FEMALE GENITAL SYSTEM

MAIN CATALOGUE

CASE 36
The patient had suffered from abdominal pain and vomiting and a mass was felt in the right vaginal fornix. Operation was performed in July 1932.
The specimen consists of an enlarged ovary measuring 7cm in maximum dimension. A tuft of hair focally projects from the surface and a window has been cut to show a well-formed tooth within the lesion.
Diagnosis: Dermoid cyst of the ovary

CASE 72
The patient was a primipara aged 24. Pregnancy progressed normally until the 4th month when occasional mild vaginal bleeding began. After 2 weeks the uterus decreased in size and the patient was allowed to resume her normal duties, though occasional bleeding with pain persisted. At the end of the 5th month the specimen was passed per vaginam.
The specimen consists of the amniotic sac and the placenta, together measuring 10 x 5 x 4cm. A malformed foetus measuring 1cm in length is attached to a short umbilical cord within the sac.
Diagnosis: Spontaneously passed products of conception

CASE 79
This specimen is from 1933.
The specimen is of a partly cystic and partly solid tumour that measures 9cm in length. The solid area is brown cellular tissue with foci of necrosis and ill-defined fibrous septa. The cyst is unilocular with a relatively thin wall and a mostly smooth lining. Part of the ovary and Fallopian tube can be seen on the external surface.
Diagnosis: Tumour of the ovary.
Histology reportedly showed granulosa cell tumour.
What is the normal role of granulosa cells of the ovary? Granulosa cells surround the growing oocyte before ovulation and produce oestrogen from a precursor steroid hormone made by cells in the adjacent theca interna.
Comment: Granulosa cell tumours are often encapsulated. They tend to be solid but may have cystic areas. Many tumours produce oestrogen.

CASE 119
No clinical information is available.
The specimen is a solid spheroidal ovarian tumour 10 x 8 x 7cm that has been partly bisected and opened out. The cut surface is pale with myxomatous areas. The surface of the tumour is relatively smooth. The fallopian tube is seen on the reverse of the specimen.
Diagnosis: Fibroma
Comment: Fibromas can often be distinguished from thecomas macroscopically as the latter tend to have a yellow colour, the colour being related to their lipid content, necessary in the synthesis of steroid hormones. Corpora lutea are yellow for the same reason. (Latin: luteus = yellow)

CASE 126
The patient was a woman aged 48 with intermittent menorrhagia.
The specimen is of a uterus opened anteriorly with attached tubes and ovaries. The uterine cavity is filled with blood clot and necrotic tumour debris. In the fundus and body of the uterus beneath the blood clot there is pale brown necrotic tumour which invades the inner-mid parts of the myometrium.
Diagnosis: Endometrial carcinoma
Comment: Macroscopically this could also be a sarcoma, but as endometrial carcinoma is the commonest primary uterine malignancy, this is the most likely diagnosis.
What are the risk factors for endometrial carcinoma? Most arise in peri and postmenopausal women in a background of endometrial hyperplasia which is oestrogen driven. Predisposing factors include systemic

hypertension, diabetes mellitus, obesity (greater synthesis of oestrogen in body fats), long standing oestrogen use, in those with a history of anovulatory cycles and with oestrogen producing tumours. These endometrial carcinomas tend to be well differentiated.
Another group of tumours arises de novo in an older population without evidence of hyperoestrogenism or endometrial hyperplasia. These tumours tend to be poorly differentiated.

CASE 148
No clinical information is available.
The specimen consists of the cervix uteri. The epithelium of the anterior and posterior lips of the ectocervix around the external os appears more friable and granular than that further out on the ectocervix.
Diagnosis: Cervical ectropion
Comment: The epithelium here looks a bit disrupted, but this area represents the normal protrusion, under the influence of oestrogen, of the more fragile endocervical epithelium onto the ectocervix, better protected elsewhere in the vaginal environment by stratified squamous epithelium. This area is where squamous metaplasia takes place, and including the squamocolumnar junction, represents the transformation zone.

CASE 405
No clinical information is available.
The specimen consists of the uterus together with the cervix, both tubes and both ovaries seen from the front. The uterine cavity is expanded by a large smooth surfaced polyp which measures some 8 x 7 x 3cm. Within the polyp are small cysts. Its tip is in the internal os. The cervix is elongated but the cervical canal appears essentially normal.
Diagnosis: Benign endometrial polyp
What is this condition and how do they present clinically? Benign endometrial polyps arise from localised areas of excessive endometrial proliferation. They may be asymptomatic, but may present with intermenstrual or postmenopausal spotting related to ulceration.

CASE 515
No clinical information is available.
The specimen consists of a spheroidal mass of brown placental tissue 6 x 6 x 5cm containing an amniotic cavity which measures 3.5 x 3 x 3cm in which a foetus is present. The mass appears to have been in the fallopian tube, part of which is present at one side.
Diagnosis: Ectopic pregnancy

CASE 562
No clinical information is available.
The specimen consists of two ovarian cysts that have been turned inside out. They show florid papillary ingrowths, partly cystic and partly solid. The outer surface of the cysts cannot be seen.
Diagnosis: Papillary serous tumours of the ovary
Comment: The specimen is not immediately recognisable as being from the ovary.

CASE 2032
No clinical information is available.
The specimen is a bisected uterus with the cervix, the whole measuring 7cm in length. On the ectocervix is a superficially necrotic brown infiltrating tumour that has penetrated the underlying cervical tissue for a depth of about 1cm.
Diagnosis: Carcinoma of the cervix

What histological features is this tumour likely to demonstrate? The commonest malignant tumour of the cervix is squamous cell carcinoma. The tumour cells which invade the stroma, as well as showing features of malignancy (nuclear enlargement, pleomorphism, high N:C ratio, prominent nucleoli, numerous mitoses) will show features of squamous differentiation: moderate amounts of eosinophilic cytoplasm, keratin formation and intercellular bridges.

CASE 2092
No clinical information is available except that the patient had a hydatidiform mole preceding this tumour.
The specimen of uterus 9cm in length demonstrates a necrotic fungating tumour on one side which fills the endometrial cavity and invades through the myometrium to form a subserosal mass.
Diagnosis: Choriocarcinoma
Comment: The fleshy haemorrhagic nature of the tumour macroscopically and its relationship to a recent history of hydatidiform mole provides a strong hint as to the diagnosis. Histology reportedly showed pleomorphic syncytial cells invading the myometrium.

CASE 2210
No clinical information is available.
The specimen consists of a longitudinal section of one Fallopian tube and a transverse slice of the other. The longitudinally sectioned tube shows considerable dilatation of its lumen and the wall is lined with caseous exudate. The outer end of the tube is sealed. The other transversely sectioned tube shows marked fibrosis of the wall.
Diagnosis: Tuberculous salpingitis
Comment: Histology reportedly showed classic caseous tuberculosis. The differential is an active chronic salpingitis with pus in the tube.

CASE 2239
No clinical history is available.
The specimen is the upper portion of the uterine body that has been divided in the coronal plane. In one cornu an ectopic pregnancy is visible with a central amniotic cavity 2cm in length surrounded by placenta and decidual tissue. No foetus is visible.
Diagnosis: Uterine cornual ectopic pregnancy

CASE 3324
No clinical information is available.
The specimen consists of the uterus, cervix and vaginal fornices. The uterus measures 8cm in length. An irregular ulcerated tumour measuring 3cm in diameter replaces much of the ectocervix.
Diagnosis: Carcinoma of the cervix
What are the predisposing factors for carcinoma of the cervix? The main risk factor is infection with certain strains of human papilloma virus (HPV) that is acquired sexually. Multiple partners, young age at first intercourse and having sexual partners who have had multiple partners increase the risk of acquiring infection. HPV infection of the metaplastic squamous epithelium at the transformation zone of the cervix can cause it to become dysplastic, probably via interference of host tumour suppressor protein function by intracellular HPV proteins. The dysplastic cells can acquire further mutations and develop into invasive squamous cell carcinoma. Immunosuppression can also increase the risk as can smoking.

CASE 3893
No clinical information is available.
The specimen consists of the uterine tube, the proximal end of which is greatly dilated and filled with clear fluid. The wall is thin, transparent and not inflamed.
Diagnosis: Hydrosalpinx

CASE 3903
No clinical information is available.
The specimen consists of a fallopian tube, parts of which are recognised on the posterior aspect of the specimen. The tube is markedly distended by blood clot and ragged haemorrhagic placental tissue. Amniotic sac is visible on the left side and from it arises the umbilical cord that extends to a normal-appearing foetus measuring 4.5cm in crown-rump length. The age of the foetus is about 9 weeks.
Diagnosis: Tubal ectopic pregnancy

CASE 3922
A woman aged 31 had a left cornual pregnancy excised. The Ascheim-Zondak test remained positive. Chest x-ray was normal. The uterus was removed 3 weeks after the previous operation.
The specimen consists of a slightly enlarged uterus with attached tubes and ovaries. In the left cornual region is a reasonably well-circumscribed haemorrhagic tumour 3cm in diameter. There are two transected unilocular cysts in the right ovary. The myometrium is thickened.
Diagnosis: Choriocarcinoma
Comment: Histology showed choriocarcinoma. The fleshy haemorrhagic nature of the tumour macroscopically and its relationship to a recent pregnancy provide a hint as to the diagnosis.

CASE 3939
No clinical information is available.
The specimen is a spherical tumour 4cm in diameter opened to show a cut surface composed of uniform brown cellular tissue. A segment of fallopian tube overlies the tumour.
Diagnosis: Brenner tumour of the ovary.
Comment: The diagnosis is not made on the macroscopic appearances. However, most other epithelial tumours are at least partially cystic, and malignant tumours (epithelial or germ cell) will generally be more malignant looking. The main macroscopic differential in this case is with some type of sex-cord stromal tumour.

CASE 4239
No clinical information is available.
The specimen consists of a pregnant uterus in the wall of which is a well-circumscribed tumour with a whorled cut surface that measures 8cm in diameter. A pregnancy at about 8-9 weeks is present in the uterine cavity. The foetus measures 4cm from crown to rump and appears normal. The endometrium is thickened by the decidual reaction.
Diagnosis: Uterine leiomyoma and pregnancy.

CASE 4677
The specimen is a coronal slice of the uterus and cervix, together measuring 9.5cm in length. The cervix contains several smooth-walled simple cysts within its stroma, the largest measuring 1 cm in length. A tiny 5mm whorled tumour (leiomyoma) is present in the myometrium at the fundus.
Diagnosis: Nabothian cysts of the cervix
Comment: Nabothian cysts are extremely common and without clinical significance. They develop from the endocervical glands.

CASE 4939
The patient was a woman aged 63 with a history of local irritation for 2 months. A lump was present which was increasing in size. There was a watery discharge. The tumour was excised.
The specimen consists of the excised portion of the vulva with, in its central parts, a flat ulcerated irregular tumour 4cm in diameter and 0.5cm in height.
Diagnosis: Carcinoma of the vulva
What histological type of tumour is this likely to be? Squamous cell carcinoma.

CASE 5007
The specimen shows a portion of uterine fundus 5 x 6cm surrounded on one side by several cysts up to 3cm in diameter, one of which appears to be filled with old blood clot. Sectioned ovary is seen to the left of an empty cyst. There are 2 separate encapsulated masses up to 4cm in diameter, which are filled with old blood and a separate piece of blood clot.
Diagnosis: Endometriosis

CASE 7291
The patient was a woman aged 40 who died of an aortic dissection related to syphilitic aortitis. She had been married twice and had one still-born child at the age of 18. Fifteen months before her death she developed a right hemiparesis that resolved in 3 months. She had been breathless for 12 months, worse for the last 2 weeks. Her final admission was precipitated by acute chest pain accompanied by shock. At post-mortem there was an abortive dissection of the ascending aorta 2cm above and anterior to the left posterior aortic cusp. A myocardial gumma was also noted.
The specimen is of the uterus, tubes and ovaries. The uterus is of normal size and appearance. Both tubes are dilated, thin-walled and filled with clear fluid. Fine strands of fibrous tissue bridge from uterus to tubes. The cervix appears normal.
Diagnosis: Bilateral hydrosalpinx with pelvic adhesions

CASE 8140
The specimen is of an enlarged uterus containing a 15cm diameter tumour with a whorled cut surface in the fundus. The cut surface also shows uniform haemorrhagic discolouration.
Diagnosis: Leiomyoma with red degeneration

CASE 8306
The patient was a woman aged 86 who had been breathless for 12 months. Latterly she had attacks of angina pectoris. She died of bronchopneumonia.
The specimen is of the uterus, tubes and ovaries seen from behind. The uterus is grossly distorted by a number of irregular subserosal masses that vary in size from 1 to 6 cm in diameter. A wedge has been cut from the largest tumour to show extensive white calcification. The tubes and ovaries appear normal.
Diagnosis: Calcified leiomyomas

CASE 9431
The patient was a woman aged 62 who developed a spinal meningioma complicated by urinary infection.
The specimen is of the uterus, tubes, ovaries and upper vagina seen from behind. A large congested fleshy polyp with a smooth surface measuring 3.5 x 2.5 x 2 cm protrudes from the external os of the cervix. The polyp is attached to the posterior wall of the endocervical canal. The tubes and ovaries appear normal.
Diagnosis: Benign endocervical polyp

CASE 10641
No clinical information is available.
The specimen consists of half a well-circumscribed oval tumour which measures 10 x 7 x 6 cm. The cut surface shows pale brown cellular tissue containing scattered simple cysts with smooth walls measuring up to 15mm in diameter. There are scattered patches of congestion.
Diagnosis: Ovarian thecoma
Comment: This specimen is not readily recognisable as ovary, nor as thecoma. Histology reportedly showed fibroblastic and myxomatous areas. In some places the cells were rounded and luteal-like.

CASE 10744
The patient was a woman aged 82 who was admitted with a megaloblastic anaemia and congestive cardiac failure. She deteriorated slowly and died.
The specimen consists of the uterus, tubes and ovaries. A fleshy ragged endometrial polyp with a variegated cut surface fills the cavity of the uterus. This is continuous with poorly demarcated tumour of similar appearance invading the myometrium. Subserosal tumour can be seen on the back of the specimen. The left ovary is distended by a simple probably unilocular cyst 4.5cm in diameter.
Diagnosis: Endometrial carcinoma
Comment: Some sarcomas of the uterus can be polypoid but as endometrial carcinoma is the commonest primary uterine malignancy, this is the most likely diagnosis.
Name some sarcomas of the uterus. Leiomyosarcoma, malignant mixed mullerian tumour (a carcinosarcoma), stromal sarcoma.

CASE 10886
The patient was a woman aged 61 who died of lymphoma.
The specimen is of the uterus and right tube and ovary. The uterine cavity contains a smooth surfaced haemorrhagic polyp 4cm long arising from the fundus. The endocervical canal is dilated and the external os appears very narrowed. The tube and ovary appear normal.
Diagnosis: Benign endometrial polyp
Comment. The haemorrhagic nature of this polyp suggests that it has infarcted following torsion.

CASE 11260
This pregnancy was 3 weeks post-mature. The woman was toxaemic and there was some foetal distress. Liquor amnii was very scanty.
The specimen consists of the placenta and a length of umbilical cord. The main mass of the placenta measures 15cm in maximum diameter and lying a little way from it is a small succenturiate lobe 5cm in diameter. Both portions of the placenta show specks of calcification. Large vessels supplying the succenturiate lobe are visible on the reverse of the specimen. The cut end of the umbilical cord appears to show only 2 vessels.
Diagnosis: Placenta with succenturiate lobe

CASE 12879
No clinical history is available.
The specimen comprises uterus, tubes and ovaries. The uterus is small. Largely within the endocervical canal is a circular intrauterine contraceptive device.
Diagnosis: Intrauterine contraceptive device

CASE 13637
The patient was a woman aged 44. The right breast had been removed 4 years previously for carcinoma. She had been breathless for 6 months and chest x-ray showed pleural effusion. Malignant cells were found in the pleural fluid and biopsy revealed adenocarcinoma. Nitrogen mustard was injected into the pleural cavity but she died suddenly 13 hours later. At post-mortem widespread secondary carcinoma was found involving the pleura, lungs, pericardium, diaphragm, liver, omentum, peritoneum and ovaries.
The specimen consists of the uterus, tubes and ovaries. The right ovary is replaced by a nodular mass of neoplastic tissue measuring 6cm in maximum diameter. The cut surface shows rather scirrhous tumour. The other ovary shows a similar though smaller neoplastic mass. There is a subserosal leiomyoma 3cm in diameter projecting from the left uterine cornu.
Diagnosis: Metastatic carcinoma to the ovaries

CASE 14237
The patient was a woman aged 87. At post-mortem a large tumour weighing
2500gm was present in the right ovary.
The specimen is a slice of this tumour that measures 21 x 10cm. The cut surface shows a mixture of pale and brown cellular tissue interspersed with fibrous septa. A few small cysts are evident.
Diagnosis: Ovarian sex cord stromal tumour
Histology showed a fibroma composed of regular spindled cells.

CASE 14515
The specimen was an incidental finding in a 65-year old woman who died of massive cerebral haemorrhage.
The specimen consists of the uterus and both fallopian tubes and ovaries. The uterus appears atrophic and the external cervical os is narrow. Protruding from the uterine fundus is a spherical tumour 5 x 6 x 7 cm. Dilated vessels can be seen on its surface. In addition there is a pedunculated nodular calcified fibroid 3cm in diameter that is attached by a pedicle 1cm long to one border of the uterine body.
Diagnosis: Leiomyomas

CASE 15469
The patient was a woman aged 72 who died from rupture of an aortic dissection into the pericardium. The specimen was an incidental finding at post-mortem.
The specimen comprises cervix and upper vagina. The epithelium for 5mm around the external os appears more fragile and granular than that further out on the ectocervix. A 5mm Nabothian cyst is also evident beneath the mucosa on one side.
Diagnosis: Cervical ectropion
Comment: This area represents the normal protrusion, under the influence of oestrogen, of the more fragile endocervical epithelium onto the ectocervix , better protected elsewhere in the vaginal environment by stratified squamous epithelium. This area is where squamous metaplasia takes place, and including the squamocolumnar junction, represents the transformation zone.

CASE 15494
No clinical information is available.
The specimen consists of an enlarged globular uterus which measures 12cm in width and with the cervix measures 13cm in length. A window has been cut in the uterus to expose a mass of friable pale yellow-brown tumour tissue comprising fine cystic fronds filling almost the entire cavity. There is an area of recent haemorrhage on one side.
Diagnosis: Hydatidiform mole

CASE 15771
The patient was a woman aged 48 who was known to have a carcinoma of the cervix for at least a year. A course of radiotherapy was given and 6 months later a left nephrostomy was performed. This became blocked and she was readmitted for investigation. A large vesico-vaginal fistula was found. The urine was heavily infected. She died after a few days.
The specimen consists of the uterus and adnexa together with the bladder and rectum. The bladder is opened from the front to disclose irregular neoplastic infiltration of the posterior bladder wall and trigone surrounding a fistulous opening 3cm in diameter into the anterior vaginal fornix. The mucosa of the rectum on the back of the specimen does not appear to be invaded.
Diagnosis: Carcinoma of the cervix with vesicovaginal fistula
What is the likely reason for the nephrostomy? The tumour was probably invading and obstructing the left ureter where it entered the bladder.

CASE 15973
The patient was a woman who presented with dyspnoea and ascites.
The specimen is half a large cystic ovarian tumour that measures 19cm in maximum diameter. There is a constriction near the centre of the tumour that divides it into two lobes. The right side is largely solid friable tumour with spaces containing mucin. The left side is mainly cystic with a more fleshy cellular protrusion at the waist of the specimen.
Diagnosis: Cystadenocarcinoma of the ovary
Comment: The complex architecture of this ovarian tumour with many solid areas strongly suggest that it is malignant.
Histology showed a papillary serous adenocarcinoma forming mucin in some areas.
(N.B. It is not immediately apparent that this specimen is ovarian)

CASE 16355
No clinical information is available.
The specimen is half an ovarian cystic tumour removed at operation. It measures 11cm in diameter and on section reveals a multilocular cystic structure. Some of the cysts contain mucin.
Diagnosis: Cystic tumour of the ovary
Comment: The macroscopic appearances of this specimen do not obviously convey its malignant or benign nature, as they often don't with ovarian tumours. However, its architecture is not particularly complex with few solid areas, so it is most likely to be benign or 'borderline' (uncertain malignant potential) in nature. The presence of mucin suggests that it is mucinous in type.
Histology reportedly showed mucinous cystadenoma.
(N.B. It is not immediately apparent that this specimen is ovarian)

CASE 16373
No clinical information is available.
The specimen consists of a complex tumour measuring 16cm in maximum dimension. Membranes and solid tissue are present posteriorly. The tumour demonstrates cystic dilation of villous structures.
Diagnosis: Hydatidiform mole

CASE 17195
The patient was a woman aged 32 who was admitted to a country hospital after a miscarriage at approximately 10 weeks pregnancy. Curettage next day produced only a little tissue and was followed by lower abdominal pain, shock and fever. Chemotherapy was begun and on the second day she was transferred to the RAH. A direct smear from the cervix showed organisms resembling *Clostridium welchii*. On admission she was moribund and jaundiced, the BP was 90/70 and there was a copious urine discharge. She died next day. At post-mortem there was generalised jaundice with an unusual brownish

tint. There were bruises and petechiae in the skin of the buttocks, loins and thighs. Both kidneys were large and swollen and intensely congested. Cultures grew *Clostridium welchii*.
The specimen is of the uterus and adnexa together with an elongated vagina and some perineal skin. The recently pregnant uterus is enlarged and measures 13cm in length. The endometrium shows ragged exudate. The uterus, cervix, upper vagina and ovaries are intensely congested.
Diagnosis: Post abortal sepsis
What is the likely pathogenesis of the bruises and petechiae in this patient? This patient probably had disseminated intravascular coagulation secondary to sepsis. Widespread coagulation in small vessels leads to a consumption coagulopathy with reduced amounts of platelets, fibrin etc for blood clotting.

CASE 17110
No clinical information is available.
The specimen consists of a unilocular cyst 8cm in diameter. Foci of calcification are present in the wall. Towards one side is a solid area which contains adipose tissue and separate cysts lined by 'skin' with hair follicles sprouting long dark hairs.
Diagnosis: Dermoid cyst of the ovary
Comment: The larger cyst originally contained thick keratinous material.

CASE 17114
No clinical information is available.
The specimen is half a considerably enlarged uterus that measures 13cm in length and 8cm antero-posteriorly. The myometrium demonstrates a diffusely whorled appearance and within it are several small spaces. Normal endometrium is nicely seen lining the endometrial cavity. An 8mm Nabothian cyst is present near the external cervical os.
Diagnosis: Adenomyosis
Comment: This is a very nice example.

CASE 17116
No clinical information is available.
The specimen consists of half a oval tumour measuring 10cm in maximum dimension. Slightly more than half of the tumour consists of a pale brown solid cellular mass with many small fibrous strands interspersed between softer brown cellular areas. The remainder of the tumour is a unilocular thin-walled cyst. No ovarian tissue or adjacent tube is seen.
Diagnosis: Brenner tumour of the ovary
Comment: The main macroscopic differential in this case is with some type of sex-cord stromal tumour. Histology showed dense interlacing strands of fibrous tissue in which there were numerous epithelial cell nests in keeping with a diagnosis of Brenner tumour.

CASE 17389
No clinical information is available.
The specimen is half a large ovarian tumour measuring 16cm in maximum dimension. Fallopian tube with fimbriae is seen on one side. The cut surface of the tumour shows numerous cysts mostly containing mucinous material. There are some pale necrotic areas.
Diagnosis: Mucinous ovarian tumour
Comment: Macroscopically this tumour demonstrates quite a complex architecture with areas of necrosis suggesting that it is malignant.

CASE 17880
The patient was a woman aged 43 who died from a glioblastoma multiforme in the left frontal lobe. The specimen was an incidental finding at post-mortem. There was a similar larger tumour in the other ovary.
The specimen consists of a unilocular cyst measuring 5cm in diameter and filled with hair.
Diagnosis: Dermoid cyst of the ovary

CASE 17986
The patient was a woman aged 48 with a history of depression. She died from a massive overdose of barbiturates and alcohol. A suicide note was found nearby.
The specimen consists of the uterus, tubes and ovaries. The uterus, cervix and right ovary and tube show no significant abnormality. The distal end of the left tube is dilated to form a hydrosalpinx measuring 5cm in diameter at its greatest extent. There is no evidence of inflammation.
Diagnosis: Hydrosalpinx

CASE 18197
The patient was a woman aged 57. The only history available is that there was fever and "toxaemia" with a palpable abdominal mass. A hysterectomy was performed.
The specimen consists of a very greatly enlarged uterus with a markedly thickened wall. It has been opened in the sagittal plane and contains a very large polypoid pale necrotic tumour measuring some 16cm in diameter and greatly distending the uterine cavity. A calcified leiomyoma 5cm in diameter is present at the fundus. In one place in the myometrium (on the left of the specimen) is a pale oval more homogenous area.
Diagnosis: Malignant tumour of the uterus
Histology showed a spindle-celled sarcoma with marked and extensive myxomatous degeneration.

CASE 18958
The patient was a woman aged 42 who had a partial gastrectomy for peptic ulcer 10 years previously. Nine years later she was readmitted with recurrent ulcer symptoms. Progressive severe abdominal pain and backache supervened. Laparotomy showed a large neoplastic ulcer in the gastric remnant and numerous secondary deposits in the liver. She died 5 months later. At post-mortem there were multiple metastases in the heart, liver, lung, kidney, para-aortic lymph nodes and both ovaries.
The specimen is of the uterus, tubes and ovaries. Both ovaries are totally replaced by nodular masses of pale, firm tumour with intervening fibrosis. The peritoneal surfaces are irregularly nodular.
Diagnosis: Krukenberg tumours of the ovaries

CASE 19315
The patient was a woman aged 26 who complained of lower abdominal pain.
The specimen consists of an opened ovarian cystic tumour measuring 12cm in diameter. There is florid intracystic papillary ingrowth of pale cauliflower-like tumour masses. The peritoneal surface is smooth and there is no evidence of external penetration by tumour.
Diagnosis: Serous papillary tumour of the ovary
Comment: Macroscopically it is difficult to ascertain whether this tumour is benign, borderline or malignant. The papillary structures appear quite orderly but are very florid. Histologically it was said to be benign.

CASE 19431
No clinical information is available.
The specimen consists of a longitudinally sectioned fallopian tube. The tube is dilated and is lined by cream coloured pus. The wall is thickened.
Diagnosis: Pyosalpinx
Histology showed marked suppurative inflammation with fibrosis of the tubal wall, with some overlying peritonitis. The lumen contained frank pus.

CASE 19691
The patient was a woman aged 67. Two years previously there had been some postmenopausal bleeding for which a dilatation and curettage was performed. No abnormality was detected. Four months before her final admission there was a further episode of vaginal bleeding. Cervical smear then showed many atypical endometrial cells suggesting the possibility of adenocarcinoma. The smear was oestrogenic and the possibility of endometrial hyperplasia from an ovarian tumour could not be excluded. Four months later the uterus, tubes and ovaries were removed.
The specimen consists of an opened small uterus together with the ovaries and tubes. One ovary is replaced by a solid tumour with a smooth peritoneal surface measuring 8cm in length by 5cm in maximum width. The cut surface shows irregular lobulation and alternation of very pale tissue with islands of brown tissue. The body of the uterus contains an irregular fleshy tumour that focally appears to invade the myometrium at the fundus. It extends into the lumen of one Fallopian tube.
Diagnosis: Ovarian sex cord-stromal tumour with endometrial carcinoma
Histology reportedly showed a well-differentiated adenocarcinoma in the uterus and a granulosa cell tumour of the ovary.
What is the relationship between the ovarian and uterine tumours of this patient? The granulosa cell tumour produced oestrogens that lead to endometrial hyperplasia and subsequently carcinoma.
What does "the smear was oestrogenic" mean? Oestrogen has an effect on the squamous cells of the cervix. Cervical smears from postmenopausal women generally appear 'atrophic' with poorly oestrogenized squamous cells (relatively less keratinized). Such smears can be distinguished from the oestrogenized smears of pre-menopausal women. This patient's cervical squamous cells had the appearance of those of a premenopausal woman due to the oestrogen being made by the ovarian tumour.

CASE 20031
The patient was a woman aged 78. The menopause had occurred at age 45. One month before her death she presented with a history of blood-stained vaginal discharge and generalised lower abdominal pain for several days. The cervical smear was negative for malignant cells and uterine curettage provided insufficient tissue. Her condition steadily declined with peripheral oedema, elevation of JVP and crepitations in the lungs. Finally there were 3 large melaena bowel actions and she died the next day. At post-mortem a chronic gastric ulcer was found.
The specimen consists of a coronal section of the uterus together with the tubes and ovaries seen from behind. Invading the right myometrium is a very poorly defined pale tumour. It invades through into adjacent parametrium.
Diagnosis: Malignant tumour of the uterus, probably endometrial carcinoma
Comment: The commonest uterine tumour is endometrial carcinoma so this is the most likely diagnosis. Histology showed poorly differentiated adenocarcinoma in keeping with endometrial carcinoma.

CASE 20595
A woman aged 53 presented with lower abdominal pain and vomiting. An acute abdominal surgical emergency was diagnosed operation was performed.
The specimen consists of fallopian tube and an attached ovarian lesion measuring 11cm in greatest dimension. Both are extremely haemorrhagic. The ovarian lesion is bilobular with a wrinkled surface.
Diagnosis: Haemorrhagic infarction of fallopian tube and an ovarian lesion.
What is the likely cause of the haemorrhagic infarction? Torsion leading to venous infarction.
Histology of the ovarian cyst showed a papillary serous cystadenoma.

CASE 20872
The patient was a hypertensive woman aged 72 who died of a massive right cerebral haemorrhage. The specimen was an incidental finding at post-mortem.
The specimen comprises uterus, tubes and ovaries. In the fundus of the uterus is a very large pale spheroidal tumour measuring 15cm in diameter. The cut surface is pale, firm and fleshy. The tubes and ovaries show no significant abnormality.
Diagnosis: Leiomyoma

CASE 20934
The patient was a diabetic woman aged 78 who had previously had a massive cerebral infarct. She died of diabetic coma. The specimen was an incidental finding at post-mortem.
The specimen is of uterus, tubes and ovaries. Within the right parametrium is a well-circumscribed round 6cm diameter tumour with a pale whorled cut surface. The ovaries and fallopian tubes appear normal.
Diagnosis: Leiomyoma
Comment: This leiomyoma probably has an attachment to the myometrium where it originated.

CASE 21173
The patient was a woman aged 42 who was admitted to hospital unconscious. She was 8 months pregnant and had had no antenatal care. She had been known to be unwell for the last 2 months and there had been headache and swelling of the ankles. Two previous pregnancies had terminated in caesarian sections and she had two living children aged 15 and 17. There had been 12 previous pregnancies altogether. After admission the BP was 190/40 and she suffered eclamptic fits. Caesarian section was performed and a live male child removed. After the operation she suffered cardiac arrest with ventricular tachycardia. Resuscitation was only partially successful and fits continued. She became decerebrate and died on the 4th day after the operation.
The specimen is the post-partum uterus together with tubes and ovaries. The uterus measures 17cm in length. The myometrium is thickened and the endometrium is haemorrhagic. The myometrium in the lower uterine segment is disrupted and the sutures are visible.
Diagnosis: Uterus 5 days after caesarian section

CASE 21200
The patient was a woman aged 55 with a history of congenital cyanotic heart disease. On admission she was aphasic but conscious and there was weakness of the right face, arm and leg. She was febrile, there was pleuritic chest pain and haemoptysis. Signs of pneumonia continued and she died on the 14th day. At post-mortem a complex congenital heart defect was found together with multiple thromboses in large arteries and veins and paradoxical emboli. The specimen was an incidental finding at post-mortem.
The specimen comprises a small uterus, bladder, tubes and ovaries. The left ovary has largely been replaced by a unilocular cyst measuring 5cm in diameter and filled with inspissated dark brown fluid.
Diagnosis: Endometriotic cyst (chocolate cyst) of the ovary

CASE 21392
The patient was a woman aged 32 who was admitted with a threatened abortion. The condition settled with rest and she was discharged on the 5th day. At that time she was thought to be 3 months pregnant. She continued to lose blood PV and was readmitted to hospital 2 weeks later with blood loss thought to be due to inevitable abortion. She passed a hydatidiform mole.
Dilatation and curettage were performed and histology showed no evidence of chorionic carcinoma. Five weeks after passing the mole a further episode of vaginal bleeding occurred and there was haemoptysis. The pregnancy test was strongly positive and treatment with methotrexate was begun. Pancytopaenia developed. She was transfused but died. At post-mortem there were pulmonary infarcts with embolized villi and the uterus was enlarged.
The specimen consists of a bisected uterus that measures 14cm in length and the left tube and ovary. There are several leiomyomas in the uterine body, the largest measuring 3.5cm in diameter. The endometrial cavity and endocervical canal are filled with blood clot. Infiltrating the myometrium on one side are hydropic villi.
Diagnosis: Invasive hydatidiform mole

CASE 21393
The patient was a woman aged 50 who had vaginal bleeding for almost a year, together with swelling of the abdomen and loss of weight. She was jaundiced and the liver was enlarged and hard. Ascites was present. Multiple vaginal deposits of tumour were found. The left leg became swollen and she died suddenly from a pulmonary embolism. Multiple metastases in liver and peritoneum were found at post-mortem.
The specimen is of the uterus and adnexa together with the upper portion of the vagina. The uterine body is large and shaggy friable necrotic tumour is present within its cavity. The myometrium does not appear infiltrated in the portion visible. Superficial fungating neoplastic deposits are present in the vagina and ectocervix, each measuring about 2cm in diameter. The parametrium on each side is infiltrated with tumour and the ovaries also appear to be involved.
Diagnosis: Probable endometrial carcinoma with extensive local spread
Comment: Although it is not obvious from where this tumour arises, endometrial spread to ovaries is more likely than ovarian spread to endometrium and the uterus appears to be more involved than the cervix. The history of vaginal bleeding suggests a uterine or cervical origin. Histology showed adenocarcinoma in the uterus that infiltrates the parametrium and the ovaries, in keeping with an endometrial origin.

CASE 21794
The patient was a woman aged 24, thought to be pregnant for 6-8 weeks.
The specimen consists of a fallopian tube divided longitudinally. An amniotic cavity 1.5cm in diameter is visible in the centre of a mass of blood clot and placental tissue that distends the tube to a maximum diameter of 3cm. A tiny foetus 3mm in length is visible in the amniotic cavity. Its limb buds are just beginning to form.
Diagnosis: Ectopic pregnancy

CASE 22012
The patient was a woman aged 73 who died from congestive cardiac failure complicating a massive old cerebral infarction. The specimen was an incidental finding at post-mortem.
The specimen is of uterus, tubes and ovaries. Within the left ovary is a 6cm diameter cyst with a smooth lining. Two comparatively well-formed teeth project from the dermoid process at its lower pole. The uterus is small in keeping with the patient's age.
Diagnosis: Dermoid cyst of the ovary
Comment: Keratinous material has been removed from the cavity of the cyst.

CASE 22013
The patient was a woman aged 81 who died from the effects of a primary sarcoma of the left atrium of the heart. The specimen was an incidental finding at post-mortem.
The specimen is of uterus, tubes and ovaries. The uterus, opened posteriorly, is small, as expected for a postmenopausal woman. In the lower posterior myometrium is a well-circumscribed spherical tumour 4cm in diameter with a pale whorled cut surface. An innocent 2cm endometrial polyp within which dilated glandular spaces are readily seen is present at the fundus.
Diagnosis: Leiomyoma and benign endometrial polyp

CASE 22017
The patient was a diabetic woman aged 70 who died from acute pancreatitis with fat necrosis and paralytic ileus. The specimen was an incidental finding at post-mortem.
The specimen comprises the left half of a uterus sectioned in the midline with attached fallopian tube. Within the uterine cavity is an elongated pale polyp 4.5cm in length whose superficial parts show dilated glandular spaces. There is dilatation of glands in the endocervical canal.
Diagnosis: Benign endometrial polyp

CASE 22410
No clinical information is available.
The specimen consists of the uterus, tubes and ovaries. The uterus is very small and atrophic. Projecting from one side is an irregular pedunculated mushroom shaped mass 3.5cm in maximum diameter. Its stalk is 2cm in length. Each ovary contains a single simple cyst, the largest measuring 4cm in diameter.
Diagnosis: Calcified pedunculated leiomyoma

CASE 22522
The patient was a woman aged 25 who died in uraemia from ureteric obstruction.
The specimen comprises uterus and adnexa, vagina, rectum, kidneys, ureters, aorta and inferior vena cava. Extensively invading and destroying the cervix and lower uterus is a necrotic pale tumour. From the posterior aspect, the rectum appears to be adherent to the tumour but has not been penetrated by it. The dilated ureters pass into the lower part of this tumour that obstructs their lower ends. The kidneys show early hydronephrosis. There is a large nodular neoplastic mass 11cm in diameter above and to the left of the uterus. A 4cm tumour mass beneath the left renal artery probably represents a lymph node metastasis.
Diagnosis: Extensive cervical carcinoma
Histology showed well-differentiated squamous carcinoma.

CASE 22603
The patient was a 42-year old mentally retarded woman who died of aspiration pneumonia.
The specimen consists of the uterus and adnexa. The uterus measures 10cm in length and contains a pale well-circumscribed tumour 6cm in diameter with a whorled cut surface in the fundus. One ovary is replaced by a large tumour measuring 19cm in diameter. Its cut surface shows areas of pale solid tissue that in some areas is haemorrhagic. There are also many cysts up to 2cm diameter in the solid tissue. The other ovary contains 3 simple cysts measuring up to 6cm in diameter and a 2.5cm area of irregular pale tumour, similar to the tumour in the other ovary.
Diagnosis: Cystadenocarcinoma of the ovary. Leiomyoma in the uterus
Comment: The complex architecture of this ovarian tumour with many solid areas strongly suggests that it is malignant. Epithelial tumours of the ovary are not uncommonly bilateral, thus the small tumour in the other ovary may be a second primary.

CASE 22973
The patient was a 78-year old diabetic woman who was admitted semicomatose with acute pulmonary oedema and anuria of 36 hours duration. She failed to respond to intensive rehydration and diuretics and died after 2 days.
The specimen consists of the uterus, adnexa, bladder and left kidney. Extensively invading cervix and lower uterus is a pale irregular tumour that fills the endometrial cavity. Tumour extensively invades the left parametrium and a subserosal mass of tumour is seen in the myometrium on the right side, which also appears to invade parametrial tissues.
The ureter is mildly dilated suggesting obstruction and there is early intrarenal hydronephrosis. From the bladder aspect there appears to be tumour beneath the trigone but the bladder mucosa has not been penetrated.
Diagnosis: Cervical carcinoma
Comment: There is no information on the histological appearance of this tumour. It extensively involves endometrium and uterus as well as cervix, but appears to be centred on the cervix, hence a cervical origin is favoured.
How can one more reliably distinguish a cervical carcinoma from an endometrial carcinoma?
Histologically, cervical carcinoma will usually be squamous and an endometrial carcinoma will usually be adenocarcinoma. Cervical carcinomas can sometimes be adenocarcinomas though these will tend to look histologically different to endometrial adenocarcinomas.

CASE 23127
The patient was a woman aged 74 who, 14 months before her death, was admitted with diarrhoea and vomiting, due to intestinal obstruction from a pelvic tumour. A biopsy showed an adenocarcinoma and she was given radiotherapy. She was admitted on the final occasion with colicky abdominal pain due to partial intestinal obstruction. She died the following day.
The specimen is a median sagittal section of the pelvic organs, with the bladder to the right and the rectum to the left, and the left kidney and ureter. The cervix uteri is replaced by a mass of necrotic tumour with a fistulous opening 2cm in diameter communicating with an abscess 6cm in diameter surrounded by tumour in the pouch of Douglas on the left side (seen from the back of the specimen). A portion of sigmoid colon arching to the left of the uterus may also communicate with this cavity. Tumour also invades, with destruction of muscularis propria, the wall of a portion of colon behind the uterus. The left ureter is dilated and marked intrarenal and extrarenal hydronephrosis of the left kidney is present.
Diagnosis: Carcinoma invading cervix and colonic wall with perforation into pouch of Douglas
Comment: Histology showed a mucin-secreting adenocarcinoma, however, the gross appearance of the specimen suggests an origin in the endocervix rather than in the colon.

CASE 23250
The patient was a 71-year old diabetic woman who died from cardiac failure as a consequence of ischaemic heart disease. The specimen was an incidental finding at post-mortem.
The specimen consists of a portion of the uterus with the fallopian tubes and ovaries seen from the front. A pale spherical well-circumscribed whorled tumour 4cm in diameter is present in the left myometrium. This has compressed the uterine cavity and surrounding myometrium. Two much smaller similar tumours are visible in the right myometrium. There is a simple cyst 4cm in diameter with a smooth lining in the right ovary that has become flattened over the lower surface of the cyst.
Diagnosis: Leiomyoma and benign ovarian cyst
Comment: The cyst looks like a simple follicular cyst but it reportedly contained opaque gelatinous fluid and keratinous material suggesting that it may be a dermoid cyst.

CASE 23336
The patient was a 23-year old woman who died from a cardiac arrhythmia superimposed on rheumatic heart disease. The specimen was an incidental finding at post-mortem.
The specimen consists of the uterus, fallopian tubes and ovaries viewed from behind. The uterus contains an intra-uterine contraceptive device in the form of a white plastic ring high up in the fundus. Attached to it is a string that protrudes from the external cervical os. The normal appearing ovaries demonstrate several corpora albicans and some small cystic follicles. There is also possibly a haemorrhagic corpus luteum in the right ovary.
Diagnosis: Intrauterine contraceptive device

CASE 23947
This 66-year old woman was a known hypertensive who was admitted unconscious after suffering a pontine haemorrhage. She died soon after admission. The uterine fibroid and cervical polyp were incidental findings.
The specimen shows the vagina, cervix and uterus with right tube and ovary. The endometrium shows cystic degeneration. There is a small cystic sessile cervical polyp protruding from the external os. A well-circumscribed round pale tumour 3.5cm in diameter is present in the right cornu.
Diagnosis: Leiomyoma and benign endocervical polyp

CASE 24047
The patient was a 73-year old woman who had been becoming progressively more short of breath for 20 months. She developed a pleural effusion that contained malignant cells. At thoracotomy there were several subpleural nodules that showed on histology adenocarcinoma with areas of mucin secretion. Her condition gradually deteriorated until her death.
The specimen shows the uterus and both tubes and ovaries seen from behind. Replacing the right ovary is an irregular lobular tumour with a smooth external surface measuring 9cm in maximum diameter. Its cut surface shows grey fleshy tissue with scattered areas of yellow necrosis. Part of the tumour is cystic. The left ovary shows a similar appearance but is solid and measures 5.5cm in diameter. The uterus contains a lobulated 5cm leiomyoma and there is a small pedunculated 1cm endocervical polyp.
Diagnosis: Bilateral cystadenocarcinoma of the ovary, uterine leiomyoma, benign endocervical polyp
Comment: Epithelial tumours of the ovary are not uncommonly bilateral, thus the small tumour in the left ovary may be a second primary. Histology showed mucin-secreting adenocarcinoma replacing ovarian tissue, thus this is a mucinous cystadenocarcinoma.

CASE 24613
The patient was a 65-year old woman who was found in a collapsed state at home. A diagnosis of subarachnoid haemorrhage was made. Her neurological signs progressed and she died. A ruptured aneurysm of the anterior communicating artery was found.
The specimen is a sagittal section of a postmenopausal uterus with a 3cm diameter well circumscribed pale tumour at the fundus. A similar 1cm tumour is present in the opposite side. On the back of the specimen further small fibroid nodules can be seen protruding from the uterine body.
Diagnosis: Leiomyomata

CASE 24860
This is a surgical specimen from a 49-year old woman. Few clinical details are available but she had been having prolonged menstrual bleeding, and there was a firm mass palpable in the left pelvis. At operation the left ovary contained a cystic tumour measuring 20cm in diameter. There was a similar 5cm diameter tumour in the right ovary, and there were secondary deposits in the liver and in lymph nodes about the colon.

The specimen shows a large ovarian tumour. The end of the fallopian tube, which is infiltrated by tumour, can be seen at one side. The tumour has been opened to reveal cystic and solid areas. Small nodules of tumour protrude from the lining of the cystic areas.
Diagnosis: Ovarian cystadenocarcinoma
Comment: The complex architecture of this ovarian tumour strongly suggests that it is malignant. The type cannot be ascertained from the macroscopic features.

CASE 24908
No clinical information is available.
The specimen is half a pregnant uterus that measures 9cm in length. The amniotic cavity surrounded by placental tissue contains a small foetus that measures about 1.5cm from crown to rump.
Diagnosis: Early uterine pregnancy

CASE 25018
A woman aged 61 was admitted with a 6-month history of abdominal distension and pain in the right upper abdominal quadrant. Laparotomy showed multiple metastatic nodules of carcinoma throughout the peritoneum. Biopsy showed mucus-secreting adenocarcinoma. Thereafter she was admitted several times for paracentesis of the abdomen for recurrent ascites. She progressively deteriorated and died. At post-mortem there was a large ascites due to multiple peritoneal carcinomatous nodules. Tumour invaded the middle of the transverse colon. The left ovary was cystic and the right ovary was enlarged, nodular and solid.
The specimen is a coronal slice through the uterus, tubes and ovaries. The larger ovary measures 7cm in maximum dimension and its cut surface shows several cysts containing pale brown mucinous material. One lower cyst demonstrates several small papillary ingrowths. The other ovary measures 4cm in maximum dimension and on section demonstrates nodules of pale solid tumour with an elongated 1cm diameter cystic space. The uterus appears unremarkable. There is a Nabothian cyst in the cervix.
Diagnosis: Bilateral ovarian cystadenocarcinoma
Histology showed the tumour to be mucinous cystadenocarcinoma. Microscopically, adenocarcinoma was also present in the endometrium at the uterine fundus and in lymphatics in the myometrium. Epithelial tumours of the ovary are not uncommonly bilateral, thus both right and left tumours may be primaries.

CASE 25061
This is a surgical specimen and no clinical details are available.
The specimen is part of a dilated fallopian tube containing a foetus about 1cm in length surrounded by amnion and placental tissue.
Diagnosis: Ectopic pregnancy

CASE 25231
The patient was a woman aged 62 who died following an aortic dissection. The specimen was an incidental finding at post-mortem.
The specimen comprises uterus, tubes and ovaries, and a cuff of vagina, seen from the front. Protruding from the uterus, mainly from the fundus, are numerous well-circumscribed rounded tumours with a whorled cut surface, the largest measuring 6cm in diameter, the smallest only a few mm in diameter. The tubes and ovaries appear unremarkable.
Diagnosis: Multiple subserosal leiomyomata

CASE 25345
The patient was a woman aged 54 who died from multiple metastases from a malignant melanoma which had been excised from behind the left knee a year previously.
The specimen consists of the uterus together with the cervix, the anterior wall of the vagina, and both tubes and ovaries. Both ovaries are irregularly enlarged by firm pale nodular tissue and thin-walled cysts measuring up to 5cm in diameter.
Diagnosis: Bilateral ovarian cystic tumours
Comment: The architecture of these tumours is somewhat complex suggesting a borderline or malignant tumour, however, histological examination reportedly showed serous cystadenoma (though criterion for histological diagnosis may have changed since then).

CASE 25446
The patient was a woman aged 93 with an 18-month history of lower abdominal pain, loss of weight and blood-stained vaginal discharge. On examination there was frank vaginal bleeding and a bulky friable cervix could be felt. She died suddenly on the 5th day.
The specimen consists of half the uterus and rectum divided in the median sagittal plane. The uterus and cervix are extensively invaded by necrotic tumour, which also fills much of the endometrial cavity. Posteriorly the tumour is adherent to the rectum but the rectal mucosa has not been penetrated.
Diagnosis: Malignant tumour invading the uterus
Comment: The bulk of the tumour involves the uterus rather than the cervix so it is probably uterine in origin. As endometrial carcinoma is the most common uterine tumour, this is the most likely diagnosis. Histology showed a poorly differentiated adenocarcinoma in keeping with endometrial carcinoma.

CASE 25451
The patient was a woman aged 58 in whom carcinoma of the bladder was diagnosed 5 months before her death, having presented with haematuria. She refused treatment but was readmitted 5 months later. Examination then showed gross jaundice, cachexia and a frozen pelvis entirely occupied by tumour. On x-ray, a vesico-vaginal fistula was demonstrated. The liver was considerably enlarged. No active treatment was given and she died a week later. At post-mortem the bladder was almost completely replaced by a very large tumour mass fungating into the lumen. There was also infiltration into the wall of the bladder posteriorly, to produce the vesico-vaginal fistula. Both ureters were involved by tumour and were dilated. There was also bilateral hydronephrosis, and many metastases in the liver.
The specimen is one half of the pelvic mass, showing the fungating pale tumour invading the posterior wall of the bladder and haemorrhagic and necrotic tumour extensively invading cervix and lower uterus. The vesico-vaginal fistula is not evident in the specimen. Tumour is also infiltrating the wall of the vagina through its whole length, mostly evident anteriorly.
Diagnosis: Bladder carcinoma extensively invading uterus, cervix and vagina
What histological type of tumour is this likely to be? It is most likely to be a transitional cell carcinoma as this is the commonest type of malignancy arising in the bladder, however, squamous cell carcinomas and adenocarcinomas can also arise in the bladder.

CASE 10828/82
The patient was a woman aged 71. No further clinical history is available.
The specimen is a bisected uterus with tubes and ovaries. Extensively infiltrating the myometrium is a solid pale tumour. The tumour infiltrates the full thickness of the muscle. Inferiorly the lesion extends as a polypoid mass into the endocervical canal. The fallopian tubes and ovaries are not involved.
Diagnosis: Malignant tumour of the uterus
Comment: Histologically this tumour was reportedly a malignant mixed mullerian tumour. These are aggressive tumours that demonstrate both carcinomatous and sarcomatous components, also being

known as carcinosarcomas. The diagnosis cannot be made from the macroscopic appearance. The macroscopic differential is with endometrial carcinoma and leiomyosarcoma.

14771/82
The patient was a woman aged 56. No further clinical history is available.
The specimen is of a polycystic ovarian tumour. Fallopian tube is seen on one side. The tumour measures 15cm in diameter and comprises many variably sized cysts. One of the smaller cysts is seen to contain mucus. The external surface is smooth and no solid areas, haemorrhage or necrosis are apparent.
Diagnosis: Mucinous tumour of the ovary.
Comment: The lack of solid areas suggests that this tumour is not malignant. On histological examination the cysts were lined by orderly, tall, columnar, mucin-secreting epithelium of endocervical type characteristic of mucinous cystadenoma.

CASE 11206/83
The patient was an 83 year old woman. On opening, the uterus was filled with pus. No further clinical information is available.
The specimen consists of the uterus. The uterus is dilated and is lined by necrotic debris. Extensively invading the myometrium is a pale necrotic tumour. The cervix is not recognisable.
Diagnosis: Pyometra with malignant tumour invading the uterus
Comment: This tumour was said to be a cervical carcinoma. This is not obvious from the specimen. The pyometra has developed because the endocervical canal had become obstructed.

CASE 422/84
The patient was a woman aged 85.
The specimen consists of a uterus that has been cut to show the endometrium and much of the adjacent myometrium and cervix has been infiltrated and destroyed by ragged necrotic pale tumour. The tumour has extended through the full thickness of the muscle coat at the fundus. A 4cm leiomyoma is present on the other side and the tumour is infiltrating its margin.
Diagnosis: Malignant tumour invading the uterus and cervix. Leiomyoma
Comment: This tumour was said to be an endometrial carcinoma.

CASE 15020/93
No clinical history is available.
The specimen is of a bisected uterus with attached tube and ovary. The uterine body is distorted by three typical leiomyomata, each well circumscribed with a whorled pale cut surface. The ovary contains a 3cm diameter thin-walled cyst with a smooth lining.
Diagnosis: Leiomyomata
Comment: The ovarian cyst may well be a simple follicular cyst. Small cysts commonly develop in the ovary. Many of them derive from distension of developing or atretic follicles.
Others probably develop from invaginations of the surface epithelium.