Imunohistochemical Features: The immuno panel comprised of CD10, smooth muscle actin (SMA), estrogen (ER) and progesterone receptors (PR), desmin, HMB-45, pancytokeratin (CK), gross cystic disease fluid protein (GCDFP)-15, GATA3, synaptophysin, chromogranin, inhibin, calretinin, WT1, MART1, and CD99. The only positive markers were ER, PR, calretinin, and inhibin (Figure 8).

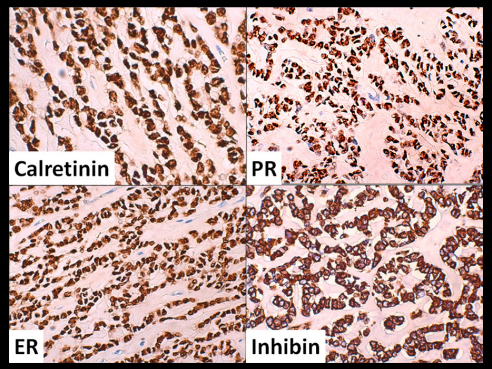

Figure 8

Adnexa was grossly and microscopically within normal limits.

FINAL DIAGNOSIS: Uterine Tumor Resembling Ovarian Sex Cord Tumor.

DISCUSSION

Morehead and Bowman[1] first described a uterine tumor resembling ovarian sex cord tumors (UTROSCTs) in 1945. Subsequently, Clement and Scully[2] described 14 such cases and further classified the neoplasms into 2 distinct subgroups based on clinical and histopathologic features. In the first group, the tumors showed a predominant endometrial stromal tumor-like differentiation and focal ovarian sex cordlike areas (<50%) and were termed endometrial stromal tumors with sex cordlike elements (ESTSCLE), whereas the neoplasms in the second group were composed predominantly of a sex cordlike component accounting for 50% to 100% of the tumor, which was, therefore, called a UTROSCT.[2] This morphologic distinction is of clinical importance because UTROSCTs usually behave benignly, whereas ESTSCLE are associated with recurrences and metastases. More recently, UTROSCTs have been considered as rare neoplasms of uncertain malignancy with polyphenotypic IHC expression characterized by positivity for sex cord, epithelial, and myoid markers.[3,4] In line with its controversial origin, in the current World Health Organization classification, UTROSCTs are placed in the "miscellaneous" category of tumors of the uterine corpus.[5] To date, sporadic case reports and occasional series of UTROSCTs have been described in the literature.[6–11]

The UTROSCT is classically considered a disease of perimenopausal and postmenopausal women. The main clinical manifestations are abnormal uterine bleeding and/or abdominal pain. Most patients have an enlarged uterus or a palpable mass.[12,13] Imaging studies are not diagnostic, and histopathology is the gold standard for diagnosis of UTROSCT.

The UTROSCTs generally present as intramural, submucosal, and subserosal masses, usually in the uterine fundus. They are usually well circumscribed and non-encapsulated, with pushing or infiltrative borders. Polypoid masses projecting into the uterine cavity are common. The