A 24-year-old woman presented to the Clinical Department of Gynaecological Endocrinology at the University Hospital in Cracow due to secondary amenorrhea, hirsutism (Ferriman-Gallwey score of 31; Fig. 1) and worsening abdominal pain of several months’ duration. During admission, abnormal levels of testosterone and AFP were noted. The patient was hospitalized and the ultrasound examination of the abdomen revealed an echogenically changed structure of the right ovary, measuring 42 × 27 mm (Fig. 2), with no clear demarcation of the tumour, showing signs of increased peripheral vascularisation (Fig. 3). Owing to low sensitivity of the ultrasound, a pelvic MRI was made. The imaging showed a well demarcated solid-cystic tumour of the following dimensions: 44 × 32 × 40 mm, with small fluid zones of 5 mm diameter, localized in the posterior part of the right ovary. The lesion was adherent to the uterine cervix, bulging into the Douglas pouch and partially abutting the rectal wall.

The patient was qualified to undergo a laparotomy and unilateral removal of the right ovary. The right ovary was removed using a classical approach and then a fragment of the left ovary and peritoneum were collected for further pathological examinations (Fig. 4).

Histological examinations showed pale cells with abundant cytoplasm, surrounded by poorly differentiated sarcomatoid cells (Fig. 5). Positive inhibin stain was observed in the sex cord elements (Fig. 6). The structure of the tumour included glandular cells from of the epithelium (Fig. 7). Immunohistochemical analysis revealed that the epithelial cells were positive for CK20 stain.

Fig. 1.

Fig. 2.
Answers should be sent to the Editorial Office until 31st May 2019. The correct answer will be announced in the next issue of the *Polish Journal of Pathology*. All participants with the highest number of correct answers to the quizzes published in vol. 70 (4 issues) will be entered into the prize draw for a book.