IGCS20_1052

86 GLIOMATOSIS PERITONEI ASSOCIATED WITH OVARIAN GERM CELL TUMOURS- A CLINICOPATHOLOGICAL CASE SERIES

[1]A Jayraj*, [1]S Kumar, [1]N Bhatla, [2]S Thulkar, [2]S Thulkar, [3]L Kumar. *[1]Department of Obstetrics and Gynaecology, All India Institute of Medical Sciences, India; [2]Department of Pathology, All India Institute of Medical Sciences, India; [3]Department of Medical Oncology, All India Institute of Medical Sciences, India*

10.1136/ijgc-2020-IGCS.81

Introduction Gliomatosis peritonei (GP) is a rare condition characterized by the presence of mature glial tissue in the peritoneum of patients with ovarian teratomas. In this study, we investigated the clinicopathological features of ovarian teratoma with GP.

Methods From 2016 to 2019, cases of ovarian teratoma with GP treated at AIIMS, New Delhi were retrospectively analyzed for pathology, treatment, survival and prognostic information.

Results The median age of five patients identified with GP was 27 years. All patients had unilateral ovarian mass with moderate to massive ascites at presentation. One patient had bilateral pleural effusion. The average tumour size was 20 cm. Preoperative serum CA-125 (median:392 IU/mL, 141–882 IU/mL) and alpha-fetoprotein levels (median:1118 ng/mL, 219–2313 ng/mL) were elevated. Four patients underwent conservative surgery, with complete cytoreduction. One patient had mature cystic teratoma, one had low grade immature teratoma and three had high grade immature teratoma. All patients had stage 1A-1C disease. Intranodal glial tissue was identified in external iliac lymph nodes of one patient. Postoperatively, all immature teratoma patients received BEP chemotherapy. One patient developed growing teratoma syndrome and underwent secondary cytoreduction. At median follow-up of 30 months, all patients were alive without disease.

Conclusion GP is associated with favorable outcomes. Presence of significant ascites or pleural effusion and elevated CA 125 and alpha-fetoprotein levels preoperatively in patients with ovarian teratoma is suggestive of gliomatosis peritonei. It may be associated with mature or immature teratoma of any grade of differentiation. Adequate sampling to rule out immature elements is necessary for a definitive diagnosis of GP.

IGCS20_1053

87 SENTINEL LYMPH NODE IDENTIFICATION IN EARLY STAGE OVARIAN CANCER: IS IT STILL POSSIBLE AFTER PRIOR TUMOR RESECTION?

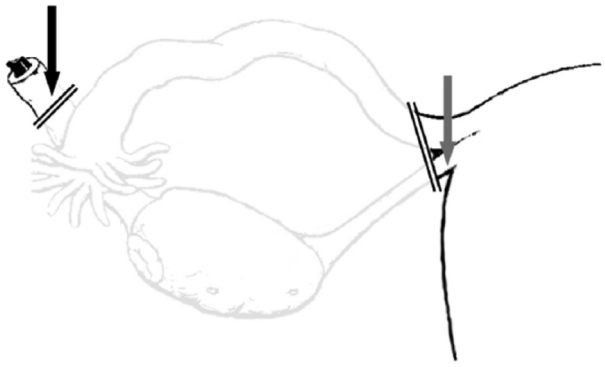
P Laven*, R Kruitwagen, S Lambrechts. *Maastricht Universitair Medisch Centrum, Netherlands*

10.1136/ijgc-2020-IGCS.82

Objective Sentinel lymph node (SLN) detection in ovarian cancer is feasible when tracers are injected before the pathological ovary is resected. This study aims to investigate whether the SLN identification is also feasible in patients whose ovarian tumor has already been resected with injection of the tracer into the ovarian ligaments stumps, i.e. in the event that a frozen section confirms malignancy.

Abstract 87 Table 1 Sentinel nodes found

Patient	Tumor side	Number of SLN	Histology during surgery	Location SLN	Histology after surgery	Metastases in the SLNs	Metastases in non-SLNs
1	Right	1	At least borderline	Paracaval low right	Mucinous	No	No
2	Left	1	Mixed	Para aortal low left	Clear cell	No	No
3	Left	2	Clear cell	Interaorta-caval, common iliac artery right	Clear cell	No	No



Abstract 87 Figure 1 Location of injection of tracers
Tracers were injected on the ventral and dorsal sides of both ligament remains.
Black arrow = remnant of infundibulo-pelvic ligament.
Grey arrow = remnant of the ovarian ligament (proper ovarian ligament).

Methods Patients who underwent laparotomy with frozen section confirming an ovarian malignancy, and those who underwent a second staging laparotomy after prior resection of a malignant ovarian mass, were included. Blue dye and a radioactive isotope were injected in the stumps of the ligamentum ovarium proprium and the ligamentum infundibulopelvicum. After an interval of at least 15-minutes, the SN(s) were identified using either the gamma-probe and/or blue dye.

Results A total of 11 patients were included in the study, the sentinel node (SLN) procedure was completed in all 11 patients. At least one SLN was identified in 3 patients, resulting in a rather low detection rate of 27,3%.

Conclusion In this study we showed that SLN procedure after (previous) resection of the tumor seems inferior to detect sentinel nodes when compared to injection of the tracer in the ovarian ligaments before tumor resection.

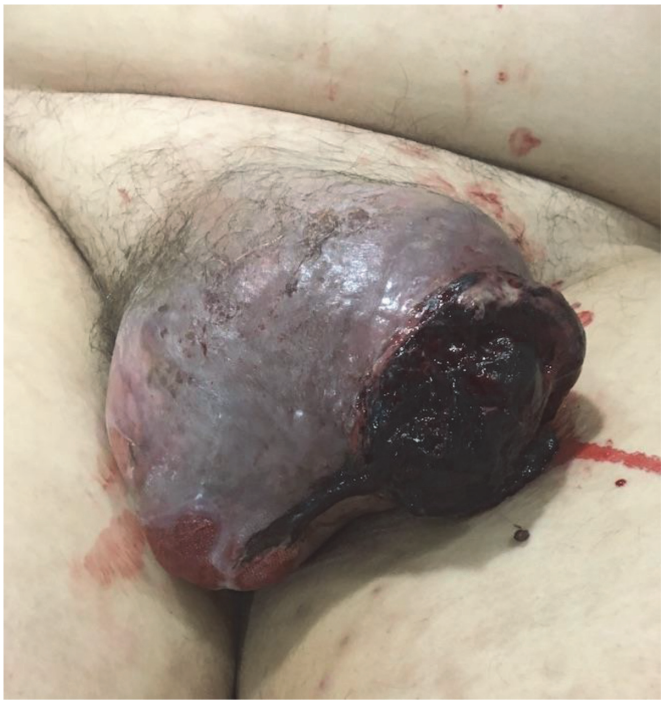
IGCS20_1054

88 DERMATOFIBROSARCOMA PROTUBERANS (DFSP) OF VULVA: CASE REPORT AT PONTIFICIA UNIVERSIDAD CATÓLICA DE CHILE

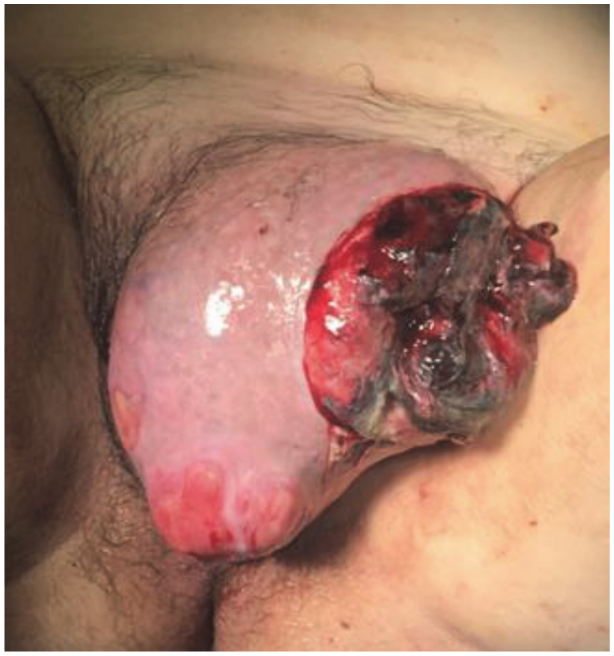
E Pertossi*, M Barriga, K García, D Mayerson, A Cuadra, S Gonzalez, P Coronado. *Pontificia Universidad Católica de Chile, Chile*

10.1136/ijgc-2020-IGCS.83

Introduction DFSP is a rare sarcoma of soft tissues. Most of them of low grade and good prognosis. More frequent in trunk of males. Here we present a case vulvar DFSP.



Abstract 88 Figure 1



Abstract 88 Figure 2

Methods Review of clinical chart, imagining, and pathology.
Case A post menopausal 50y-old patient, nulliparous with no medical history who presented vulvar lesion of fast growing and bleeding. Physical examination evidenced a tumor of 20 cm. compromising the mount of venus to the left with ulcerated areas. MRI and CT-scan confirmed a vulvar solid mass of 12.5 cm. without deep infiltration and hemorrhagic areas. Pathology concluded myxoid-DFSP. Neoadjuvant radiotherapy was given to decreased size with good results. Then, radical hemivulvectomy was performed with selective groin dissection of a suspicious lymph node. Ultrafast biopsy technique was used meanwhile the wound was covered with moltopren, and 24h later deep close margin, was informed so amplification of margin and rectus flap was performed successfully.
Discussion DFSP of vulvar location represents <1% of cases. Has slow growing and rarely lymph node compromise and local recurrences. Pathology usually exhibits spindle cells, with CD34 IHC stain positivity, nevertheless 10 to 20% could have aggressive sarcomatous areas. The usual treatment is radical vulvectomy or Mohs technique. Owing the proximity of gentle structures margins status represents a challenge. For this reason, RT can be an alternative to reduce size before surgery as in this case. Reaching a sure oncological result and maintaining esthetics.

IGCS20_1055

89 **LARGE CELL NEUROENDOCRINE CARCINOMA (LCNEC) OF THE ENDOMETRIUM : CASE REPORT AT HOSPITAL SÓTERO DEL RÍO, CHILE**

E Pertossi*, N Saez, M Urzúa, P LeCerf, O Puga. *Hospital Sótero del Río/Pontificia Universidad Católica de Chile, Chile*

10.1136/ijgc-2020-IGCS.84

Introduction Type I endometrial carcinoma (EC) is the most common uterine cancer, with known risk factors as obesity. Type II EC is less frequent, with high risk histologies including LCNEC.
Case A 62-year-old woman with type 2 diabetes, hypertension and obesity who had menopausal bleeding with an enlarged uterus, up to the umbilicus. CT-scan showed an enlarged uterus with a solid tumor filling the cavity and no evidence of dissemination. Endometrial sampling was performed with no evident dysplasia. Laparotomy revealed a 24 cm uterus and enlarged pelvic lymph nodes. TH+BSO was performed. Frozen section informed high grade carcinoma. Pelvic and para-aortic lymphadenectomy and omentectomy were then performed. Definitive pathology concluded a LCNEC of the endometrium infiltrating 93% of the myometrium with LVI+, without extrauterine spread (Stage IB). Afterwards, the patient received 6 cycles of etoposide plus cisplatin. To date, she's been 20 months disease free.
Discussion LCNEC of the endometrium has 28% 5-year overall survival. A recently published case series concludes that menopausal bleeding is the most common symptom. This aggressive histology has been included into type II EC, nevertheless, there is no consensus on pathologic criteria for diagnosis. WHO refers that diagnosis should be done with the presence of large carcinoma cells and high mitosis count, and presence of any of the following IHQ stains: chromogranine A, synaptophysin, CD56 or enolase enzyme. Here, the diagnosis was based on typical architectural large cells and CD56 positivity.