 7 cases who presented with inguinal lymphadenopathy as the initial manifestation between January 2014 to January 2016. All patients underwent tru-cut biopsy from inguinal area. Morphology and IHC were suggestive of ovarian origin or female genital Tract origin. Two patients underwent primary debulking surgery while four patients were managed by neo-adjuvant chemotherapy followed by interval cytoreductive surgery owing to relatively poor performance status at presentation. One patient underwent secondary debulking in which inguinal Lymph node was positive for metastatic deposits.

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Shikha Madan

Primary pure ovarian leiomyosarcomas constitute a malignant subgroup of ovarian smooth muscle tumors which comprise only 1% of ovarian tumors. Their origin, etiology, histologic features, clinical behavior, and optimal treatment are still obscure. We report a case of leiomyosarcoma of ovary, diagnosed on histopathology in a 30 year old female.

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Pure primary non gestational choriocarcinoma ovary – diagnostic dilemma and treatment intricacy

Abhishek Soni, Nupur Bansal, A. K. Dhull, Vivek Kaushal, A. K. Chauhan

Introduction: Germ cell tumors of the ovary include all neoplasm derived from primordial germ cells of the embryonal gonad. Five percent of germ cell tumors are malignant, representing three to five per cent of all ovarian carcinomas of which pure primary non-gestational ovarian choriocarcinoma accounts for less than one per cent of ovarian tumors. Primary choriocarcinoma of ovary could be gestational or nongestational in origin. They pose diagnostic challenges in reproductive age group patients because of elevated human chorionic gonadotrophin (hCG). Non-gestational choriocarcinoma (NGCO) is resistant to single agent chemotherapy, requiring more aggressive combination chemotherapy post surgery. Due to the rarity of the disease, this article reviews the treatment protocol for NGCO.
Methods: All the articles related to choriocarcinoma of ovary at Pubmed, Google scholarly article and Scopus were assessed and reviewed and their references were also reviewed and included in this article.
Discussion: Clinical diagnosis of NGCO is often challenging because the clinical symptoms are often nonspecific and can mimic other, more common conditions that occur in young women, such as a hemorrhagic ovarian cyst, tubo-ovarian abscess, ovarian torsion, and ectopic pregnancy. The symptoms of vaginal bleeding, elevated hCG level, pelvic pain, and an adnexal mass often lead to incorrect diagnosis of ectopic pregnancy, threatened or incomplete abortion, cervical polyp, or other types of malignancy. Non-gestational choriocarcinomas have been found to be resistant to single agent chemotherapy, have a worse prognosis, and therefore require aggressive combination chemotherapy. Adjuvant chemotherapy with the EMA (etoposide 100mg/m2, methotrexate 100mg/m2, actinomycin-D 0.5mg) regimen may be given, for six to nine courses at seven days interval. Studies suggest that the disease responds well to the combination of surgery and postoperative adjuvant chemotherapy. However, long term effects of such therapy should be further studied with more cases.
Conclusion: Because of the small number of patients with pure ovarian choriocarcinoma, a consensus on the treatment regimen including surgery and chemotherapy is lacking. Surgery with adjuvant combination chemotherapy is the standard treatment of choice.

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Juvenile granulosa cell tumor

Geetanjali Tuteja, S. Unmesh, S. Shree, Archana, S. Rudra
MMIMSR, Mullana, Ambala, Haryana, India

The differential diagnosis for precocious puberty in a young female includes peripheral causes. This case report documents a rare cause of isosexual precocious puberty, a juvenile granulosa cell tumour of the ovary–and a brief literature review. A one year-old baby girl presented with mass abdomen, vaginal discharge and rapid onset of pubertal development. She underwent an exploratory laparotomy