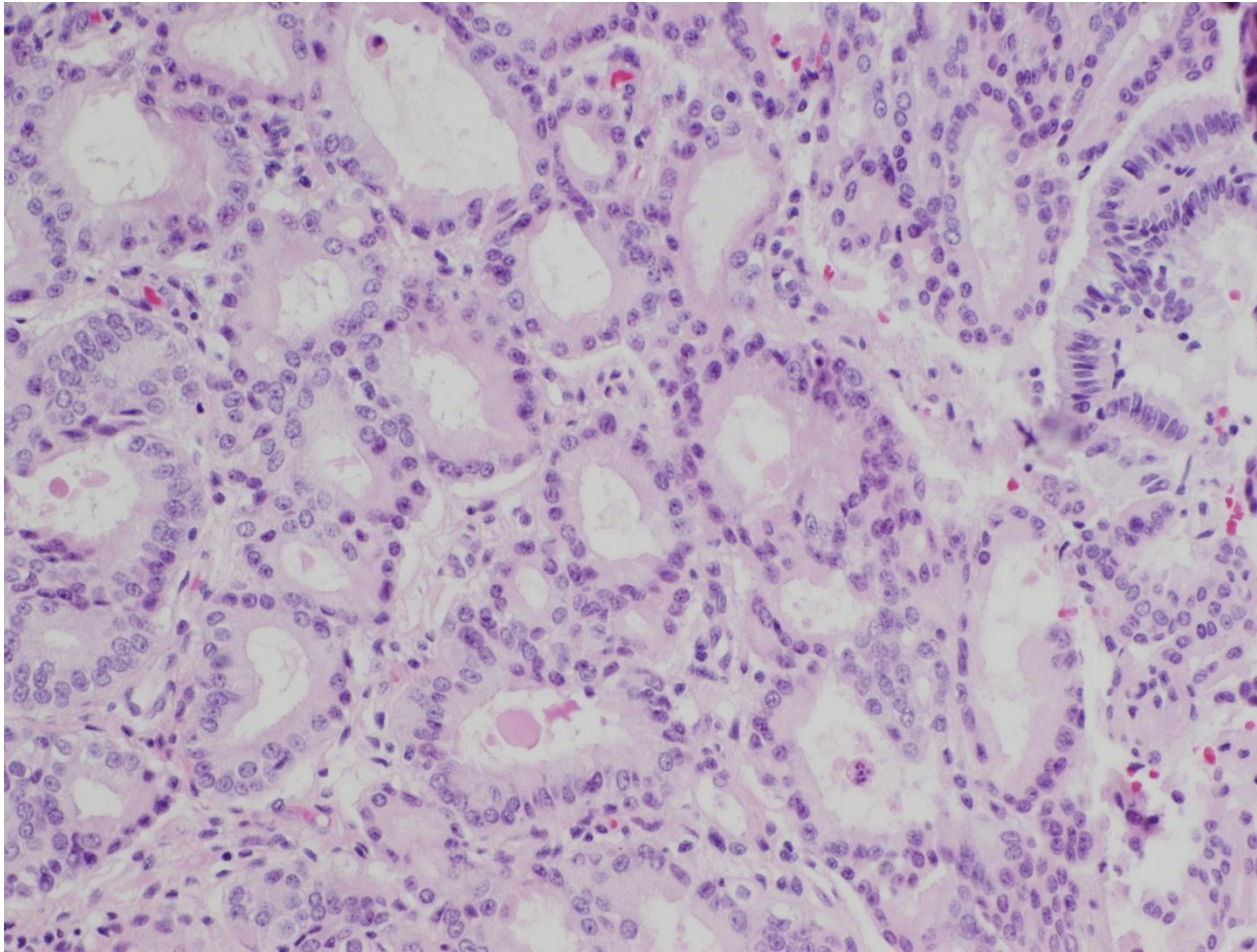
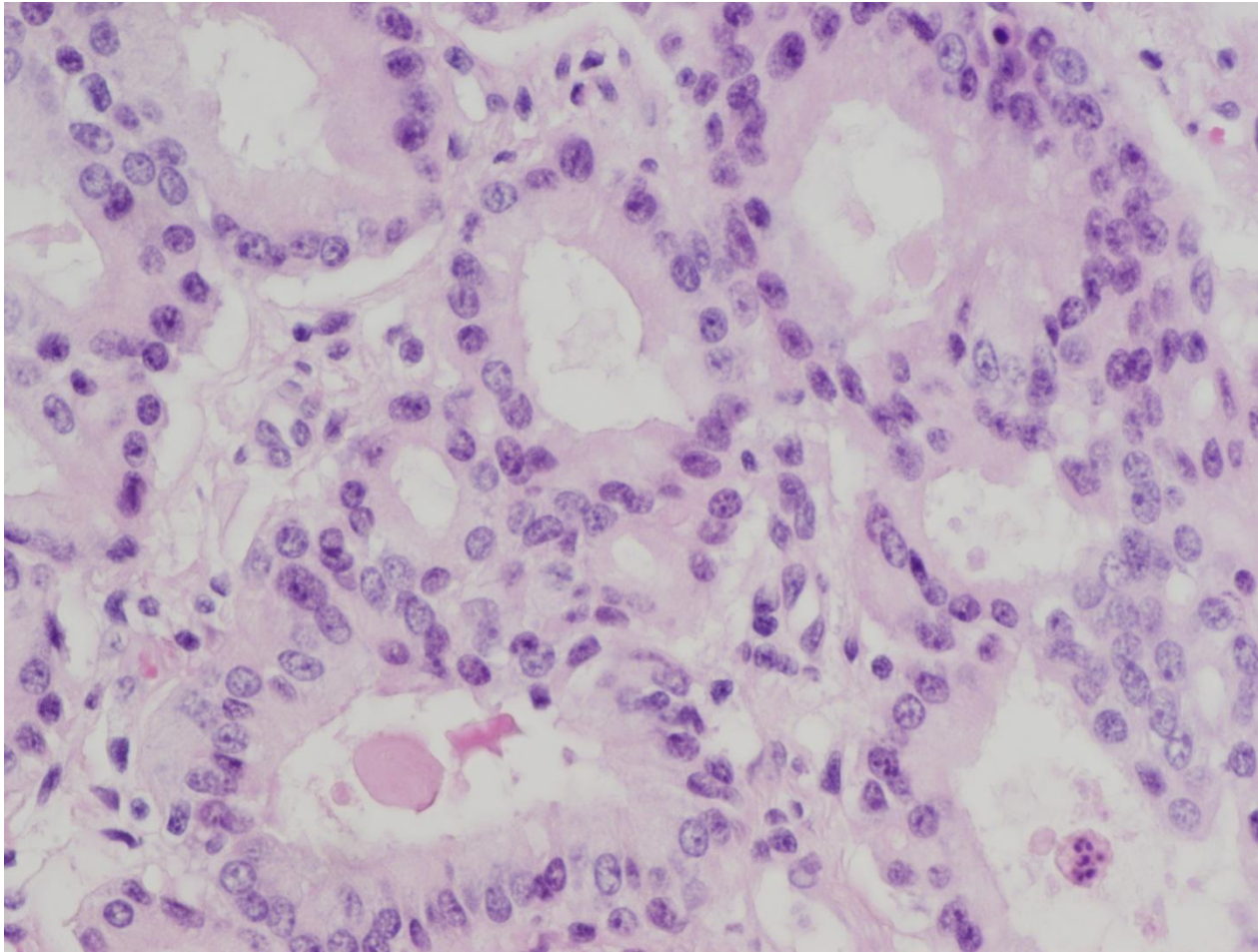


Microglandular (MGH-like) EEC



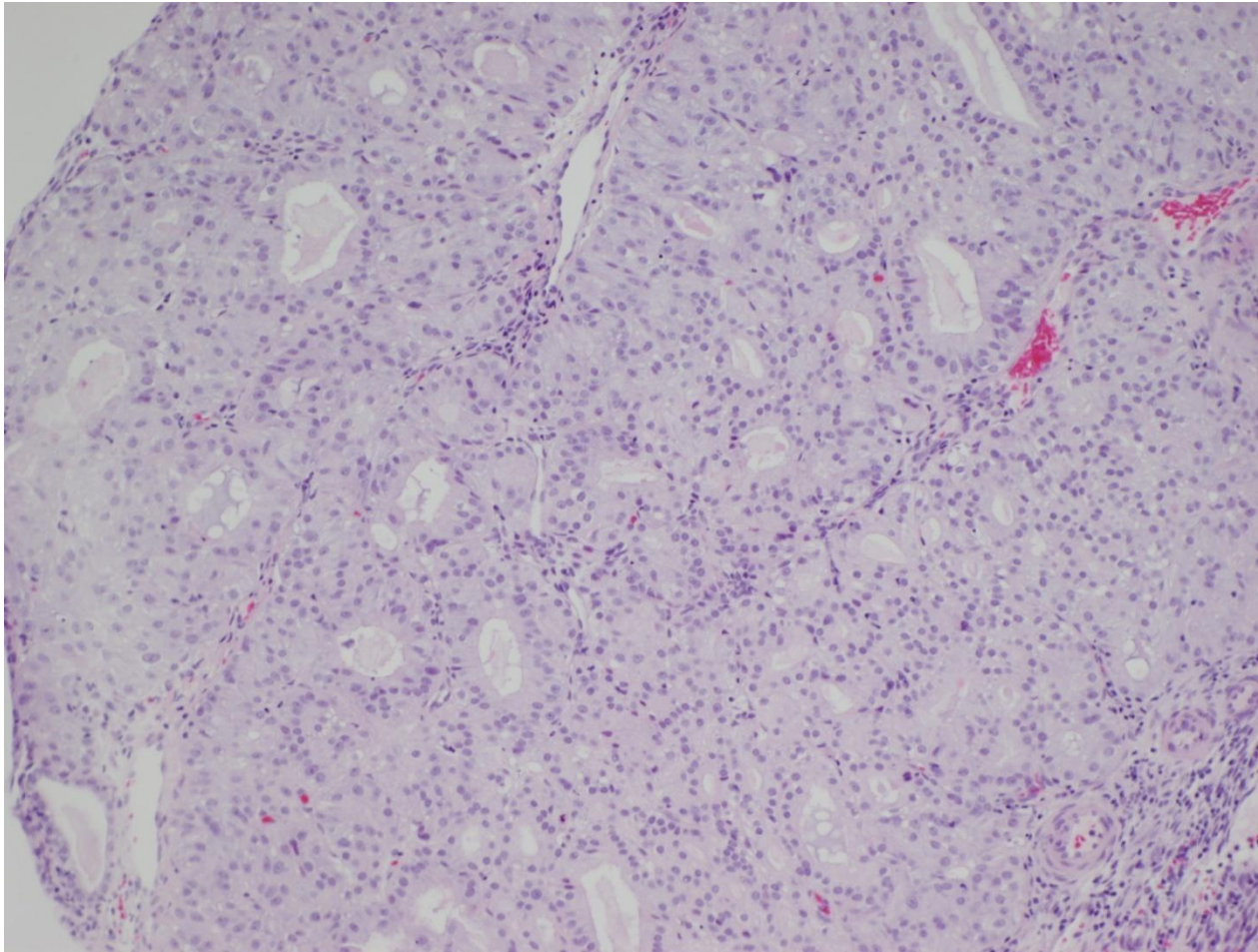
Mild atypia, lack infranuclear vacuoles

Microglandular (MGH-like) EEC



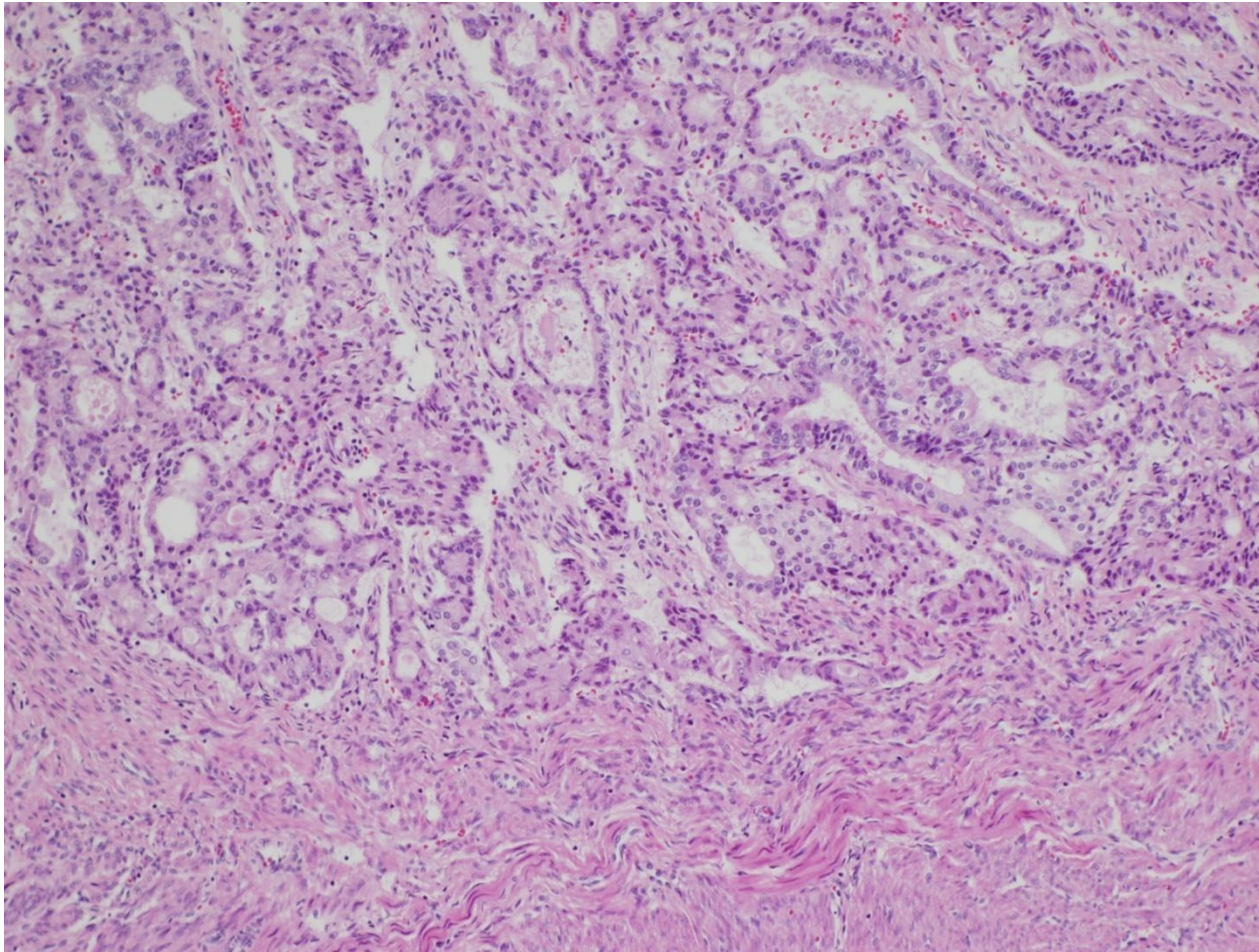
Mild atypia, lack infranuclear vacuoles

Microglandular (MGH-like) EEC



Co-existent squamous metaplasia

Microglandular (MGH-like) EEC

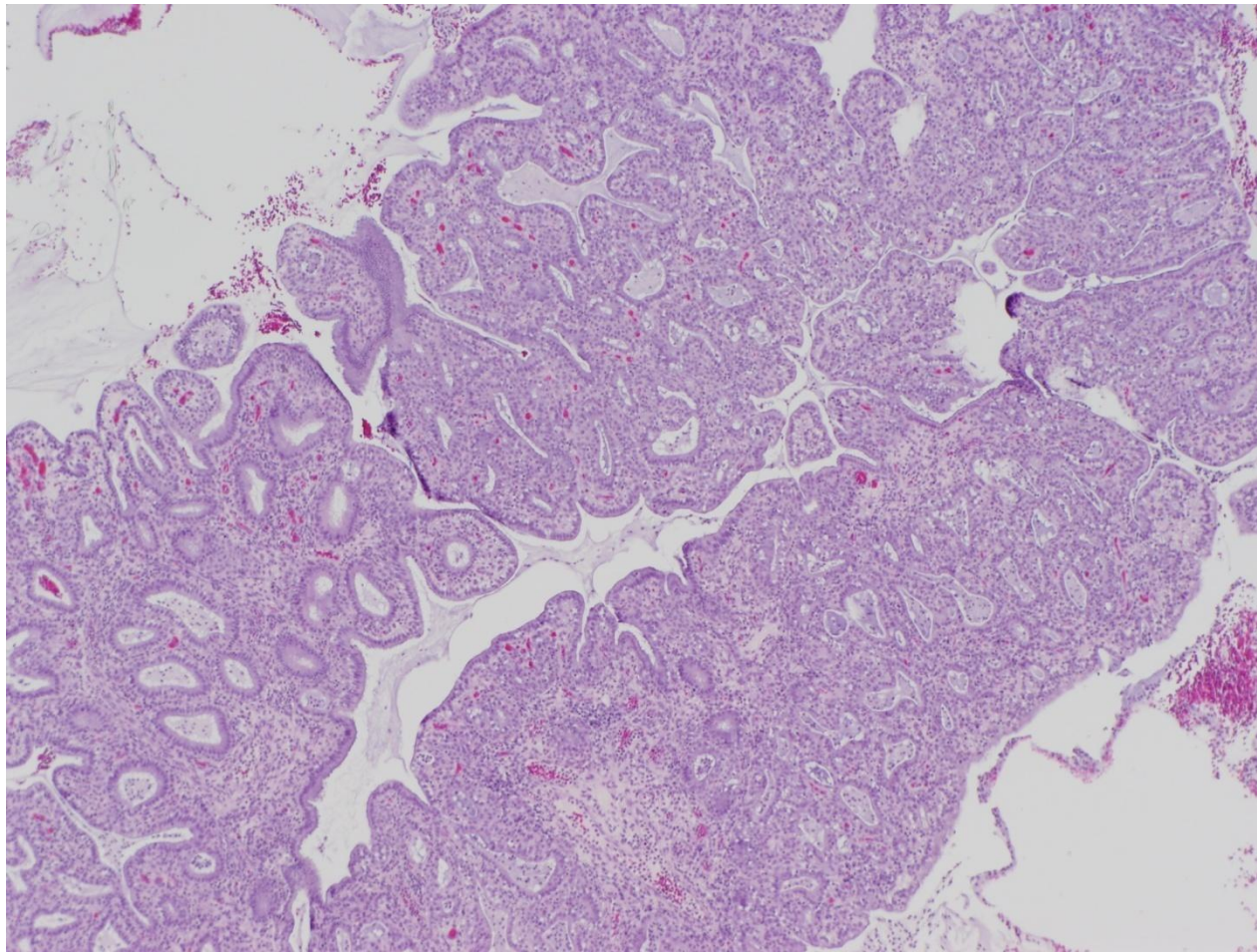


Myoinvasion

Microglandular hyperplasia

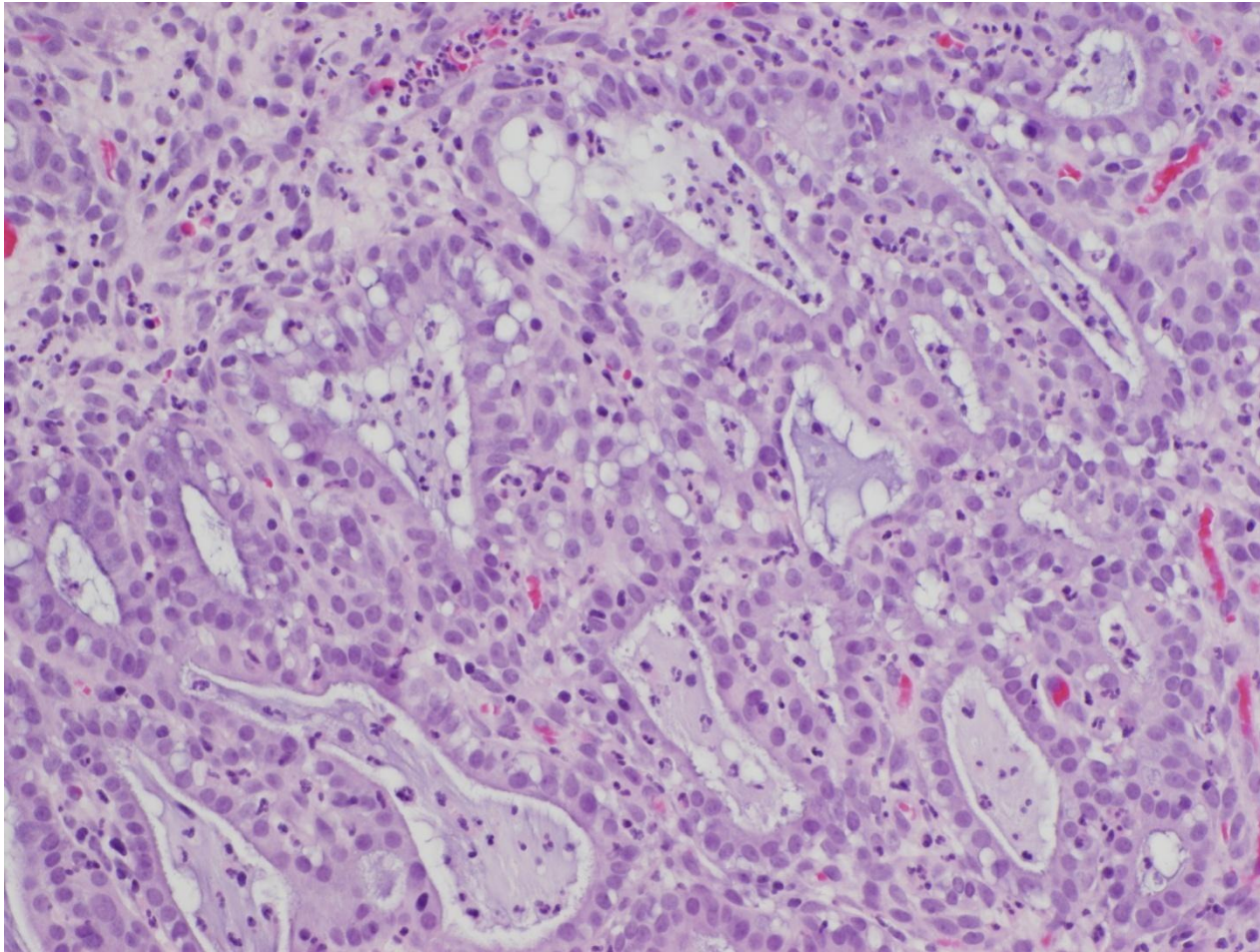
- Almost always cervical
- Exogenous hormones
- Closely packed glands
- Cuboidal cells, infranuclear vacuoles
- Uniformly bland, few mitoses
- Squamous metaplasia, reserve cell hyperplasia
- Solid, reticular patterns can be more concerning

Microglandular hyperplasia



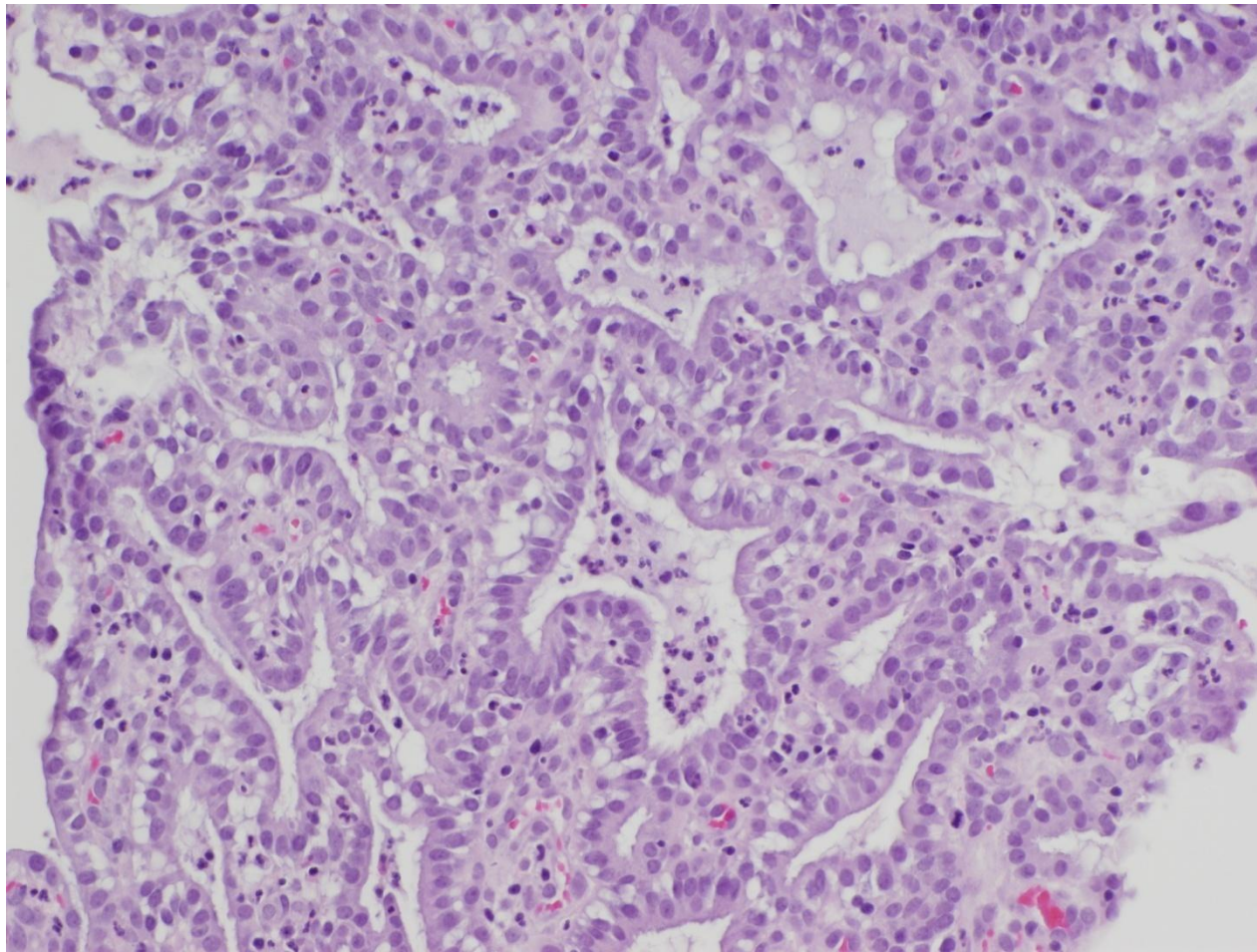
Involving pre-existing EC polyp

Microglandular hyperplasia



Intranuclear vacuoles, bland cytology

Microglandular hyperplasia



Bland cytology, no apparent mitotic activity

MGH-like EEC vs. MGH

MGH-like EEC

- Endometrial
- Merging with EEC/MC, hyperplasia, morules, foam cells, endometrial tissue*
- Mild atypia
- Increased mitoses
- Lack IN vacuoles
- Higher Ki67

MGH

- Almost always cervical
- Inflammation, squamous metaplasia, reserve cell hyperplasia
- Bland
- Few mitoses
- Infranuclear vacuoles
- Low Ki67

Discussion

- EEC is heterogeneous with many subtypes that each raise a specific ddx
- EEC with clear cells, papillae, high grade components, and mucinous (microglandular) differentiation are some common examples of challenging subtypes

Discussion

- General rules:
 - Look for evidence of conventional patterns
 - Assess for merging versus discrete components
 - Search for background lesions (e.g. AEH, EIC)
 - Identify characteristic / specific findings (e.g. morules, hyaline bodies)
 - ER, p16, and p53 IHC in particular can help

References

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