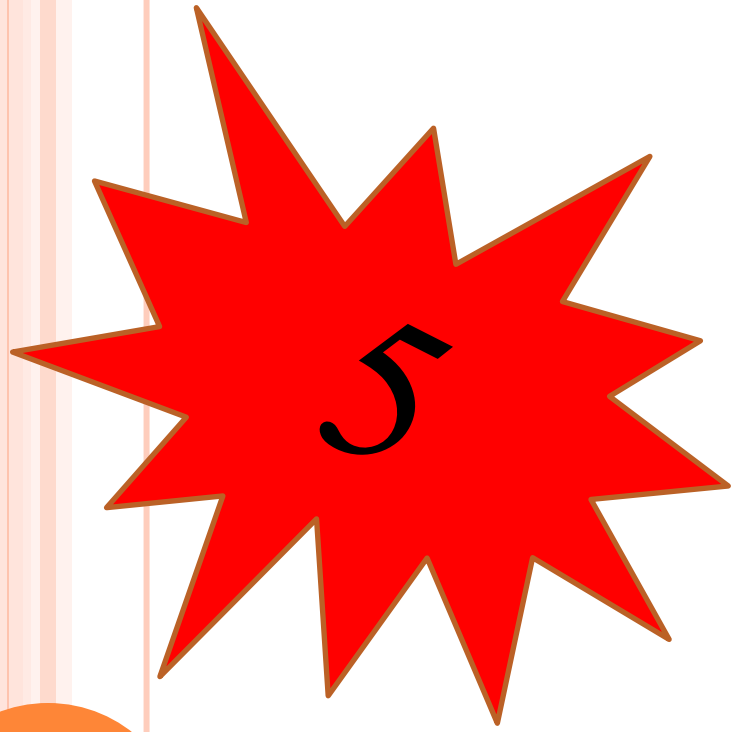


Synchronous endometrial and ovarian carcinoma

Narges,Zamani MD

HISTORY

- A 44-year-old, NG, premenopausal woman presented with recent abdominal pain and history of infertility .

- PMH &DH & FH : negative
- PH/EX: huge mobile mass was detected

  Speculum exam was normal

TVS

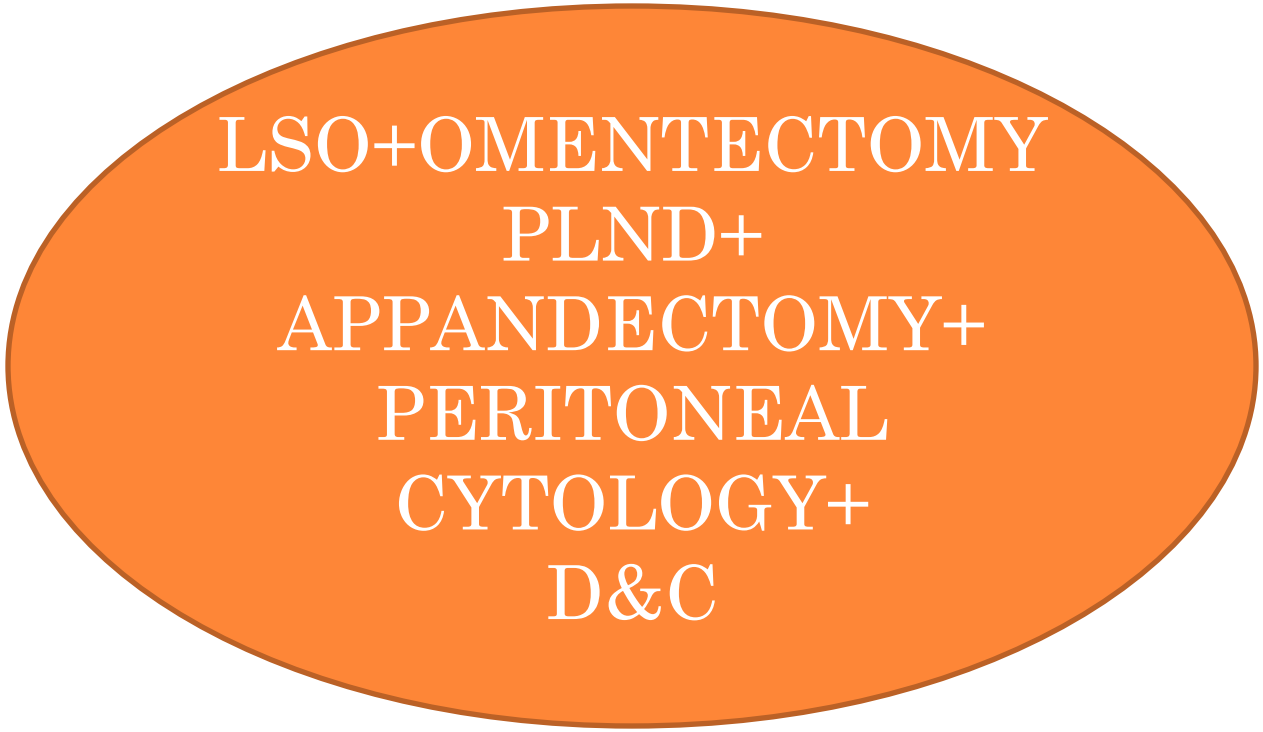
- A solid-cystic mass measured 200*150*70 mm in left adenxa
- Uterus is 86*49*90 mm with heterogeneous myometrium
- Endometrial thickness is increased

TUMOR MARKERS

- CA125 : 272
- CA19-9 :115
- CEA :0.8

SURGEY

- FROZEN : Positive for malignancy



PATHOLOGY

- **Lt adnexa** :

Endometrioid adenocarcinoma G2

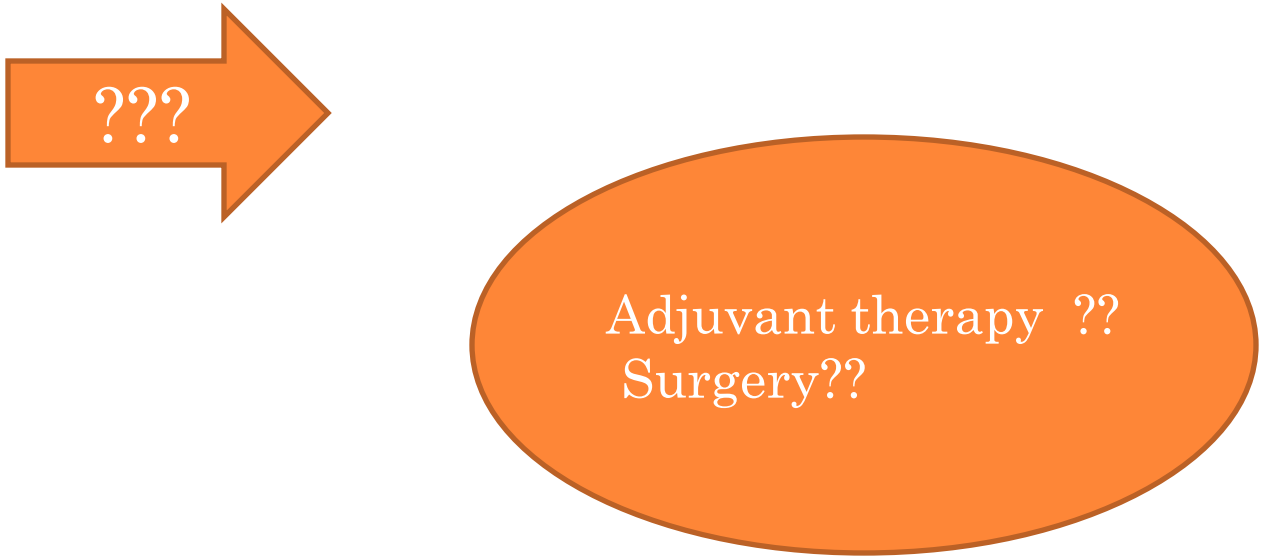
- Capsule of tumor is intact
- Pelvic lymph node :free of tumor
- Omentum : free of tumor
- Appendix :free of tumor
- Cytology :negatvie
- **Endometrial curetting**:

endometrial adenocarcinoma,endometrioid type

PATHOLOGY

ENDOMETRIOID ADENOCARCIMA G2 IN Lt ovary AND Endomerium

MANAGEMENT OPTIONS



MANAGEMENT

1. **Abdominal & Pelvic MRI** : uterus is larger than normal with heterogenous myometrium ,others organ are normal
2. **Oocyte cryopreservation**
3. **surgery**

SURGERY

TAH+RSO+PARAAORTC LYMPHADENECTOMY

PATHOLOGY

- **ENDOMERIUM:** endometriod adenocarcinoma G2
- **MYOMETRIAL INVASION** :not identified
- **CERVIX** :free of tumor
- **RSO** : free of tumor
- **PARA aortic LYMPH NODE** : free of tumor
- **LVSI** : negative

PATHOLOGY

- Synchronous endometrial and ovarian carcinoma

Endometrioid carcinoma of ovary (stage Ia G2) & Endometrioid carcinoma in endometrium (stage Ia G2)

DISTINCTION OF INDEPENDENT PRIMARY CARCINOMAS OF THE ENDOMETRIUM AND ADNEXA FROM METASTATIC SPREAD BETWEEN THESE SITES

TABLE 3. *Traditional clinicopathologic features that favor an independent origin of synchronous endometrial and ovarian endometrioid carcinomas*

Endometrial tumor	Low tumor grade; absence of, or only superficial, myometrial invasion; absence of vascular invasion; background atypical endometrial hyperplasia/endometrial intraepithelial neoplasia
Ovarian tumor	Low tumor grade; unilateral ovarian involvement; unifocal parenchymal tumor distribution; absence of capsular, multifocal or hilar tumor distribution, absence of vascular invasion; presence of endometrioid adenofibroma or endometriosis

Colin Stewart. Et.al, International Journal of Gynecological Pathology, 2018, 38:S75–S92

- Immunohistochemistry
  - Has generally been considered of limited value as there is significant overlap in the immunoprofile of endometrial and ovarian endometrioid adenocarcinoma
  - However, different beta-catenin and mismatch repair protein expression patterns can be helpful. Also vimentin can be helpful

- Molecular study
  - Recent studies suggest that the traditional view that most synchronous low-grade endometrial and ovarian endometrioid adenocarcinomas are independent neoplasms may be incorrect

Colin Stewart. Et.al, International Journal of Gynecological Pathology, 2018, 38:S75–S92

- In practice, no single criterion is perfect and it is important to integrate all available clinicopathologic, immunohistochemical and molecular data in the assessment of problematic diagnostic cases.

Colin Stewart. Et.al, International Journal of Gynecological Pathology, 2018, 38:S75–S92

MANAGEMENT

- **IN CASES OF SEOC**

What are the best adjuvant treatment strategies for patients with SEOC ???

MANAGEMENT

- Chemotherapy T+C : 6 courses
- brachytherapy