A rather unusual case

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Clinical history

* 47 yr old female

* Full cervical screening history

1984 -1989  Negative tests x 3
1990       Moderate dyskaryosis
1991 -2012  Negative samples x 7
**Clinical history..**

<table>
<thead>
<tr>
<th>Year</th>
<th>Event</th>
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<tr>
<td>2013</td>
<td>Urodynamic tests for stress incontinence</td>
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| Feb 14 | **Seen in Gynaecology**  
Complains of menorrhagia.  
Tranexamic acid medication and Mirena coil inserted. |
| Aug 14 | Reviewed at Gynaecology – all resolved. |
| Jan 15 | **Routine smear at GP surgery.**  
Copious discharge from cervix, sample collected and sent for Non-gynae investigation. |
• Cytology – LBC sample

• 14\textsuperscript{th} day of cycle
• Blood and proteinaceous debris in background
• Cellularity adequate
• Evidence of TZ sampling
• Reported as negative.
General view x 10 magnification
**Cytology – discharge from cervix**

* **Clinical History**
  Watery loss from cervix.

* **Macroscopic Description**
  1ml cloudy thick colourless fluid

* **Microscopic Description**
  Mature squamous cells and background mixed flora of bacteria. No inflammatory cells seen and no malignant cells identified.
  The material is not diagnostic

* **Final Diagnosis**
  Cervical discharge - no malignant cells seen.
Mar 15  Referred back into Gynaecology
   Now complains of 3 months PCB and continuous watery discharge
? urine

Clinical: Not urine, discharge coming from vagina.
Vessels on cervix but no obvious lesion.
Bulky retroverted uterus.
No obvious pathology, and coil correctly sited.
Physiological cyst – Nabothian.
Copious watery discharge.
Cervical biopsy and endocervical biopsy taken.
* **Cervical biopsy**

Metaplastic squamous epithelium showing CIN1. Immunohistochemistry for p16 shows no staining. Small amount of glandular epithelium included shows no evidence of glandular neoplasia.

* **Endocervical biopsy**

Strips of endocervical type and intestinal type epithelium - with goblet cells-columnar form. The endocervical epithelium’s nuclei show basal location with no marked pleomorphism although appear pseudostratified in areas. No mitotic figures noted.
It has been stated in a review article that:

‘Benign intestinal metaplasia involving endocervical glands has been described, but it is probably an extremely rare phenomenon, if it occurs at all, and the presence of goblet cells almost always indicates CGIN.’


Therefore cervical intraepithelial glandular neoplasia is a likely diagnosis in this case and a repeat biopsy is advisable since this biopsy lacks tissue architecture.
Dec 15
Cervical biopsy:
Confirmed as CIN1

Endocervical biopsy
Multiple endocervical gland fragments present in which there are goblet cells, an unusual finding, which raises the possibility of CGIN elsewhere in the endocervix, but there is no evidence of CGIN in this biopsy.

April 2016 - LLETZ Cone biopsy undertaken.
**Microscopic Description**
Sections show no obvious evidence of malignancy in either squamous or glandular epithelium.

IHC marker p16/Ki67 is corroborative (p16 negative, Ki67 low/parabasal). The glands do show focal goblet cell metaplasia in the canal. There is however no evidence of CGIN seen.

**Further IHC markers:**
CEA some very focal positivity
ER and PR showed focal loss of reaction.
P53 negative

**Final Diagnosis**
Lletz cone biopsy cervix - no evidence of CGIN or CIN, p16 negative. Goblet cell metaplasia present but of doubtful significance as absence of p16 staining
Histology
• No CIN
• Abnormal endocervical glandular proliferation – features subtle
• Mild nuclear enlargement with occasional mitotic figures
• Abnormal gland architecture surrounded by desmoplastic stromal response.
• Small groups and single cells with abundant eosinophilic response.

Immunohistochemistry:
• Diffuse positivity with CEA, CK7, MUC6 and PAX8
• Wild-type immunoreactivity with p53
• CA125 focally positive
• CK20, CDX2, ER, PR and p16 largely negative (Occasional positivity with ER)
Primary cervical gastric-type adenocarcinoma (non-HPV-related cervical adenocarcinoma)

**Classic adenoma malignum** (mucinous variant of minimal deviation adenocarcinoma) forms the well differentiated end of this spectrum. Loss of staining with hormone receptors useful in distinguishing from normal endocervical glands.

**Extremely difficult case to interpret**
Summary – Invasive adenocarcinoma – corresponding to gastric-type adenocarcinoma
Acknowledgments

* Colposcopy team Dorset County Hospital for sharing this interesting case

Photographic images:
* Dr Alina Chefani
  Pathology department, Dorset County Hospital
* Dr Andrzej Karmolinski
  Consultant Pathologist, Musgrove Park Hospital
Incidental finding on routine screening.

Q. What is it?

A. It’s a Symphylan. Distantly related to true centipedes Lives in soil and leaf litter. Carnivorous