AOGD Clinical Meet on 30.6.23

at Indraprastha Apollo Hospital

Abstract-1

A rare case of vulval tumor(Granular cell tumor)

Dr. Sushma Sinha,MD, OBG, MRCOG, FRCOG, FIMSA,Sr Consultant, Obstetrics and Gynaecology
Dr. D Anusha MS OBGY

Introduction:- Granular cell tumor (GCT) is a rare mesenchymal neoplasm of neurogenic origin and was first described on tongue by Abrikossoff in 1926. Although GCT arises mostly from the head and neck region, particularly the tongue, it is not usual in the vulva where 5–15% of all GCTs occur. Only 130 cases of GCT of vulva have been reported so far worldwide. GCTs occur in patients of any age but are most common in fourth to sixth decades of life. GCTs are encountered in females two times more common than men. They generally occur as small, slow growing, and skin-colored nodule. The differential diagnosis includes vulval leiomyoma, bartholins cyst, melanoma, hidradenoma. Diagnosis is mainly by histopathology complemented by immunohistochemistry. Treatment is by surgical excision. Majority of GCTs are benign, although approximately 1% to 2% of cases may be malignant, which has a high rate of metastases as well as a short survival. Here we present a rare case of 38 year old with histologically verified GCT encountered in our institute.

Case report: Mrs. X, 38 year old female came from North East to OPD of Indraprastha Apollo Hospital with complaints of bartholins cyst on the left side of vagina for 1 month. It was not very painful but had mild discomfort. She had consulted a gynecologist in Arunachal Pradesh who diagnosed the lump as Bartholins cyst. There was no history of discharge, fever, or weight loss. Her family history was un-remarkeable. Examination showed bulky uterus. A large mass, firm to hard in consistency, irregular, lying on the left side in vulvovaginal area measuring approximately 4 x 4 cm. Decision for excision of vulvovaginal mass was taken and proceeded with under general anesthesia. On excision grossly round, hard in consistency, calcified mass was noted which looked just like leiomyoma. Histopathology of excised

growth showed a tumor composed of cells arranged in nests and cords. The tumor cells were round to polygonal with abundant granular cytoplasm with round nuclei. No necrosis seen. No atypia or increased mitosis seen. Reported as cellular neoplasm with eosinophilic granular cytoplasm. On immunohistochemistry the cells showed diffuse, cytoplasmic expression of S-100 and patchy expression of CD68 and were negative for Desmin. ki67 proliferation index was 1 to 2%. Final conclusion based on histological features and immunohistochemistry profile was of a Granular cell tumor.

Discussion: Granular cell tumor (GCT) is a soft tissue tumor consisting of eosinophilic granular cytoplasm, which can be found throughout the body. This tumor typically affects in the skin and subcutaneous tissues, the breast, the head and neck. Vulvar granular cell tumors account for an unusual presentation with rare occurrence with 130 cases reported in literature. Majority of GCTs are benign, although approximately 1% to 2% of cases may be malignant, which has a high rate of metastases as well as a short survival. The tumor is poorly circumscribed with irregular margins and is yellow-gray and fleshy on cross section. Diagnostic delay is another vital issue which, to some extent, could neglect malignant GCT of the vulva. Because many patients reported in the literature, plenty of time delay between the onset of the nodule and the final histological diagnosis of GCT of the vulva, has been noted. Microscopic findings are usually sufficient, but immunohistochemistry can also be helpful in confirming the diagnosis. On microscopy the cells are round to polyhedral with indistinct margins and granular cytoplasm. They occur in ribbons or clumps separated by hyalinised stroma and collagen fibers. Nuclei are uniform, small and dark staining. The granular appearance is due to the accumulation of lysosomes. In about half the cases the squamous epithelium overlying the tumor shows pseudoepitheliomatous hyperplasia which may be mistaken for squamous carcinoma. The cells are immunoreactive for S-100 protein, are periodic acid Schiff positive, diastase resistant. Some histological features are associated with increased risk of metastasis. These features are necrosis, increased mitotic activity (>2 mitosis/10 HPF), spindling, vesicular nuclei with prominent nucleoli, high nucleocytoplasmic ratio, and pleomorphism. Tumors with three or more of these are considered malignant those with 1 or 2 features atypical , absence of above are considered benign. In addition, Ki-67 immunostain values greater than 10% can help to classify malignant cases histologically. Treatment is by surgical excision. Because the tumors often have

irregular margins and because groups of tumor cells often extend beyond the macroscopic limits of growth wide excision is necessary. In contrast to 20% recurrence rates with positive margins, the clear margins are 2% to 8%. Typically, the metastases within 2 years are reported in the majority of malignant cases, and the rate of mortality is approximately close to 60 % within 3 years.[15]

Conclusion: Vulvar Granular Cell Tumor is of very rare occurrence and is often misdiagnosed as Bartholins cyst and vulval leiomyoma in view of its location. Though it can be differentiated from bartholins cyst clinically, because of firm to solid consistency, it is almost impossible to distinguish among vulval leiomyoma and granular cell tumor morphologically and can only be confirmed after histopathology and immunohistochemistry studies. As there is a slight chance of 1 to 2% of these tumors being malignant and the tumor being poorly circumscribed in most of the cases, a proper excision with wide margins is of paramount importance to ensure complete cure.

Abstract-2

Genetics toolkit for Obstetrics and Gynaecology

Dr. Divya Aggarwal,Consultant, Obstetrics and Gynaecology, Indraprastha Apollo Hospital, New Delhi

Background:- Genetics can truly claim to be central basic science of this century. Genetic concepts and testings are increasingly becoming common in obstetric and gynaecological consultations, particularly in relation to reproductive issues and, to aspects of gynaecological oncology.

Discussion:- In the presentation, we have used case examples which were appropriately referred for genetic consultations and illustrate how genetics influences clinical practice of Obstetrics and Gynaecology. The illustrations provide an overview of commonly used and newly developed laboratory genetic techniques that support investigation and diagnosis. Relevant aspects of genetic counselling are also discussed. Common Gynae & obstetric clinic conditions discussed are recurrent pregnancy loss, role of genetic testing in common gynaecologic cancers including breast cancer, foetal prenatal microarray and exome test for

definite cause and prognosis in a case of foetal malformation, prevention of genetic disease by foetal preimplantation genetic test in a case of family history of suspected genetic disorder. We aim to give an overview of the strengths, utility as well as limitations of various genetic investigations as a basic understanding of these is imperative for clinical practice in this era where all medicine is moving towards genetic based personalized choices and treatments.

Abstract-3

Case report of abnormal uterine bleeding caused due to isthmocoele- hysteroscopic picture and laparotomy management

Dr. Geeta Chadha, Dr. Nilima, Consultant, Obstetrics and Gynaecology
Indraprastha Apollo Hospital, New Delhi

Background:- Isthmocele is a pouch-like defect on the anterior wall of the uterus at the isthmus. It appears as a fluid-filled pouch in the anterior uterine wall at the site of a previous cesarean section scar. The blood flow during menstruation through the cervical region may be hampered by the presence of isthmocele. This can also cause pelvic pain in the suprapubic area, infertility and abnormal post menstrual bleeding. The global incidence is somewhere between 6.2% and 36%, with an average rate of 21.1%.

Case scenario:- We are presenting a case of 33 years old P1L1 with history of LSCS done in March 2022 with complaints of continuous bleeding per vaginum for 5-6 months , not responding to medical management. She gives history of pain lower abdomen on and off and had intermittent spotting and bleeding continuously since LSCS. General and systemic examination was normal. Per speculum and per vaginal examination showed normal findings. A transvaginal ultrasonography was done which was suggestive of a normal sized uterus with a diverticulum in the anterior wall of the uterine isthmus, at the site of her previous cesarean scar tissue- a cesarean scar defect of 20.0 × 15.6 mm was identified, with a residual myometrial thickness over the defect of 2.6 mm. MRI (19/05/2022): Isthmocele - Hypointense content within the isthmocoele . After proper counselling patient was prepared for hysteroscopy followed by repair of isthmocele via laparotomy. Hysteroscopy revealed a crater just above the internal os with accumulated blood , fundus and ostia could not be visualised because of the irregularity. Resectoscope inserted and resection of raised

edges of the isthmocele done followed by repair of isthmocoele via laparotomy. Postoperative period was uneventful, patient was discharged on 3rd day of surgery. With in 3 months of surgery, she has improved symptomatically with resumption of regular cycles.

Discussion:-Though isthmocele was first described in 1985 by Stewart et al , the increased reporting of isthmocele in recent times is attributed to the surge in caesarean section rates all over the world. Isthmocele is an iatrogenic pathology associated with obstetric and gynecological complications. Etiology could be poor tissue healing or surgical techniques favouring niche formation. It's imperative to address to its causes during caesarean section to prevent it.