IGCS20_1302

A RARE CASE OF NASOPHARYNGEAL CARCINOMA METASTASIS TO MALE BREAST

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Introduction

Nasopharyngeal carcinoma (NPC) is a rare malignancy with an incidence of 0.5–2 per 100,000 in Europe and the United States, it almost occur in young and middle-aged adults, the incidence is higher in the Chinese and Tunisian population.

Case Report

A 41-year-old male presented in March 2019 with a lump in the right upper neck region, which had been growing for four months. Physical examination identified multiple circular lumps, which were palpable on the right upper third of the neck on the sternocleidomastoid (facies medialis). Examination of the head and neck by computed tomography (CT) showed thickening of the soft tissues of the right wall of the nasopharynx and bilateral cervical lymphadenopathy with a maximum node size of ~9×1.5 cm, also it identified a suspect mass in the right breast. The patient underwent then a Breast ultrasound that showed a two-aval shaped micolobulated hypoechoic mass without spiculations measuring respectively 10 mm and 12 mm located in the upper outer quadrant and behind the nipple of the right breast, associated with right axillary lymph node. Our patient underwent an ultrasound-guided biopsy, the histological examination confirmed the diagnosis of breast metastasis.

In conclusion, the present case confirmed that NPC may also metastasize to male breast. Although, there is no established guideline for the treatment, a multidisciplinary approach is always beneficial to the patient.

IGCS20_1304

ARE OBSTETRICS AND GYNAECOLOGY TRAINEES CONFIDENT AND COMPETENT IN THE CARE OF FRAIL GYNAECOLOGICAL ONCOLOGY PATIENTS?


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Introduction

Older patients undergoing cancer surgery are at increased risk of post-operative morbidity and mortality. Frailty is particularly prevalent in this patient cohort and is a major contributor to adverse outcomes. A survey was conducted to assess the confidence and knowledge of trainees in obstetrics and gynaecology (O&G) regarding identification and management of perioperative issues encountered in frail gynaecological oncology patients.

Methods

A web-based survey on the management of frail perioperative patients was disseminated to doctors-in-training (trainees) in O&G in the United Kingdom (UK) and Ireland.

Results

Of the 666 trainees who participated, 67% (n=425/666) reported inadequate training in the perioperative management of frail patients. Validated frailty assessment tools were used by only 9% (n=59/638) of trainees and less than 1% (n=4/613) were able to correctly identify the diagnostic features of frailty. Common misconceptions included the use of chronological age and gender in frailty assessments. The majority trainees (>75%) correctly answered a series of questions relating to mental capacity; however, only 6% (n=36/606) were able to correctly identify all three diagnostic features of delirium. 87% (n=495/571) of trainees supported closer collaboration with geriatricians and a multi-disciplinary approach.

Conclusions

O&G trainees reported inadequate training in the perioperative care of frail gynaecological oncology patients, and overwhelmingly favoured input from geriatricians. Routine use of validated frailty assessment tools may aid diagnosis of frailty in the perioperative setting. There is an unmet need for formal education in the management of frail surgical patients within the UK and Irish O&G curriculum.

IGCS20_1307

UNIQUE CASE SERIES OF COEXISTING ENDOMETRIAL AND HEMATOLOGIC MALIGNANCIES

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Introduction

Coexistent primary neoplasms in the same individual can present as synchronous or metachronous. In the setting of endometrial cancer, most concomitant primary sites include ovarian, colon, and breast cancer.

The coexistence of endometrial and hematologic malignancies is rare and unique, with only 7 cases reported in the literature.

Over a time interval of 10 years, we have encountered this unusual condition in 7 patients of our own. This is the most extensive case series of concurrent hematologic and endometrial malignancies.

Methods

Retrospective chart review from 2002–2012.

Results

Our patients were referred to a gynecologic oncology office from the years 2002 and 2012 due to suspected endometrial cancer.

All of our patients underwent surgical diagnoses and staging for endometrial cancer. The findings of significantly enlarged lymph nodes as described in the operative reports of 5 out of 7 patients.

Conclusions and Implications

The presence of two primary malignancies may translate into a unique diagnostic and treatment situation where the presence of the other may impact surgical, medical, and radiation management for one cancer.
As clinicians, it is essential to be aware of the most common signs, symptoms, laboratory, imaging, and intraoperative findings of various pathologies. This knowledge could make a positive impact on patient care.

**IGCS20_1309**

**CASE REPORT: RECURRENT PARAVAGINAL AGGRESSIVE ANGIOMYXOMA FIVE YEARS AFTER INITIAL EXCISION AND DIAGNOSIS**

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**Introduction** Aggressive angiomyxoma is a rare mesenchymal tumour found mainly in the pelvis and perineum of women of reproductive age. Although benign, the tumour is deemed aggressive due to the frequency of local infiltration. The mainstay of treatment is surgical excision. Neoadjuvant use of GNRH analogues to limit tumour growth prior to surgical excision has been reported. Reports suggest a recurrence rate ranging from 30 to 72 percent.

**Methods** This case describes a 39 year old woman who was re-referred to the gynaecological oncology service with suspected recurrence of paravaginal angiomyxoma, five years after surgery to remove the primary tumour.

**Results** Preoperative magnetic resonance imaging revealed a paravaginal mass measuring 5 cm x 4.5 cm x 5.5 cm extending from the lower vagina and gradually tapering at the level of the vulva on the left side. Following six months of treatment with GNRH analogue, the mass was excised under general anaesthesia. A multilobular tumour extending from the fat of the left labium to the bladder neck and the ischiorectal fossa was excised. Excision beyond the gross margins of...

<table>
<thead>
<tr>
<th>Case No</th>
<th>Age (years)</th>
<th>Histology</th>
<th>Stage</th>
<th>Rx</th>
<th>Site</th>
<th>Histology</th>
<th>Lineage</th>
<th>Intraoperative Findings</th>
<th>Rx</th>
<th>Follow up</th>
</tr>
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<tbody>
<tr>
<td>1</td>
<td>73y/o</td>
<td>Endometrioid adenocarcinoma G3</td>
<td>IA</td>
<td>RATEH BSO LND</td>
<td>Pelvic and paraaortic nodes</td>
<td>Non-Hodgkin Small lymphocytic lymphoma</td>
<td>B cells</td>
<td>Enlarged lymph nodes intraop</td>
<td>Chemotherapy and radiotherapy</td>
<td>Died 2 years later from recurrent metastatic endometrial cancer</td>
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<tr>
<td>2</td>
<td>70y/o</td>
<td>Endometrioid adenocarcinoma G1</td>
<td>IA</td>
<td>RATEH BSO LND</td>
<td>Pelvic nodes</td>
<td>Non-Hodgkin Small lymphocytic lymphoma (B cell-CLL)</td>
<td>B cells</td>
<td>Enlarged lymph nodes intraop</td>
<td>Clinical trial Chemotherapy</td>
<td>Lost follow up</td>
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<tr>
<td>3</td>
<td>59y/o</td>
<td>Carcinosarcoma MMMT</td>
<td>IB</td>
<td>TAH BSO LND + chemotheray</td>
<td>Paraaortic nodes</td>
<td>Recurrent (treated 20 years before) Anaplastic Large cell lymphoma</td>
<td>T cells</td>
<td>Enlarged lymph nodes intraop</td>
<td>Chemotherapy</td>
<td>Died 7 years later</td>
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<tr>
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<td>75y/o</td>
<td>Endometrioid adenocarcinoma G2</td>
<td>IB</td>
<td>TAH BSO LND</td>
<td>Pelvic nodes</td>
<td>Diagnosed 5 years before Non-Hodgkin Small lymphocytic lymphoma (B CELL-CLL)</td>
<td>B cells</td>
<td>-</td>
<td>Chemotherapy</td>
<td>Died 3 years later</td>
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<td>84y/o</td>
<td>Endometrioid adenocarcinoma G1</td>
<td>IA</td>
<td>RATEH BSO LND</td>
<td>Pelvic nodes</td>
<td>Mature B cell neoplasm with extensive plasmacytic differentiation</td>
<td>B cells</td>
<td>-</td>
<td>No therapy Indicated</td>
<td>Lost 1/2</td>
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<td>52y/o</td>
<td>Endometrioid adenocarcinoma G1</td>
<td>IA</td>
<td>RATEH BSO LND</td>
<td>Pelvic &amp; aortic nodes</td>
<td>Mature B cell non Hodgkin follicular lymphoma</td>
<td>B cells</td>
<td>Extremely enlarged pelvic and paraaortic nodes densely adhered to vessels</td>
<td>Chemotherapy</td>
<td>Last follow up was 7/2019</td>
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<td>7</td>
<td>54y/o</td>
<td>Endometrioid adenocarcinoma G2</td>
<td>IIC</td>
<td>RATEH BSO LND, OM, chemotherapy + and radiotherapy</td>
<td>Pelvic &amp; paraaortic nodes</td>
<td>B cell lymphoma</td>
<td>B cells</td>
<td>Enlarged lymph nodes</td>
<td>No therapy indicated</td>
<td>Last follow up was 8/2019</td>
</tr>
</tbody>
</table>

**RATEH:** Robotic assisted laparoscopic hysterectomy, BSO: bilateral salpingo oophorectomy, LND: lymph node dissection, OM: omentectomy