



**Abstract 343 Figure 1** DFS (1A) and OS (2B) in the entire cohort stratified according to TFD (cut-off 3.5 mm)

presence of previously established pathologic risk factors. TFD was measured histologically on the hysterectomy specimen.

**Results** 368 patients were included in the study. 115 (31.2%) patients had  $TFD \leq 3.5$  mm and 253 (68.8%) had  $TFD > 3.5$  mm.  $TFD \leq 3.5$  mm was associated with worse 5-year disease-free survival (DFS) and overall survival (OS), compared with  $TFD > 3.5$  mm ( $p=0.028$  and  $p=0.041$ , respectively) (figure 1). DFS and OS differences were more evident in subgroups of patients who did not receive adjuvant treatment (DFS,  $p=0.001$  and OS,  $p=0.001$ ) and who underwent laparotomy approach (DFS,  $p=0.017$  and OS,  $p=0.034$ ).  $TFD \leq 3.5$  mm represented the strongest predictor for lymph node metastasis and pathologic parametrial involvement at both univariate and multivariate analysis (table 1).

**Conclusions**  $TFD \leq 3.5$  mm represents a poor prognostic factor significantly associated with lymph node metastasis and pathologic parametrial infiltration. The possibility to obtain this parameter by radiological imaging makes it the easiest measurable pre-operative marker to predict the presence of high-risk pathologic factors.

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### COMPARISON OF CLINICAL PATHOLOGICAL AND SURVIVAL OUTCOMES BETWEEN SEROUS AND NON-SEROUS OVARIAN CANCER

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**Objectives** To compare the clinical-pathological features and survival outcomes of women with serous and non-serous epithelial ovarian cancer.

**Methods** Retrospective study of 151 patients staged surgically in Salah Azaiez Tunisian cancer center, between 2000 and 2010.

**Results** We performed primary debulking surgery in 128 patients (84.8%) and 23 patients (15.2%) underwent interval debulking surgery. Maximal cytoreduction (R0) was achieved in 67 of patients (44.4%), 39 patients had a residual disease  $\leq 1$  cm (25.8%) and 45 patients had a residual disease  $> 1$  cm (28.8%). Lymphadenectomy was performed in 57% of cases. The histological type was clearly established for all women: 109 cases of serous carcinomas (72.2%) and 71 non-serous tumors (14 endometrioid, 12 mucinous, 7 clear cell carcinomas, 2 malignant Brenner tumors, 6 undifferentiated and one case of seromucinous carcinoma). The comparison of serous (SEOC) to non-serous tumor types (NSEOC) by univariate analysis showed that SEOC were associated to higher serum level of CA 125 exceeding 1000 U/ml (47.7% vs 19%,  $p=0.001$ ), higher quantity of ascites exceeding 1 litre (40.4% vs 21.4%,  $p=0.029$ ) with more frequent cacinomatosis in the upper abdomen (48.6% vs 21.4%,  $p=0.002$ ) and more residual disease R1/R2 (65.1% vs 31%,  $p<0.0001$ ), bilateral tumors (74.1% vs 45.2%,  $p=0.001$ ), advanced FIGO stage III-IV (88.1% vs 50%,  $p<0.0001$ ), pelvic lymph metastasis (LNM) (11.7% vs 4.2%) as well as paraaortic LNM (16.7% vs 8.3%,  $p=0.012$ ), higher LN ratio ( $12.57 \pm 21.96$  vs  $1.77 \pm 5.62$ ,  $p=0.01$ ) and lymphovascular invasion (43.1% vs 9.5%,  $p<0.0001$ ). NSEOC were associated to higher rates of 5-years overall survival (31.3% vs 54.2%,  $p=0.006$ ) and recurrence free survival (31.8% vs 64.6%,  $p=0.002$ ).

**Conclusion** The management of EOC should take into account differences between histological subtypes.

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### A CASE OF MIXED ADENOCARCINOMA OF UTERUS WITH BLADDER INVASION ORIGINATING FROM ADENOMYOSIS

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**Introduction** Adenocarcinomas originating from uterine adenomyosis are extremely rare. In addition, mixed adenocarcinoma of uterus with endometrial carcinoma and serous carcinoma is relatively infrequent.

**Case Presentation** A 52-year-old woman with a chief complaint of hematuria referred to our urology department. Tumor markers were elevated: Cancer antigen (CA) 19-9 58.6 U/ml, CA 125 101.5 U/ml. Urinary cytology, cervical cytology, and intimal cytology were all adenocarcinoma. Cystoscopy revealed protuberant lesions from posterior wall of the bladder. MRI showed a continuous tumor from anterior wall of the uterine body to the lumen of the posterior bladder, and CT showed an enlarged retroperitoneal lymph node. Transurethral resection of bladder tumor was performed to excise the tumor, which was also diagnosed as adenocarcinoma. A modified radical hysterectomy, bilateral salpingo-oophorectomy, partial cystectomy, lymph node biopsy and omentectomy were