Dharamshila Hospital and Research Centre, New Delhi, India

Concurrent different histopathological types of gynecologic tumors arise rarely. We present ovarian serous and cervical squamous cell carcinoma formed synchronously. A 51-year-old woman with a poor general condition was admitted with gradual distension of abdomen for 1 year with gradual loss of weight and appetite for the last three months and pain in the abdomen and irregular vaginal bleeding for the last two months. There was no family history of malignancy of genital tract, breast or colon. On examination she was cachexic, pale, dehydrated, tachypnoeic and had edema over feet. Per abdomen examination revealed solid, non-mobile palpable mass arising from pelvis. Per vaginal examination revealed large mass in pelvis and uterus can not be felt separately on per speculum examination there was small endocervical erosion, hypertrophied cervix. On per rectal examination bilateral parametria were free. Her tumor marker were evaluated and CA-125 was found to be raised (CA 125: 915.6 u/ml U/mL); rest tumor markers were normal. Cervical punch biopsy was suggestive of moderately differentiated carcinoma and pap smear was also suggestive of cervical cancer. MRI findings revealed a mass of altered signal intensity 2.5 × 1.5 × 2.2 cm with diffusion restriction and post contrast enhancement in the anterior lip of cervix and another large, lobulated predominantly solid mass, hypo intense on T1, intermediate on T2 with diffusion restriction and post contrast enhancement in the right adnexal region abutting the small bowel and sigmoid colon optimal debulking surgery with standard protocol was done. Histopathology report revealed squamous cell carcinoma of cervix, grade III and high grade serous cystadenocarcinoma of ovary. Tumour deposits from ovary were seen on right fallopian tube and right parametrium. Squamous cell carcinoma cervix involved ectocervix, endocervix and infiltrated near full thickness of cervical stroma, endomyometrium, vaginal cuff, paracervical tissue omentum and appendix were free of tumour. Twenty five right pelvic lymphnodes dissected were free of tumour, (00/25). One out of fifteen lymphnode dissected were involved with extra capsular extent, 01/15 and thirteen para aortic lymph node dissected were free of tumor. Immunohistochemistry markers: Ovarian mass-tumour cell expressed ck, vimentin, wt-1 with focal Ck positivity, no expression of ck20, p63,ck5/6 and CEA seen. Cervical tumour-tumour cells expressed ck, ck7, p63 and ck5/6 no expression of ck20, wt-1. Based on our case report we need to keep in mind that even if patient presents with symptoms pertaining to a single malignancy; still the rare possibility of synchronous malignancies should be looked for by doing proper investigations. In our case, patient had symptoms pertaining to ovarian malignancy; whereas cervical malignancy was diagnosed after investigating the patient. Histologic examination should be done properly as the prognosis depends on the malignancies being metastatic or synchronous one appropriate management should be offered in all such cases. Long term follow up of such patients should be maintained to determine the prognosis.

Miscellaneous: Poster Abstract

Unusual clinical presentation of chriocarcinoma in young patients – Neulological meatastasis

Sushma Yadav

Pt. BDS PGIMS, Rohtak, Haryana, India

Introduction: Choriocarcinoma is a malignant trophoblastic tumor, usually of placenta and characterized by 'early hematogenous spread' to lungs. Choriocarcinoma of placenta is preceded by – H. Mole (50%), spontaneous abortion (20%), ectopic pregnancy (2%) and normal term pregnancy (20%-30%). It is chemosensitive tumor and even in metastatic lesion cure rate is 90%-95%. Most common site of metastasis is lung and vagina, vulva, kidney, liver, ovaries, brain and intestine. If tumor is not diagnosed and managed timely, because of its vascularity, it bleeds profusely leading to death.

Cases: We encountered 2 rare cases, with age of 25 and 27 years respectively with choriocarcinoma with unusual clinical presentation. Both patients presented with neurological symptoms of brain metastasis and succumbed to death within a short span of time. In both cases histopathological report failed to detect chorio-carcinoma but b-HCG and radiological findings were suggestive of choriocarcinoma.

Conclusion: If b–HCG level are unusually high with radiological findings, the patients should be considered for chemotherapy even if HPE is inconclusive. Without chemotherapy chorio-carcinoma has a rapid progression and mortality which can be prevented by early suspicion and timely management.

Miscellaneous: Video Abstract

R-veil in carcinoma vulva

Vandana Jain, Rupinder Sekhon, Shveta Giri, Sudhir Rawal

Background: Vulvar cancer accounts for about 3-5% of gynaecologic malignancies. Prognosis is strongly dependent on presence of inguinofemoral lymph node metastases. Effective management of regional lymph nodes is the most important factor in the curative management of early vulvar cancer. Despite careful dissection and maintaining vascularity of skin, surgical morbidity is seen in 50% cases. Video – endoscopic inguinofemoral lymphadenectomy was developed by Bishoff in 2003 by dissecting two cadaveric models and in one patient with stage T3N1M0 penile carcinoma. VEIL is an alternative to reduce the morbidity without compromising the oncologic outcomes. VEIL has continued to evolve into single site and robotic variants. R-VEIL is a minimally invasive procedure duplicating the standard open procedure with less morbidity.

Aims and Objectives: A video presentation to describe the technique of R-VEIL in vulvar cancer and discuss the advantages and outcome.

Conclusions: R–VEIL is an attractive minimally invasive technique to do inguinal block dissection in a single sitting in patients with vulvar carcinoma as the surgeon does not get tired as happens in VEIL technique. R-VEIL allows the removal of inguinal lymph nodes within the same limits as in open procedure and potentially reduces surgical morbidity. It is better accepted cosmetically and reduces hospital stay. Long term oncological results are not available. Randomized multi-institutional studies are required to prove its efficacy over open counterpart.

Miscellaneous: Poster Abstract

Radical excision of a massive vulvo-vaginal mass

J. Meena, A. Parthasarathy, R. Vatsa, N. Singh, S. Kumar, K. K. Roy, S. Singhal

Department of Obstetrics and gynaecology, AIIMS, New Delhi, India

Background: Vulvo-vaginal masses has a varied presentation and causes. The most common differential diagnosis are condylomata acuminata, vulvular abscess, vulvular/vaginal cysts, vulval carcinoma, vulval lipoma, angiomyofibroblastoma and aggressive angiomyxoma. Surgical excision of the mass is the main method of treatment and the outcome differs with the histological diagnosis. We present a video of excision of a massive Vulvo vaginal mass in toto.

Case: A 45 year old P3 L3 female, presented with complaint of mass in perineal area and discharge per vaginum for 2 years. The mass was growing progressively and reached the present size. On examination there was a 9 × 8 cm irregular firm to cystic mass, arising from posterior wall of vagina and protruding out of introitus with bossellated surface. The mass also extended into right ischiorectal fossa, 10 × 10 cm mass with cystic, smooth surface that was irreducible with no cough impulse. CECT abdomen and pelvis revealed a well-defined 12 × 10 × 8 cm mass in right perineum arising from right lower lateral vaginal wall with ischiorectal fossa extension. There was no extension into cervix, bladder or rectum. Biopsy taken from the mass was inconclusive. A wide local excision was done under general anesthesia wherein an ischiorectal and vaginal mass of size 30 × 10 cm with irregular margin was excised in toto. Histopathology was suggestive of aggressive angiomyxoma. The patient is under follow up.

Discussion: Aggressive Angiomyxoma is a rare slow growing locally invasive mesenchymal tumor and has a substantial potential for recurrence. It is often misdiagnosed. Pre-operative diagnosis is difficult due to rarity of this entity and absence of diagnostic features, but it should be considered in case of masses in genital, perianal and pelvic region in a woman of reproductive age. Radical surgical excision is the first line of management. A long term follow up of the case is necessary and MRI is preferred method for detecting recurrences.

Miscellaneous: Video Abstract

Minimally invasive treatment options to borderline ovarian tumors

Punita Bhardwaj, T. K. Das, S. Batra, Roman

Gynaecology Endoscopy, Robotic Surgery Unit, Institute of Obstetrics and Gynaecology, Sir Ganga Ram Hospital, New Delhi, India