

She had a known medical history of hypertension. At admission, gynecological observation was limited by the presence of a large, solid vaginal mass. After urethral catheterisation and bladder voiding, a transvaginal ultrasound (US) was performed. In the right adnexal area, a multiloculated cyst with low level echogenicity was observed, 96 x 106 x 95 mm, colour score 2. The images were also notable for the presence of a mass in the posterior vaginal wall, measuring 49 x 57 x 56 mm, with a cystic and a solid component suggestive of a hemorrhagic cyst (figure 1a). This was histologically confirmed by needle aspiration (figure 1a). The remaining US was unremarkable. The patient was referred for surgical staging of the ovarian mass (hysterectomy, adnexectomy and frozen section analysis). Pathology of the ovarian cyst was consistent with mucinous cystadenoma. At vaginal closing, a firm nodular mass was identified and excised– (figure 1b). Morphologic and immunohistochemical study of the vaginal mass rendered the diagnosis of a Gastrointestinal Stromal Tumour (GIST). The authors believe that the initially aspirated vaginal cyst was a different entity.

GISTs are rare entities thought to arise from mesenchymal cells, most commonly from the gastrointestinal tract. Although they are known to occur in extra-gastrointestinal locations (EGISTs), their presence in the vagina is particularly unusual, and most cases are benign. To the best of our knowledge, this is the first case of a vaginal EGIST with anuria as the clinical presentation (mass-compressive effect) and it is remarkable for its rarity both location-wise and in terms of its exuberant presentation. Our report shows enlightening ultrasound features of this entity and highlights the importance of including EGISTs in the differential diagnosis of vaginal masses.

Supporting information can be found in the online version of this abstract

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Transvaginal colour Doppler ultrasound as diagnostic modality in decision-making for cervical cancer in pregnancy: a case report

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A 38-year-old G42 (2012) diabetic was diagnosed with squamous cell carcinoma of the cervix and opted for preservation of pregnancy. Her Pap smear in the first trimester revealed atypical glandular cells of undetermined significance. Cervical punch biopsy done at 20 weeks showed squamous cell carcinoma, which was clinically staged as Stage IB2.

Transvaginal colour Doppler sonography at 33 weeks revealed a 3cm hypoechoic mass in the posterior cervix, with absence of parametrial invasion. Colour Doppler ultrasound demonstrated abundant vascularisation. Counselling was done, and patient opted to deliver near term. After a course of corticosteroids, and a repeat scan revealing no progression of invasion, the patient underwent classical Caesarean section with Radical Hysterectomy,

Bilateral Salpingo-oophorectomy, Bilateral Lymph Node Dissection at 36 weeks gestation. Patient delivered to a healthy baby boy who had an unremarkable postnatal course. Gross examination revealed a tumour at the posterior cervix, with no involvement of the uterine corpus and parametria. Biopsy showed invasive squamous cell carcinoma, large-cell non-keratinizing, with no parametrial infiltration.

This case shows that although there is a risk of tumour progression, delaying definitive treatment may be done in early stage disease to improve fetal survival. The multidisciplinary team, guided by prenatal ultrasound, can assess tumour invasion and make decisions for timing of delivery and extent of surgery, in order to ensure the best maternal and fetal outcomes.

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Cervicovaginal localisation of non-Hodgkin's lymphoma: ultrasound features

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Vaginal involvement in non-Hodgkin's lymphoma (NHL) is a rare condition. We present two cases:

1. An asymptomatic 72-year-old woman with lymphadenopathies was referred to our centre after PET-CT detection of an anterior cervical wall's lesion. Speculum examination and Pap smear were negative. On ultrasound evaluation, both vagina and cervix were totally replaced by hypoechoic and richly vascularised tissue of 52x39x53 mm in size, with irregular margins, extended from the vagina to the internal os of the endocervical canal. Vaginal fornices were obliterated. The uterine body was normal. Vaginal biopsy resulted in NHL.
2. A 60-year-old woman was referred to our centre for postrenal kidney failure. On transvaginal ultrasound evaluation we found hypoechoic and richly vascularised tissue of 53x41x49 mm in size in the posterior wall of the vagina, extended along the cervix (figure 1). Vaginal fornices were obliterated. The uterine body was normal. On transabdominal evaluation, both adnexal regions were occupied by solid lesions of 88 x 48 x 54mm and 89 x 56 x 71mm in size, with irregular margins, inhomogeneous echopattern and rich vascularisation. Two solid lesions of 25 x 28mm and 66 x 31 x 52mm in size, with similar ultrasound features, were detected respectively on the anterior vesical wall and in left hypochondrium. Hydroureteronephrosis was confirmed. Vaginal biopsy resulted in NHL.

In our experience, these ultrasound features were useful in the differential diagnosis between cervicovaginal primitive tumour and localisation of lymphoma: the presence of a cervicovaginal hypoechoic and richly vascularised tissue, in contrast to a normal finding at the speculum examination.

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