Tumor board cases Monday 20/05/2019

Name	Age	Diagnosis	Clinic	Staging	Imaging	Lab & Pathology	Surgery	Chemo-radiotherapy
Zozo Abdelgalil Taea	66 Y	?? NEC of the cervix	Tuesday Clinic Dr. Ahmed Ramadan	Clinically FIGO stage IIB	**MRI pelvis:** enlarged uterus with increase SI of myometrium. There is defined mass with endometrial cavity, post contrast heterogeneous enhancement with anterior cystic changes. Blurring of junctional zone with poor endometrial myometrial junction.. Suggestive mild myometrial invasion, measures 5x9x5 cm. No Cx extension or parametrial infiltration ???. **Barium enema :** free **Cystopscope :** free **EUA:** large cervical mass measuring 5 cm , indurated , bleeding on touch . Infiltrating lower 1/3 of posterior vaginal wall and anterior vaginal wall. Obliterated fornices of vagina. Bimanual examination : uterus mobile anterior , posterior with limited mobility on both sides. Uterus fundal level reaching 18 weeks. - PR: bulging mass on rectal wall occluding lumen with parametric infiltration on both sides.	**Biopsy from cervical mass :** Poorly differentiated carcinoma P63 neg….exclude sq c c Synapto and chromo neg exclude neuroendocrine ca Poorly differentiated ؟؟ adenocarcinoma or undifferentiated carcinoma Stromal neoplasm ؟؟ For further IHC Cyclin D1: diffuse positive nuclear reaction in tumour cells. E-cadherin: loss of membranous reaction in tumour cells. CK7,CK5/6, CD10: negative. High grade endometrial carcinoma vs. high grade ESS. **CA 125:** 127 up to 35	**New Biopsy form endometrial tissue.** 8/5/2019	
Warda Abdelnaby ali	43 Y	Ovarian Cancer	Tuesday Clinic Dr. Ahmed Ramadan	FIGO stage IA??	**Post contrast MRI pelvis:** well defined mulilocular lower pelvic midline adenxal mass partially solid ,, partially cystic (8*15*14 cm). Mild pelvic ascitis. No detected significant pelvic LNs. **CT chest abdomen and pelvis:** Bulky Cx stump, Few bilateral int iliac LNs, Rt PALN 5 mm. Enlarged thyroid gland with hypodense nodules 5*5 cm **Upper GI endoscopy:** lower end esophagitis, mild diffuse gastritis. **Lower GI endoscopy: pending**	**Pathology:** Lt ovary show large mass (20*17*6 cm). tumor focally infiltrating the ovarian capsule. Picture consistent with mod diff.adenocarcinoma with focal signet ring like cells ?? Metastatic. IHC : Primary ovarian carcinoid with focal atypia	**TAH&BSO** No formal surgical staging performed	For upper and lower GI endoscopy CT chest abdomen and pelvis if done

Sabrin Abdelhady Ahmed	29 Y	?? Sarcoma of the Cervix	Surgical Oncology Ward Dr. Abeer Mohamed	Unknown	**EUA:** Obliteration of ant and Lt lat vaginal fornices, slight obliteration of RT lat fornix. **MRI pelvis without contrast:** Rt functional ovarian cyst**.** No evidence of residual tumor at cx. **CT chest abdomen and pelvis:** free	**Polypectomy of Cx polyp:** Sarcoma botryoides for Desmin, SMA and Ki67**.** Intermediate grade RMS	Excision of cervical polyp TAH 8/5/2019.	
Reham Ashraf Abdelaziz	17 Y	Ovarian mucinous carcinoma	Surgical Oncology Dr. Basel Refky	FIGO Stage III	**Post Contrast MRI Abdomen and pelvis:** large partially cystic partially solid multiloculated RT adenxial lesion, extending posteriorly to Douglas pouch displacing the surrounding loops. Heterogeneous contrast enhancement of the solid component 14*11.5*15.5 cm. Another small similar lesions seen at the Douglas pouch largest 2.5 cm …deposits. No ascites.	**Rt ovarian cyst 4/2017:** Borderline mucinous tumor. **Surgical staging 4/2019:** Mucinous cystadenocarcinoma with seromucinous type of Rt ovary with malignant mural tumor nodule. Omentum infiltrated by tumor tissue. Appendix Free. Ascites no malignant cells. CK7+, CK20, WT-1 non specific reaction.	Lap. ovarian cystectomy 4/2017. RT SO, Omentectomy, and appendectomy 4/2019	
Samia Elsayed Mohamed	58 Y	Advanced carcinoma of the Cx.	Clinical Oncology Clinic Tuesday Clinic	Stage IIIC	**EUA:** cervix and upper vagina are seats of multiple necrotic friable masses affecting upper 2/3 of vagina with parametrial infiltration Mostly on RT side**.** **MRI pelvis with contrast:** waiting report. **CT chest abdomen and pelvis:** few small mediastinal LN , largest 10x5 mm pretracheal. Few tiny RT pulmonary nodules likely insignificant. Bulky cervix forming soft tissue mass associated with haziness of surrounding fat planes inseparable from lower rectum its seen in close related to post surface of UB mass 4.5 cm. Multiple enlarged bil ext iliac LN largest 3 cm on RT side.	**Bx:** poorly differentiated non keratinizing SqCC		

Asmahan Abdelsalam Abo Mosalam	68 Y	Locally recurrent vulval Cancer with pulmonary mets	Clinical Oncology Tuesday Clinic	Stage IV	**MRI Abd & pelvis 4/2019:** stationary course as regard ST in tumor bed 6*7 cm. No significant pelvic lymphadenopathy. **CT chest:** Pulmonary nodules ?? mets Exam 12/5/2019: ulcer 3*4 cm at rt side of labia majora. No inguinal LNs	**WLE with bilateral inguinal LND 11/2014:** Three ulcers 2*1 cm and 1.5*1 cm G II Sq CC with involvement of surface epithelium with dysplasia at the margin. Free 12 and 7 dissected LN. **Wedge Bx from recurrent vulval lesion 4/2019:** Poorly differentiated Squamous cell carcinoma confirmed by positive P63 & CK5/6.	Primary WLE and Bil inguinal LND 11/2014. Multiple recurrences with multiple excision with SM last 4/2019 (Wedge Bx). Reconstructive surgery for urethral stenosis 1/2017	Postop RT 1/2016.
Mlo Elain Abdel Satar Abdel Hay.	54 Y	Metastatic endometrial cancer	Clinical Oncology Tuesday Clinic	Stage IV	**CT chest abdomen and pelvis:** 24-2-2019: multilocular cystic mass 3.5*6*5 cm in lt adenxial region , contacting adj. intestinal loops , UB , encasing lt. ureter with dilated lt. ureter , mild ascitis , bilateral enlarged iliac LNs . largest lt side with central breakdown 1.3*1 cm Revision: No recurrence. **Abd Xray erect:** multiple air fluid levels. MRI abdomen and pelvis 5/2/2019: no detected residual tumor or recurence no pelvic ln no ascites	**TAH & BSO 12/2017:** uterine mass 3.5*4.5 cm invading >1/2 of myometrium no cx infiltration, GII endometroid carcinoma, infiltrated 2/6 LNs (misdiagnosed initially as peritoneal nodules) **Palliative surgery:** terminal ileum infiltration by moderately differentiated adenocarcinoma from outside up to the mucosa. Metastatic deposits in 1/3 regional LNS by without extranodal extension. Sigmoid colon Focal serosal infiltration by moderately differentiated adenocarcinoma. Free both surgical margins from tumor tissue. Inflammatory aspirate with suspicious epithelial cells**.**	TAH &BSO 12/2017 Palliative bowel resection for IO 4/2019.	Adjuvant 7 cycles of CT (Taxol-carboplatin) last 5/2018 Adjuvant EBRT 45 Gy/25 Fractions ended 8/2018.