Diagnosis Discrepancy		✓
Primary Tumor Site Discrepancy		✓
HIPAA Discrepancy		✓
Prior Malignancy History		
Dual/Synchronous Primary Noted		
Case is (circle):	QUALIFIED / DISQUALIFIED	
Reviewer Initials	Date Reviewed	

lw 10/30/11

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SURGICAL PATHOLOGY

ICD-O-3

adenocarcinoma, endometrioid, NOS 8380/3
Site endometrium C54.1 lw 10/30/11

ACCESSION NUMBER:
RECEIVED:
ORDERING PHYSICIAN:
PATIENT NAME:
SURGICAL PATHOLOGY REPORT

FINAL PATHOLOGIC DIAGNOSIS
MICROSCOPIC EXAMINATION AND DIAGNOSIS

A. UTERUS, AND RIGHT AND LEFT ADNEXA, HYSTERECTOMY BILATERAL SALPINGO-OOPHORECTOMY:
UTERUS:
Endometrioid endometrial adenocarcinoma with squamous differentiation extending into the cervix with invasion of the cervical stroma and full thickness invasion of the myometrium (see comment and cancer protocol below).
Right uterine adnexa obliterated by tumor.

B. BLADDER WALL, PARTIAL EXCISION: Endometrial adenocarcinoma invading the muscularis propria from outside in.
Secondary inflammation and marked submucosal edema.

C. LYMPH NODES, RIGHT PELVIC, LYMPHADENECTOMY: Metastatic endometrial carcinoma in one of eleven lymph nodes.

D. PERITONEUM, BIOPSY: Metastatic endometrial adenocarcinoma.

E. LEFT PELVIC LYMPH NODES, LYMPHADENECTOMY:
Metastatic endometrial carcinoma in one of five lymph nodes.

F. ILEUM, SEGMENTAL RESECTION: Metastatic endometrial carcinoma extending from outside in all the way into the mucosa with perforation evident in slide F3.
Margins free of tumor.
Metastatic endometrial carcinoma in one of five lymph nodes.

G. OMENTUM, OMENTECTOMY: Benign adipose tissue.

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H. VERMIFORM APPENDIX, APPENDECTOMY: Benign appendix with fibrous luminal obliteration.

I. LYMPH NODE, PERIAORTIC, BIOPSY: One lymph node, benign.

COMMENT:
The tumor is a poorly differentiated endometrioid endometrial adenocarcinoma with squamous differentiation and focal neuroendocrine differentiation. Histologically, the tumors in the ileum and urinary bladder present an appearance suggestive of neuroendocrine differentiation with the tumor in the ileum particularly suggestive of neuroendocrine differentiation and that in the bladder more suggestive of more poorly differentiated neuroendocrine tumor. However, immunohistochemical stains to cytokeratins 7 and 20, synaptophysin and chromogranin applied to blocks A7 (uterus), B2 (urinary bladder) and F2 (ileum), show the tumor in all three sites to be strongly reactive for cytokeratin 7 with only focal strong dot cytoplasmic reactivity for cytokeratin 20 in the ileum and focal reactivity to chromogranin in the endometrium and the ileum. There is no reactivity to synaptophysin in any of the three sites. The block from the ileum was also stained for CD56 and shows weak diffuse reactivity. The positive and negative controls worked appropriately.* The above findings are most consistent with a primary poorly differentiated endometrioid endometrial adenocarcinoma with squamous differentiation and focal neuroendocrine differentiation. I do not see evidence of serous endometrial carcinoma, however, disregarding its classification the present tumor has already expressed its poor biological nature.

* "These tests were developed and their performance characteristics determined by . They have not been cleared or approved by the U.S. Food and Drug Administration. The FDA has determined that such clearance or approval is not necessary. These tests are used for clinical purposes. They should not be regarded as investigational or for research. This laboratory is certified under the Clinical Laboratory Improvement Amendments of 1988 (CLIA) as qualified to perform high complexity clinical laboratory testing."

GYN: ENDOMETRIAL HYSTERECTOMY CANCER PROTOCOL

[redacted]

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SPECIMEN TYPE: Hysterectomy
TUMOR SIZE: Greatest dimension: 11
Additional dimensions: 10 x 9.5 cm
OTHER ORGANS PRESENT: Left ovary
Left fallopian tube
HISTOLOGIC TYPE: Endometrioid adenocarcinoma, not otherwise characterized
HISTOLOGIC GRADE: FIGO Architectural Grade: Grade 3
FIGO Nuclear Grade: Grade 2
FIGO Final Grade: Grade 3
DEPTH OF MYOMETRIAL INVASION: (100 %)
ENDOCERVICAL INVOLVEMENT: Cervical stromal invasion
INVOLVEMENT OF OTHER STRUCTURES: Right tube and ovary
MARGINS: Cannot be assessed
LYMPHOVASCULAR INVASION: Present
AJCC (FIGO) STAGE
PRIMARY TUMOR: pT4 (IVA)
REGIONAL LYMPH NODES: pN1
Number involved: 2
Number examined: 17
DISTANT METASTASIS: pM1 (IVB)
Site(s): Intraabdominal lymph node (1/5, specimen F)

I have personally reviewed the slides and/or other related materials referenced, and have edited the report as part of my pathologic assessment and final interpretation.

***Electronically Signed Out By:
Ph.D.***

Specimen(s) Received
A: Uterus and bilateral tubes and ovaries
B: Bladder wall with tumor
C: Right pelvic lymph nodes
D: Peritoneal biopsy
E: Left pelvic lymph nodes
F: Portion of ileum
G: Omentum
H: Appendix

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REFERENCE:

I: Periaortic lymph node

Clinical History
Endometrial carcinoma.

Gross Description
A. A 470 g uterus with adnexal structures attached is received. The uterus is 13 x 12 x 8 cm. The left ovary is 6.4 g and 1.5 x 1.0 x 0.4 cm The left tube is 6.5 cm in length x 0.5 cm in diameter. The left ovary and left tube are separated from the uterus and wrapped. On the right side of the uterus there is a large fungating mass through the serosa which has replaced the right ovary The ectocervical mucosa is 2.2 x 2.0 cm and has a 1.1 x 1.0 cm patent os. The os has red-tan friable tissue extending through it. The resection margin is inked black and the uterus is opened to reveal a fungating mass that has multiple areas of myometrial invasion. The dominant mass is 11 x 10 x 9.5 cm and has eroded through the right wall of the uterus. In this area the tumor appears to have encased and replaced the right tube and ovary. The tumor comes within 2 cm from the os. Sectioning through the left ovary and tube reveals normal-appearing white-tan lobulated ovarian tissue and the tube with a normal-appearing patent lumen. Tissue is submitted as follows:

BLOCK SUMMARY:

A1-A2 anterior cervix, tandem section with blue ink - opposing surfaces (A2 containing tumor with closest approach to cervix);
A3-A4 representative section of posterior cervix, blue ink - tandem section opposing surfaces;
A5-A6 anterior uterine wall full thickness section, tandem surfaces inked blue;
A7-A8 posterior uterine wall full thickness section, blue ink - tandem, opposing surfaces;
A9-A10 representative sections of locally invasive tumor into right adnexal structures;
A11 representative section of left tube and ovary.

B An 8 x 7 x 3 cm fragment of tissue is received. On one aspect there is roughened white-tan apparent tumor. On the opposite aspect there is an apparent 3.6 x 2.0 cm area of apparent mucosa.

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Representative sections are submitted in cassette B1-B3.

C. Multiple yellow-tan fragments of adipose tissue aggregate to 8 x 6 x 2.0 cm. Lymph node search is performed revealing multiple lymph nodes ranging in size from 0.5 cm up to 2.0 cm in greatest dimension are identified Tissue is submitted as follows:

BLOCK SUMMARY:

C1 three apparent nodes;
C2 two apparent nodes;
C3 single node bisected.
C4 single node bisected;
C5 single node bisected;
C6 single node bisected;
C7-C8 single node bisected;
C9-C10 single node bisected.

D. Multiple yellow-tan soft tissue fragments aggregate to 4 x 3.5 x 1.0 cm are received. On one aspect there is a roughened white-tan apparent tumor implant present. Representative sections are submitted in cassettes D1-D2.

E. Five apparent lymph nodes are found ranging in size from 1 cm up to 3.4 cm in maximum dimension. Tissue is submitted as follows:

BLOCK SUMMARY:

E1 single apparent node;
E2 single apparent node bisected;
E3 single apparent node bisected;
E4 representative sections of large node;
E5 representative sections of largest node.

F. A 32 cm in length x 2.5 cm in diameter segment of small intestine is received unoriented. Staple lines are inked black and shaved On the serosal surface there are two surface tumor nodules. One is 6.5 cm x 3.0 cm and comes within 1 cm of one of the staple lines The second tumor nodule is 4.5 x 3.0 cm and comes within 11 cm of the opposite staple line margin. The specimen is opened to reveal normal tan-brown mucosa with appropriate folds. However there is an apparent perforation at the smaller of the two surface tumor nodules. This perforation measures 15 cm from one staple line and 17 cm from the opposite staple line Tissue is submitted as follows.

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BLOCK SUMMARY:

F1 section from staple line with close approach with tumor;
F2 representative section of larger tumor implant;
F3 representative section of smaller tumor implant with perforation;
F4 representative section of normal-appearing intestine;
F5 representative section from opposite staple line.

Sectioning through the mesentery of the small bowel reveals a single apparent tumor implant which measures up to 1.9 cm in greatest dimension. Representative section of this is submitted in cassette F6 and four apparent lymph nodes ranging in size from 0.6 up to 1.2 cm in greatest dimension are identified. These are submitted as follows:

F7 single apparent node bisected;
F8 two apparent nodes;
F9 single apparent node bisected.

G. A 14 cm x 9 cm x up to 2.0 cm segment of yellow-tan adipose tissue consistent with omentum is received. Sectioning reveals normal-appearing yellow-tan adipose tissue. Representative sections are submitted in cassettes G1-G2.

H. A 3.5 cm in length x up to 0.5 cm in diameter apparent appendix is received with yellow-tan adipose tissue extending off of one aspect up to 2.2 cm. Sectioning through the appendix reveals normal-appearing appendix with tan-pink serosa, wall thickness averaging 0.2 cm with a pink patent lumen and normal-appearing mucosa. Tissue is submitted as follows:

BLOCK SUMMARY:

H1 representative cross section from proximal tip and middle end of appendix (proximal tip with blue ink) and longitudinal section through distal tip.

I A 4.0 x 1.8 x 1.0 cm red-brown fragment of soft tissue is received. Sectioning reveals a single apparent lymph node measuring up to 3.6 cm in greatest dimension. Representative sections of this node are submitted in cassettes I1-I2. Please note approximately 60% of the lymph node is submitted for histologic evaluation.

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Uterus and bilateral tubes and ovaries

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