Abstract 14 Figure 1 Testicular Seminoma – From left to right coronal reconstruction of CT scan and US images depicting RIF mass in red arrow and twisted pedicle in yellow arrow. Histopathology image demonstrate malignant cell proliferation of classical seminomatous non-cohesive, large, round & atypical cells with atypical nuclei owing prominent nucleoli & granular cytoplasm in right gonad

circumference fallopian tube and fimbria were identified bilaterally. Because of bilateral orchidectomy with normal male karyotype and normal male secondary sexual characters, regular testosterone hormone replacement therapy (testosterone 1000 mg/every 3 month) was instituted.

Conclusion Patients with persistent Mullerian duct syndrome or internal male pseudohermaphroditism have 46 XY karyotype, near normal development of secondary sexual characters and persistent Mullerian duct structures i.e., uterus, cervix, fallopian tubes and proximal vagina. Our patient was diagnosed very late possibly due to cultural issues and stigmata attached to pseudohermaphroditism.

15 OVARIAN GERM CELL TUMOURS; EXPERIENCE OF A REGIONAL CENTRE

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Introduction Ovarian germ cell tumours are rare but aggressive cancers which have histological and treatment similarities with the more common male germ cell tumours. However the outcomes are poorer for women with germ cell tumours than for men.¹ Historically, in the west of Scotland, female germ cells patients were managed within standard gynaecological cancer services and male patients in a dedicated germ cell unit. Due to the highly specialised nature of the condition and the experience of the clinicians using similar chemotherapy regimens, the management of ovarian germ cells was incorporated into the germ cell unit. We present the experiences of this unit over the last 6 years.

Method We reviewed data from all women with ovarian germ cell tumours treated or followed up under the regional germ cell unit. Fertility is an important consideration for these young women and we investigated the rate of fertility sparing surgery, utilisation of pre-chemotherapy fertility treatments and the rate of successful pregnancies. With the Introduction of the Cisplatin, Vincristine, Methotrexate, Bleomycin with alternate Actinomycin, Cyclophosphamide and Etoposide chemotherapy regimen (POMB/ACE) there was a concern that this will cause problems with monitoring during treatment as it associated with elevation of alpha fetoprotein (AFP) levels which is used as a marker or response. We compared AFP levels between POMB/ACE and the bleomycin, etoposide, cisplatin (BEP) regimen used in the adjuvant or neo-adjuvant setting.

Results 26 patients have been treated or followed up by the unit over the last 6 years. Median follow up is 55 months

(range 3 months – 31 years). The all-cause mortality is 0 and the relapse rate is 19%. Relapses were spread equally through the treatment groups. 21 out of 24 eligible patients received fertility sparing surgery. Of these there has been 6 successful pregnancies following treatment.

There was no significant difference in AFP levels between BEP and POMB/ACE groups.

Conclusions Outcomes for ovarian germ cell patients in the west of Scotland are comparable to published case series. The low incidence makes it difficult to identify statistically significant differences however we hope to promote collaboration and gather more data through a national ovarian germ cell database set up through the Scottish Germ Cell Group.

REFERENCE

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16 A CASE OF PYREXIA OF UNKNOWN ORIGIN AND RECURRENT HOSPITAL ADMISSIONS IN A CARDIAC PATIENT

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Introduction Pyrexia of unknown origin (PUO) is defined as a temperature greater than 38.3°C on several occasions, accompanied by three weeks of illness and a failure to reach a diagnosis after one week of inpatient investigations.¹ We describe a case of a 72-year-old man with a significant cardiac history and a pacemaker *in-situ* presented to the emergency department of a district general hospital with sepsis five days after he had his pacemaker unit batteries changed. He had deranged vital signs, productive cough and pyrexia. He had a normal chest plain radiograph (CXR). However, with right basal crackles on auscultation, he was empirically treated for a lower respiratory tract infection (LRTI) with intravenous antibiotics. The patient was discharged but had to be readmitted four times over the span of 4 months due to recurrent pyrexia. Repeated Trans-thoracic (TTE) and Trans-oesophageal (TOE) echocardiograms, and CT neck/thorax/abdomen/pelvis were done however no evidence of infection was found on the scans. A FDG-PET scan [figure 1] was eventually done which showed evidence of pacemaker-lead infection. His pacemaker unit was removed and replaced with a REVEAL device. He improved clinically with no further hospital admission to date.

Methods Routine blood test only showed raised WCC and CRP. Connective tissue disease screen, viral and tumour

Abstract 16 Figure 1 FDG-PET scan images showing increased focal activity around pacemaker leads