Which one is the primary?

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A 55-year old postmenopausal lady presented with a painless lump in the left groin which had progressed to its current size over last one and half months. Clinically the lump measured 9x9 cm and was hard, immobile, nontender, non-reducible, with regular margins and there were no other positive findings on physical examination (Figure 1). Fine needle aspiration cytology from the lump revealed carcinoma with areas of necrosis and immunohistochemistry was CK7+ (focal), p53+ (diffuse and strong), CK20- which suggested "primary ovarian carcinoma". A PET-CT was done which showed increased FDG uptake in a normal sized left ovary, multiple avid para-aortic and pelvic nodes largest measuring 4x2.8 cm and 7.8X7.9X9.9 cm avid mass in left inguinal area. In view of unresectable disease in the groin she was planned for neoadjuvant chemotherapy follow by interval cytoreductive surgery.

This was an unusual presentation of carcinoma ovary where PET-CT and immunohistochemistry helped in making a diagnosis. Published literature suggests that this presentation in lymph nodes without any clinical disease in the parent organ and peritoneal disease is not a usual finding (1). Diagnosis and management requires a multidisciplinary approach. These cases have been traditionally classified as stage IV but a recent retrospective study suggested that ovarian cancer patients with stage IV solely due to inguinal nodal metastases have similar survival as those with pelvic/para-aortic nodal involvement and improved survival compared to those harboring distant metastases (2).

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