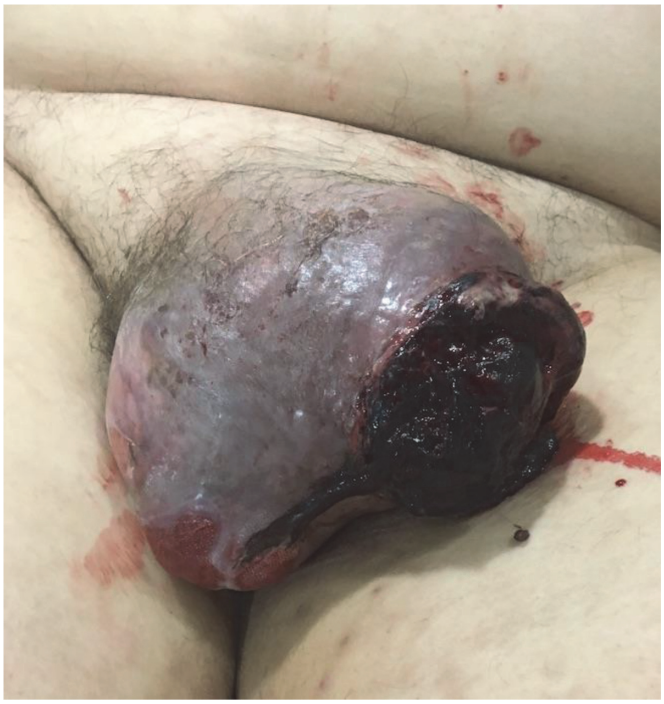
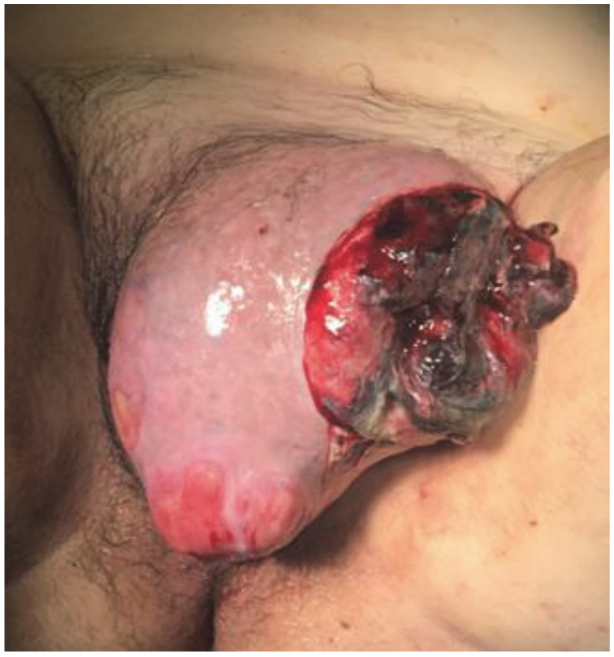


Abstract 88 Figure 1



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

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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.