

CLINICAL HISTORY:

Surg Path

Malignant neoplasm corporis uteri.

GROSS EXAMINATION:

A. "Uterus, cervix, bilateral tubes and ovaries". Received fresh is a 116 gm, $9.5 \times 6.4 \times 4.1$ cm uterus with bilateral attached adnexa. The opened specimen discloses an exophytic 6 x 4.5 cm white-tan tumor in the anterior endometrial cavity, extending from the fundus to the lower uterine segment. The tumor is 1.2 cm thick and penetrates 0.1 cm into the underlying 2.1 cm thick myometrium. The remainder of the endometrial cavity $(6.5 \times 4 \text{ cm})$ is lined by a thin 0.1 cm endometrium overlying a focally trabeculated myometrium. The endocervical canal is trabeculated yellow-tan with no apparent gross lesions and the exocervix is smooth and glistening with a patent 0.9 os. A representative section of the mass has been frozen as AF1 and AF2 and the frozen section remnants are submitted in blocks A1 and A2. Additional representative sections submitted as follows:

BLOCK SUMMARY:

A3anterior cervix

A4anterior endocervical canal

A5posterior cervix

A6posterior endocervical canal

A7-A11 tumor and wall (block A7-A10 are two slides, bisected)

uninvolved posterior endomyometrium

The left adnexa is composed of a discontinuous 2.5 cm long, 0.5 cm in diameter fimbriated fallopian tube with attached mesentery and an attached 4 \times 1.5 \times 1 cm white-tan ovary. Sectioning demonstrates a grossly unremarkable cut surface and representative sections are submitted in A13.

The right adnexa is composed of a discontinuous 2.1 cm long, 0.5 cm in diameter fimbriated fallopian tube with an attached 3 \times 2 \times 1.7 cm white-tan ovary. Sectioning demonstrates a grossly unremarkable cut surface and representative cross sections are submitted in block A14.

B. "Left pelvic nodes", received fresh and placed in formalin is a 10 x 8.5 \times 2 cm aggregate of yellow-tan fibroadipose tissue dissected for apparent lymph node candidates. Twenty-three lymph node candidates are identified from 0.3 to 2.2 cm in greatest dimension and are submitted as follows:

B1four lymph node candidates

B2four lymph node candidates

B3three lymph node candidates

B4two lymph node candidates

two lymph node candidates

B6one lymph node candidate, bisected

one lymph node candidate, bisected B7-

B8two lymph node candidates

B9one lymph node candidate, bisected

greatest dimension and are submitted as follows:

B10one lymph node candidate one lymph node candidate, bisected B12-B13 largest lymph node candidate, bisected C. "Right pelvic nodes", received fresh and placed in formalin is a 12 \times 9 \times 5 cm aggregate of pink-tan fibrofatty tissue dissected for apparent lymph node candidates. Twenty lymph node candidates are identified from 0.4 to 4 cm in

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four lymph node candidates
C1-
         two lymph node candidates
C2-
         three lymph node candidates
iC3-
         two lymph node candidates
·C4-
         two lymph node candidates
C5-
         one lymph node candidate, bisected
C6-
         one lymph node candidate, bisected
C7-
         one lymph node candidate, bisected
C8-
         one lymph node candidate, bisected
C9-
C10-C11 one lymph node candidate, bisected
C12-C13 one lymph node candidate, bisected
C14-C17 largest lymph node candidate, sectioned
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INTRA OPERATIVE CONSULTATION:

A. "Uterus, cervix, bilateral tubes and ovaries:

AF1-2 (0.1 cm into a 2.1 cm) thick myometrium full-thickness, bisected-low grade adenocarcinoma superficially invasive into myometrium (less than one fourth). Can not completely exclude a serous adenocarcinoma

MICROSCOPIC EXAMINATION:

Microscopic examination is performed.

PATHOLOGIC STAGE:

PROCEDURE: HYSTERECTOMY, OOPHORECTOMY & LYMPHADENECTOMY

PATHOLOGIC STAGE (AJCC 6th Edition): pTlb pN0 pMX

NOTE: Information on pathology stage and the operative procedure is transmitted to this Institution's Cancer Registry as required for accreditation by the Commission on Cancer. Pathology stage is based solely upon the current tissue specimen being evaluated, and does not incorporate information on any specimens submitted separately to our Cytology section, past pathology information, imaging studies, or clinical or operative findings. Pathology stage is only a component to be considered in determining the clinical stage, and should not be confused with nor substituted for it. The exact operative procedure is available in the surgeon's operative report.

DIAGNOSIS:

A. UTERUS: 116 GRAMS

ENDOMETRIUM:

TUMOR SITE: ANTERIOR WALL

HISTOLOGIC TYPE: ENDOMETRIOID ADENOCARCINOMA.

FIGO GRADE: (1)

TUMOR SIZE: 6 X 4.5 X 1.3 CM.

MAXIMUM DEPTH OF MYOMETRIAL INVASION: 0.1 CM, IN A 2.1 THICK WALL.

LYMPHATIC/VASCULAR INVASION: NEGATIVE

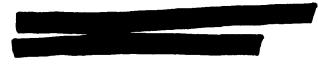
ADJACENT NON-NEOPLASTIC ENDOMETRIUM: ATROPHIC

REMAINING MYOMETRIUM: ADENOMYOSIS CERVIX: NO PATHOLOGIC DIAGNOSIS. SEROSA: NO PATHOLOGIC DIAGNOSIS. SPECIMEN MARGINS: NOT INVOLVED

THE FOLLOWING SPECIMENS ARE FREE OF TUMOR:

- A. OVARIES AND FALLOPIAN TUBES, BILATERAL: NO PATHOLOGIC DIAGNOSIS.
- B. LEFT PELVIC LYMPH NODES: NO TUMOR IN 24 LYMPH NODES (0/24).
- C. RIGHT PELVIC LYMPH NODES: NO TUMOR IN 22 LYMPH NODES (0/22).

I certify that I personally conducted the diagnostic evaluation of the above specimen(s) and have rendered the above diagnosis(es).



CI ADDENDUM 1: