IMMUNOHISTOCHEMISTRY SHOULD BE APPLIED IN CLASSIFICATION OF HIGH-GRASSENDOMETRIAL CARCINOMAS

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Introduction/Background High grade endometrial carcinomas include serous carcinomas, clear cell carcinomas, FIGO grade 3 endometrioid carcinomas, undifferentiated carcinomas, and carcinosarcomas. Often the morphologic and immunohistochemical profile overlap significantly, with interobserver reproducibility in subtyping high-grade endometrial carcinomas is suboptimal. In patients with serous and clear cell carcinomas compared with those with grade 3 endometrioid, poor outcomes were reported. Undifferentiated carcinomas and carcinosarcomas are also well known as highly aggressive. So, distinguishing this tumor from FIGO grade 3 endometrioid carcinoma is of clinical importance. The aim of our study was to determine if there are significant differences regarding histotyping without and with the use of a panel of immunohistochemical markers.

Methodology One hundred sixty-eight patients admitted in the Gynecological Department of Emergency Hospital of Oradea were diagnosed with endometrial carcinomas over a 2-year period (2020–2021) on curettage specimen. Immunohistochemical staining of ER, PR, p16, p53, Napsin A, PAX8, E-Cadherin was performed in selected cases.

Results Out of 168 cases, 51 patients (30.35%) had high grade endometrial carcinomas. Among these, by using only morphological examination, we diagnosed 26 cases (50.98%) as serous carcinomas, 14 cases (27.45%) as FIGO grade 3 endometrioid carcinomas, 5 cases (9.8%) as clear cell carcinomas, 4 cases (7.84%) as carcinosarcomas and only 2 cases (3.92%) as undifferentiated carcinomas. Following immunohistochemical tests, we determined that 28 cases (54.9%) were serous, 12 cases (23.52%) were endometrioid, 3 cases (5.88%) were clear cell, 4 cases (7.84%) were undifferentiated carcinomas.

Conclusion In our cohort, 4 cases were misdiagnosed (2 clear cell carcinomas were actually serous carcinomas, and 2 FIGO grade 3 endometrioid carcinomas was reclassified as undifferentiated carcinomas). The accuracy of diagnosis increased from 92.15 to 100%, underlining the utility of ancillary tests which should be performed in conjunction with careful histologic evaluation.

EXTRAPERITONEAL PARAARCTIC LYMPHADENECTOMY IN ENDOMETRIAL CANCER PATIENT WITH MORBID OBESITY: TEN STEPS OF THE TECHNIQUE

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Introduction/Background Ten steps of extraperitoneal paraaortic lymphadenectomy in endometrial cancer patient with morbid obesity was demonstrated in this video. Ten steps surgery can perform in a standardized safe and easy way.

Methodology Ten step video demonstration of surgical video of morbid obese patient

Results A 49-year-old obese patient with a BMI of 36.8 kg/m2 presented with abnormal uterine bleeding. A Diagnostic DnC was performed after the gynecological examination of the patient. As the result came to be a grade 2 endometrial adenocarcinoma, the patient underwent preoperative evaluation of pelvic MRI, upper abdominal and thoracic CT. On the MRI, a mmass of 48 * 32 * 25 mm in size with deep myometrial invasion was observed. Pathological lymph nodes were not observed. Also, There were no signs of pathological lymph nodes or lung metastasis on the CT. Preoperative CA 125 value was 17. After preoperative evaluation, staging surgery was planned for the patient, and hysterectomy, unilateral salpingoofoectomy, extra peritoneal paraaortic lymph node dissection and pelvic lymph node dissection operations were performed.

Conclusion Initiation of staging surgery with extraperitoneal paraaortic lymphadenectomy in obese endometrial cancer patients provides favorable pressure effects and facilitates the surgery because of bowel free surgical field.