IGCS 2025 CAPE TOWN

Annual Global Meeting, November 5–7, 2025

IGCS 2025 Abstracts: E-Poster Viewing (Case Reports)

Registered delegates will have access to all submitted Case Report E-Posters via the IGCS 2025 mobile application, IGCS 360 Educational Portal, and the onsite E-Poster stations.

Poster presenters were given the option to submit an audio file with a short presentation together with their E-Posters. Submitted audio files will be available together with their E-Posters via the IGCS 360 Educational Portal.

CP001 / #851

Topic: *AS02. Clinical Disciplines / AS02a. Diagnostics & Imaging*

NEEDLE TRACT SEEDING FOLLOWING INGUINAL LYMPH NODE BIOPSY FOR SUSPECTED METASTASIS: AN OVERLOOKED RISK

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Background/Introduction: Tumor seeding is defined as implantation of tumor cells by contamination of surrounding tissue after examination, excision or ablation of a tumor. If tumor cells are scattered in a puncture route this is referred to as needle tract seeding.

Case Presentation: In a 20-year retrospective cohort of patients with a vulvar carcinoma we selected patients with sentinel, inguinal or bulky node assessment (n=200). We found tumor positive nodes in 53 patients (26%). In 29 patients, needle aspiration cytology (in one or more lymph nodes) was performed prior to resection to confirm metastasis. Extra nodal growth of tumor cells was found in 84% of these patients, while this was 40% in patients that did not undergo diagnostic needle aspiration cytology (p = 0.008).

Discussion: Whilst it was thought that displaced tumor cells lack viability and thus do not progress into tumor foci, the phenomenon of needle tract seeding has been frequently described after biopsies of primary tumor, e.g. in breast cancer. The biopsy technique has therefore been altered using a coaxial needle system. No such measures are taken for needle biopsies of lymph nodes with suspected metastasis. Lymph node resection strategy, (it est) surgical completeness, should consider the risk of extranodal growth if needle aspiration cytology was performed.

Conclusion: Needle tract seeding of lymphogenic metastasized tumor cells is an overlooked complication of cytologic assessment of lymph nodes, potentially changing tumor stage. Preventive measures, e.g. the use of coaxial needle system, should be taken.

CP002 / #637

Topic: *AS02. Clinical Disciplines / AS02a. Diagnostics & Imaging*

CASE REPORT OF PRIMARY OVARIAN CARCINOID NEUROENDOCRINE TUMOR

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Background/Introduction: Primary ovarian carcinoid tumors are rare neuroendocrine neoplasms, constituting >0.1% of all ovarian tumors and 1% of carcinoid tumors. They originate from neuroendocrine cells within mature cystic teratomas and present either as nonspecific pelvic masses or with hormonal symptoms such as carcinoid syndrome.

Case Presentation: A 79-year-old woman presented progressive abdominal distension and shortness of breath. MRI revealed 23 cm complex pelvic mass and right pleural effusion, with elevated CA 125 (608 U/mL) and negative pleural cytology. She underwent total abdominal hysterectomy with bilateral salpingo-oophorectomy and peritoneal staging. Frozen section showed malignancy only. Histopathology confirmed well-differentiated neuroendocrine tumor (stromal carcinoid component), positive for synaptophysin and chromogranin, with lymphovascular invasion and paratubal involvement, staged at least 2b. Due advanced age, she was observed without postoperative treatment. Postoperatively, CA 125 and 5-hydroxyindoleacetic acid (5-HIAA) normalized, pleural effusion resolved, and she remained disease-free at 18 months.

Discussion: Primary ovarian carcinoids are classified insular, trabecular, strumal, and mucinous subtypes, with the insular type most common and typically associated with carcinoid syndrome[1]. These tumors are almost always unilateral and mostly affect peri- or postmenopausal women. Surgical excision is the mainstay treatment. Routine lymphadenectomy is not generally recommended. For well-differentiated, localized tumors, adjuvant therapy is not indicated. There are no established guidelines for advanced disease management. Early-stage, well differentiated tumors have good prognosis [2, 3].

Conclusion: Although rare, ovarian carcinoid tumors should be considered in women with ovarian masses and neuroendocrine symptoms. Complete surgical removal offers excellent outcomes in early-stage disease. Long-term follow-up is recommended to monitor for recurrence.

CP003 / #241

Topic: *AS02. Clinical Disciplines / AS02a. Diagnostics & Imaging*

FROM ADNEXAL MASS TO URETERAL MALIGNANCY: UNEXPECTED DIAGNOSTIC PITFALL IN PELVIC ONCOLOGY

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Background/Introduction: The differential diagnosis of an adnexal mass is broad and must include non-gynecologic origins. We present a case of pelvic pain initially attributed to an adnexal mass, later diagnosed as a periureteral malignancy.

Case Presentation: 35-year-old with newly diagnosed complex 9x6cm right adnexal mass, as shown in image 1, presented with abdominal pain. MRI, as shown in image 2, revealed severe right hydronephrosis and hydroureter extending to the level of the mass. Tumor markers (CA-125, CEA, LDH, b-hCG, inhibin B) were within normal limits. Nuclear renal scan showed significant impairment of the right kidney with a differential function of 6%. The patient underwent exploratory laparotomy and the mass was noted to be a periureteral tumor involving the right distal ureter at the insertion of the bladder requiring nephroureterectomy (R0). Final pathology revealed a periureteral myxoid neoplasm of uncertain malignant potential.

Discussion: Myxoid neoplasms are a rare group of mesenchymal tumors, histologically made up of abundant extracellular mucoid matrix, and can be benign or malignant. These tumors often involve the extremities but rarely may involve the urinary tract. The evaluation and management of these tumors present unique clinical challenges, given the lack of well-established treatment guidelines.

Conclusion: A patient presenting with pelvic pain and an adnexal mass on imaging was ultimately diagnosed with a periureteral myxoid neoplasm on final pathology. This case underscores the necessity of maintaining a broad differential diagnosis when assessing patients with presumed adnexal masses.

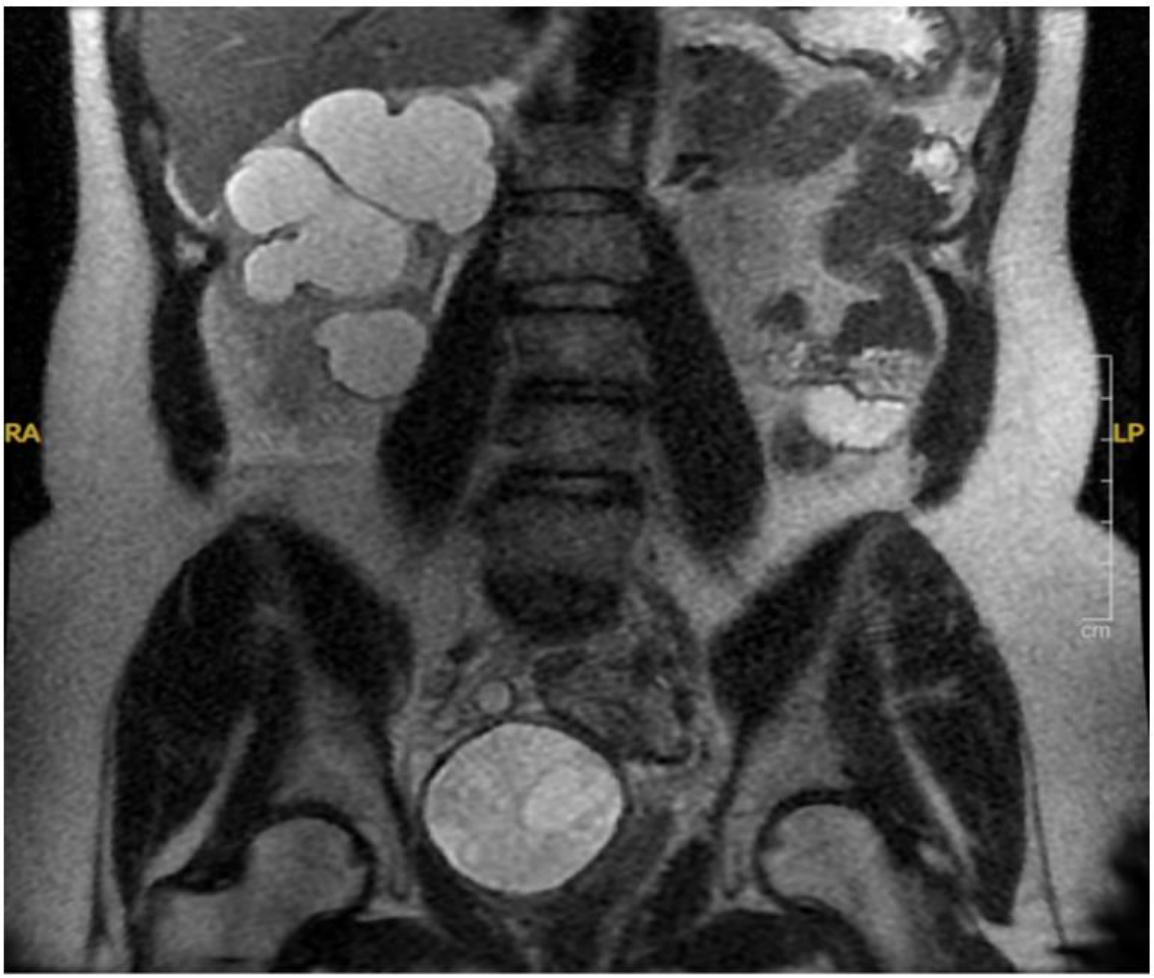

Image 1: CT abdomen pelvis showing 9x6x6cm right adnexal mass, ORADS 4, with evidence of right hydronephrosis

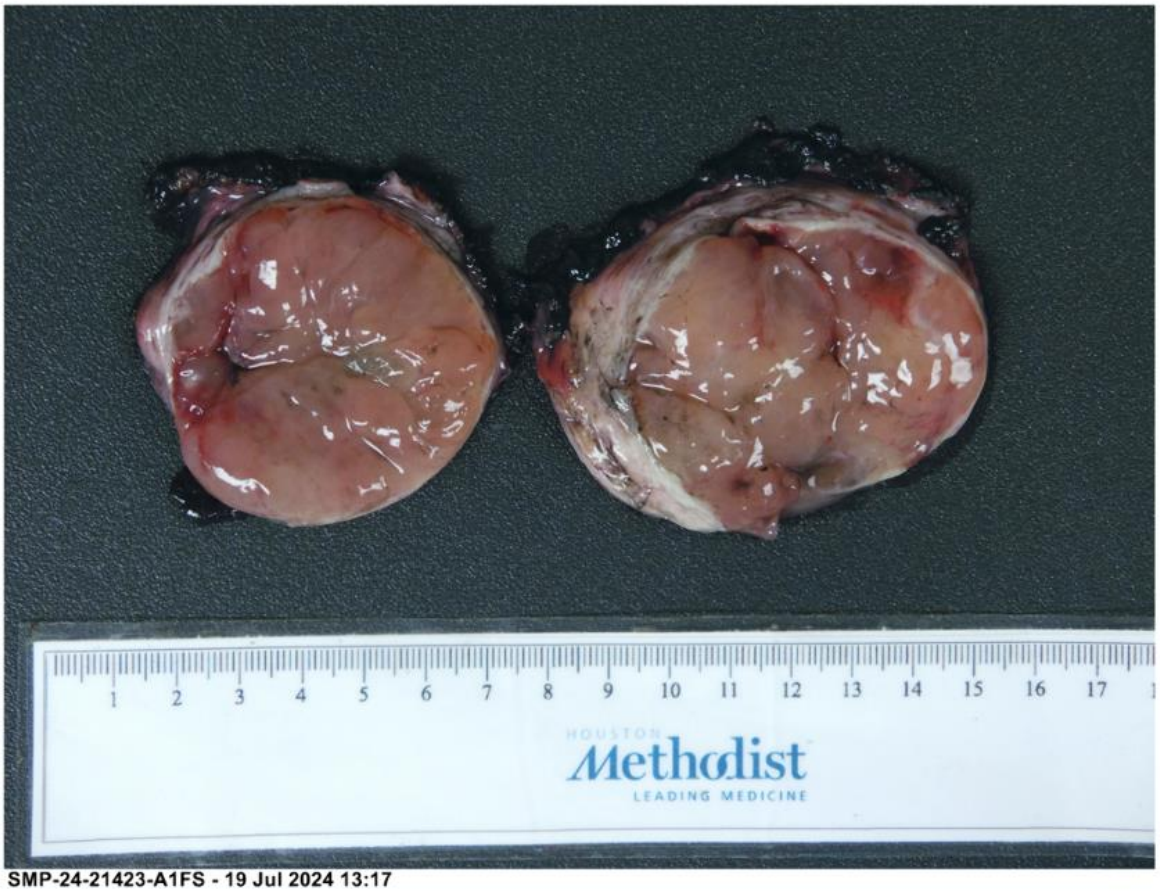

Image 2: Gross image of the 8.2 x 7.7 x 6.3 cm spherical mass arising from the soft tissue adjacent to the ureter with no definitive involvement of the ureter.

CP004 / #500

Topic: *AS02. Clinical Disciplines / AS02c. Pathology, Cytology & Disease Pathogenesis*

CLINICO-PATHOLOGICAL CORRELATION OF TMMR VERSUS RADICAL HYSTERECTOMY

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Background/Introduction: INTRODUCTION Nerve sparing radical hysterectomy(NSRH Type C1) is often used technique in surgical management of cervical carcinoma. Total Mesometrial Resection(TMMR) is an evolving technique which follows embryological planes of dissection.

Case Presentation: METHODS: 259 patients from 2010 to 2023 operated for carcinoma cervix were analysed. During 2010 to 2020 ,surgical technique was NSRH type C1.From 2020 ,we adopted TMMR. We analysed our database of 53 patients on clinical & pathological parameters of NSRH &TMMR

Discussion: RESULTS: Out of 53 patients, 42 underwent NSRH type C1 & 11 underwent TMMR. In 42 NSRH, 20 underwent laparoscopic resection & 22 underwent open technique. Out of 11 TMMR,9 underwent open approach & 2 were laparoscopic approach.Mean Operative time of TMMR was 327minutes & it is 118minutes more than NSRH which took 209minutes.Hospital stay was not different in both techniques. TMMR yielded a better parametrial margin, better vaginal margin & more number of pelvic lymph nodes when compared to NSRH.

	NSRH		TMMR	
Numbers	42		11	
Total operative time(average)	209minutes		327minutes	
Hospital Stay(average)	5.9days		6.7days	
Pathological Dimension of primary(average)	26.1mm		28.1mm	
Para dimension (average)-open approach((n)22 vs n(9))	(rt)29mm	(lt)26mm	(rt)31mm	(lt)32mm
Para dimension (average)-laparoscopic approach(n(20) vs n(2))	(rt)33.5mm	(lt)31mm	(rt)17.5mm	(lt)22.5mm
Vaginal margin-anterior	22mm		34mm	
Vaginal margin-posterior	25mm		39mm	
Lymph nodal yield-open approach((n)22 vs n(9))	25nodes		37nodes	
Lymph nodal yield-laparoscopic approach (n(20)vs n(2))	19nodes		50nodes	

Conclusion: TMMR technique yielded a better parametrial margin, better vaginal margin & more number of pelvic lymph nodes.TMMR technique appears to be a promising technique with better pathological parameters when compared to NSRH.

CP005 / #746

Topic: *AS02. Clinical Disciplines / AS02c. Pathology, Cytology & Disease Pathogenesis*

FINDING THE RARE AMONG THE UNUSUAL: A PRIMARY PAPILLARY THYROID CARCINOMA IN AN OVARIAN TUMOUR

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Background/Introduction: Ovarian teratomas are commonly benign findings containing mature tissues of ectodermal, mesodermal and endodermal origin. Malignant transformation is possible but rare. Thyroid tissue within mature teratomas has been described in 5-20 % of cases. Teratomas entirely or predominantly composed of thyroid tissue have been described first in 1888 as Struma ovarii.

Case Presentation: A 70-year-old postmenopausal woman presented at our tertiary referral university hospital with an multilocular-solid adnexal mass and ascites. She was oligosymptomatic with slightly elevated Ca125 (48 U/ml, reference: below 35 U/ml). Explorative Laparotomy was performed for suspected ovarian cancer with bilateral adnexectomy, peritoneal sampling and omentectomy, no macroscopically suspicious lesions were found. Postoperative recovery was normal. Final pathology reported a papillary thyroid carcinoma (PTC) deriving from a mature teratoma/struma ovarii. She was referred to Endocrinology for further care.

Discussion: Systematic literature review demonstrates PTC in the ovary is a rare diagnosis. The largest published case series of 118 ovarian mature teratomas containing thyroid tissue collected over 25 years included 10 cases of PTC. If confined to the ovary without rupture prognosis is good, full tumour excision seems sufficient. Adequate screening of the thyroid gland is necessary because primary PTC in the ovary vs. metastastes to the ovary show nearly identical histology with positivity for TTF1, PAX8 and thyroglobulin.

Conclusion: This rare case of papillary thyroid carcinoma of the ovary demonstrates the importance of thorough pathological review in all cases of suspected ovarian cancer due to the myriads of benignant and malignant tumour presenting as masses of the ovary. Accurate diagnosis is the foundation of further necessary diagnostics and correct treatment.

CP006 / #598

Topic: *AS02. Clinical Disciplines / AS02c. Pathology, Cytology & Disease Pathogenesis*

OVARIAN ENDOMETRIOID CARCINOMA MIMICKING SEX CORD TUMOR- A DIAGNOSTIC DILEMMA WITH A MYRIAD OF HISTOMORPHOLOGICAL AND IMMUNOHISTOCHEMICAL DIFFERENTIALS

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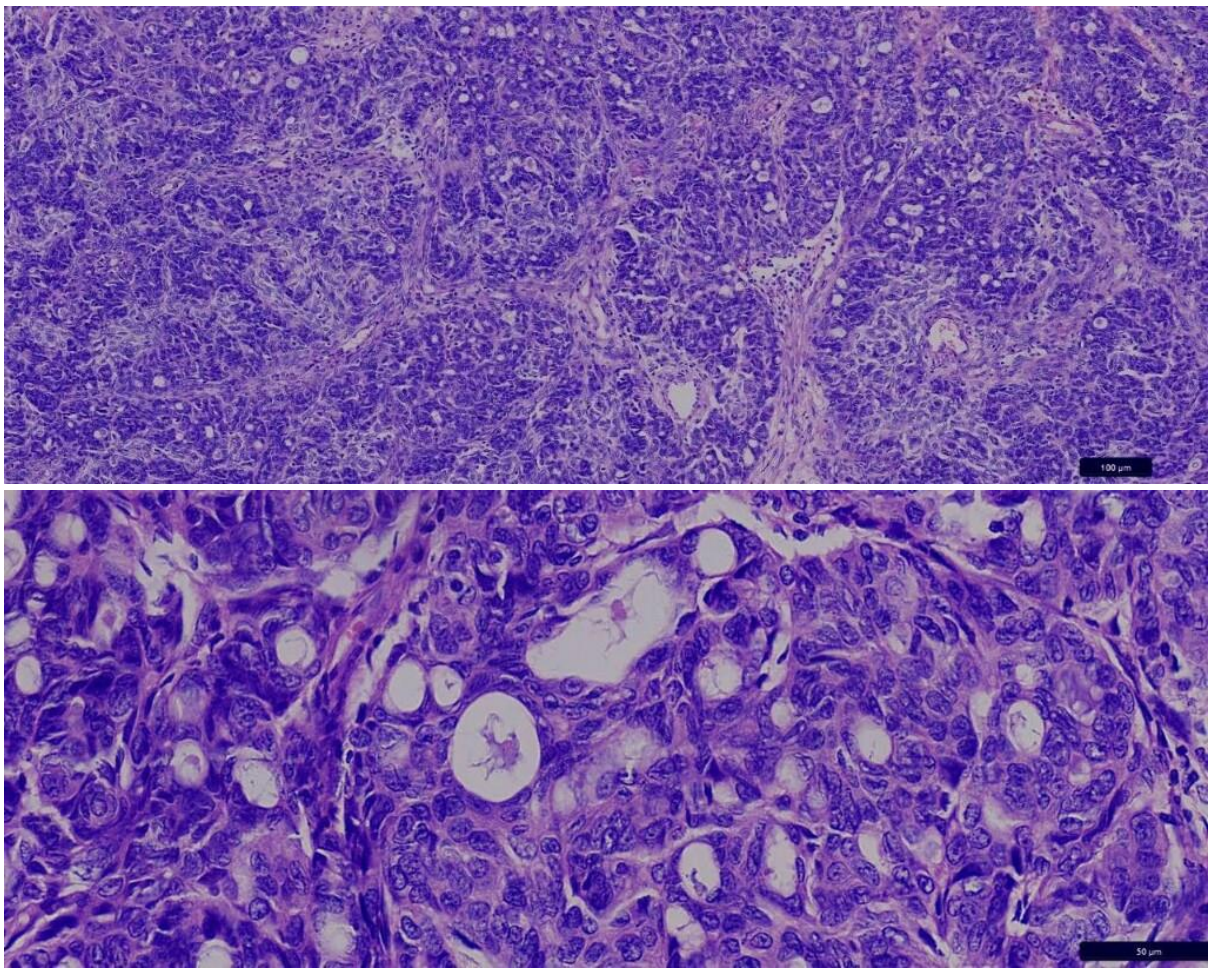
Background/Introduction: Endometrioid carcinoma (EC) mimicking sex cord tumors can show morphological heterogeneity with a wide range of architectural patterns and overlapping immunohistochemical features, thereby constituting a diagnostic pitfall. Accurate differentiation is essential in such a case due to distinct therapeutic and prognostic implications.

Case Presentation:



A 55 years old female patient presented with intermittent lower abdominal pain. MRI abdomen demonstrated a right ovarian cyst measuring 14 x 11 cm. The patient underwent total abdominal hysterectomy with bilateral salpingo-oophorectomy. Grossly, the right ovarian mass shows yellow-tan, lobulated cut surface.

Microscopically, representative sections displayed a tumor exhibiting various patterns of configuration including diffuse sheets, nests, solid cords, trabeculae and tubules; no foci of conventional endometrioid carcinoma with glandular morphology were evident. Immunohistochemistry showed diffuse strong positivity for CK8/18, CK7 and beta-catenin (nuclear positivity) while PAX8, WT1, Inhibin, Calretinin, FOXL2 were negative. PTEN expression was lost in tumor cells. Overall morphological as well as immunohistochemical features ultimately favored the possibility of Sex cord like Endometrioid carcinoma.The patient thereby underwent 6 cycles of adjuvant systemic chemotherapy.

Discussion: Awareness of this rare variant of Ovarian endometrioid carcinoma and the application of a comprehensive immunohistochemical panel are pivotal for correct diagnosis. Differentiation is critical as management strategies for epithelial ovarian cancer differ significantly from those for Sex cord tumor, especially regarding chemotherapy sensitivity and surveillance protocols.

Conclusion: Endometrioid carcinoma with sex cord-like patterns is a diagnostic mimic of sex cord tumor. Pathologists and clinicians should maintain a high index of suspicion and use immunohistochemistry to ensure accurate diagnosis, avoiding potential mismanagement.

CP007 / #1059

Topic: *AS02. Clinical Disciplines / AS02d. Radiation Oncology*

OPTIMIZING RADIATION THERAPY DELIVERY IN POST-HYSTERECTOMY PROLAPSE: A CASE FOR VAGINAL PESSARY USE

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Background/Introduction: The co-occurrence of pelvic organ prolapse (POP) and uterine malignancy requiring adjuvant radiation therapy is rare, and standardized management approaches are not well established. This case highlights a practical strategy for optimizing radiation delivery in a patient with post-hysterectomy POP undergoing treatment for advanced-stage endometrial cancer.

Case Presentation: A 70-year-old woman with FIGO stage IIIC endometrial cancer underwent robotic surgical staging followed by six cycles of adjuvant carboplatin and paclitaxel chemotherapy. During radiation therapy planning, physical examination and CT imaging revealed total vaginal cuff procidentia, with bladder prolapse into the radiation field (Figure 1). Initial management with a ring pessary was unsuccessful due to displacement. Subsequently, a 3.0-inch Gelhorn pessary was placed, maintaining adequate anatomical positioning throughout repeat CT simulation. This allowed for safer delineation of the clinical target volume, reducing bladder exposure (Figure 2). The patient commenced external beam radiotherapy (EBRT) 34 days after chemotherapy, receiving 45 Gy in 25 fractions. The pessary remained in situ throughout treatment without displacement, and only minor side effects were reported.

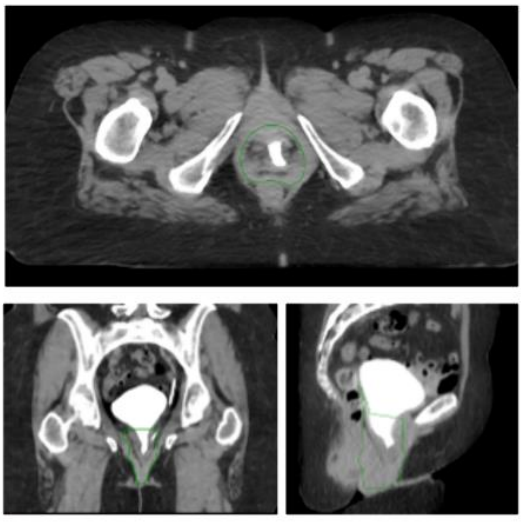

Figure 1. CT scan prior to pessary placement

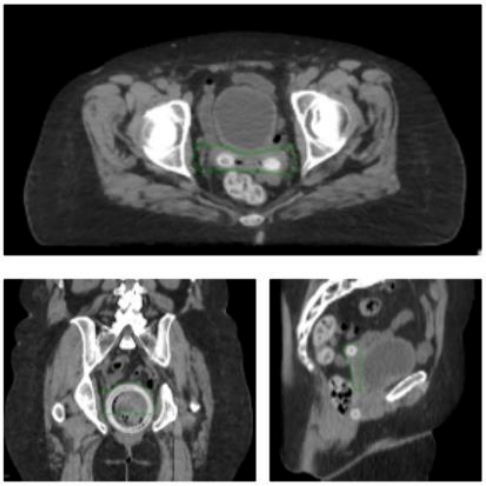

Figure 2. CT scan post pessary placement

Discussion: In patients with POP undergoing adjuvant pelvic EBRT, a vaginal pessary offers a noninvasive, well-tolerated alternative to surgical repair or repeated reductions. This approach enables timely radiation delivery while minimizing organ-at-risk exposure. Multidisciplinary collaboration is essential to ensure optimal treatment outcomes in such complex clinical scenarios.

Conclusion: The use of a vaginal pessary can effectively manage POP in patients requiring adjuvant radiation therapy post-hysterectomy, facilitating safer treatment delivery and highlighting the importance of individualized, multidisciplinary care strategies.

CP008 / #704

Topic: *AS02. Clinical Disciplines / AS02e. Surgical Techniques & Perioperative Management*

NON-PUERPERAL UTERINE INVERSION DUE TO NECROTIC PROLAPSED FIBROID: A CASE REPORT

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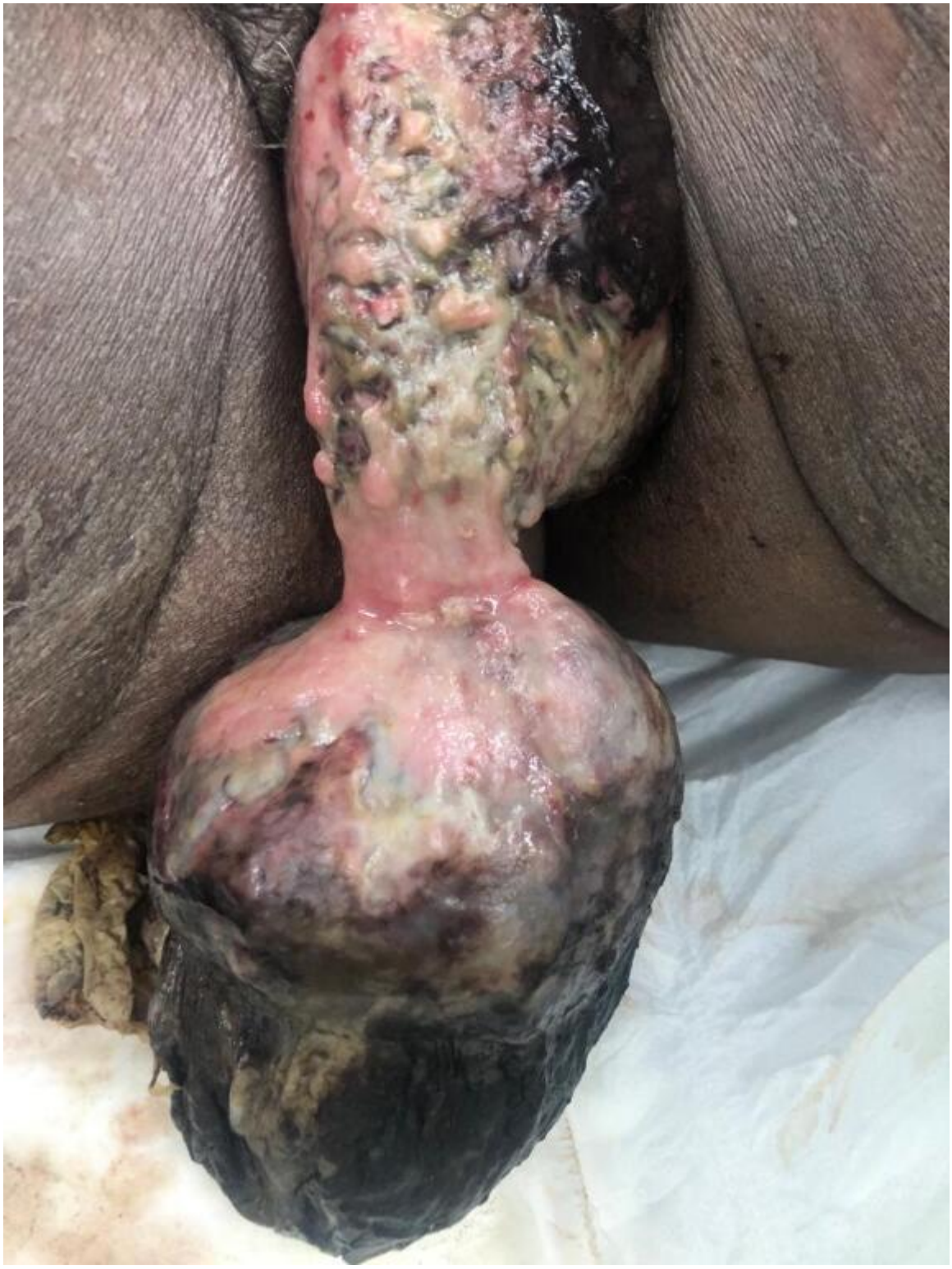
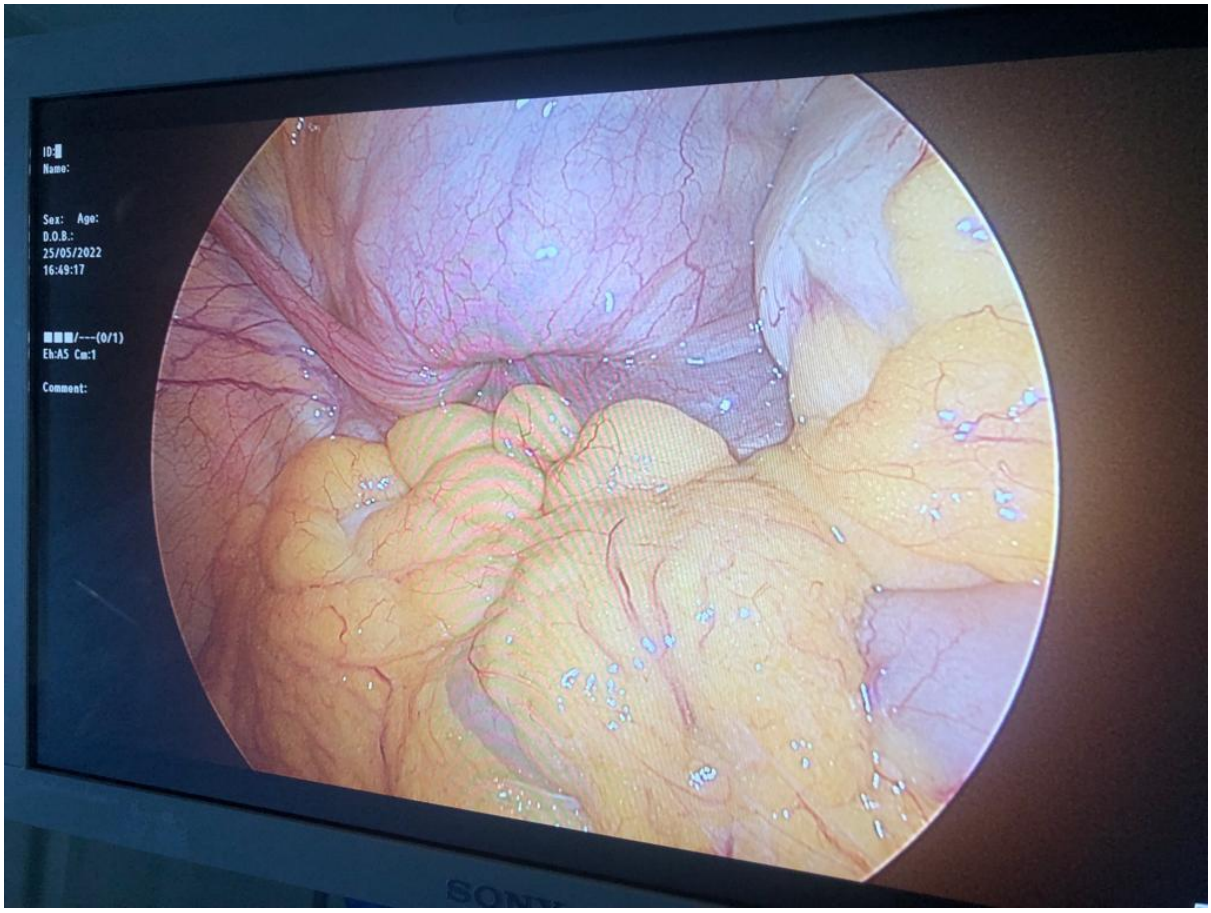
Background/Introduction: Case report describes a rare instance of non-puerperal uterine inversion

Case Presentation: 43-year-old multiparous woman who presented with a three-week history of offensive vaginal discharge and mild pelvic discomfort. Clinical examination revealed a large necrotic mass protruding through the vaginal introitus in shocked patient , with laboratory findings showing anemia , and thrombocytosis. Initial considerations included a pedunculated fibroid, Uterine sarcoma Or pedunculated fibroid with uterine inversion. The patient underwent prompt resuscitation with intravenous fluids, antibiotics, blood transfusions, and analgesics. Diagnostic laparoscopy confirmed stage III uterine inversion. A staged surgical approach was employed: vaginal myomectomy to remove the necrotic fibroid, followed by laparotomy and the Haultain procedure to correct the inversion. Given the extent of tissue necrosis, a total abdominal hysterectomy with bilateral salpingectomy was performed, preserving the ovaries. Histopathology confirmed infarcted leiomyoma with acute on chronic endomyometritis and salpingitis. Tissue culture identified *Enterococcus faecali*





Discussion: Non-puerperal uterine inversion, most often linked to submucosal fundal fibroids or uterine mass , is extremely rare and presents diagnostic and therapeutic challenges. Surgical correction varies depending on the chronicity, with options including the Haultain, Huntington, Spinelli, and Kustner procedures. In acute inversion, manual repositioning via the Johnson maneuver is preferred

Conclusion: This case underscores the importance of early recognition, diagnostic laparoscopy, and timely surgical intervention in managing this life-threatening gynecological condition.

CP009 / #624

Topic: *AS02. Clinical Disciplines / AS02e. Surgical Techniques & Perioperative Management*

NEGATIVE PRESSURE WOUND THERAPY IN PERIOPERATIVE MANAGEMENT OF VULVAR CANCER RELAPSE SURGERY

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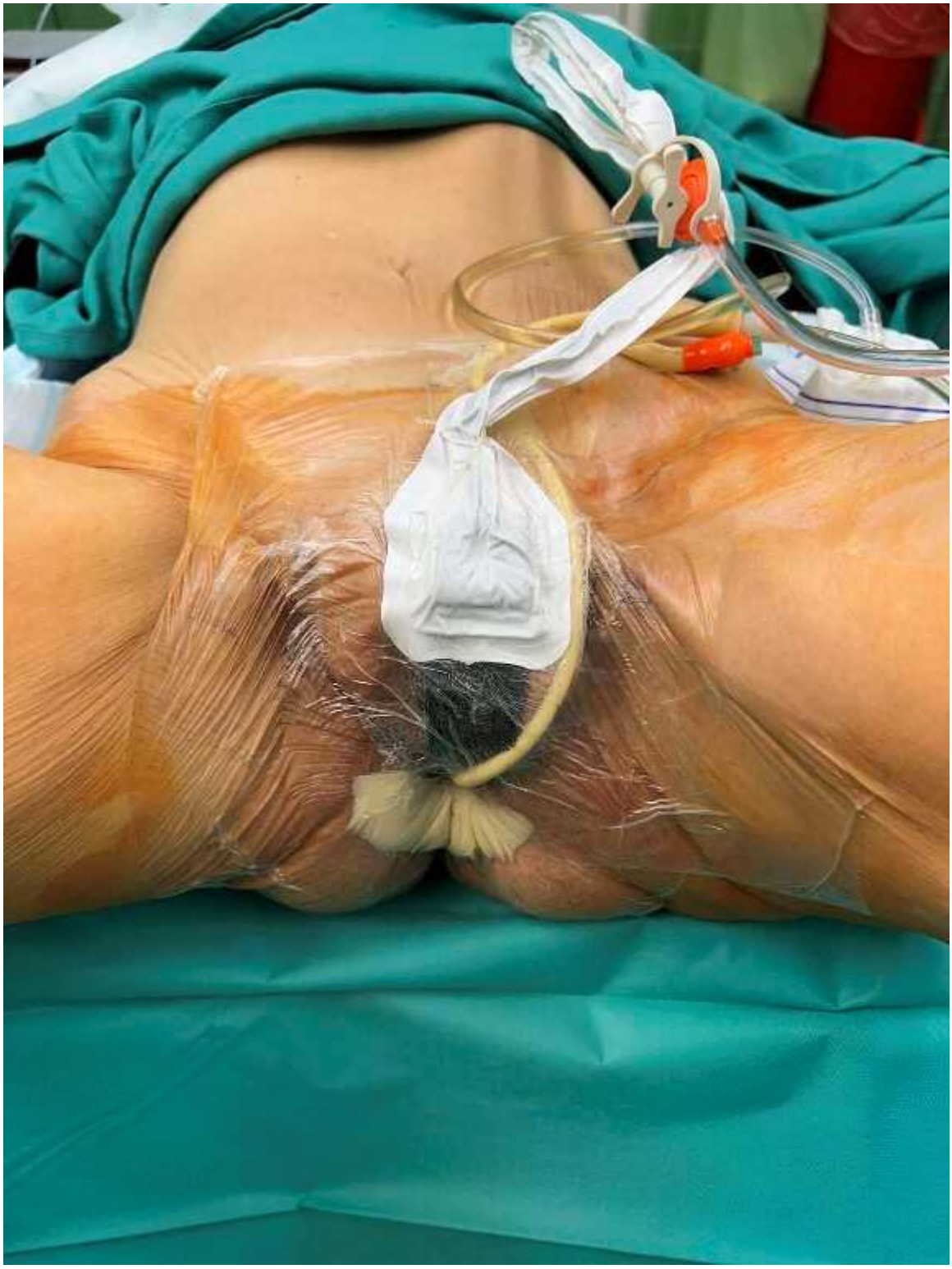
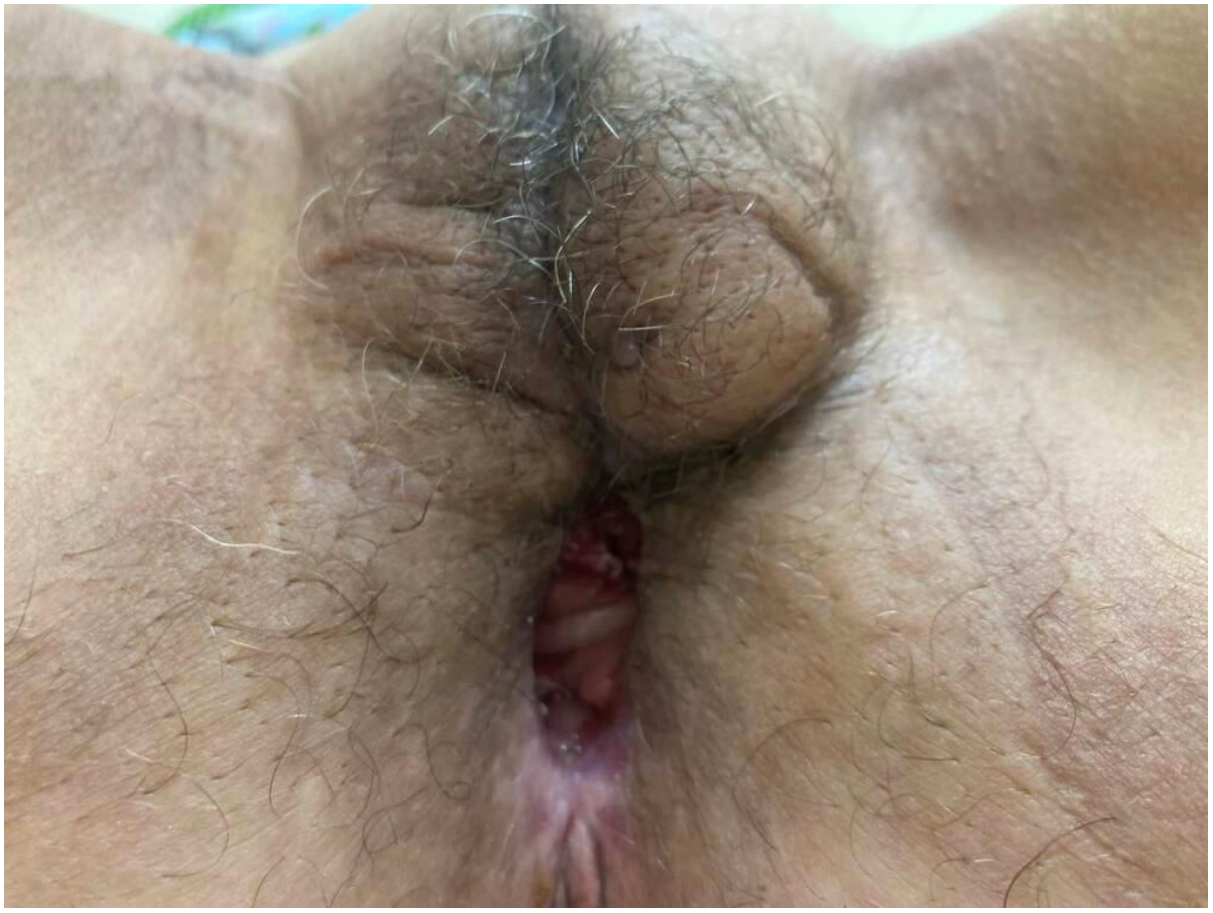
Background/Introduction: Wounds after radical vulvar cancer surgeries have always been a challenge for gynecologic oncology specialists. Women diagnosed with vulvar cancer are often older patients with comorbidites (diabetes and obsesity) which can impede healing process. Another important factor impairing postoperative care is operating in previously radiated area. Negative pressure wound therapy is a possible solution that can be preventively implemented in complex cases. We present a case of patient who underwent surgery due to vulvar cancer relapse after operation and radiation therapy. Negative pressure dressing was used to facilitate wound healing process.

Case Presentation: 65-year old woman was diagnosed with vulvar cancer recurrence 35 years after primary surgical treatment complemented with adjuvant radiotherapy. As a treatment of relapse she underwent radical vulvar excision including removal of distal, infiltrated portion of urethra. A negative pressure dressing was placed just after the procedure in the operating room. We used a stoma paste to adjust and seal the dressing. The pressure set was at 120 mmHg. Dressing was replaced after 72 hours and removed 6 days after procedure. The postoperative period was uneventful. Wound was completely healed one month after surgery.





Discussion: The strongest impediment to the healing process in vulvar area is the chronic exposure to urine and feces. Utilizing negative pressure dressing helps minimizing wound contamination. Impact on increasing oxygenation was also proven which is particularly important in previously radiated tissue otherwise poorly oxygenated. Uncomplicated, rapid wound preparation enables adjuvant treatment implementation without delay.

Conclusion: Negative pressure dressings may improve healing process after vulvar surgeries.

CP010 / #747

Topic: *AS02. Clinical Disciplines / AS02e. Surgical Techniques & Perioperative Management*

LAPAROSCOPIC MANAGEMENT OF A LARGE OVARIAN CYST IN A PRE-MENARCHEAL: ERGONOMIC ADAPTATIONS IN A LOW-RESOURCE SETTING

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Background/Introduction: Ovarian cysts in pre-menarcheal girls present unique surgical challenges due to concerns about malignancy, fertility preservation and anatomical limitations. Although most cysts are benign, timely surgical intervention is critical to avoid complications such as torsion or rupture. Laparoscopic management is increasingly preferred for its minimally invasive benefits, though it requires technical adaptations in pediatric patients.

Case Presentation: A 10-year-old pre-menarcheal girl presented with an incidentally discovered right ovarian cyst measuring 8 cm. Tumor markers were normal and MRI findings were inconclusive. Laparoscopic ovarian cystectomy was performed using three 5-mm ports. A supra-umbilical primary port was inserted using the open (Hasson) technique to enhance visualization and minimize vascular injury. In the absence of pediatric instruments, standard adult laparoscopic tools were used successfully. The operating table was lowered to improve ergonomics. Controlled aspiration of the cyst minimized spillage, and ovarian tissue was preserved meticulously. The patient recovered uneventfully. Follow-up for six months by ultrasound confirmed normal ovarian architecture and no recurrence.

Discussion: This case highlights the feasibility of laparoscopic ovarian cystectomy in a pediatric patient, even in low-resource settings. Supra-umbilical access, low insufflation pressures and ergonomic adjustments facilitated safe and effective surgery. The use of adult instruments compensated for the lack of pediatric-specific equipment. Laparoscopy provided reduced morbidity, quicker recovery and superior cosmetic results compared to laparotomy.

Conclusion: Laparoscopic management of large ovarian cysts in pre-menarcheal children is safe and effective when appropriate modifications are made, even in low-resource settings. It should be considered the preferred approach when surgical expertise and careful planning are available.

CP011 / #1130

Topic: *AS02. Clinical Disciplines / AS02e. Surgical Techniques & Perioperative Management*

A RARE CASE OF INCIDENTAL PELVIC NODE SCHISTOSOMIASIS IN EARLY-STAGE CERVICAL CANCER. A CLINICAL DILEMMA IN A SETTING WITH LIMITTED INTRAOPERATIVE FROZEN SECTION ACCESS.

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Background/Introduction: Limitations of different imaging modalities in assessing low volume nodal disease for early-stage cervical cancer are well documented. Intra-operative nodal assessment using frozen section is recommended to minimise morbidity associated with multimodal therapies, especially in abnormal looking nodes.

Case Presentation: A 43-year-old lady was referred to our gynae-oncology unit with inadvertent moderately differentiated cervical adenocarcinoma. Tumour size of 10mm with middle third cervical stromal involvement, no LVSI, P16 diffusely positive and no schistosomiasis. No travel history, living with HIV on treatment. Staging CT scan was negative for regional and distant metastasis. Completion radical surgery was offered. Intra-operatively, pelvic nodes looked abnormal. Unfortunately, frozen section services were not available. Though generally not ideal, we proceeded with surgery based on risk-benefit local factors. Definitive histology revealed calcified schistosoma ova in two of the nine right pelvic nodes with no local residual or nodal metastatic disease.

Discussion: We didn't find a similar case in our literature search. CT scan assessment missed the calcifications in the pelvic nodes which underscores the documented limitations of different imaging modalities both in sensitivity and specificity for nodal assessment in small volume disease. While frozen section has its own limitations, it is a recommended intraoperative triage tool. Calcified ova could be identified, and the dilemma resolved.

Conclusion: Multimodal strategies are crucial in staging early-stage cervical cancer as per evidence-based guidelines. While low resource settings may not afford all these strategies, every effort must be made to acquire and utilise available resources to improve oncological outcomes.

CP012 / #777

Topic: *AS02. Clinical Disciplines / AS02e. Surgical Techniques & Perioperative Management*

MANAGEMENT OF CHYLOUS ASCITES FOLLOWING GYNAECOLOGICAL ONCOLOGY SURGERY - CASE REPORT AND LITERATURE REVIEW

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Background/Introduction: Chylous ascites can occur following gynaecological oncology surgery due to disruption of lymphatic vessels. We present a case of chylous ascites following para-aortic lymph node dissection successfully managed with octreotide therapy alongside standard of care dietary interventions without parenteral nutrition (PN).

Case Presentation: A 64-year-old female developed high volume chylous drain output following abdominal hysterectomy and para-aortic lymph node dissection for ovarian cancer. She was managed with a low-fat diet and medium-chain triglycerides (MCT) for six days with no improvement. Octreotide was commenced on day nine and there was rapid improvement in chylous drain output. Following three days of octreotide therapy there was resolution of chylous output with no further recurrence at six week follow up.

Discussion: Chylous ascites causes significant morbidity and prolonged hospital admissions. Current literature suggests a stepwise approach, utilising a low-fat diet with MCT and PN, consideration of octreotide, image guided sclerotherapy, surgical exploration and finally peritoneovenous shunting. There are few examples in the literature of octreotide used without the adjunct of PN. Octreotide as definitive treatment is advantageous due to lower complication rates, low cost and avoidance of central line placement.

Conclusion: We present a case of chylous ascites successfully managed with octreotide therapy without PN. Octreotide therapy without PN should be considered as a treatment option given its low cost, reduced risk profile and potential to reduce duration of admission.

CP013 / #628

Topic: *AS03. Patient-Centered Care / AS03a. Fertility & Pregnancy*

VULVAL CANCER IN PREGNANCY: MORE THAN AN ITCH

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Background/Introduction: Vulval cancer in pregnancy is rare and unexpected with literature confined to less than 45 documented cases. Management is further complicated by the social, psychological and physiological changes of the perinatal period. The psychosexual impact in young women remains challenging.

Case Presentation: A forty-year-old HIV positive woman, is referred 6 weeks post caesarean delivery with HPV-related vulval cancer. Despite syndromic treatment for vulval itch during her first trimester, symptoms worsened - a peri-clitoral lesion developed. After diagnosis at 28 weeks' gestation, she declined referral until after pregnancy. As a FIGO stage 1B at referral, tumour 4cm*2cm. She deferred surgical intervention until1 year after delivery, she was exclusively breastfeeding and the infant's primary carer. Complete surgical resection with negative lymph nodes was achieved.

Discussion: Concomitant HIV and HPV infections has led to an increasing prevalence of vulval cancer in reproductive aged women. Locally nearly 70% of cases occur in women younger than 50. Internationally 25% of new cases are HPV associated. Physiologial changes of pregnancy to the vulva often cause symptoms that overlap with those of vulval cancer. This may obscure suspicion and delay the diagnosis. Histological sampling of the vulva is often delayed trialling medical treatment and HCW's hesitancy. Perinatal mothers often prioritize their baby's needs above their own health, which may negatively impact oncologic outcomes. Opportunistic cervical screening in pregnancy should include a vulval examination as is recommended during routine screening.

Conclusion: Management during the perinatal period requires a multidisciplinary patient-centered approach. Increasing awareness of HPV related gynaecological cancers during pregnancy is vital.

CP014 / #1020

Topic: *AS03. Patient-Centered Care / AS03a. Fertility & Pregnancy*

DIAGNOSIS AND MANAGEMENT OF PLACENTAL SITE TROPHOBLASTIC TUMOR IN LOW RESOURCE SETTING

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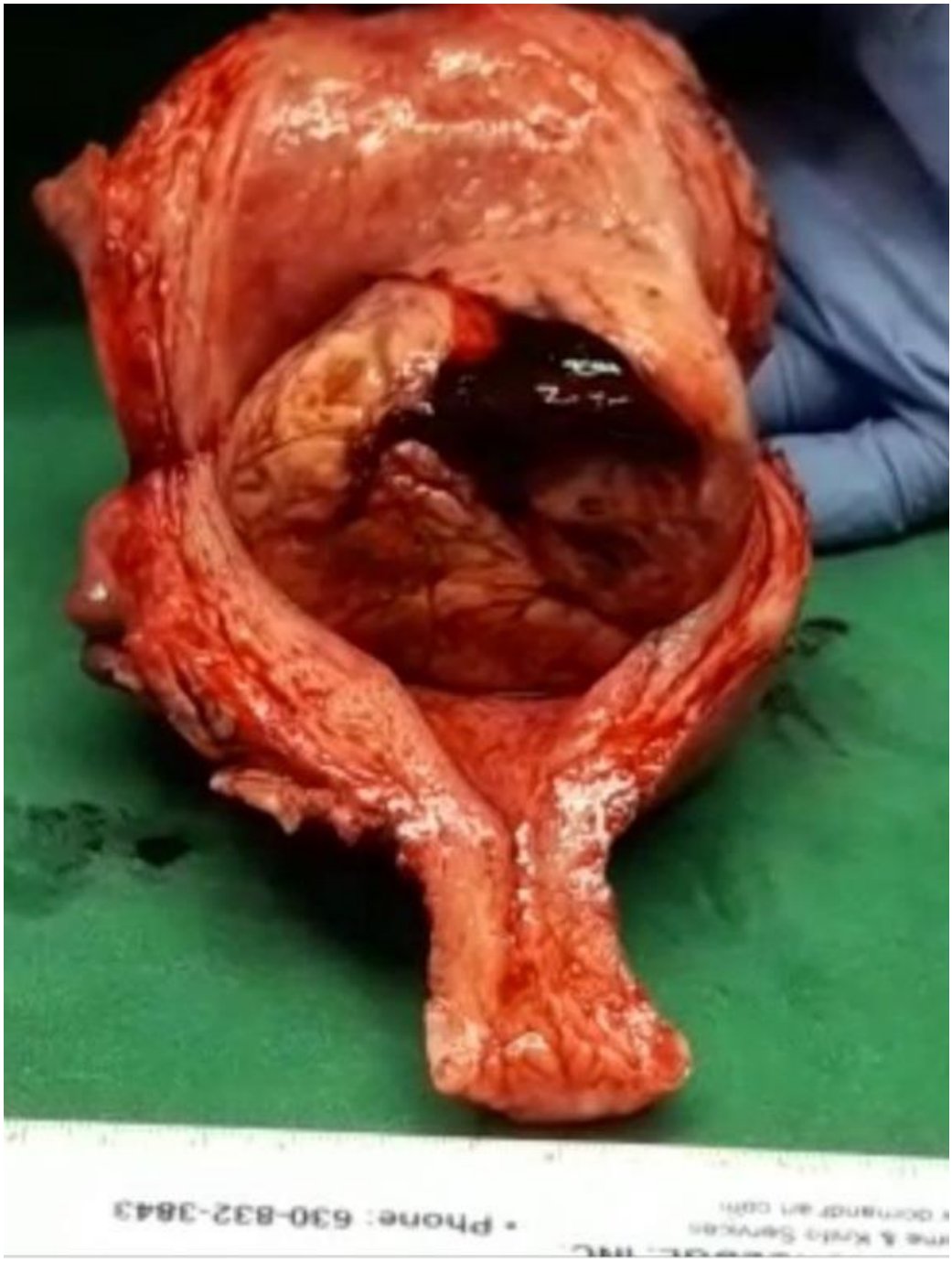
Background/Introduction: Placental site trophoblastic tumor is a rare form of gestational trophoblastic disease and global incidence of 1/100,000 and mortality reports as high as 25%. It is estimated that globally, there are < 500 reported cases in the literature of placental site trophoblastic tumor.

Case Presentation: 26-year-old with previous complete molar pregnancy treated with suction curettage and 6 cycles of multiagent chemotherapy. Four years later, a normal pregnancy. Four years after incomplete abortion medically managed. Investigated for abnormal uterine bleeding and incidental finding of mildly elevated hCG, elevated hPL, and inconclusive radiological imaging. Final pathology and immunohistochemistry from hysterectomy confirmed placental site trophoblastic tumor. No evidence of metastatic disease on postoperative imaging; values returned to zero. Five years later presented with shortness of breath, imaging revealed mass in mid and lower zones of right lung. Lung biopsy consistent with placental site trophoblastic tumor; hCG (81, 395). Disease progression after two cycles of Pembrolizumab. Subsequently treated with Etoposide and Cisplatin for 6 cycles, then retreated with Pembrolizumab for 5 cycles. Currently, no evidence of disease.



Discussion: The case highlights the complexities of managing GTD and the need for continued surveillance. Financial toxicity was a major factor in the care of this patient, as case reports have reported complete remission with Pembrolizumab; however cost of treatment delayed care.

Conclusion: Placental site trophoblastic tumor is a rare and potentially curable condition if diagnosed early. Histopathology is the mainstay in the diagnosis of placental site trophoblastic tumor as there are no classical radiological features that will assist in preoperative diagnosis.

CP015 / #434

Topic: *AS03. Patient-Centered Care / AS03a. Fertility & Pregnancy*

SURVEILLANCE AFTER FERTILITY-SPARING TREATMENT OF EARLY-STAGE ENDOMETRIAL CANCER IN YOUNG WOMEN

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Background/Introduction: Endometrial carcinoma is the second most common gynecologic cancer, affecting mainly postmenopausal women and only 3-5% of young women. The standard treatment is total hysterectomy with bilateral salpingo-oophorectomy; however, in young women, fertility preservation should be considered.

Case Presentation: A 21-year-old nulligravid woman presented with abnormal uterine bleeding and anemia. Transvaginal ultrasound and hysterosonography revealed an endometrial thickness of 21 mm and two endometrial polyps. Hysteroscopy and gynecologic curettage were performed, revealing complex atypical hyperplasia with foci of well-differentiated endometrioid adenocarcinoma, FIGO stage IA. MRI showed a neoplastic-appearing lesion in the endometrial fundus and left cornual region, without evidence of myometrial invasion. PET-CT demonstrated nonspecific mild hypermetabolic activity in an external obturator lymph node. The multidisciplinary team decided on conservative, fertility-preserving management, including laparoscopic biopsy of the obturator lymph node, bilateral sentinel lymph node mapping, hysteroscopic tumor resection, and insertion of a levonorgestrel-releasing intrauterine device (LNG-IUD) following oocyte cryopreservation. Lymph node pathology was negative. A complete pathological response of the endometrium was documented at six months. A follow-up every six months with MRI, transvaginal ultrasound, and hysteroscopic endometrial biopsy was scheduled. At the two-year follow-up, no tumor recurrence was detected. Fertility is not desired yet.

Discussion: There is no high-quality evidence regarding adequate surveillance when opting for non-standard management, and no expectation of prompt fertility

Conclusion: Conservative management with resection of the endometrial lesion, LNG-IUD, and close follow-up with imaging, hysteroscopy, and endometrial biopsy after oocyte preservation is an alternative for early-stage endometrial carcinoma in young women desiring fertility preservation without early expectation.

CP016 / #878

Topic: *AS03. Patient-Centered Care / AS03b. Palliative, Symptomatic & Supportive Care*

PROPORTIONALITY OF CARE IN ADVANCED CERVICAL CANCER: THE CENTRAL ROLE OF INTEGRATED PALLIATIVE CARE.

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Background/Introduction: Advanced-stage cervical cancer presents a complex clinical scenario where early integration of palliative care is crucial to ensure quality of life, symptom control, and proportionate therapeutic decision-making.

Case Presentation: A 59-year-old previously healthy woman was diagnosed with locally advanced cervical cancer in 2013 and underwent curative-intent treatment with chemotherapy, radiotherapy, and brachytherapy. In 2020, she experienced an unresectable local recurrence, refractory to platinum-based palliative chemotherapy. Immunotherapy with cemiplimab was initiated, achieving disease control for 18 months. She later developed multiple complications: recurrent urinary tract infections caused by multidrug-resistant organisms, rectovaginal fistula, chronic vaginal bleeding, and malignant bowel obstruction. The therapeutic approach prioritized comfort, employing tranexamic acid, multimodal analgesia (methadone, gabapentin, amitriptyline, metamizole), and proportionate palliative surgeries (partial colectomy, colostomy, bilateral nephrostomy, and ureteral stenting). The patient died in January 2025, after 22 months of predominantly palliative care follow-up.

Discussion: Palliative care played a pivotal role through proportional interventions and a multidisciplinary approach. Immunotherapy contributed to extended survival and symptomatic control. This case highlights the importance of early palliative integration even in the presence of active disease, and the need to evaluate therapeutic proportionality according to the patient's context.

Conclusion: Integrated palliative care enhances dignity, functionality, and quality of life in advanced oncologic settings, reaffirming its central role in gynecologic oncology.

CP017 / #695

Topic: *AS03. Patient-Centered Care / AS03b. Palliative, Symptomatic & Supportive Care*

URETEROVAGINAL FISTULA AS A SURGICAL COMPLICATION IN ADVANCED UTERINE CARCINOSARCOMA WITH VAGINAL METASTASIS IN A LOW-RESOURCE SETTING

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Background/Introduction: Uterine carcinosarcomas are rare, aggressive tumors accounting for 2–5% of uterine malignancies, typically presenting in postmenopausal women with advanced-stage disease. Ureterovaginal fistulas (UVFs) are uncommon surgical complications, occurring in 0.5–2.5% of major gynecologic procedures.

Case Presentation: A 67-year-old woman presented with postmenopausal bleeding and weight loss. Biopsy done prior to presentation significant for adenocarcinoma. Examination revealed enlarged uterus with cervical lesion and no palpable inguinal lymph nodes. Treated with 6 cycles of neoadjuvant chemotherapy, followed by cytoreductive surgery. Intraoperative findings: pelvic sidewall involvement, diaphragmatic and peritoneal seeding, anterior vaginal nodularity. Postoperative histopathology: uterine carcinosarcoma with heterologous rhabdomyoblastic differentiation involving the uterus, adnexa, cervix, omentum, and a separate vaginal metastasis. Metastatic tumor was also identified in mesenteric lymph nodes (FIGO Stage IVB). On postoperative day 7, the patient developed continuous urinary leakage. An indwelling catheter was placed for two weeks. Cystography was negative, and CT urography revealed a left ureterovaginal fistula. Spontaneous resolution of fistula at 8-week visit.

Discussion: This case highlights two rare features: (1) vaginal metastasis with heterologous sarcomatous elements, (2) transient ureterovaginal fistula resolving without surgery—reported in <30% of UVF cases managed conservatively. Diagnosis and care were further challenged by limited imaging and interventional access typical in low-resource settings.

Conclusion: Uterine carcinosarcoma remains a rare, highly aggressive uterine tumor with a high risk of recurrence and complex metastatic patterns. Vaginal metastasis and postoperative UVF add to the clinical complexity, particularly in low-resource settings where conservative management may still be successful with timely intervention.

CP018 / #986

Topic: *AS03. Patient-Centered Care / AS03b. Palliative, Symptomatic & Supportive Care*

A GYNAECOLOGY-ONCOLOGY FELLOW REFLECTS ON THE PALLIATIVE CARE ROTATION AT GROOTE SCHUUR HOSPITAL, SOUTH AFRICA

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Background/Introduction: Many gynaecology-oncology patients present with advanced disease. Therefore, it is essential that gynaecology-oncologists learn basic principles of palliative care.

Case Presentation: A recent gynaecology-oncology fellow at Groote Schuur Hospital reflected on the value of her palliative care rotation. Working as a part of the palliative care, rather than surgical team, she learned that palliative care addresses all aspects of patient distress, including physical, financial, psychosocial, and spiritual. She was able to appreciate the value of stopping disease-targeted treatments when there was little impact on quality of life and shifting towards supportive care for both the patient and family. Family meetings were pivotal tools to give families time to understand the diagnosis and what their loved one would need to live with the disease. Multidisciplinary teams were effectively utilized to improve patient quality of life, including offering supportive counselling, nutritional support, mobility devices, and financial grants. Families had access to ongoing telephonic support after discharge which was essential for continuity of care and preventing readmissions.

Discussion: The fellow noted that her palliative care rotation had a profound impact on her future practice. After the rotation she felt more empowered to integrate palliative care into her own patient care, support the establishment of a palliative care team at her home hospital, and advocate for palliative care rotations to be integrated into post graduate gynaecology training in Zimbabwe.

Conclusion: This fellow's experience highlights the professional impact of palliative care rotations on gynaecology-oncology trainees so that they are equipped to holistically manage future palliative care patients with advanced disease.

CP019 / #559

Topic: *AS03. Patient-Centered Care / AS03b. Palliative, Symptomatic & Supportive Care*

SALVAGE SURGERY FOR RECURRENT OR RESIDUAL DISEASE POST RADIATION FOR LOCALLY ADVANCED CERVICAL CANCER

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Background/Introduction: Cervical cancer is commonly diagnosed among Nepalese women and is the commonest cause of cancer related deaths. For locally advanced cervical cancer (LACC), stages IB3 to IVA, concurrent chemoradiotherapy (CCRT) is the standard of care. While CCRT achieves high rates of initial response, a subset of patients develop residual/recurrent disease, posing substantial clinical challenge. In carefully selected cases, salvage surgery may offer a potentially curative option.

Case Presentation: We evaluated four cases of residual/recurrent cervical cancer. All received CCRT initially for LACC. Three had early central recurrence within a year; one underwent salvage radical hysterectomy and lives with disease while two underwent extrafacial hysterectomy and have been disease free. The fourth case had late recurrence and underwent pelvic exenteration and is currently disease free.

Discussion: Definitive radiotherapy improves tumor control in LACC, but local relapse may occur in 10-40%. Salvage surgery (pelvic exenteration or hysterectomy), following radiotherapy can be curative but is associated with high risk of postoperative complications.Van Kol reported survival of 69% following salvage surgery after a mean follow up period of 24.9 months and 31% relapsed. Hence, careful patient selection is important. MRI and FDG-PET/CT is optimal for identifying recurrence. Hoejimakers et al state sensitivity and specificity of biopsy to detect residual disease to be 88.9% and 100% respectively. Timing of biopsy is crucial, as biopsies taken too early may detect residual disease undergoing active regression.

Conclusion: Residual disease after CCRT is associated with poor survival. Histopathological diagnosis is most accurate. Salvage surgery can be beneficial among carefully selected cases despite high morbidity.

CP020 / #804

Topic: *AS03. Patient-Centered Care / AS03b. Palliative, Symptomatic & Supportive Care*

ABDOMINAL TUBERCULOSIS WAS INITIALLY TREATED WITH EXTENSIVE SURGERY AND CHEMOTHERAPY

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Background/Introduction: Abdominal tuberculosis mimics ovarian carcinoma by its vague symptoms and non-specific signs. The incidence of peritoneal TB among all forms of TB varies between 0.1% and 0.7% globally representing 4%–10% of extra-pulmonary TB and 25%–60% of abdominal TB cases. The actual prevalence of peritoneal TB in Uganda is not known but is reported to be a significant issue.

Case Presentation: A 32-year-old nulliparous presented with a history of progressive abdominal and pelvic pain associated with distension for two months. No weight loss. CA125-513; laparotomy found miliary nodules all over intraabdominal organs, gross ascites with bilateral ovarian masses, USO done and histology concluded metastatic adenocarcinoma with granulomatous inflammation. She received three cycles of paclitaxel and carboplatin but progressed to have massive pleural effusion. All signs and symptoms resolved within two weeks of anti-tuberculosis. A gynecology pathologist's review of the tissue revealed no evidence of adenocarcinoma.

Discussion: There is a thin line between the clinical presentation of extrapulmonary TB and ovarian cancer as evidenced in this case. Laparoscopic tissue biopsy is a fundamental tool to avoid extended surgery in a case like this provided the biopsy tissue is reviewed by an expert gynecology pathologist. These are lacking in many LMICs exposing patients to extensive surgeries and chemotherapy with associated morbidities.

Conclusion: There remains a big gap in the diagnosis of extrapulmonary TB in Low- and middle-income countries where TB prevalence is highest.

CP021 / #1119

Topic: *AS03. Patient-Centered Care / AS03c. Patient Advocacy & Survivorship*

GYNECOLOGICAL EXAMINATION AND CERVICAL CANCER SCREENING IN PREGNANY: A STEP TOWARD 90-70-90 WORLD HEALTH ORGANIZATION'S CERVICAL CANCER ELIMINATION TARGET

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Background/Introduction: The incidence of gynecological malignancy, in particular cervical cancer, during pregnancy is increasing. While the diagnosis of cervical cancer during pregnancy is important, screening for the disease during same period may afford the opportunity to detect and treat pre-malignant lesions. This will help achieve the WHO 90-70-90 target to eliminate cervical cancer by 2030

Case Presentation: Case 1: A 37-year-old woman living with HIV(WLWH) presented with vaginal bleeding in pregnancy with hemoglobin of 6.9 g/dl. Vaginal examination revealed a cervical mass. She was admitted for blood transfusion and monitoring. She developed fetal distress and delivered via caesarian section(CS). Cervical biopsy was taken. Invasive non-keratinising, moderately differentiated squamous cell carcinoma (SCC) stage IIA1 was reported. She was treated with chemoradiation and is being followed up.
Case 2: A 37-year-old WLWH delivered at term via CS for fetal distress at term. At a routine examination, a cervical mass was noticed and biopsy was taken. Invasive moderately differentiated, non-keratinizing SCC was confirmed. Patient was staged as IIIB, treated with radiotherapy. Her condition deteriorated on day 3 of treatment. She died seven days later

Discussion: Routine gynecological examination, inspecting cervix and taking biopsy can lead to early detection and appropriate cervical cancer management; thus avoiding late case presentation which are associated with high morbidity and mortality. When performed by experienced personnel, cervical cancer screening and taking a biopsy do not affect the pregnancy outcomes.

Conclusion: Opportunities like antenatal classes should be viewed as a convenient moment for cervical cancer screening or early detection, especially in WLWH

CP022 / #642

Topic: *AS06. Tumor Types / AS06a. Breast Cancer*

PRIMARY RECTAL MUCINOUS ADENOCARCINOMA METASTASIS TO THE BREAST IN AN 18-YEAR OLD FEMALE : A CASE REPORT

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Background/Introduction: Primary breast cancer is the most common malignancy in females . Metastasis to the breast from rectal carcinoma is extremely rare and accounts for 0.43% of all breast malignancies . Breast metastasis can mimic a primary breast cancer and may present confusing diagnostic problems. The most common tumor that metastasize to the breast is a contralateral breast carcinoma followed by malignant melanoma, lymphoma, sarcoma , lung , ovary, kidney , stomach and carcinoid tumors .

Case Presentation: Here, we report a case of a 18-year – old female presented with right breast lump in outpatient department of a private hospital. Lumpectomy was done and it was reported as mucinous carcinoma of right breast . She again developed right breast lump five months after the first operation . Core biopsy was done and reported as mucinous carcinoma of right breast with recurrence. At the same time she noticed per rectal bleeding and alteration of bowel habit . Colonoscopy reveals rectal growth and rectal biopsy shows mucinous adenocarcinoma.

Discussion: The immunohistochemistry findings from right breast lump and rectal growth shows CK 20 positive , CK 7 negative , GATA-3 negative and CDX2 positive. Histomorphological evaluation and immunohistochemistry are in support of rectal adenocarcinoma (primary) and the breast reveal metastatic adenocarcinoma of colorectal origin .

Conclusion: Histopathology with immunohistochemistry is very important tool in the diagnosis of cases of this nature but the clinical correlation should be taken into consideration at multidisciplinary team meetings to decide the final management of the patient.

CP023 / #1047

Topic: *AS06. Tumor Types / AS06a. Breast Cancer*

NEOADJUVANT RADIOTHERAPY FOR LOCALLY ADVANCED AND CHEMOTHERAPY-REFRACTORY BREAST CANCER: A CASE REPORT

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Background/Introduction: Locally advanced breast cancer (LABC) requires aggressive, multimodal treatment. Despite established standard therapy—comprising surgery, chemotherapy, and postoperative radiotherapy—some patients exhibit disease progression during neoadjuvant chemotherapy. In this context, neoadjuvant radiotherapy (NART) has emerged as a promising alternative to induce tumor downstaging and facilitate surgical resection.

Case Presentation: We report the case of a patient with LABC, clinical stage cT2N1, who presented with locoregional disease progression during neoadjuvant chemotherapy. A multidisciplinary tumor board recommended a therapeutic shift to capecitabine combined with NART. Following completion of this regimen, imaging revealed a partial radiological response with significant tumor volume reduction. The patient underwent modified radical mastectomy with axillary lymph node dissection. Final pathology demonstrated negative surgical margins, and the procedure was uneventful.

Discussion: This case supports current evidence suggesting that NART is a feasible and effective option for selected patients with LABC, particularly in cases of resistance to systemic therapy. NART may contribute to pathological downstaging while maintaining a safety profile comparable to standard treatment protocols.

Conclusion: Neoadjuvant radiotherapy may be considered a valuable strategy in the management of chemotherapy-refractory LABC. Further prospective studies are warranted to define its role and long-term oncologic outcomes.

CP024 / #999

Topic: *AS06. Tumor Types / AS06a. Breast Cancer*

A PECULIAR CASE OF OCCULT LOBULAR BREAST CARCINOMA PRESENTED WITH BILATERAL OVARIAN LESIONS: A CASE REPORT

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Background/Introduction: Occult breast cancer is an intriguing heterogeneous phenomenon characterized by histologically-proven metastatic carcinoma of breast origin and the absence of an identifiable clinical and/or radiological primary breast tumor. Here, the authors report a case of lobular OBC in a 55-year-old woman presented with bilateral ovarian masses. Therefore, we aim to highlight the importance of considering metastatic lesions of unknown origin even in the absence of detectable primary tumors.

Case Presentation: A 55-year-old lady with a history of ulcerative colitis initially presented to our clinic with stress incontinence. Sonographic imaging of the abdomen revealed two malignant-looking solid masses in both ovaries.She underwent laparoscopy. In IHC panel CKAE1/AE3, GATA-3, and GCDFP-15 which confirm the diagnosis of metastatic carcinoma of breast origin.

Discussion: In our current case, the breast lesion was not detected by MRI and PET/CT studies. In the absence of evidence of a primary breast tumor, our diagnosis was made based on immunohistochemistry profile of breast cancer which fulfilled the diagnostical criteria of OBC. The bilaterality of ovarian involvement and discohesive and monomorphic cytomorphology of tumor cells along with the single file pattern of distribution were the first cues in our case that raise the possibility of metastasis

Conclusion: In the presence of misleading clinical and laboratory findings, identification of metastatic lesions depends on pathological examination and immunohistochemical confirmation.Moreover, there are no clear guidelines for the management and treatment of OBC due to its rarity and heterogenicity. Therefore, providing further information from clinical practice is essential in improving our understanding of this entity.

CP025 / #1053

Topic: *AS06. Tumor Types / AS06b. Cervical Cancer*

REIRRADIATION AS TREATMENT OF PREVIOUSLY IRRADIATED CARCINOMA CERVIX-CASE SERIES DESCRIBING 2 CASES

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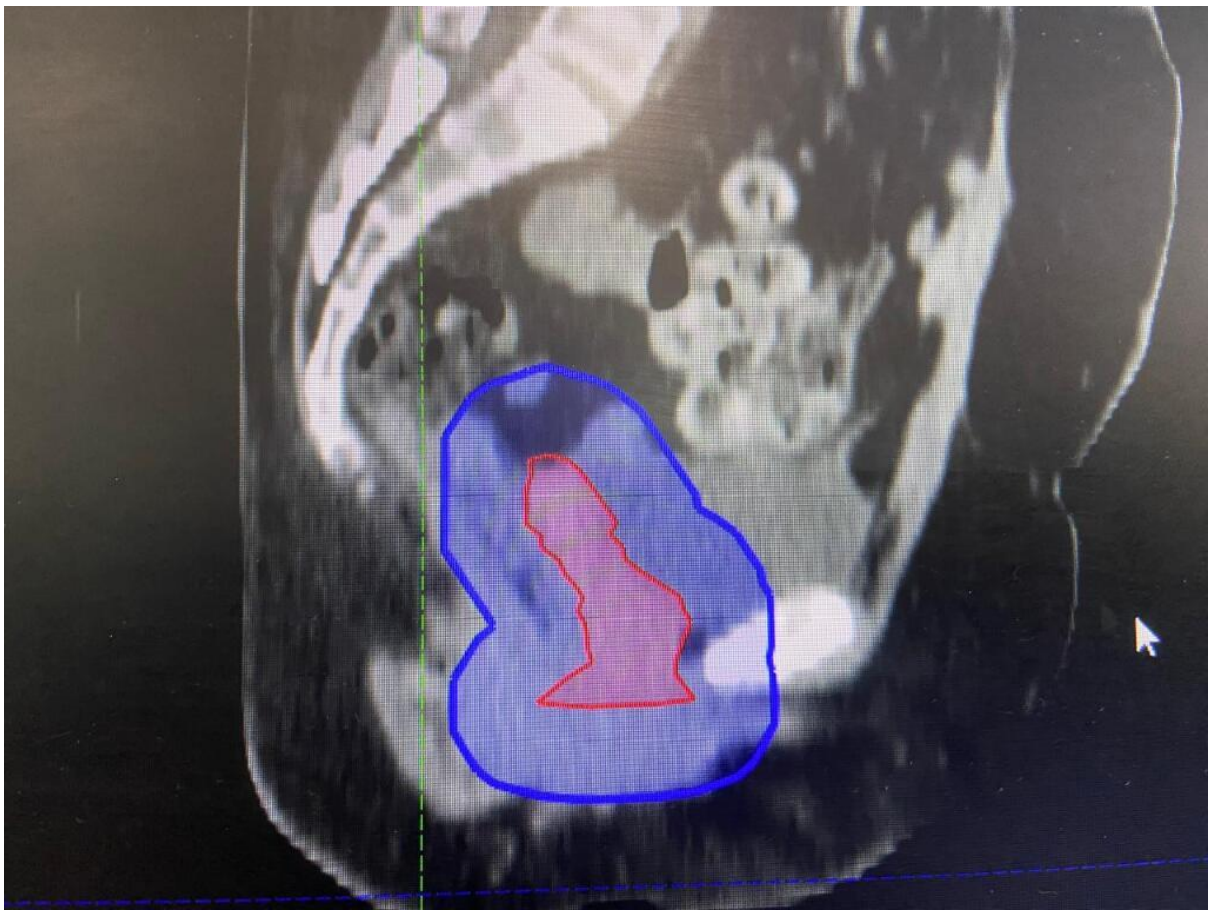
Background/Introduction: Reirradiation for treatment of recurrence post primary radiation is rarely done. Recent improvement in radiotherapy technique such as Intensity Modulated Radiotherapy (IMRT) has better safety profile, keeping curative potential.

Case Presentation:



Case No 1: 45 years lady underwent abdominal hysterectomy and B/L salpingoophorectomy in April 2020. Histopathology was carcinoma cervix involving cervix and both parametrium. She underwent concurrent chemoradiation followed by Brachytherapy. She presented in March 2022 with recurrence in pelvis, vaginal vault, anterior abdominal wall involving ileum causing intestinal obstruction. She underwent diagnostic laparoscopy and loop ileostomy on 16/04/2022. She was started on systemic

chemotherapy with Paclitaxel, Carboplatin and Bevacizumab and on monthly maintenance Bevacizumab. She had recurrence on vault in July 2023. Ultimately, she was treated with IMRT 50.4 Gy in 28 fraction in July 2023. She was disease free till May 2024. Case no2: 34 years lady was diagnosed with carcinoma cervix stage IIB-moderately differentiated squamous cell carcinoma in 2011. She had been treated with Concurrent chemoradiotherapy followed by brachytherapy. She had recurrence confined to cervix in 2023. She refused surgery. She received concurrent chemoradiation 46 Gy in 28 fraction followed by brachytherapy 8Gy in 2 fractions. She is disease free after 2 years of follow-up. Both patients did not suffer any major complication post radiotherapy

Discussion: Both cases achieved good disease free survival with minimal complication. Kim et al reirradiation cohort 5 yrs PFS 33.2% OS 66.5%, LFFS 21 months.

Conclusion: Reirradiation is a understudied useful modality, which require good clinical trial.

CP026 / #614

Topic: *AS06. Tumor Types / AS06b. Cervical Cancer*

CERVICAL MELANOMA WITH CEREBRAL DISSEMINATION: A DIAGNOSTIC AND THERAPEUTIC CHALLENGE IN GYNECOLOGIC ONCOLOGY

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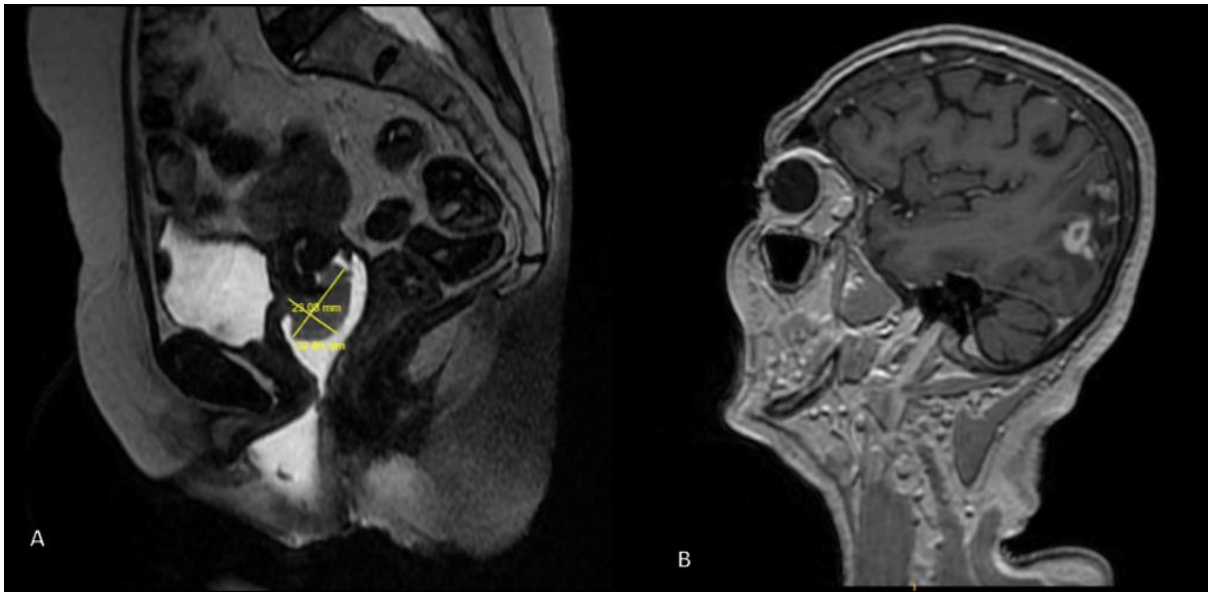
Background/Introduction: Primary malignant melanoma of the cervix (PMMC) is a rare gynecological cancer, representing less than 1% of all cervical malignancies. There is no standardized treatment, particularly in metastatic settings where surgical intrevention is not a feasible option. Individual case reports are essential to inform future clinical decisions.

Case Presentation: A 63-year-old patient presented postmenopausal uterine bleeding. Examination revealed an exophytic cervical mass with involvement of the anterior vaginal wall. Biopsy confirmed epithelioid malignant melanoma with high cell proliferation and positive immunohistochemistry for specific melanoma markers. Primary cutaneous lesion was ruled out; imaging studies revealed a cervical mass infiltrating the vagina, with regional lymphadenopathy and brain metastasis. Classified as FIGO IVB and staged T4N1M1 cervical mucosa melanoma. Multidisciplinary team considered ablative-dose radiotherapy to the cervix and brain metastases, subsequently with immunotherapy (nivolumab + ipilimumab), with palliative intent.



Discussion: PMMC, although rare, may involve distant organs like the brain. While the standard treatment in this stage is not established, management is often extrapolated from cutaneous melanoma. Radiotherapy in PMMC is used mainly in palliative or adjuvant treatment, though its effectiveness is unclear. For brain metastases,

stereotactic radiotherapy commonly used in metastatic cutaneous melanoma provides local control and improved survival and may be a viable option in cervical melanoma. Immunotherapy agents like Ipilimumab and Nivolumab have also been utilized in cervical melanoma, demonstrating potential benefits in controlling metastatic disease.

Conclusion: Metastatic cervical melanoma poses significant treatment challenges. Radiotherapy and immunotherapy offer potential benefits but additional research is needed to optimize care and improve outcomes.

CP027 / #623

Topic: *AS06. Tumor Types / AS06b. Cervical Cancer*

PMS2 MUTATION AND ITS RELATIONSHIP WITH NON-HPV-ASSOCIATED ENDOCERVICAL CANCER: A CASE REPORT WITH AGGRESSIVE PRESENTATION.

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Background/Introduction: Endocervical adenocarcinoma (EAC) accounts for 20-25% of all cervical carcinomas. They are classified as HPV-associated (HPVA) and HPV-independent (HPVI), the latter representing 10-20% of cases. The association of EAC with mismatch repair deficiency (MMR-D) is rare. (1) (2)
Objective: To describe a clinical case of endocervical carcinoma in a patient with MMR-D and its relation to oncogenesis.

Case Presentation: A 36-year-old patient with a biopsy showing moderately differentiated endocervical adenocarcinoma, managed surgically. Pathology report indicated a tumor size of 2 cm, stromal invasion reaching one-third depth, and presence of lymphovascular invasion. PET-CT study revealed hypermetabolic cervical and left supraclavicular lymphadenopathies. Genetic testing showed evidence of PMS2 mutation (NM_000535.7): c.400C>T p.(Arg134Ter), heterozygous.

Discussion: HPVI EAC has an estimated incidence 5.6 times higher in carriers than in the general population (95% CI: 2.3-13.8; p = 0.001), with an accumulated risk at age 80 of 4.5% (95% CI: 1.9-10.7%) compared to 0.8% in the general population. (3) It has been demonstrated that loss of MMR is extremely rare, but low levels of MSH-2 predict a poor prognosis in cervical cancer, and low MSH-2 levels are associated with a higher mutational burden. (1)

Conclusion: Mismatch repair deficiency (MMR-D) could explain the development of HPV-independent endocervical cancer; however, limited literature prevents definitive conclusions about a direct correlation.

CP028 / #834

Topic: *AS06. Tumor Types / AS06b. Cervical Cancer*

CLINICAL AND RADIOLOGICAL DISCORDANCE IN CARCINOMA CERVIX STAGING - SURGICAL DILEMMA !

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Background/Introduction: Cervical cancer staging updated in 2018 includes separation of stage IB disease into three categories based on tumor size as well as the incorporation of nodal status into pre-treatment clinical staging after radiological evaluation. Physical examination remains the gold standard for determination of direct extension to surrounding structures and decision to perform upfront Radical Hysterectomy . The accuracy of clinical staging with examination varies by stage and ranges from 57.4% to 87.5% for patients with clinical stage IB disease

Case Presentation: A case of a 58 year old lady who presented with complaints of postmenopausal bleeding. On examination she was found to have a hypertrophied cervix with parametrial thickening on one side with no evidence of locally advanced disease. Contrast enhanced MRI pelvis showed an irregular circumferential mass involving the cervix and upper 2/3rd of vagina extending into adjoining tissue with focal loss of fat planes with the rectum posteriorly. Cervical biopsy was taken and suggestive of moderately differentiated squamous cell carcinoma. In view of disparity between the imaging reports and clinical evaluation, case was discussed in multidisciplinary tumor board and decision for examination under anaesthesia(EUA) and proceed for radical hysterectomy (RH) if final impression of early cancer cervix was taken. Patient underwent EUA and Radical hysterectomy with Retroperitoneal Lymph Node Sampling. On histopathology it was found to be Stage 1B3 disease with no lymphovascular space invasion, no nodal involvement and no parametrial invasion.

Discussion: Primary radical hysterectomy for patients with stage IB3cervical cancer provides good survival with acceptablemorbidity.

Conclusion: Clinical evaluation by gynaecological oncologist remains invaluable decision changer in cervix confined carcinoma.

CP029 / #894

Topic: *AS06. Tumor Types / AS06b. Cervical Cancer*

DE-ESCALATING FIRST-LINE TREATMENT IN STAGE IVB OR RECURRENT CERVICAL CANCER: A SINGLE-CENTER CASE SERIES ON OUTCOMES WITH IMMUNOTHERAPY ALONE

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Background/Introduction: Chemo-immunotherapy (IO) is the preferred first-line treatment for stage IVB or recurrent cervical cancer. However, limited data exist on the efficacy and safety of using IO-alone as a de-escalation strategy. We report outcomes from a case series of selected patients treated with IO-alone

Case Presentation: The authors reviewed a cervical cancer database from a tertiary academic to identify patients with stage IVB or recurrent disease treated with IO-alone. The authors used the Kaplan-Meier method to estimate progression-free survival (PFS) and overall survival (OS). Among 582 patients treated between 2015 and 2021, 18 met the inclusion criteria. The median age was 43 years (range 28–84); 67% had squamous cell carcinoma, 11% adenocarcinoma, and 80% expressed PD-L1. CPS scores were <1 in 20%, 1–10 in 33%, and >10 in 47%. Most patients had oligo-metastatic disease (83%). Treatment with IO-alone began a median of 7 months after platinum-based chemotherapy. Indications included prior adjuvant (44%) or neoadjuvant (22%) chemotherapy, clinical trial participation (11%), or patient preference (22%). Median PFS and OS were 27 months and 82 months, respectively.

Discussion: In other malignancies, such as lung and bladder cancer, biomarker-driven treatment strategies have validated the use of IO-alone. These findings highlight the need for further investigations into de-escalated palliative therapy in this patient population to refine treatment options and improve patient outcomes.

Conclusion: These findings support the need for clinical trials evaluating IO-alone as a first-line treatment option for de-escalation in stage IVB or recurrent cervical cancer. Biomarker development is needed to better identify candidates for personalized therapy.

CP030 / #1138

Topic: *AS06. Tumor Types / AS06b. Cervical Cancer*

LONG BONE METASTASES FROM CERVICAL CANCER

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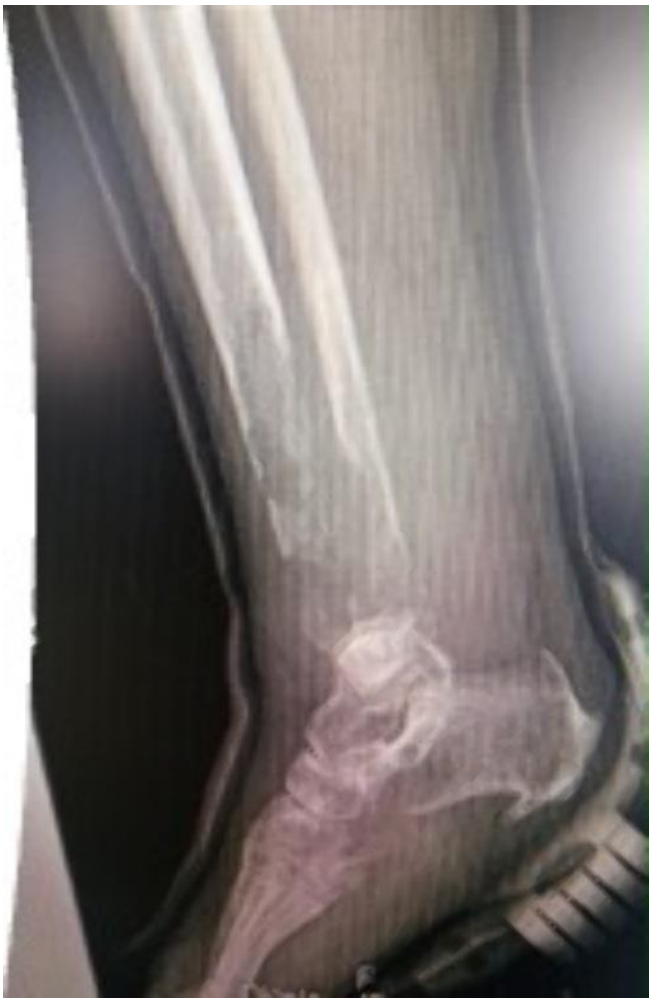
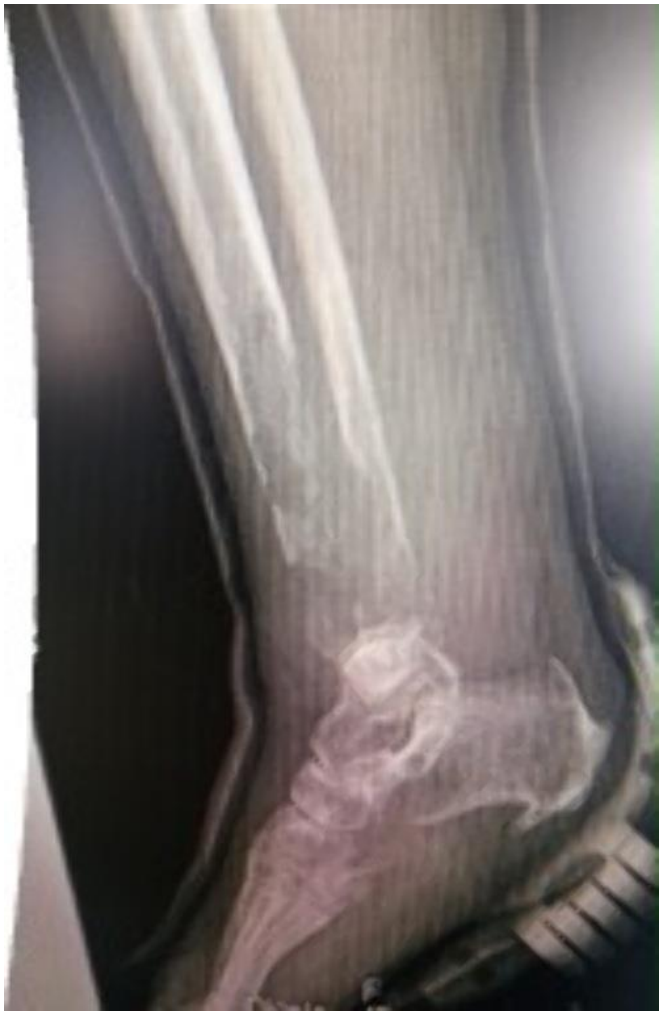
Background/Introduction: Cervical cancer is the fourth most common cancer globally, with a high burden in low to middle-income countries due to limited screening. While curable when detected early,distant metastases-typically to para-aortic lymph nodes, lungs or supraclavicular lymph nodes are associated with poor outcomes

Case Presentation: A 52 year old woman with no co-morbidities presented with a painful, swolen right lower leg. Imaging revealed a moth eaten appearance and pathological fractures of the tibia and fibula, suggestive of bone malignancy. Further evaluation uncovered a cervical mass. Biopsy confirmed squamous cell carcinoma of the cervix, staged FIGO IVB due to bone metastases. Bone biopsy showed poorly differentiated carcinoma,P63 positive. She received palliative radiotherapy: 8GY to the pelvis and 5Gy to the leg.





Discussion: Cervical cancer remains a leading casue of cancer death in women in developing countries, with a South African incidence rate of 35.3 per 100 000. Bone metastases occur in 1.8-6.6% of cervical cancer cases, most often in the axial skeleton. Metastases to long bones is rare (0.1-4.4%) and indicate advanced disease with a poor prognosis. pallaitive radiotherapy can provide significant pain relief.

Conclusion: This case underscores the importance of thorough diagnostic evaluation and histological confirmation in unusual presentations. Long bone metastases from cervical cancer are rare and signal poor prognosis highlighting the need for early detection and effective treatment strategies.

CP031 / #1052

Topic: *AS06. Tumor Types / AS06c. Endometrial & Uterine Corpus Cancers*

BIOLOGICAL BEHAVIOR RATHER THAN HISTOLOGY OR MOLECULAR PATHOLOGY INFLUENCES TREATMENT IN STUMP

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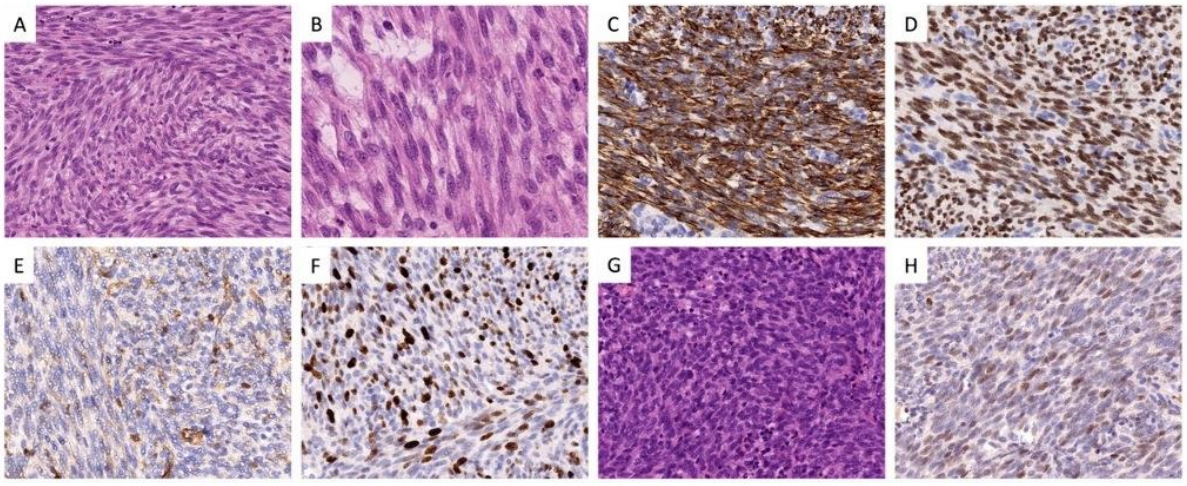
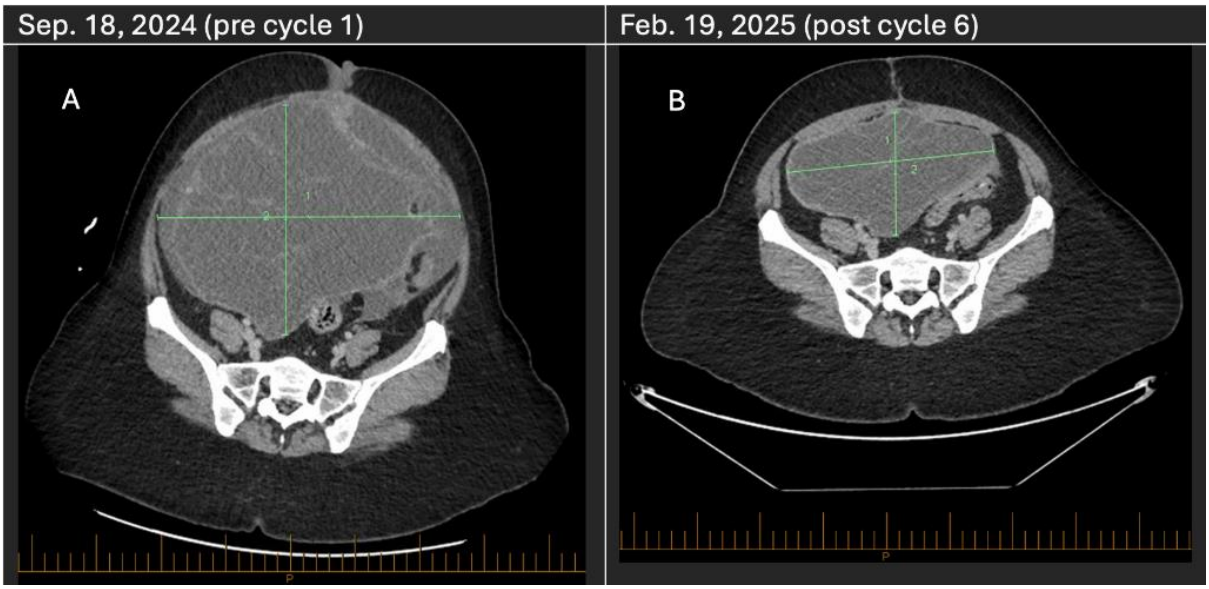
Background/Introduction: Smooth muscle tumors of uncertain malignant potential (STUMP) are rare uterine tumors with features between benign leiomyomas and leiomyosarcomas. While most follow an indolent course, a subset can behave aggressively. Diagnosis relies on histologic features, but these often fail to predict behavior. Surgical resection is the standard treatment while systemic therapy is rarely used and the data is limited.

Case Presentation: A 44-year-old woman underwent hysterectomy for presumed fibroids. Initial pathology indicated leiomyoma, but this was reclassified as STUMP after her first recurrence with peritoneal disease. She had two further recurrences over four years. Each specimen showed STUMP with low mitotic index and no definitive necrosis. At her third recurrence, she presented with a large pelvic mass, ascites, and bowel involvement, making surgery unfeasible. The patient was treated with doxorubicin and trabectedin. After six cycles, she experienced significant tumor reduction and resolution of ascites without major toxicity.



H&E images from 2020 specimen 20X and 40X(A,B). Diffuse desmin(C) and ER(D) expression, CD10(E) negative. Ki-67(F) elevated. 2023 specimen at 20X(G).



Abdominal CT before(A) and after(B) 6 cycles of Doxorubicin and Trabectedin

Discussion: This case underscores the limitations of pathology in predicting clinical behavior in STUMP. Despite low-grade histology, the patient exhibited aggressive disease requiring systemic therapy. The favorable response to a leiomyosarcoma regimen supports using clinical behavior to guide treatment decisions.

Conclusion: In STUMP, biologic behavior may be more informative than histology or molecular testing. Selected patients with recurrent, aggressive disease may benefit from systemic therapy such as doxorubicin and trabectedin, even when conventional histologic criteria suggest low malignant potential.

CP032 / #881

Topic: *AS06. Tumor Types / AS06c. Endometrial & Uterine Corpus Cancers*

POSTMENOPAUSAL BLEEDING AND OSSEOUS METAPLASIA: AN UNCOMMON PRESENTATION OF GRADE 3 ENDOMETRIAL CARCINOMA

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Background/Introduction: Endometrial carcinoma is the most common gynecologic malignancy in postmenopausal women, typically presenting with abnormal uterine bleeding. Initial evaluation through endometrial biopsy may be inconclusive in cases of limited sampling or rare histologic variants. Osseous metaplasia is an extremely rare stromal condition in endometrial carcinomas, characterized by ectopic bone formation, with few reported cases. Its presence may hinder early and accurate diagnosis.

Case Presentation: An 80-year-old woman (G5P3A2) presented with light vaginal bleeding since October 2024. She underwent hysteroscopy with polypectomy in November 2024, with benign histology. Due to persistent symptoms, MRI revealed endometrial thickening with myometrial invasion. Laparoscopic oncologic staging surgery was performed: total hysterectomy, bilateral salpingo-oophorectomy, pelvic lymphadenectomy, and omentectomy. Histopathology showed grade 3 (FIGO) endometrioid carcinoma with extensive squamous differentiation, osteoclast-like giant cells, and stromal osseous metaplasia with mature bone formation. Myometrial invasion was <50%. Final staging: pT1a pN1a / FIGO IIIC1. Immunohistochemistry was negative for hormone receptors, with microsatellite stability.

Discussion: Osseous metaplasia is rare and of uncertain etiology, potentially resulting from tumor necrosis, chronic inflammation, or aberrant stromal differentiation. Although not clearly associated with prognosis, it may delay diagnosis.

Conclusion: Persistent postmenopausal bleeding requires continued investigation despite negative biopsies. This case underscores the importance of integrating clinical, radiologic, and histologic data in identifying rare variants.

CP033 / #1067

Topic: *AS06. Tumor Types / AS06c. Endometrial & Uterine Corpus Cancers*

EWING'S SARCOMA OF THE GENITAL TRACT: A RARE AND ATYPICAL CASE PRESENTATION

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Background/Introduction: Ewing's sarcoma (ES) is a rare malignant tumor that primarily affects bone, with less frequent involvement of soft tissues, and is even rarer in the female genital tract. We report a rare case of ES in a 29-year-old nulliparous woman who presented with urinary retention, a pelvic-abdominal mass, and metastases to the liver and spleen.

Case Presentation: A 29-year-old nulliparous woman presented with lower abdominal pain, urinary retention, and a large pelvic-abdominal mass measuring 11×16×16 cm with microcalcifications, displacing the uterus to the left and multiple hypodense, non-enhancing lesions in the liver and spleen on a CT scan. Exploratory laparotomy revealed a 10×5 cm necrotic mass on the right broad ligament, extending to the pelvic sidewall and vagina, along with multiple other masses on the uterus extending to the pouch of Douglas (measuring 5×5, 7×7, and 2×4 cm)[Fig. 1A]. The broad ligament mass was resected and sent for histopathology [Fig. 1B-C]. and FISH analysis, confirming Ewing's sarcoma with EWSR1 gene rearrangement.

Fig. 1

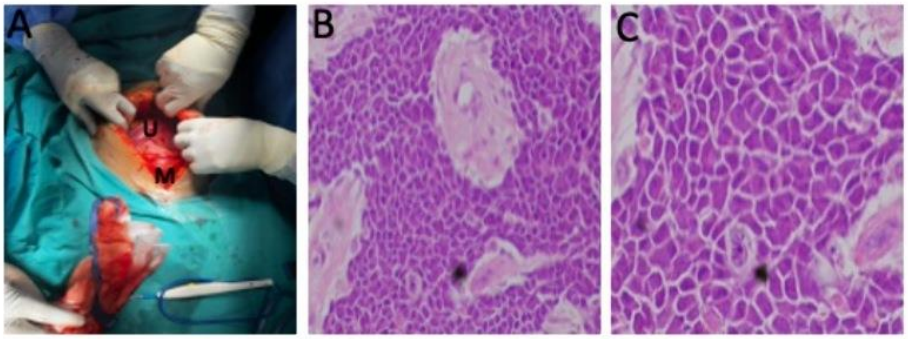

Fig. 1 A-C: Photograph and Microscopic sections. A photograph (**A**) showing the mass (M) on the anterior aspect of the abdominal wall below the uterus (U). Microscopic sections after H-E stain (**B-C**) from myometrium showing a small round cell tumour with hyperchromatic nuclei and scanty cytoplasm. The tumour is arranged in solid nests and cords and also discohesive areas are present with tumour necrosis. There is brisk mitotic activity.

Discussion: There is currently no established standard of care for Ewing's sarcoma involving the uterus. Complete surgical resection is generally preferred, as no superior chemotherapy protocol has been identified. In this case, complete resection was not feasible due to the extensive tumor burden. Postoperatively, the VDC-IE chemotherapy regimen was initiated, but had to be discontinued due to poor tolerance.

Conclusion: This case presented a significant therapeutic challenge, as surgical resection was not feasible and chemotherapy was discontinued due to intolerable side effects. Radiotherapy remains the only available option, though the prognosis is poor.

CP034 / #380

Topic: *AS06. Tumor Types / AS06c. Endometrial & Uterine Corpus Cancers*

FROM DIAGNOSIS TO MOTHERHOOD : A RARE JOURNEY OF NAVIGATING PREGNANCY AFTER ENDOMETRIAL CANCER

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Background/Introduction: A diagnosis of cancer is life-altering, especially of endometrium occurring in young age due to its potential impact on reproductive outcomes. Treatment usually involves radical surgery with or without adjuvant therapy, which eliminates the possibility of future pregnancy. However, for women who undergo fertility-sparing surgery or hormonal therapy, the chance of conception remains but also associated with poor outcomes. In our case study we report a notable case of 32 years-old nulliparous woman who was diagnosed with endometrial carcinoma who underwent fertility preserving treatment and her journey to the motherhood with a healthy baby.

Case Presentation: A 32 years old nulliparous woman diagnosed with well differentiated endometrioid adenocarcinoma of endometrium, FIGO STAGE 1 (2023). Immunohistochemistry markers were suggestive of ER positive, PR positive, HER 2 neu negative and p53 wild type. Underwent hormonal therapy for 3 months after which she had spontaneous conception and delivered a healthy baby at term. She is disease free at 2 years of follow up with no evidence of recurrence.

Discussion: Various meta-analysis reported the successful pregnancy outcome in women undergoing progestin treatment is only 20 %. Despite all the challenges faced, she had a journey of hope and resilience. Her inspiring story adds to a growing narrative of optimism and medical progress, offering inspiration to many who walk this challenging path.

Conclusion: With comprehensive care, women can embrace the possibility of motherhood, even after facing cancer diagnosis. Advances in oncology and reproductive medicine have paved the way for improved outcomes after undergoing hormonal therapy for early endometrial cancer.

CP035 / #679

Topic: *AS06. Tumor Types / AS06c. Endometrial & Uterine Corpus Cancers*

COMPLETE PATHOLOGICAL RESPONSE TO NEOADJUVANT IMMUNOTHERAPY IN A RESISTANT LOCALLY ADVANCED ENDOMETRIAL ENDOMETRIOID ADENOCARCINOMA CASE : CASE REPORT

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Background/Introduction: Endometrial cancer, when diagnosed early, typically carries a favorable prognosis. However, treatment becomes more challenging in advanced or inoperable stages. Immunotherapy has recently emerged as a promising and well-tolerated treatment for various solid malignancies, including advanced endometrial cancer. This report presents a rare case of grade I endometrioid adenocarcinoma with locally advanced disease, unresponsive to standard neoadjuvant chemotherapy, but achieving a complete pathological response following immunotherapy.

Case Presentation: In 2021, a 36-year-old woman with FIGO grade 1, stage IIIC2 dMMR endometrial cancer and comorbid DVT with an IVC filter was unfit for surgery. She received neoadjuvant carboplatin-paclitaxel, followed by pembrolizumab and lenvatinib. After nine cycles, imaging showed marked response. Surgery revealed no residual tumor, highlighting immunotherapy's potential in advanced, chemotherapy-refractory dMMR endometrial cancer.

Discussion: This patient with advanced dMMR endometrial cancer showed a remarkable clinical and radiologic response to neoadjuvant pembrolizumab and lenvatinib after progressing on standard chemotherapy. Surgery was initially deferred due to extensive thromboembolism and disease extent. After nine cycles of immunotherapy, she underwent surgery with a complete pathological and radiological response. This aligns with findings from the KEYNOTE-775 trial, which demonstrated improved outcomes with pembrolizumab–lenvatinib in previously treated endometrial cancer. Unlike many patients, she experienced no adverse effects. This case highlights the potential of immunotherapy in select dMMR cases, even when surgery is not initially feasible.

Conclusion: Immunotherapy with pembrolizumab and lenvatinib achieved complete pathological response in chemotherapy-resistant dMMR endometrial cancer, offering a promising, well-tolerated option when surgery is initially not feasible.

CP036 / #440

Topic: *AS06. Tumor Types / AS06c. Endometrial & Uterine Corpus Cancers*

EXTRA RENAL WILMS TUMOR OF THE UTERINE CORPUS IN A 12-YEAR-OLD; DIAGNOSTIC CHALLENGE AND LITERATURE REVIEW

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Background/Introduction: Wilms' tumor (WT), or nephroblastoma, is an uncommon malignant neoplasm occurring in pediatric patients. Its extrarenal location is rare and has been reported in various sites,with only 10 cases arising in the uterine corpus.The origin of EWT is still debated. Embryologic renal remnants, as metanephric blastema, merged during paramesonephric (Müllerian) ducts may account for the origin of uterine or cervical EWT. Histopathology of both WT and its extrarenal counterparts shows a triphasic differentiation, consisting of blastemal tissue, mesenchyme, and epithelium. Data regarding prognosis and treatment options are limited due to the rarity of this entity.

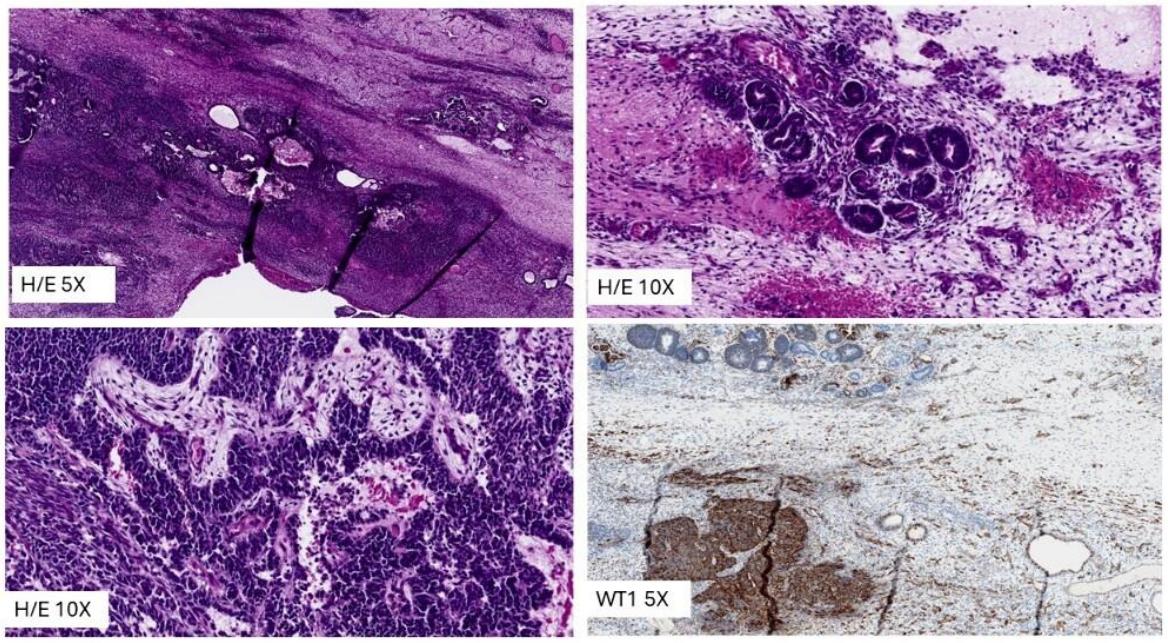
Case Presentation: twelve years old girl presented with one-month history of prolonged vaginal bleeding and discharge with symptoms of anaemia. No history of trauma or sexual encounter. Patient taken for examination under anaesthesia, polypoid smooth mass noted protruding from the vaginal introitus not able to reach the stalk.Excision of the mass done.Cervix noted to be bulky and dilated. Endometrial biopsy taken. Initial histology of both the mass and the sampling showed endometrial adenocarcinoma. She was lost to follow-up and presented four months later with recurrence of the mass.MRI revealed an endometrial polyp.The girl underwent hysterectomy, bilateral salpingectomy, and pelvic nodal sampling with final histology and immunohistochemistry (IHC) confirming extra renal Wilms tumor. She received the Wilms tumor protocol chemotherapy for high-risk

Discussion:

Table I. Wilms tumor arising in the uterine corpus previously reported in literature.

Publication (1st Author, year) [ref.]	Age	Symptoms	Extrauterine extension (site)	IHC1 positive stains	IHC negative stains	Molecular analysis	Treatment	Outcome (Follow-up)
Bittencourt, 1981	14	Cramps, vaginal mass	Mesosalpinx, posterior vaginal fornix	NA	NA	NA	TAH/BSO, XRT, chemotherapy	Alive, NED (5.7ys)
Comerci, 1993	22	Menometrorrhagia	No	NA	NA	NA	TAH	Alive, NED (2ys)
Iskrant, 1999	77	Polypoid mass, vaginal bleeding	Peritoneal washing cytology	Desmin, GFAP	NA	NA	TAH/BSO, XRT	Alive, NED (4mo)
Muc, 2001	42	Vaginal bleeding, necrotic protruding mass	Transmural uterine extension	NA	NA	NA	TAH/BSO, subtotal resection, XRT	Recurrence at6mo, DOD 1y after recurrence
McAlpine, 2005	44	Vaginal bleeding	No	NA	ER, PR and CD 10	NA	TAH, BSO, complete surgical staging, CHT	Alive, NED(1y)
LeBlebici, 2009	16	Weight loss, abdominal pain, and vaginal bleeding	Parametrial soft tissues, ligamentum rotundum, sacrouterine ligament	Vimentin (B,S), desmin (S),CK (E)	NA	NA	Inoperable, CHT	Dies of CHT complications (few days, not stated)
Garcia-Galvis, 2009	62	Vaginal bleeding	No	CD56, CD57, CD99, NSE (E,S,B) synaptophysin (B,S), CAM5.2 (E),WT1 (E,S), desmin, myoglobin (S)	NEU-N, GFAP, Chromogranin, CK2, CK20, AFP, A-Actin, TTF-1	NA	TAH/BSO, XRT, CHT	Alive, NED(14 mo)
Cao, 2017	60	Vaginal bleeding	No	WT-1,CK, CD56, Vimentin, PS3, CD99, ki67(70%)	ER, PR, CK20, Desmin, NSE, SMA and a-inhibin	NA	TAH/BSO, CHT	Alive, NED(18 mo)
Pinto, 2018	33	Vaginal bleeding, pelvic pain	No	CK, desmin, SALL4, WT1, PAX8, ki67 (80%)	ER, myogenin, myo-D1, S-100, p16, and CD34	NA	Modified radical hysterectomy, BSO, omentectomy	NA
L. Alessandrini et al 2023	59	Abdominal pain		CKAE9/AE3 CKMNF116 CK18, EMA, PS3, PAX-8, WT-1, CD10, CD56 MCHI, MSH2 PMS2, MSH6	Inhibin, SMA, Desmin, ER, P16	CNVin genes *FGFR23, FGF6, FGFR2, RPS6KB1.*	TAH/BSO, omentectomy, appendectomy; CHT	Alive, evidence of disease (6 mo)
Present Case	12	Vaginal Bleeding, Vaginal Discharge	No	WT,1, CD56, PAX08, MCH, PMS 2, MSH 6, MSH 2	ER, GATA3, TTF-1		TAH, +SALPINGECINY, +PELVIC, NODAL SAMPLING	Alive

Pathology slides



Conclusion: Wilms tumor of the uterus is an exceptionally rare malignancy occurring in patients with a broad age range. Proper histopathologic examination associated with a wide immunohistochemical panel is sufficient for a correct diagnosis.

CP037 / #1084

Topic: *AS06. Tumor Types / AS06c. Endometrial & Uterine Corpus Cancers*

CASE REPORT: HIGH-GRADE ENDOMETRIAL STROMAL SARCOMA WITH NTRK FUSION AND RESPONSE TO LAROTRECTINIB

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Background/Introduction: High-grade endometrial stromal sarcoma (HGESS) is an infrequent and highly aggressive uterine neoplasm. Recent molecular discoveries have identified recurrent gene fusions, notably involving NTRK, which hold significant diagnostic and therapeutic implications. The advent of targeted therapy with TRK inhibitors offers promising outcomes in NTRK fusion-positive tumors.

Case Presentation: A 42-year-old woman presented with vaginal bleeding and a 5 cm cervical mass, initially presumed to be a leiomyoma. Surgical excision and histopathological evaluation confirmed a high-grade sarcoma involving the cervix, with a mitotic index of 12–18 mitoses per 10 high-power fields. Molecular analysis identified an NTRK gene fusion. The patient subsequently underwent a complementary robotic staging, remaining disease-free for four years, until pelvic recurrence, treated initially with Gemcitabine and Docetaxel. Upon disease progression, and based on results from further molecular profiling ,confirming NTRK fusion, the patient was initiated on Larotrectinib, a selective TRK inhibitor. After three months, imaging demonstrated a marked reduction in pelvic and pulmonary lesions, with sustained disease control over four years.

Discussion: The case underscores the importance of comprehensive molecular diagnostics in uterine sarcomas. The identification of actionable targets such as NTRK fusions has revolutionized treatment paradigms, enabling personalized therapeutic approaches. The demonstrated efficacy of Larotrectinib emphasizes the critical role of molecular profiling in optimizing outcomes for patients with aggressive tumors like HGESS.

Conclusion: Incorporating advanced molecular diagnostic techniques into routine clinical practice is essential for the optimal management of HGESS. Targeted therapies, exemplified by Larotrectinib, hold considerable promise for improving prognosis in NTRK fusion-positive cases.

CP038 / #831

Topic: *AS06. Tumor Types / AS06d. Ovarian Cancer*

OVARIAN FIBROMA A RARE CASE OF BENIGN OVARIAN TUMOR PRESENTING WITH MEIGS SYNDROME IN BENGHAZI MEDICAL CENTER

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Background/Introduction: Ovarian fibroma is a rare, benign tumor from ovarian sex cord-stromal cells, typically affecting peri- and postmenopausal women. Often asymptomatic, it can cause abdominal symptoms or present with Meigs' syndrome. Imaging aids diagnosis, but confirmation is via histopathology. Tumors are solid, fibrous, and usually unilateral. Surgical removal is curative, with the approach depending on patient age and fertility goals. Prognosis is excellent, with low recurrence risk after excision.

Case Presentation: A 53-year-old postmenopausal woman presented with abdominal distention and pain. Imaging revealed bilateral ovarian masses and ascites, with a high RMI I score of 616.5. CT suggested possible ovarian malignancy. She underwent total abdominal hysterectomy with bilateral salpingo-oophorectomy. Histopathology showed a benign left ovarian fibroma, uterine fibroids, and no malignancy. The patient recovered uneventfully and remained symptom-free at six-month follow-up.

Discussion: Ovarian fibromas are rare, benign sex cord-stromal tumors, often affecting middle-aged and older women. Though typically asymptomatic, they may present with Meigs’ syndrome, mimicking malignancy. Diagnosis relies on imaging and histopathology, as radiologic features often overlap with cancer. Surgical excision is curative with excellent prognosis. Rarely, fibromas associate with Gorlin syndrome or undergo malignant transformation, underscoring the need for accurate diagnosis and tailored surgical management.

Conclusion: Ovarian fibromas are rare, benign tumors that may mimic malignancy, particularly when presenting with Meigs' syndrome. Accurate diagnosis via imaging and histopathology is key to avoiding overtreatment. Surgical excision is curative, with low recurrence. Management should consider age, fertility desires, and potential syndromic associations like Gorlin syndrome for optimal patient outcomes.

CP039 / #832

Topic: *AS06. Tumor Types / AS06d. Ovarian Cancer*

UNUSUAL PRESENTATION OF THE STRUMA OVARIANIUM. A REPORT ON TWO CASES.

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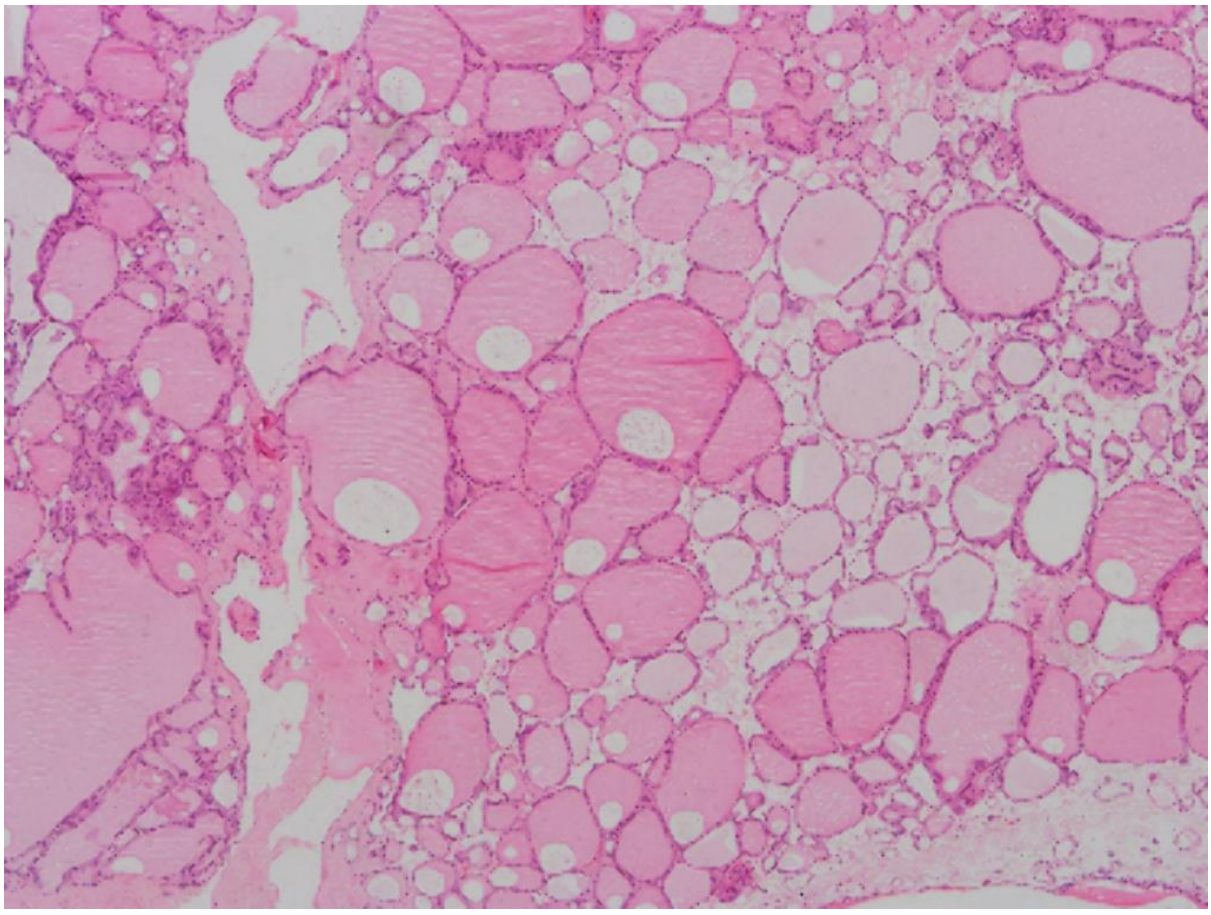
Background/Introduction: Struma ovarii is a rare tumor that accounts for between 0.5% and 1%. Because it is a rare tumor, diagnostic imaging and subsequent treatment criteria are not defined, leading to erroneous preoperative diagnoses of malignancy or prolonged surgeries.

Case Presentation: A 49-year-old woman presented with abdominal distension, Ca125 >1000U/ml and a solid cystic tumor measuring 95x69x86mm, ascites and a peritoneal carcinomatosis index of 13 points. Intraoperative findings described a right paratubal tumor measuring 15x12cm was sent for frozen biopsy, and reported struma ovarii. On microscopic examination, the tumor had a lobular growth pattern and was composed of thyroid follicles. Figure A.



A 39-year-old patient presented with a 15cm mobile abdominopelvic mass with ascites. Ultrasound revealed a multilocular cyst with a smooth, nonvascularized internal wall measuring 147x91x100mm, Ca125 30.4 U/ml and Ca19-9 286.63 U/ml. The left adnexa was sent for frozen biopsy, with the result of benign struma ovarii.

Discussion: Our cases represent two rare clinical presentations of benign struma ovarii. One of them, with clinical findings of ascites, very elevated Ca125 levels, and a complex pelvic tumor, suggested a malignant pelvic neoplasia. Both the clinical presentation and imaging findings mimic epithelial ovarian carcinoma. A preoperative misdiagnosis of ovarian cancer leads to a search for a diagnostic strategy to determine the appropriate treatment.

Conclusion: Treatment of struma ovarii remains a challenge. Correct diagnosis through intraoperative frozen section analysis will avoid radical surgery in patients with ovarian stroma, pseudo-Meigs syndrome, and elevated CA-125 levels. Conservative surgery is recommended for patients with benign struma ovarii.

CP040 / #340

Topic: *AS06. Tumor Types / AS06d. Ovarian Cancer*

AORTIC THROMBOSIS ASSOCIATED TO LOW GRADE EPITHELIAL OVARIAN CANCER IN A 26 YEAR OLD PATIENT

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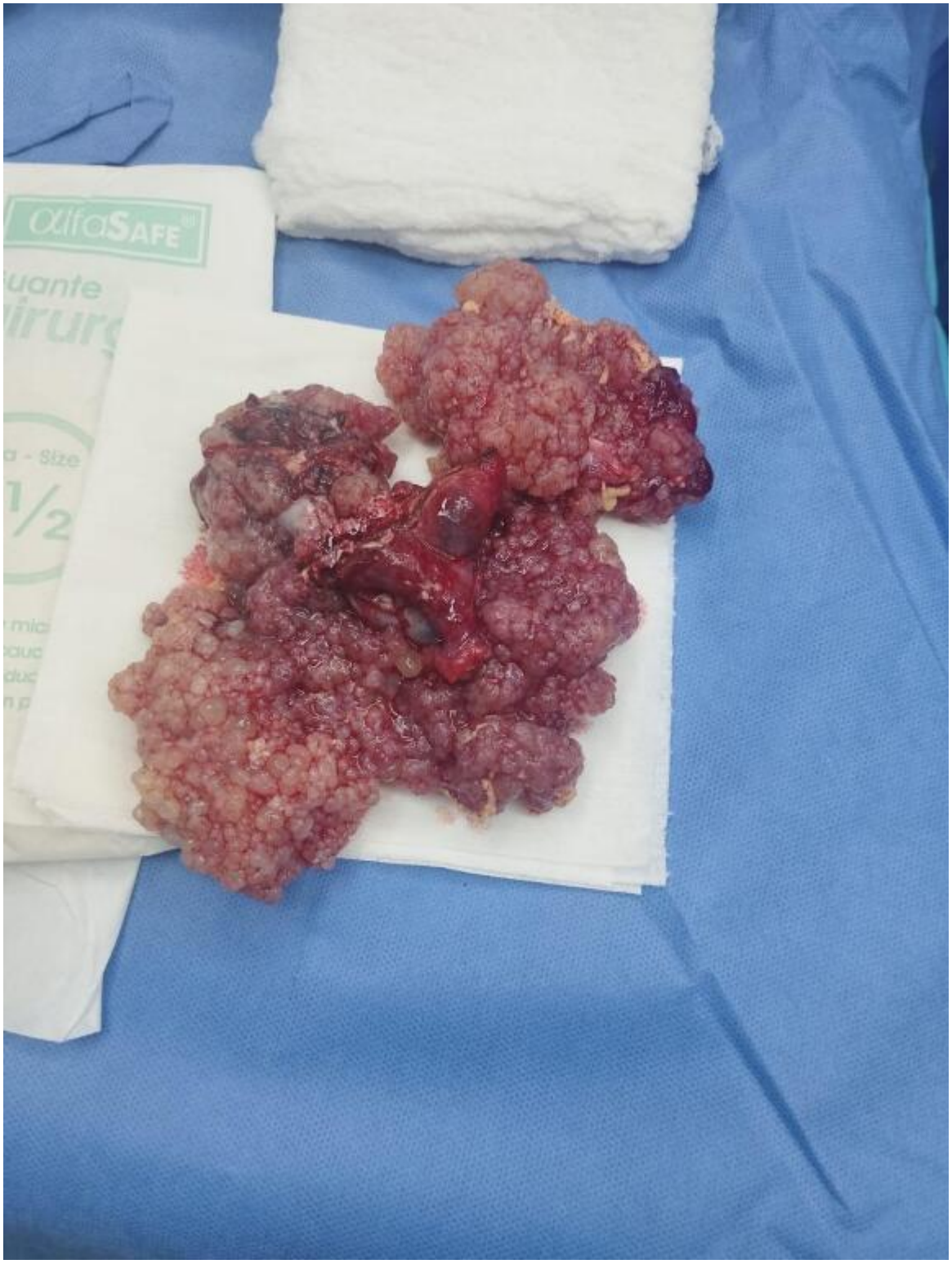
Background/Introduction: Epitelial ovarian cancer(EOC) accounts for 90% of cases, high-grade serous carcinoma being the most representative subtipe. Thrombotic events such as deep vein thrombosis have been related to EOC with an incidence of 9.4%, while thrombotic arterial events are even more rare, with an incidence of 1.74%.

Case Presentation: A 26 year old patient with an 11cm multiloculated pelvic mass and elevated Ca125 was programed for primary cytoreductive surgery. Her past medical history was positive for right subclavian thrombosis and an unclear diagnosis of antiphospholipid syndrome(APS). In her immediate postoperative recovery she developed critical ischemia of her left extremity. Abdominal and left leg AngioCT reported stenosis of 60% of the infrarenal aorta and complete oclusion of the left external iliac artery. Endovascular procedure was effectively performed without any complications. APS antibodies were requested, however they turned to be all negative. Definitive pathology reported low-grade serous ovarian cancer stage IIIC.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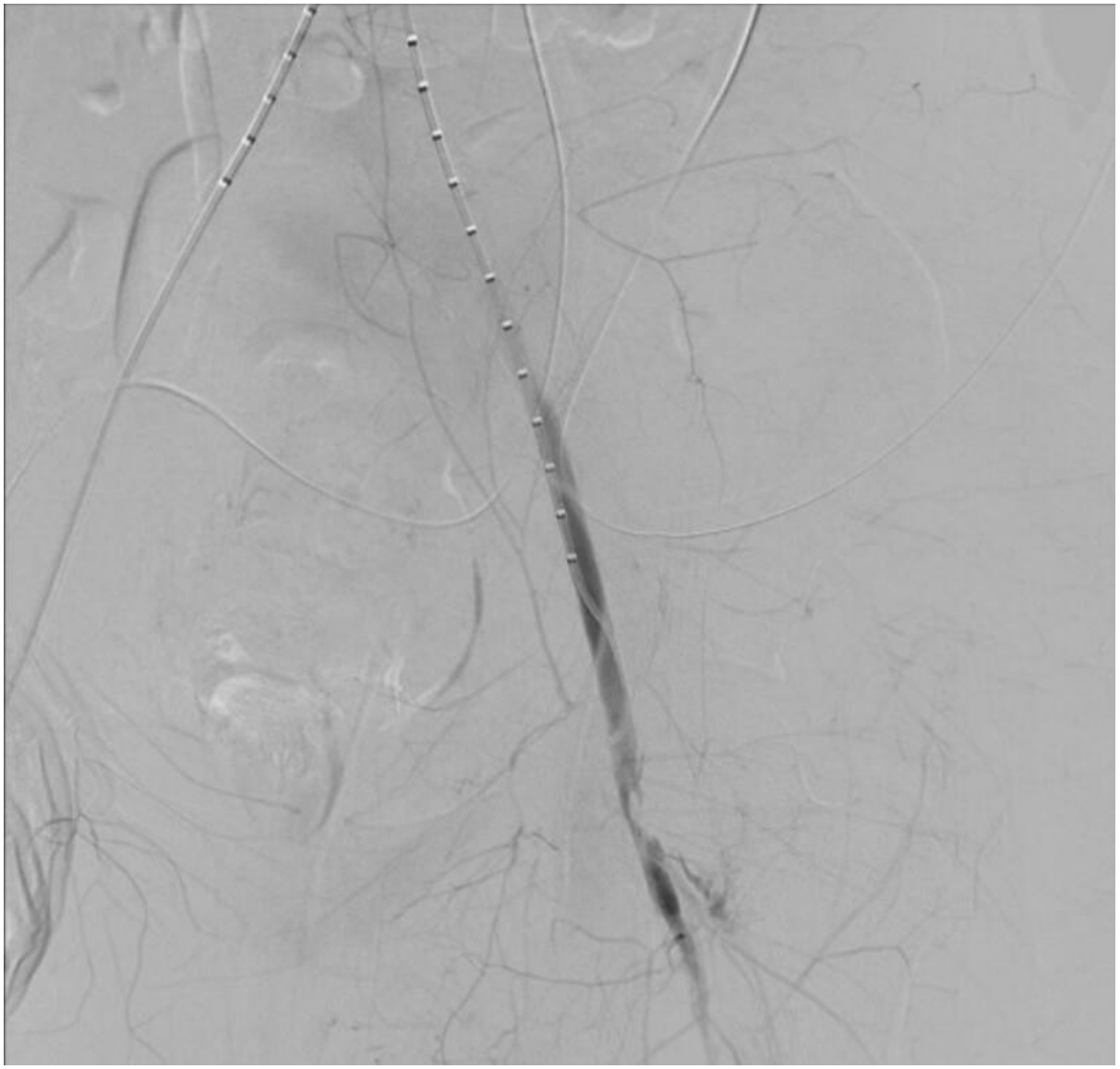

Discussion: With negative APS antibodies, we wondered the reason behind this event. We found a similar case in a 41 year old patient who at the time of EOC diagnosis presented with positive APS antibodies and a extensive arterial thrombosis. After cytoreduction, control APS antibodies turned negative and her thrombosis resolved. Our hypothesis is that the effect of the non-coding RNAs(IncRNAs) and microRNAs(mRNAs) released by the tumor could cause the development of APS as a paraneoplastic syndrome, which will only resolve with surgical excision of the mass.

Conclusion: Arterial thrombosis is not commonly related to EOC, which is why its presentation should be carefully evaluated.

CP041 / #577

Topic: *AS06. Tumor Types / AS06d. Ovarian Cancer*

MIXED EPITHELIAL CARCINOMA: A RARE CONVERGENCE OF MALIGNANCIES - ENDOMETRIOID, MUCINOUS, AND SEROUS SUBTYPES

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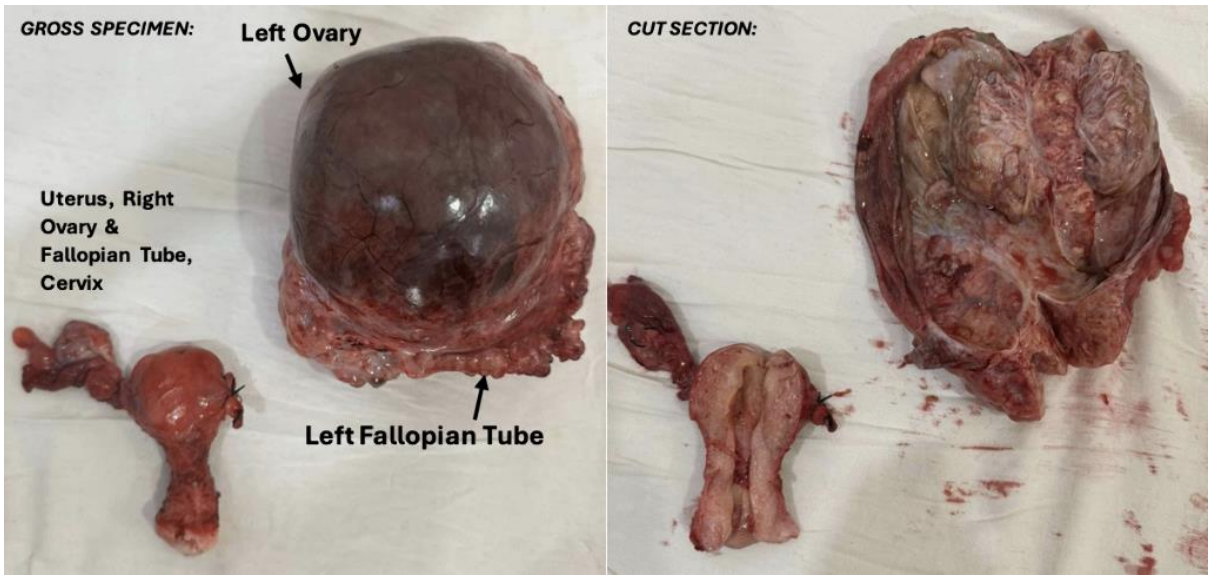
Background/Introduction: Mixed epithelial ovarian tumors are defined as the presence of admixtures of two or more of the five primary cell types: serous, mucinous, endometrioid, clear cell, and Brenner or transitional. Neoplasms that comprise a minor component in excess of 10% are classified as mixed carcinomas by the World Health Organization (WHO). These tumors make up less than 4% of all ovarian epithelial stromal neoplasms.

Case Presentation: A 44-year-old presented with abdominal pain. Ultrasound revealed a cystic, solid mass in the left ovary. The CA-125 is 45.90 U/ml. She underwent total abdominal hysterectomy with bilateral salpingo-oophorectomy, complete surgical staging. Histopathological examination revealed a high-grade differentiated carcinoma with mixed endometrioid, mucinous, and serous, staged as FIGO – IA.



Discussion: The diagnosis of mixed epithelial tumors is challenging due to their rarity. According to Kurman et al., ovarian malignancies are of de novo origin. 80% of women with ovarian carcinoma of epithelial origin have elevated serum CA 125 levels, with the frequency of elevation correlating with the clinically detected stage. It is peculiar to have a slightly elevated CA-125 of 45.90 U/ml for a mixed epithelial tumors that were considered high grade. The most significant prognostic factor is the FIGO staging. A number of factors are linked to long-term survival, including lower CA-125 levels,

nonserous histotypes, early-stage disease, no gross residual disease after surgery, and younger age at diagnosis.

Conclusion: Ovarian epithelial cancer is the most lethal gynecologic malignancy. This high lethality is due to histologic types that are relatively chemo-resistant, despite the availability of current chemotherapeutic and surgical treatments.

CP042 / #632

Topic: *AS06. Tumor Types / AS06d. Ovarian Cancer*

MIMICS OF OVARIAN CANCER: A DIAGNOSTIC CONUNDRUM AND NEED FOR HISTOLOGIC CONFIRMATION.

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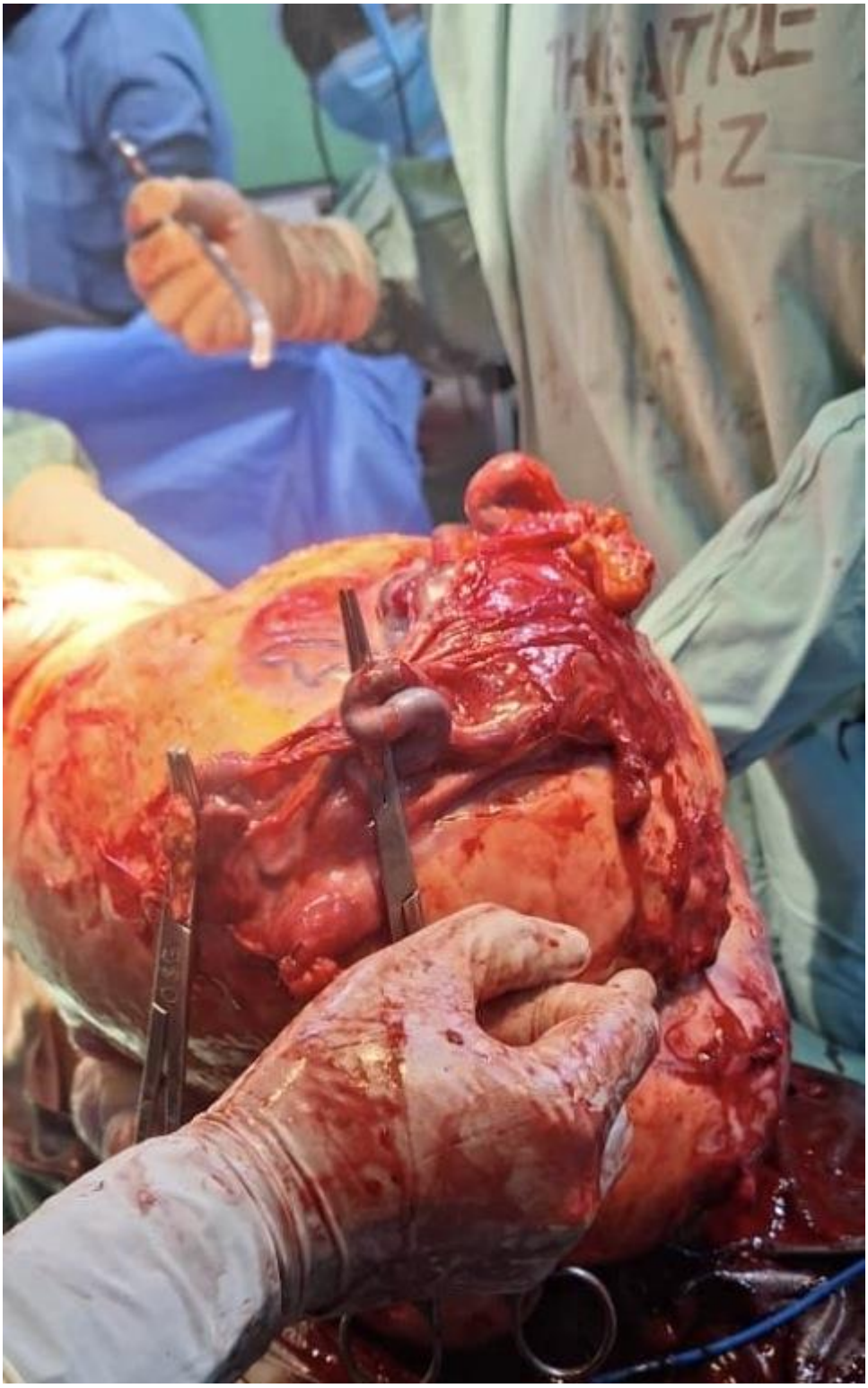
[1]Ahmadu Bello University Teaching Hospital, Zaria, Nigeria, [2]University of Miami, Miami, United States of America

Background/Introduction: Histologic confirmation of ovarian cancer (OC) in Nigeria can be challenging due to unaffordable healthcare and limited facility and skill for interventional radiology and laparoscopic surgey, leading to presumptive treatment with neo-adjuvant chemotherapy. This case study highlights diagnostic complexities and management challenges of significant mimics of ovarian cancer while emphasizing the need for confirmatory diagnosis over suspicion-based treatment. We retrospectively reviewed four cases (February – March 2025) initially suspected of advanced OC but later confirmed to be other conditions. We analyzed case files for medical history and examination findings, theatre records, radiologic images, and histopathologic slides.

Case Presentation: Four cases with initial clinico-radiologic suspicion of advanced ovarian cancer were later found to be incorrect. All presented with pelvic mass, elevated CA-125, ascites and had advanced imaging discussed at multi-disciplinary team meetings. Three had reactive cytology on their ascitic fluid. All cases were single nulliparous young women aged 21-37 years. Final diagnoses included endometriosis (two cases), huge multiple uterine fibroids (one case) and chronic granulomatous disease from abdominal tuberculosis (one case). Two had unindicated surgical menopause and one received unnecessary neo-adjuvant chemotherapy. All patients have commenced treatment for their disease and currently asymptomatic.



Discussion: Mimics of OC have been previously documented. The MDT plays a pivotal role in recognizing cliinical and imaging patterns suggestive of specific mimics, avoiding wrong treatments. Surgery/biopsy is still required and awareness of imaging limitations is critical. Wrong treatments can be avoided if every suspicion is confirmed

Conclusion: Histologic confirmation of OC is important to prevent misdiagnoses and inappropriate treatments.

CP043 / #657

Topic: *AS06. Tumor Types / AS06d. Ovarian Cancer*

BEYOND THE PELVIS: BONE METASTASIS IN CARCINOMA OVARY-CLINICAL REFLECTIONS FROM A CASE SERIES AND LITERATURE REVIEW

Baishali Roy[1], Sachin Khurana[2], Raja Pramanik[2], Prabhat Malik[2], Seema Singhal[1], Rajesh Kumari[1], Jyoti Meena[1], Anju Singh[1], Nilanchali Singh[1]
[1]ALL INDIA INSTITUTE OF MEDICAL SCIENCES, Department Of Obstetrics And Gynaecology, New Delhi, India, [2]ALL INDIA INSTITUTE OF MEDICAL SCIENCES, Department Of Medical Oncology, New Delhi, India

Background/Introduction: Bone metastases are rare in carcinoma ovary,occurring in 0.1–0.12% of cases and typically present at recurrence rather than at initial diagnosis.We report a case series of five patients with carcinoma ovary and bone metastases treated at our hospital.

Case Presentation: Our cohort had a total of 5 ovarian cancer patients.They had mean age 51.6 years,an average CA-125 level of 1499 U/mL.Four patients had bone metastases at initial presentation,while one developed skeletal involvement during platinum-resistant relapse.Sites of metastasis included the acetabulum(Fig.1),pubic bones,chest wall(Fig.2) and upper extremities.One patient had widespread skeletal involvement with sclerotic lesions while the rest had focal lytic lesions.Four patients had high-grade serous carcinoma;one had neuroendocrine histology.All 5 received NACT with standard Paclitaxel-Carboplatin (HGSOC)and Etoposide-Carboplatin(neuroendocrine carcinoma),Bevacizumab added for 4.Three patients underwent cytoreductive surgery:two achieved CC-0 resection,one had CC-3.Two patients with unifocal metastasis experienced significant pain relief following palliative radiotherapy(20 Gy in 5 fractions)-one to the pelvis and one to the chest wall.

Discussion: Bone metastasis in carcinoma ovary is suggestive of hematogenous spread and typically has poor prognosis. Though studies reveal a prevalence among non serous histology, here 4 were HGSOC. Usually bone metastasis are seen to develop in a recurrent setting, here 4 patients had during initial presentation. Liver and bone metastasis are usually associated and are suggestive of hematogenous dissemination,though here only 2 patients had liver metastasis.Selected patients can benefit from cytoreduction and EBRT to the affected bone.

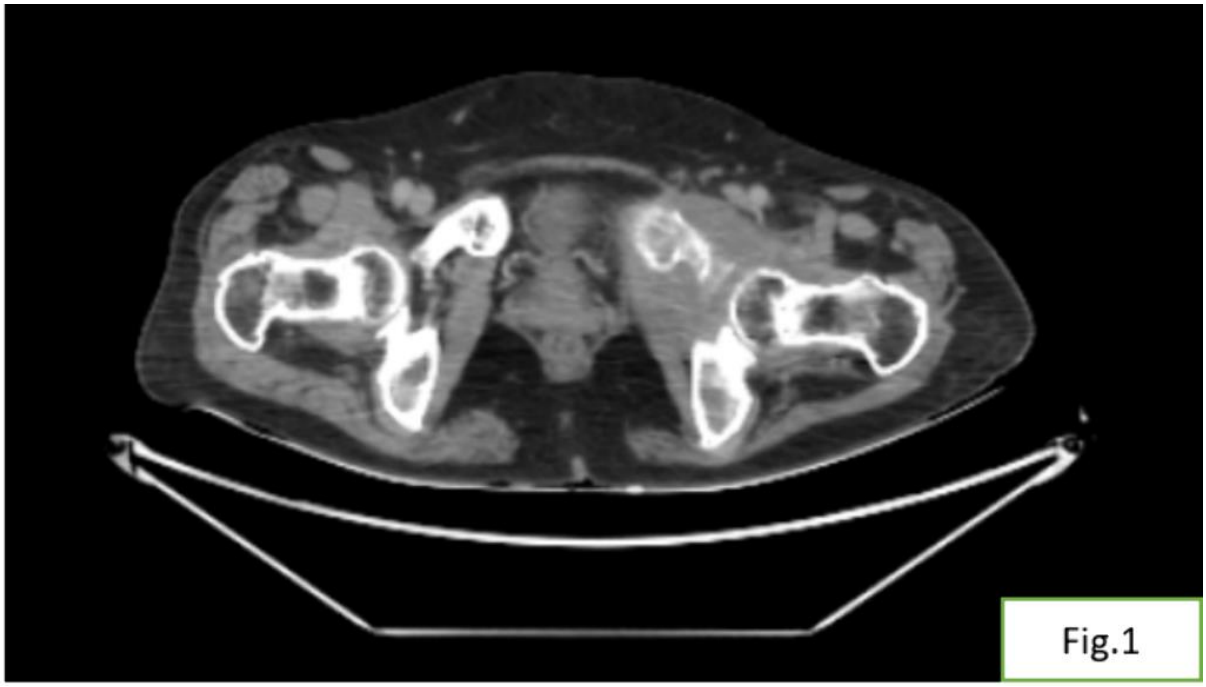


Fig.1

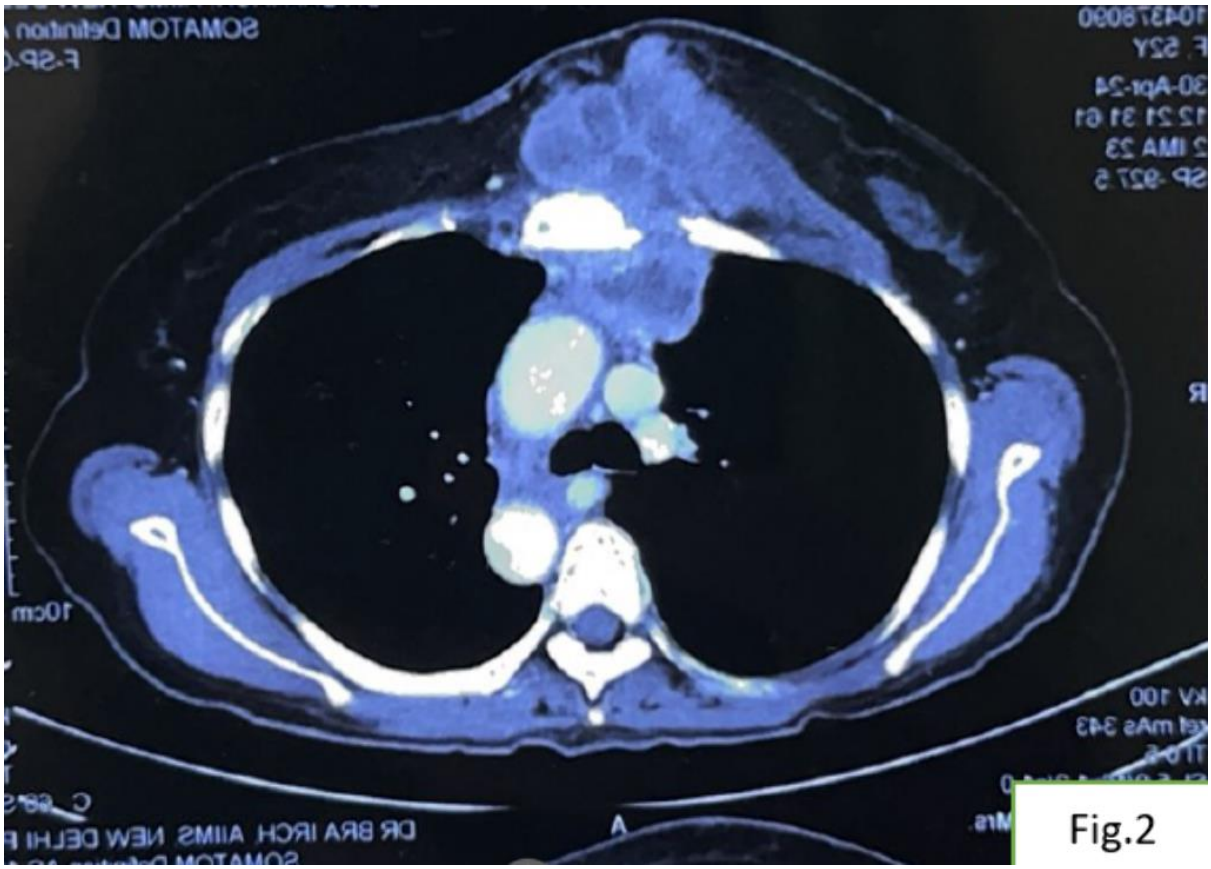


Fig.2

Conclusion: This category of patients are difficult to manage and mostly treated with palliative intent, though maximum cytoreductive efforts can improve survival.

CP044 / #517

Topic: *AS06. Tumor Types / AS06d. Ovarian Cancer*

IS RAD50 CLINICALLY RELEVANT? A CASE SUGGESTING POTENTIAL RISK

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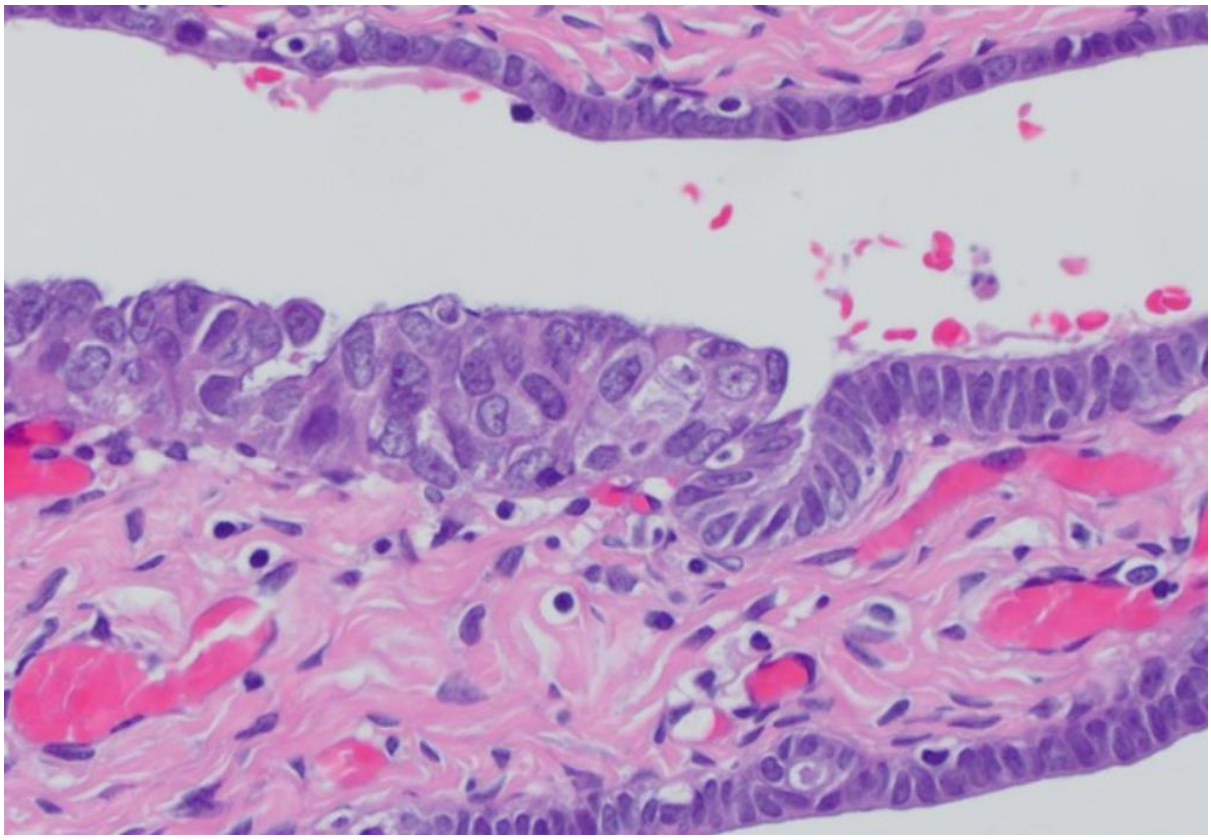
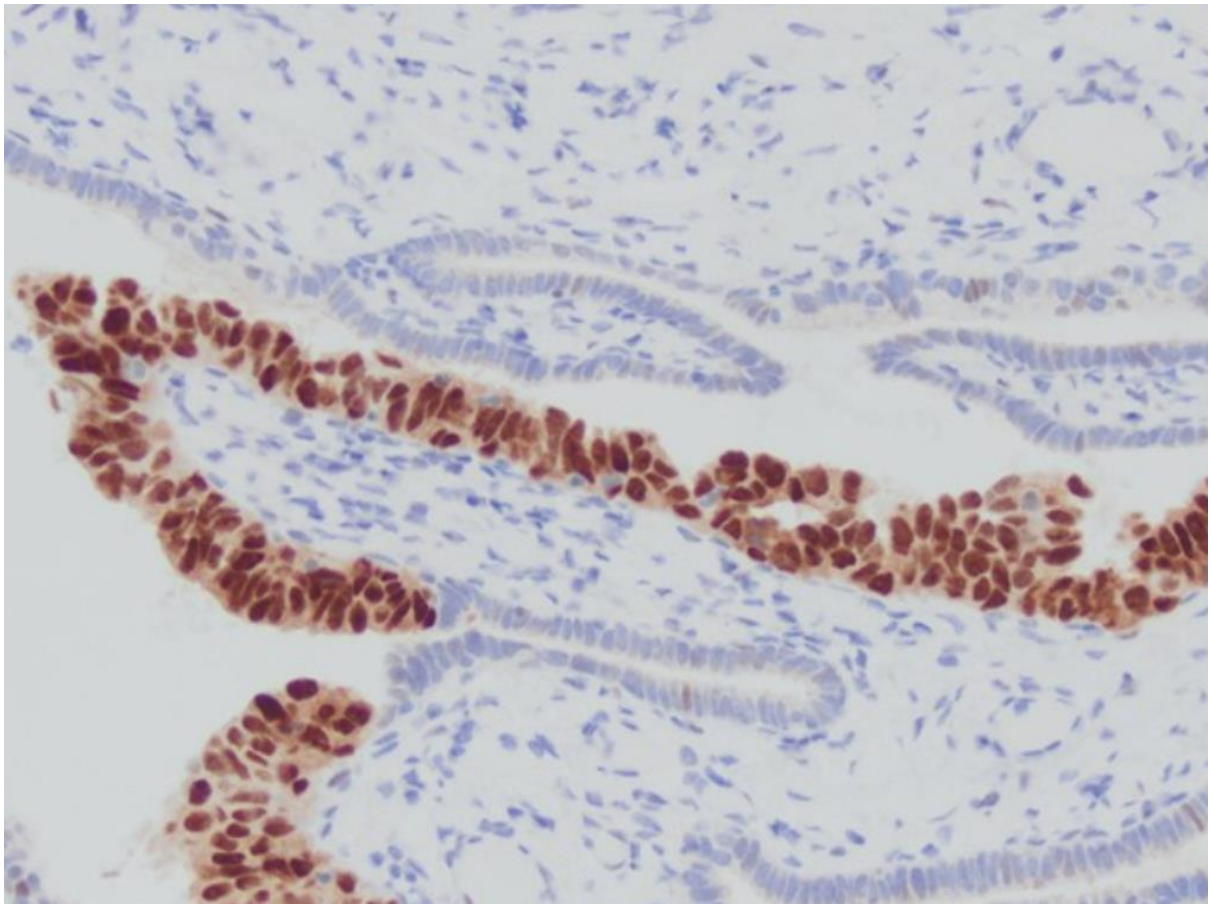
Background/Introduction: This study presents a rare case of a STIC lesion detected after risk-reducing surgery in a patient with a heterozygous RAD50 mutation, aiming to highlight the potential clinical significance of RAD50 in ovarian cancer risk, especially in the context of DNA repair pathway deficiencies.

Case Presentation:





A 55-year-old female patient was diagnosed at age 53 with invasive micropapillary carcinoma of the left breast. Following neoadjuvant therapy, the pathological stage after surgery was reported as ypT1cN1a. The patient had no comorbidities, did not smoke, and had no family history of breast, ovarian, or other malignancies. A panel based genetic analysis revealed a heterozygous RAD50 mutation. After comprehensive genetic counseling and individualized risk assessment, the patient elected to laparoscopic hysterectomy and bilateral salpingo-oophorectomy for risk-reduction purposes. Intraoperative exploration of the pelvis and abdomen was unremarkable. Postoperative histopathological examination identified a “p53 signature” in the right fallopian tube and a serous tubal intraepithelial carcinoma (STIC) lesion at the fimbrial end of the left fallopian tube. No malignancy was observed in the ovaries or endometrial tissue.

Discussion: The association between heterozygous RAD50 mutations and ovarian cancer remains unclear. In this case, the detection of a STIC lesion in a breast cancer patient with a RAD50 mutation suggests a possible oncogenic role of this gene.

Conclusion: In addition to BRCA1/2, risk-reducing surgery may be considered on an individualized basis for mutations in genes such as RAD51C/D, BRIP1, MMR genes. This case highlights the need for further studies to clarify the potential role of RAD50 mutations in ovarian carcinogenesis.

CP045 / #713

Topic: *AS06. Tumor Types / AS06d. Ovarian Cancer*

SCHWANNOMA OF RIGHT URETER PRESENTED AS RIGHT ADNEXAL MASS: A CASE REPORT

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Tehran university of medical science, Assistant Professor Of Gynecology, Tehran, Iran

Background/Introduction: Schwannomas are tumors of myelinated peripheral nerve sheath, potentially occurring in any body part. Their occurrence in retroperitoneum especially in genitourinary tract is extremely rare. Definite diagnosis is made based on histopathological and immunohistochemistry examination of the resected tumor. We reported an extremely rare case of ureteral schwannoma that was diagnosed pre-operatively as adnexal tumor based on radiologic findings.

Case Presentation: A 63-year-old obese woman presented to our department with an intermittent history of vague abdominal pain.Transvaginal ultrasonography revealed a cystic lesion with septation and solid foci measuring 61x47 mm possibly originating from right adnexa. During laparotomy, a well-circumscribed ovoid mass with a smooth surface arising from the right ureter wall. Unfortunately, the patient did not participate in post-operative follow-up visits and developed hydronephrosis 3 weeks.

Discussion: Although schwannomas can potentially arise from myelinated nerve sheaths of any part of the body, their occurrence in retroperitoneum is extremely rare, accounting for about 4% of primary retroperitoneal tumors. Pelvic schwannomas are even rarer and only have been reported in 0.3% to 3.2% of the cases. Extremely rare occurrence of schwannoma of urinary tract has been reported in the kidneys, urinary bladder, and urethra . To our knowledge, this is the first reported case of schwannoma in a female ureter. Moreover, our patient did not have any history or findings suggestive of Von Recklinghausen's disease, which make our case more exceptional.

Conclusion: Pelvic schwannoma should be included in the differential diagnosis of any unilateral well-circumscribed heterogeneous retroperitoneal masses with inconclusive clinical and radiological findings.

CP046 / #638

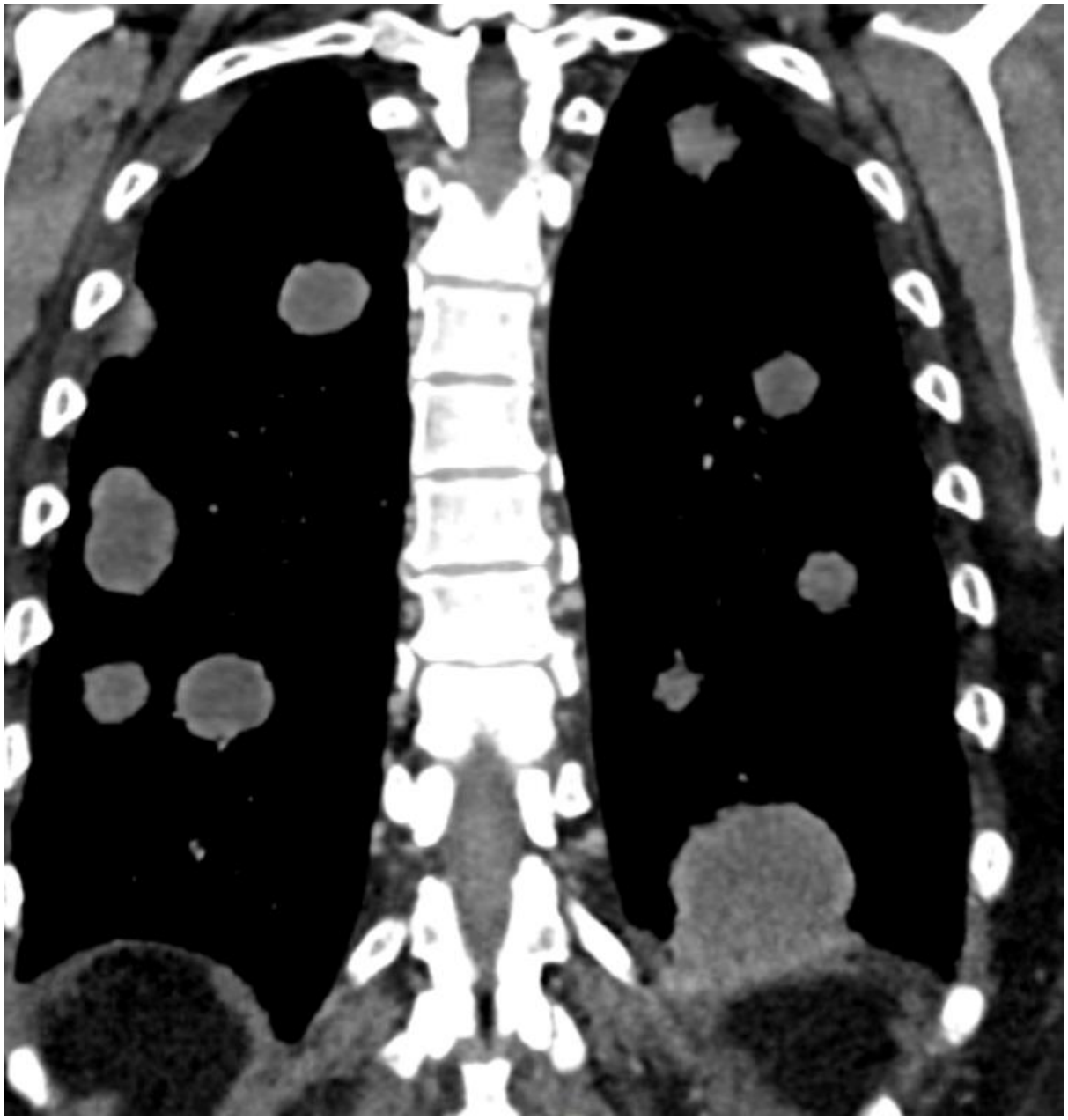
Topic: *AS06. Tumor Types / AS06e. Trophoblastic Disease & Rare Tumors*

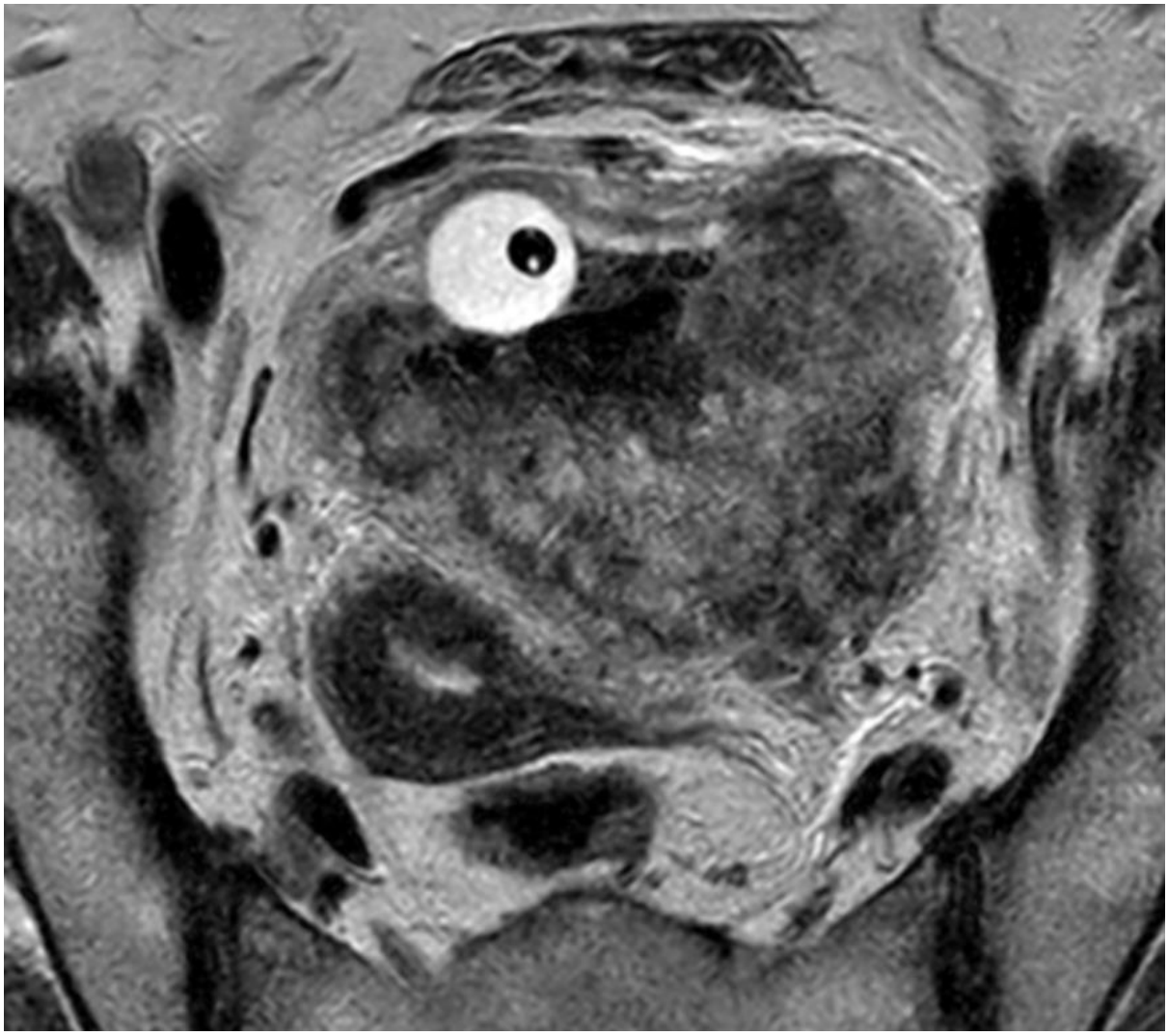
GYNECOLOGICAL CANCER SIMULATOR BLADDER CORIOCARCINOMA, SOTERO DEL RIO HOSPITAL, SANTIAGO DE CHILE, YEAR 2025

Pablo Avalos, Cristobal Valdés, Fernanda Troncoso, Gabriela Vera
Hospital Sótero del Río, Santiago, Chile

Background/Introduction: Choriocarcinoma can be gestational and non-gestational. We describe the case of a 57-year-old patient with suspected non-gestational choriocarcinoma, who was finally diagnosed as suspected metastatic bladder choriocarcinoma during her study.

Case Presentation: A 57-year-old patient, tobacco use for 39 years. Gynecology consultation for 3 months of genital bleeding. Examination was performed under anesthesia, and a tumor was observed in the anterior vaginal wall, without compromising it, with a healthy neck and no bleeding. CT TAP reports a tumor adjacent to the uterine anterior wall, 11 cm, with extensive areas of necrosis, without adenopathies. Thorax: 20 cannonball injuries. b-HCG was requested in the case of suspected hematogenous metastasis, which was found in 87,000. Urology performs diagnostic cystoscopy, but it is suspended due to heavy bleeding. Follow-up tests: hemoglobin of 7.2 and b-HCG of 73000. MRI pelvis: bladder tumor with multiple areas of necrosis, b-HCG, 72 hrs post cystoscopy, 97000. Given this, urology and medical oncology take the case for management.





Discussion: Early diagnosis of non-gestational choriocarcinoma is crucial to improve patient prognosis and survival

Conclusion: The objective of this case report is to incorporate the diagnosis of non-gestational choriocarcinoma, as opposed to clinical symptoms suggestive of it, since its prognosis and management is similar to that of the gestational type

CP047 / #976

Topic: *AS06. Tumor Types / AS06e. Trophoblastic Disease & Rare Tumors*

THE OCCURRENCE OF SYNCHRONOUS UTERINE EPITHELIOID TROPHOBLASTIC TUMOUR AND MUCINOUS ADENOCARCINOMA OF THE CAECUM WITH DIAGNOSTIC CHALLENGES: A CASE REPORT

Kotti-Emily Mukucha[1], Wan Jung Tsai[2], Dr Jackie Chokoe Maluleke[2,3], Tracey Adams[1,4,5]
[1]Groote Schuur Hospital, University of Cape Town, Gynecologic Oncology Unit, Department Of Obstetrics And Gynaecology, Cape Town, South Africa, [2]National Health Laboratory Service University of Cape Town, Pathology University Of Cape Town, Cape Town, South Africa, [3]University of Cape Town/NHLS, Pathology, Division Of Anatomical Pathology, Cape Town, South Africa, [4]South African Medical Research Centre, Gynaecological Cancer Research Centre, Cape Town, South Africa, [5]Global Surgery Unit, University of Cape Town, Cape Town, South Africa

Background/Introduction: Epithelioid trophoblastic tumour (ETT) is a rare form of gestational trophoblastic neoplasia, accounting for less than 2% of all gestational trophoblastic diseases. Its rarity presents diagnostic challenges. We discuss a rare case of synchronous ETT tumour with a pelvic tumour, the diagnostic challenges and literature review.

Case Presentation: A 39-year-old multiparous woman, presented with a history of abdominal pain and heavy vaginal bleeding. Clinically she had a palpable abdominal mass, and endometrial sampling confirmed a poorly differentiated uterine carcinoma. Tumour markers were submitted to the laboratory **(Table 1)**. She underwent a laparotomy, and intraoperative findings were that of a caecal mass, a bulky 20-weeks gestational size uterus with normal appearing fallopian tubes and ovaries. Complete staging surgery with bowel resection and anastomosis were performed. The final histology confirmed synchronous malignancies: uterine epithelioid trophoblastic tumour **(Fig.1 A-B)** while the caecal mass histology confirmed mucinous adenocarcinoma **(Fig.1C).**

Table 1: Serial serum β-HCG and tumour marker values

Date	Serum β-HCG (IU/L)	Other Tumour Markers
04/10/2024	2,033	CA125: 20 LDH: 204 AFP: 4.2 CEA: 8.3
07/10/2024	3,601	
09/10/2024	3,608	
23/10/2024	4,077	
04/12/2024	88 (postoperative)	

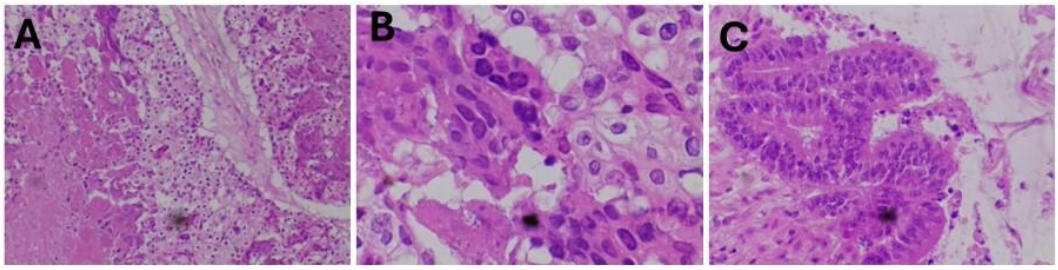


Fig. 1: **Microscopic histologic sections after H-E stain**. Epithelioid trophoblastic tumour (**A – B**), at magnification X 100 (**A**) and X 400 (**B**). M . The neoplastic cells are relatively uniform, with a moderate amount of finely granular eosinophilic to clear cytoplasm, distinct cell membranes, and round nuclei with distinct small nucleoli. Extensive geographical necrosis is present. Eosinophilic hyaline-like material is seen in the centre of tumour nests. A moderately differentiated mucinous adenocarcinoma grade 2 (**C**).

Discussion: ETT often present with very low BHCG levels, which might present a diagnostic challenge. It can often be misdiagnosed as other epithelial carcinomas of the female genital tract. The mildly elevated CEA was not prioritized pre-operatively. The histopathology and immunohistochemical stains confirmed the diagnosis of epithelioid trophoblastic tumour **(Fig.1 A-B)**.

Conclusion: In view of its rarity, minimal clinical symptoms and very low serum BHCG levels, the initial diagnosis of ETT can be challenging, moreover when another pelvic tumour is present. Thorough pathological review is required to make a final diagnosis, and tumour marker values may always provide a clue.

CP048 / #403

Topic: *AS06. Tumor Types / AS06e. Trophoblastic Disease & Rare Tumors*

HIDDEN IN PLAIN SIGHT: DESMOPLASTIC SMALL ROUND CELL TUMOUR (DSRCT) PRESENTING AS A GYNAECOLOGICAL MALIGNANCY

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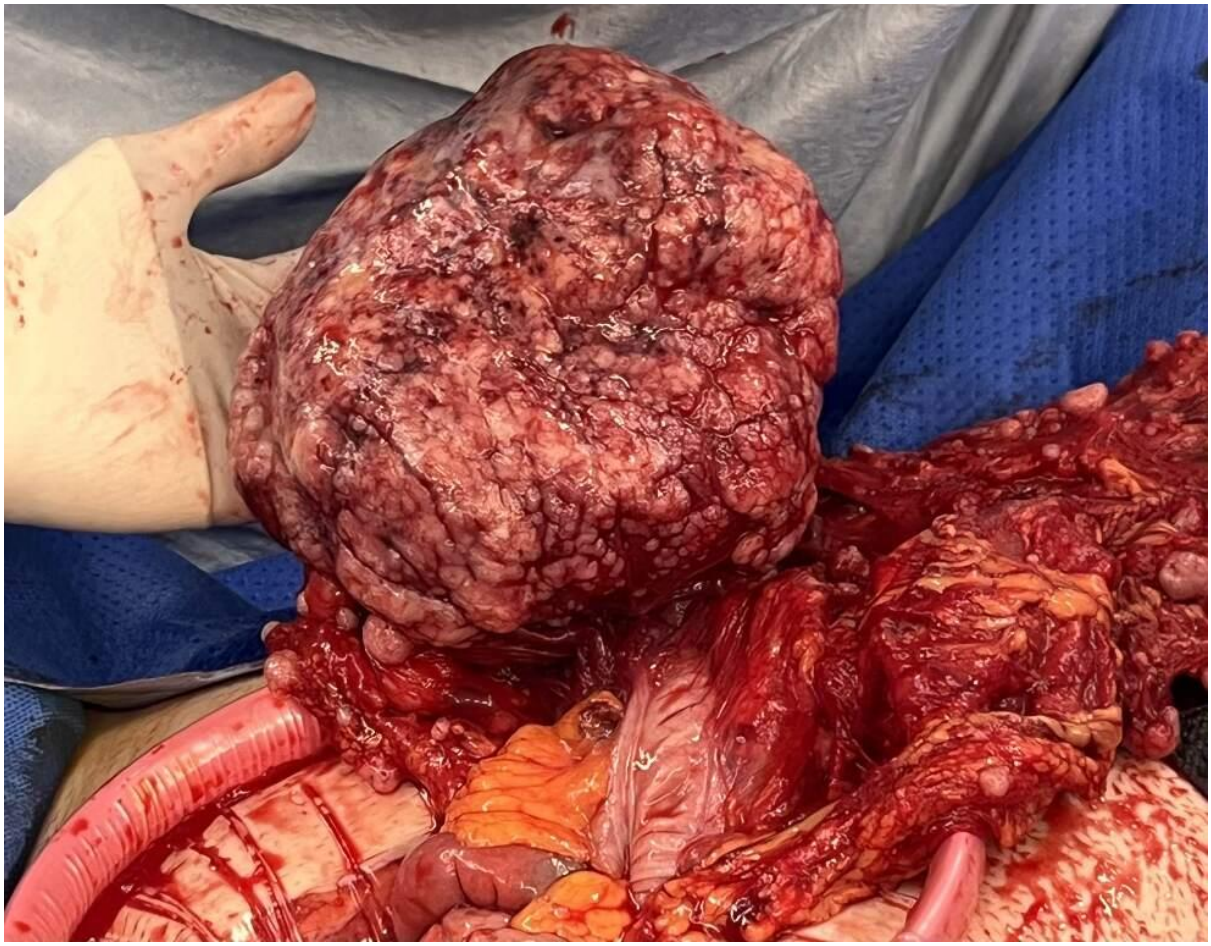
Liverpool Hospital, Sydney, Australia

Background/Introduction: DSRCT is an aggressive mesenchymal malignancy first described in 1989. Fewer than 300 cases are documented; three-quarters occur in males, yet diagnostic confusion is greatest in young women in whom the tumour masquerades as ovarian cancer. The pathognomonic EWSR1-WT1 fusion (t11;22) drives tumorigenesis. We present a diagnostically challenging case and outline management.

Case Presentation: A 22-year-old woman presented with four weeks of abdominal pain and bloating. CT demonstrated a 13 × 8 cm vascular pelvic mass, peritoneal nodularity and ascites. CA-125 was 310 U/mL; LDH 551 U/L. Exploratory laparotomy found a 12 x 12cm omental mass with widespread nodular extra-pelvic and pelvic metastatic deposits, 300ml of ascites. Omental mass was resected with >5cm residual disease throughout abdomen. Histology showed nests of small round blue cells within desmoplastic stroma. Immunoprofile was desmin+, pancytokeratin+, nuclear WT1+; RT-PCR confirmed the EWSR1-WT1 fusion. The patient began the P6 protocol (vincristine/doxorubicin/cyclophosphamide alternating with ifosfamide/etoposide) on postoperative week 4.



Discussion: DSRCT is misidentified in ~30 % of cases because imaging and markers overlap germ-cell tumours. Definitive diagnosis requires integrated morphology, immunohistochemistry and molecular testing. Best practice couples' dose-intense chemotherapy with maximal cytoreduction; whole-abdominal radiotherapy or HIPEC is considered after macroscopic clearance. Despite multimodality therapy, median survival is 17–24 months and five-year survival <20 %.

Conclusion: DSRCT should be considered when young women present with unexplained peritoneal masses. Rapid molecular confirmation and referral to a sarcoma-focused multidisciplinary team enable timely multimodal therapy. Trial enrolment exploring HIPEC, IGF-1R blockade or GD2-directed immunotherapy is encouraged

CP049 / #368

Topic: *AS06. Tumor Types / AS06e. Trophoblastic Disease & Rare Tumors*

TWIN PREGNANCY CONSISTING OF A LIVEBORN INFANT WITH MULTIPLE ANOMALIES AND A COMPLETE HYDATIFORM MOLE WITH SECONDARY GESTATIONAL CHORIOCARCINOMA

Elise Yates[1], Nancy Landez[2], Abigail Bagdasaryants[1], Alwyn Mathew[1], Monisha Singh[3], Anuj Suri[1]
[1]Houston Methodist Hospital, Department Of Obstetrics And Gynecology, Houston, United States of America, [2]Unified Women's Healthcare of Texas, Department Of Obstetrics And Gynecology, San Antonio, United States of America, [3]Houston Methodist Hospital, Department Of Medical Oncology, Houston, United States of America

Background/Introduction: Twin gestation with a complete hydatidiform molar pregnancy and a coexisting normal fetus (CHMCF) is rare, posing a higher risk of high-risk gestational trophoblastic neoplasia (GTN) and obstetric complications, with no standardized treatment guidelines.

Case Presentation: A 27-year-old female presents with vomiting, vaginal bleeding, and tachycardia five weeks following cesarean section at 27.4 weeks gestation for severe fetal growth restriction with multiple fetal and placental anomalies. Laboratory testing showed severe hyperthyroidism and a quantitative beta- hCG of over 700,000. Imaging revealed a uterine mass with bilateral pulmonary nodules. CT guided biopsy of the pulmonary nodules confirmed the diagnosis of choriocarcinoma, FIGO Stage III:12. Pathology from the cesarean delivery was re-reviewed and demonstrated a previously unrecognized twin pregnancy consisting of a liveborn infant with multiple anomalies and a complete hydatidiform mole with secondary gestational choriocarcinoma at the time of delivery. The patient underwent a total of 8 cycles of multiagent chemotherapy (EMA-CO: etoposide, methotrexate, actinomycin D, with alternating treatments of cyclophosphamide and vincristine) with subsequent remission.

Discussion: CHMCF is a rare condition usually diagnosed antepartum via ultrasound or, less commonly, at delivery through placental examination. The clinical presentation, evaluation, and treatment of postpartum diagnoses are previously undescribed, and the impact of delayed diagnosis on disease severity remains unknown.

Conclusion: This case highlights the need for careful pathology review and clinical suspicion of CHMCF in patients with obstetric complications, offering valuable insights for gynecologic oncologists managing this rare condition.

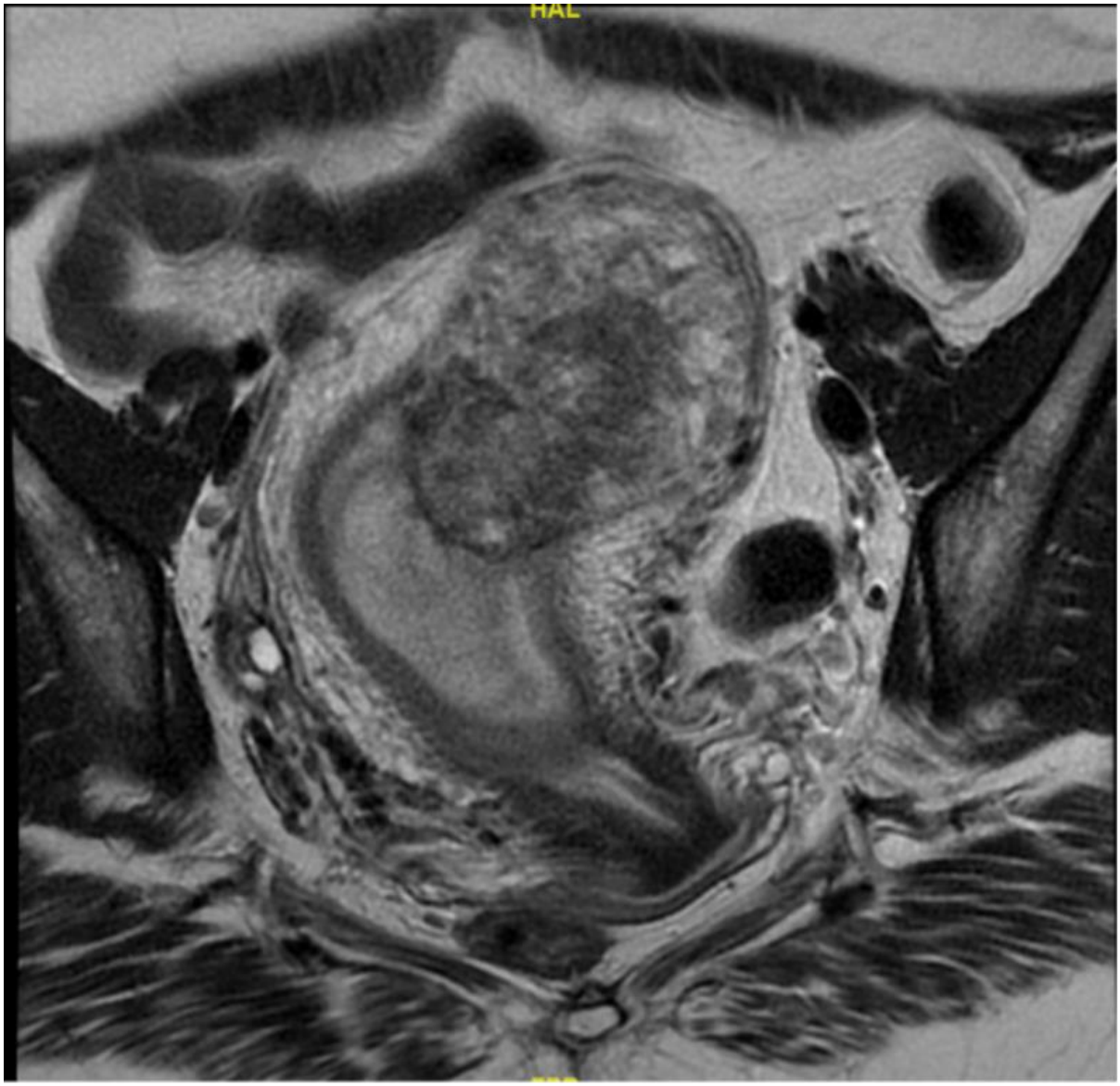


Figure 1: MRI pelvis showing 6.0x6.4x5.6cm mass in the uterine fundus

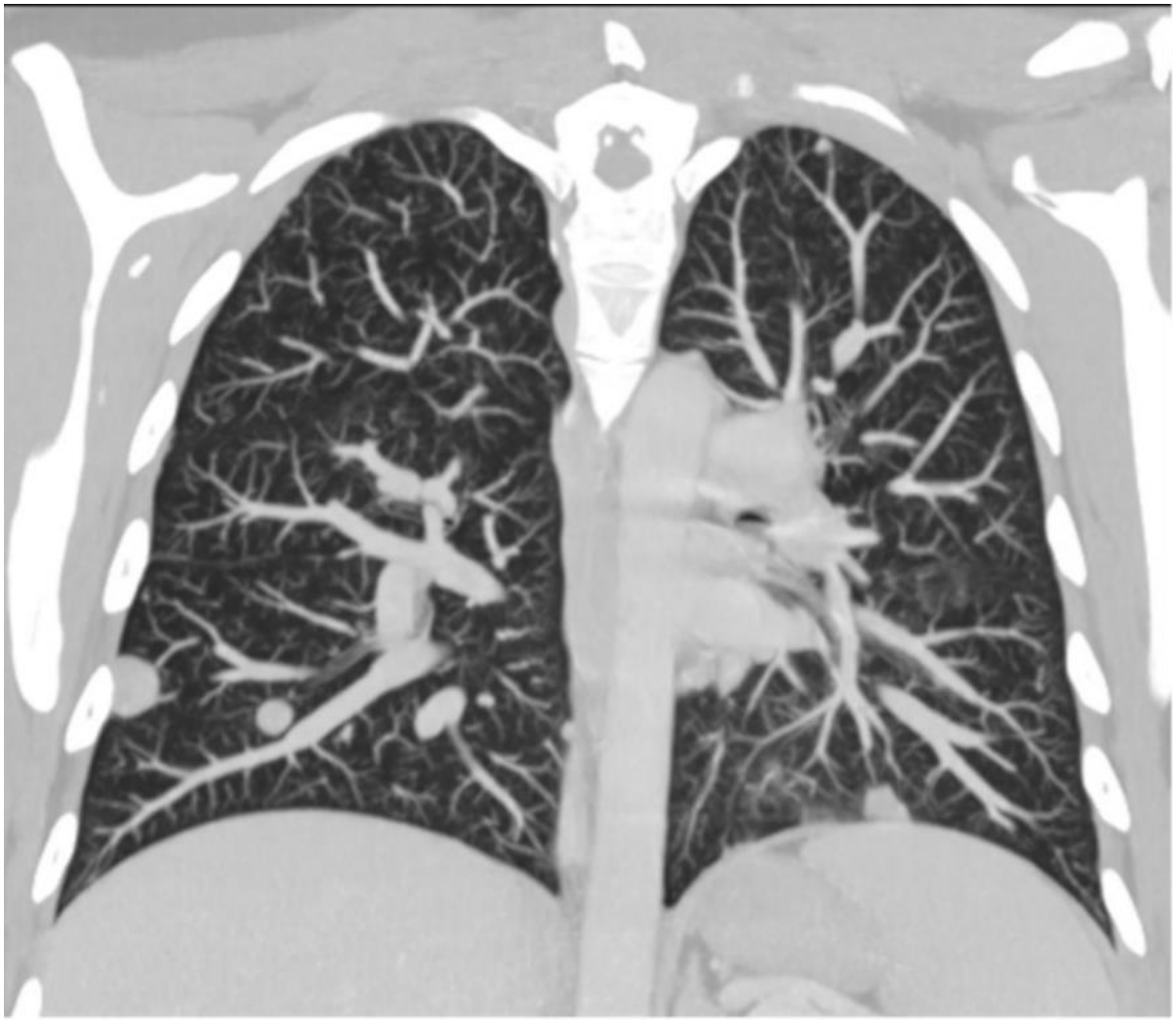


Figure 2: CT CAP showing multiple pulmonary nodules concerning for metastasis

CP050 / #1103

Topic: *AS06. Tumor Types / AS06f. Vulvar & Vaginal Cancer*

LEIOMYOSARCOMA OF THE VULVA. REPORT OF A RARE CASE.

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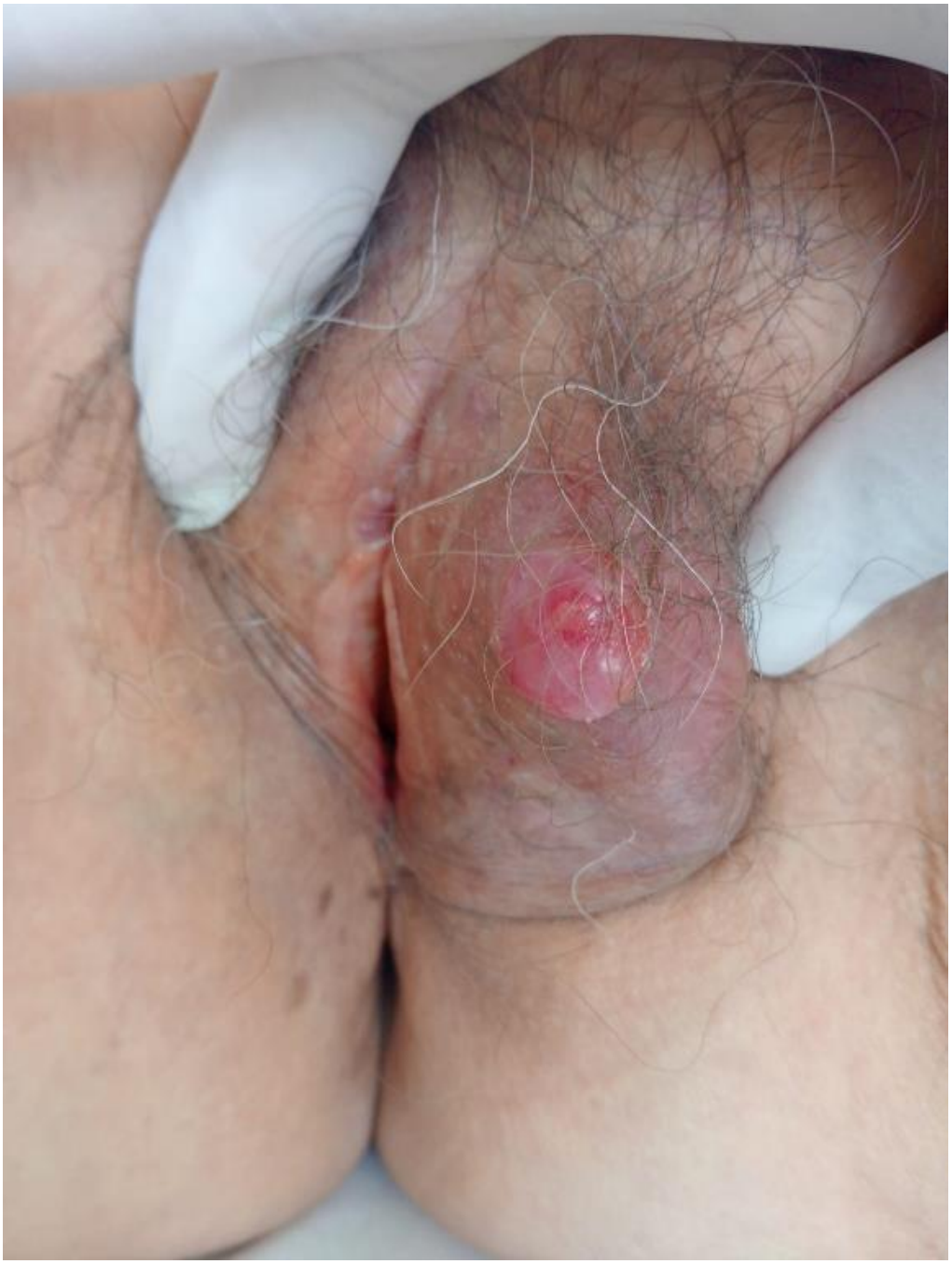
Hospital Nacional Edgardo Rebagliati Martins, Lima, Lima, Peru

Background/Introduction: Vulvar sarcomas represent <3%. Clinically, they present as painless nodules, often on the labia majora, in the Bartholin gland area, clitoris, and labia minora. Surgical treatment methods are extensive. To date, there are no guidelines on the diagnosis, treatment, and prognosis of these tumors.

Case Presentation: A 72-year-old presented a tumor on the left hemivulva. Pelvic examination showed a tumor dependent on the anterior third of the left labia majora measuring 5cm with mobile adenopathies measuring 1.5cm in the right groin. Figure A. The punch biopsy concluded as fragments with malignant neoplasia with marked cellular pleomorphism, and immunohistochemistry revealed pankeratin: negative. Vimentin: positive. P16: positive. Desmin: negative.CD34: negative, making the results inconclusive and suggesting melanoma. Bilateral inguinal sentinel lymph node identification and radical local resection of the left hemivulva were performed. Microscopic examination revealed a high-grade leiomyosarcoma with negative inguinal lymph nodes (0/5), in addition to surgical margins at 2 mm. Due to suspicion of persistent disease and close margins, margin expansion was performed with negative histological results. She received adjuvant interstitial brachytherapy and currently has no evidence of disease. Figure A.



Discussion: Isolated cases and limited series of cases of vulvar leiomyosarcoma have been described in the literature. There are no definitive therapeutic algorithms due to the rarity of the disease. Management is surgical, requiring the entire tumor to be removed with histologically verified clear resection margins, followed by radiotherapy, which is not necessary for low-grade leiomyosarcoma.

Conclusion: Vulvar tumors are difficult to distinguish macroscopically. An accurate histological diagnosis allows for appropriate treatment.

CP051 / #960

Topic: *AS06. Tumor Types / AS06f. Vulvar & Vaginal Cancer*

VULVAR ADENOCARCINOMA OF BREAST ORIGIN

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imgo, cordoba, Argentina

Background/Introduction: Primary vulvar adenocarcinomas are rare tumors. They are classified within extramammary Paget's disease, sweat gland carcinomas, and mammary gland adenocarcinomas of the vulva, tumors that share some histological features.

Case Presentation: 75 years old woman. 2 months evolution of itch and vulvar tumor. Vulvar biopsy: MALIGNANT EPITHELIAL CLEAR CELL NEOPLASM. Protein S 100 NEGATIVE; POSITIVE: CEA, CYTOKERATINS 7 AND 20. Hemivulvectomy + right inguinal sentinel node biopsy with blue dye: tumor 4X4X2 CM. 1 SENTINEL NODE (-). Free tumor margins of invasive desease, and in contact with Paget desease. CK7 + MELANA: NEGATIVE; GDFP15 POSITIVE: Adenocarcinoma of breast origin and extramammary Paget's disease Distance STAGING: NEGATIVE. 2 months later, presented with an indurated lesion on the right vulvar lip and vulvar, with inguinal satellites. Radical vulvectomy was performed with right inguinal lymphadenectomy. Tumor: 12 cm extencion of tumor, 5/6 isolated lymph nodes were involved, with extensive extranodal involvement.

Discussion: Primary vulvar adenocarcinomas are rare tumors. They are classified within extramammary Paget's disease, sweat gland carcinomas, and mammary gland adenocarcinomas of the vulva. Mammary-type anogenital glands are differentiated from normal sweat glands by demonstrating positivity for estrogen and progesterone receptors. Ectopic breast tissue may be in multiple locations, also described in the vulva and in other body areas. Both mammary-like glands and those with ectopic breast tissue are susceptible to the physiological, dysplastic, and malignant changes observed in normal breast parenchyma.

Conclusion: This is a rare vulvar tipe of vulvar cancer with a torpid evolution. Biological behavior determines the prognosis of the disease, regardless of histology.

CP052 / #1074

Topic: *AS06. Tumor Types / AS06f. Vulvar & Vaginal Cancer*

WHEN INFLAMMATION MASQUERADES AS MALIGNANCY: VULVAL CHRON'S DISEASE MIMICKING VULVAL CANCER

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Background/Introduction: Vulval Crohn's disease (VCD) is a rare condition characterised by granulomatous inflammation of the vulva. It can sometimes mimic vulval malignancy, creating a diagnostic challenge. In 20-36% of cases, VCD can occur before any gastrointestinal symptoms, or even in the absence of them.

Case Presentation: We present a case series of four patients referred to the regional gynaecological oncology service with a suspicious vulval lesion. Subsequent clinical assessment and vulval biopsy confirmed VCD.

Discussion: Clinical Features suggestive of VCD include "knife-cut" linear ulcers, asymmetrical vulval oedema, fissuring and perianal involvement. A vulval biopsy is the gold standard for diagnosis with histological examination revealing chronic inflammation with non-caseating granulomas, which are characteristic of Chron's disease. In some cases, imaging like MRI might be used to assess the extent of the disease or to look for associated fistulas or abscesses, but it's not typically used to differentiate VCD from malignancy directly.

Conclusion: VCD can present with unusual features that may raise concern for malignancy, careful clinical evaluation and, most importantly, tissue biopsy with histological analysis is essential to establish the correct diagnosis.

CP053 / #1114

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VULVAR MELANOMA. CASE REPORT

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Background/Introduction: Vulvar malignant melanoma is the second most common subtype of all vulvar cancers, accounting for 5–10%. It has the poorest prognosis. Histology is essential for diagnosis. Treatment requires multidisciplinary management, with surgical intervention being the cornerstone.

Case Presentation: A 70-year-old woman with a vulvar biopsy revealed vulvar melanoma. Physical examination revealed a 3-cm nodular exophytic lesion with a melanocytic base in the lower third of the anterior aspect of the vagina, 2 cm from the urethra. Figure A. There were no suspicious lymphadenopathy. Pathology review revealed a malignant neoplasm arranged in epithelioid nests and solid areas with melanin pigment. Breslow index: 5 mm. S100: positive. The diagnosis of vulvar melanoma was confirmed with pathologic findings. MRI of the vaginal canal in the distal outer third showed 13x6mm mural thickening with contrast enhancement. No lymph node involvement. Following a multidisciplinary meeting, a radical vulvectomy, bilateral inguinofemoral lymphadenectomy, distal urethral resection, bladder cerclage, double MONTI continent urinary diversion, and bladder trimming were performed. Figure B. Histopathological examination revealed a malignant nodular tumor of invasive melanoma. Breslow index: 6mm, Clark index: IV, 5 mm from the nearest margin. Free lymph nodes were present. She received perineal radiotherapy due to margin issues.

Figure A.

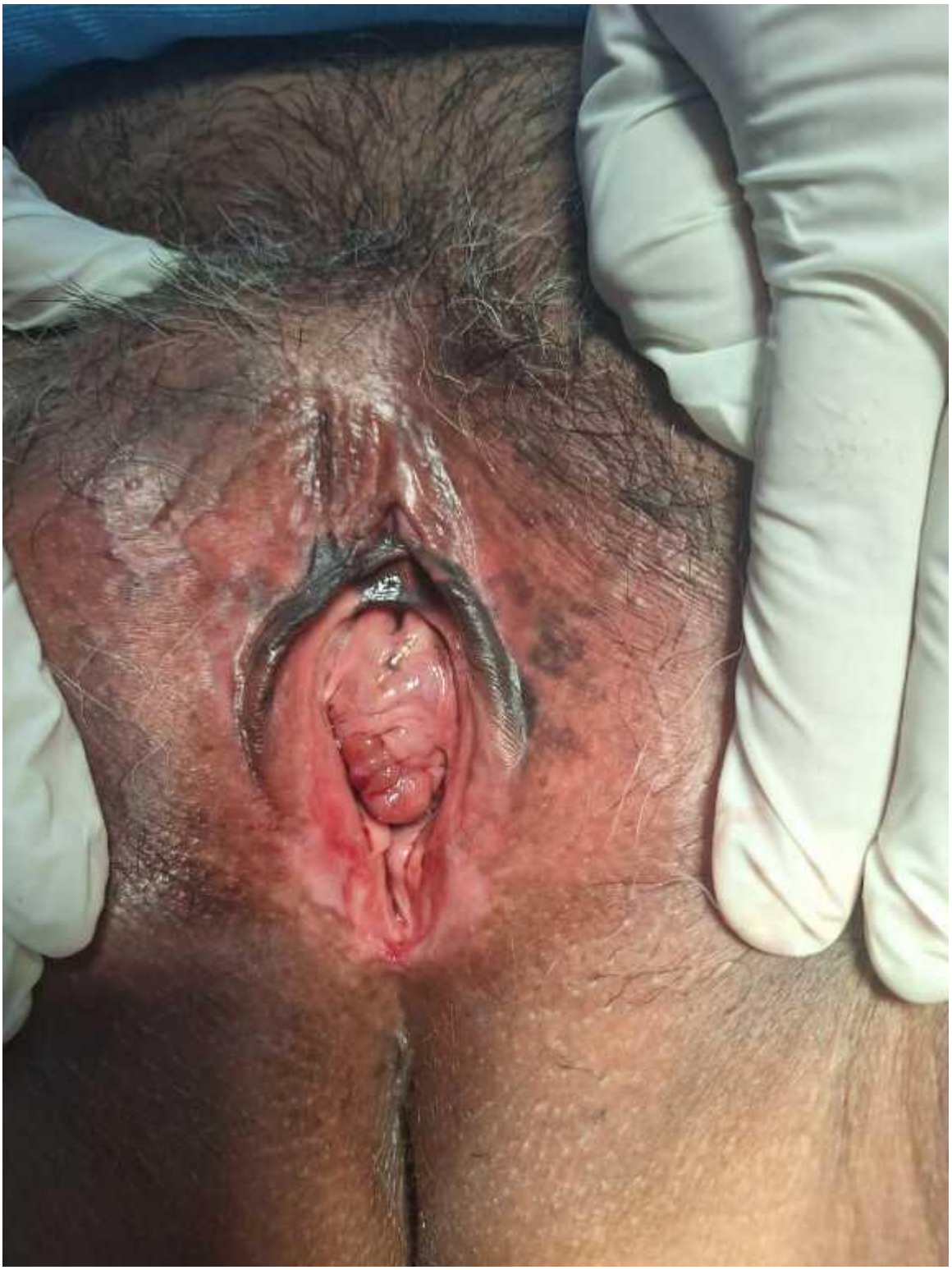
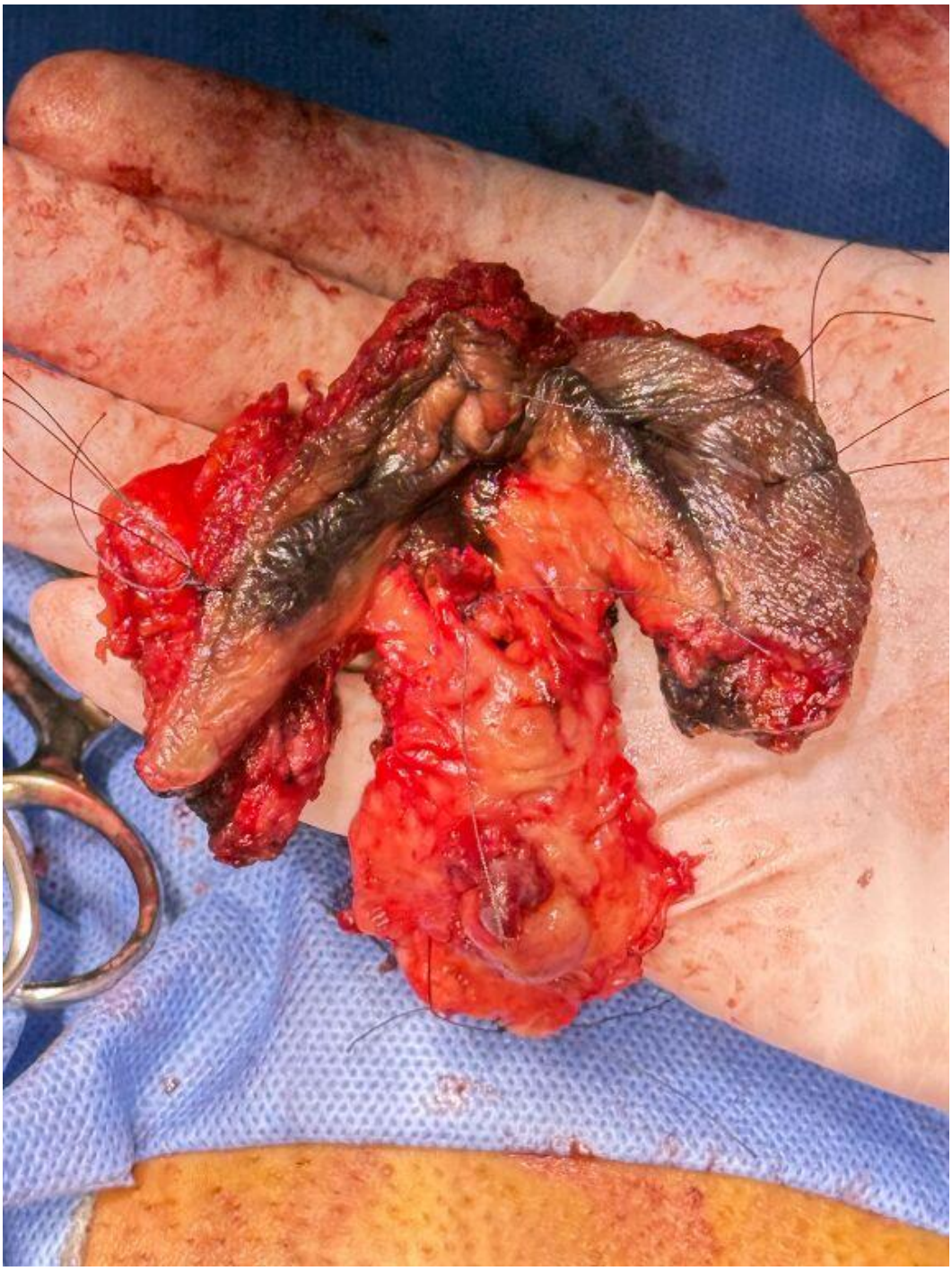


Figure B.



Discussion: There are no management standards. Poor prognostic features include Breslow level V, positive surgical margin, and lymph node involvement.

Conclusion: Genital melanomas are rare but aggressive tumors. Surgery with adequate margins is the main treatment. Radiation therapy may be useful as an adjunctive therapy.

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A CASE OF PRIMARY VAGINAL ADENOCARCINOMA OF INTESTINAL TYPE IN A 35 YEAR OLD PRIMIPARA: A CASE REPORT

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Background/Introduction: Vaginal cancers account for only approximately less than 2% of all gynecologic malignancies and are more commonly encountered as metastatic from other gynecologic primary. Moreover, primary vaginal carcinomas are much less commonly observed, with squamous cell carcinoma in the background of an HPV infection being the predominant type.

Case Presentation: Reported is a case of a young, 35 year old primipara with a painless posterior vaginal wall mass with intermittent episodes of vaginal spotting who underwent excision and biopsy. Histologic examination revealed an invasive adenocarcinoma of intestinal type, posing a diagnostic challenge in distinguishing between a primary vaginal carcinoma and a metastatic disease from an underlying primary tumor elsewhere. Extensive radiologic, histopathologic, and metastatic workup were conducted, and with no conclusive evidence of an occult carcinoma existing elsewhere, a diagnosis of primary vaginal cancer was made. Treatment was initiated with double agent chemotherapy with Carboplatin and Paclitaxel followed by radiation therapy.

Discussion: In the Philippines, no cases of intestinal type primary vaginal adenocarcinoma have been reported, with only a total of 23 documented cases worldwide. Moreover, intestinal type vaginal adenocarcinoma is one of the rarest forms of vaginal cancer, making it a challenge to most gynecologists.

Conclusion: In return, its prognosis remains poor, and optimal treatment guidelines have not been well established. The unfamiliar nature of this disease could potentially lead to delays in its diagnosis and treatment which can impact the overall prognosis of this disease.