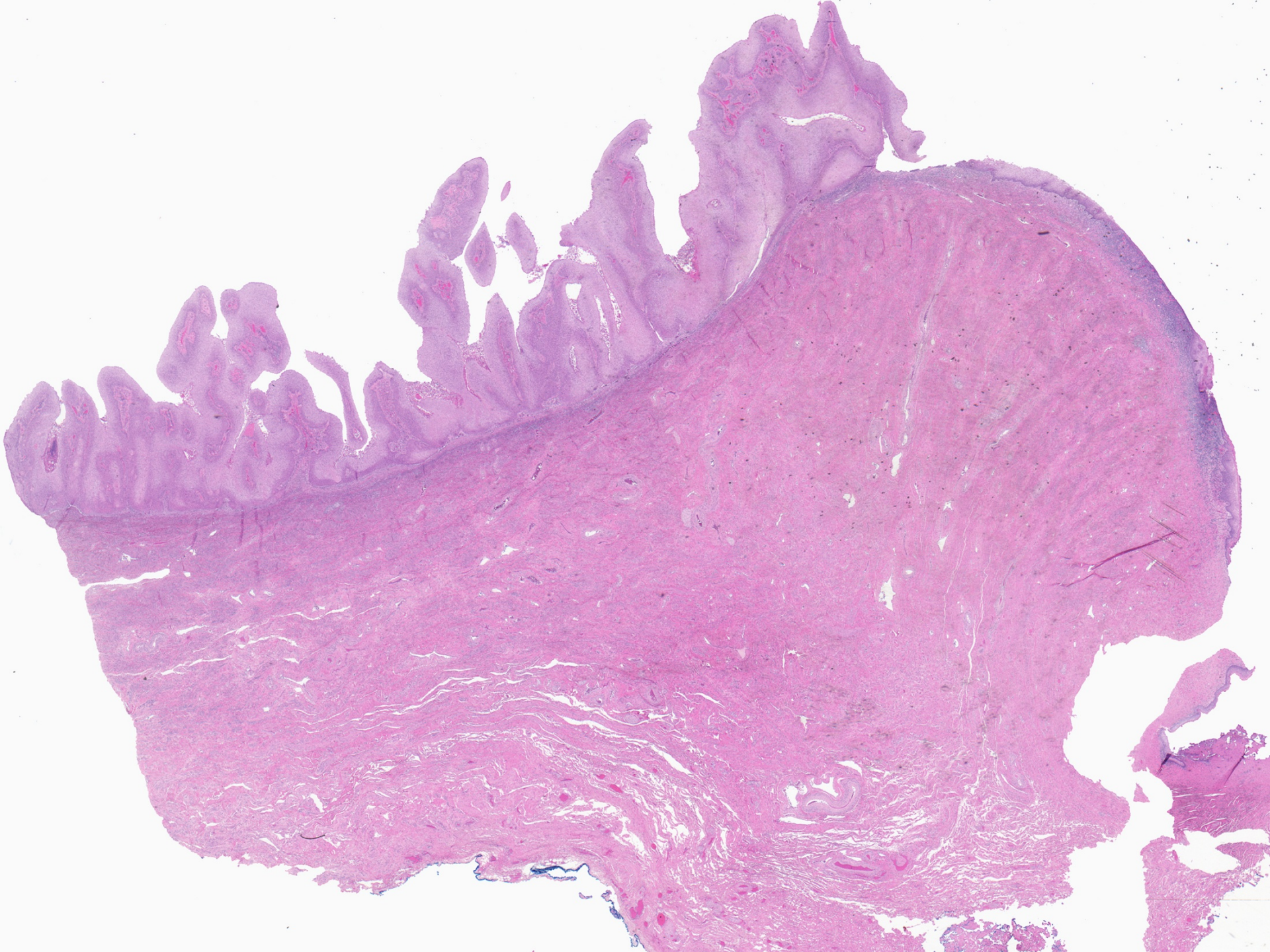
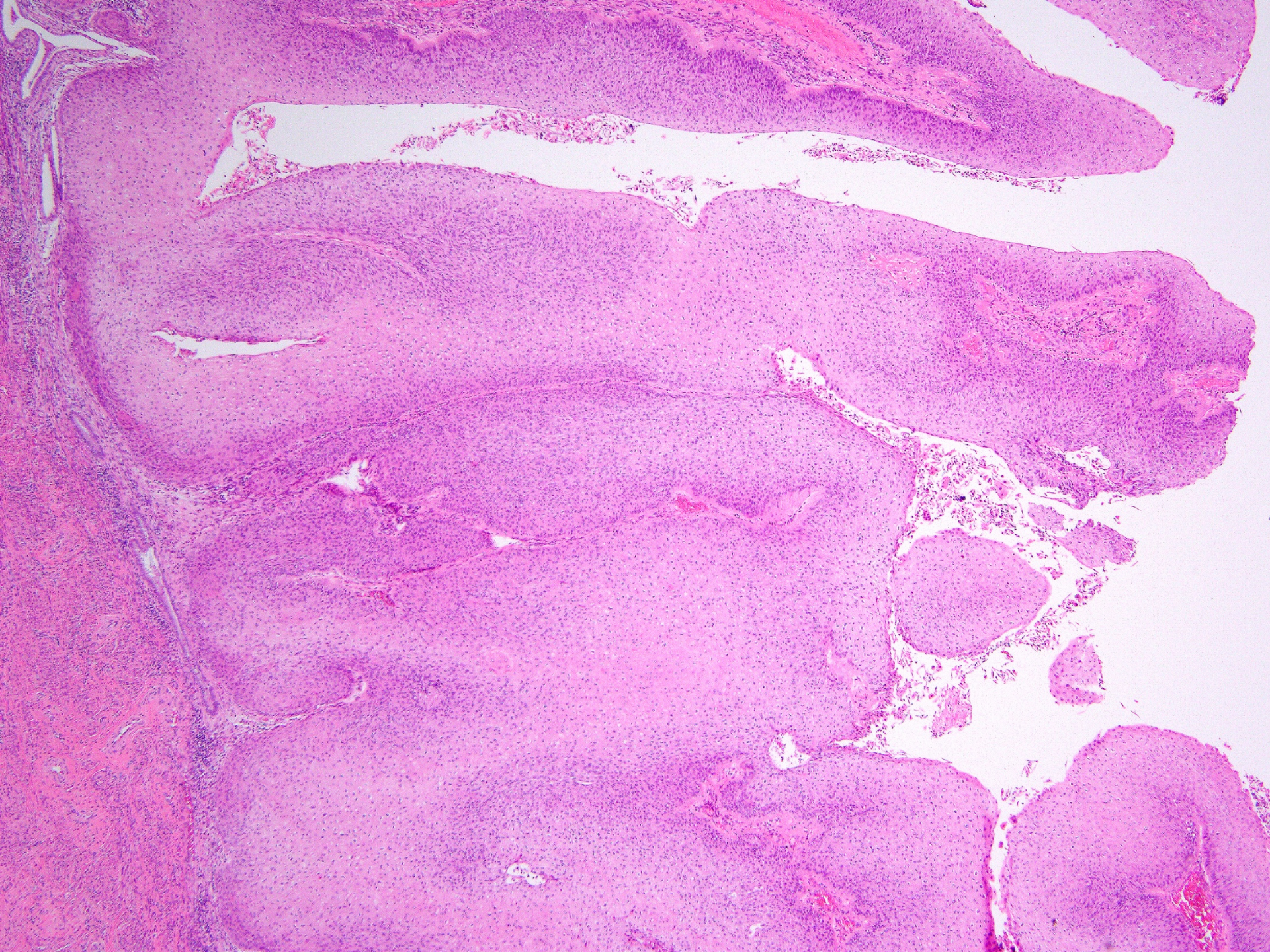
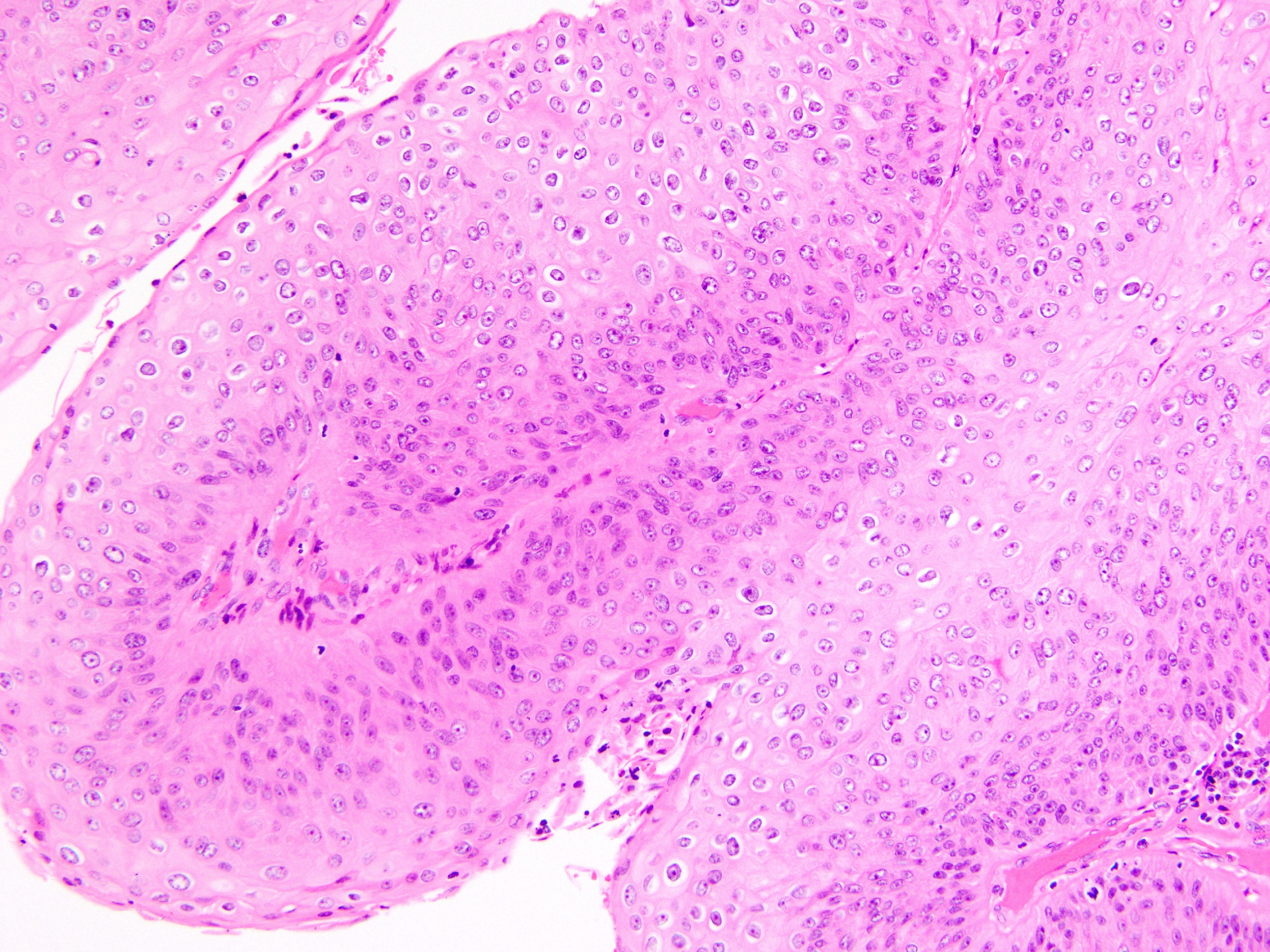
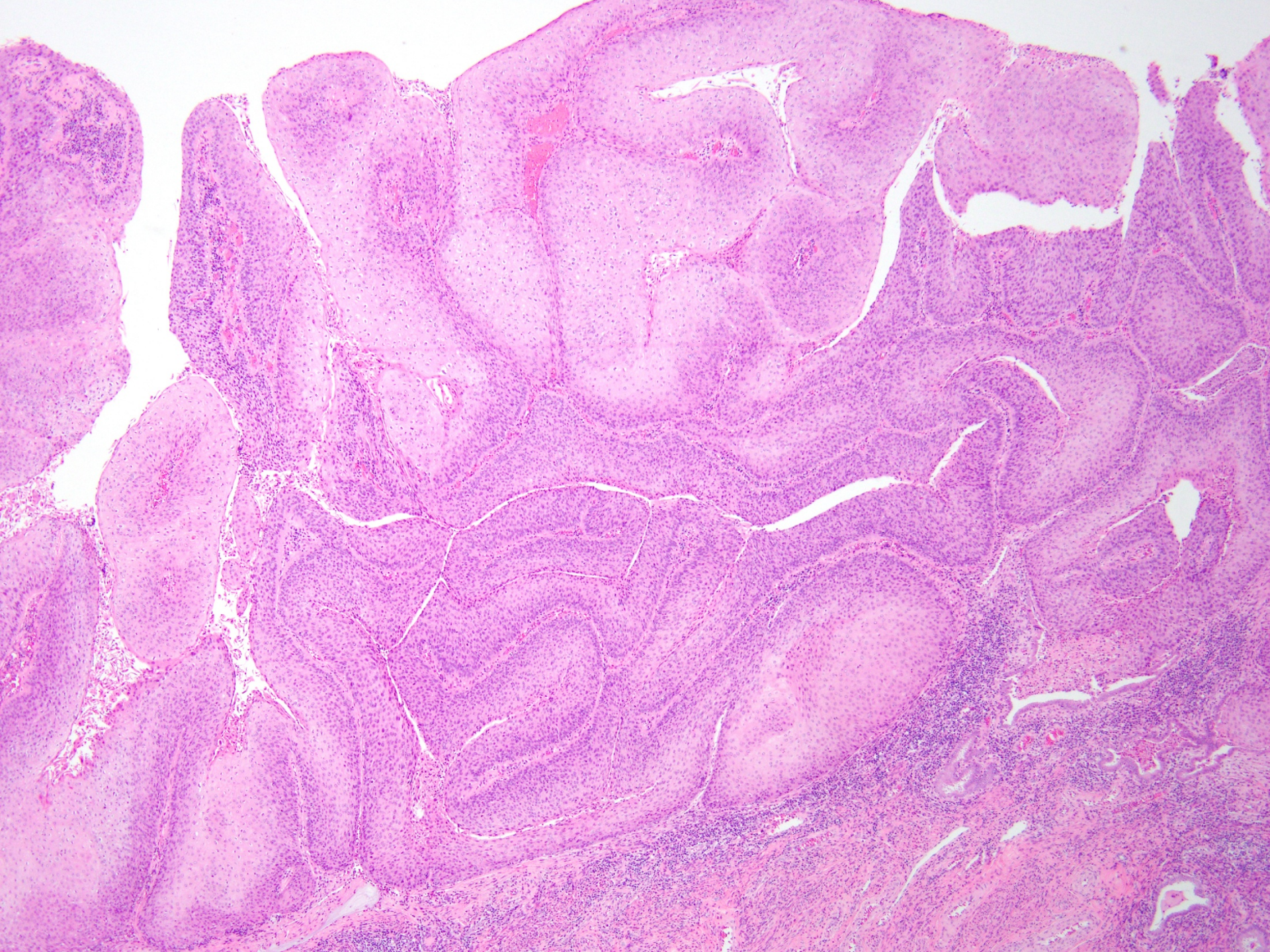
CASE 1

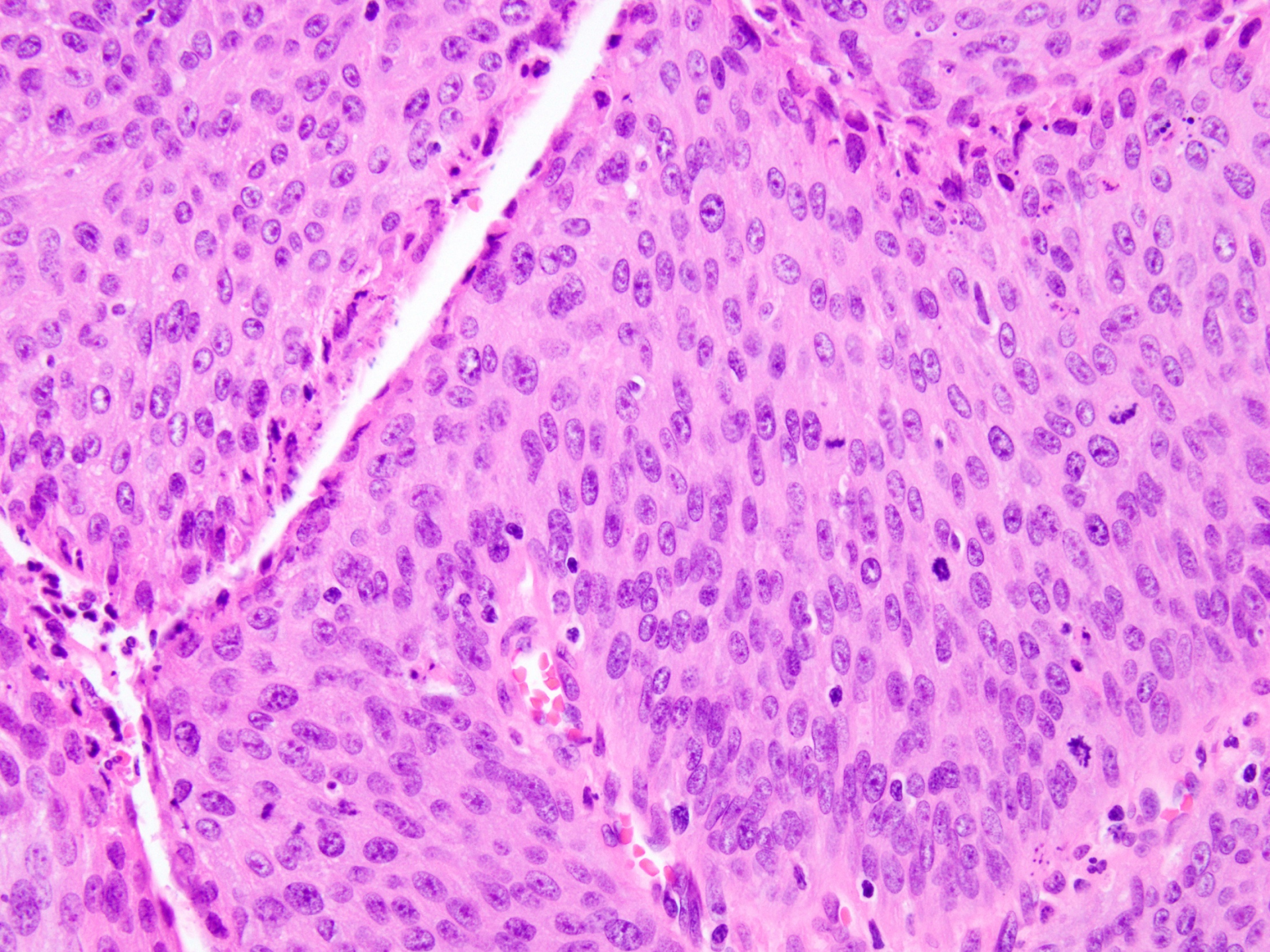
- A 56 year old woman was diagnosed with papillary squamous cell carcinoma on prior cervical biopsy (slides not available for review). Hysterectomy shows a tan, papillary mass (3.5 cm) involving the cervical os and endocervical canal and “extending” 0.2 cm into underlying cervical stroma.

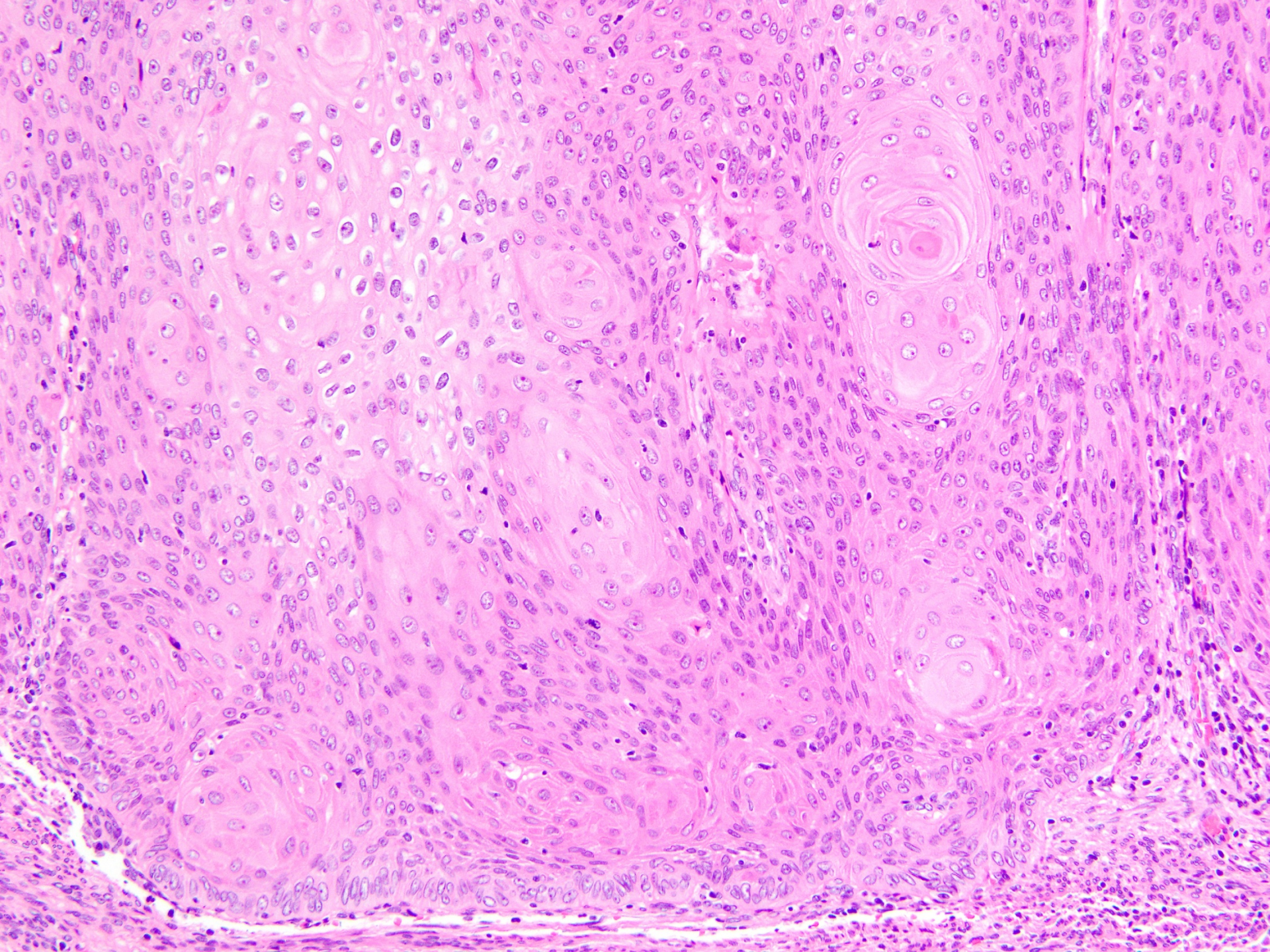






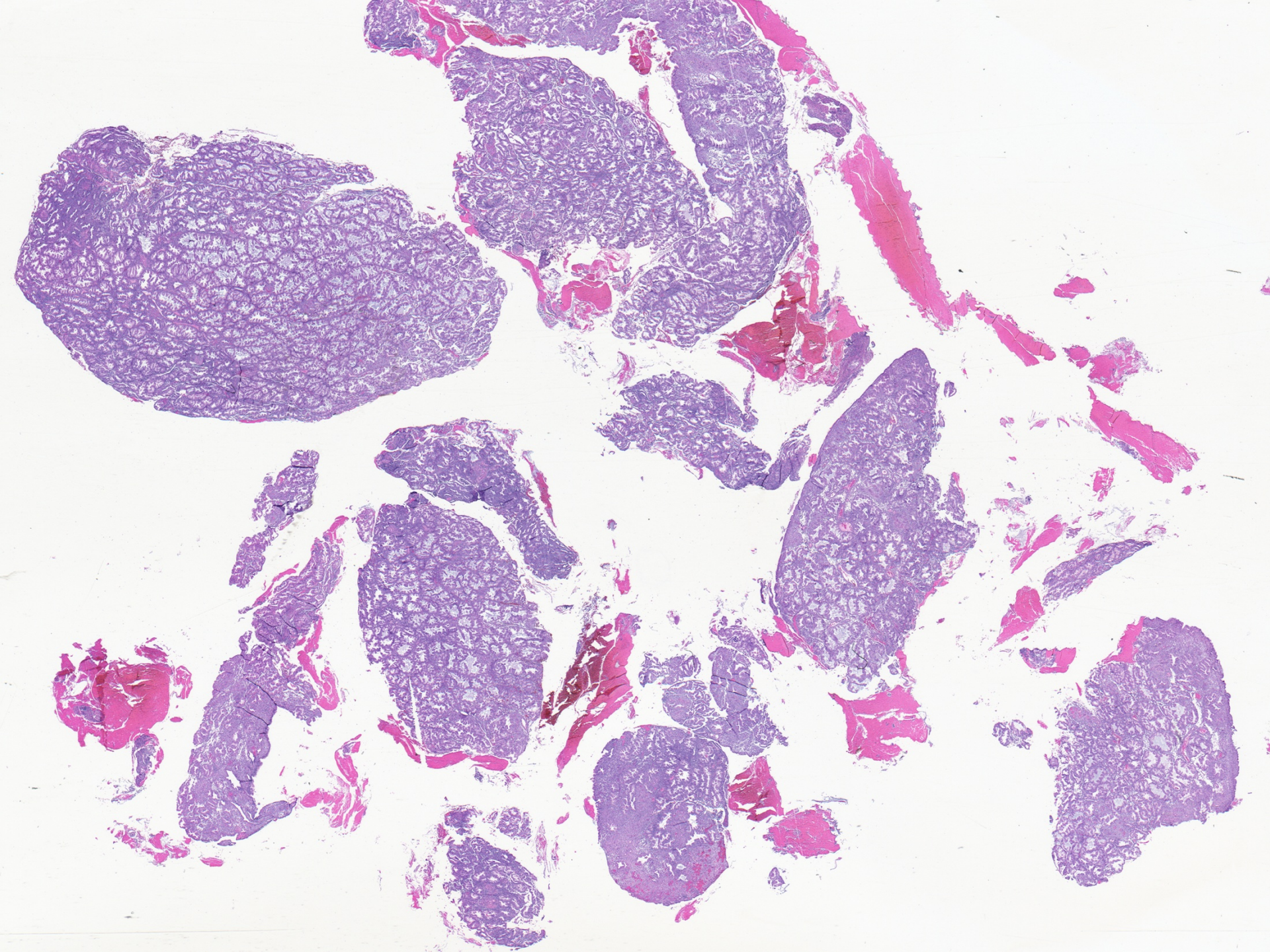


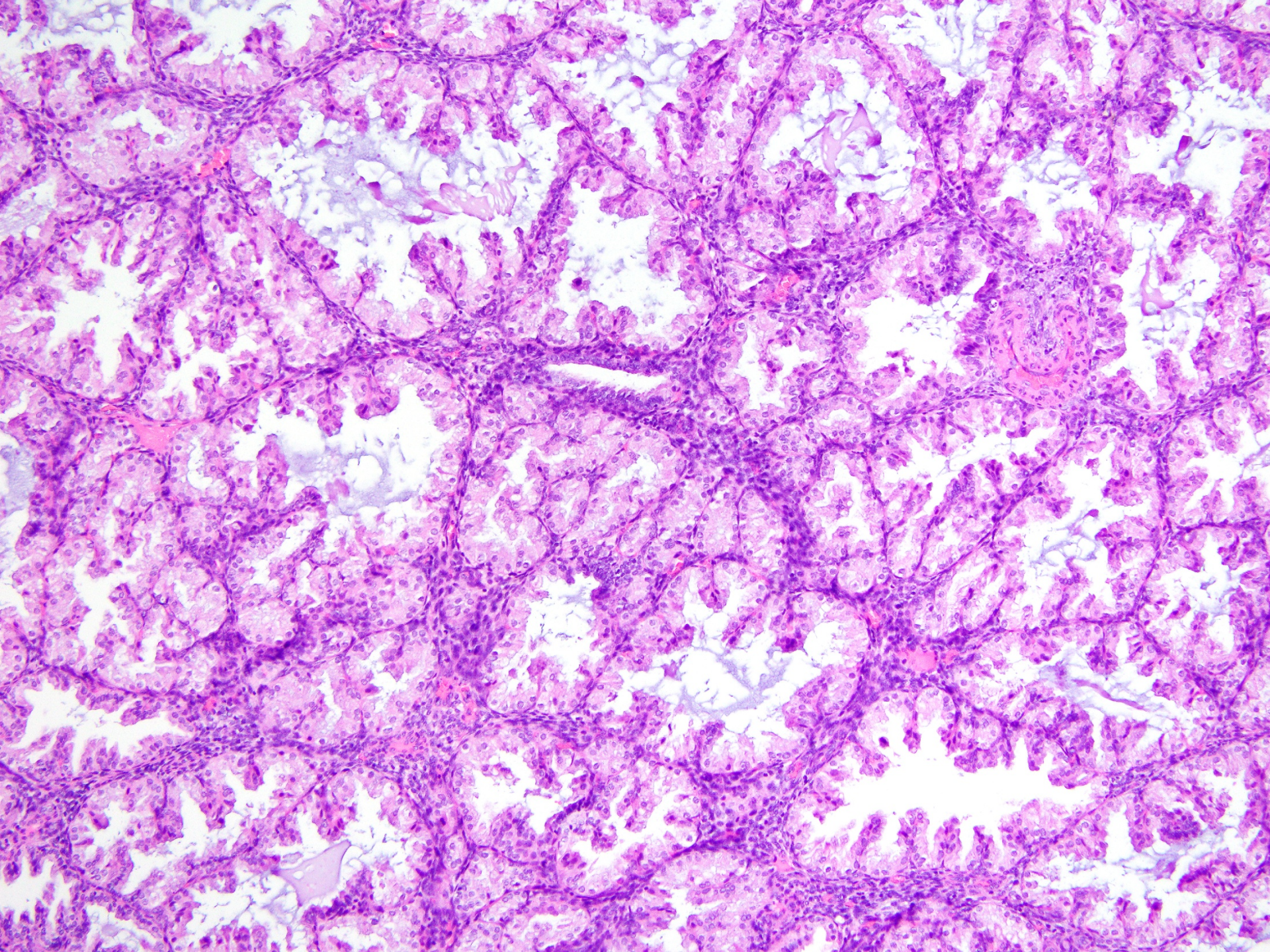


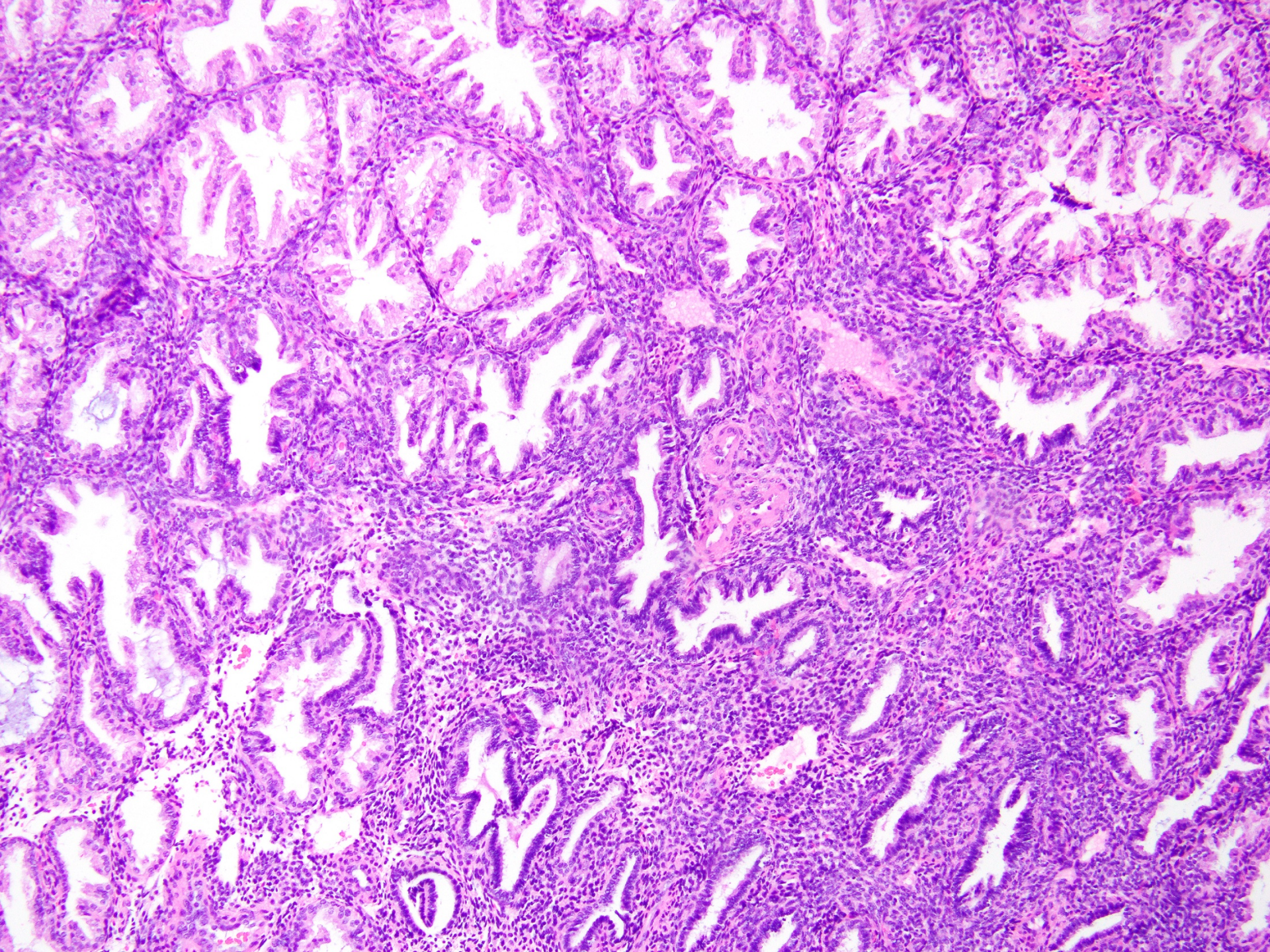


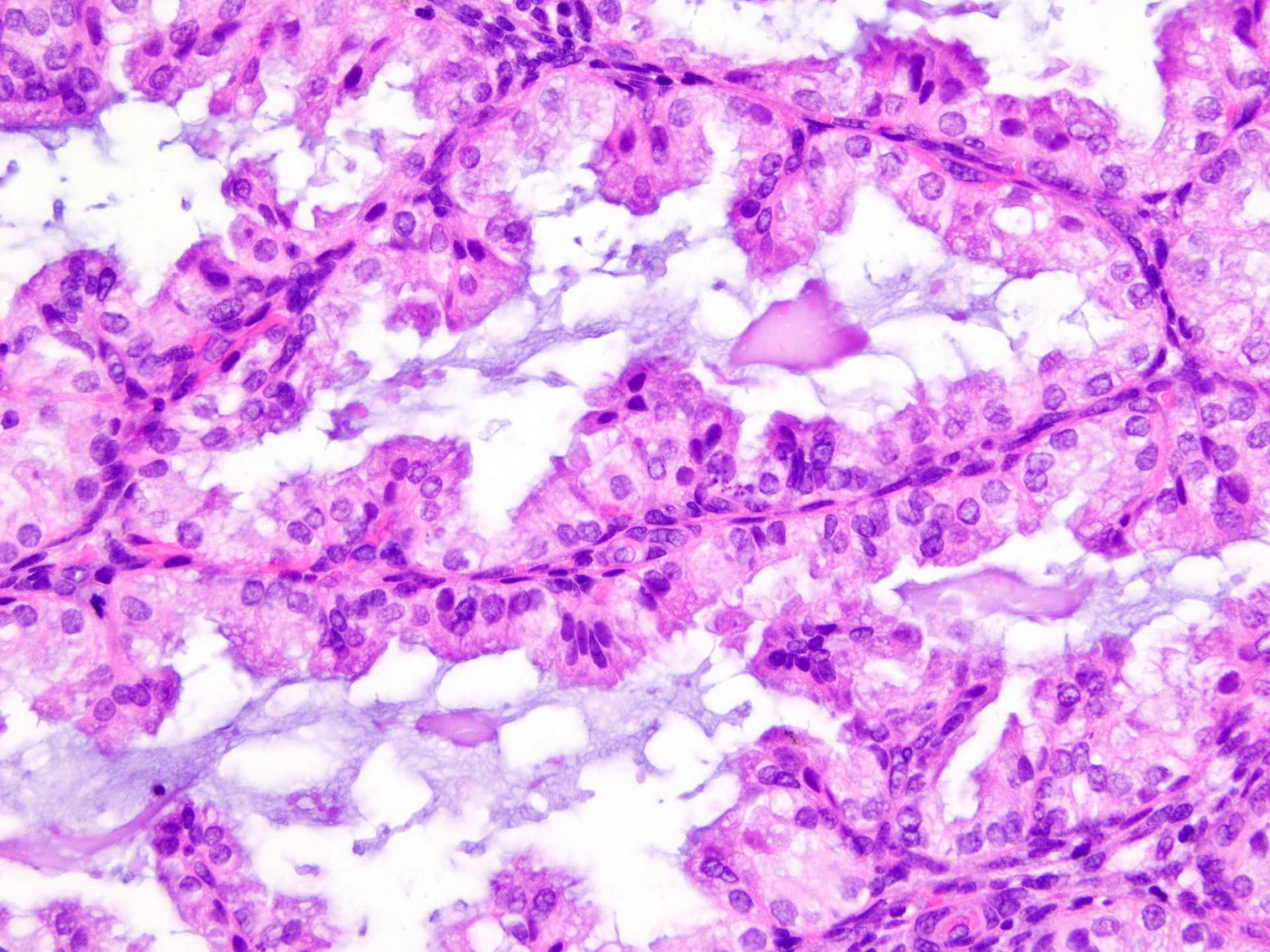
CASE 2

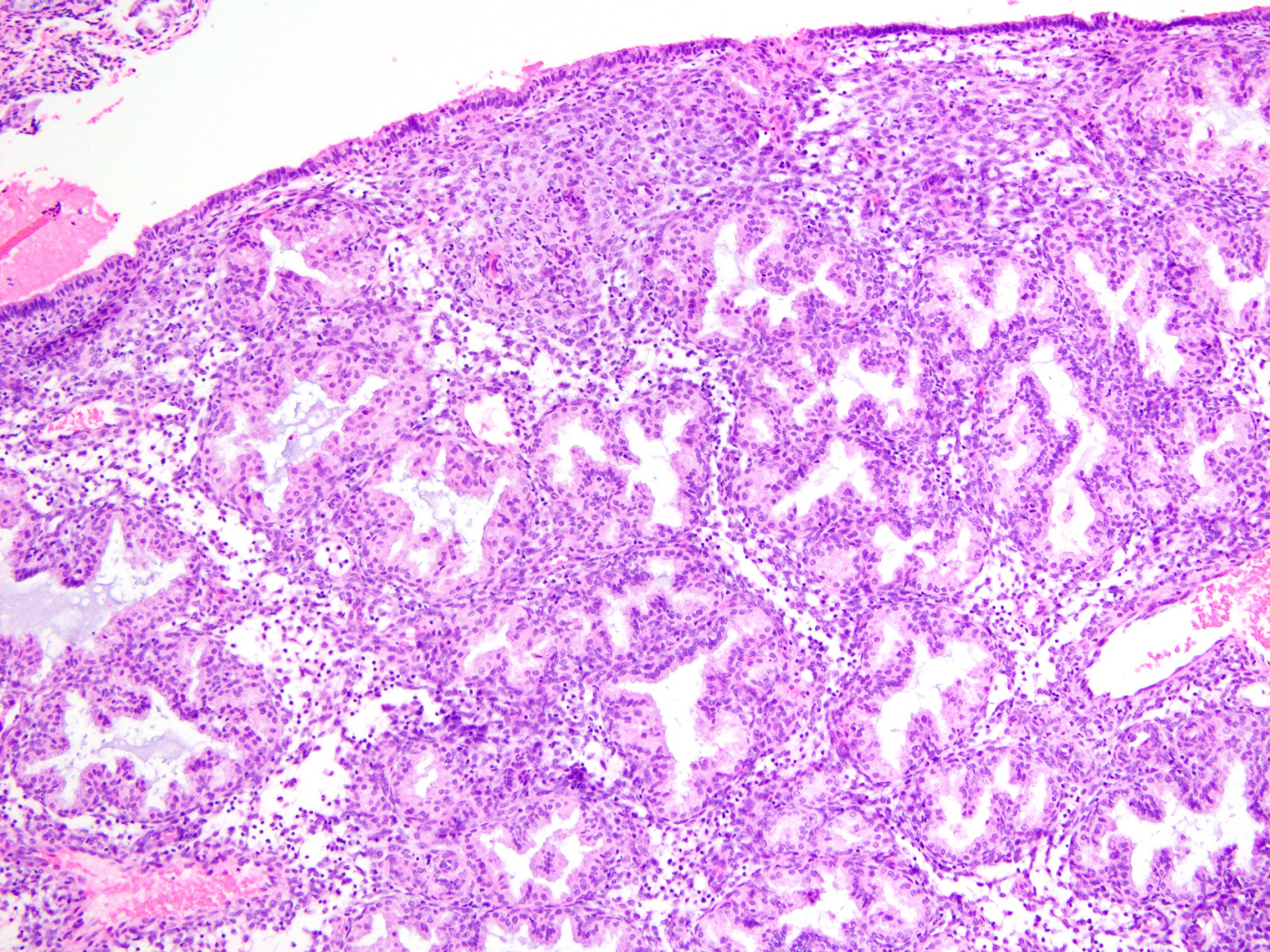
- A 33 year old woman presents with abnormal uterine bleeding. She has a history of infertility and previously removed endometrial polyps.





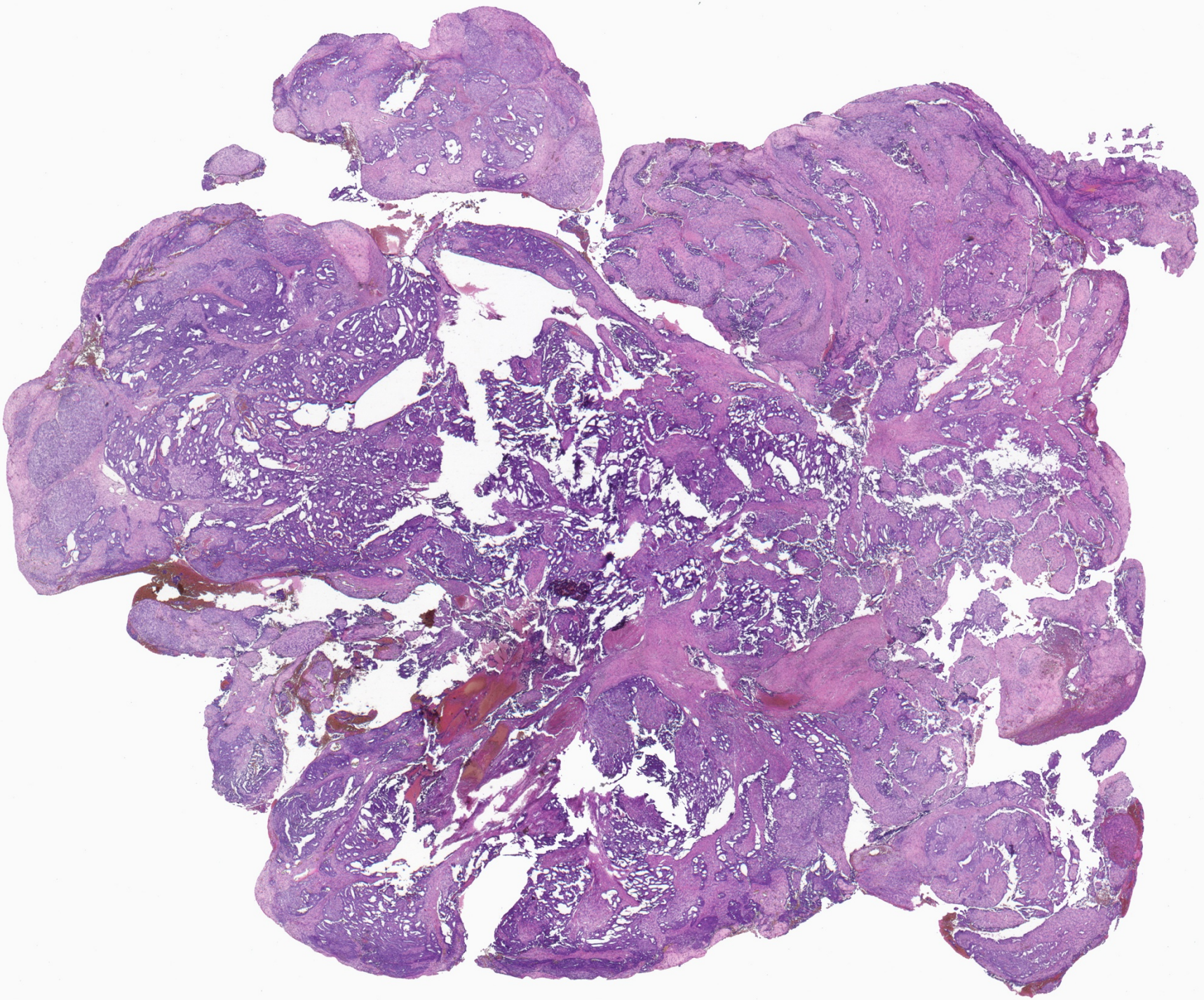


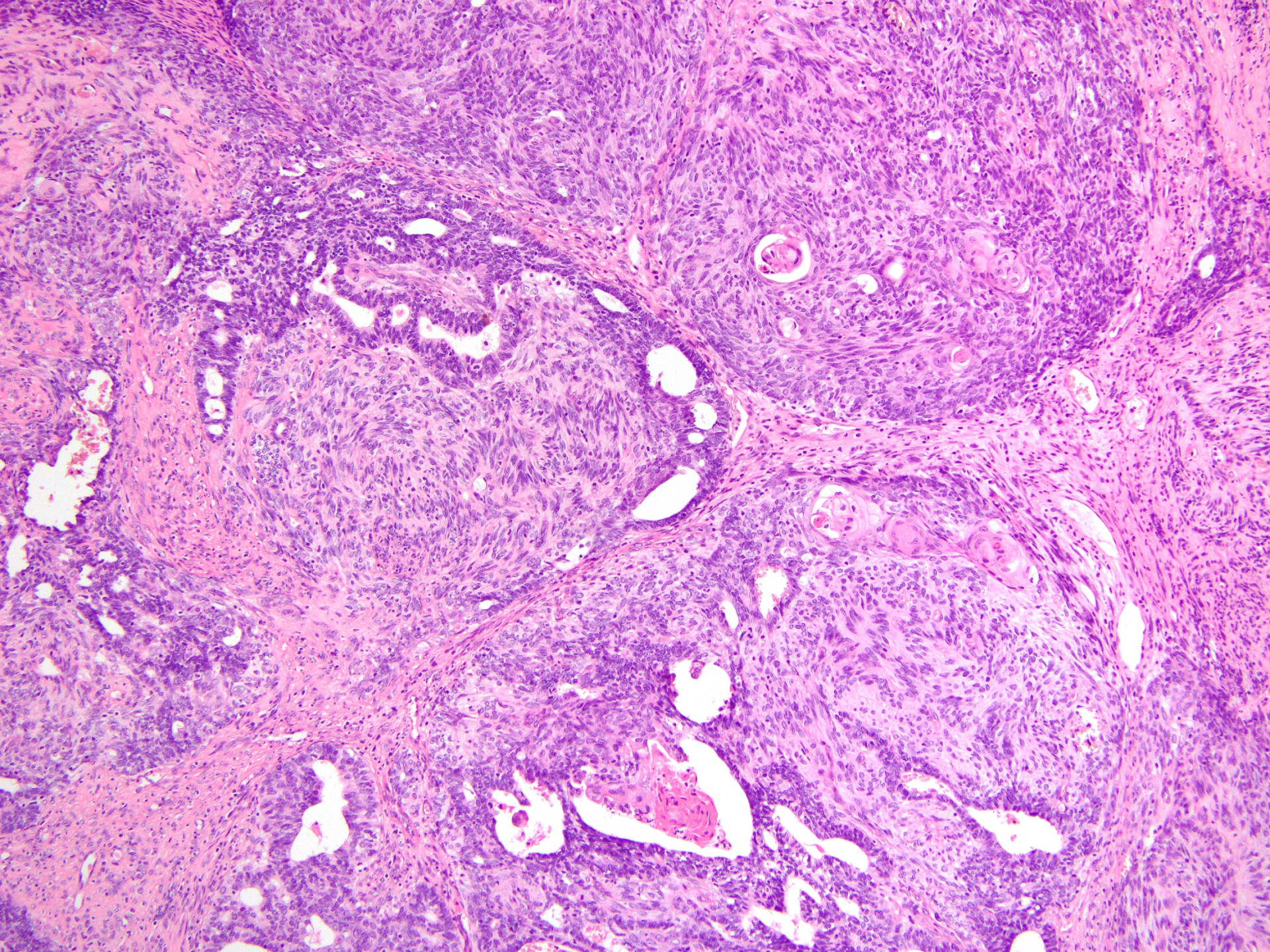


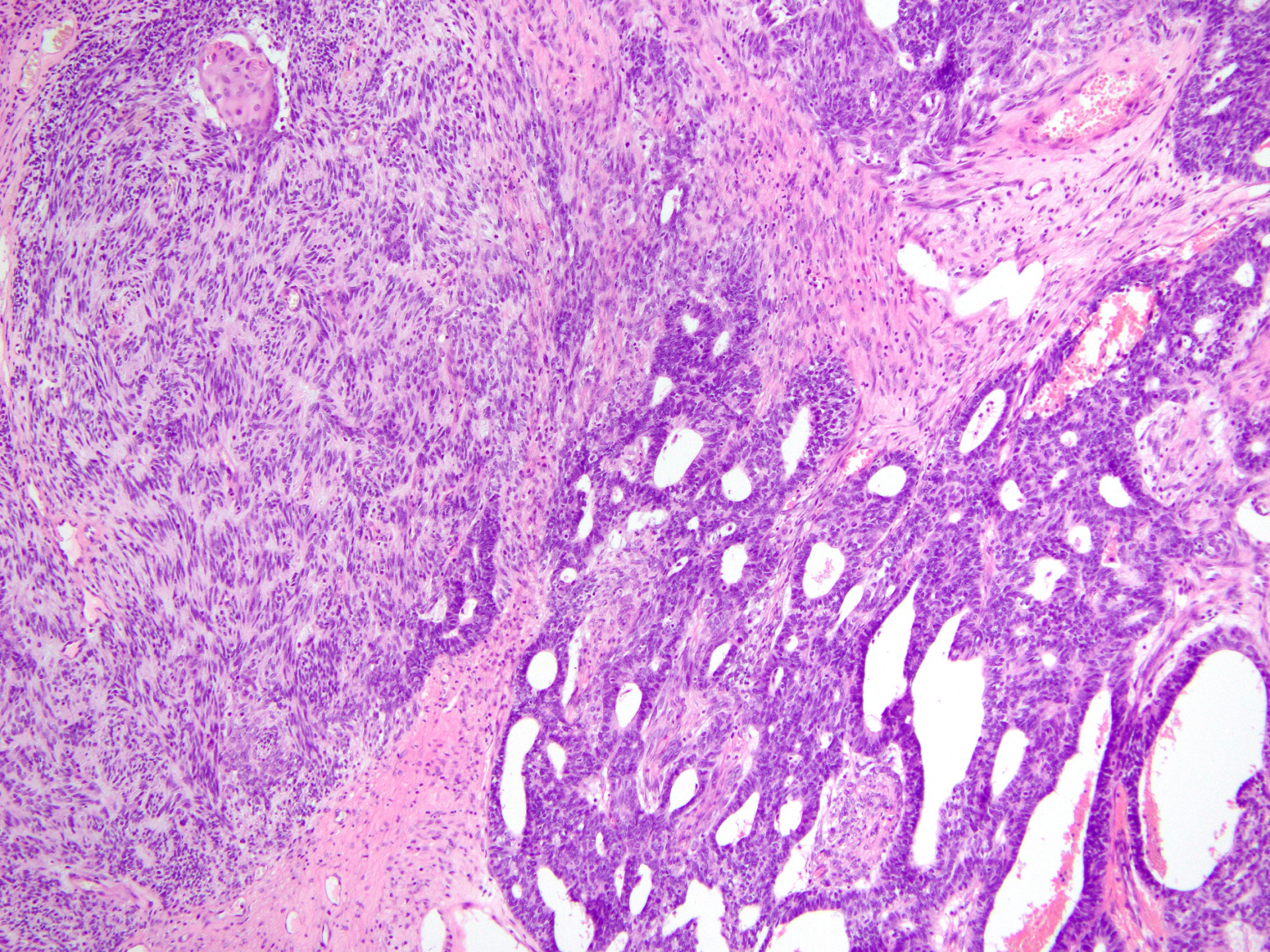


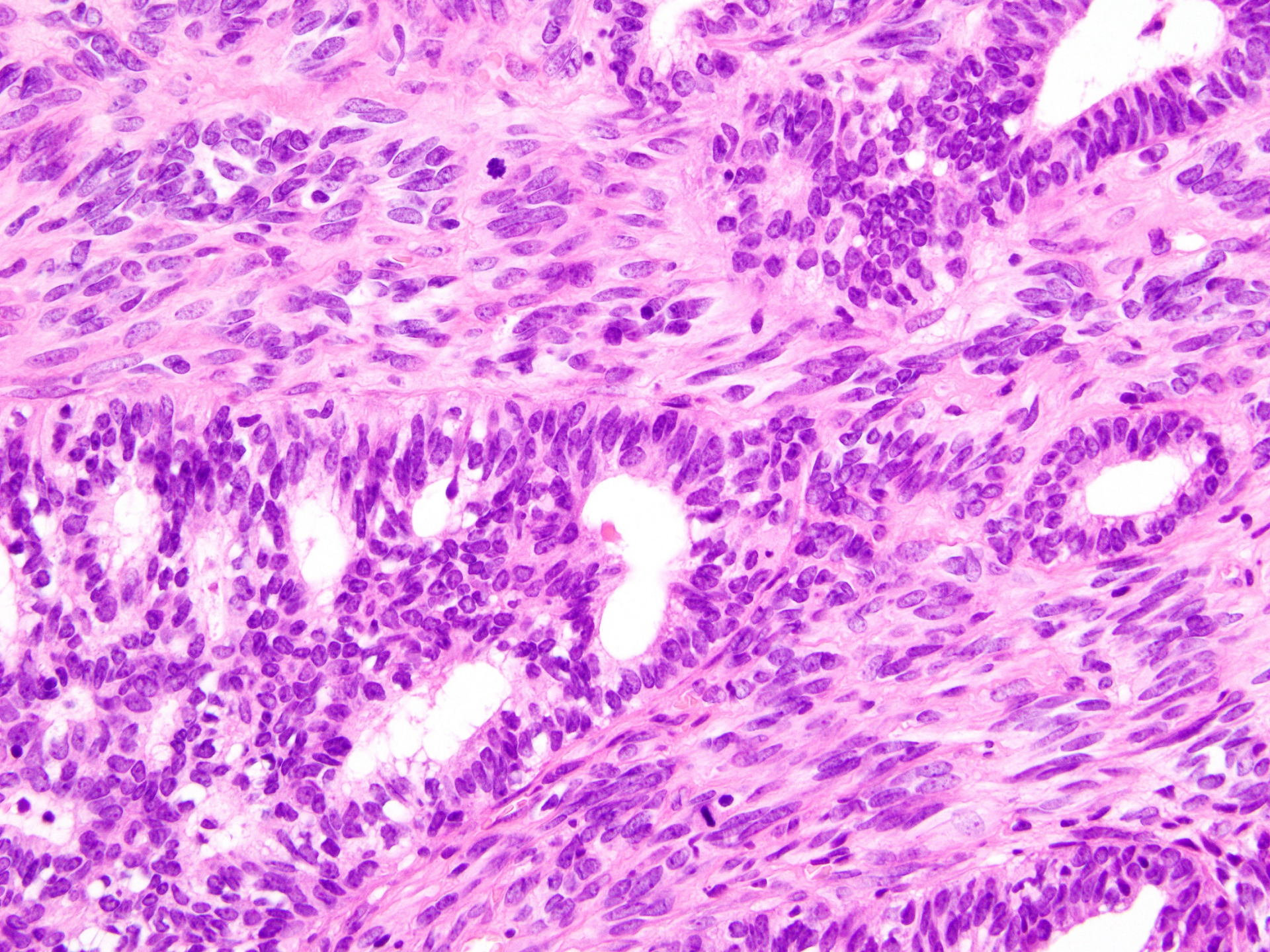
CASE 3

- A 50 year old woman with a history of DVT/PE s/p IVC filter being treated with anticoagulant therapy was admitted with heavy vaginal bleeding. Pelvic examination revealed a barrel cervix and features concerning for parametrial invasion. Pelvic CT demonstrated a 10.5 cm cervical mass, a thickened heterogeneous endometrial stripe and pelvic sidewall lymphadenopathy. A biopsy of the cervical mass was performed.



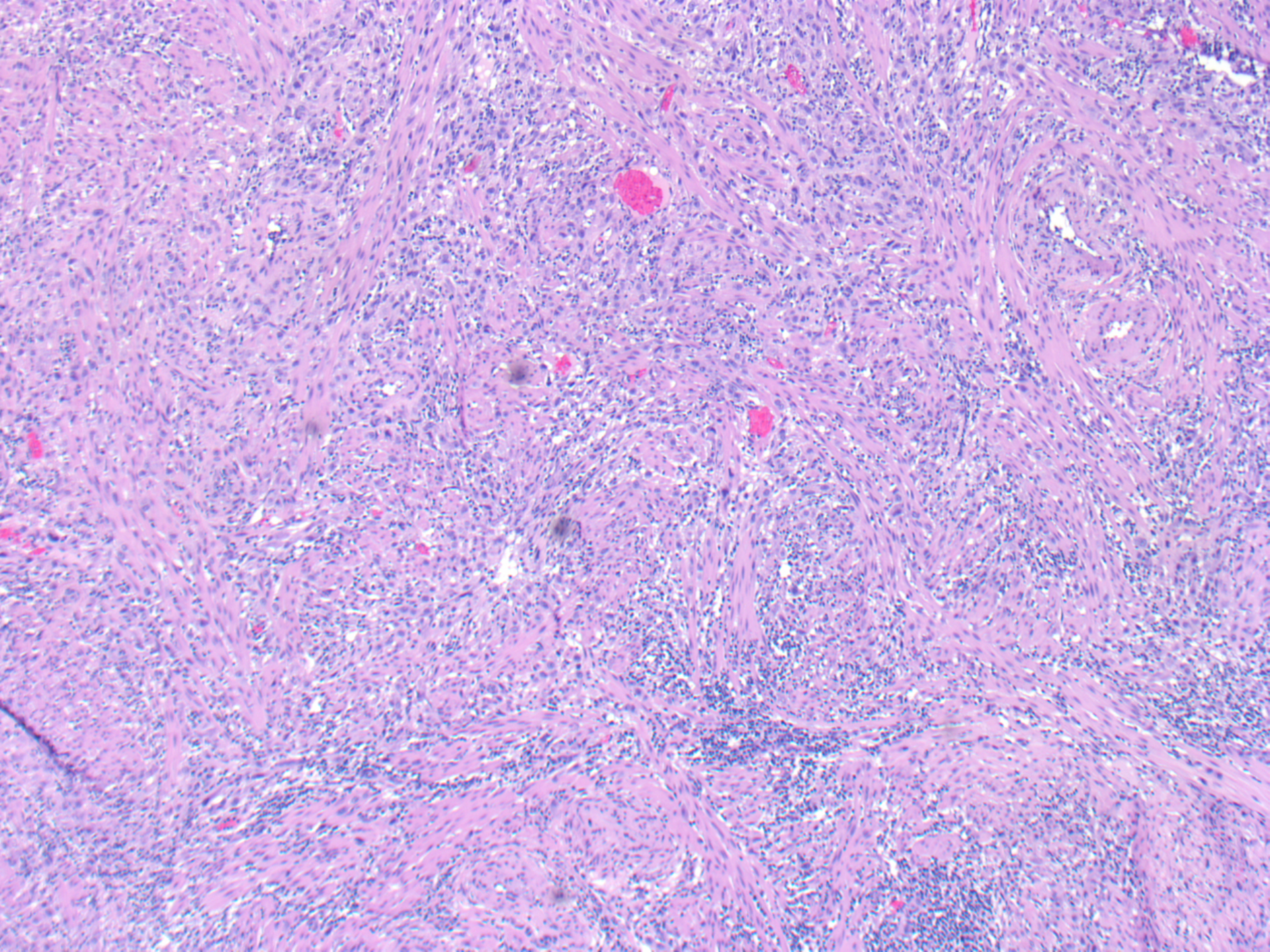


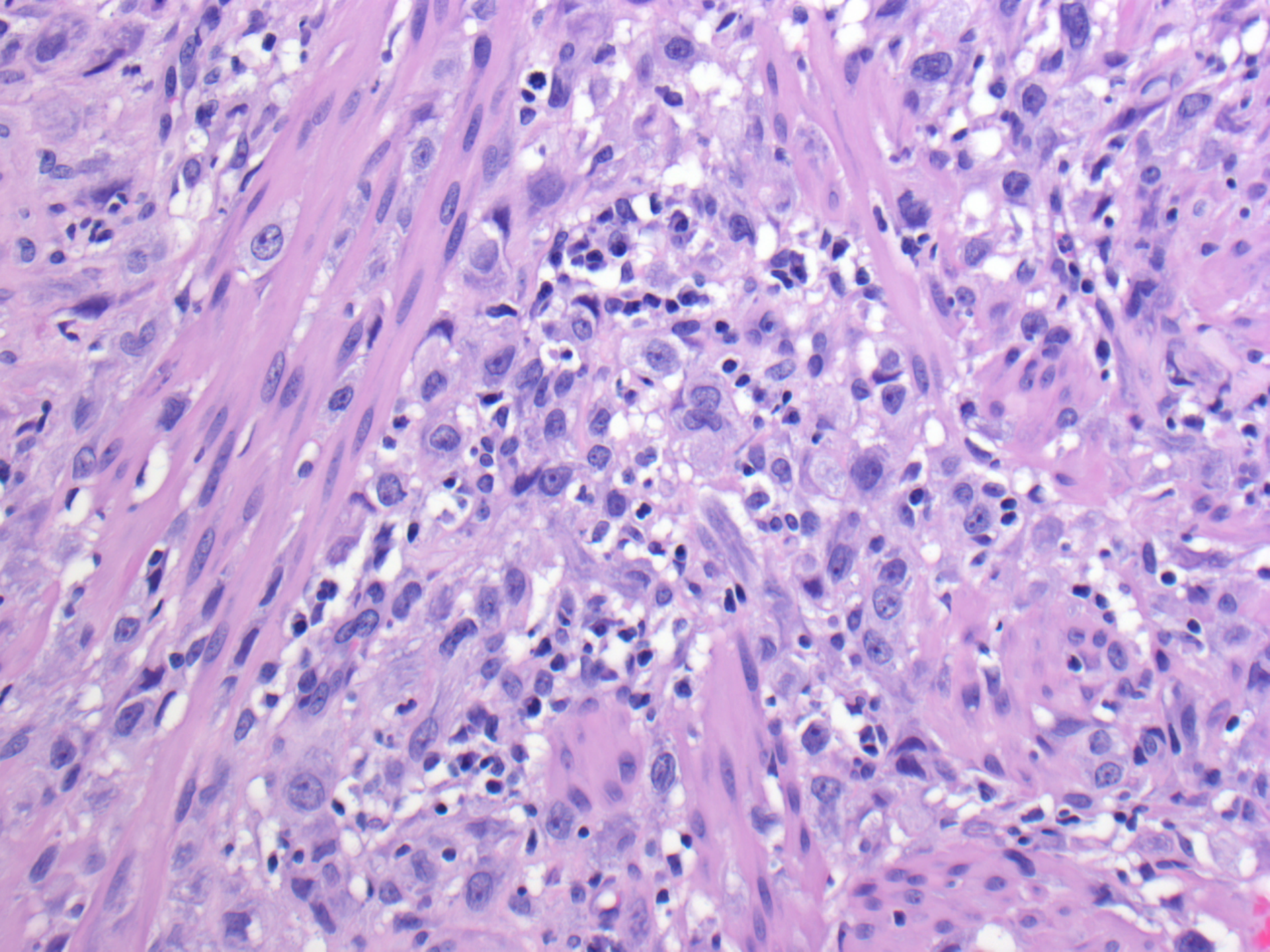


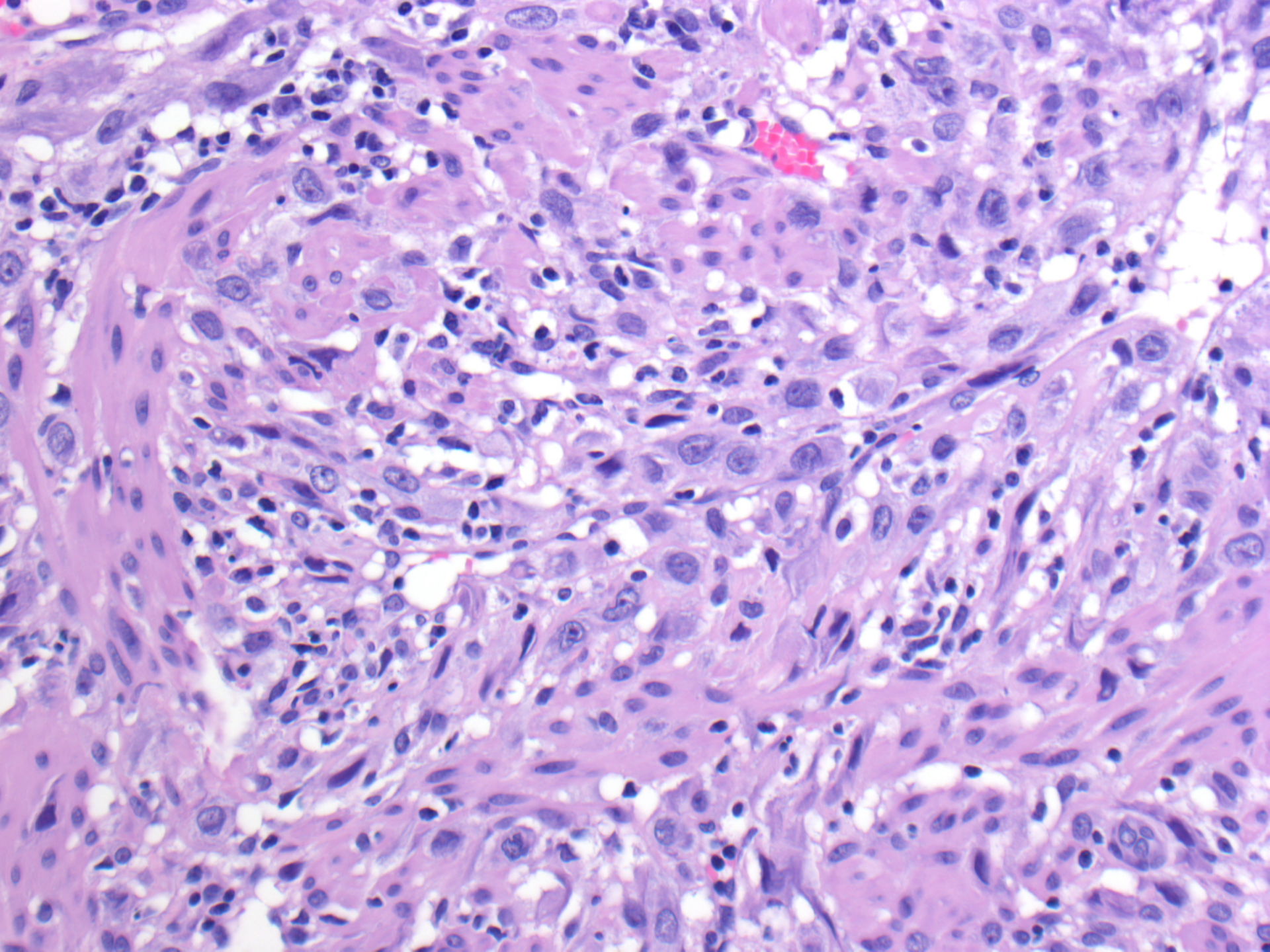


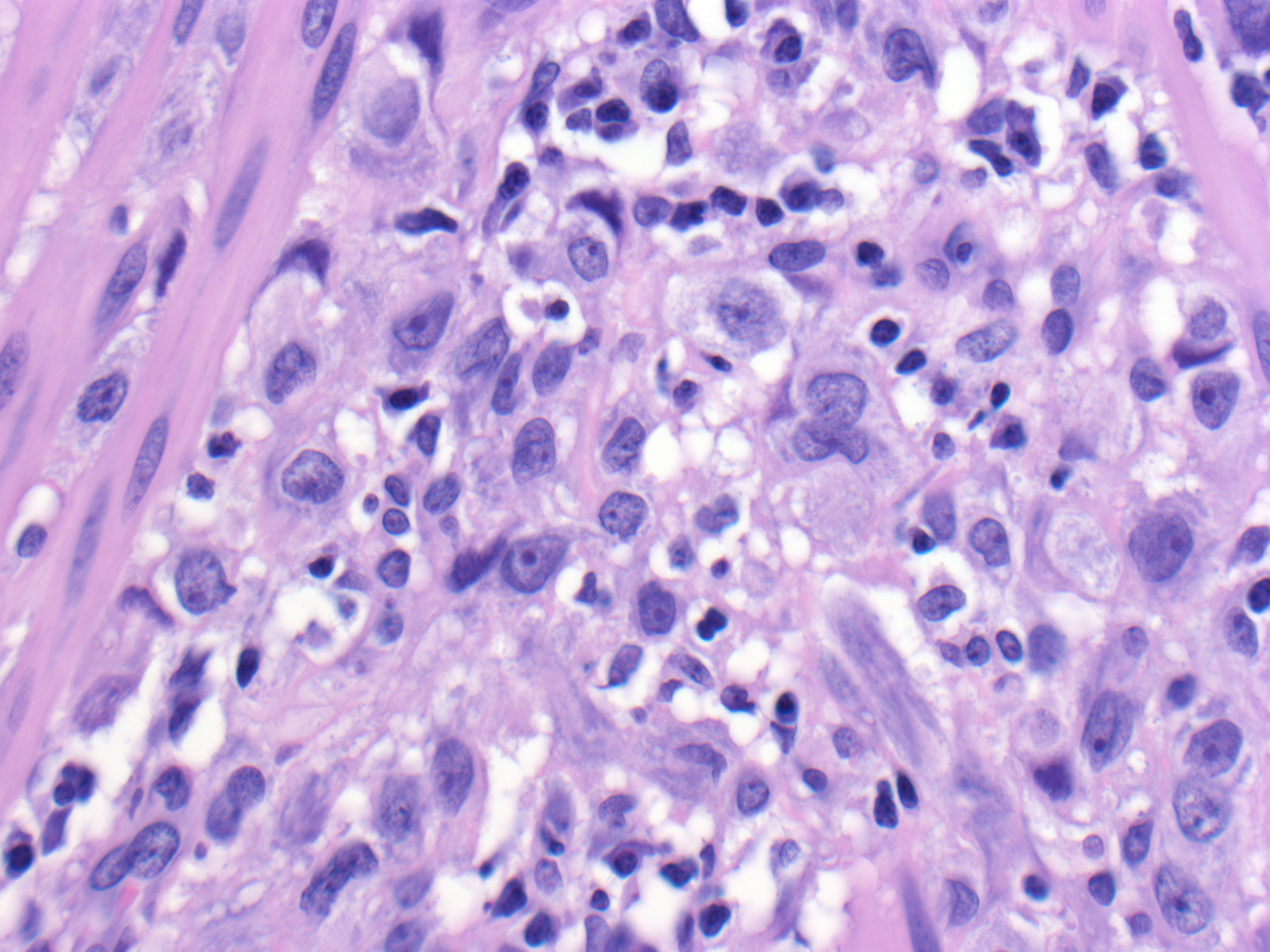
Case 4

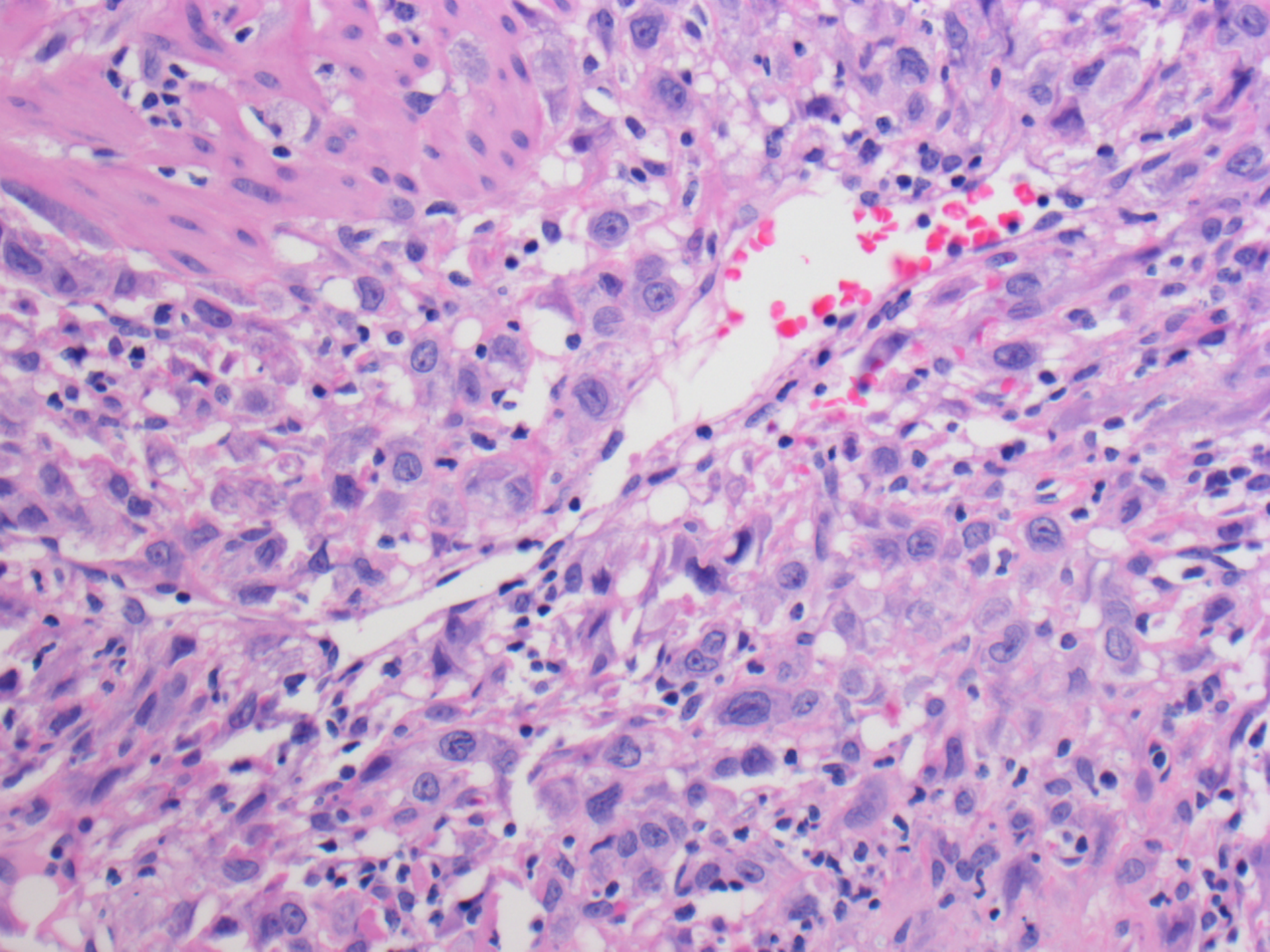
The patient is a 36 year old woman with a missed abortion. A dilatation and curettage was performed. The pathologist received a 6 x 4 x 2 cm aggregate of gray tan tissue and some spongy appearing tissue. No fetal tissue was identified. The clinician was concerned about the possibility of a hydatidiform mole and the pathologist was concerned about the solid tissue fragments. (Courtesy of Steven D. Demartini, MD)

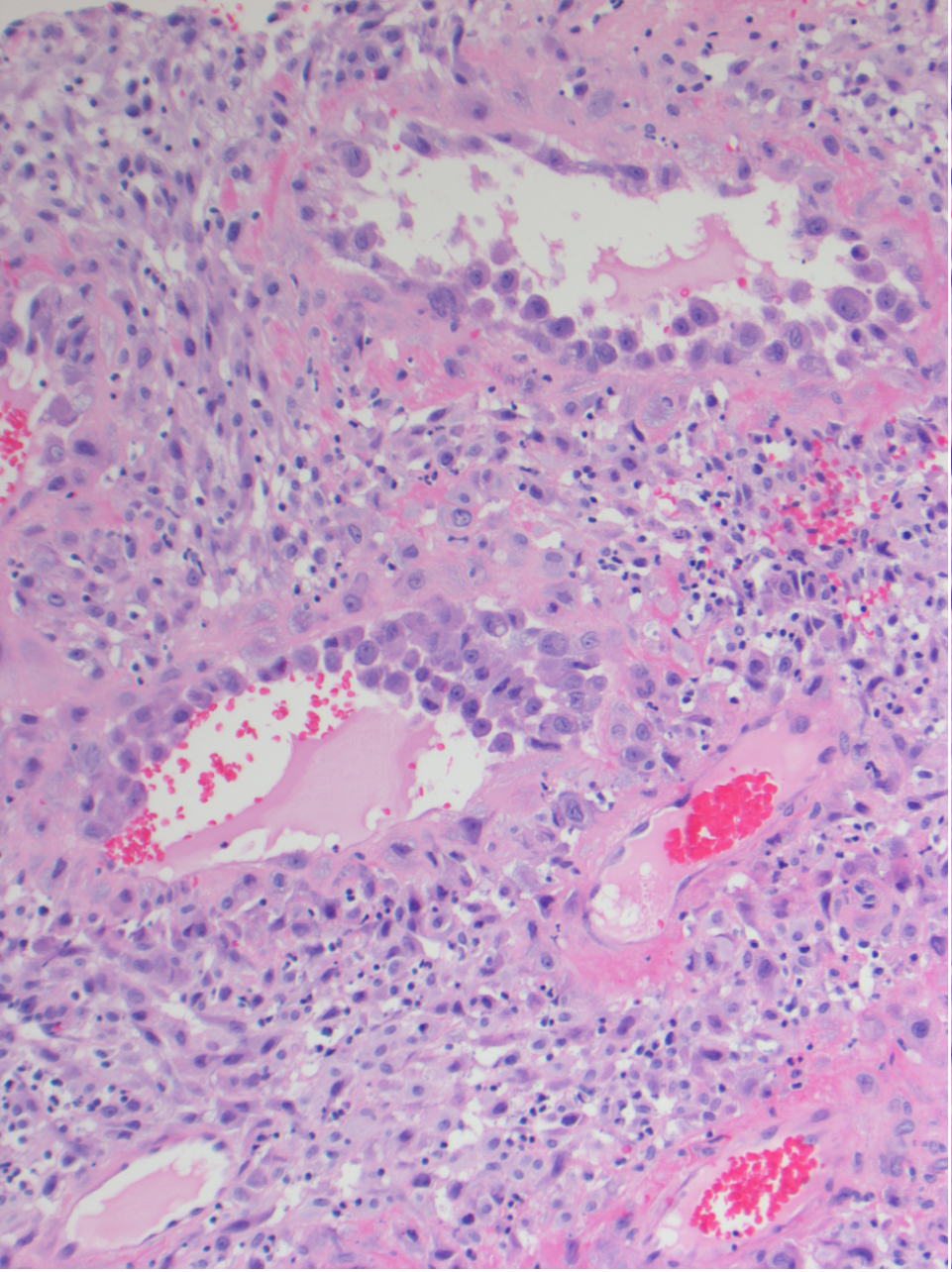
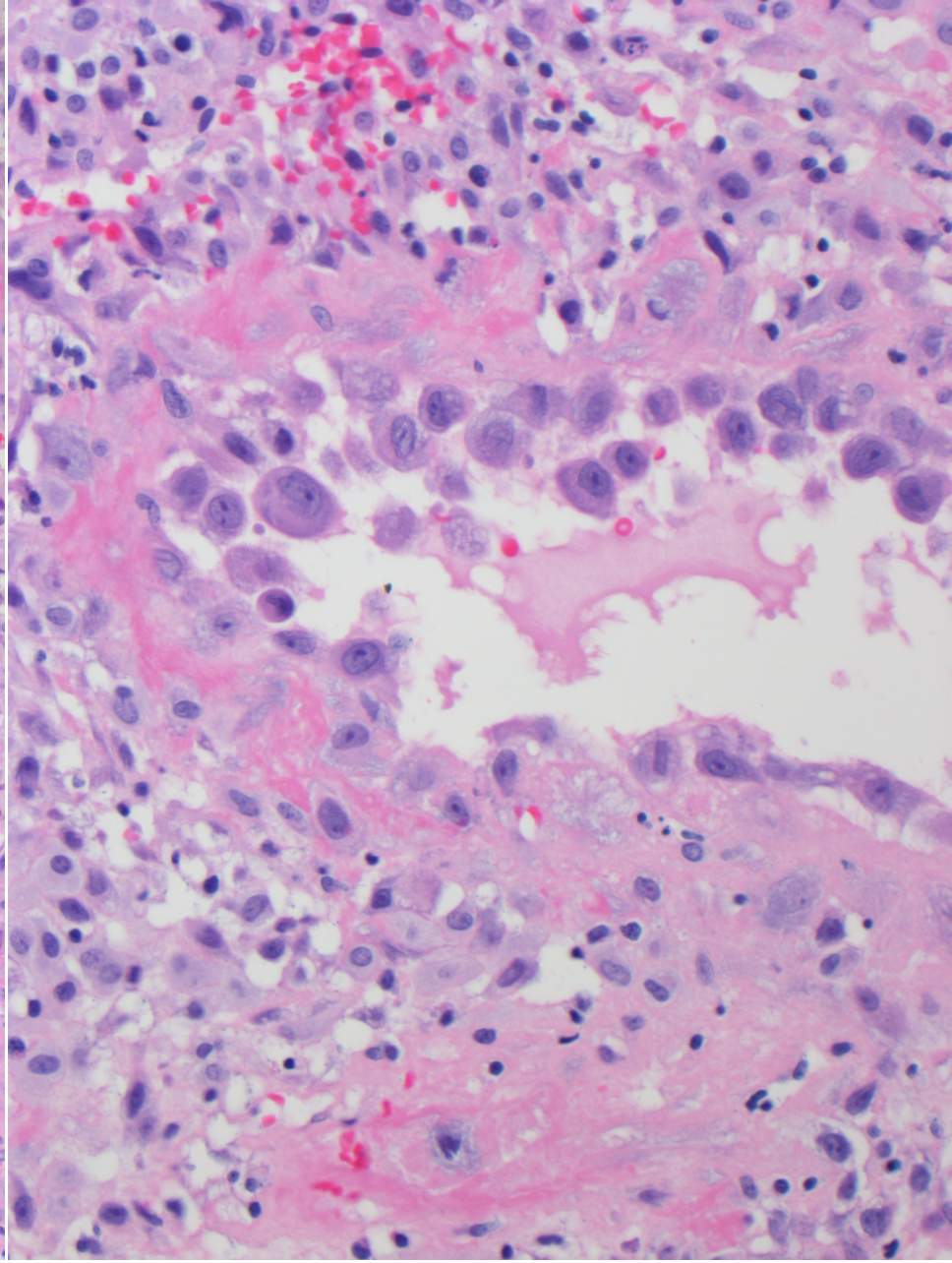


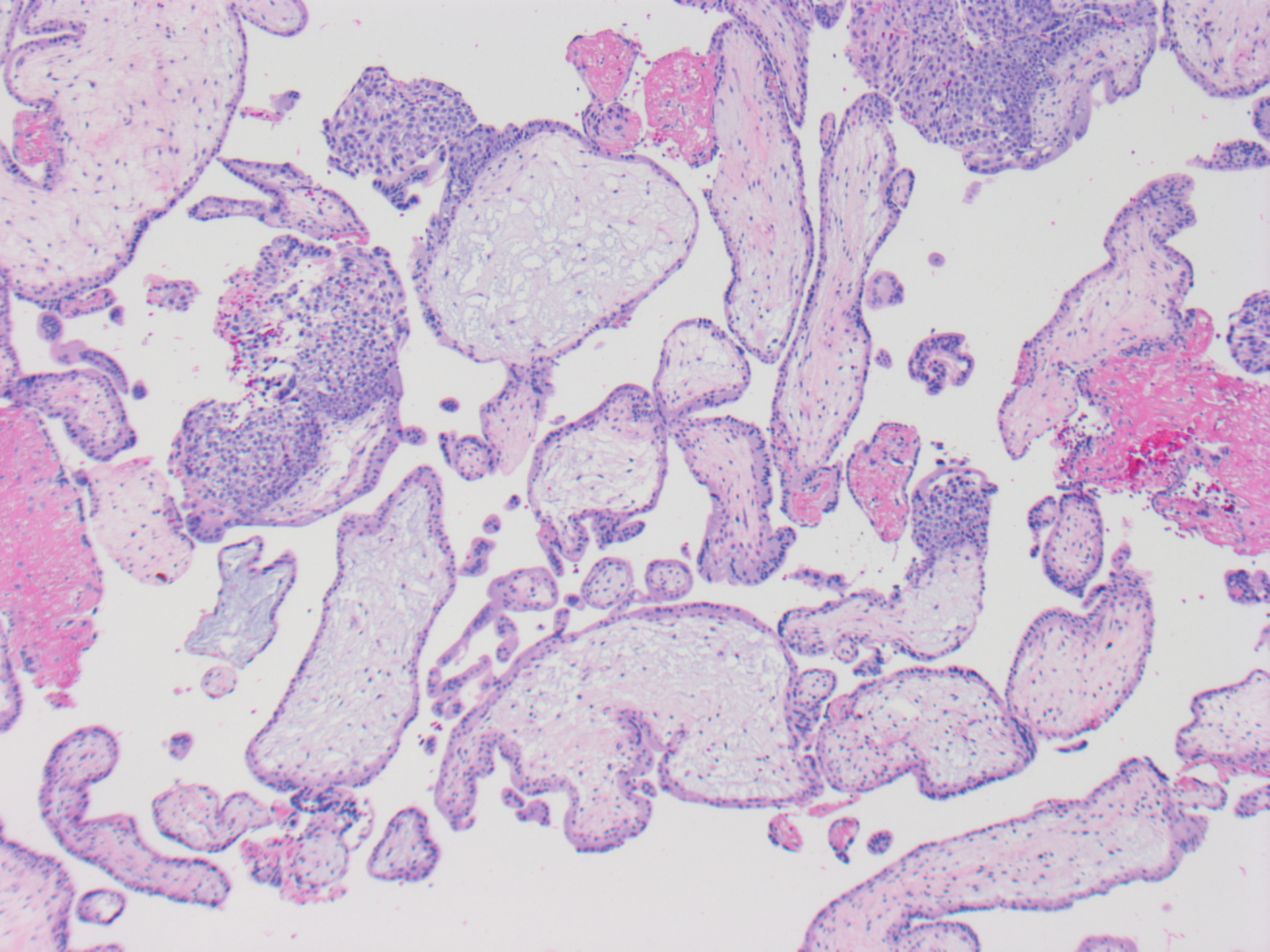








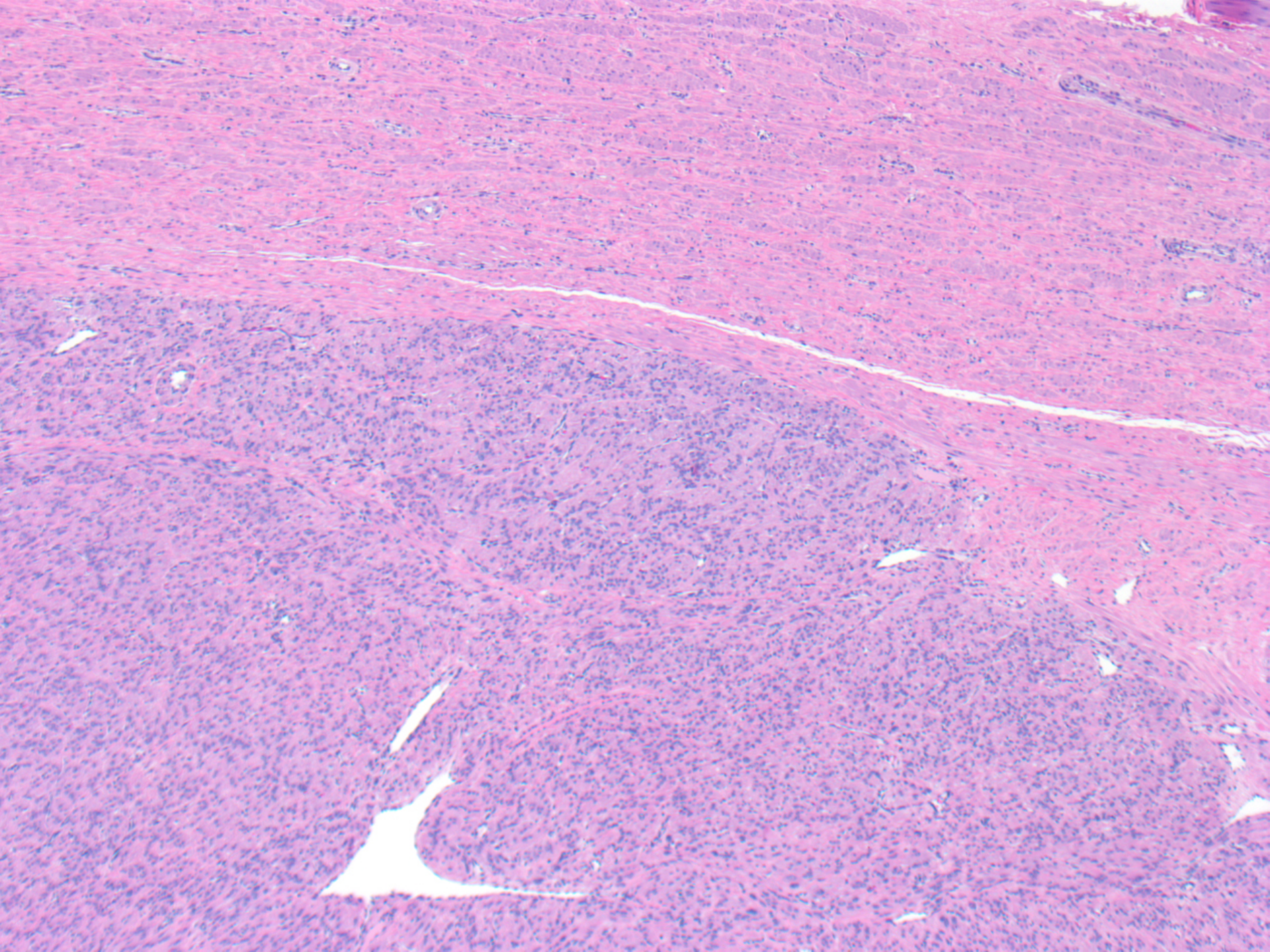



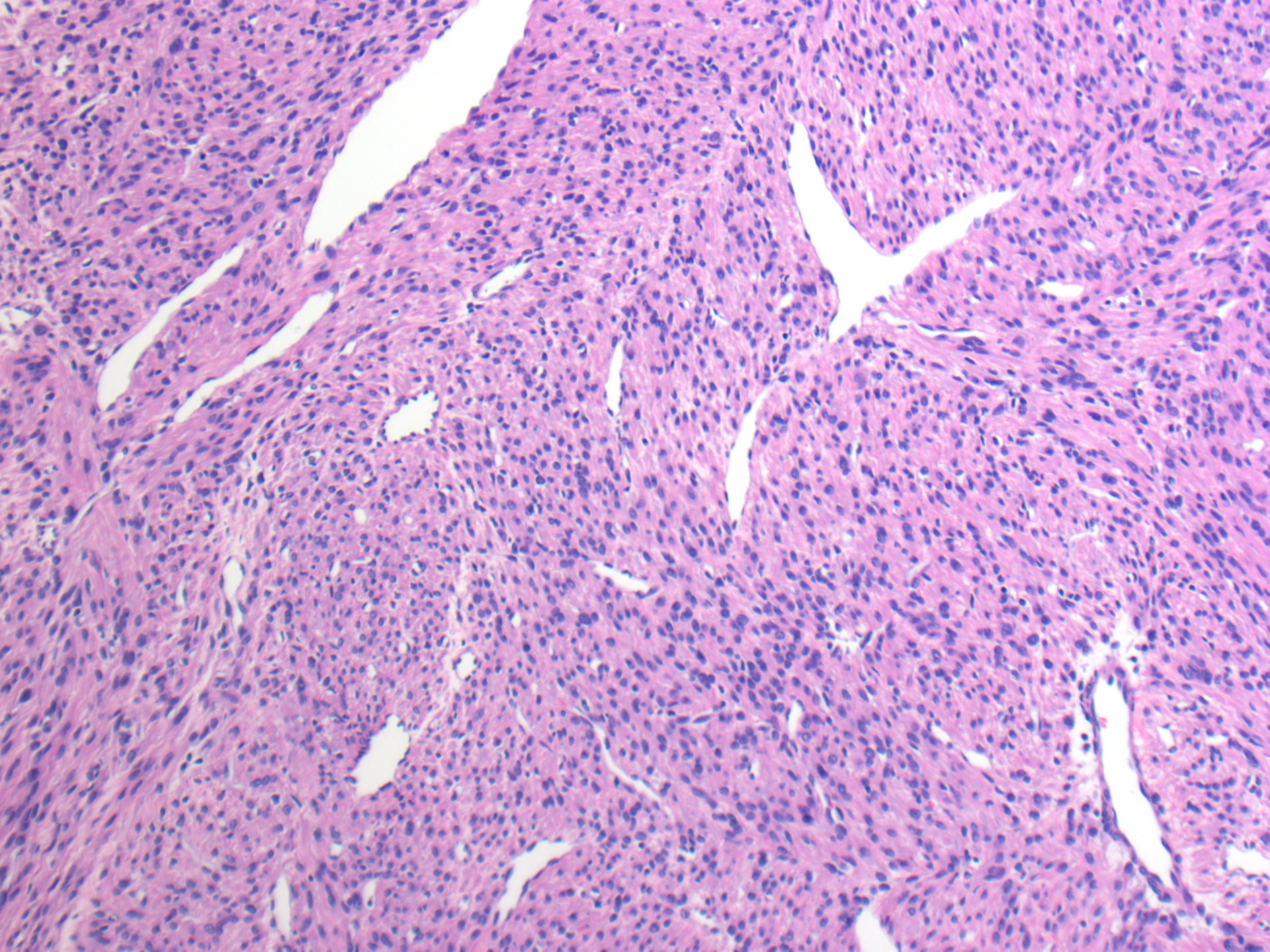


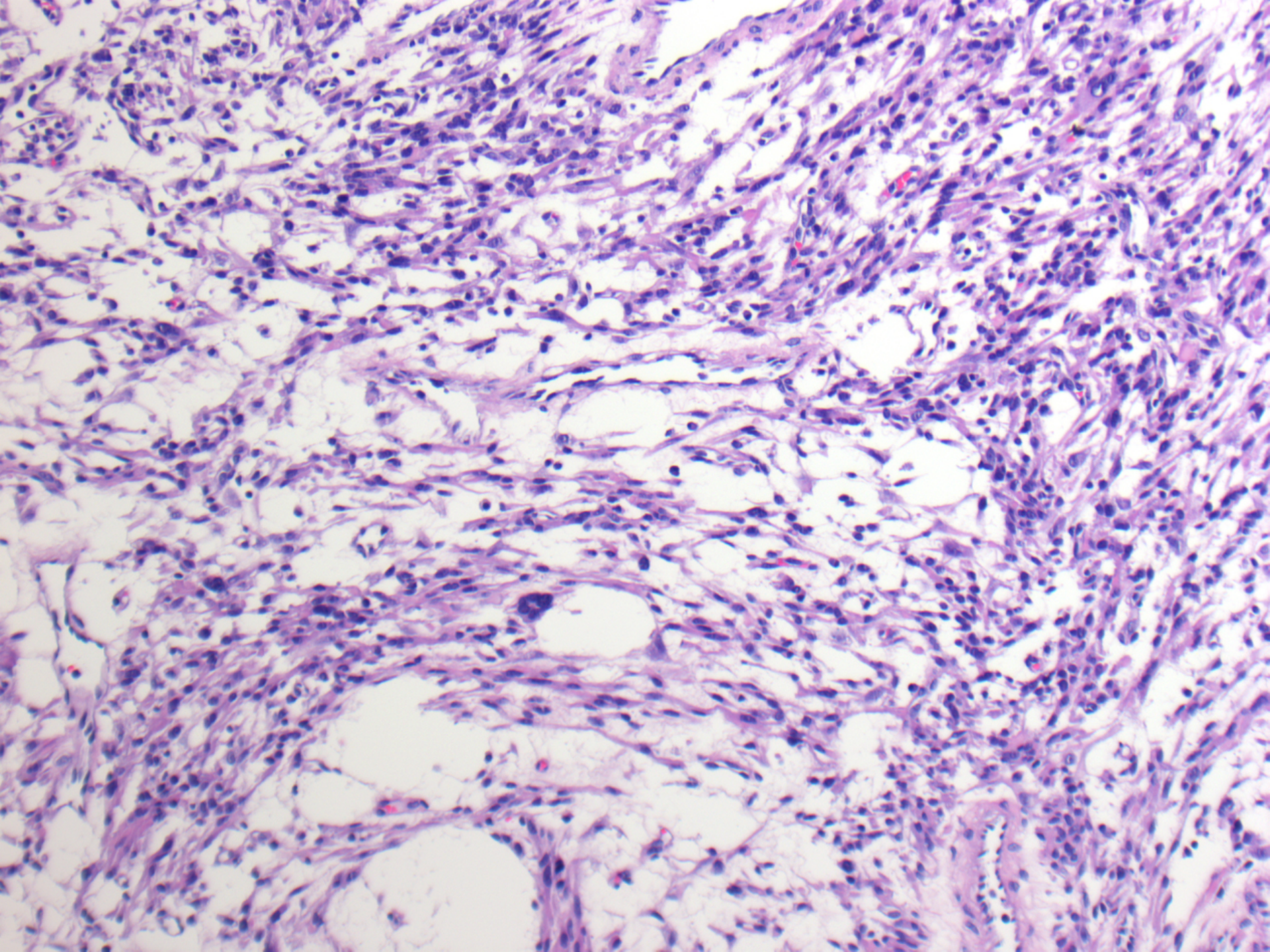
Case 5

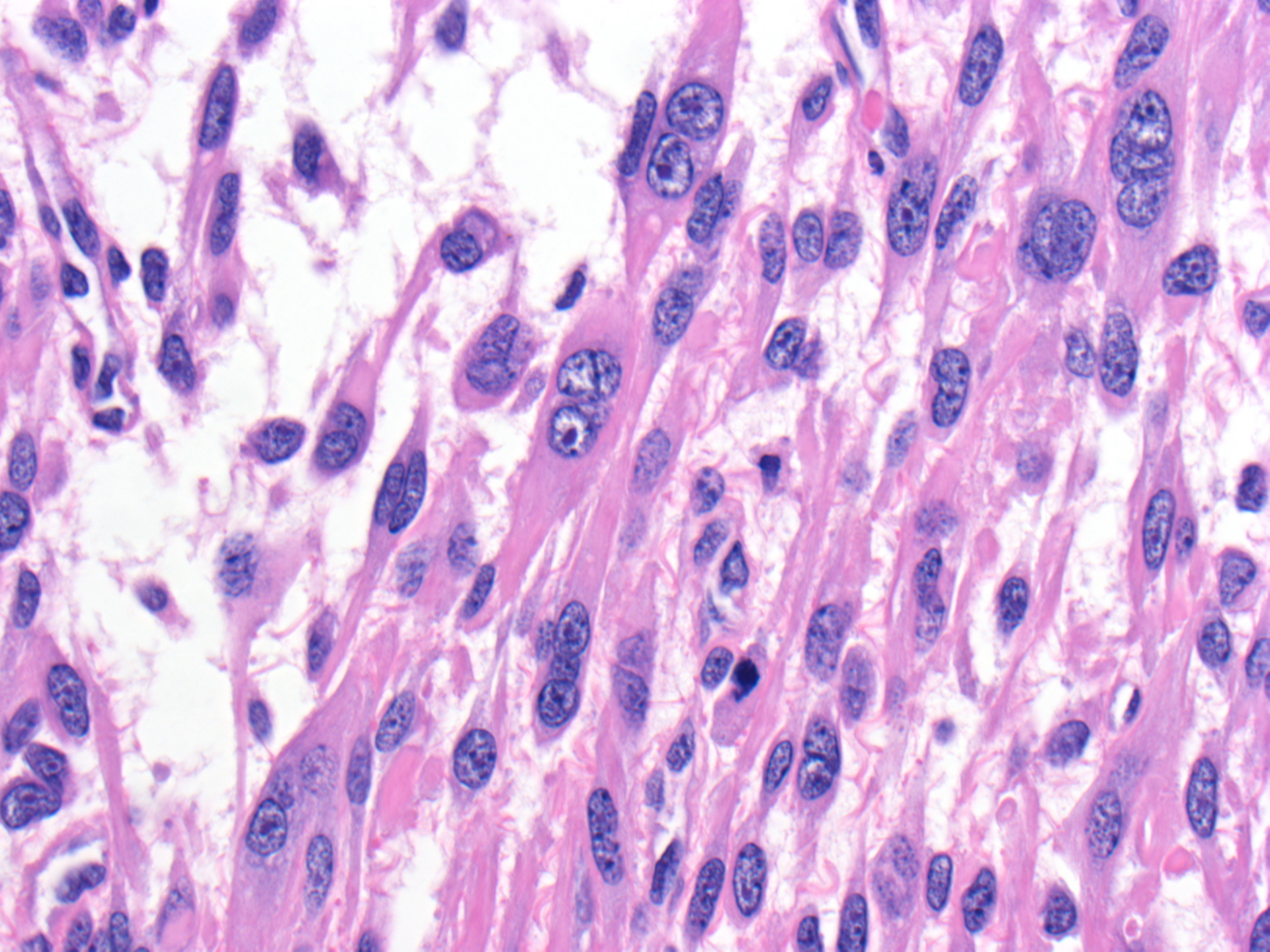
The patient is a 29 year old woman with multiple uterine masses, for which she underwent myomectomy. No other significant history was known. 7 smooth muscle tumors were received in the pathology laboratory. They measured 15x13x6 cm in aggregate and weighed 346 gm. The cut surfaces were tan-white and whorled with no areas of necrosis or hemorrhage. One of them showed unusual histologic features.

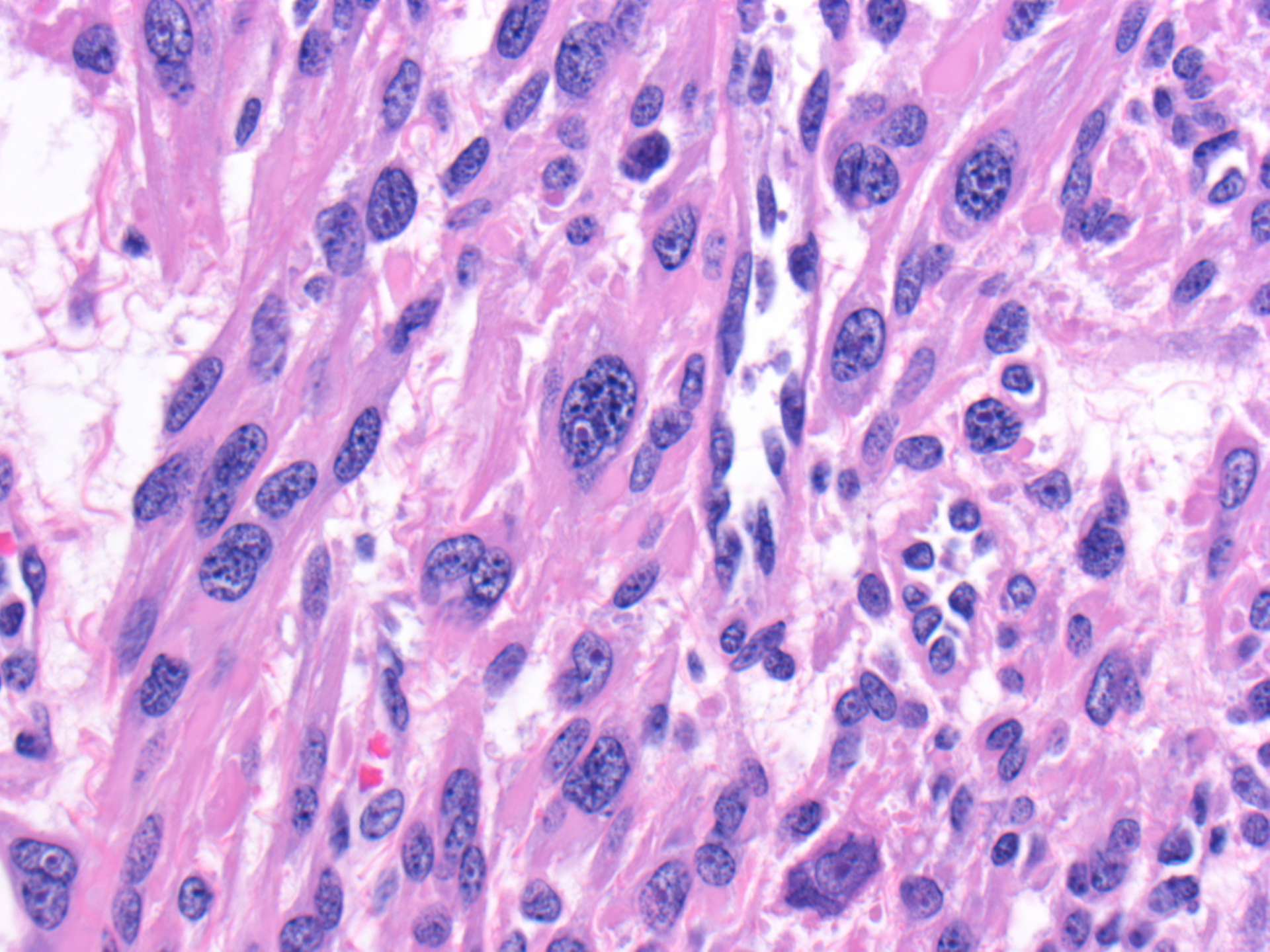
(Courtesy of Daniel Phillips, MD)

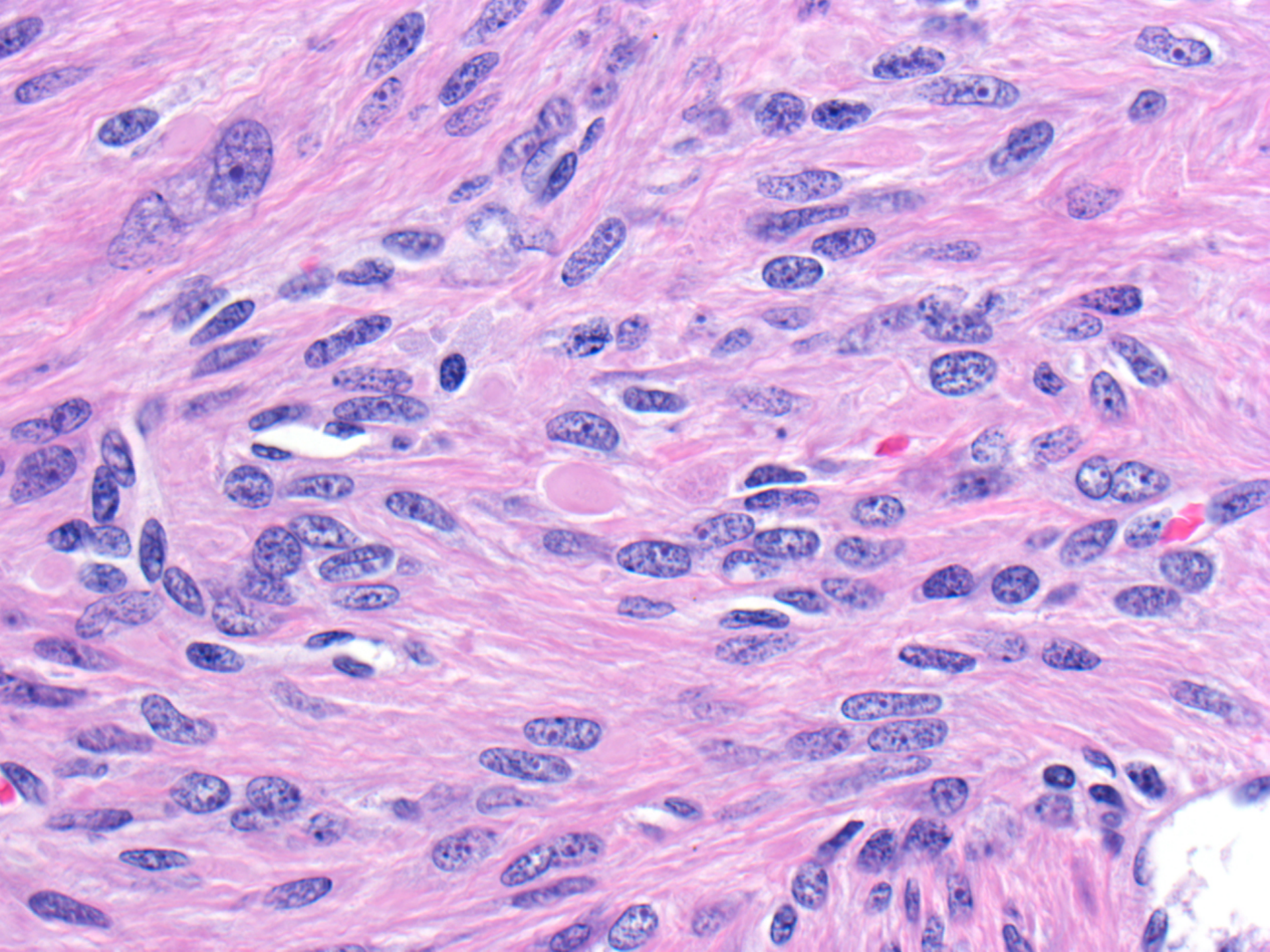






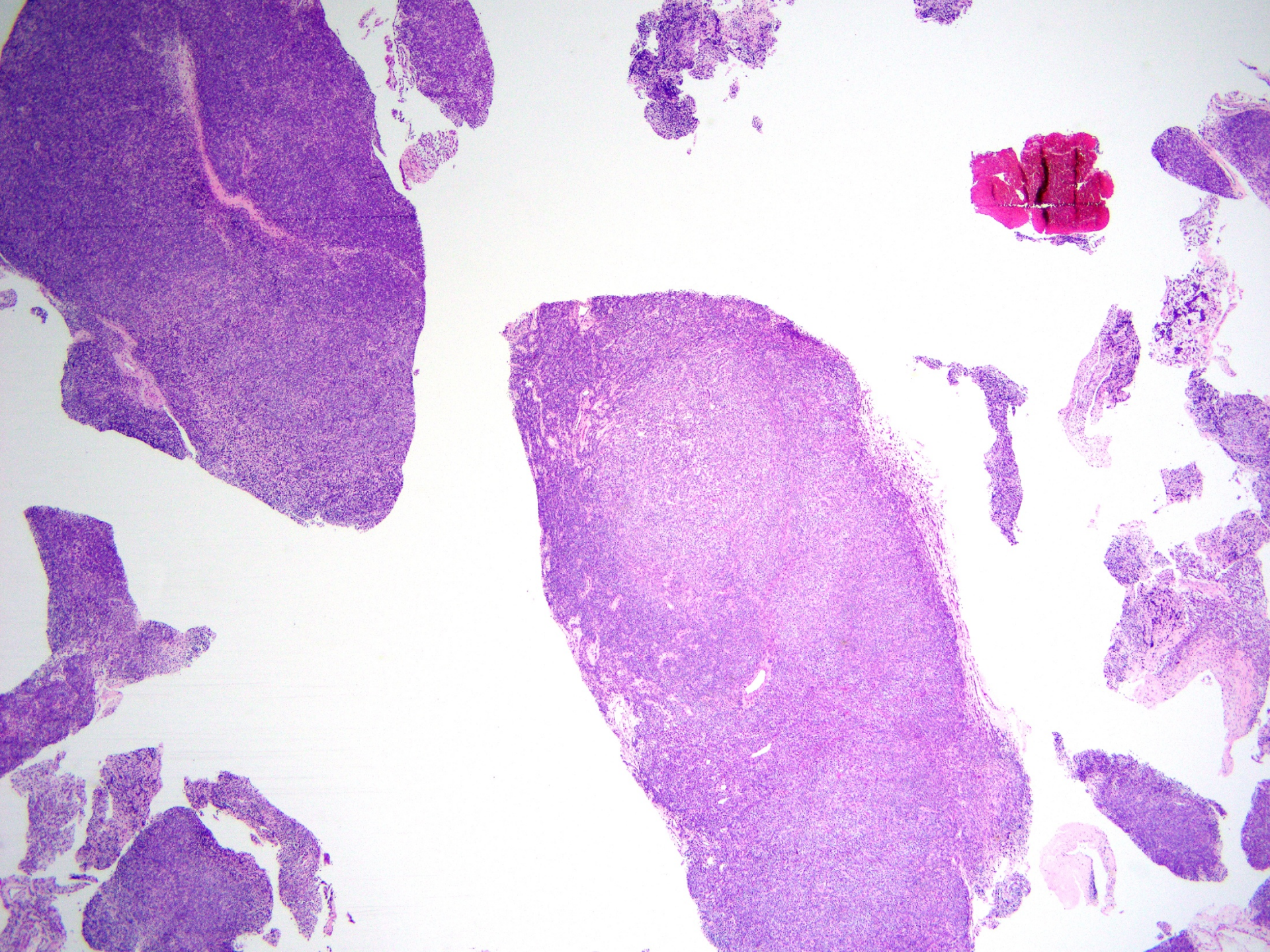


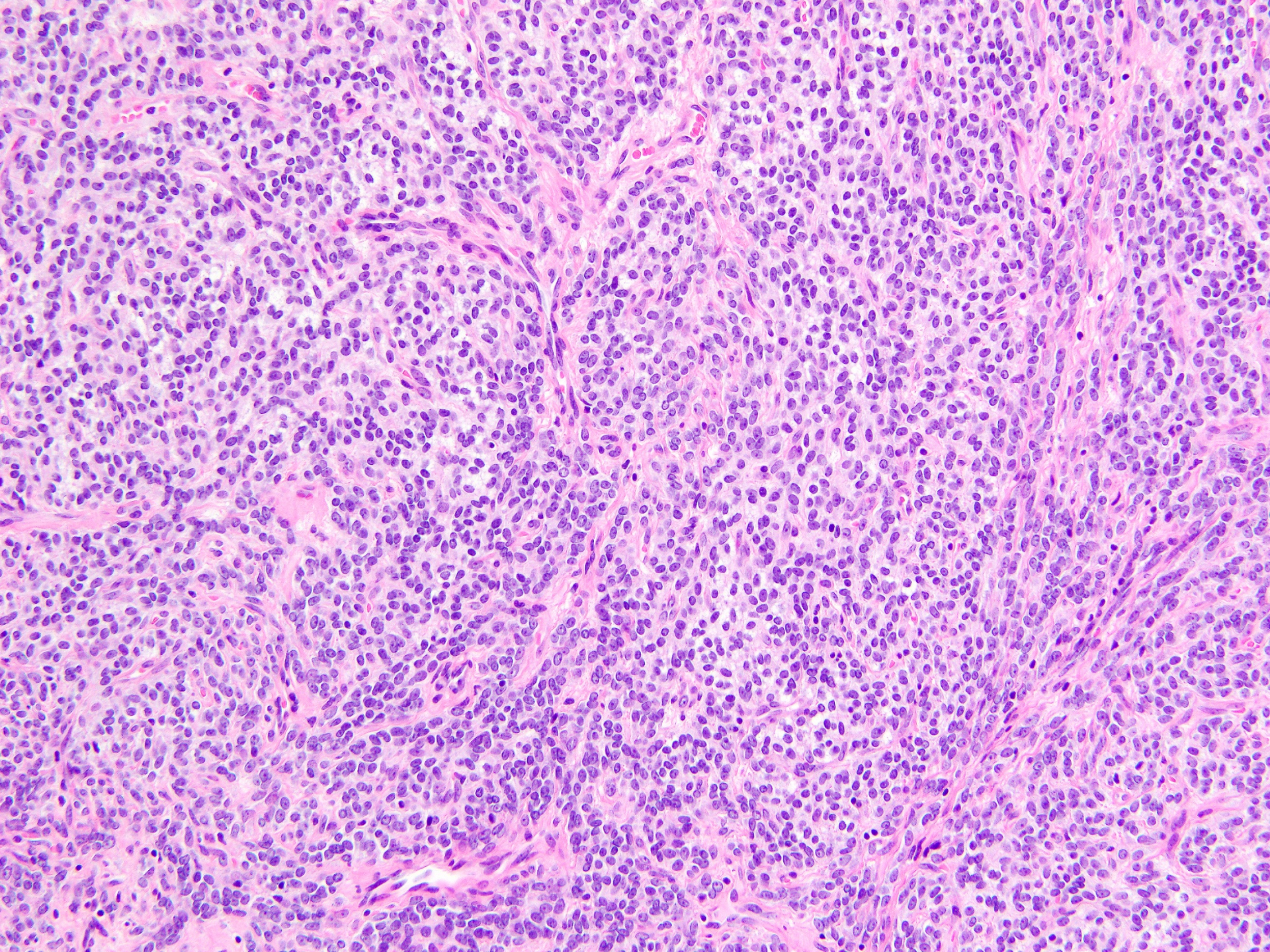


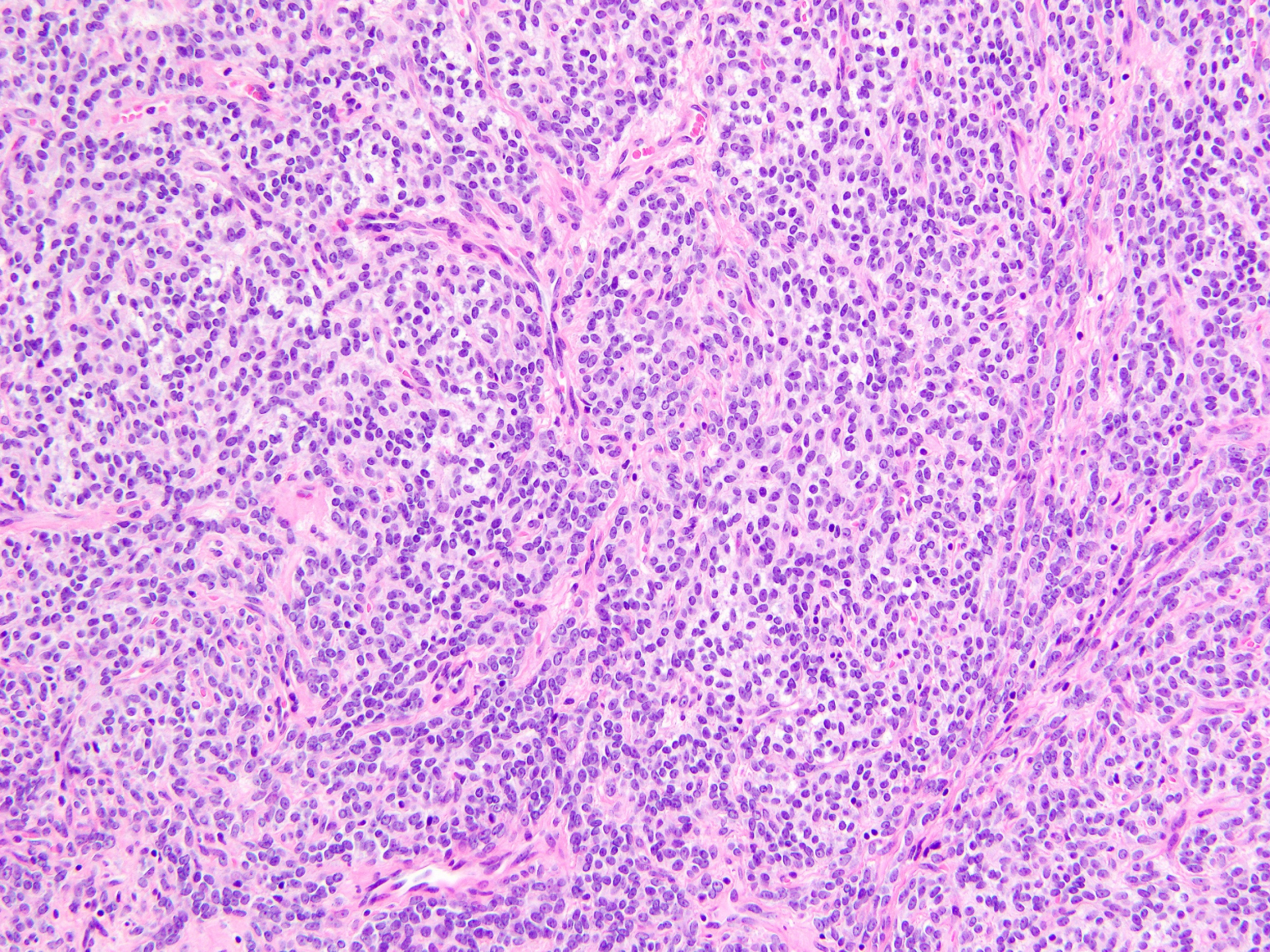


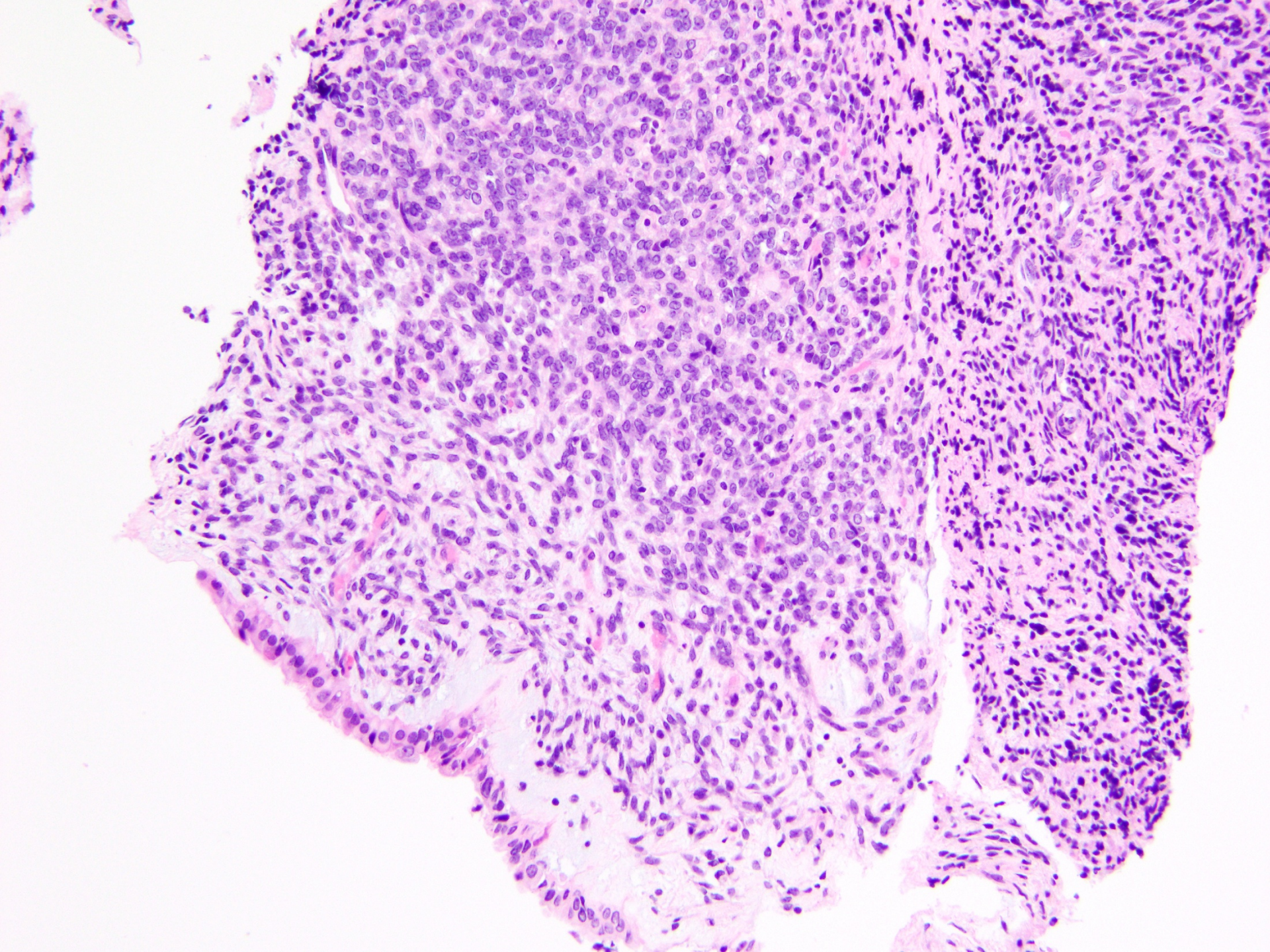
CASE 6

- A 49 year old woman presents with menorrhagia and irregular cycles. She has a past history of PCOS and fibroids. On hysteroscopy, a probable submucosal fibroid and endometrial polyps are seen. An endometrial curettage was performed.



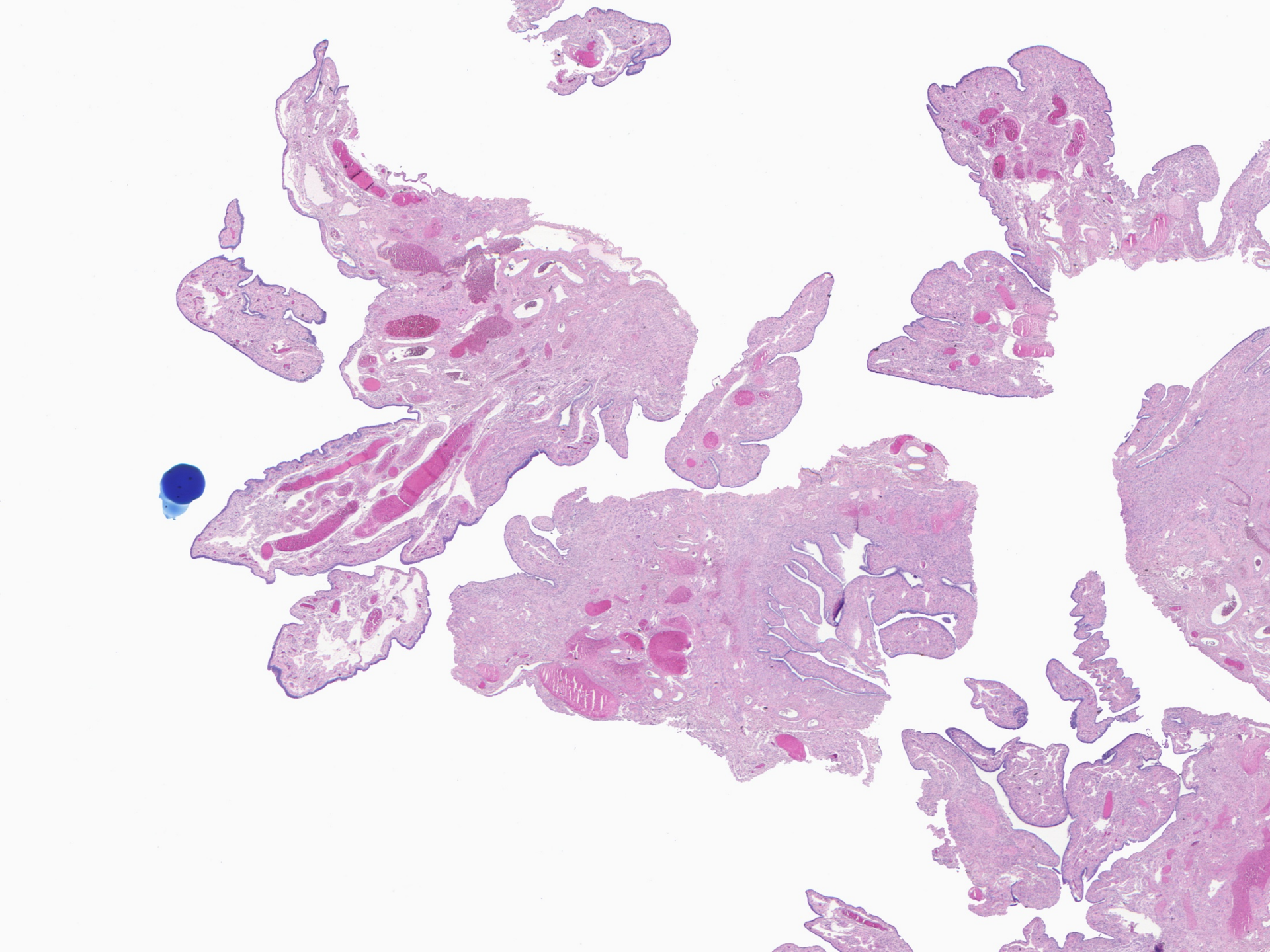


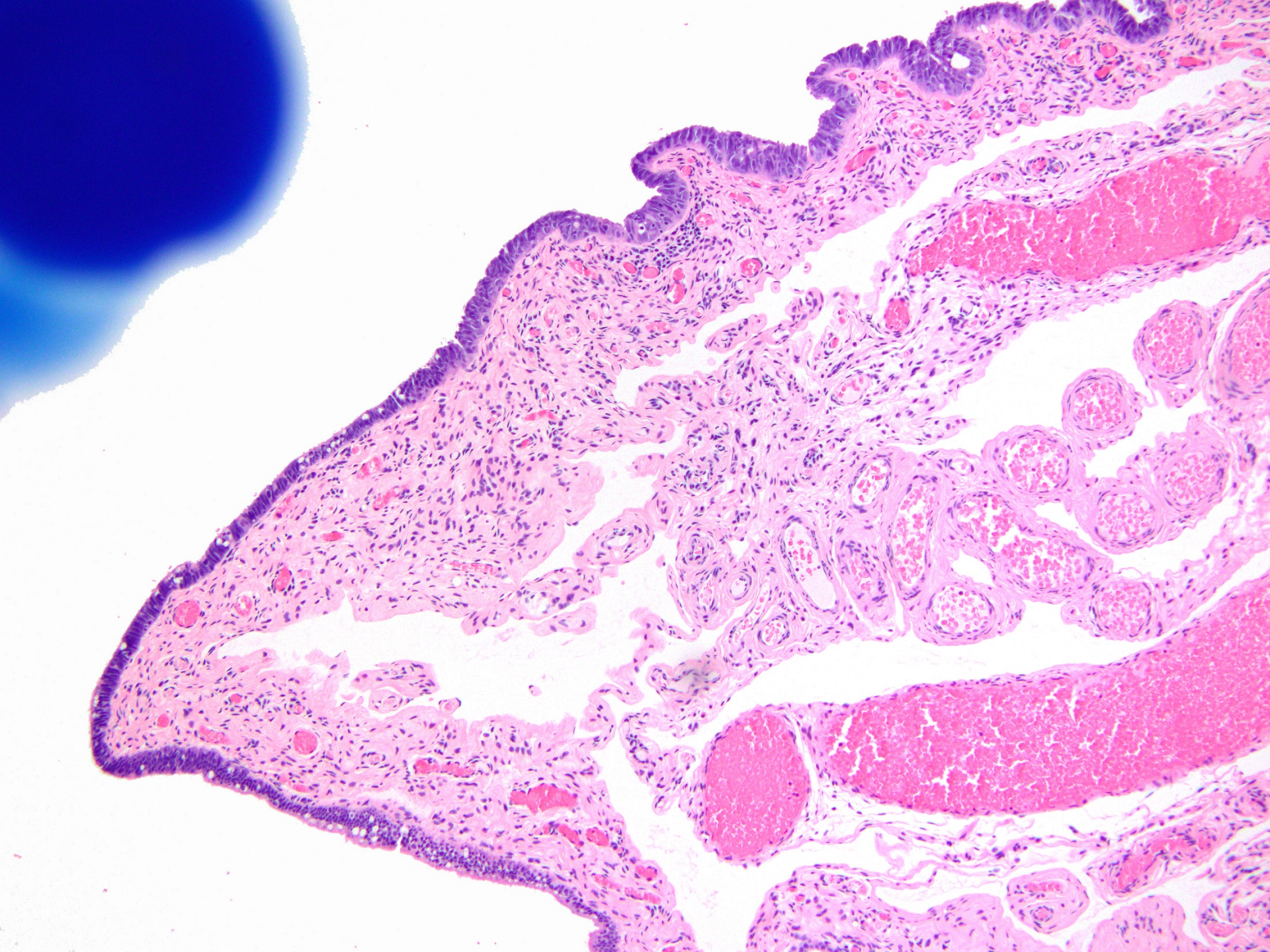


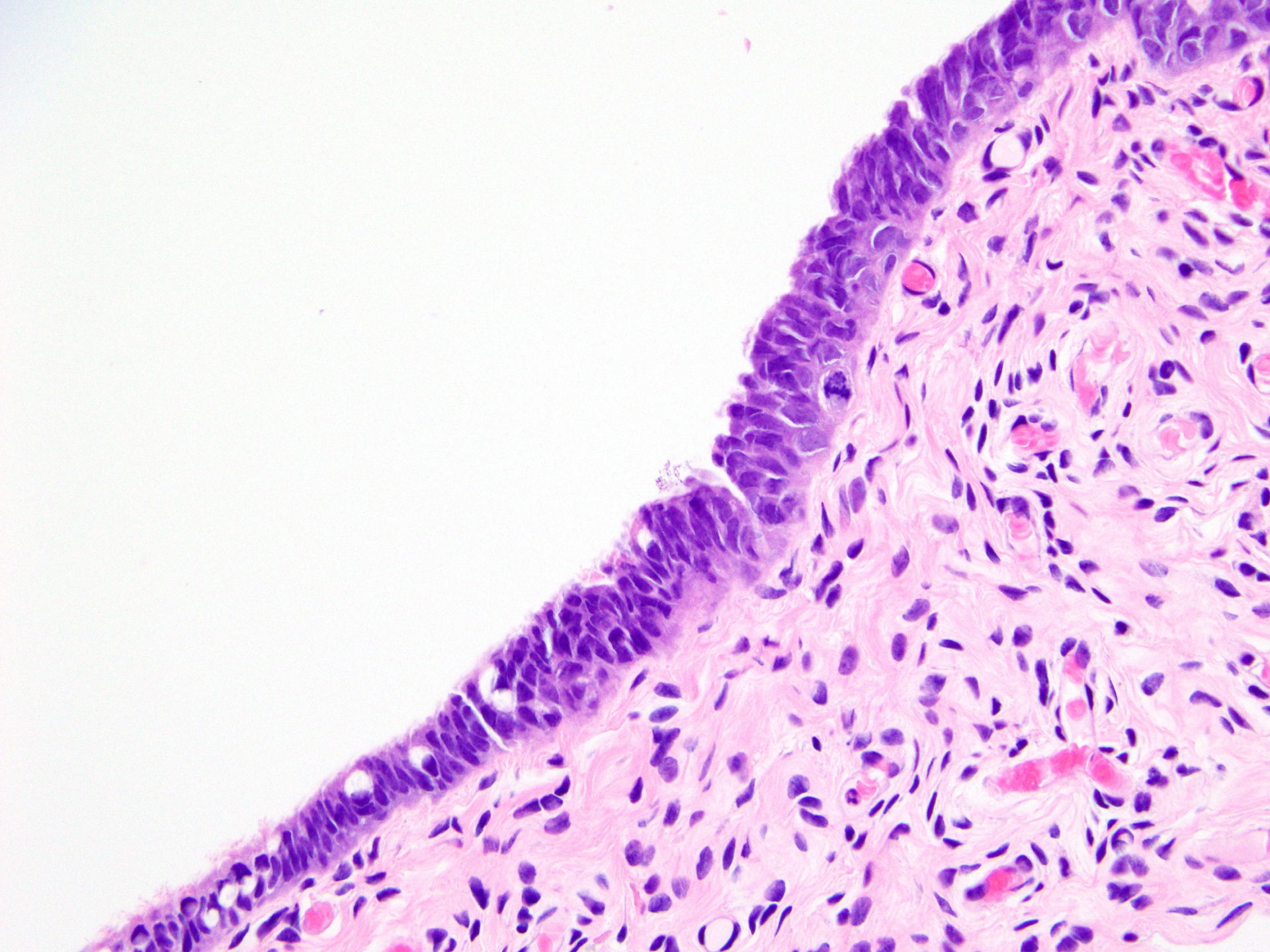


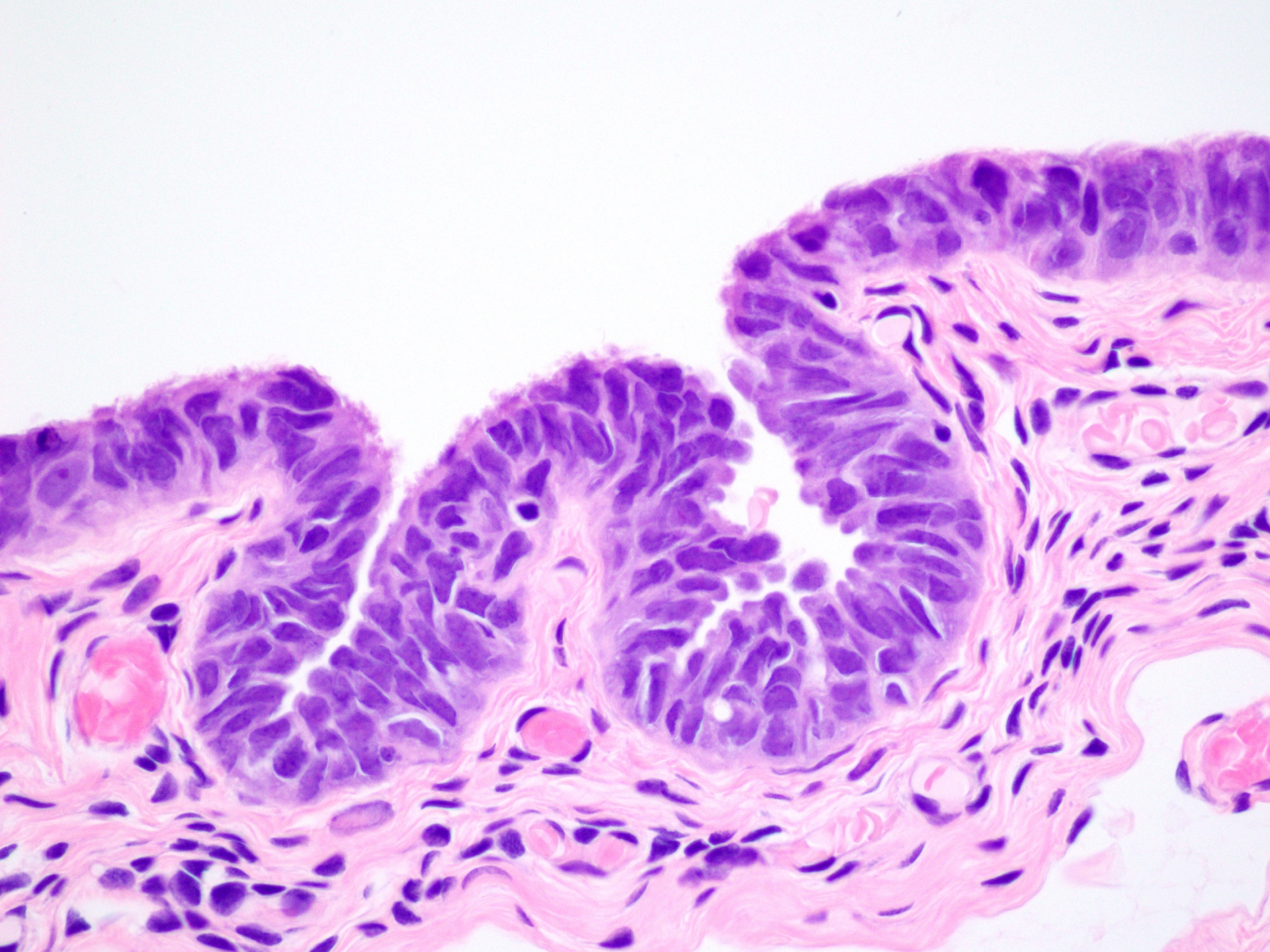
CASE 7

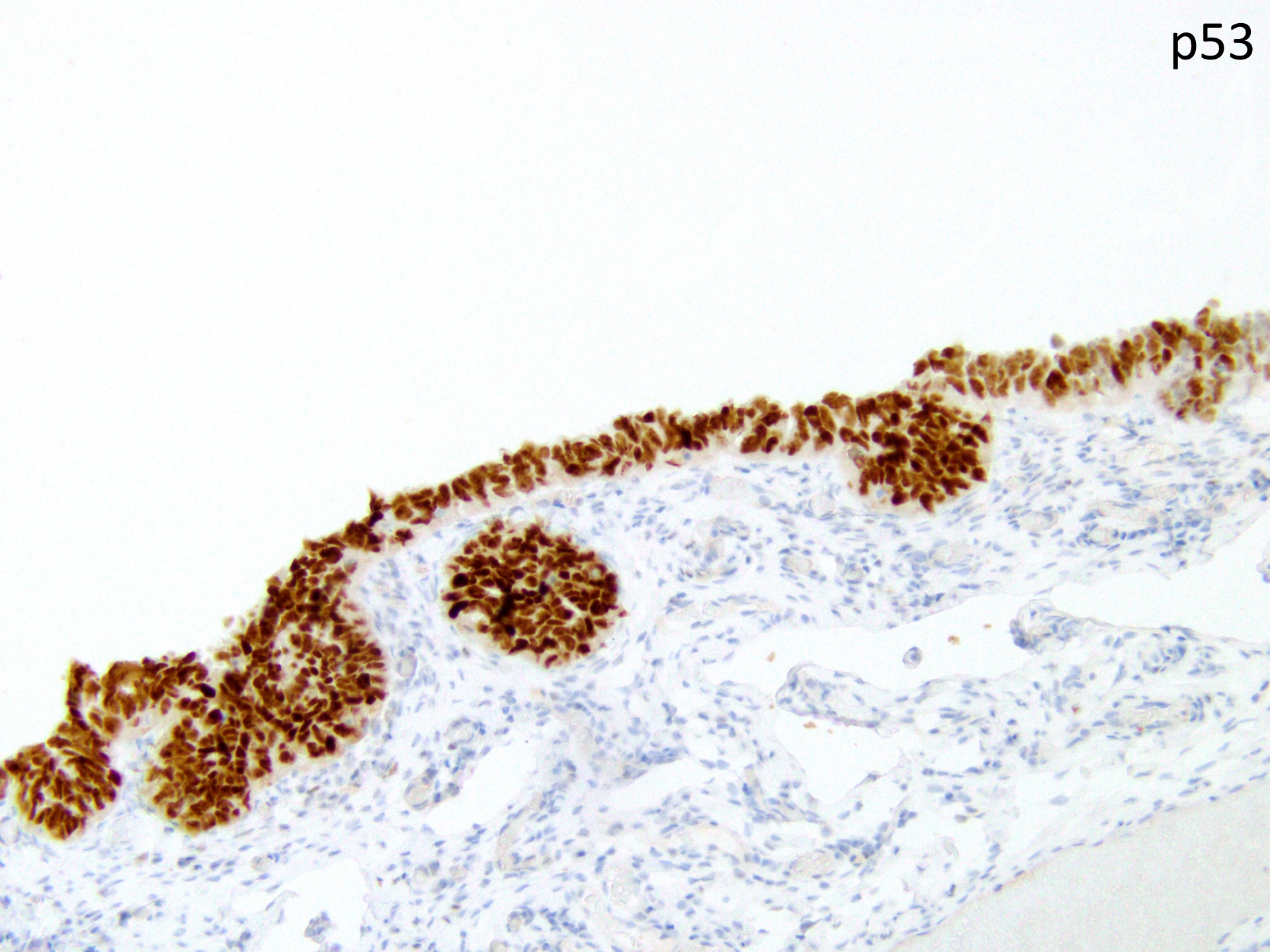
- A 59 year old woman with a history of breast cancer has a hysterectomy and bilateral salpingo-oophorectomy. No further history is provided. The cervix, endometrium, myometrium and ovaries are histologically unremarkable.







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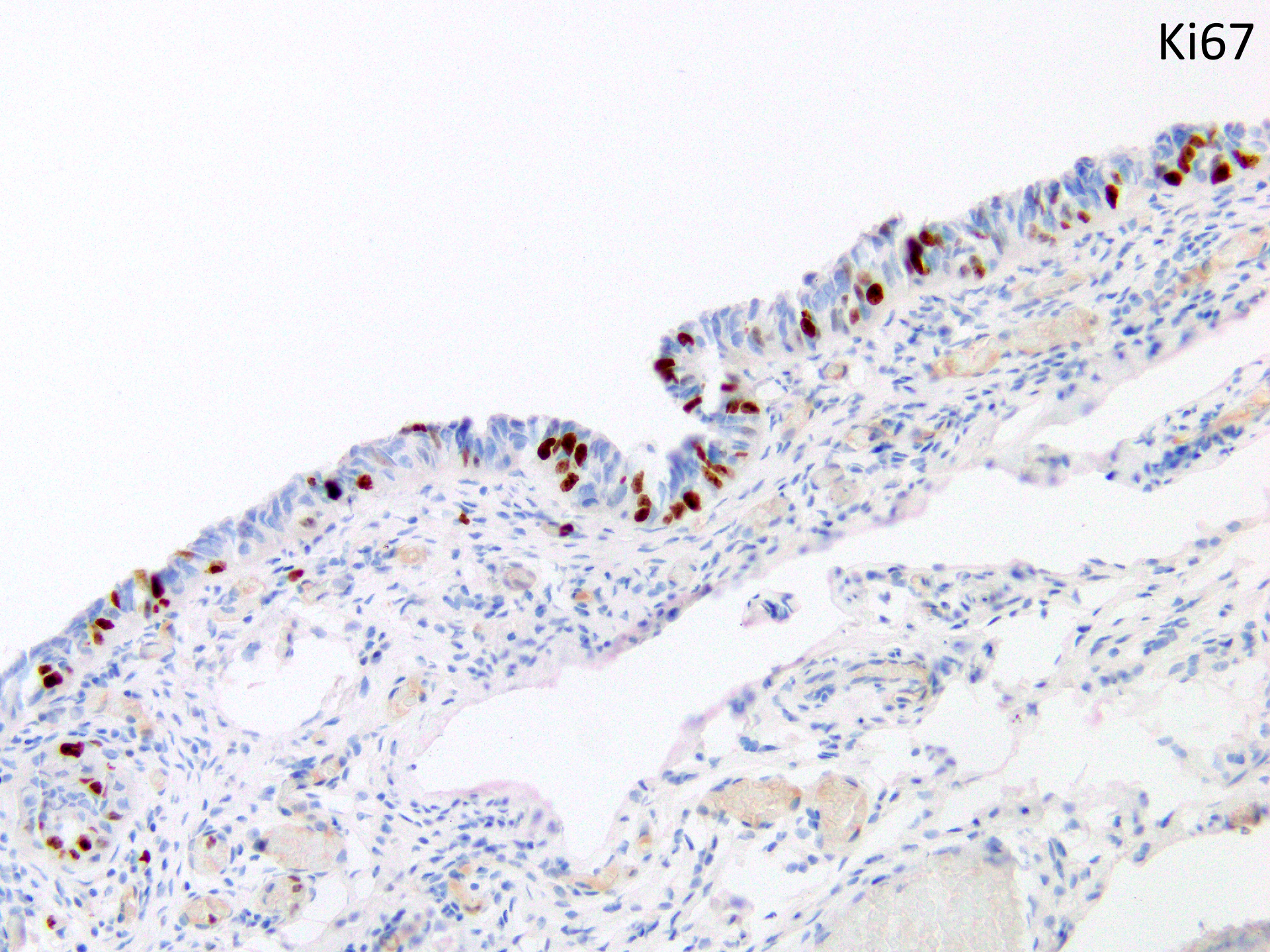
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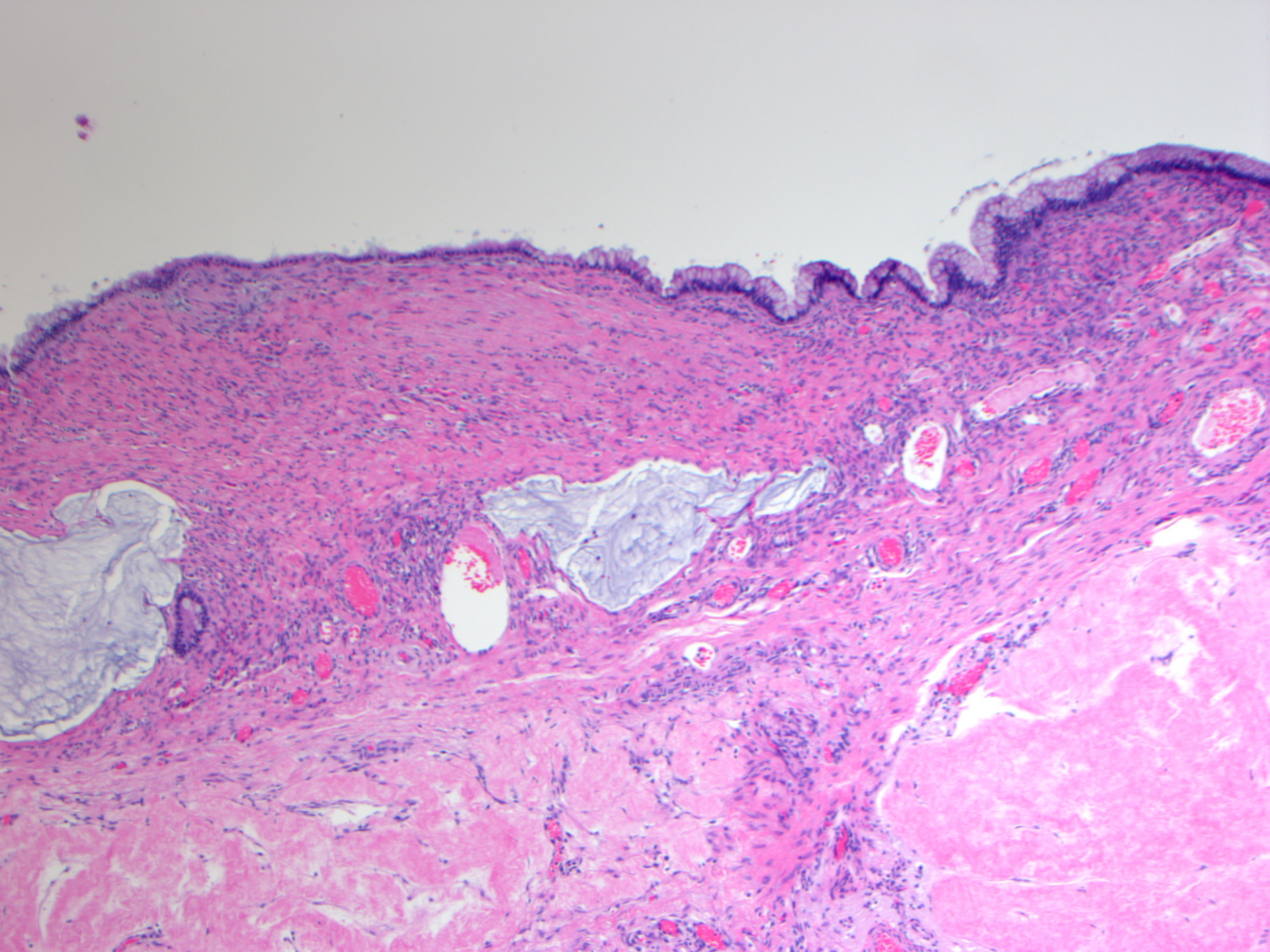
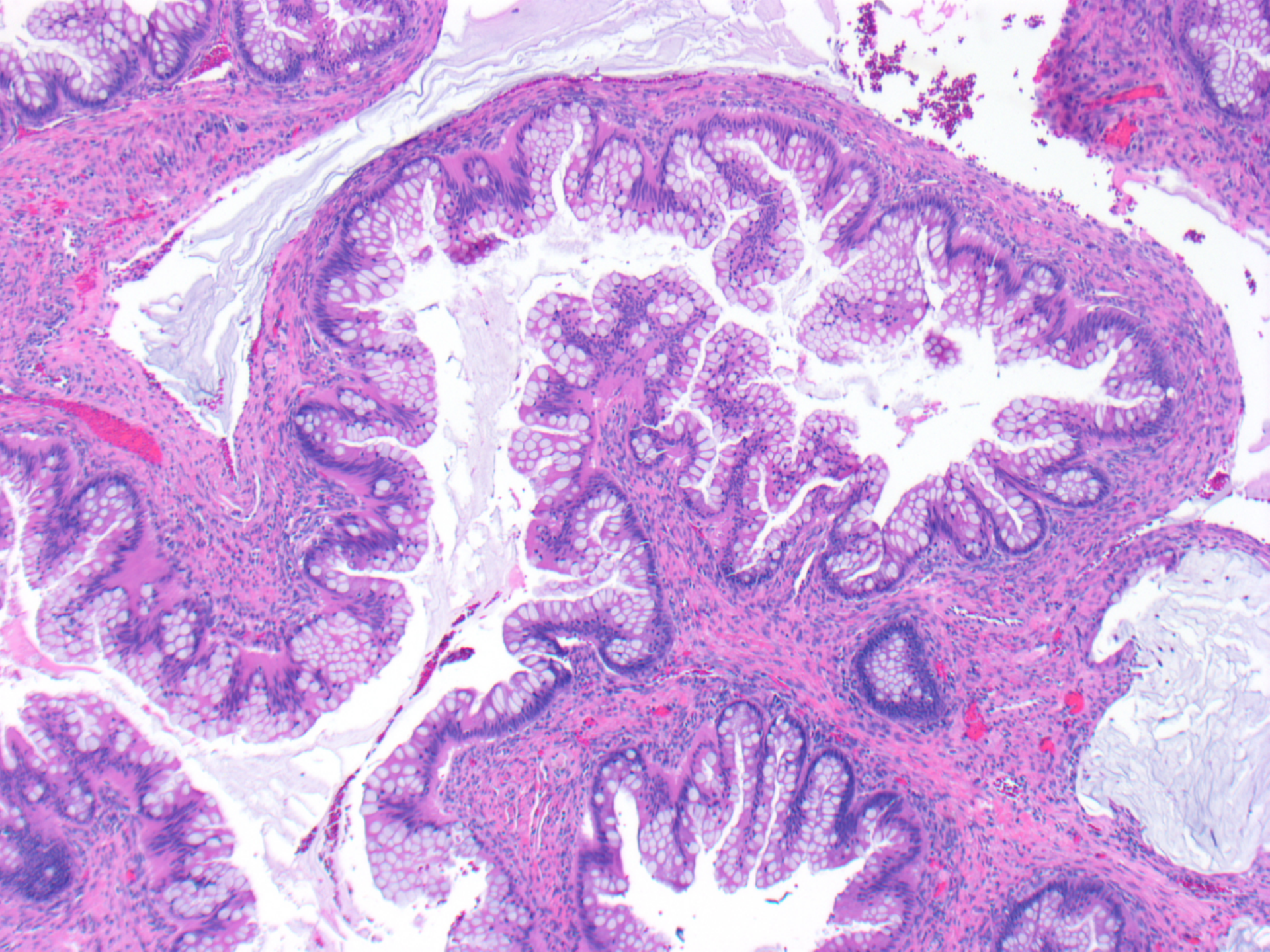
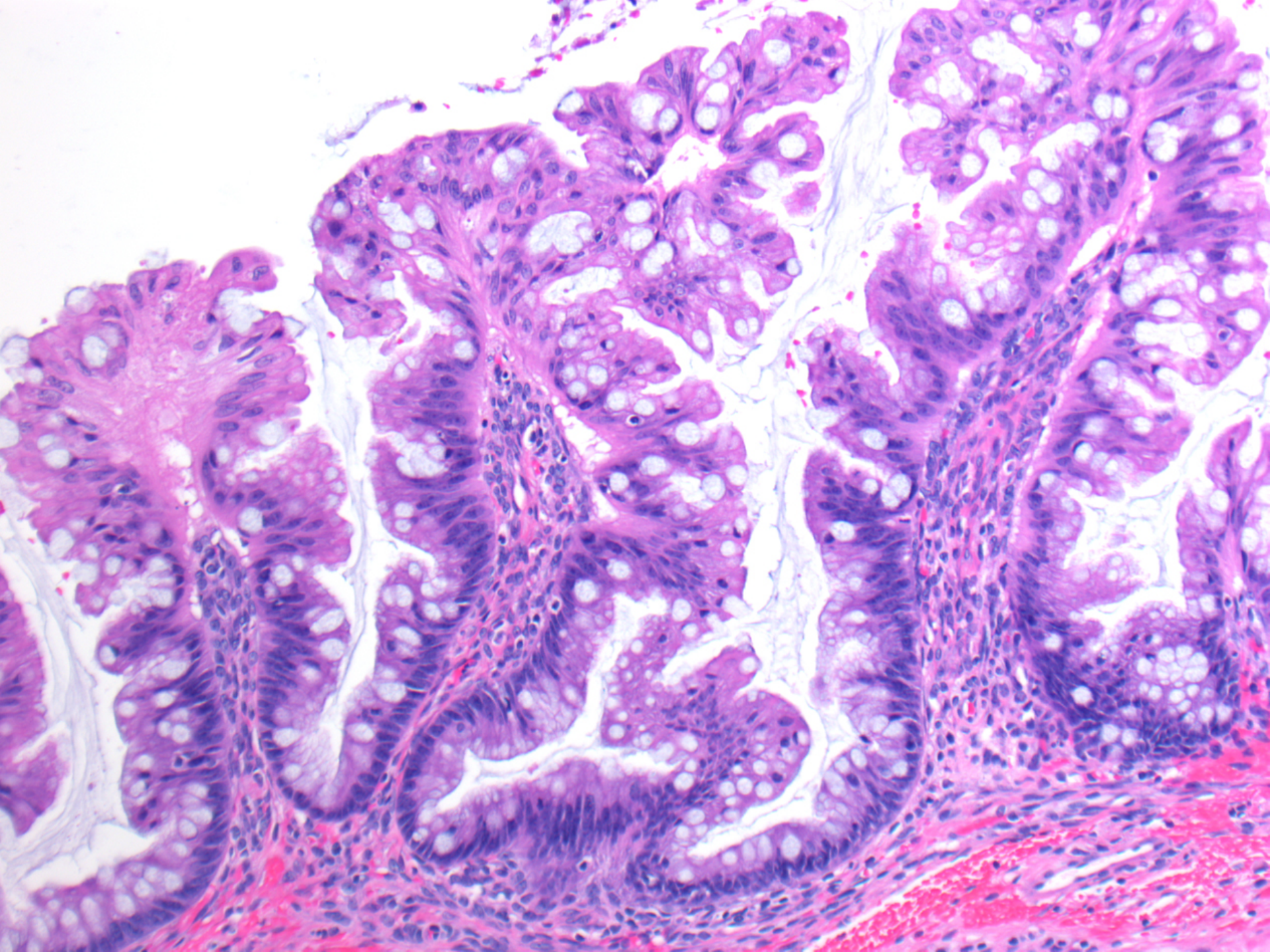
Case 8

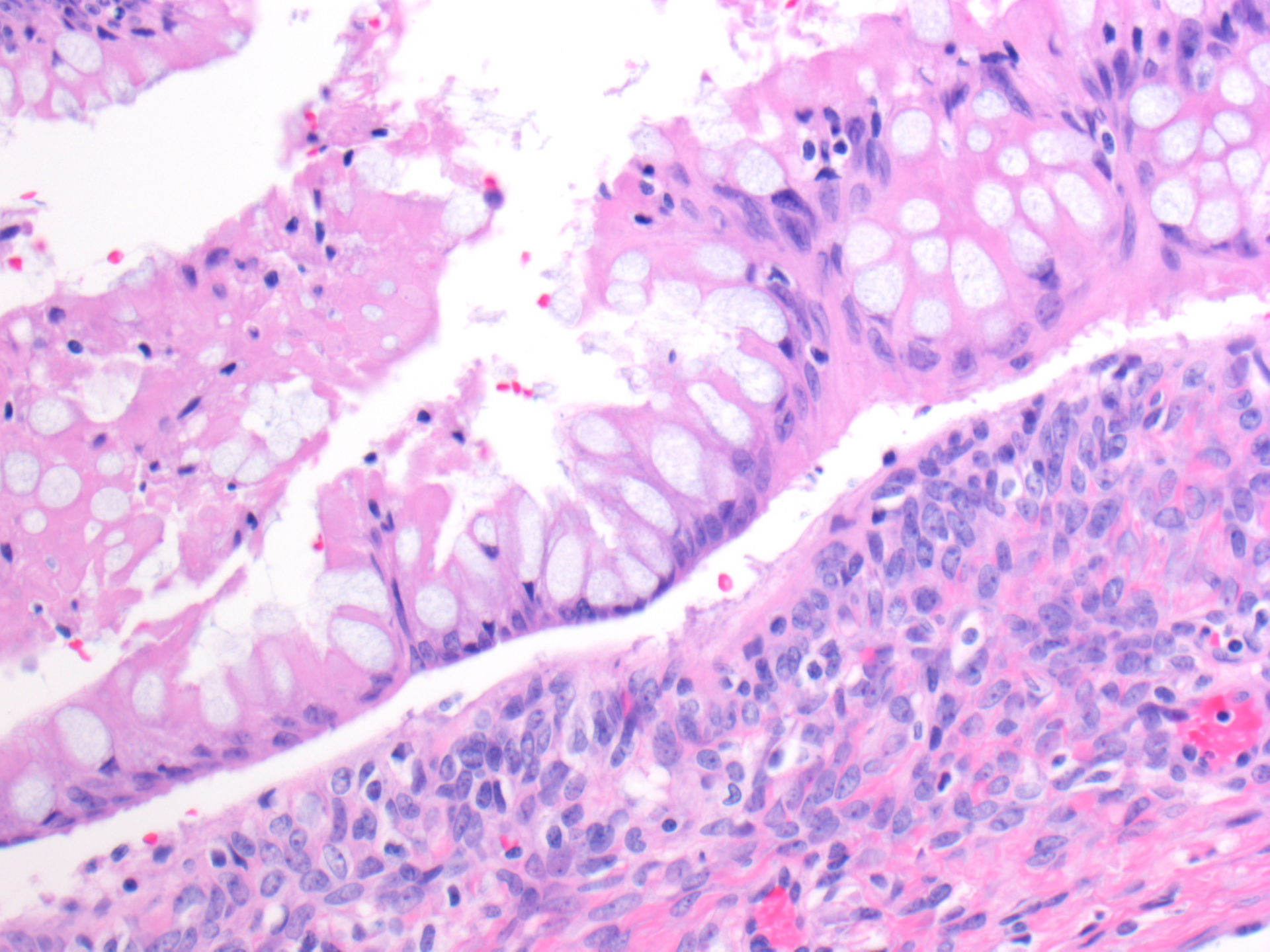
The patient is a 56 year old woman who presented with abdominal pain, scattered free air on imaging studies, apparent peritonitis, and a large adnexal mass. At surgery, she was found to have diverticulosis and diverticulitis of the sigmoid colon. There appeared to be a perforated diverticulum with acute serositis. A bilateral salpingo-oophorectomy and appendectomy, and an endometrial curettage were performed. The ovary measured 9.6 cm and was a multiloculated cystic lesion filled with mucinous material. A 1.2 cm firm tan-pink area was identified in the cyst wall.

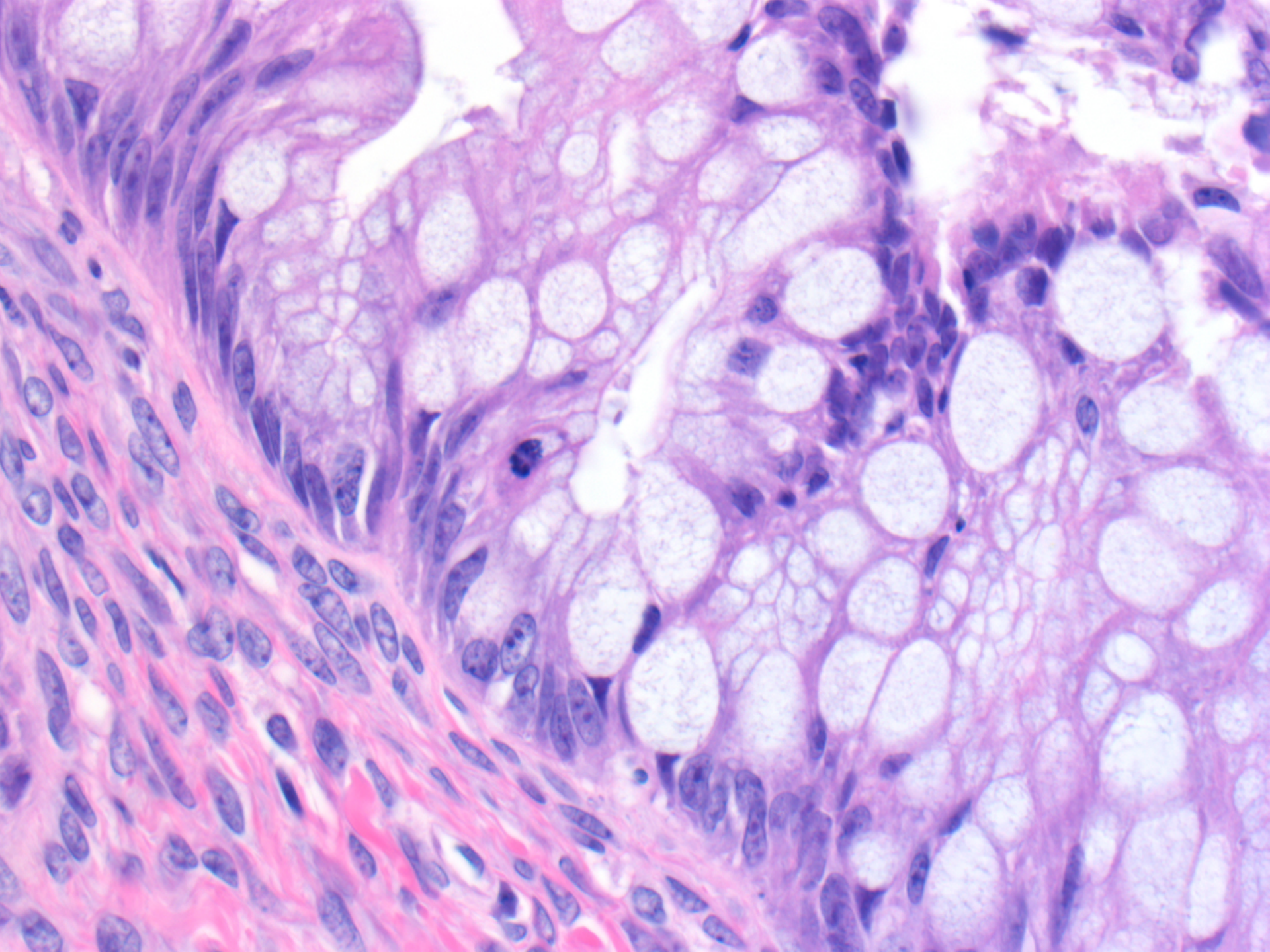
(Courtesy of Carlene A. Hawksley, MD)

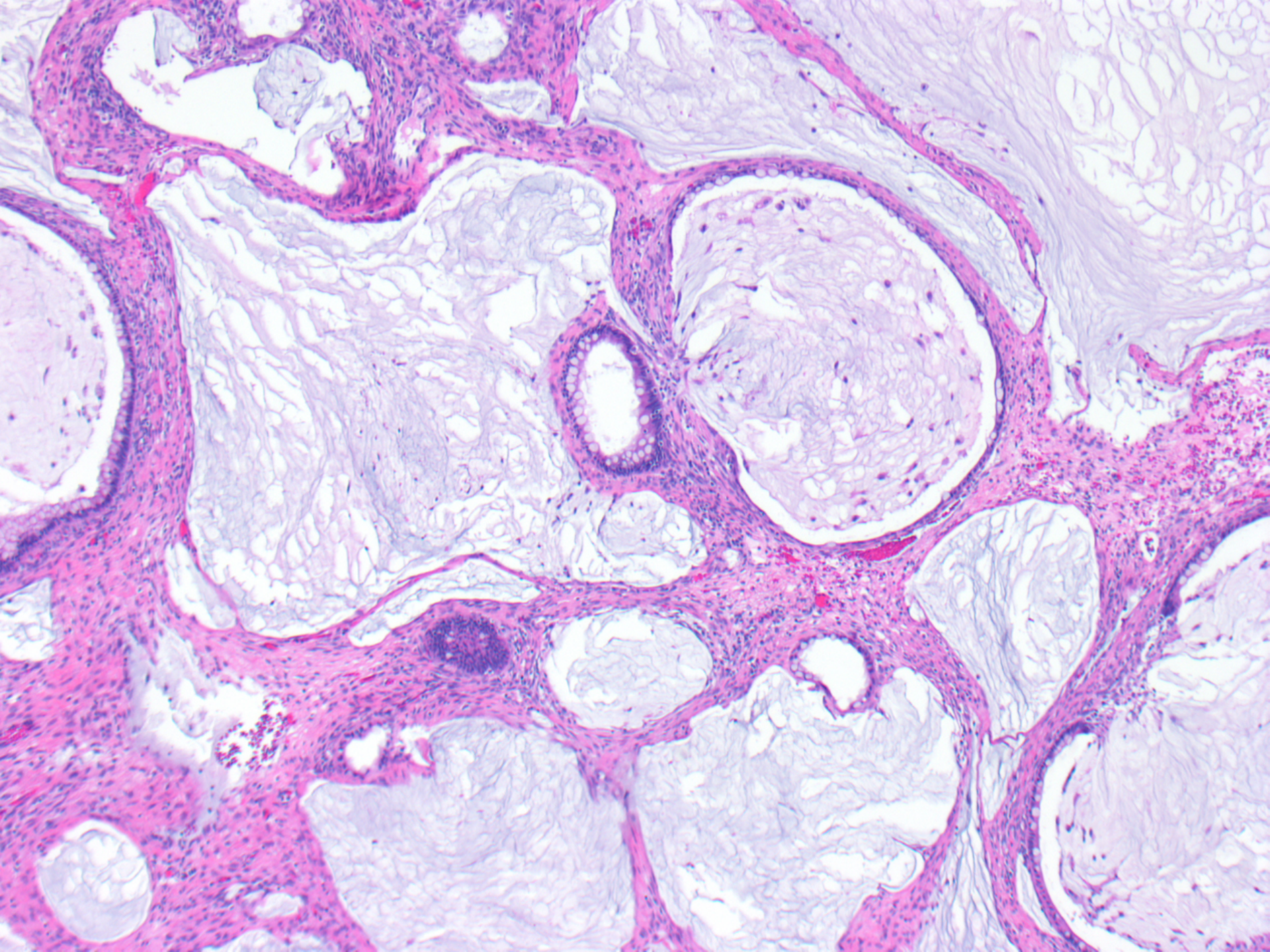


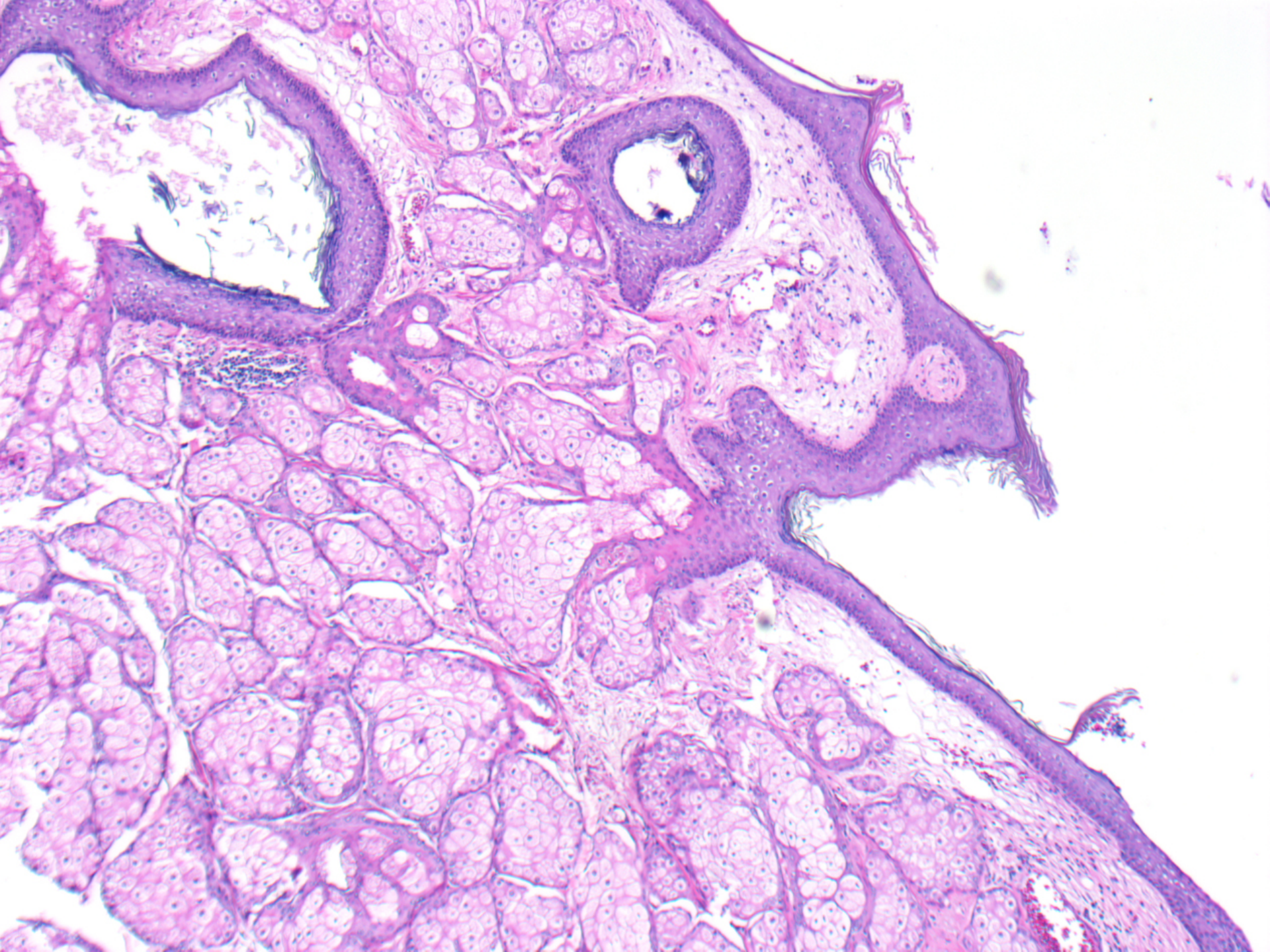








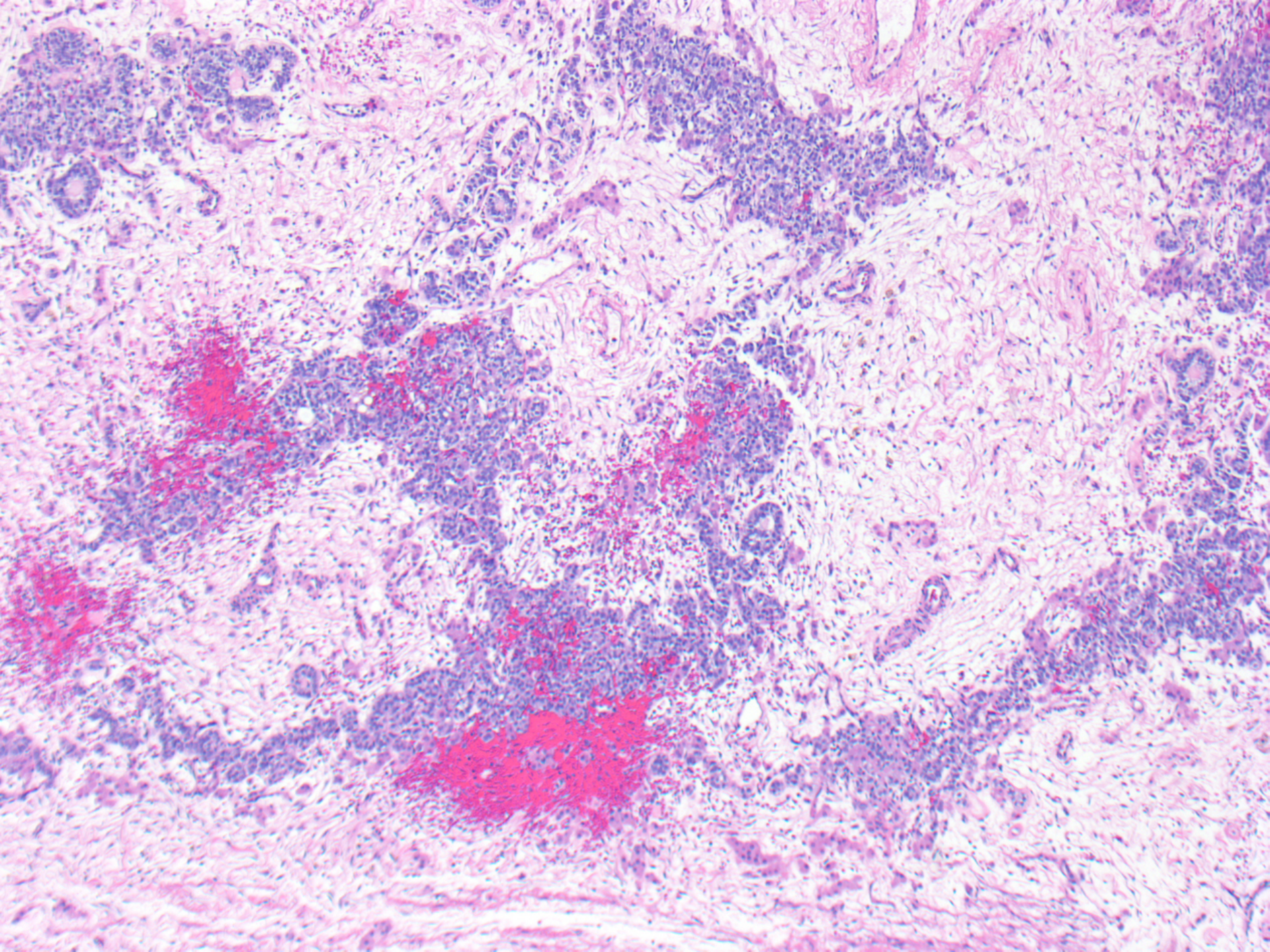


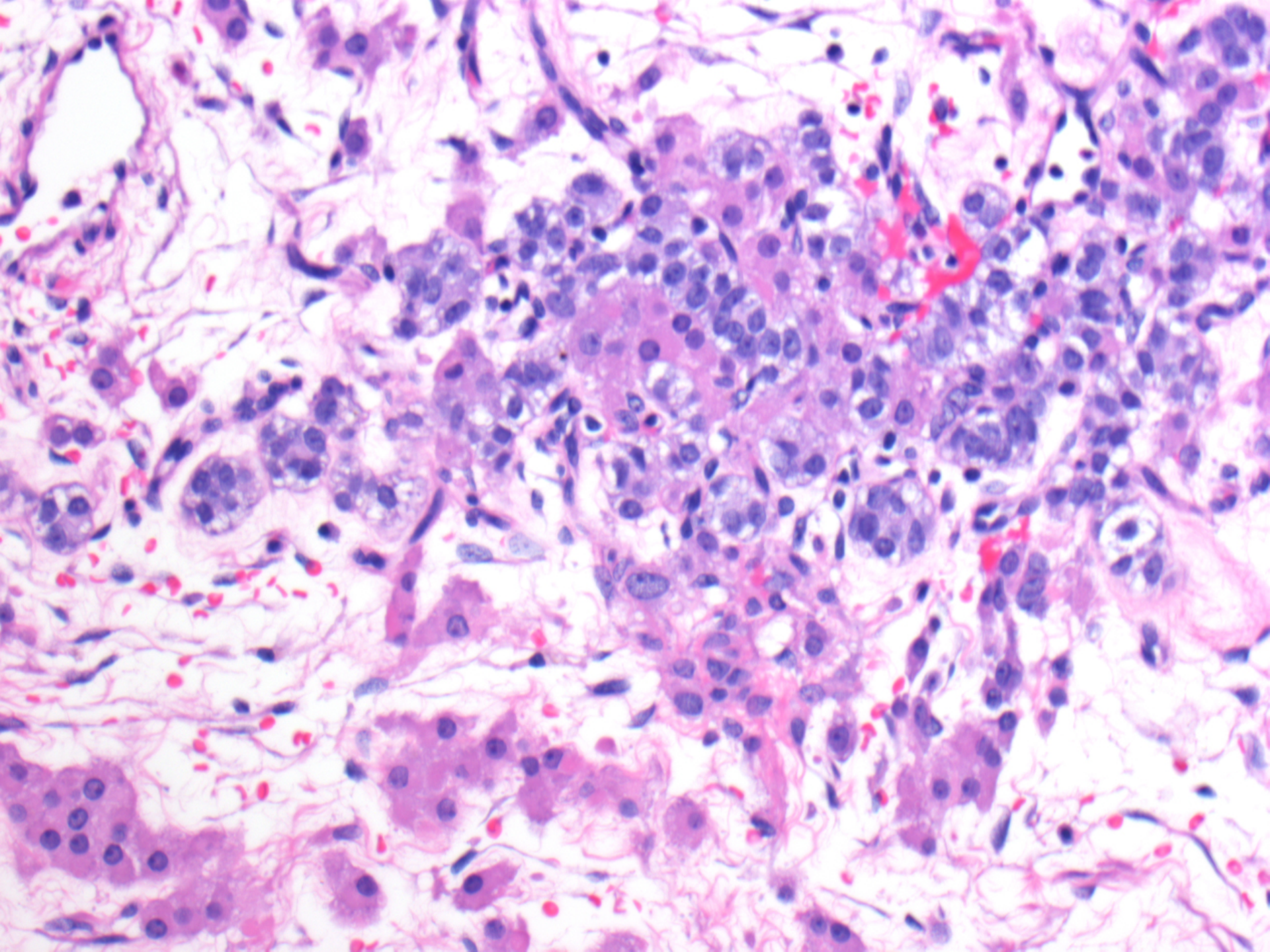


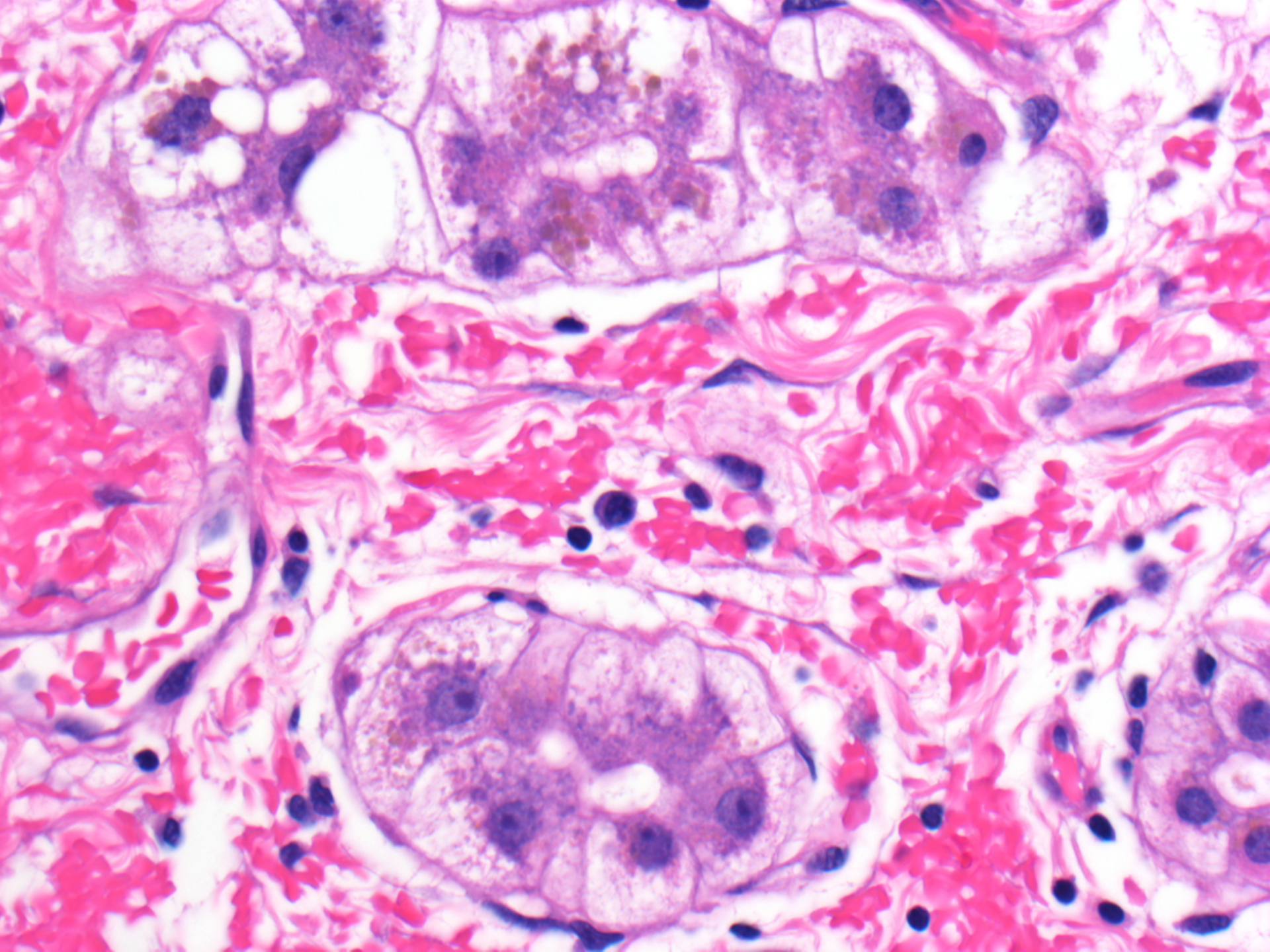
Case 9

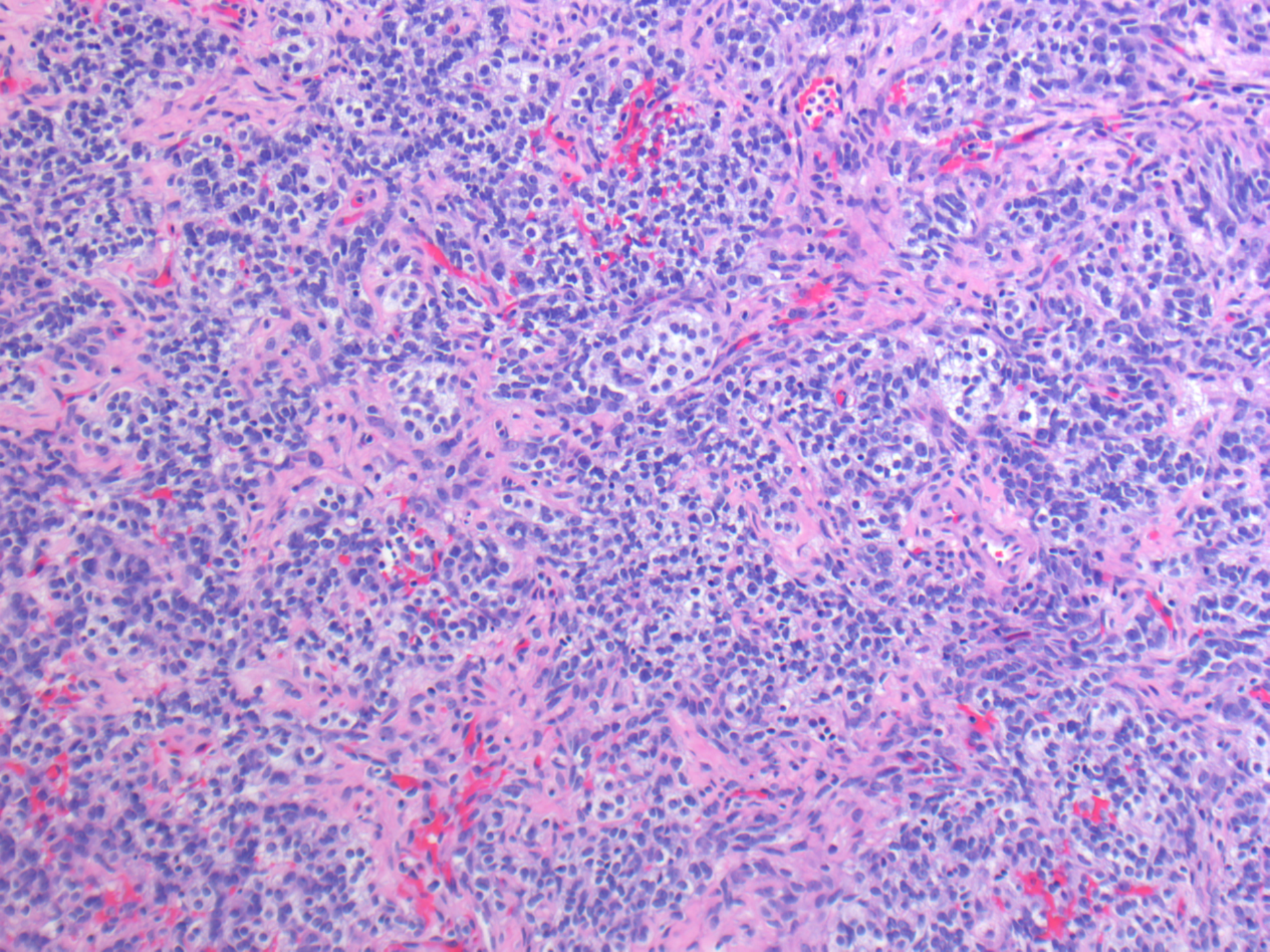
The patient is a 23 year old woman with a normal menstrual cycle. She was found to have a pelvic mass at the time of a routine gyn exam. Ultrasound showed a complex cystic left adnexal mass with enhancing septations and right hydronephrosis and hydroureter secondary to mechanical obstruction by the mass. The serum CA-125, CEA, AFP, LDH and Inhibin A were within normal limits. At surgery she was found to have a mostly cystic mass containing serous yellow fluid. There was no evidence of intraperitoneal tumor spread. A left salpingo-oophorectomy was performed.

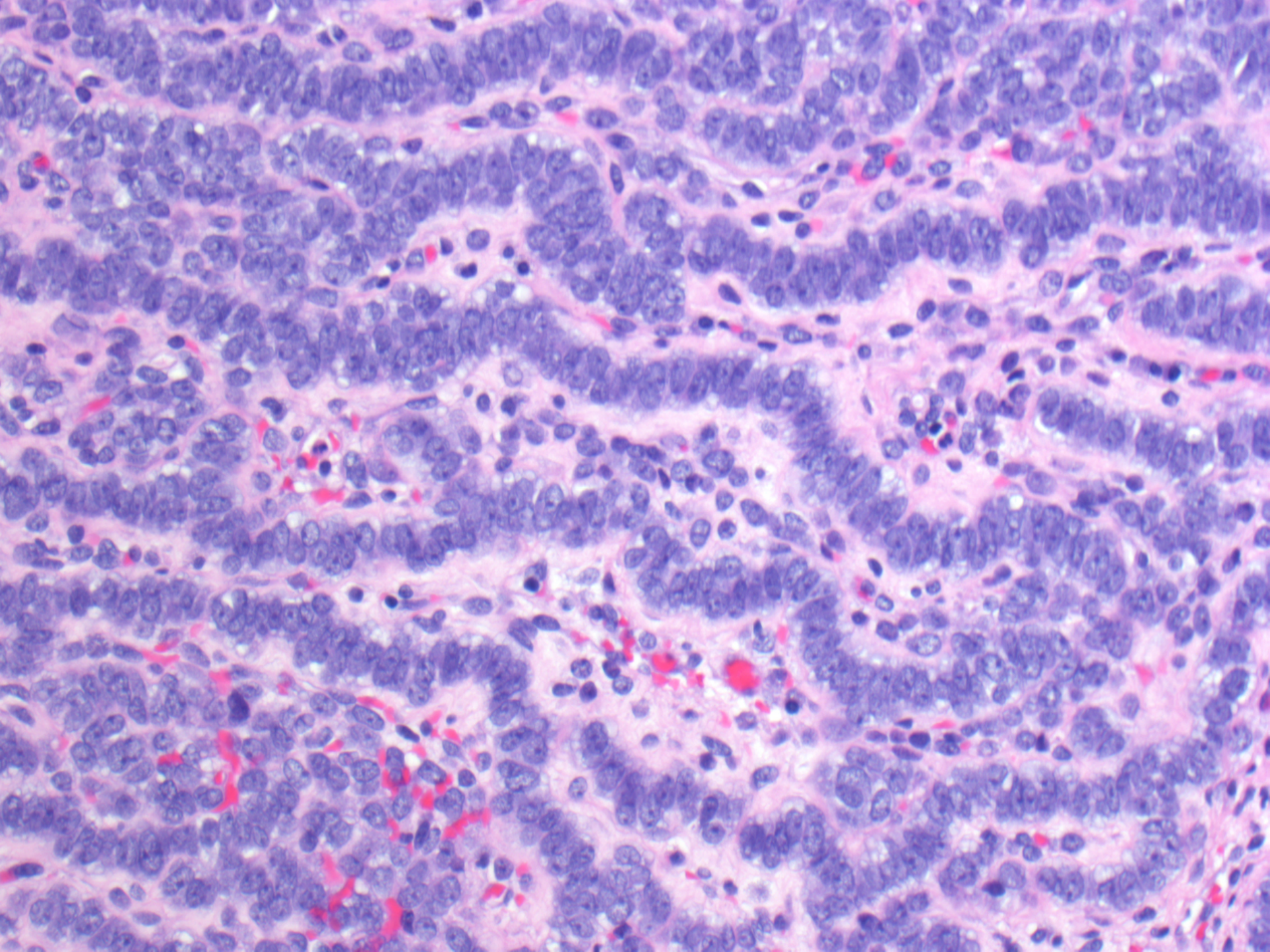
(Courtesy of Laura R. Hofmeister, MD)

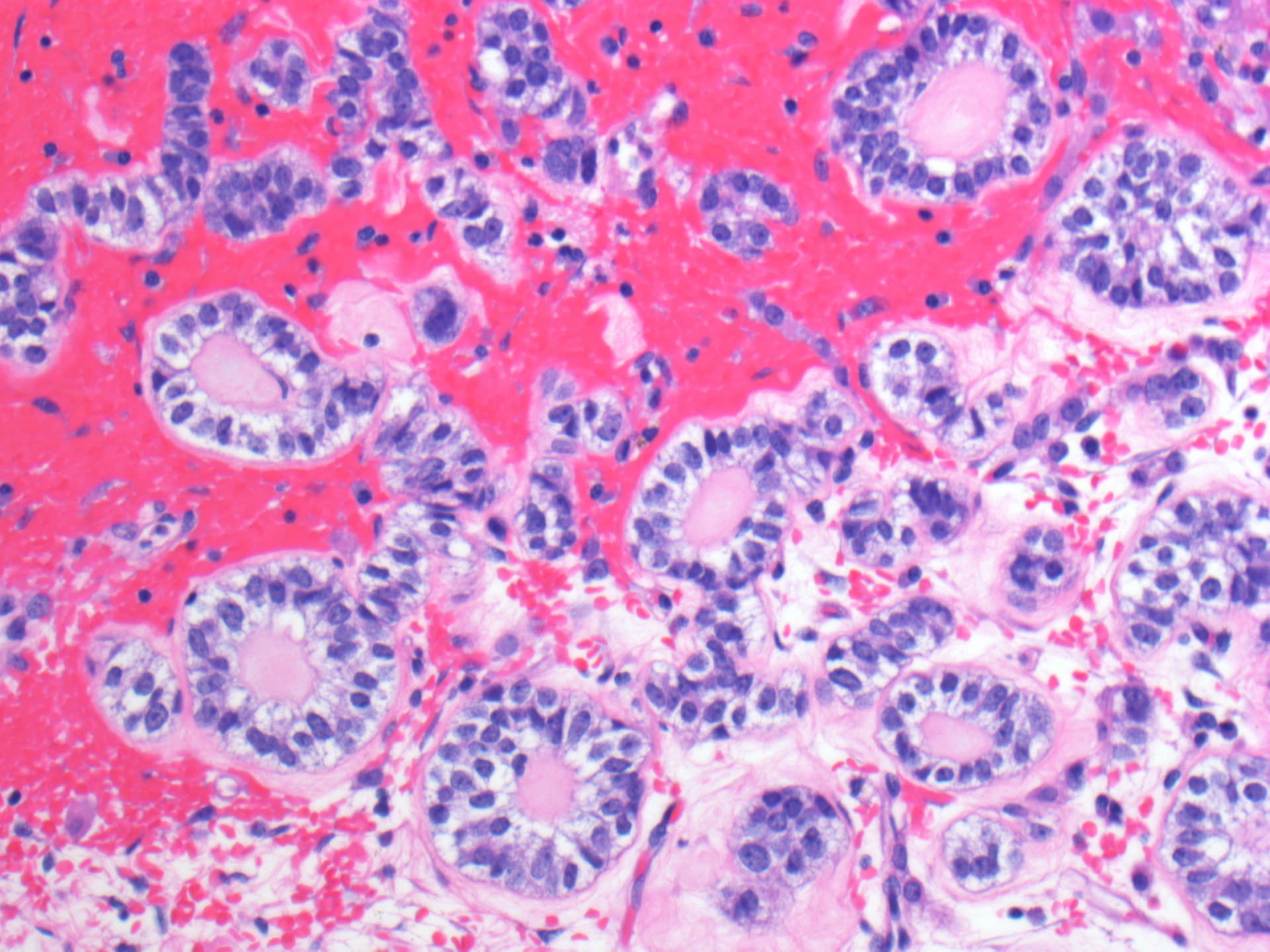


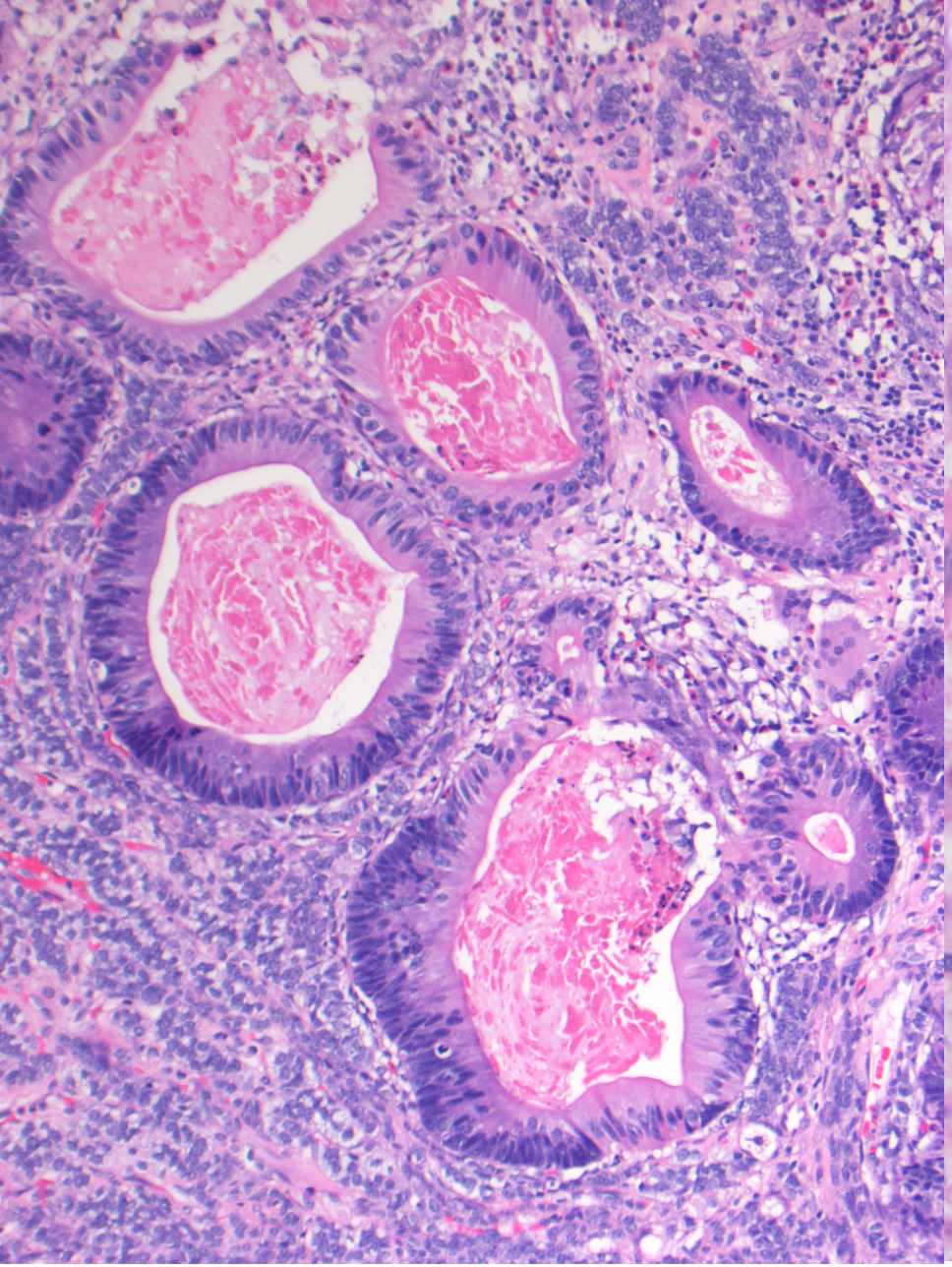


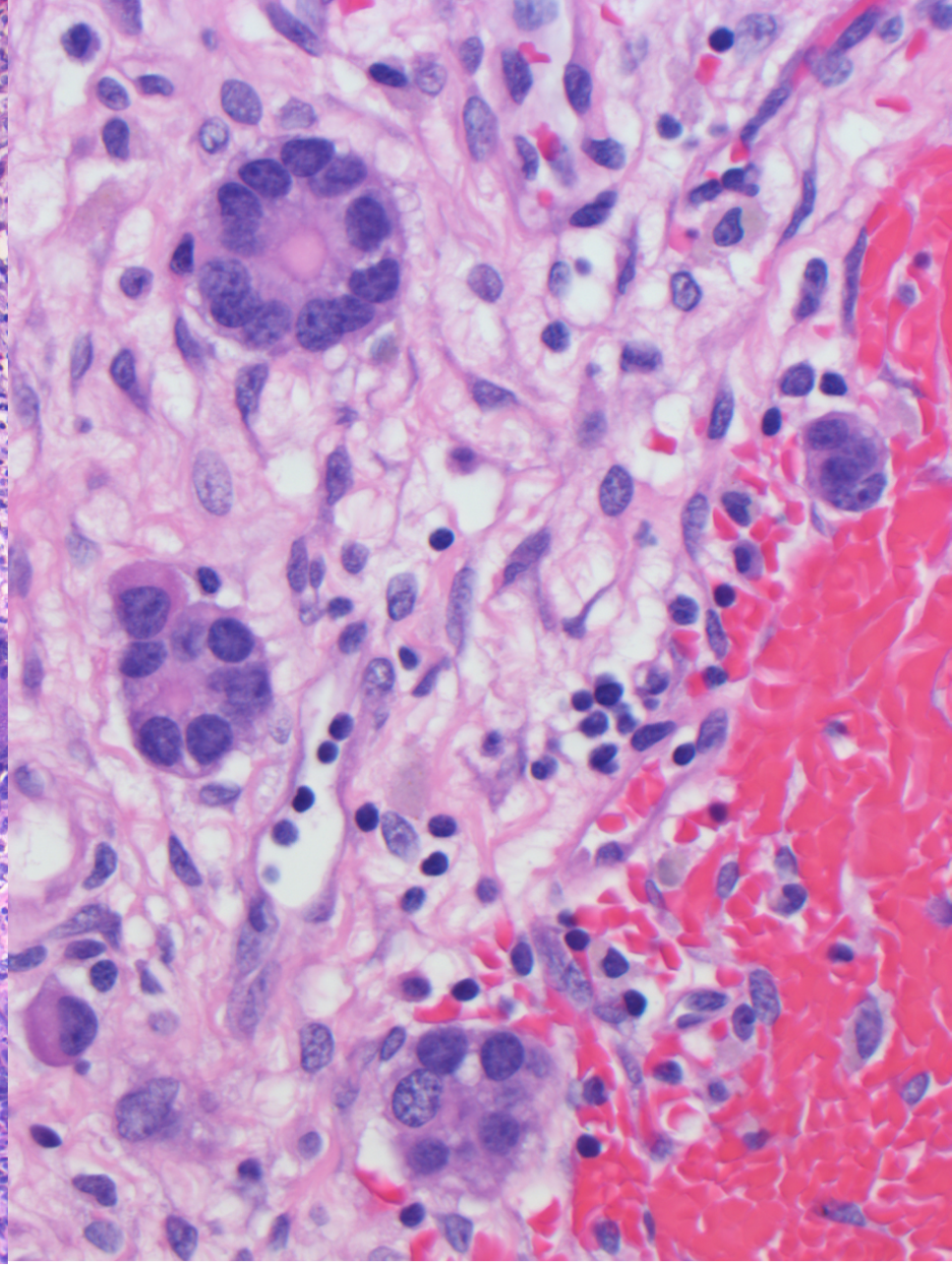












Case 10

The patient is a 36 year old woman. She was diagnosed with atypical endometrial hyperplasia in 2012, but was lost to follow-up. In March, 2015 she was again seen, and an endometrial biopsy showed “atypical hyperplasia, cannot exclude endometrial adenocarcinoma.” In April, 2016 she presented to the ER with abdominal pain and nausea. A CT scan showed a left adnexal mass, massive ascites, and peritoneal tumor spread. The ascitic fluid cytology was interpreted as showing adenocarcinoma. The immunophenotype was unusual. The cells were negative for WT1, PAX8, ER, and napsin. Cytokeratin was positive, a subset of cells were positive for CDX2 and p53, and only rare cells showed staining for CK7. Nevertheless, a gynecologic tumor was high on the differential diagnosis list given the clinical history and presentation, and she was treated with cisplatinum/carboplatinum/taxol. In November, 2016 she underwent TAH, BSO, omentectomy, and pelvic nodule sampling. The surgeon noted that there was considerable residual intra-abdominal/pelvic disease and a liver mass.

(Courtesy of Elena Hristova, MD)