



Operative Procedure:

DA Vinci radical hysterectomy, lymph node dissection.

Pre-Operative Diagnosis:

Cervical cancer.

Post-Operative Diagnosis:

Cervical cancer

Specimen Received:

- A: Right internal iliac SLN
- B: Left obturator SLN (FS)
- C: Right pelvic LN
- D: Left pelvic LN
- E: Uterus, cervix

Immunohistochemical

Interpretation

Immunostains performed on sections A1, A2, B1 and B2 are negative with appropriate controls.

Final Pathologic Diagnosis:

- A: Right internal iliac sentinel lymph node, excision:  
Two lymph nodes, negative for tumor (0/2). See Note.
- B: Left obturator sentinel lymph node, excision:  
One lymph node, negative for tumor (0/1). See Note.  
Frozen section diagnosis confirmed.
- C: Right pelvic lymph node, excision:  
Five lymph nodes, negative for tumor (0/5).
- D: Left pelvic lymph node, excision:  
Six lymph nodes, negative for tumor (0/6).
- E: Uterus, cervix, hysterectomy:  
Poorly differentiated squamous cell carcinoma.

Specimen: Cervix, Uterine corpus, portion of Vagina  
Procedure: Radical hysterectomy  
Tumor site: Ectocervix

ICD O-3

Carcinoma, squamous cell NOS  
8070/3

Site Cervix NOS  
C53.9

JW 3/8/14

Tumor size: 3.0 x2.5 x1.5 cm  
Histologic Type: Squamous cell carcinoma  
Histologic Grade: High (poorly differentiated)  
Margins: Margins uninvolved by invasive carcinoma  
If uninvolved, distance of invasive carcinoma from closest margin  
(peri-ectocervical soft tissue): 0.6 cm  
Parametria: Uninvolved by invasive carcinoma  
Vagina: Uninvolved by invasive carcinoma  
Lymph-Vascular Invasion: Absent  
Pathologic Staging (pTNM [FIGO]):  
TNM Descriptors (select all that apply): none known  
Primary Tumor (pT): pT1b  
Regional Lymph Nodes (pN): pNo  
Number examined: 15  
Number involved: 0  
Distant Metastasis (pM): pMX  
Additional Pathologic Findings: Inactive endometrium

The examination of this case material and the preparation of this report were performed by the staff pathologist.

**Note:**

CK AE1/AE3 immunostains are pending. An addendum report will follow.

**Intraoperative Consult Diagnosis:**

FSB: Left obturator sentinel lymph node:

One lymph node negative for metastatic tumor.

F/S TAT: 15 mins.

**Gross Description:**

The specimens are received in five containers labeled with the patient's name,

Part A is received in formalin labeled "right internal iliac" and consists of a portion of yellow-tan fibroadipose tissue that is 2.5 x 1.2 x 0.5 cm. Sectioning reveals two possible lymph nodes, 0.8 and 1 cm in greatest dimension. These lymph nodes are each sectioned at 3 mm intervals and entirely submitted separately in cassettes A1 and A2.

Part B is received fresh for frozen section labeled "left obturator sentinel lymph node, FSB+X" and consists of an aggregate of yellow-tan fibroadipose tissue, 2 x 1.5 x 0.5 cm. A representative portion is submitted in toto for frozen section microscopy.

The specimen is entirely submitted as follows:

- B1 residual frozen section tissue;
- B2 remaining specimen.

Part C is received in formalin labeled "right pelvic lymph node" and consists of

a portion of yellow-tan fibroadipose tissue, 5.5 x 3 x 1.8 cm. Sectioning reveals a few lymph nodes that range from 0.6 cm up to 6.5 cm.

These lymph nodes are entirely submitted as follows:

- C1 multiple whole lymph nodes;
- C2 one lymph node sectioned;
- C3-4 one lymph node sectioned.

Part D is received in formalin labeled "left pelvic lymph nodes" and consists of a portion of yellow-tan fibroadipose tissue, 5 x 3 by up to 2 cm. Sectioning reveals a few lymph nodes ranging from 0.6 to 2.5 cm.

These lymph nodes are entirely submitted as follows:

- D1 multiple whole lymph nodes;
- D2 one lymph node trisected;
- D3 one lymph node bisected;
- D4 one lymph node bisected.

Part E is received fresh and subsequently placed in formalin labeled "uterus and cervix" and consists of a uterus and cervix received with attached vaginal cuff. The specimen has a weight of 149 grams and overall dimensions of 9 x 7 by up to 3.5 cm. The specimen is received with attached bilateral parametrial soft tissues. The paracervical and parametrial tissues are inked.

The serosal surfaces of the specimen are purple-tan and predominantly smooth. The surface of the vaginal cuff is purple-tan, wrinkled. The ectocervix is remarkable for a gray-white, ill defined mass that has dimensions of 3 x 2.5 cm. This mass surrounds the cervical os that is patent with a greatest dimension of 1.5 cm. Upon sectioning, the aforementioned mass on the ectocervix extends into the endocervical canal with the third dimension being 1.9 cm. The mass appears to be confined to the endocervical canal and does not appear to extend to the lower uterine segment. The mass is at least 1 cm from the vaginal cuff margin. The cut surface of the mass is tan-white, firm and granular.

Sectioning through the uterine corpus reveals a pink-tan trabeculated myometrium that has a thickness of 2.4 cm. The endometrial cavity has the usual configuration and is lined by pink-tan, glistening endometrium with a thickness up to 0.3 cm.

Sectioning through the right parametrial tissues reveals no definitive lymph nodes.

Sectioning through the left parametrial soft tissue reveals one possible lymph node, 0.4 cm.

No adnexal structures are present.

Representative sections are submitted as follows:

- E1 vaginal cuff margin en face (12 to 3 o'clock);

- E2 vaginal cuff margin en face (3 to 6 o'clock);
- E3 vaginal cuff margin en face (6 to 9 o'clock);
- E4 vaginal cuff margin en face (9 to 12 o'clock);
- E5 cervical mass at 12 o'clock;
- E6 cervical mass at 3 o'clock;
- E7 cervical mass at 9 o'clock;
- E8 cervical mass at 6 o'clock;
- E9 anterior lower uterine segment;
- E10 posterior lower uterine segment;
- E11 anterior endomyometrium;
- E12 posterior endomyometrium;
- E13-16 entirety of right side of parametrial soft tissues;
- E17 one possible lymph node from left parametrial soft tissues;
- E18-21 entirety of left parametrial soft tissues.

**Microscopic Description:**

The final diagnosis of each specimen incorporates the microscopic examination findings.

**END OF REPORT**

**Surgical Pathology Report**

\* Procedure/Addenda present \*

Taken:            DOB:            (Age:    ) Gender: F

Cr#	12/17/13	Yes	No
Diagnosis Discrepancy			/
Primary Tumor Site Discrepancy			/
HIPAA Discrepancy			/
Prior Malignancy History			/
Dual/Synchronous Primary			/
Case is (circle):	QUALIFIED	DISQUALIFIED	
Reviewer Initials	DATE	Date Reviewed:	12/4/13