AGOI Association of Gynaecologic Oncologists of India

From the Desk of President & Secretary, AGOI

Dear members of Association of Gynaecologic Oncologists of India,

We are proud to announce the release of the Second E-Newsletter of AGOI. We plan to bring out 4 quarterly issues in a year. The contents of the Newsletter will include recent articles/updates related to Gyn- Oncology, interesting case reports, information on Cancer-awareness activities on World Gyn- Cancer Days, activities of all AGOI-State Chapters in the current year, information related to upcoming Webinars, State / National / International Conferences, CMEs & Workshops. Information regarding AGOI Fellowship Progamme and Young Gyn-Oncologists Training Programme & Centres where it can be persued, will be available to the reader.

The organization intends to give emphasis on 'Preventive Gyn-Oncology ', along with treatment. We encourage our esteemed members to conduct 'Awareness Programmes' in all parts of India and implement HPV Vaccination to the target Female Population. We also encourage skill development and promote use of newer technologies like Minimal Invasive Surgeries (Laparoscopy & Robotic). Training in Gyn Oncosurgery including Exenterative surgeries is also provided through hands-on cadaveric workshops, held during conferences or at other times of the year as decided by Executive Body of AGOI. Strategic Alliance with IGCS, done recently has paved the way for advancing research and sharing knowledge with our international partners. We also work in association with other international Organsations like ESGO.

All other information is available in detail on our website (www.agoi.org) It is very important dear members, to actively engage in awareness activities on personal basis or through State Chapters. This will go a long way in preventing or even eliminating Gynaecological Cancers.

Jai Hind !
Warm regards,
Jita Parija - President AGOI
Bhagyalaxmi Nayak – Secretary AGOI

Dear members of Association of Gynaecologic Oncologists of India,

We are going to publish the second issue of AGOI newsletter as per the decision of AGOI Executive committee. This edition contains messages from elected president and secretary of AGOI ,few articles on recent advances in the field of gynaecology contributed by our members ,activities of various state societies of AGOI along with upcoming events .

Gynaecological cancers were treated by gynaecologists in the past who dealt with all the subspecialities of Obstetrics and Gynaecology , including obstetrics. So treating gynaecological cancers were not proper and focussed intensely. There was a need of a subspecialty which can deliver comprehensive care to women with cancer. Gynaecologic Oncology as a subspecialty has evolved in 1970-80 in western world and over last 2 to 3 decades in India to fulfil that goal. With advances in surgical techniques, chemotherapy, radiation therapy, targeted therapy, immunotherapy , fertility preservation and palliative care in a frame work of multidisciplinary involvement , outcomes can be enhanced. As we continue our journey to combat gynecologic cancers, it is essential to emphasize the importance of awareness, early detection, and specialized care. These cancers affect millions of women worldwide, and by working together, we can make a significant difference.
By prioritizing women's health and promoting education, we can empower women to take control of their well-being. Let's continue to support research, awareness initiatives, and specialized care for those affected by gynecologic cancers.

As a gynecologic oncologist, staying abreast of the latest developments in this field and working collaboratively with other specialists is essential for providing the best possible care for gynaecological cancers' and AGOI is committed to execute it.

Long live AGOI

Dr Ashok Kumar Padhy_Editor
Dr Sony Nanda_Co-editor

Results of Online Y- GOG Zonal (Preliminary) Rounds 2025 (Candidates Shortlisted for YGOG Finals)

Sr. No.	NAME	TOPIC	ZONE	RANK
1	Saroj Rajan	Multimodal Prehabilitation in Indian Women with Advanced Ovarian Cancer: Enhancing Nutritional, Psychological, and Surgical Recovery	North	1st
2	Sholanki Halder	Patient-Reported Sexual Health Outcomes and Health-Related Quality of Life in Cervical Cancer Survivorship Care: A Systematic Quality Improvement Intervention	North	2nd
3	Aleena P	Sentinel Lymph Node Mapping and Pathological Ultrastaging - Real World Data from a Tertiary Cancer Centre (South Zone)	South	1st
4	Meghapriya	TITLE: Survival outcome of stage IIIC HGSCO and impact of C125 kinetics, CCS and CRS on the survival	South	2nd
5	G. Raja	An observational study exploring the association of the completeness of cytoreductive surgery and surgical complexity score with the BRCA mutation status in patients with high-grade serous ovarian cancer- an interim analysis.	East	1st
6	Priyanka Jain	Relation between CA125 and CT PCI with laparotomy PCI in patients of AEOC who have received NACT	East	2nd
7	Vidushi Gupta	Tailoring the Management in Locally Advanced Vulval Cancer: A State Cancer Institutional Experience in Neoadjuvant Therapy	West	1st
8	Shiva Gautam	Correlation of Chemotherapy Response Score with Serological and Radiological Assessment of Response and Survival Outcomes in Ovarian Cancer: A Prospective Study at State Cancer Centre	West	2nd

ಕಿದ್ವಾಯಿ ಆಸ್ಪತ್ರೆಯಲ್ಲಿ ಉಚಿತ ರೊಬೊಟಿಕ್ ಚಿಕಿತ್ಸೆ: ನಿರ್ದೇಶಕ

ಆಸ್ಪತ್ರೆಯಲ್ಲಿ 'ರೊಬೊಟಿಕ್' ಶಸ್ತ್ರಚಿಕಿತ್ಸೆ ಕಾರ್ಯಾಗಾರಕ್ಕೆ ಚಾಲನೆ

■ ಉದಯವಾಣಿ ಸಮಾಚಾರ

ಬೆಂಗಳೂರು: ವೈದ್ಯಕೀಯ ಅಭ್ಯಾಸ ಮಾಡುತ್ತಿರುವವರಿಗೆ ರೊಬೊಟಿಕ್ ಶಸ್ತ್ರ ಚಿಕಿತ್ಸೆ ಕಾರ್ಯಾಗಾರಗಳು ಕಲಿಕೆಗೆ ಆಧಾರವಾಗಲಿದೆ ಎಂದು ವೈದ್ಯಕೀಯ ಶಿಕ್ಷಣ ಇಲಾಖೆ ಪ್ರಧಾನ ಕಾರ್ಯದರ್ಶಿ ಮೊಹಮ್ಮದ್ ಮೊಹ್ಸಿನ್ ಅವರು ಅಭಿಪ್ರಾಯಪಟ್ಟರು.

ಕಿದ್ವಾಯಿ ಸ್ಮಾರಕ ಗಂಥಿ ಸಂಸ್ಥೆಯ ಸ್ತ್ರೀರೋಗ ಗಂಥಿಶಾಸ್ತ್ರ ವಿಭಾಗ ಮತ್ತು ಕರ್ನಾಟಕ ಸ್ಟೇಟ್ ಚಾಪ್ಟರ್ ಆಸೋಸಿಯೇಷನ್ ಆಫ್ ಗೈನೆಕಾಲಾಜಿಕ್ ಆಂಕಾಲಜಿಸ್ಟ್ ಆಫ್ ಇಂಡಿಯಾ ಸಂಸ್ಥೆಯ ಇನ್ಫೋಸಿಸ್ ಸಭಾಂಗಣದಲ್ಲಿ ಆಯೋಜಿಸಿದ್ದ ರೊಬೊಟಿಕ್ ಶಸ್ತ್ರ ಚಿಕಿತ್ಸೆ ಕಾರ್ಯಾಗಾರಕ್ಕೆ ಚಾಲನೆ ನೀಡಿ ಮಾತನಾಡಿದರು.

ವೈದ್ಯಕೀಯ ಸಂಶೋಧನೆಗಳಿಗೆ ಹೆಚ್ಚು ಒತ್ತು ನೀಡುವ ಮೂಲಕ ಕ್ಯಾನ್ಸರ್ ನಿಯಂತ್ರಣಕ್ಕೆ ಆದ್ಯತೆ ನೀಡಬೇಕು. ವೈದ್ಯಕೀಯ ವಿದ್ಯಾರ್ಥಿಗಳ ಜೊತೆಗೆ ಪ್ಯಾರಾ ಮೆಡಿಕಲ್ ವಿದ್ಯಾರ್ಥಿಗಳು ಸಂಶೋಧನೆಯಲ್ಲಿ ತೊಡಗಬೇಕು. ಕಾರ್ಯಾಗಾರಗಳು ಹೆಚ್ಚಾಗಿ ಆಯೋಜಿಸುವ ಮೂಲಕ ವೈದ್ಯಕೀಯ ಸಂಶೋಧನೆಗೆ ಸಹಕಾರಿಯಾಗಲಿದೆ ಎಂದು ತಿಳಿಸಿದರು.

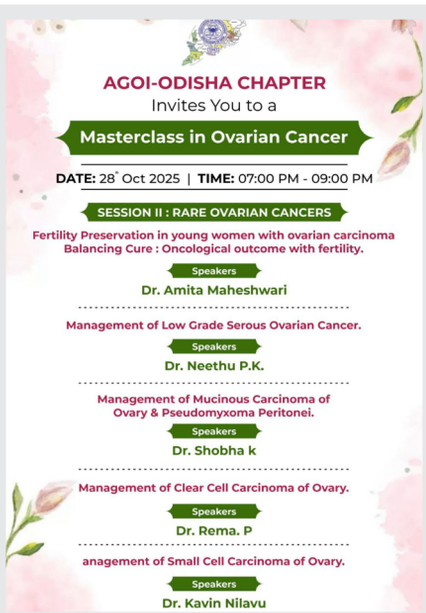
ಕಿದ್ವಾಯಿ ಸ್ಮಾರಕ ಗಂಥಿ ಸಂಸ್ಥೆಯಲ್ಲಿ ೨ ಸಾವಿರಕ್ಕೂ ಹೆಚ್ಚು ರೊಬೊಟಿಕ್ ಶಸ್ತ್ರಚಿಕಿತ್ಸೆಗಳನ್ನು ನಡೆಸಲಾಗಿದೆ. ಬಿಪಿಎಲ್ ಹೊಂದಿರುವ ರೋಗಿಗಳಿಗೆ ಉಚಿತವಾಗಿ ರೊಬೊಟಿಕ್ ಶಸ್ತ್ರ ಚಿಕಿತ್ಸೆ ನೀಡಲಾಗುತ್ತಿದೆ ಎಂದರು.

ಸಂಸ್ಥೆಯ ನಿರ್ದೇಶಕ ಡಾ.ಟಿ.ನವೀನ್ ಮಾತನಾಡಿ, ನಮ್ಮ ಸಂಸ್ಥೆಯಲ್ಲಿ ಬಡ ರೋಗಿಗಳಿಗೆ ಉಚಿತವಾಗಿ ರೊಬೊಟಿಕ್ ಶಸ್ತ್ರ ಚಿಕಿತ್ಸೆ ನಡೆಸಲಾಗುತ್ತಿದೆ. ಆಸ್ಪತ್ರೆಯು ಆಧ್ಯಾಧುನಿಕ ಸೌಲಭ್ಯಗಳನ್ನು ಅಳವಡಿಸಿಕೊಳ್ಳುತ್ತಿದ್ದು, ವಿಶ್ವಮಟ್ಟಕ್ಕೆ ಬೆಳೆಯುತ್ತಿದೆ. ಕ್ಯಾನ್ಸರ್ ರೋಗಿಗಳಿಗೆ ಬೇಕಾದ ಎಲ್ಲ ಮೂಲಭೂತ ಸೌಲಭ್ಯಗಳನ್ನು ಕಲ್ಪಿಸಲಾಗುತ್ತಿದೆ. ಆಸ್ಪತ್ರೆಗೆ ಬೇಕಾದ ಎಲ್ಲಾ ವೈದ್ಯಕೀಯ ಸೌಲಭ್ಯಗಳನ್ನು ರಾಜ್ಯ ಸರ್ಕಾರ ಒದಗಿಸುತ್ತಿದೆ. ರಾಜ್ಯದಲ್ಲಿ ಕ್ಯಾನ್ಸರ್ ನಿಯಂತ್ರಣ ಹಾಗೂ ತ್ವರಿತ ಚಿಕಿತ್ಸೆಗೆ ಫೆಂಫರೆಲ್ ಕ್ಯಾನ್ಸರ್ ಘಟಕಗಳನ್ನು ತೆರೆಯಲಾಗುತ್ತಿದೆ ಎಂದು ಹೇಳಿದರು.

ಸ್ತ್ರೀರೋಗ ಗಂಥಿಶಾಸ್ತ್ರ ವಿಭಾಗದ ಮುಖ್ಯಸ್ಥರಾದ ಡಾ.ಕೆ. ಶೋಭಾ, ಸಂಸ್ಥೆಯ ಮುಖ್ಯ ಆಡಳಿತಾಧಿಕಾರಿ ಬಿ.ಪಿ.ಸರೋಜಾ ಇತರರಿದ್ದರು.

Paid Tribute to legendary Dr. Shankaranarayan Rengaswamy

AGOI Regional Chapter Activities



Decoding NSMP endometrial cancers: From exclusion to precision.

Rohini Kulkarni.

The No Specific Molecular Profile (NSMP) subgroup, formerly termed "copy-number low," represents the largest category of endometrial cancers, comprising about 40–50% of cases [1]. Unlike other TCGA-defined groups, NSMP tumors lack mismatch repair deficiency, POLE exonuclease mutations, or abnormal p53 expression. Histologically, they are predominantly low-grade endometrioid carcinomas(75-85%), with 15-25% being high grade endometrioid/ non-endometrioid histology; making them biologically non-uniform. [2,3].

One of the defining features of NSMP cancers is their heterogeneity in clinical behaviour. Outcomes are generally intermediate, yet a proportion demonstrate either favourable or unexpectedly poor prognosis [4]. This variation has prompted attempts to refine risk stratification within this subgroup.

Recent evidence emphasizes the prognostic importance of estrogen receptor (ER) expression and L1 cell adhesion molecule (L1CAM) status. Most NSMP tumors (about 85%) are ER-positive and hormone-driven, correlating with indolent disease and potential responsiveness to endocrine therapy [5–7]. In contrast, ER-negative NSMP tumors display aggressive histopathologic features, higher recurrence rates, and reduced survival [3,6].

Similarly, L1CAM overexpression, though present only in a subset of NSMP tumors (5-10%), identifies a population with increased risk of distant metastasis and poor outcomes[5,8]. Latest findings from the results of PORTEC-4a trial presented at ESTRO 2025 provide clinical validation for the role of L1CAM in treatment stratification. In this trial, adjuvant therapy decisions for high intermediate risk category endometrial cancer patients were guided by molecular features. Women with unfavourable profiles including L1CAM overexpression were allocated to pelvic radiotherapy instead of standard vaginal brachytherapy. Reported locoregional recurrence was 8.4% in the molecularly guided unfavourable group versus 30.5% in matched controls, underscoring that L1CAM is one of the biomarkers which can meaningfully guide adjuvant management and improve outcomes [9].

Integration of ER and L1CAM into molecular stratification has therefore been proposed, creating prognostically distinct categories:

- ER-positive, L1CAM-negative: favorable risk, hormone-driven disease.
- ER-negative and/or L1CAM-positive: unfavorable risk, aggressive biology.

In summary, the NSMP subgroup is a "catch-all" defined by exclusion, yet recognition of its internal heterogeneity, particularly through ER and L1CAM subclassification is refining prognostic accuracy and may guide personalized treatment decisions in this subgroup of endometrial cancer patients.

Metastatic endometrial cancer with an elusive preoperative diagnosis

Authors

Shalini Rajaram1, Lakhwinder Singh2, Trisha Chattoraj2, Devika Kamat2, Priyanka Rajandran[2]

Professor and Program Lead MCh Gynecologic Oncology, Department of Obstetrics and Gynecology, All India Institute of Medical Sciences, Rishikesh[1]

Mch Gynecologic Oncology Fellow, Department of Obstetrics and Gynecology, All India Institute of Medical Sciences, Rishikesh[2]

Introduction

Endometrial cancer is one of the most common gynecological malignancies, typically presenting in postmenopausal women with abnormal uterine bleeding, allowing for early-stage diagnosis and management. However, a subset of tumors, particularly those of high-grade histology such as uterine serous carcinoma (USC), are characterized by an aggressive course, early dissemination, and atypical presentations. USC accounts for approximately 10% of endometrial cancers but is responsible for a disproportionate number of relapses and deaths due to its propensity for early extrauterine spread, often in the absence of significant myometrial invasion or obvious uterine symptoms−−− . Diagnosis can be challenging, particularly when imaging and biopsy findings are inconclusive. The presence of malignant ascites and diffuse peritoneal involvement may mimic advanced ovarian carcinoma or cancer of unknown primary origin. Here, we report a rare and diagnostically challenging case of serous carcinoma confined to an endometrial polyp presenting with malignant ascites, extensive peritoneal metastasis, and deep vein thrombosis, without any prior uterine symptoms. The case highlights the diagnostic dilemmas and underscores the importance of a multidisciplinary approach, histopathological confirmation, and consideration of USC in atypical metastatic presentations.

Case presentation

A postmenopausal woman in her 70s presented to the gynecologic oncology outpatient department with complaints of dull-aching lower abdominal pain progressing over two months, accompanied by abdominal distension, early satiety, and loss of appetite. She also reported left lower limb pain and swelling extending up to the mid-thigh. There was no history of postmenopausal bleeding, vaginal discharge, or bowel/bladder disturbances. She had attained menopause 15 years prior with an uneventful perimenopausal transition. Obstetric history included four normal vaginal deliveries and tubal ligation, with three living children. There was no

history of comorbidities or familial malignancies. On examination, she had an ECOG performance score of 1. General physical and systemic examination was unremarkable, with no palpable lymphadenopathy. Abdominal examination revealed distension with ascites but no palpable masses or organomegaly. Per speculum findings were normal. Bimanual pelvic examination revealed a mobile, enlarged uterus corresponding to 16 weeks' size; the pouch of Douglas was free with normal rectal mucosa.

Ultrasound imaging revealed gross ascites and a hyperechoic myometrial lesion, suggestive of leiomyoma. Doppler ultrasound of the lower limbs showed echogenic thrombus in the left femoral vein extending to the left common iliac vein. Therapeutic anticoagulation was initiated, and an IVC filter was placed. Diagnostic paracentesis revealed malignant cells in the ascitic fluid after second tap. Tumor markers showed CA-125 at 134 U/mL, CEA 0.35 ng/mL, and CA 19.9 at 8.3 U/mL. Contrast-enhanced CT (CECT) of thorax, abdomen, and pelvis revealed a 9.6 × 10.6 × 9.6 cm peripherally enhancing lesion with internal hemorrhage and papillary projections in the uterine fundus, with gross ascites and omental thickening—suggestive of a possible malignant uterine tumor. Extensive DVT involving the left femoral, iliac, and external iliac veins was noted. Breast evaluation, colonoscopy, and upper GI endoscopy were unremarkable. An ultrasound-guided biopsy of the uterine mass suggested a smooth muscle neoplasm favoring leiomyoma. A subsequent ultrasound-guided omental biopsy was performed which was also inconclusive and showed fibrofatty tissue with no malignant changes. PET-CT showed a non-FDG-avid thyroid lesion and a bulky uterus with a mildly FDG-avid (SUV max 7.5) uterine lesion. FDG-avid omental and mesenteric thickening (SUV max 5.2) were seen with moderate to severe ascites.

Following a multidisciplinary tumor board discussion and in the absence of a confirmed primary, the patient underwent exploratory laparotomy. Intraoperatively, three litres of ascites were drained. The uterus was globular and 16 weeks in size, densely adherent to the bladder and lateral pelvic peritoneum. Bilateral adnexa appeared normal. Omental caking and peritoneal deposits were noted throughout the abdomen, including bowel serosa and mesentery (PCI score: 26). As complete cytoreduction was not feasible, a total hysterectomy with bilateral salpingo-oophorectomy, total omentectomy and mesenteric biopsies was performed. Frozen section of omentum revealed adenocarcinoma. The patient recovered uneventfully postoperatively and continued therapeutic thromboprophylaxis.

Final histopathology showed serous adenocarcinoma confined to an endometrial polyp with lymphovascular space invasion (LVSI) but no myometrial invasion. Tumor deposits were present on the surfaces of both ovaries, fallopian tubes, omentum, and mesentery. Immunohistochemistry revealed PAX8 and p16 block positivity, p53 overexpression, focal WT1 positivity, weak ER positivity, MMR proficiency, and Her2/Neu wildtype. A final diagnosis of Stage IVB primary serous carcinoma of an endometrial polyp with ovarian, tubal, and peritoneal metastasis was made. The

patient was started on systemic chemotherapy with paclitaxel and carboplatin, with treatment response assessment planned after three cycles.

Discussion

The above case highlights the challenges encountered in the preoperative evaluation as highlighted in the case initially with final diagnosis of primary serous carcinoma of endometrial polyp with extensive metastases and no myometrial invasion. Atypical presentations can limit the diagnostic utility of standard modalities. In our case, ascitic fluid cytology showed malignant cells, but extensive serological, radiological, and pathological evaluations failed to reveal the primary site of origin necessitating surgical exploration.

Diagnosing primary uterine serous carcinoma (USC) and distinguishing it from serous carcinomas at other sites in the female genital tract—particularly ovarian serous carcinoma (OSC)—can be challenging, especially in advanced cases with multifocal involvement . USC often arises in an atrophic endometrium, frequently originating from endometrial polyps, and may show extrauterine spread in >50% even when the primary tumor is superficially invasive or confined to the endometrium. Histologically, USC is characterized by papillary structures (with or without fibrovascular cores), marked nuclear atypia, slit-like spaces, solid growth, scant cytoplasm (occasionally abundant), frequent mitoses, and sometimes psammoma bodies or cilia. These features may overlap with FIGO grade 3 endometrioid carcinoma, complicating diagnosis. On immunohistochemistry USC typically shows strong p53 and p16 expression, PAX8, AE1/AE3, and CK7 positivity, while it is usually negative or only focally positive for CK20, ER, PR, and WT1. Notably, WT1 is expressed in up to 97% of OSCs but only 20–49% of USCs, providing a useful differentiator. Similarly, ER positivity is seen in approximately 64% of OSCs but only 11% of USCs. HER2/neu overexpression—demonstrated by strong, complete membranous staining—is present in 16–62% of USCs and absent in OSCs and serous carcinomas of other sites, offering another valuable diagnostic clue and potential therapeutic target. According to TCGA, over 90% of USCs belong to the copy-number high (serous-like) group with p53 mutations. Mismatch repair protein loss is uncommon but seen in about 10% of cases . In synchronous endometrial and ovarian tumors—common in disseminated disease—distinguishing primary site relies on integrating morphology, immunophenotype, and clinical context. Despite subtle differences, IHC markers like WT1, ER, and HER2/neu can aid in differentiating USC from OSC when used in a comprehensive panel . This was also true in the present case, where a combination of morphological features and an immunohistochemical panel, including WT1, PAX8, p53, p16, ER, MMR proteins, and HER2/neu was used to establish the diagnosis of primary USC.

The management of advanced or recurrent endometrial carcinoma has evolved significantly in recent years with the incorporation of molecular classification, revised staging system, and immunotherapy .

The Cancer Genome Atlas (TCGA) revolutionized the field by identifying four molecular subtypes of endometrial carcinoma: copy-number high (serous-like), copy-number low, microsatellite instability-high (MSI-H), and POLE-ultramutated. The copy-number high group includes nearly all serous carcinomas and many FIGO grade 3 endometrioid tumors, and is associated with TP53 mutations, genomic instability, and poor prognosis . The 2023 FIGO staging system, based on ESGO/ESTRO/ESP guidelines, integrates histotype, lymphovascular space invasion (LVSI), and molecular subtype to enhance prognostic accuracy and inform treatment decisions . In advanced-stage disease, systemic therapy is the cornerstone of treatment and would have been offered to this patient if preoperative diagnosis was made. Surgery is reserved for cases where complete macroscopic cytoreduction is feasible with acceptable morbidity or considered as delayed cytoreduction in patients showing a favorable response to chemotherapy .

Conclusion

This case highlights the diagnostic challenges of endometrial serous carcinoma presenting with extensive metastases and no uterine symptoms such as bleeding. Despite comprehensive imaging, tumor markers, and targeted biopsies, the primary lesion remained undetected preoperatively. It underscores the limitations of conventional diagnostic algorithms in atypical presentations and the pivotal role of surgical exploration, histopathology, immunohistochemistry, and molecular testing in establishing an accurate diagnosis. of molecular classification, revised staging system, and immunotherapy.

Upcoming
CONFERENCES