T1 case

Clinical history:

This is a 39 year-old woman, who had been pregnant twice but both with spontaneous abortion. Four years ago, she had taken tests for her karyotype, but no abnormality was found. She sought out infertility counseling, and found a pelvic mass on sonography. The mass shows predominantly solid component, and increased blood flow is noted under Doppler ultrasound.

During the operation, a pedunculated mass hanging over the broad ligament over anterior uterus was seen. Although intra-operation frozen consultation showed malignant nature, the patient insisted on preserving fertility functions, thus the surgeon performed gross total excision of the mass with preservation of uterus. Initiation of chemotherapy treatment was given after the operation.

However, two years after the operation, a huge pelvic mass was found on abdominal computed tomography scan. Operation of total abdominal hysterectomy, bilateral salpingo-oophorectomy, and peritoneal mass excision was performed.

Gross findings:

The specimen on broad ligament, taken in the first operation, is a myxoid tumor measuring 16x9x4 cm. On cut, it is heterogeneous in color, soft in consistency and shows cystic changes with necrosis and hemorrhage.

T2 case

Clinical history:

This 48 y/o woman, G4P3A1 (s/p C/S x3), with normal menstrual cycle, denied any systemic disease. She had menorrhagia and right lower abdominal mass noted since August, 2013. However, the mass became larger since March, 2014. At physical examination, a firm and irregular mass over right lower abdomen was palpated. The abdominal CT showed a 20 x 9.4 x 6.2 cm lobulated, semi-solid mass, arising from right side rectus abdominis muscle. She received the procedure of ATH, BSO, partial omentectomy and excision of peritoneal mass on 08-19-2014. The representative slide was taken from the peritoneal mass.

Gross Findings:

On gross examination, the peritoneal mass was multilocular cystic and partially solid. There were also one endometrial polyp, two uterine intramural myomas, and one cyst adjacent to the left fallopian tube.

J1 case

Clinical history:

A 30-year-old Japanese female at 34th gestation weeks presented with lower abdominal pain and tenderness. Imaging studies indicated prominent ascites and intraabdominal hemorrhage. A clinical diagnosis was intrauterine and extrauterine pregnancies. Emergency laparotomy revealed rupture of the left circle ligament with marked hemorrhage.

Gross Findings:

The submitted specimen measuring 10cm in aggregates was hematoma with a 2cm hemorrhagic nodule in the left circle ligament.

J2 case

Clinical history:

A 72-year-old gravida 4, para 2 Japanese woman with distention in the lower right abdomen was referred to Kumamoto University Hospital. On physical and bimanual examination, thumb tip- to over hen's egg-sized masses were palpated in the right lower abdomen and the pouch of Douglas. MRI of the pelvis revealed multiple masses with high intensity on T2- and diffusion-weighted images. Abnormal accumulation of FDG was detected on PET-CT scan with diffuse spread to the pelvic cavity. On laboratory examination, serum CA125 level was elevated to 154.9 U/mL. We preoperatively diagnosed the patient with advanced ovarian cancer.

Gross Findings:

Laparotomy revealed a goose egg-sized tumor surrounding the left side of the rectum. Although millet- to over hen's egg-sized disseminated nodules were observed over the mesentery and greater omentum similar to a "mukago (propagule) ," they were easily detached from the peritoneum. The uterus and bilateral adnexae had a normal appearance, although disseminated nodules were also found on their surface.

K1 Case

Clinical History

A 43-year-old woman was admitted to the hospital due to increased level of serum C-reactive protein, CA125 and CA19-9. She had a past history of IgA nephropathy and end stage renal disease during 16 years and has treated by hemodialysis. She took an abdominopelvic CT which showed a large multiseptated left ovarian cystic tumor (16 cm in greatest diameter). Gynecological surgeon took a left salpingo-oophorectomy with appendectomy. In operation field, the pelvic cavity was filled with a large amount of mucoid material. Grossly, the surface of left cystic ovary and appendix was covered by mucoid material. Cut section of the left cystic ovary reveals a multilocular cysts which contains mucinous material. A part of the lining of the cyst wall was covered by keratinous material and cyst wall also showed multiple hair shafts. Cut section of appendix was grossly unremarkable. Two H&E slides were distributed. Each slide was taken from left ovarian tumor and appendix.

K2 Case

Clinical History

A 41-year-old woman complained abdominal pain and was referred to our hospital in 2016 due to refractory peritonitis to laparoscopic surgery and antibiotic medication. She had a history of cesarean section two times in 2007 and 2014. She had craniotomy and tumor removal of meningioma three times in 2001, 2005 and 2006. She also had total thyroidectomy due to thyroid cancer in 2012. Abdomino-pelvic CT revealed moderate amount of ascites with omentomesenteric haziness and diffuse peritoneal thickening. Radiologic diagnosis was rule-out tuberculous peritonitis with differential diagnoses of carcinomatosis of unkown origin, peritoneal mesothelioma, and primary peritoneal serous carcinoma. Diagnostic laparoscopy and omentum biopsy were done (submitted slide). During further work-up, multiple lymph nodes with increase FDG uptake in both neck, mediastinum, and both axillae were found in whole-body PET-CT. Excisional biopsy of left cervical lymph nodes was performed (slide not submitted).