Results: Gross examination revealed a bulky tan-brown, solid intrauterine mass. The cut surface was pink to grey with yellow necrotic areas. Microscopic examination showed neoplasia with an infiltrative border, resembling a "finger-like" appearance, predominantly composed of spindle cells with severe nuclear atypia. Accompanying epithelioid cells with oval to round central nuclei, large eosinophilic to clear granular cytoplasm had a nested pattern separated by a delicate vascular network. Bizarre giant cells were observed. There were 10 mitoses in 10 high power fields. Lymphovascular invasion was evident. Immunohistochemically the tumour cells express HMB-45, melan-A, SMA, desmin, caldesmon, oestrogen receptor, CD10, p53, and strong diffuse TFE3. S100, myogenin, Myo-D1, beta-catenin were negative.
Conclusion: It is important to differentiate malignant PEComa from smooth muscle tumours of the uterus. Additionally, the distinction between TFE3 translocation associated and Tuberous Sclerosis Complex (TSC)-related PEComa has a therapeutic value. A further molecular genetic examination should be offered to patients. Resistance to mTOR inhibitors has been reported in TFE3-translocated PEComas.

E-PS-11-042
Invasive stratified mucin producing carcinoma and usual type endocervical adenocarcinoma of the cervix: a case report
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Background & objectives: Invasive stratified mucin-producing carcinoma(iSMILE) has invasive nests of stratified columnar cells with peripheral palisading and variable amounts of intracytoplasmic mucin, resembling its in situ counterpart which has high risk HPV associated carcinogenesis methods.
Methods: 43 year old female patient presented with intermittent vaginal bleeding and she underwent cervical biopsy. Biopsy diagnosis was carcinoma. She underwent radical hysterectomy. Macroscopically tumour was 4.5x2.5x2 cm with cream colour and small cystic cavities located in the exocervix and protruding towards the endocervix. Microscopically tumour had two components as iSMILE and endocervical adenocarcinoma of the usual type.
Results: The tumour cells had spherical nucleus, distinct and sharp cytoplasmic borders. In iSMILE component the tumour had abundant intracytoplasmic mucin . iSMILE component showed an infiltrative growth of tumour cell nests with a finger-like pattern of invasion. Irregularly shaped, angulated or fragmented glands with an adjacent desmoplastic stromal reaction were present in adenocarcinoma component. Immunhistochemically tumour cells were positive with p16("block-like"expression pattern),PAX-8,and CK7 and negative with HNF1beta,NapsinA,GATA3,Calretinin for both components.
Conclusion: The present data and those obtained from the literature suggest that iSMILE represent a distinct subtype of invasive endocervical adenocarcinoma, associated with high-risk HPV-infection carcinogenesis and may be seen together with usual endocervical adenocarcinoma component.

E-PS-11-043
Serous adenofibroma of the fallopian tube with coexistent ectopic tubal pregnancy
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Background & objectives: Serous adenofibromas of the fallopian tube are rare tumours considered to be analogous to their counterparts in the ovary. They are usually small and incidental finding during surgery.
We present a 34-year old patient with previous history of uterine bleeding.
Methods: The patient was misdiagnosed in another institution as miscarriage. Due to persistent elevation of the HCG serum levels (from 2350 IU/L to 5980 IU/L), ultrasound examination was performed, which led to suspected left ectopic tubal pregnancy. Five days after receiving methotrexate, the patient was again admitted to the hospital with abdominal pain and vomiting. Left fallopian tube was surgically removed.
Results: Histopathologic examination confirmed ruptured ectopic tubal pregnancy in the isthmic portion. Small, 4 mm firm yellow nodule was attached to the fimbriae. On microscopic examination, the nodule was well-demarcated and consisted of intersected fibroblasts and hyalinized collagen bundles with few slit-like or cystic spaces covered with benign epithelium. Stromal cells were focally positive for inhibin and CD10, whereas epithelial cells coexpressed vimentin and cytokeratin 7, as well as oestrogen receptor.
Conclusion: Ectopic pregnancy in this patient might have potentially been caused by the presence of tubal adenofibroma. Even though only few cases of coexistent ectopic tubal pregnancy and serous adenofibroma of the fallopian tube have been published in the literature, ectopic tubal pregnancy associated with other benign tumours, such as adenomatoid tumour, leiomyoma or mature cystic teratoma have been reported. These tumours might lead to partial obstruction of the fallopian tube or mimic ectopic pregnancy.

E-PS-11-045
Incidental primary extranodal ovarian diffuse large B-cell lymphoma (DLBCL): a case report
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Background & objectives: Ovarian lymphomas are usually secondary and indication of disseminated disease. Primary ovarian lymphomas are rare and the prognosis is better. We describe a primary ovarian DLBCL in a 57-years-old woman who underwent surgery for a cyst in the fallopian tube.
Methods: We received left fallopian tube measuring 6cm long and 0,5cm in diameter and ovary whose dimensions were 4x1,5x0,3cm. There was a paratubal cyst measuring 7cm in its greatest dimension. The frozen sections were negative (benign paratubal cyst). On permanent sections there were two lesions in the ovary measuring 0,5 and 1,3 cm respectively.
Results: The first one was a benign transitional (Brenner) tumour. The second one was composed of a diffuse proliferation of relatively large pleiomorphic cells with vesicular nuclei and often prominent nucleoli. The immunohistochemical survey showed: Vimentin(+), LCA(+), KerAE1/AE3(-), CD20(+), CD3(-), Bcl2(-), Bcl6(+/-), CyclinD1(-), CD10(-), CD68(-), CD10(-), absence of clonal light chains. The proliferation index was 60%. The diagnosis was DLBCL,NOS with a further note for additional tests to prove the origin. A bone marrow trephine biopsy was performed which was negative, as other diagnostic imaging techniques. So the final diagnosis was primary DLBCL, NOS. The patient received 8 circles of RCHOP, and she is free of disease, one year later.
Conclusion: Primary ovarian lymphomas are rare. Their prognosis is better than secondary lymphomas which have to be excluded clinically. In our case the patient is free of disease one year later.

E-PS-11-046
HPV profile of adenocarcinoma of the uterine cervix: a 10 year-histopathological review of 242 cases in a large prevention centre
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