Round Table
The Israeli Society of Gynecological Oncology

CERAMI'S

ITALIAN RESTAURANT

MENUE

- **Starter**
  Actual case - hot from the oven
- **Main dish**
  Prof N. Colombo
- **Desert**
  A case of non epithelial OV ca.

There is no right or wrong - this is the art of medicine

Case #1 -Background

- **40 years old patient G4P2LC2**
  - Symptomatic intramural myoma 10 X7 cm
  - Menometrorrhagia: anemia
  - Dysmenorrhea
  - Endo sampling: normal proliferative endometrium
  - Cervical cytology 6 months ago – normal
- **Past medical history**
  - No background comorbidity
  - No previous surgical interventions
- **Family history**
  - Mother: diagnosed with breast carcinoma (2006)

Question 1:

How do you treat a symptomatic intramural fibroid over 10cm?

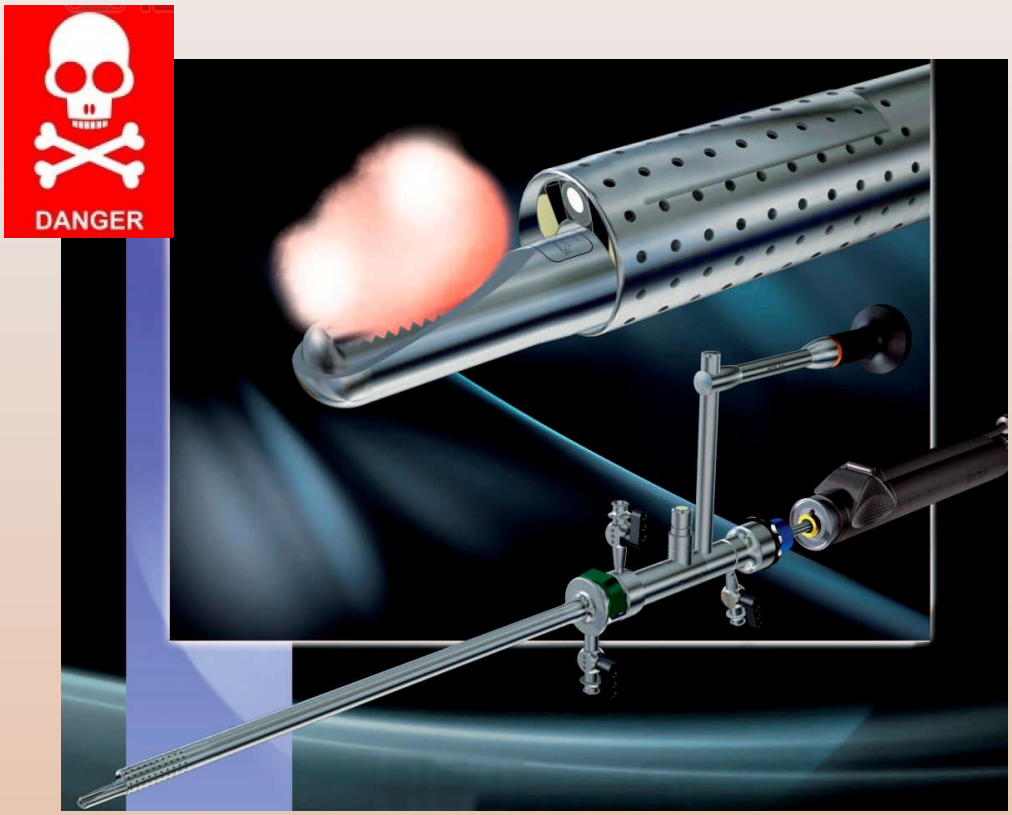
Question 1:

How do you treat symptomatic intramural fibroid more than 10 cm?

- **Passive**
- **Active**
- **Aggressive**

Current disease

- 11/2013
  - Underwent an uneventful laparoscopic subtotal hysterectomy with morcellation.



Question 2:

Do you morcellate a fibroid or an enlarged uterus?

Laparoscopic Uterine Power Morcellation in Hysterectomy and Myomectomy: FDA Safety Communication

Date Issued: April 17, 2014

The FDA is concerned about women undergoing laparoscopic power morcellation for the treatment of uterine fibroids and the risk of inadvertent spread of unsuspected cancer to the abdominal and pelvic cavities

Laparoscopic Uterine Power Morcellation in Hysterectomy and Myomectomy: FDA Safety Communication

Importantly, based on an FDA analysis of currently available data, it is estimated that 1 in 350 women undergoing hysterectomy or myomectomy for the treatment of fibroids is found to have an unsuspected uterine sarcoma, a type of uterine cancer that includes leiomyosarcoma. If laparoscopic power morcellation is performed in women with unsuspected uterine sarcoma, there is a risk that the procedure will spread the cancerous tissue within the abdomen and pelvis, significantly worsening the patient's likelihood of long-term survival.

Question 3:

What is your preoperative evaluation for a planned morcellation case?

FDA Safety Communication

For this reason, and because there is no reliable method for predicting whether a woman with fibroids may have a uterine sarcoma, the FDA discourages the use of laparoscopic power morcellation during hysterectomy or myomectomy for uterine fibroids.

Current disease

- **Preoperative evaluation**
  - **Abdominal and pelvic US**
    - Pelvic abdominal mass 15/11 cm
    - Bilateral normal ovaries
  - **CT - abdomen & pelvis was not performed**
  - **No tumor markers were taken**

Current disease

- **11/2013**
  - **Explorative laparoscopy:**
    - Enlarged uterus with a 14 cm dominant fibroid and normal ovaries.
    - Normal ovaries
  - **Underwent a laparoscopic subtotal hysterectomy with morcellation and bilateral Oophorectomy .**

Histology

80% of the fragments show hyalinized necrosis. Only 20% of the tissue is viable and shows spindle cells without atypia. The nuclei are uniform, minimally enlarged size.
The mitosis count is difficult due to the small amount of viable tumor, although 3 mitotic figures were found in 10HPF.

These 2 cell criteria are enough for the problematic diagnosis of smooth muscle tumor of uncertain malignant potential STUMP.

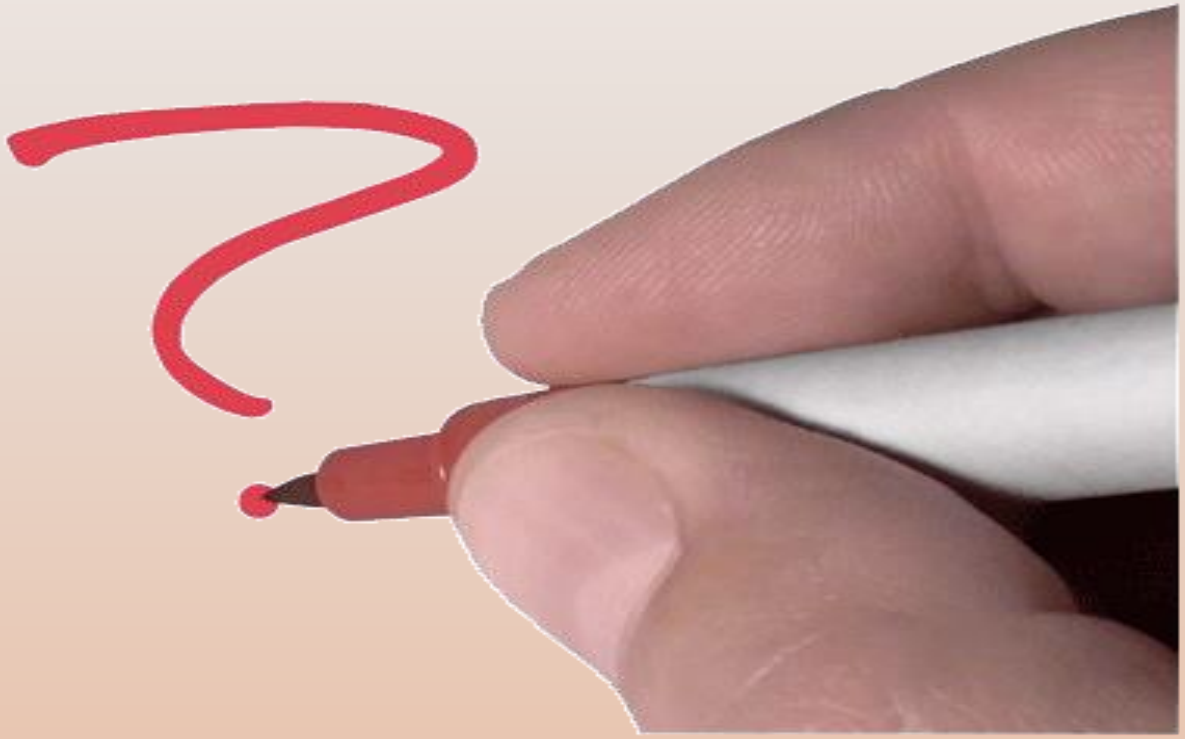
Muscle tumors uncertain maligant potential (STUMP: group IVA) have some characteristics of sarcomas, but do not meet full diagnostic criteria. These tumors are rare and thus, the paucity of data make it difficult to describe their clinical behavior.

Quade et al. Pathology of the female reproductive tract . Oxford 2009

Question 4:

What will you do next ?

1. How do you treat STUMP's ?
2. How do you treat morcellated STUMP's?



Clinical features and management

The clinical manifestation of STUMP are the same as benign leiomyomas and uterine sarcomas, ie, uterine mass abnormal uterine bleeding, and pelvic pain/pressure. Likewise, there is no imaging modality that can reliably distinguish these lesions from other uterine tumors.

Stewart EA. Up to date March 2014

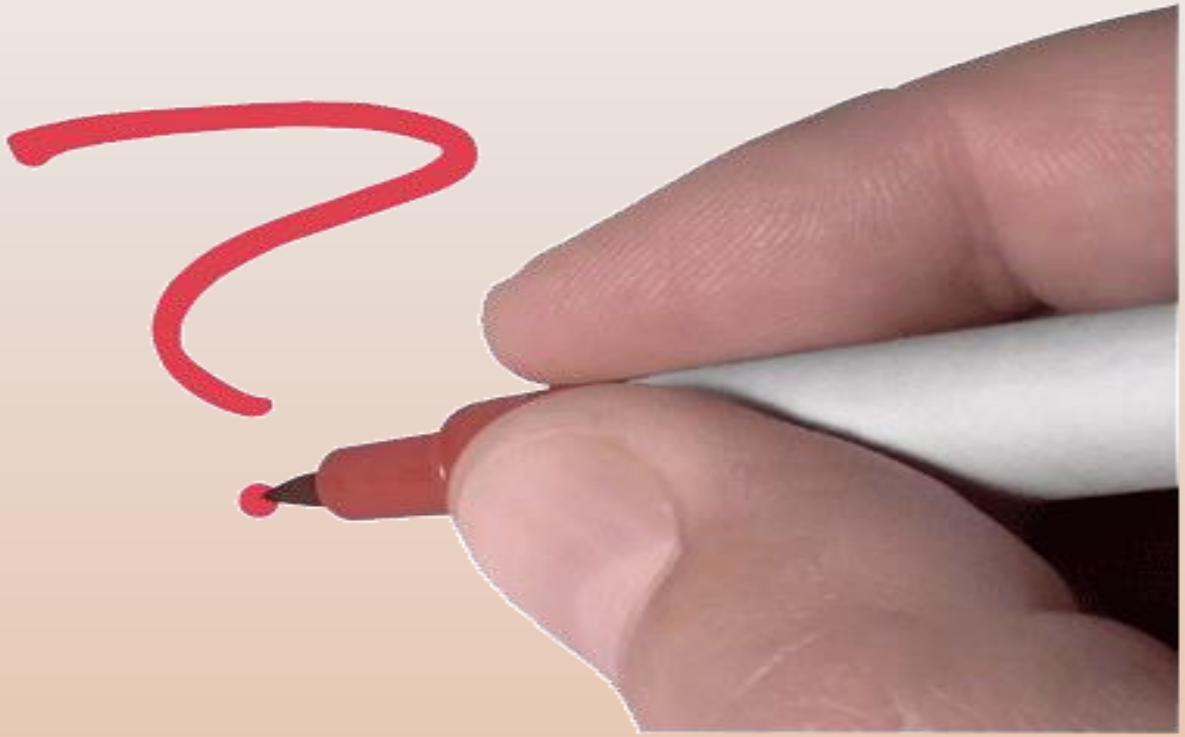
STUMP is diagnosed following myomectomy or hysterectomy. There are no available guidelines regarding whether hysterectomy, if not already performed, is required in women with this diagnosis. For women who have been diagnosed with STUMP following myomectomy, a detailed discussion should be held with the patient to review the characteristics of the tumor and the patient's plans for future pregnancy.

Stewart EA. Up to date March 2014

Question 4:

What will you do next ?

1. How do you treat STUMP's ?
2. How do you treat morcellated STUMP's?



Published in final edited form as:
Genes Chromosomes Cancer. 2010 December ; 49(12): 1152–1160. doi:10.1002/gcc.20824.

Disseminated Peritoneal Leiomyomatosis after Laparoscopic Supracervical Hysterectomy with Characteristic Molecular Cytogenetic Findings of Uterine Leiomyoma

Zehra Ordulu[1], **Paola Dal Cin**[2], **Wilson W.S. Chong**[3], **Kwong Wai Choy**[3], **Charles Lee**[2], **Michael G. Muto**[1], **Bradley J. Quade**[2], and **Cynthia C. Morton**[1,2,*]

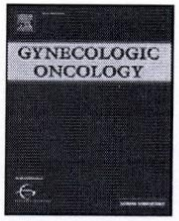
[1] Department of Obstetrics, Gynecology and Reproductive Biology, Harvard Medical School, Boston, MA 02115

Gynecologic Oncology 132 (2014) 360–365

Contents lists available at ScienceDirect

Gynecologic Oncology

journal homepage: www.elsevier.com/locate/ygyno



The value of re-exploration in patients with inadvertently morcellated uterine sarcoma ☆

Titilope Oduyebo [a,b,d,1], Alejandro J. Rauh-Hain [b,d], Emily E. Meserve [c,d], Michael A. Seidman [c,d], Emily Hinchcliff [a,b,d], Suzanne George [d,e], Bradley Quade [c,d], Marisa R. Nucci [c,d], Marcela G. Del Carmen [b,d], Michael G. Muto [a,d,*]

CONCLUSIONS:

Surgical re-exploration is likely to show findings of disseminated peritoneal sarcomatosis in a significant number of pts after morcellation procedure (Nov 2013)

OPEN ACCESS Freely available online

PLOS ONE

Peritoneal Dissemination Complicating Morcellation of Uterine Mesenchymal Neoplasms

Michael A. Seidman[1]*, Titilope Oduyebo[2], Michael G. Muto[2], Christopher P. Crum[1], Marisa R. Nucci[1], Bradley J. Quade[1]

1 Division of Women's and Perinatal Pathology, Department of Pathology, Brigham & Women's Hospital/Harvard Medical School, Boston, Massachussetts, United States of America, 2 Division of Gynecologic Oncology, Department of Obstetrics and Gynecology, Brigham & Women's Hospital/Harvard Medical School, Boston, Massachussetts,

CONCLUSIONS:

Data suggest uterine morcellation carries a risk of disseminating unexpected malignancy with apparent associated increased In mortality much higher than appreciated currently (Nov 2012)

Finally ……..

- Revision of pathology –STUMP
- MDT recommendation:
  - Explorative laparoscopy & stumpectomy
  - Pt decided to perform a close F/U

CERAMI'S

ITALIAN RESTAURANT

MENUE

- **Starter**
  Actual case for our time
- **Main dish**
  Prof N. Colombo
- **Desert**
  A case of non epithelial OV ca.

Round Table
The Israeli Society Gynecological Oncology

CASE # 3 - Background

- **17 years old girl**
- **Admitted to the pediatric surgery ward due to acute abdominal pain**
- **On examination tender abdomen, palpable pelvic/abdominal mass**
- **Abdominal US:**
  - Pelvic abdominal mass 21/11 cm
  - Bilateral hydronephrosis

CASE # 3 - Background

17 years old girl

- **Past gynecological history**
  - Menarche at the age of 13
  - Irregular menstrual periods, dysmenorrhea
  - No contraception
  - Normal development
    - No hirsutism / virilization
- **Past medical history**
  - No background comorbidity
  - No previous surgical interventions
- **Family history**
  - Mother: recently diagnosed with lymphoma

Current disease

- **CT - abdomen & pelvis**
  - Irregular pelvic - abdominal mass 23/11/8 cm
- **No tumor markers taken**
- **Explorative laparotomy :**
  - Rt. ovarian solid mass
  - Rt. oophorectomy performed

Histology

Sex cord stromal tumor, most compatible with sertoli cell tumor, intermediately differentiated

Question 1:

What will you do next?

Question 2:

Which protocol of chemotherapy?

Current disease

- **12/2012**
  - Referral to the Gynecologic Oncology team
  - “Radiological staging”
    - PET-CT: No evidence of metastatic spread
    - Testosterone levels within normal range (1.7 nmol/L)
  - MDT meeting
    - Due to moderate differentiation - adjuvant chemotherapy recommended

Current disease

- **Between 01/2013 - 03/2013: three cycles of chemotherapy - BEP protocol**
  - Well tolerated
  - 06/2013
    - Normal menstrual bleeding
    - Normal testosterone levels
    - PET-CT : no evidence of disease

Question 3:

Will you consider any fertility preservation technique?

Current disease

- Between 01/2013 - 03/2013: three cycles of chemotherapy - BEP protocol

  - **Prior to initiation of chemo - fertility consultation**
    - **Retrieval and freezing of oocytes**

Current disease

- **03/2014**
  - Vague abdominal pain
  - Normal testosterone levels
  - PET-CT : suspected pelvic mass

Question 3:

What is next?

Recurrence

- **MDT meeting : surgical exploration recommended**
  - 05/2014: explorative laparotomy
    - 15 cm solid - gelatinous mass in the Douglas pouch
      - Adherent to the uterus and left ovary
      - No other pathological findings in the pelvis or abdomen
  - Excision of the mass with partial excision of the left ovary.
  - Omentectomy
  - No macroscopically residual disease
  - Histology: **Recurrent Sertoli Leydig cell tumor, poorly differentiated, sarcomatoid type, no heterologous elements, omentum free of tumor.**

Question 4:

What is the preferred treatment for recurrent disease ?

Recurrence

- **MDT recommendation:**
  - **Second line chemotherapy: Carboplatin and Taxol**
    - Currently under treatment


Thank You !