Case: A 50-year-old postmenopausal woman presented with irregular vaginal bleeding for 1 year. Ultrasonography revealed a well-delineated, 1.5 cm hyperechoic polypoid mass in the fundus. Total abdominal hysterectomy with bilateral salpingoophorectomy was performed. On gross examination, both external and cut surfaces of the polypoid fundic mass was a homogenously yellow in color. Microscopically, the tumor was composed of mature adipose tissue with some vascular network but no other identifiable components such as smooth muscles cells or fibrous elements. Immunohistochemically, the tumor was positive for S-100 protein, whereas no reaction with smooth muscle actin or desmin was noted.
Conclusions: Most lipomatous tumors of the uterus are predominantly of mixed-type tumors, such as lipoleiomyoma or fibrolipoma. However, only limited number of pure lipomas arising in the uterus has been reported to date. Although its pathologic diagnosis is quite straightforward, from clinical standpoint it may cause preoperative diagnostic confusion.

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Ovarian mucinous cystadenoma with mural nodule of poorly differentiated squamous cell carcinoma. report of a case

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Background: Mural nodules associated with mucinous and serous tumors of the ovary may represent a reactive process, a benign tumor, or a malignant neoplasm. Thus, the prognosis of the ovarian tumor can be dramatically modified by the presence of this nodule. We report the clinicopathologic and immunohistochemical findings of a case of a mural nodule of anaplastic squamous cell carcinoma associated with ovarian mucinous cystic tumor.
Case Report: The patient was a 66-year-old postmenopausal woman (gravida 1, para 1) with a 6-month history of increasing abdominal fullness. An abdominal ultrasound revealed a multilocular left ovarian cyst with a solid component. After total abdominal hysterectomy and bilateral salpingo-oophorectomy, the diagnosis of a mucinous cystadenoma with a focus of FIGO stage IC anaplastic carcinoma in the left ovary was made. The patient received six courses of chemotherapy; 3 months after completing chemotherapy, she developed rectosygmoidal wall metastases. Despite rectosygmoid resection and additional chemotherapy and radiotherapy, the disease persisted in the pelvis and the patient died 14 months after initial operation. The primary tumor nodule as well as metastatic rectosygmoid tumors were studied by conventional and immunohistochemical methods.
Results: The left ovarian tumor measured 8.5 × 8 × 6 cm. On cut sectioning, it was multilocular with a solid 4.5 × 4 × 3 cm mural nodule. Microscopically, the cyst wall was predominantly lined with benign mucinous epithelium, with rare foci of endometriosis found in smaller locules. The solid area of the mural nodule showed nests of spindle or polygonal highly malignant cells with admixed inflammatory cells. Necrosis and hemorrhage were also present. The ovarian capsule was invaded by the pleomorphic tumor cells. In favor of a diagnosis of anaplastic carcinoma were poor circumscription of the nodule with lymph-vascular involvement and absence of a prominent inflammatory reaction with multinucleated giant cells of the epulis type. In addition, the metastatic rectosygmoid tumor showed poorly differentiated squamous cell carcinomatous features. Immunohistochemically, the atypical cells of the nodule as well as a metastatic tumor were uniformly positive for epithelial markers such as pan-cytokeratin, high-molecular weight cytokeratin, cytokeratin 7 and epithelial membrane antigen, negative for carcinoembryonic antigen and focally weakly positive for vimentin. Many of these cells were also immunoreactive for p53 (80–90%) and Ki67 (40–50%).
Conclusions: The occurrence of ovarian mucinous cystic tumor with mural nodule of poorly differentiated squamous cell carcinoma is evidently very uncommon, because we have not found a similar case in the literature. The malignant nodules composed of sarcoma or anaplastic carcinoma such as in our case are associated with an unfavorable outcome and must be distinguished from other sarcoma-like nodules that may also occur in the wall of mucinous ovarian tumors. Therefore, the implementation of strict morphologic criteria supplemented by immunohistochemistry aids in the sometimes difficult differential diagnosis among these types of mural nodules.

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Large cell neuroendocrine carcinoma of the uterine cervix associated with hr-hpv-16/18. a report of two cases and review of literature

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Background: Large cell neuroendocrine carcinoma (LCNEC) of the uterine cervix is a rare and aggressive tumor. Less than 50 cases are documented in the literature. Their association with the integration of HPV DNA type 16 or 18 has been documented in a few studies. The most common HPV identified has been type 16. We report the clinicopathologic and immunohistochemical characteristics and the presence of HPV DNA in 2 cases of cervical LCNEC.
Cases: The two patients were 32 and 56 years (case1, 2 respectively) and presented vaginal bleeding with abnormal Pap smears. Colposcopy showed an exophytic cervical mass. The biopsy revealed a neuroendocrine carcinoma (case 1) and an undifferentiated carcinoma probably of squamous type (case 2). Clinically there was no evidence of metastasis. The 2 patients underwent hysterectomy with pelvic lymphadenectomy. Grossly, cervical lesions were ill-defined, polypoid, of 2 and 3 cm (case 1 and 2 respectively) The sectioned surfaces were beige or yellow–gray and focally hemorrhagic and necrotic. Histologically, the tumors densely cellular showed large cells that exhibited organoid nesting, trabecular, sheets palisading and rosette-like growth patterns with a high mitotic rate, apoptotic cells and foci of necrosis. Invasive adenocarcinoma was present adjacent to the tumor (case 2). The tumor cells were, CD56+, NSE+, EGFR+, p16+, p53+, KL1+, vimentin-, chromogranin-, synaptophysine-, CK7-, CK5/6-, BcL2-, RO-, RP-, HER2-

