

PATOLOGICA GINECOLOGIA II

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**DEPTO. ANATOMIA PATOLOGICA
HOSPITAL SAN BORJA ARRIARAN**

UNIVERSIDAD DE CHILE

2016

PATOLOGIA VULVAR

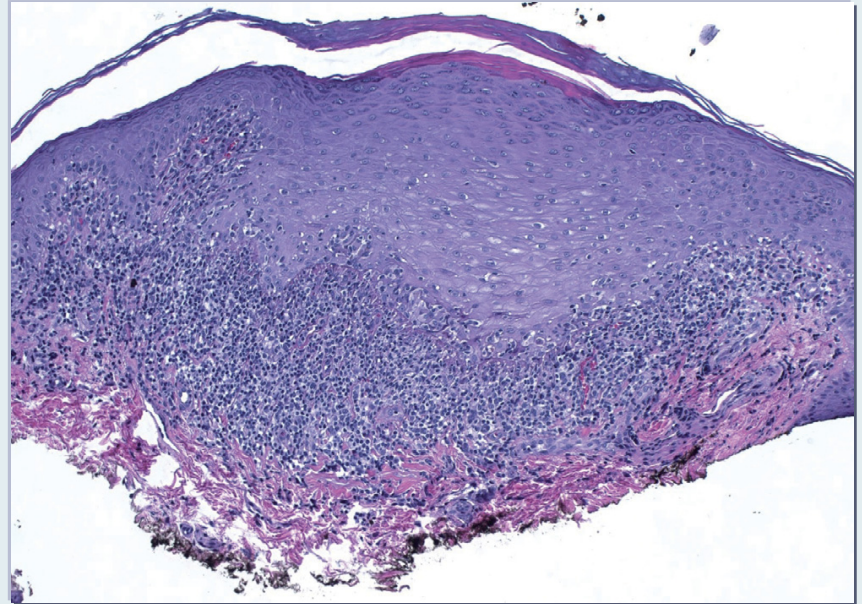
INFLAMATORIA

LIQUEN SIMPLE:

Infiltrado crónico en banda

Acantosis

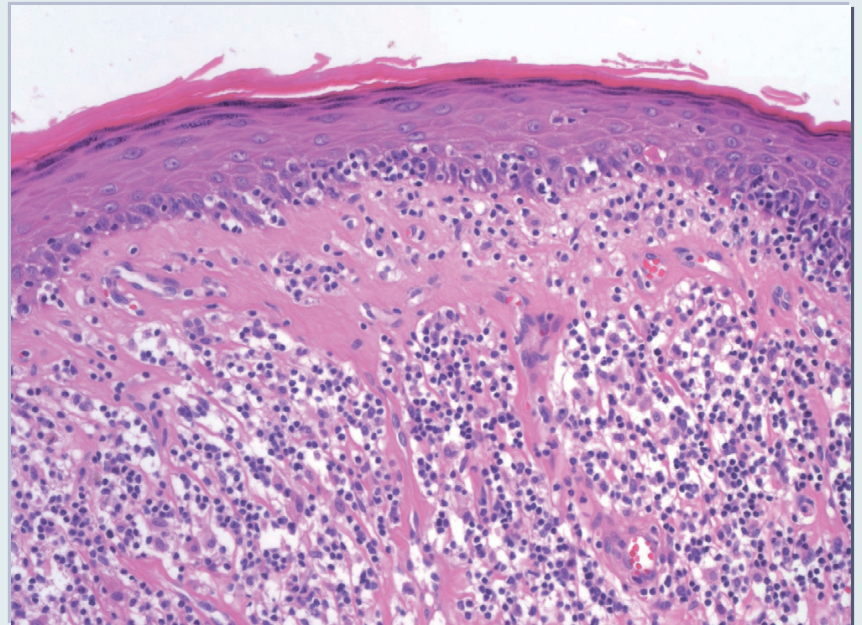
Hiperqueratosis-hipergranulosis



LIQUEN ESCLEROSO:

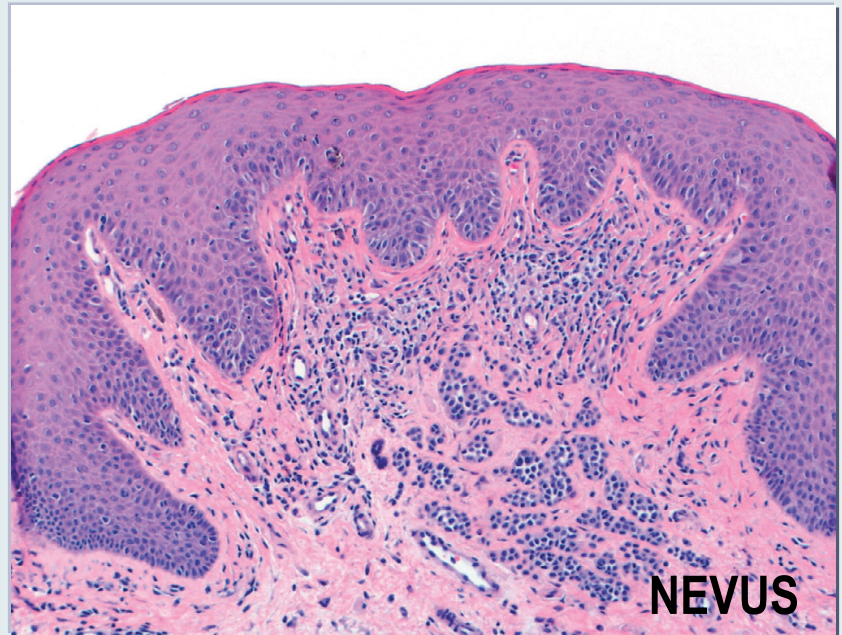
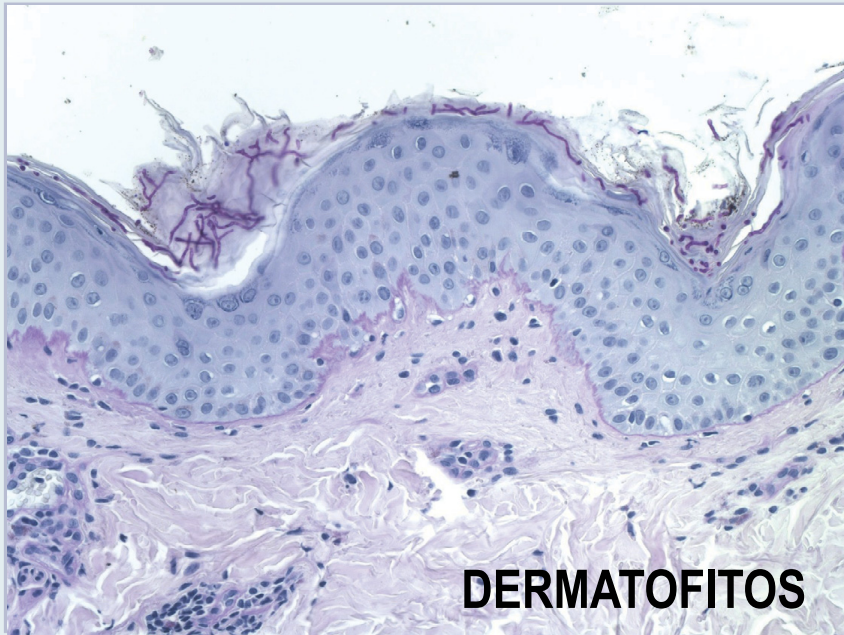
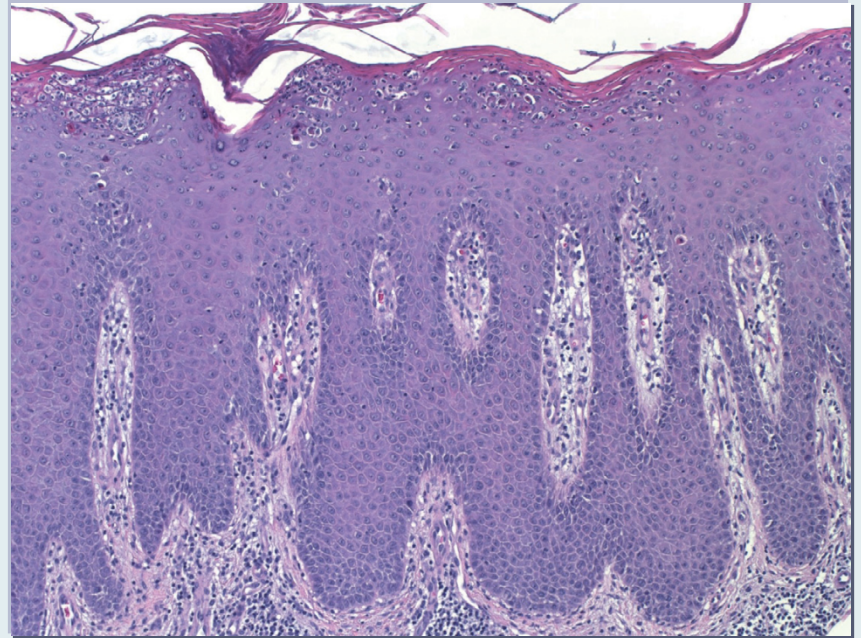
Homogenización del colágeno dérmico

Infiltrado en banda



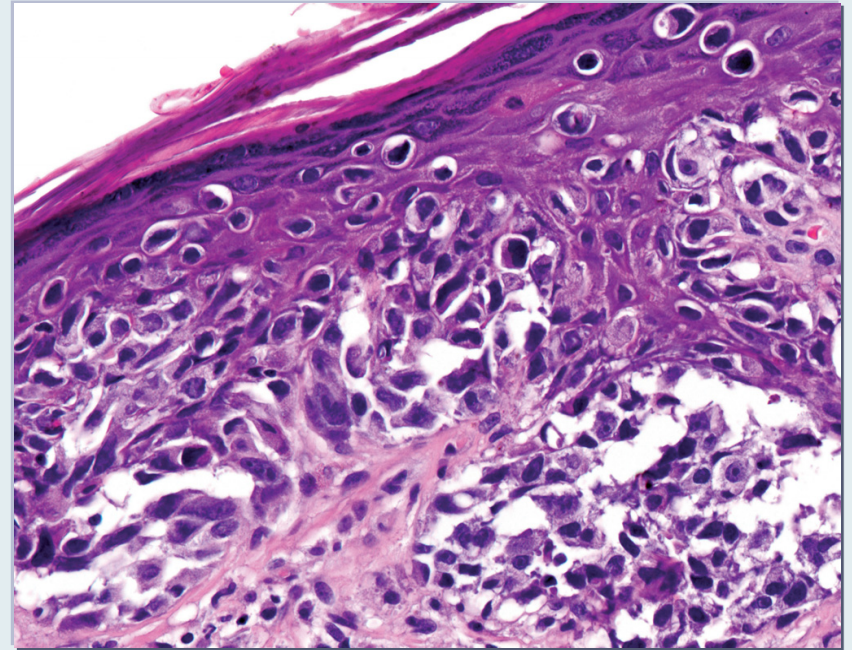
PSORIASIS:

- HIPERPLASIA EPIDÉRMICA
- ACÚMULOS DE NEUTRÓFILOS EN CAPAS SUPERIORES
- PARAQUERATOSIS
- PÉRDIDA DE CAPA GRANULOSA



MELANOMA

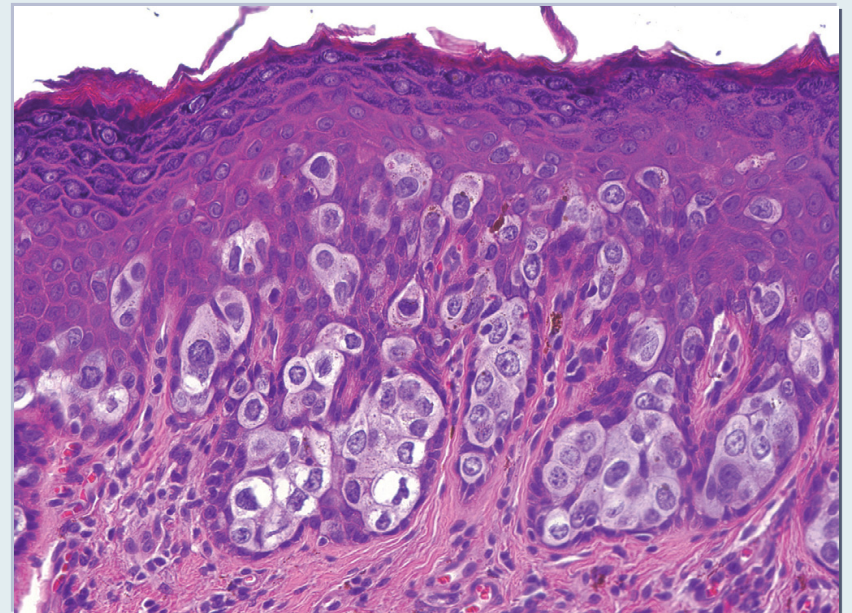
PROLIFERACION DE CELULAS
MELANICAS ATIPICAS EN NIDOS CON
ASCENSO A EPIDERMIS



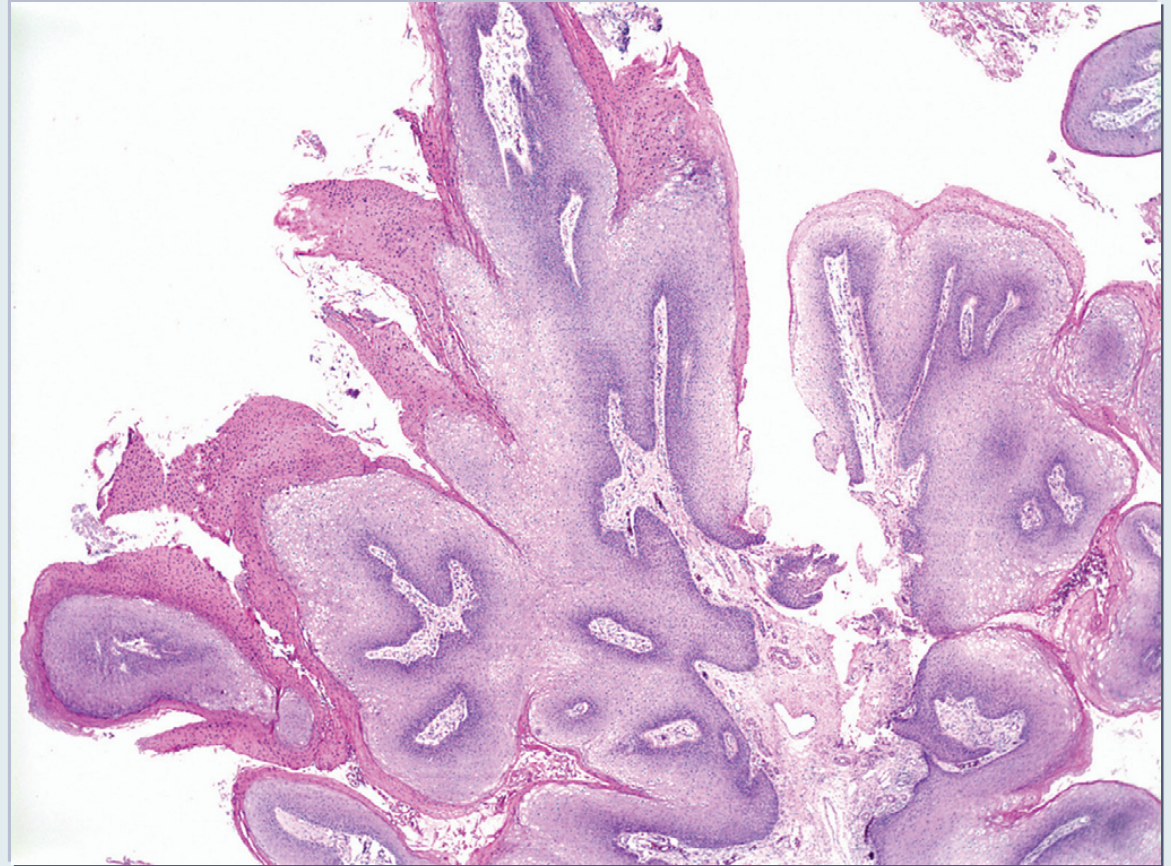
ENFERMEDAD DE PAGET EXTRAMAMARIA

ADENOCARCINOMA INTRAEPITELIAL

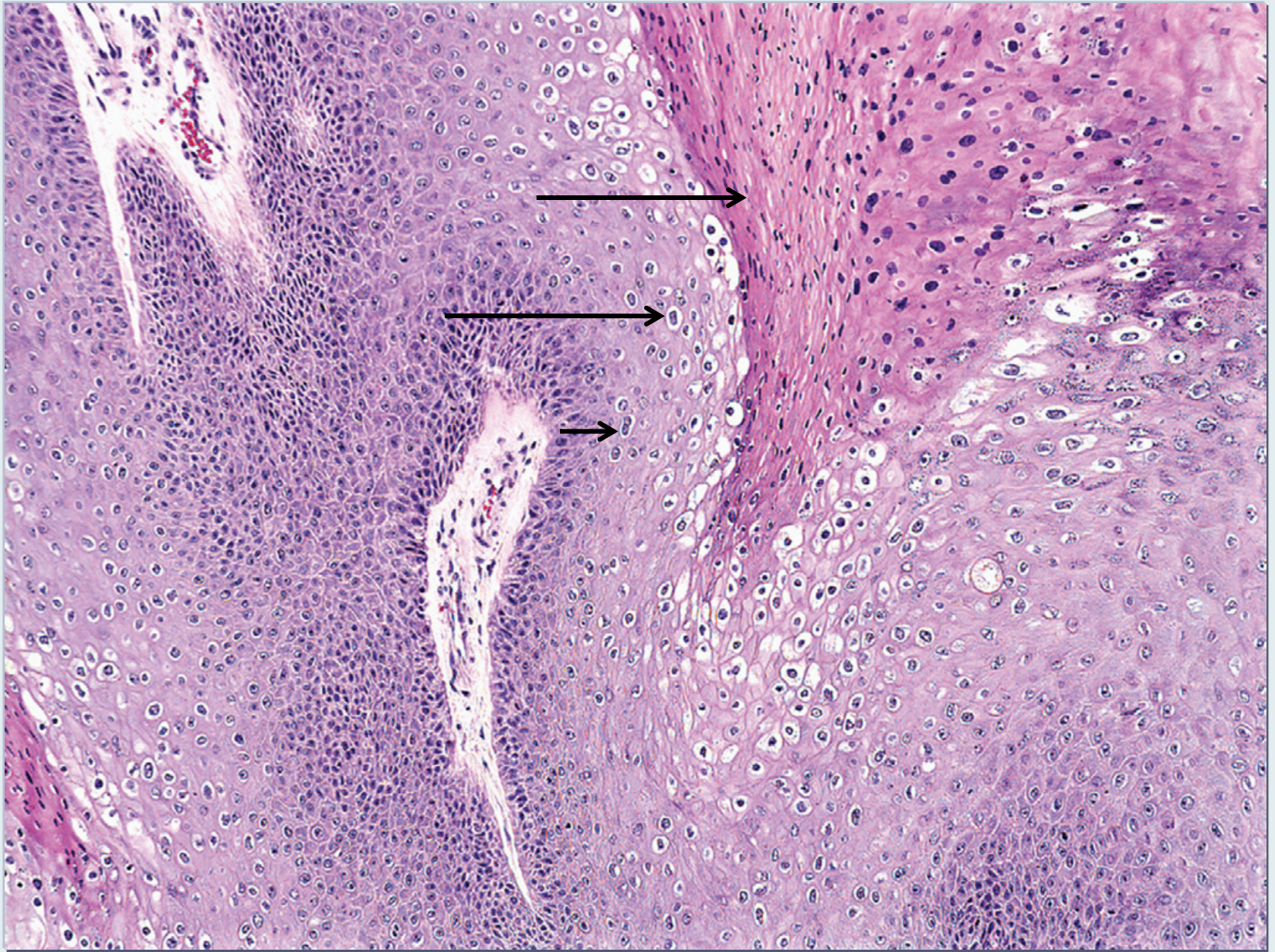
25% CASOS SE ENCUENTRA LESIÓN
SUBYACENTE (COLON, RECTO,
VEJIGA, URETRA , CERVICAL)



CONDILOMA ACUMINADO



**Lesiones papilares y verrucosas que afectan la epidermis y las mucosas.
Se caracteriza por papilomatosis, acantosis, hiperqueratosis...**



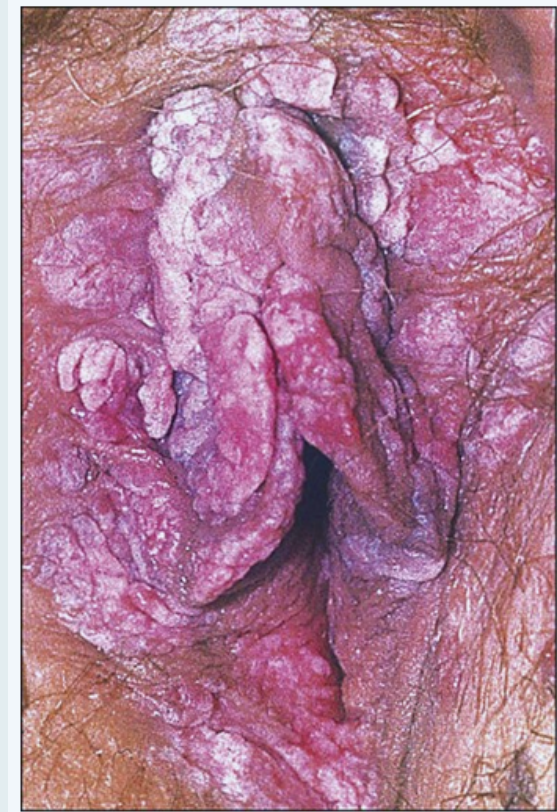
LESION INTRAEPITELIAL ESCAMOSA VULVAR

NEOPLASIA INTRAEPITELIAL VULVAR

(VIN)

Proliferación neoplásica intraepitelial del epitelio vulvar con desorden en la maduración y anormalidades nucleares

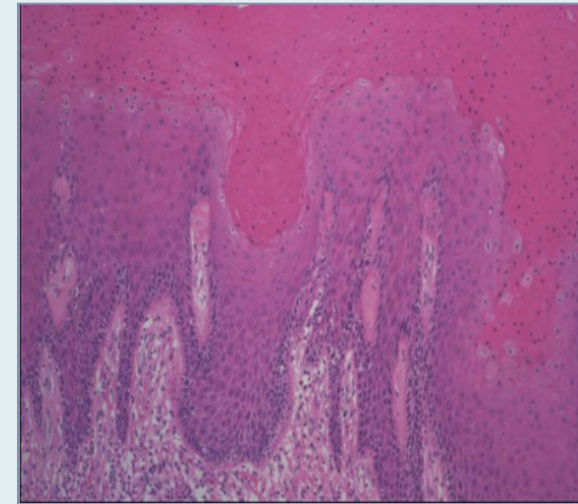
- 2,1/100.000 mujeres/año
- Incidencia está aumentando en menores de 30 años
- Afecta piel vulvar, perineal, piel y mucosa anal
- Relacionada con inmunosupresión y tabaco
- Produce prurito
- Hay grados y variantes



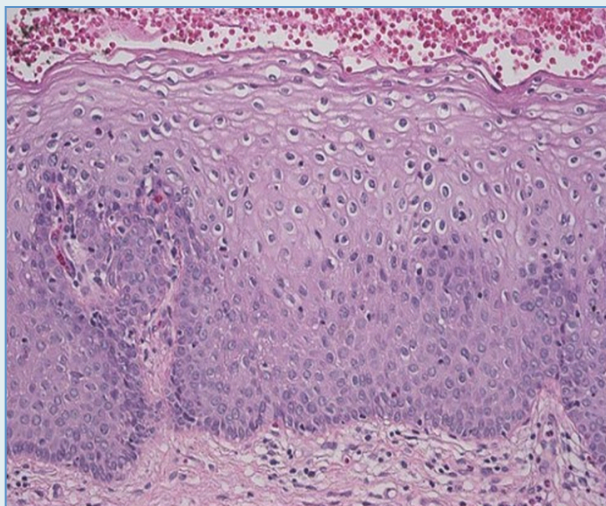
VIN 3 "WARTY"

NEOPLASIA INTRAEPITELIAL VULVAR

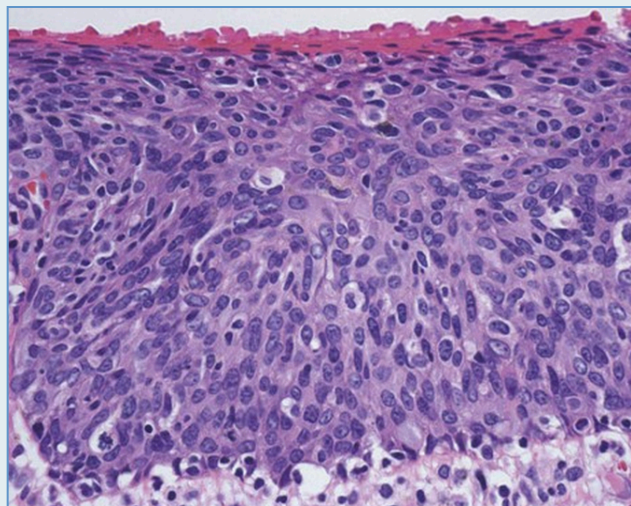
1986 VIN Terminology	2009 ISSVD Terminology	2012 CAP/ASCCP Terminology
VIN 1	Condyloma HPV changes	Low grade squamous intraepithelial lesion (VIN 1)
VIN 2	VIN, usual type (uVIN)	High grade squamous intraepithelial lesion (VIN 2-3)
VIN 3	VIN, usual type (uVIN) or VIN, differentiated type (dVIN)	High grade squamous intraepithelial lesion (VIN 2-3) or VIN, differentiated type



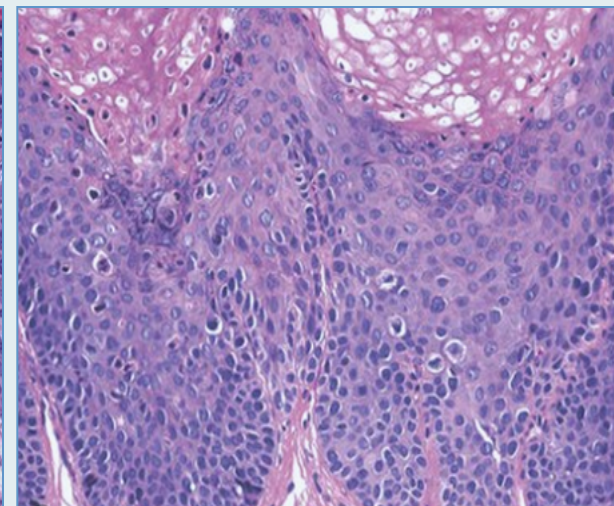
VIN 3 Diferenciada (AG)



VIN1 "usual-basaloide" (BG)

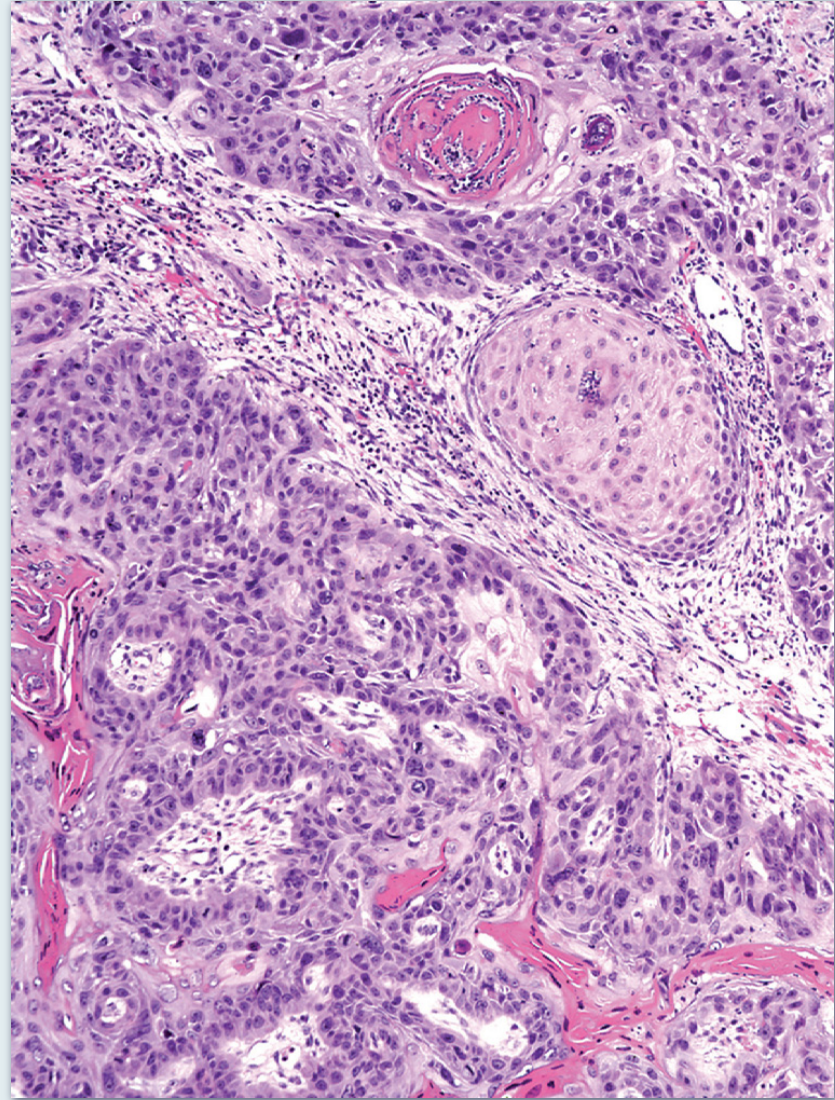


VIN 3 "usual-basaloide" (AG)



VIN 3 "usual-warty" (AG)

CARCINOMA ESCAMOSO VULVAR

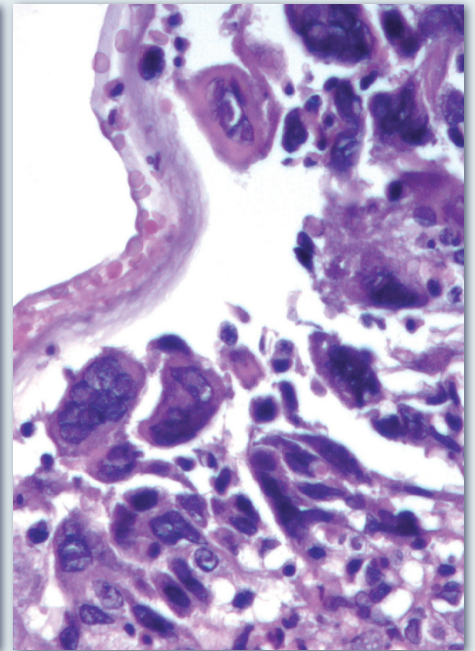
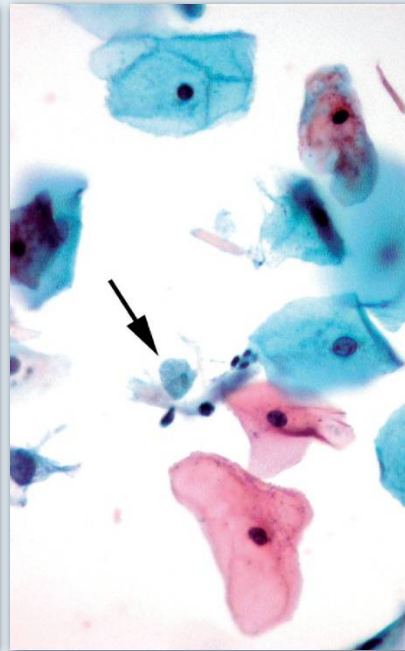
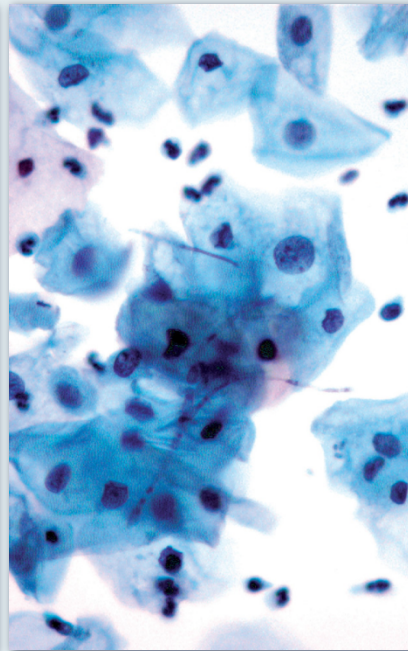
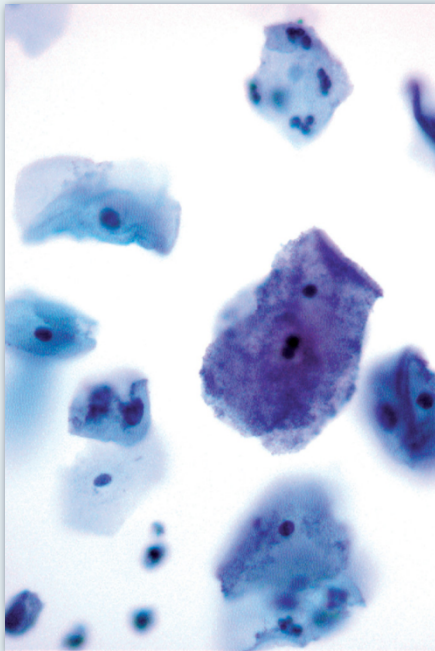


PATOLOGÍA VAGINAL

CONGENITAS: ATRESIA, AGENESIA

INFECCIOSAS:

- VAGINOSIS BACTERIANA: cambio de lactobacilo a flora mixta (Mycoplasma, Gardnerella, anaerobios)
- Otras: Cándida, tricomonas, herpes.



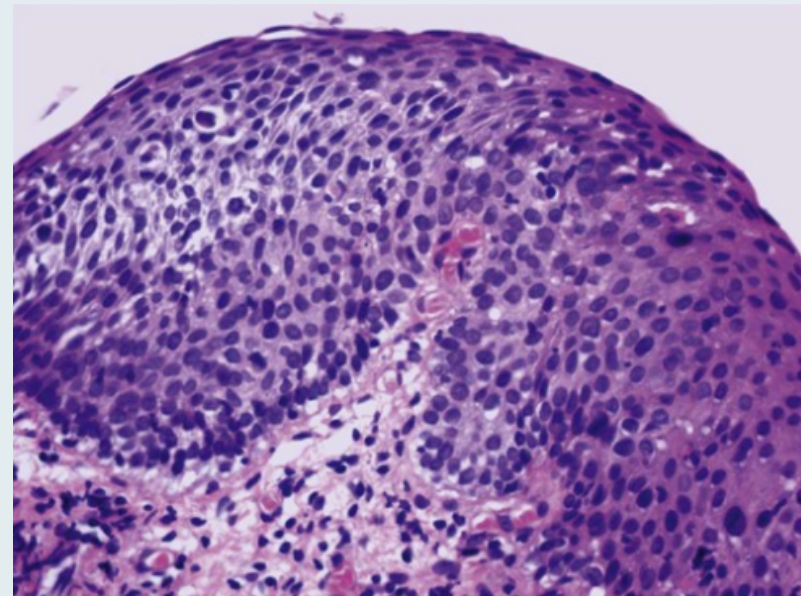
LESION INTRAEPITELIAL ESCAMOSA VAGINAL

NEOPLASIA INTRAEPITELIAL VAGINAL

(VaIN)

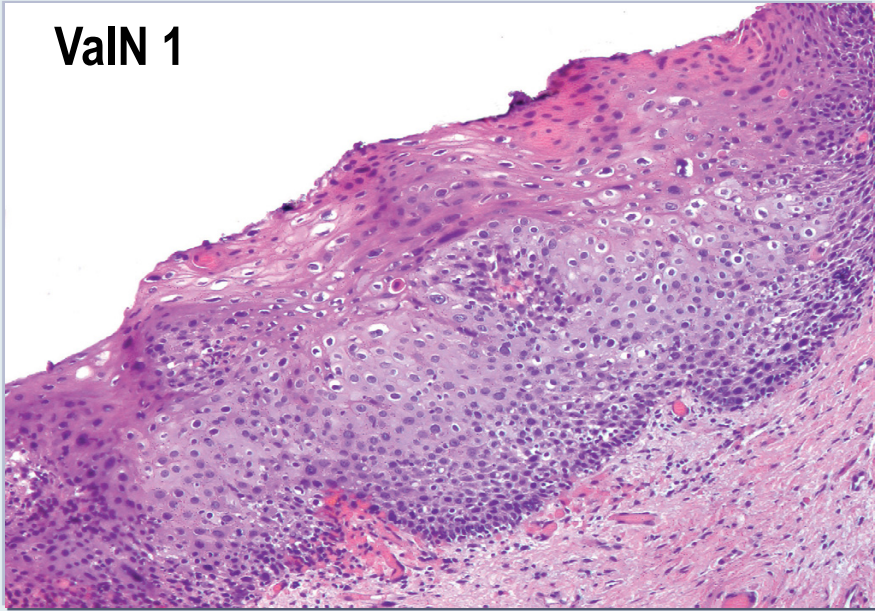
Lesión caracterizada por grados variables de atipia y maduración de los keratinocitos, confinados al epitelio.

- 0,2 - 0,3 por 100.000 mujeres (USA)
- Tercio superior
- 12-40% recurre localmente
- 2-12% desarrolla un carcinoma escamoso
- Edad: 16-84 años, promedio 35-55 años
- Generalmente pesquisado en PAP

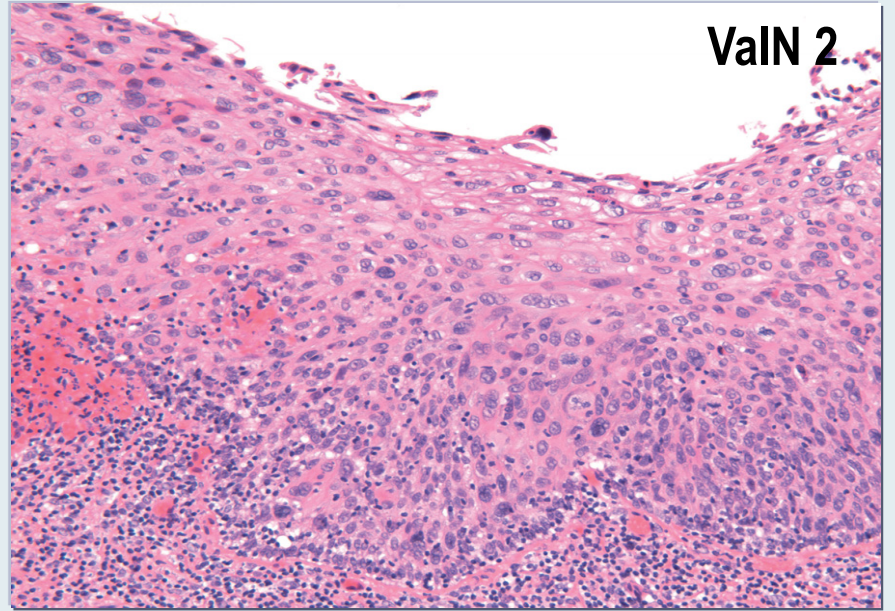


VaIN 3

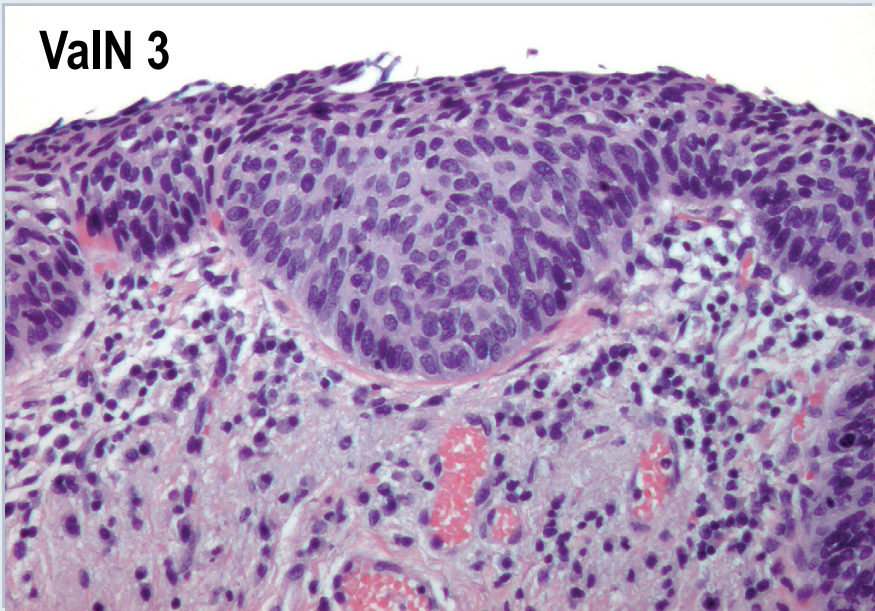
VaIN 1



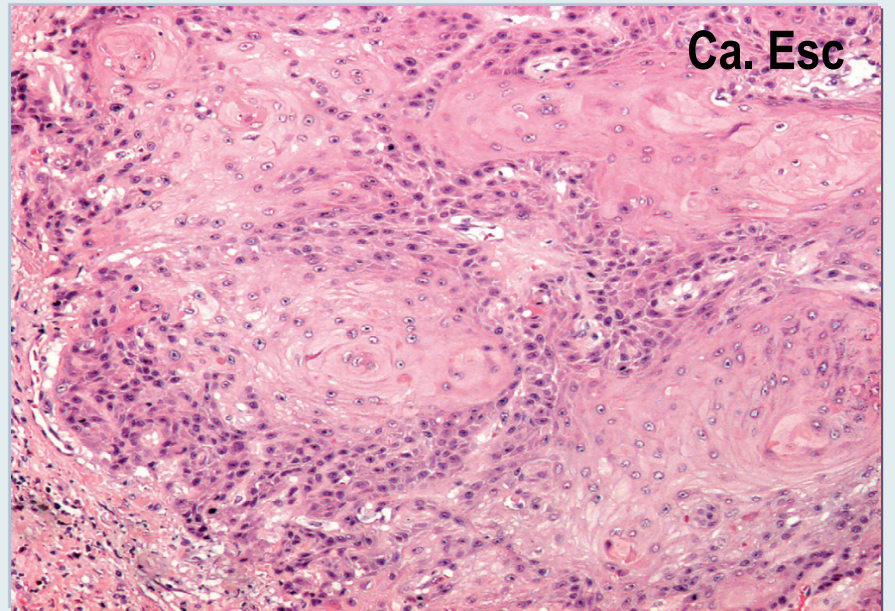
VaIN 2



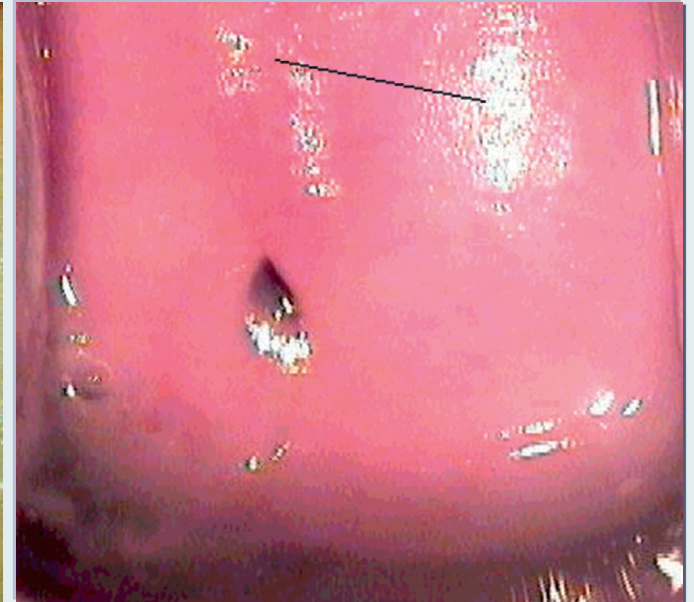
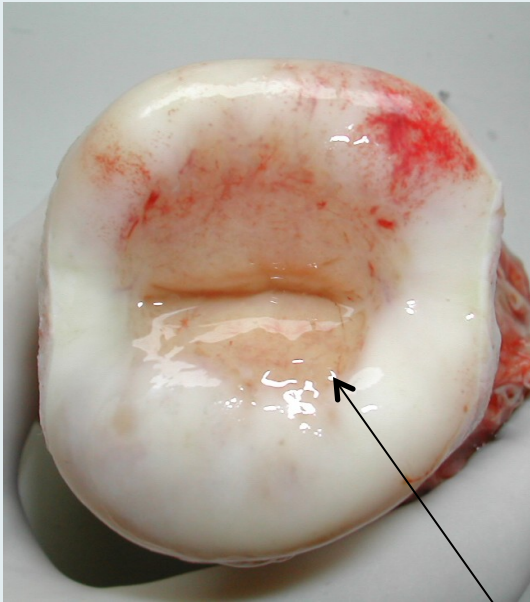
VaIN 3



Ca. Esc

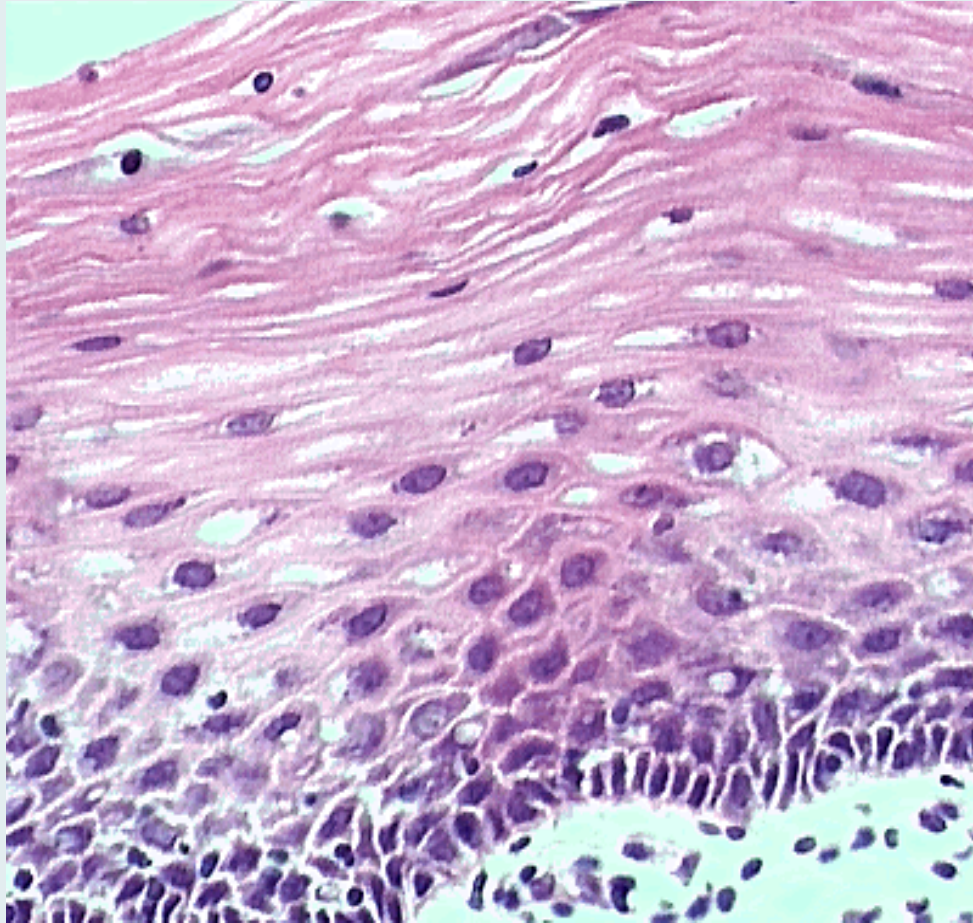


PATOLOGIA DEL CUELLO UTERINO

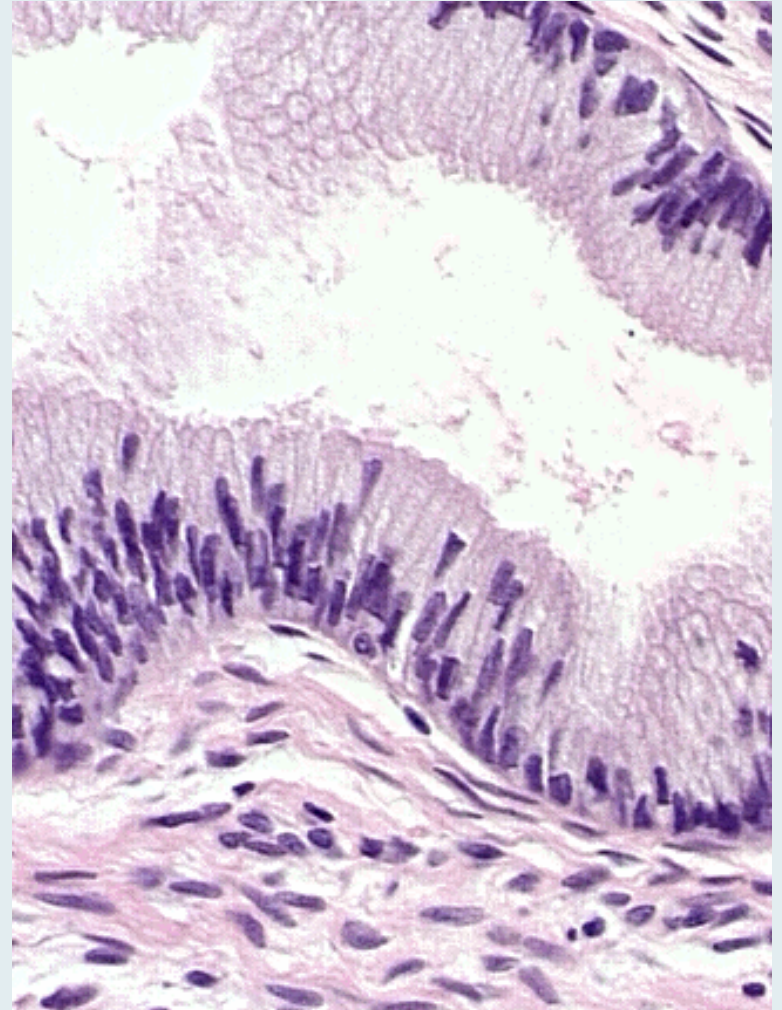


**UNION ESCAMOCOLUMNAR
CERVIX NORMAL**

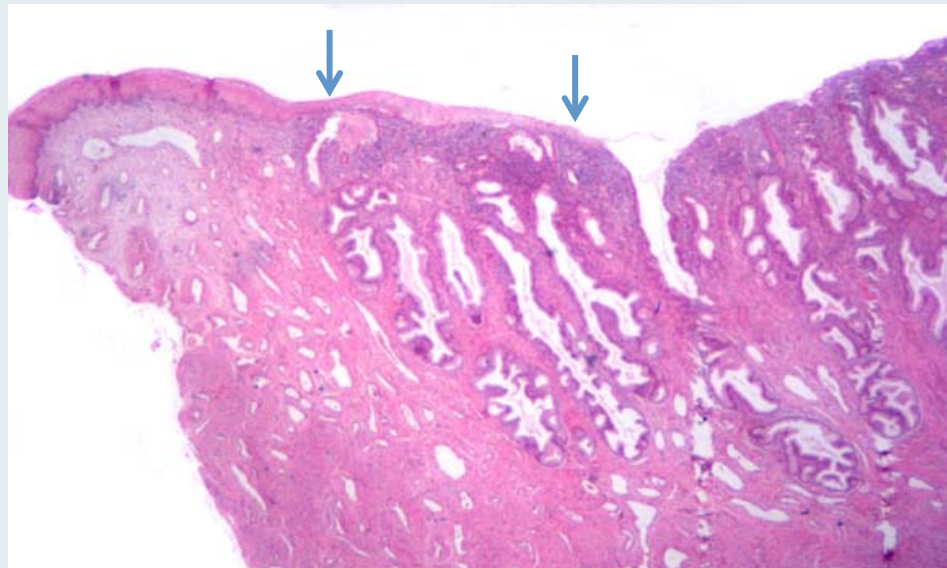
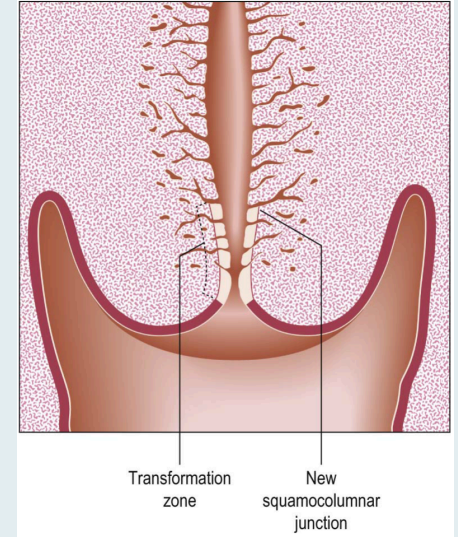
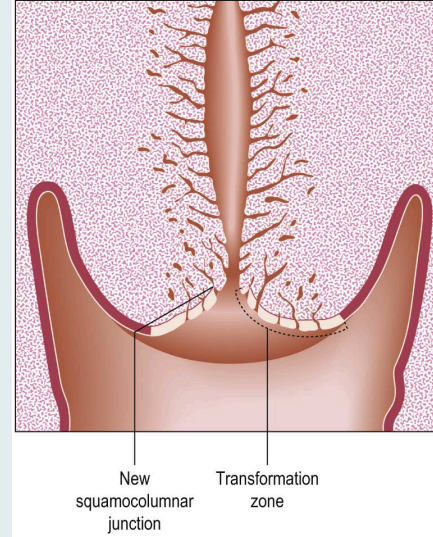
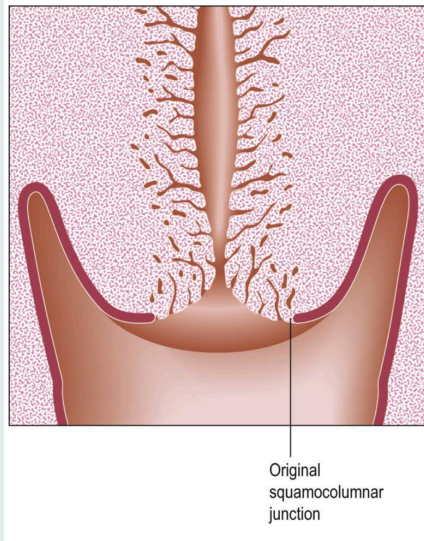
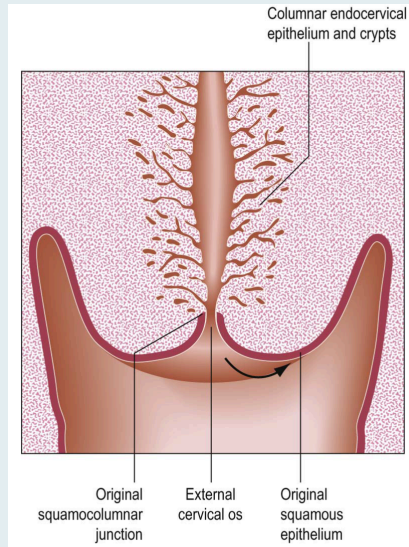
EXOCERVIX

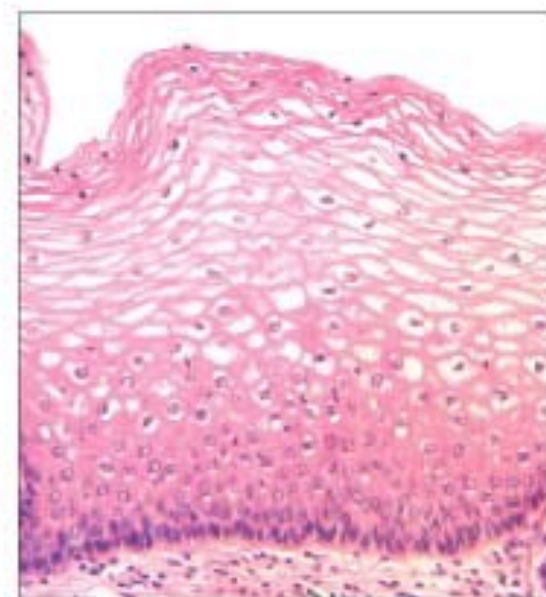
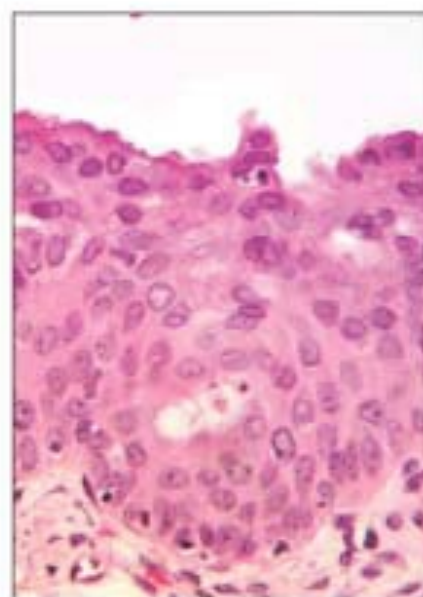
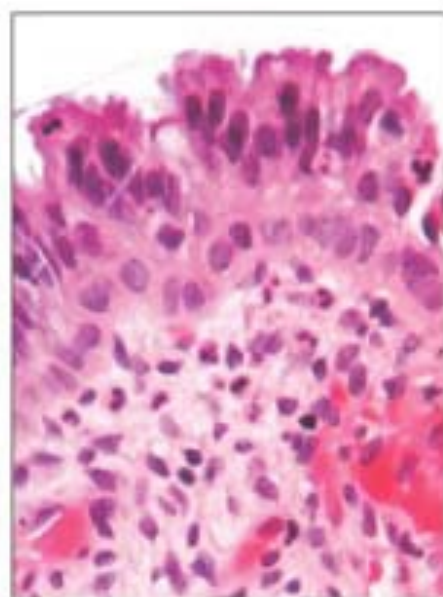
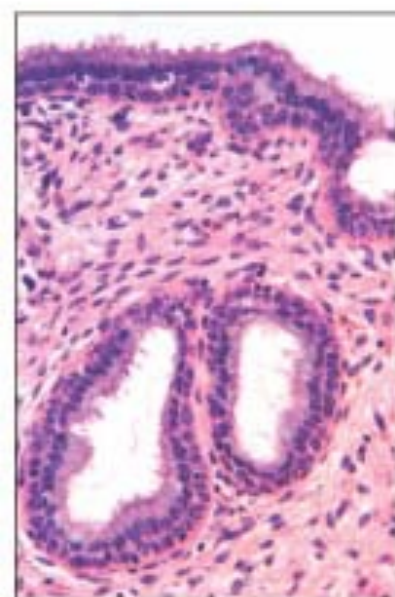
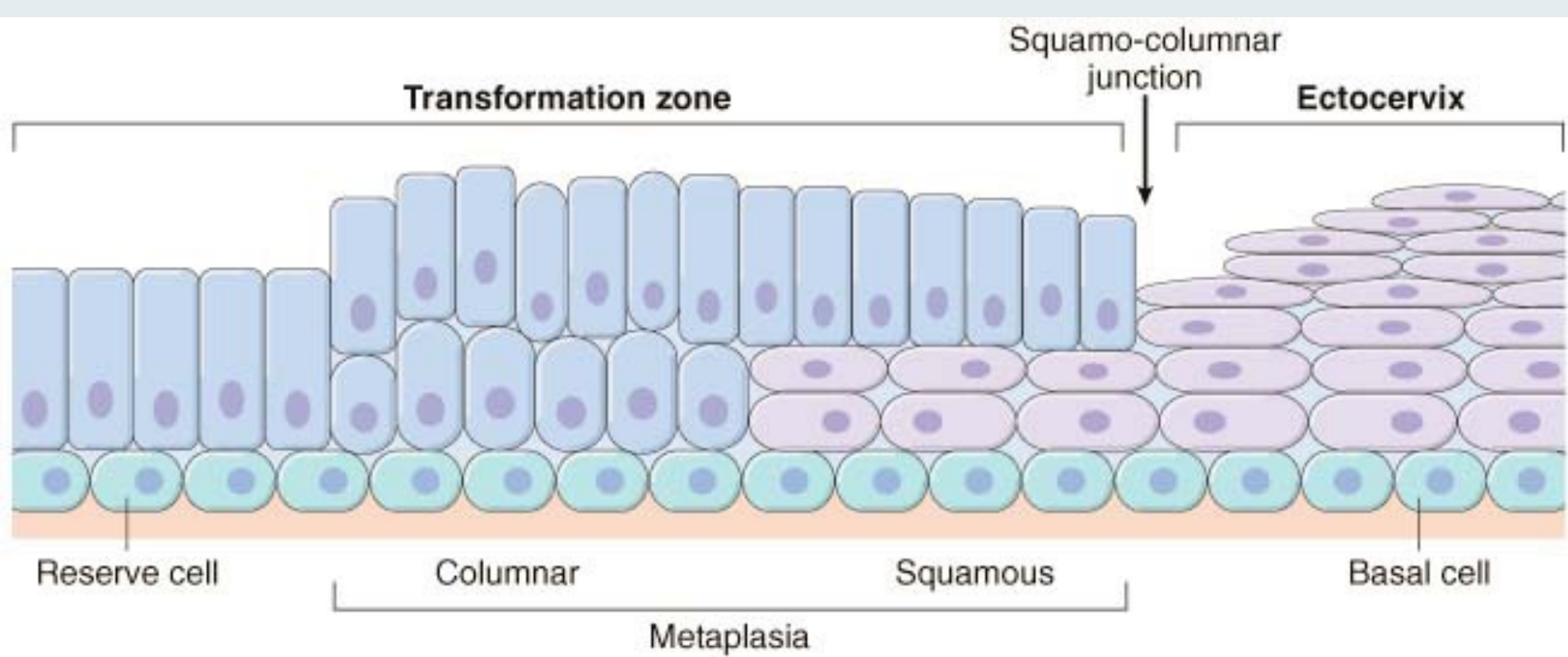


ENDOCERVIX



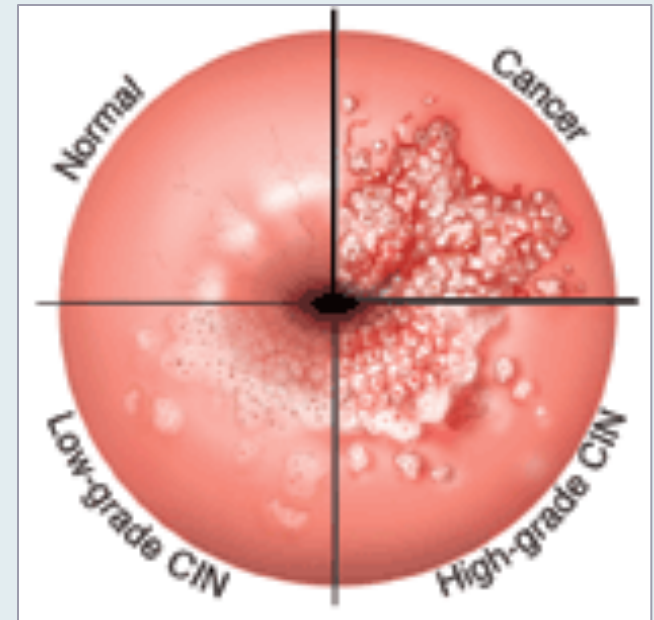
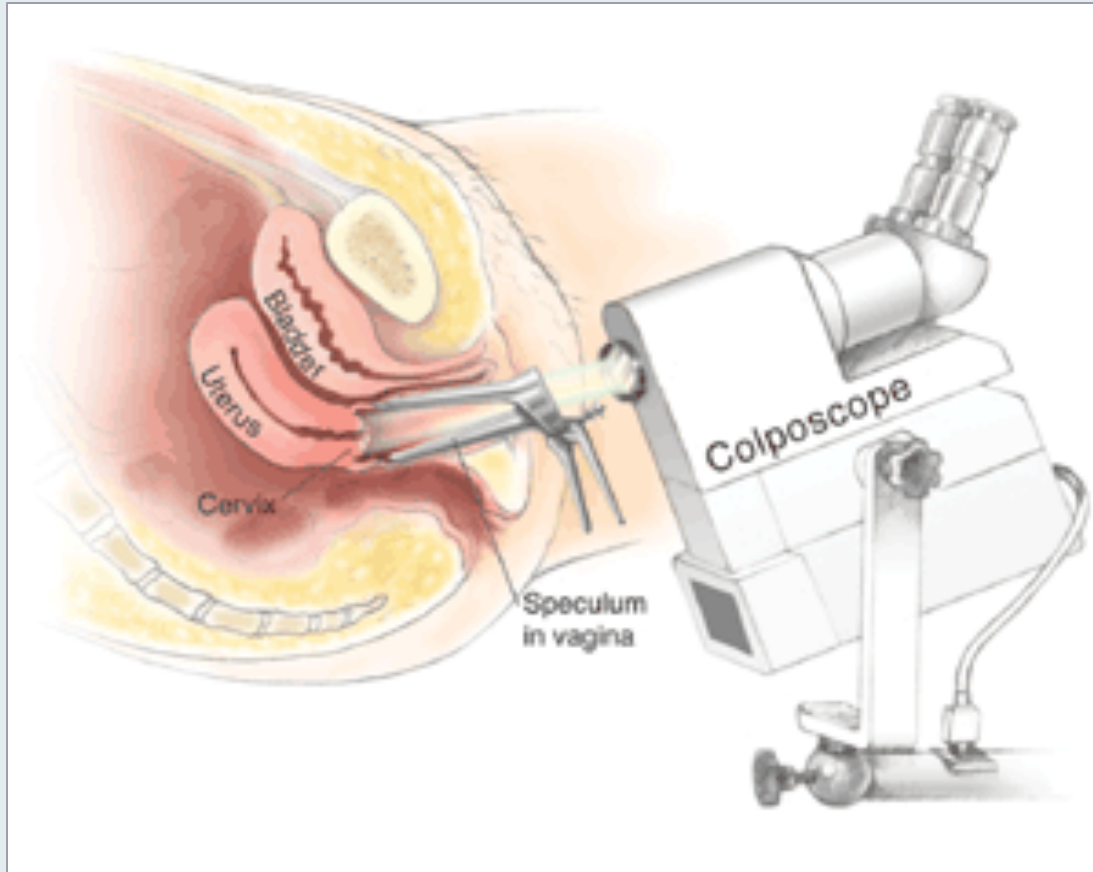
ZONA DE TRANSFORMACION





EXAMEN DEL CUELLO UTERINO

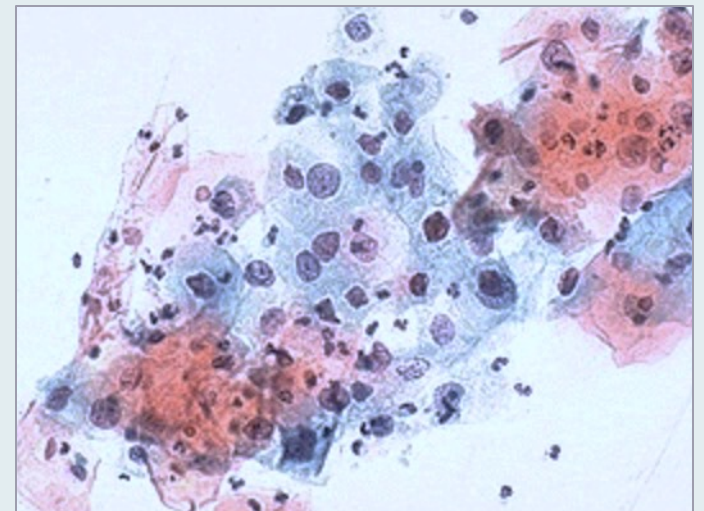
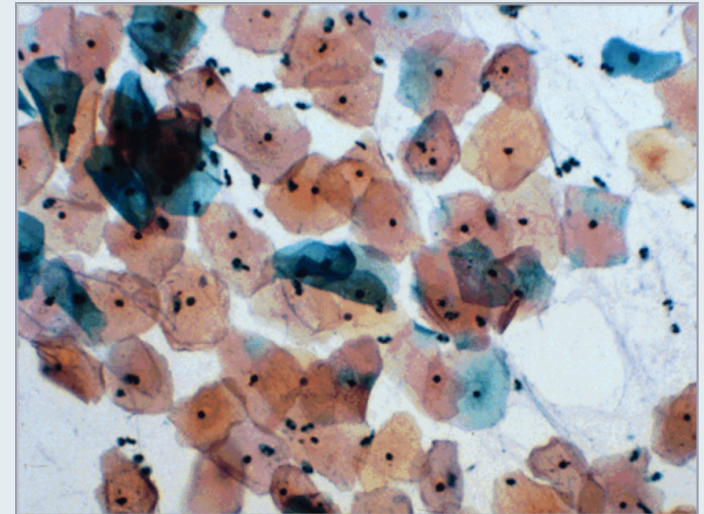
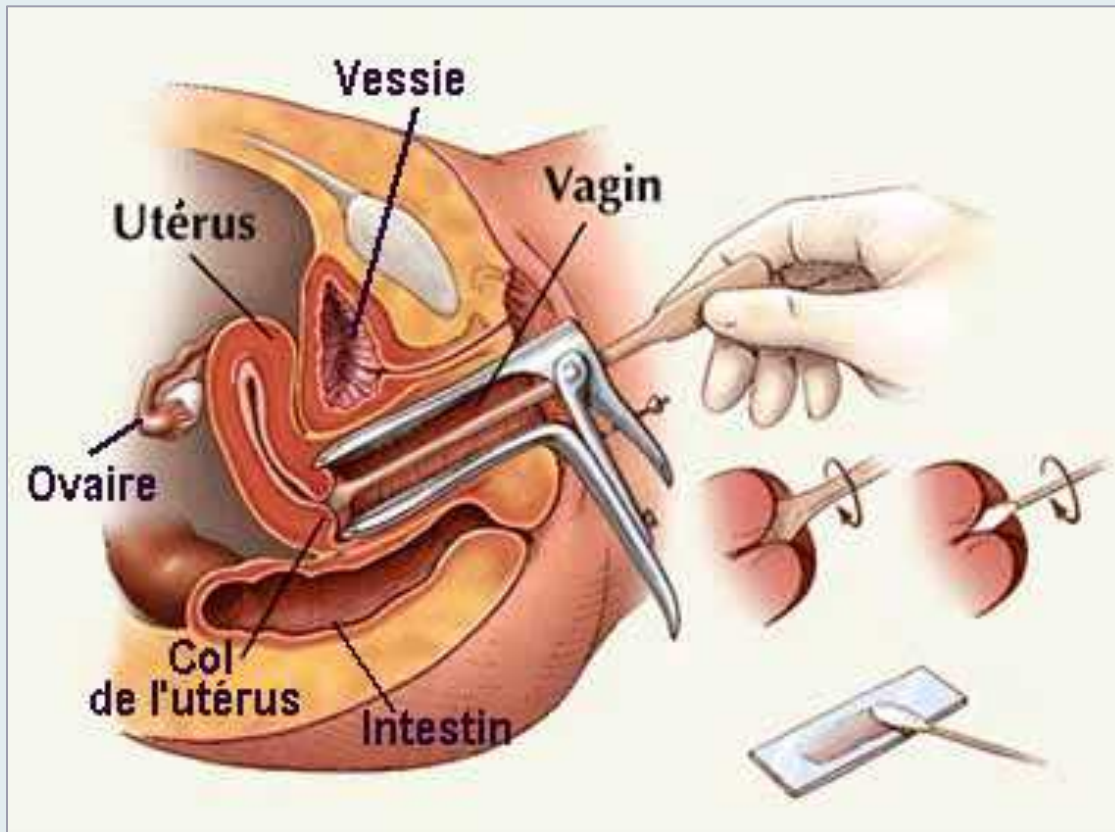
COLPOSCOPIA



EXAMEN VISUAL Y TOMA DE BIOPSIA

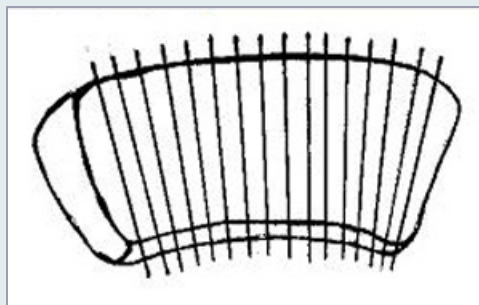
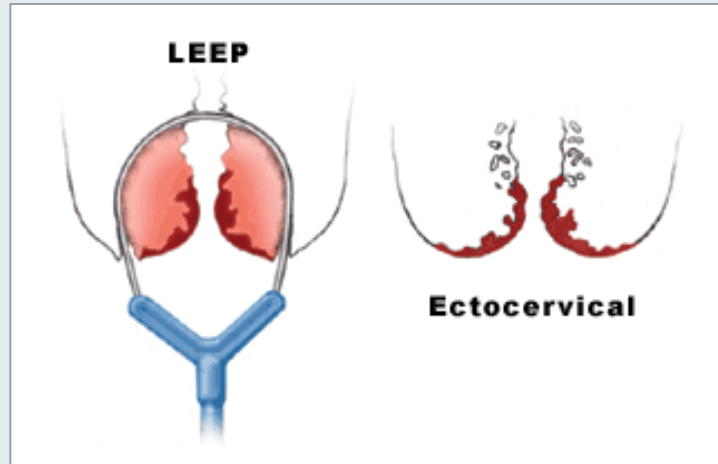
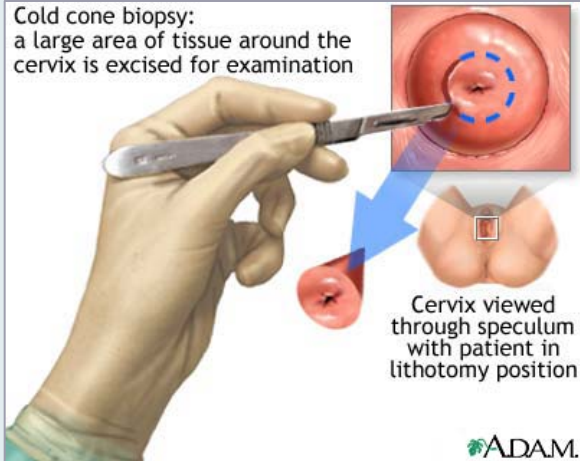
EXAMEN DEL CUELLO UTERINO

CITOLOGIA EXFOLIATIVA CERVICAL-PAP

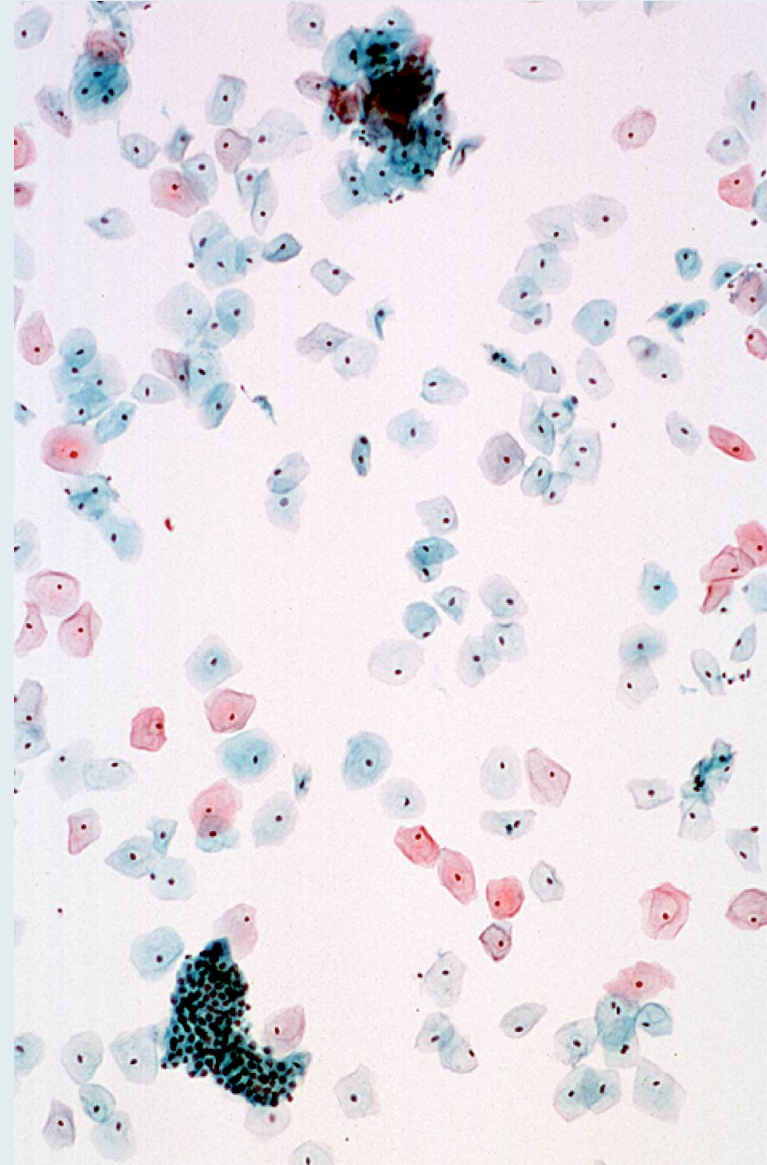
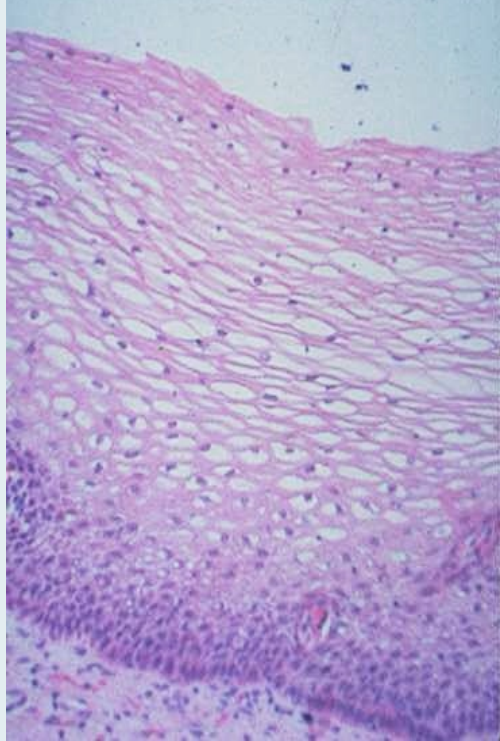


CONO CERVICAL

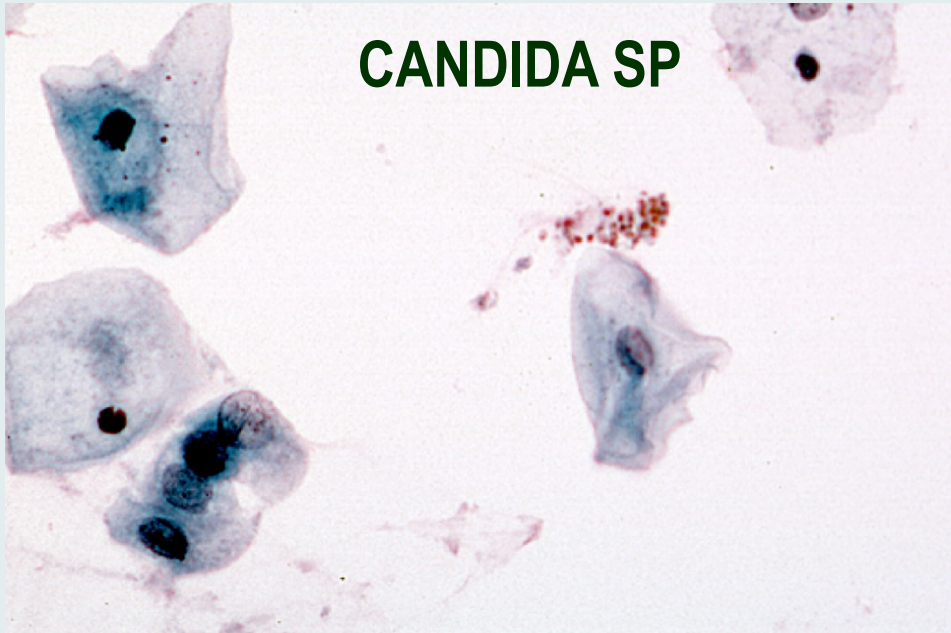
Cold cone biopsy:
a large area of tissue around the
cervix is excised for examination



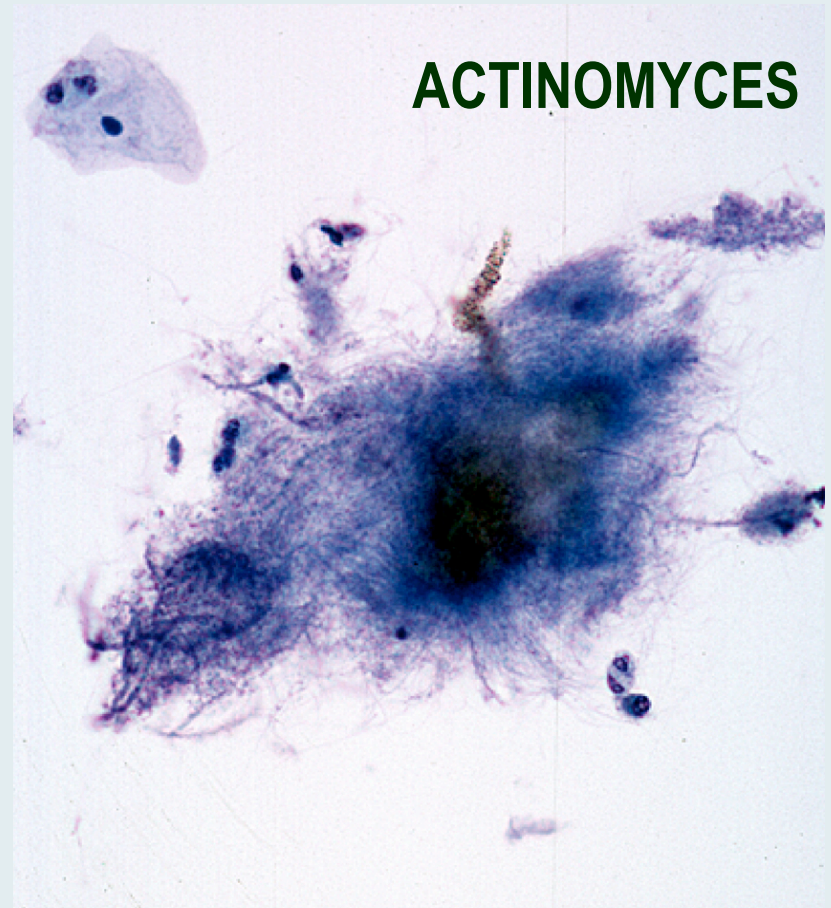
CITOLOGIA CUELLO UTERINO: PAP NORMAL



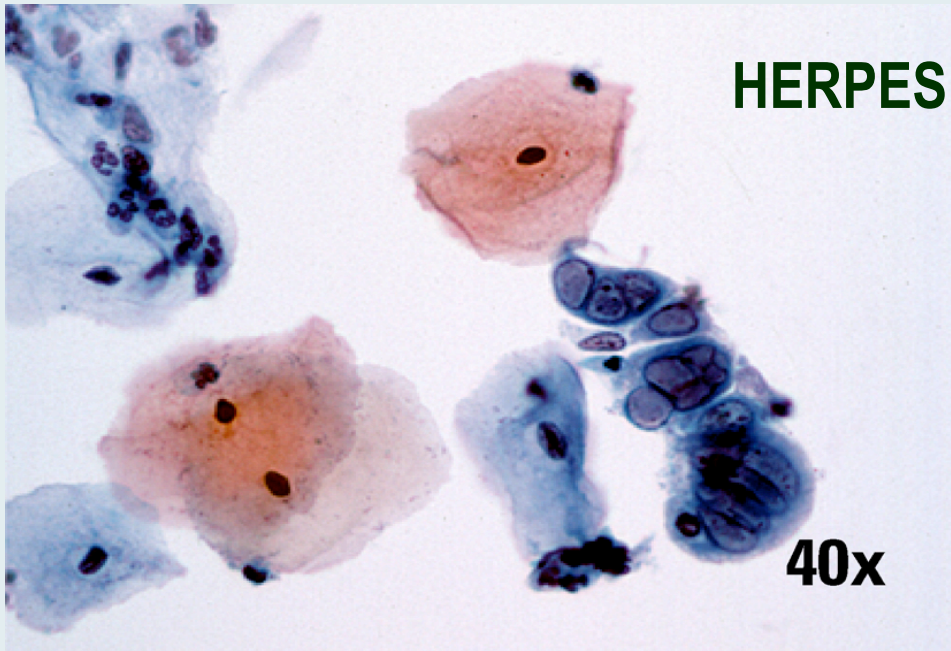
CANDIDA SP



ACTINOMYCES



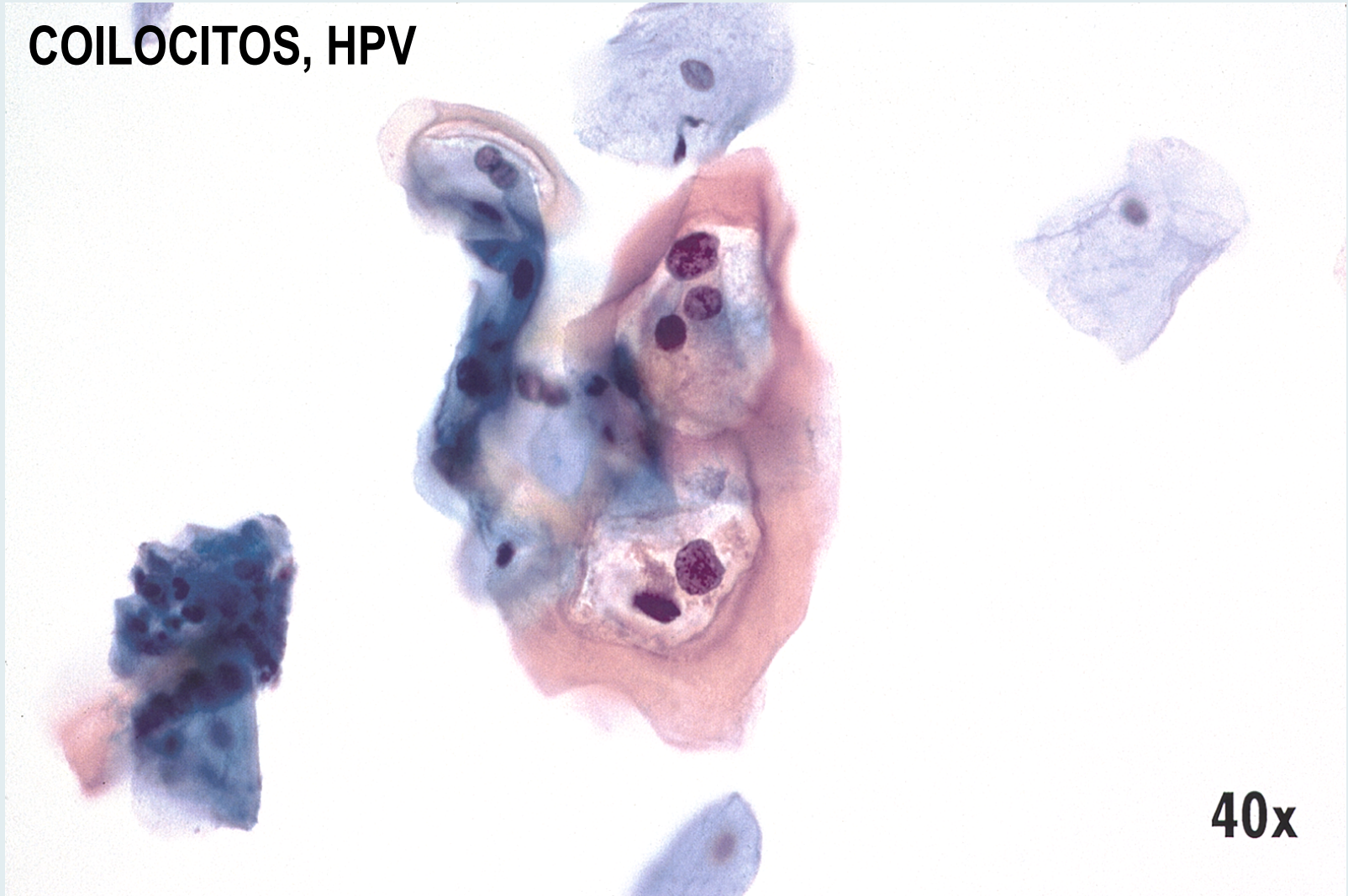
HERPES



40x

Coilocitos, Virus Papiloma Humano (HPV)

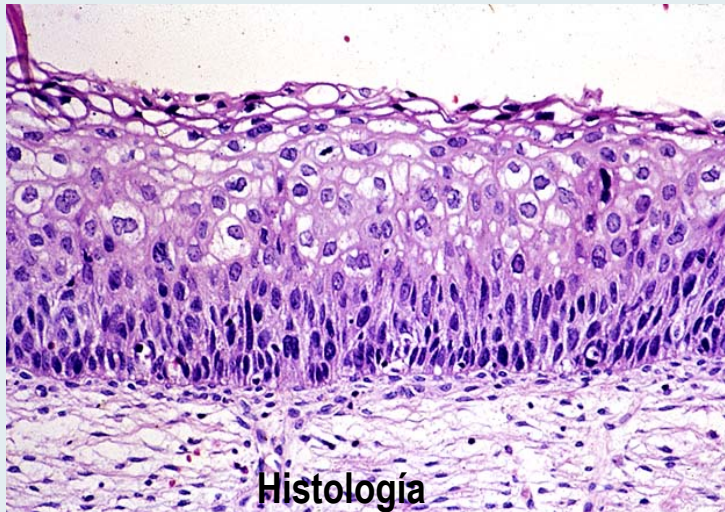
COILOCITOS, HPV



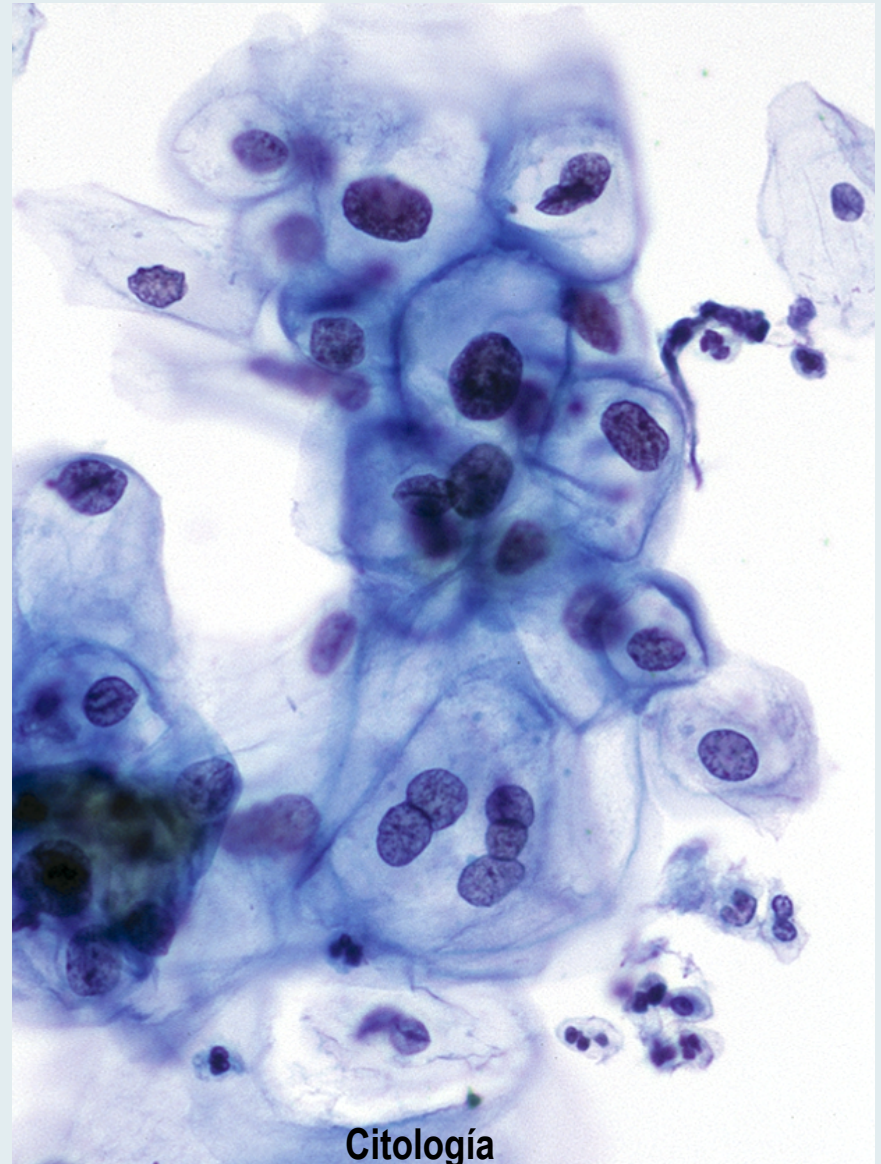
Neoplasia Intraepitelial (NIE I) o Lesión intraepitelial escamosa de bajo grado (LIE BG)



Visión colposcópica

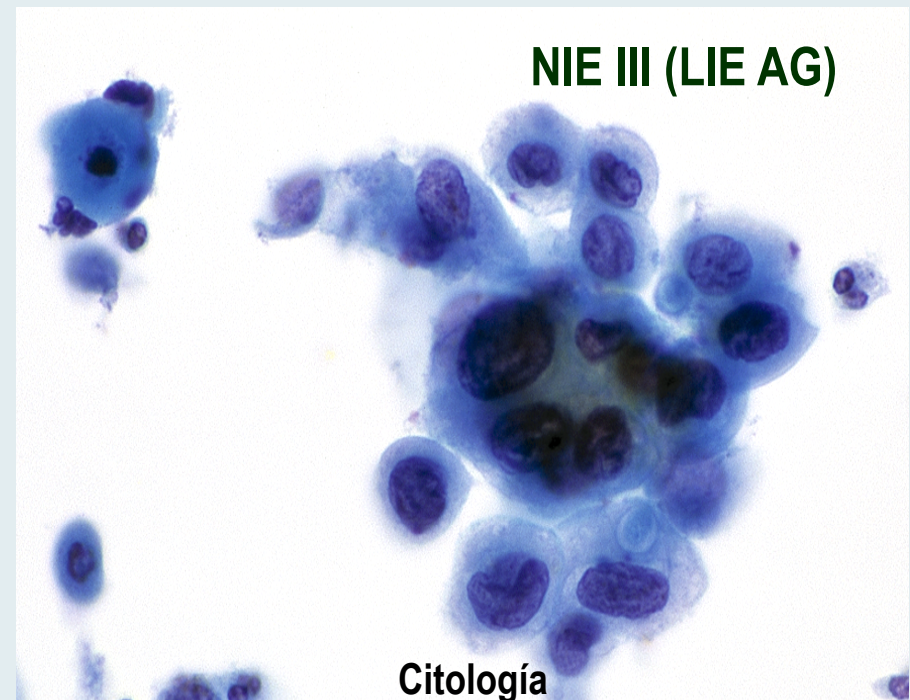
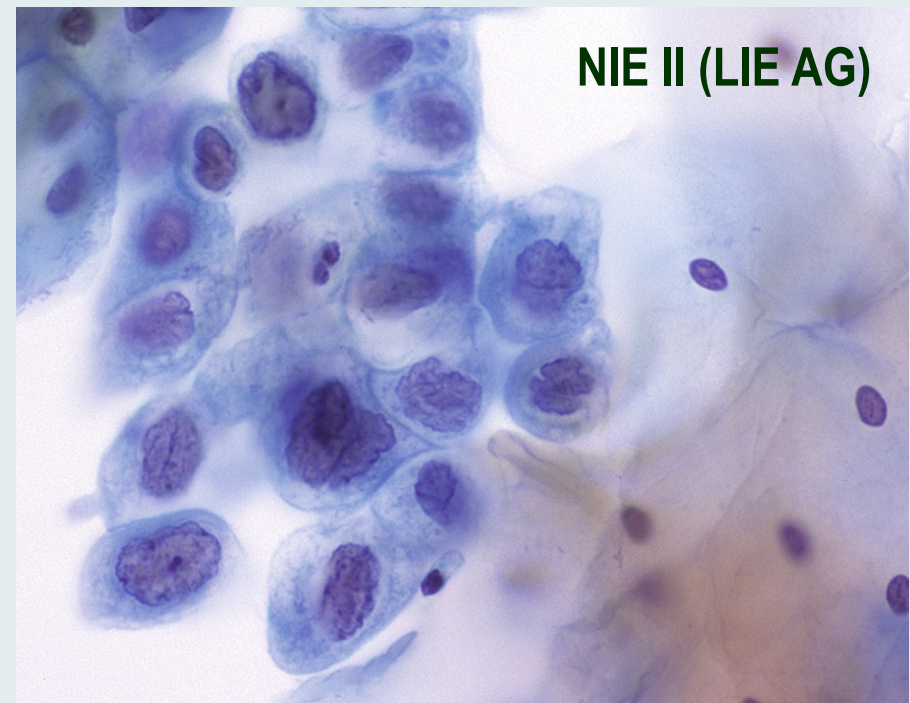
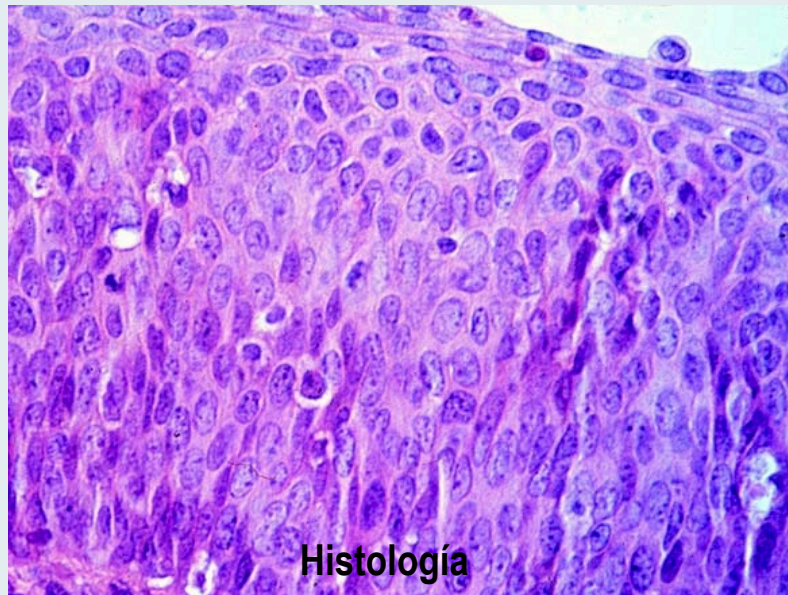
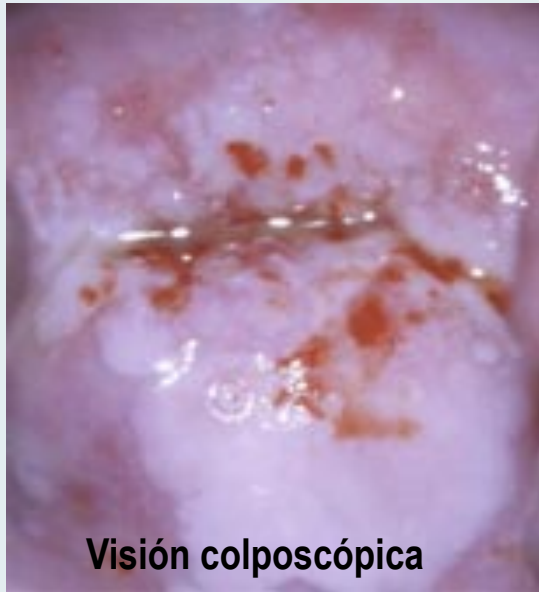


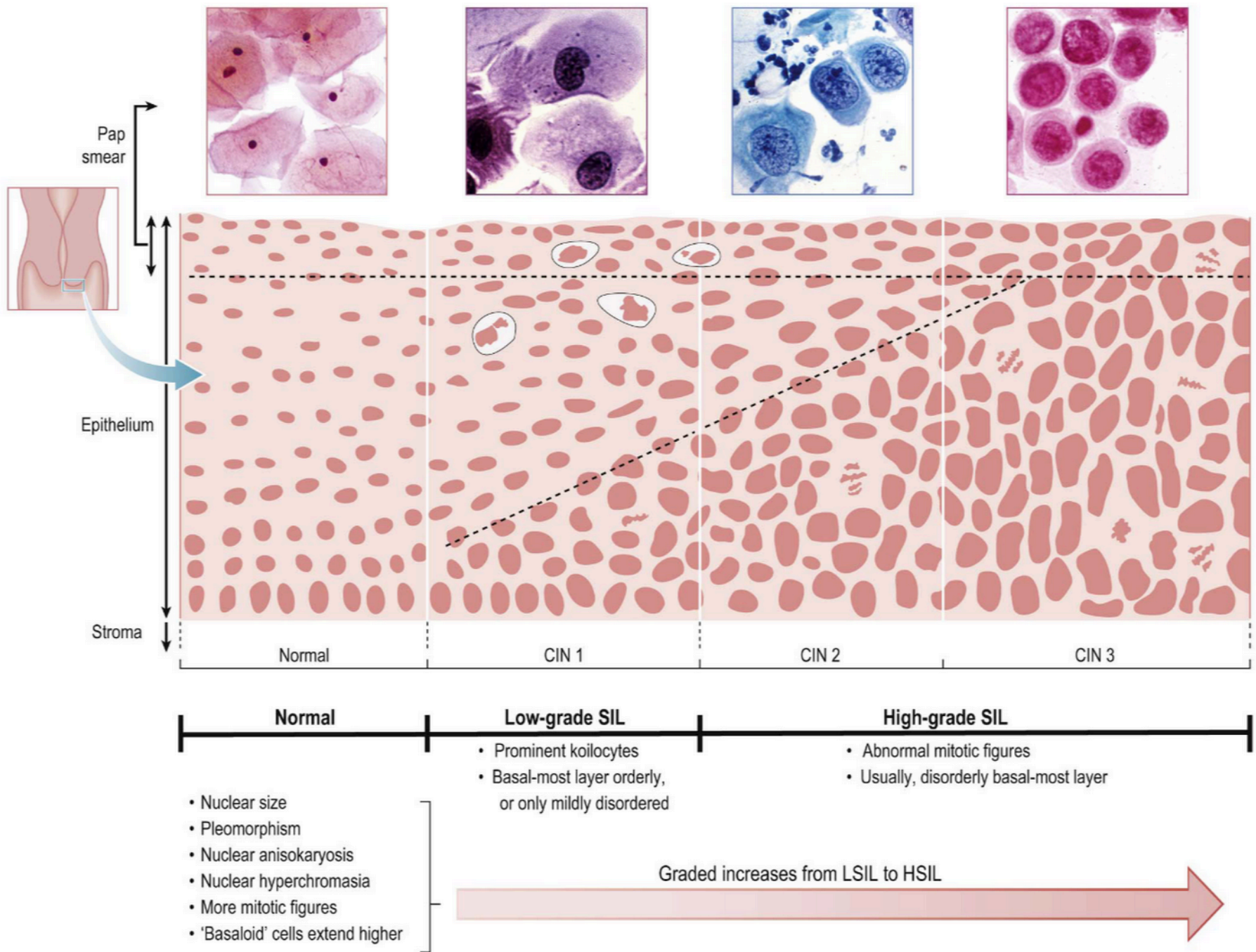
Histología



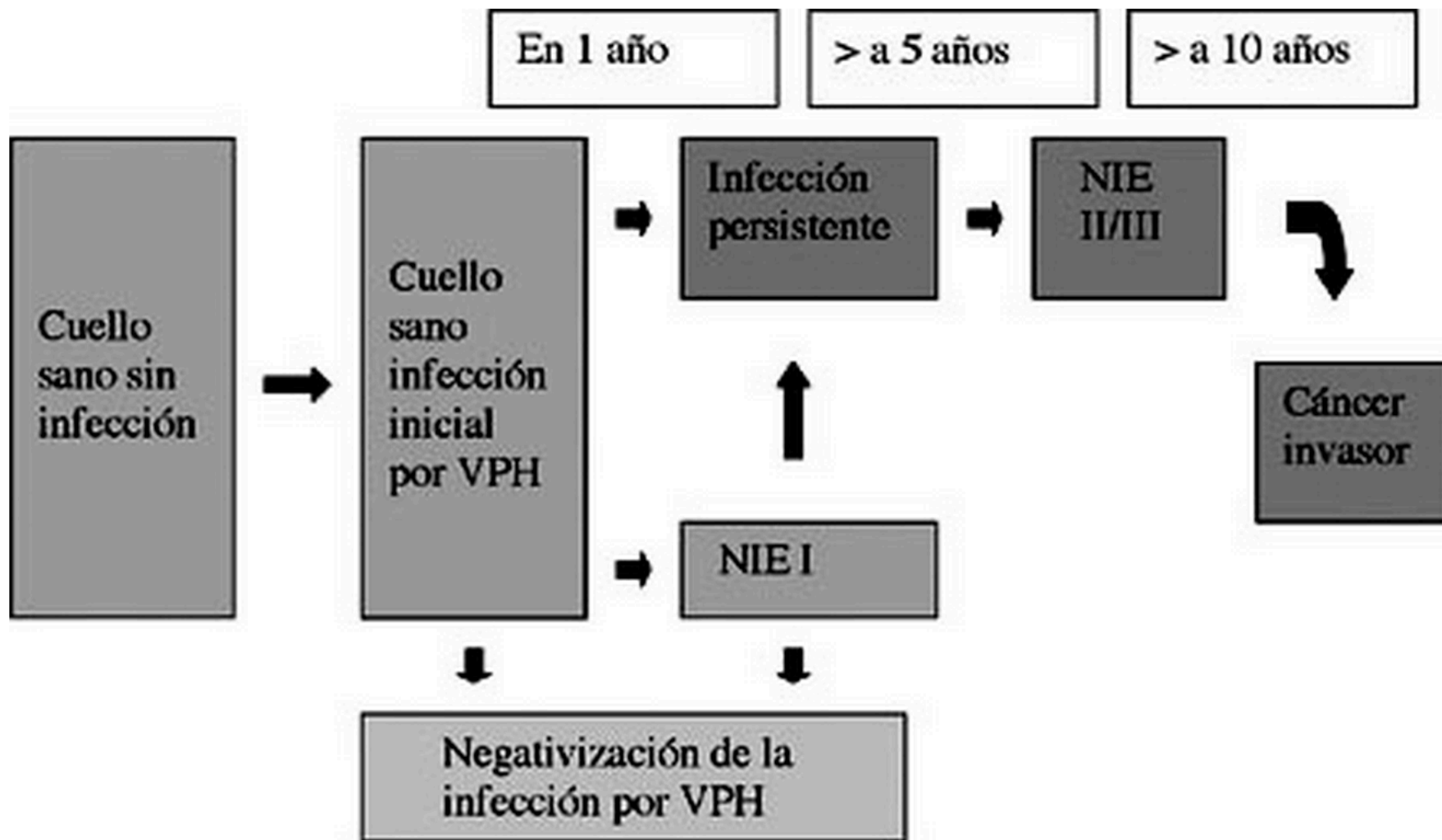
Citología

Lesión intraepitelial de alto grado





CARCINOGENESIS CERVICAL

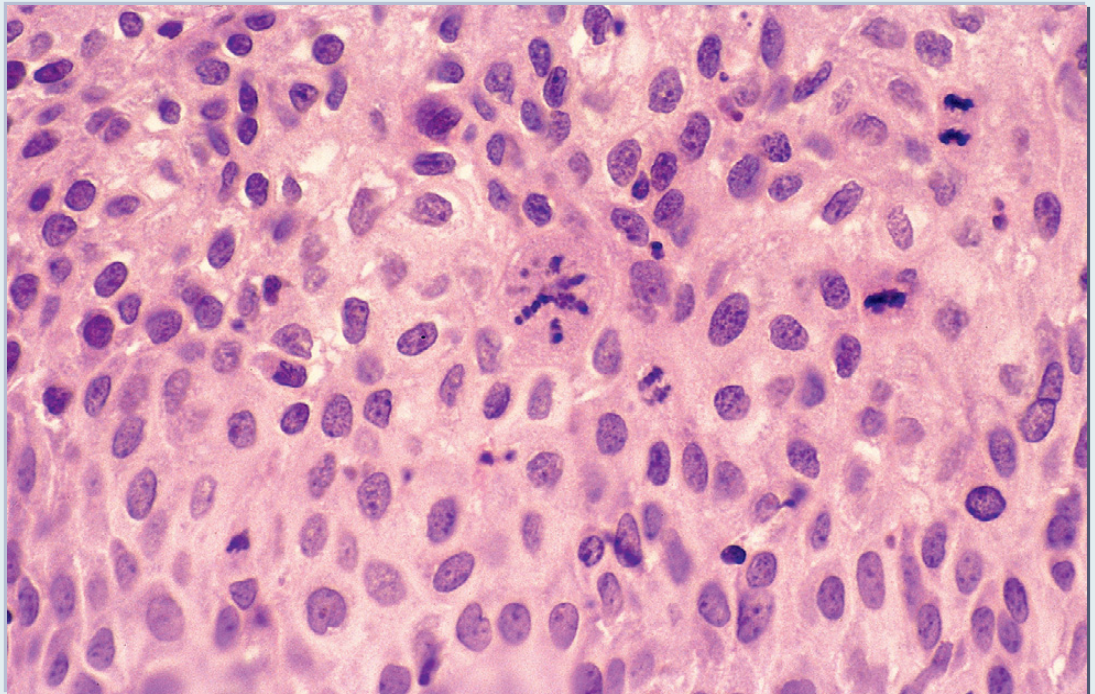
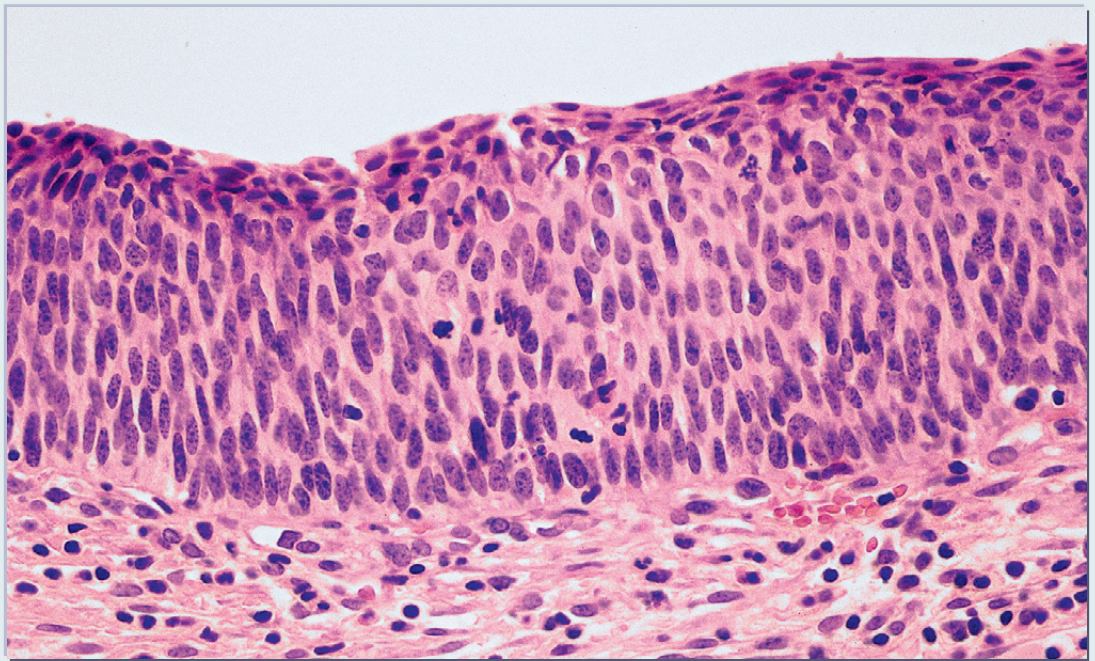


(4,8-8,1 MESES BAJO RIESGO, 16 MESES ALTO RIESGO)

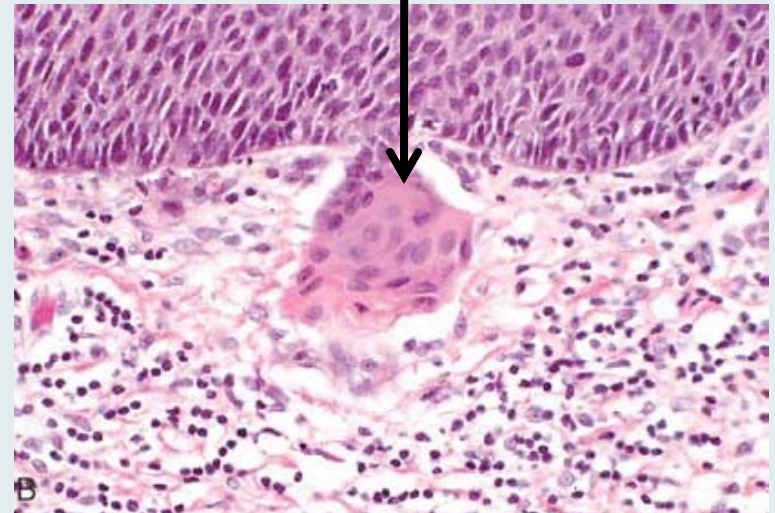
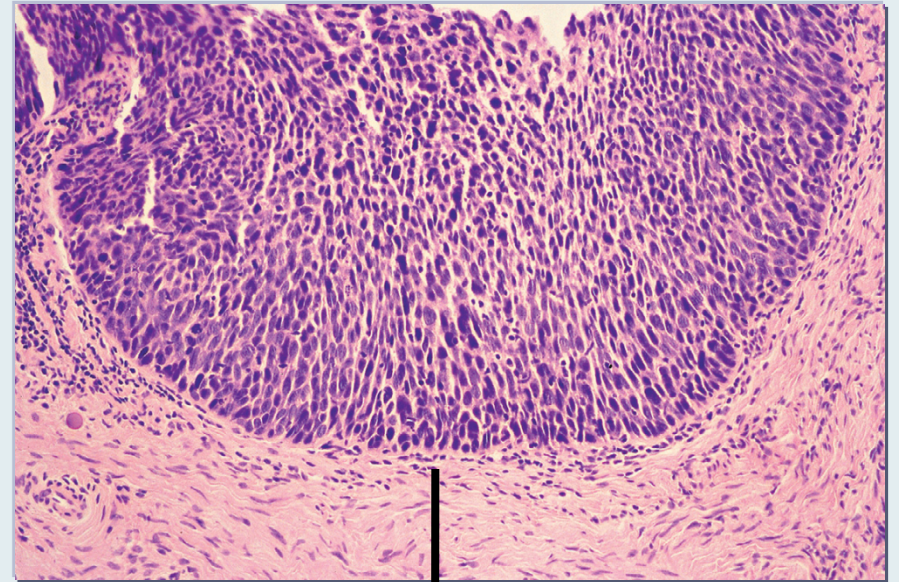
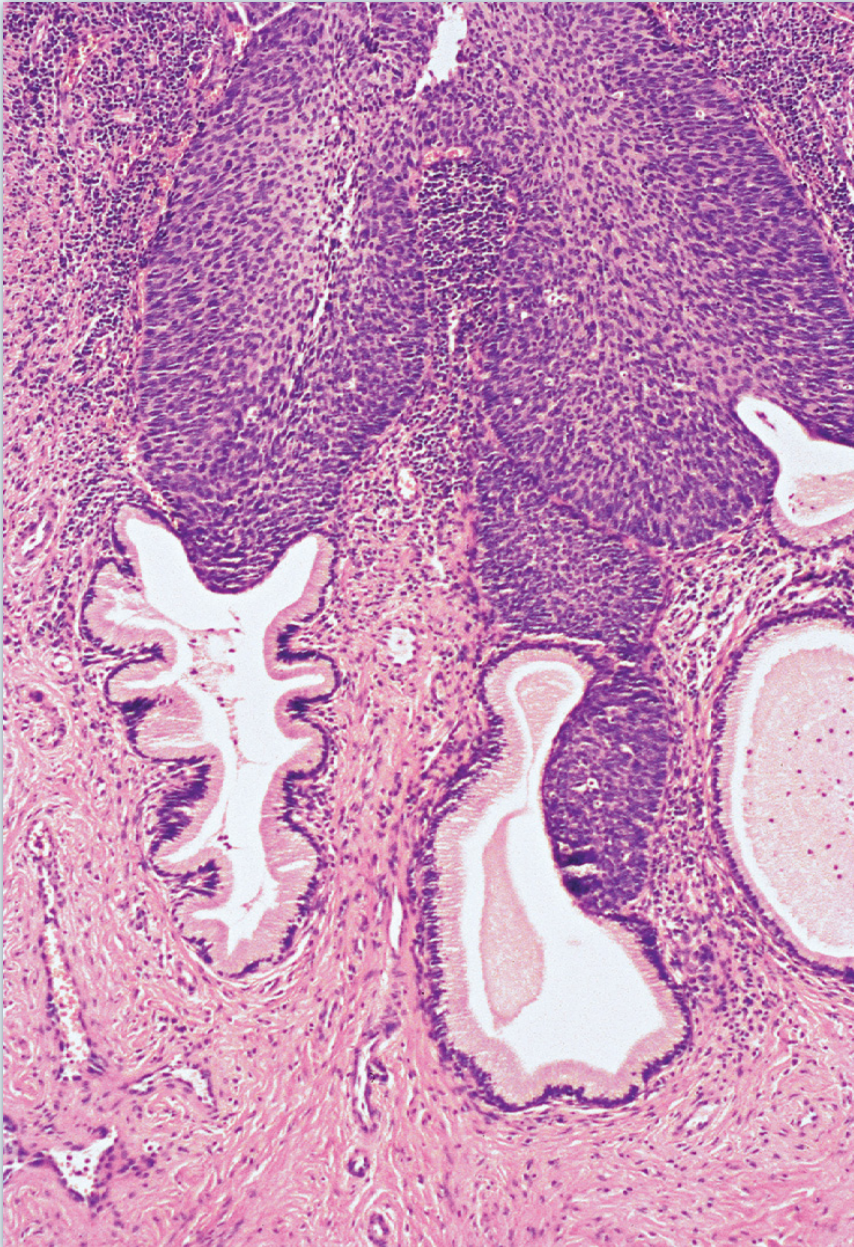
CARCINOMA IN SITU

NIE III (LIE AG)

- 1. PÉRDIDA DE MADURACIÓN (ESTRATIFICACION) EN TODO EL ESPESOR DEL EPITELIO**
- 2. PÉRDIDA DE POLARIDAD**
- 3. ALTERACIÓN NUCLEO-CITOPLASMA**
- 4. FIGURAS MITÓTICAS EN TODOS LOS NIVELES**

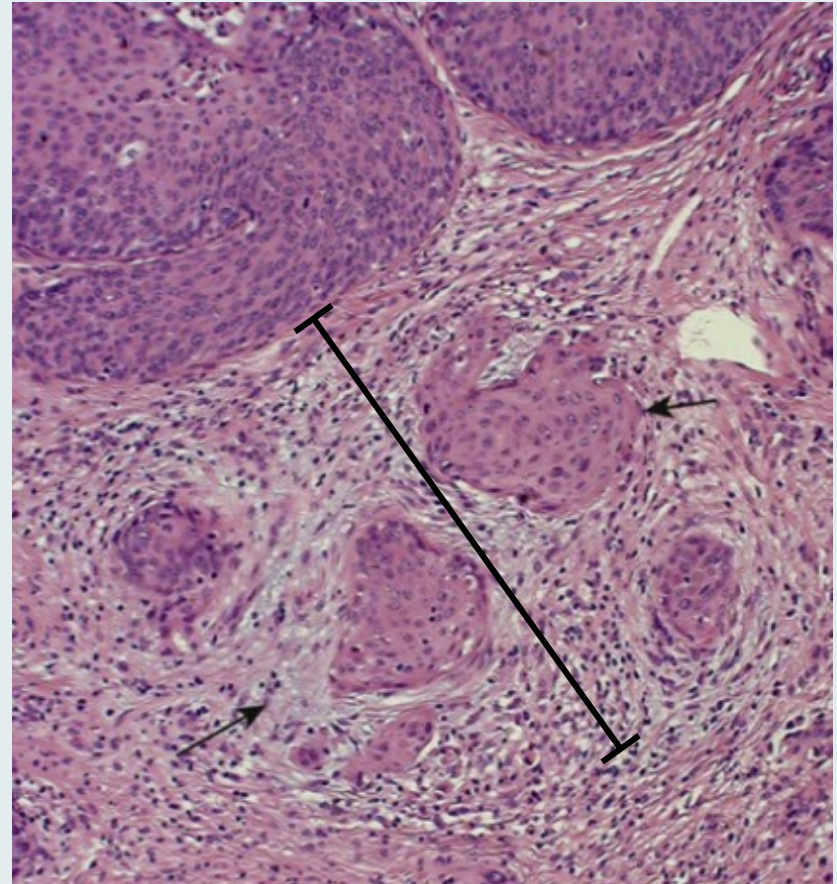
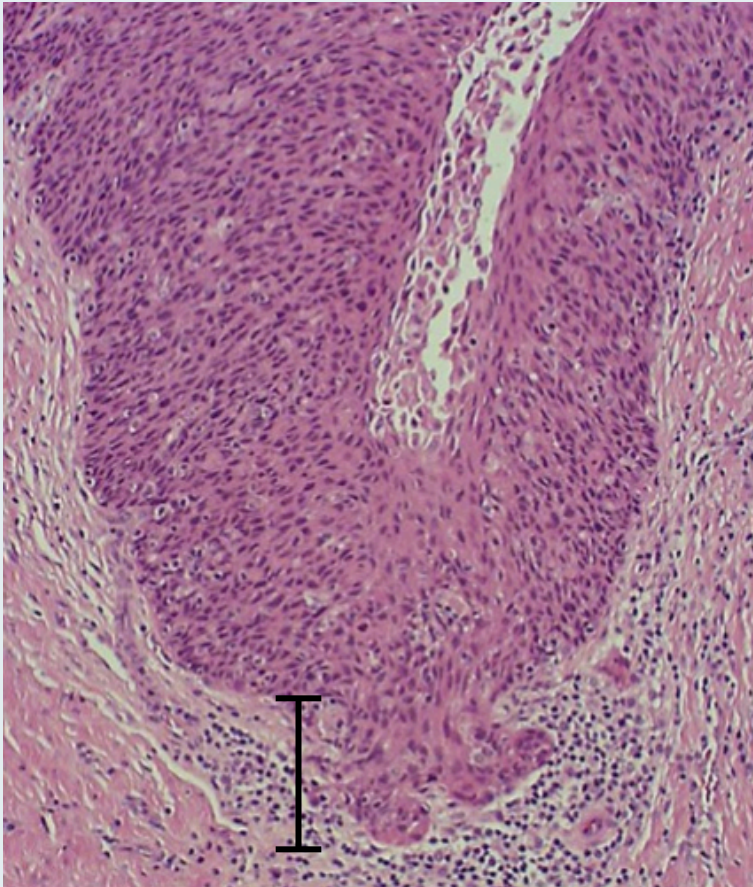


COMPROMISO GLANDULAR (CARCINOMA IN SITU)



MICROINVASION

CARCINOMA ESCAMOSO MICROINVASOR

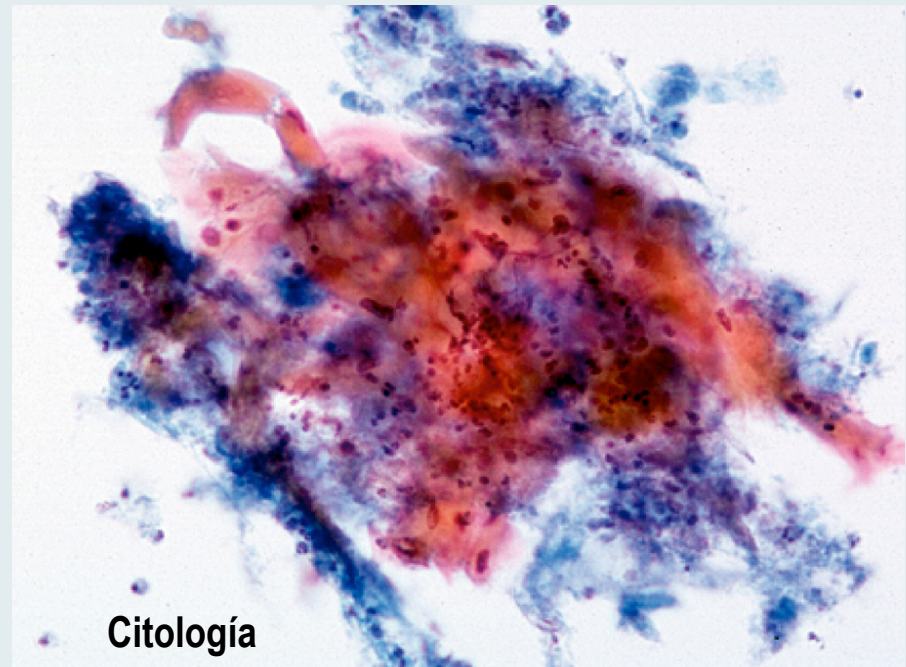
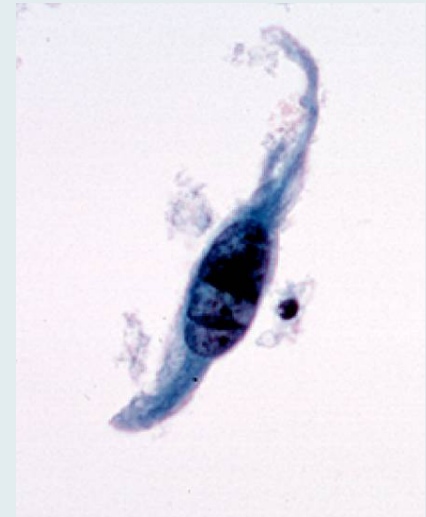
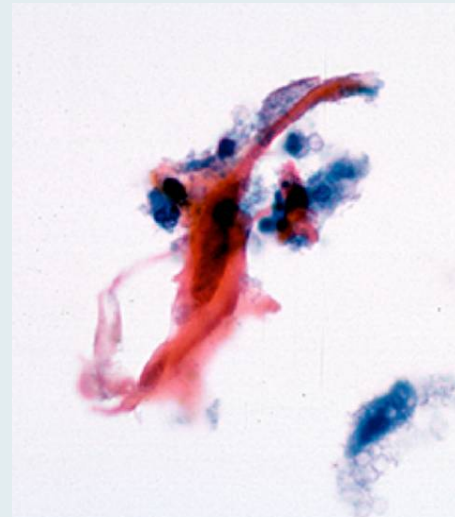
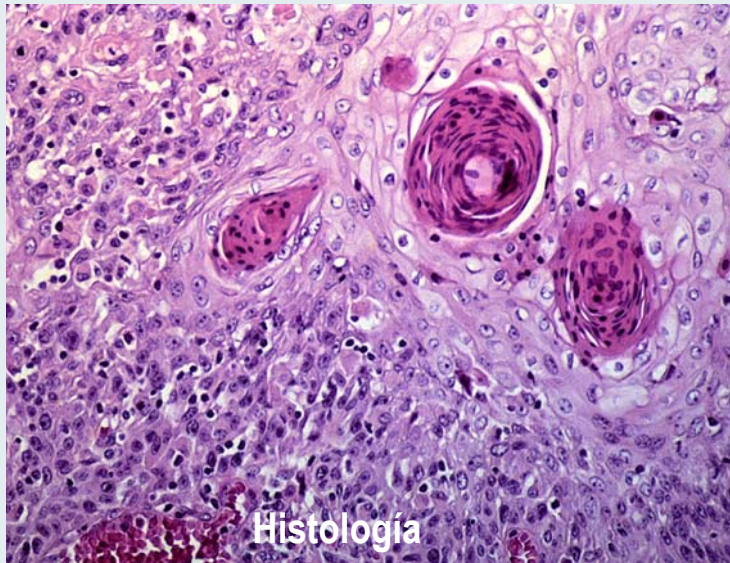
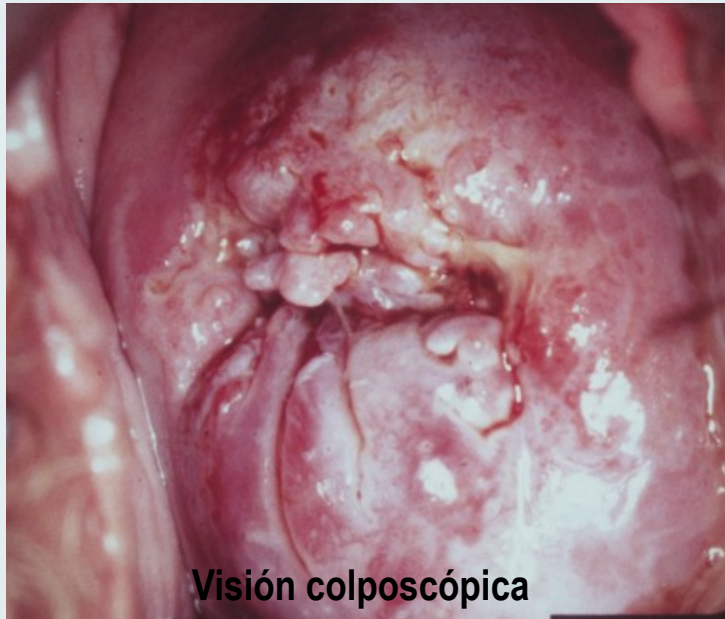


INVASIÓN MENOR DE 5 MM (< 3 y entre 3,1-5mm) EN PROFUNDIDAD Y MENOR DE 7 MM DE EXTENSION SUPERFICIAL

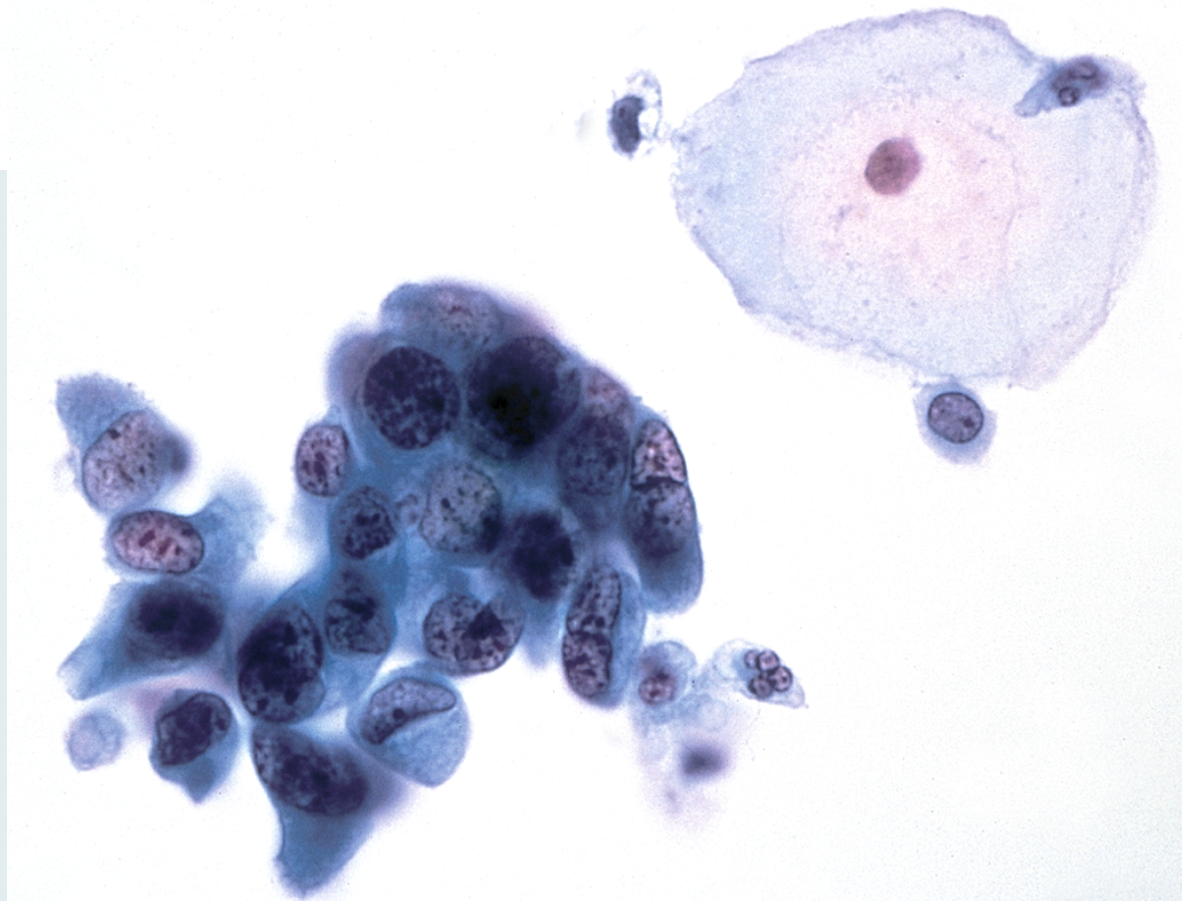
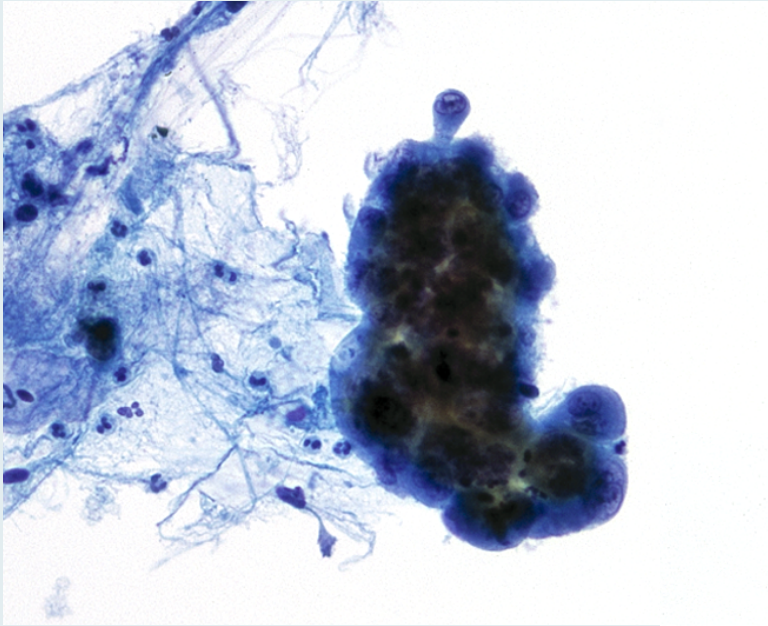
CARCINOMA ESCAMOSO INVASOR



CARCINOMA ESCAMOSO INVASOR



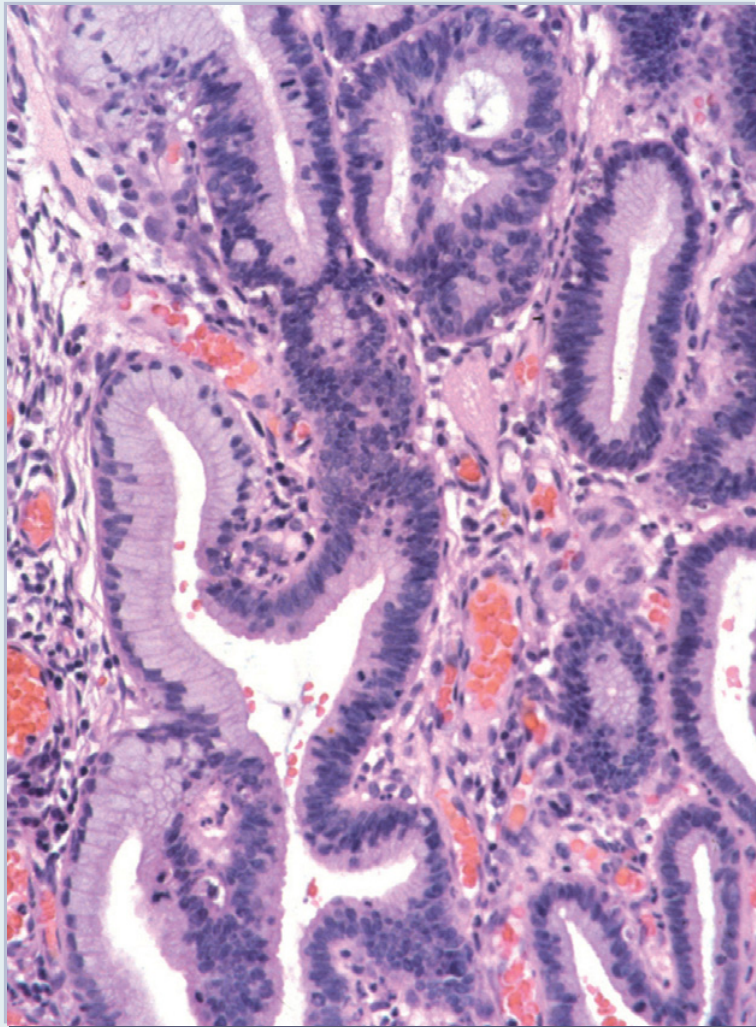
ADENOCARCINOMA



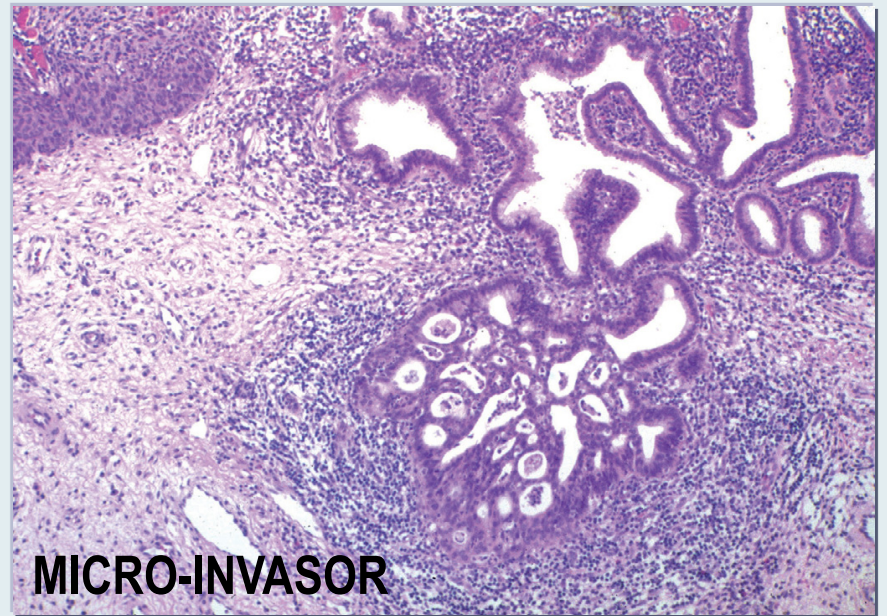
ADENOCARCINOMA CERVICAL INVASOR



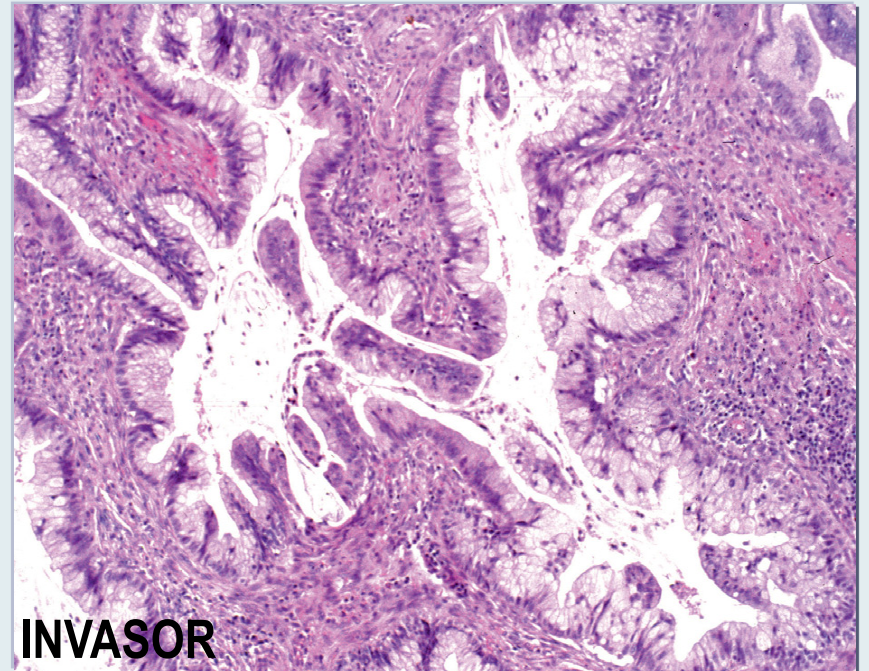
ADENOCARCINOMA CERVICAL



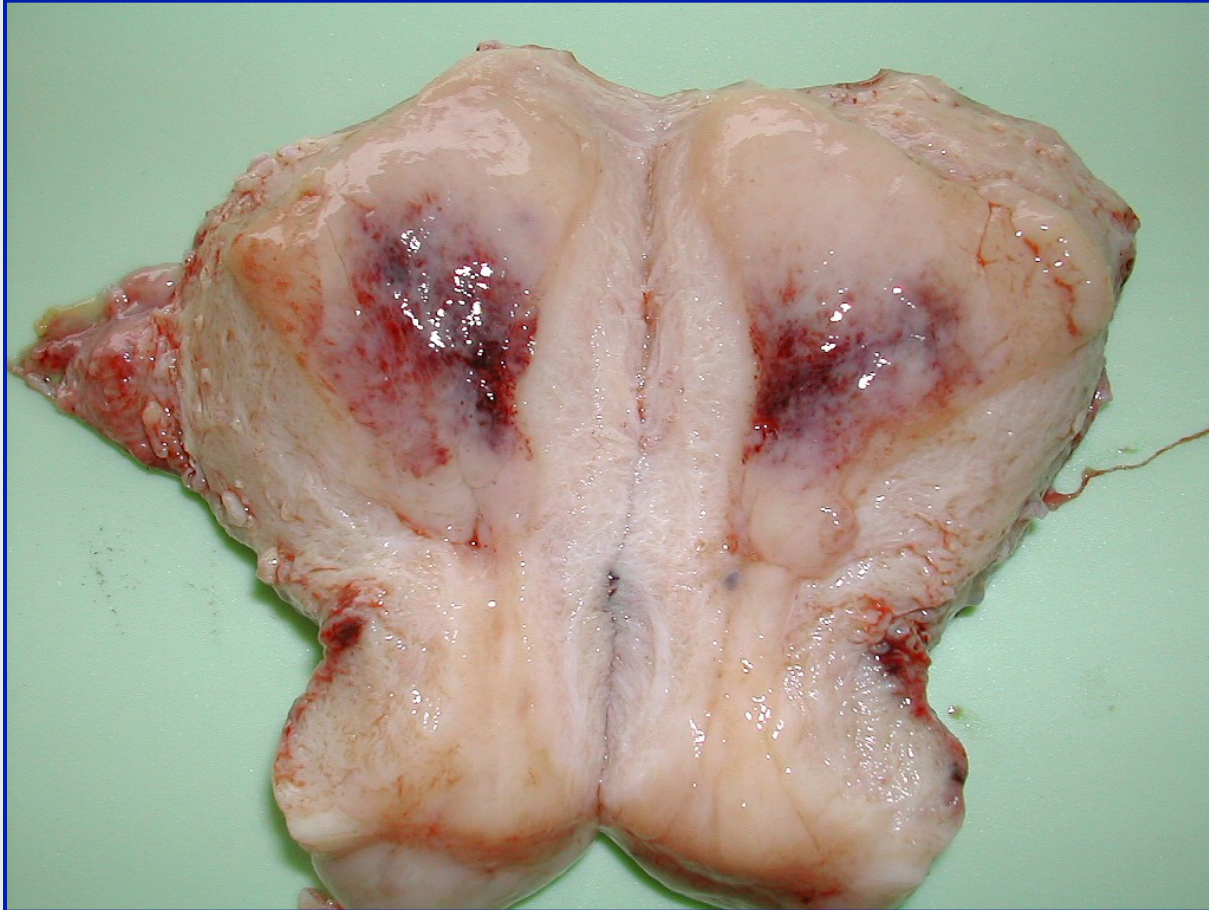
IN SITU



INVASOR



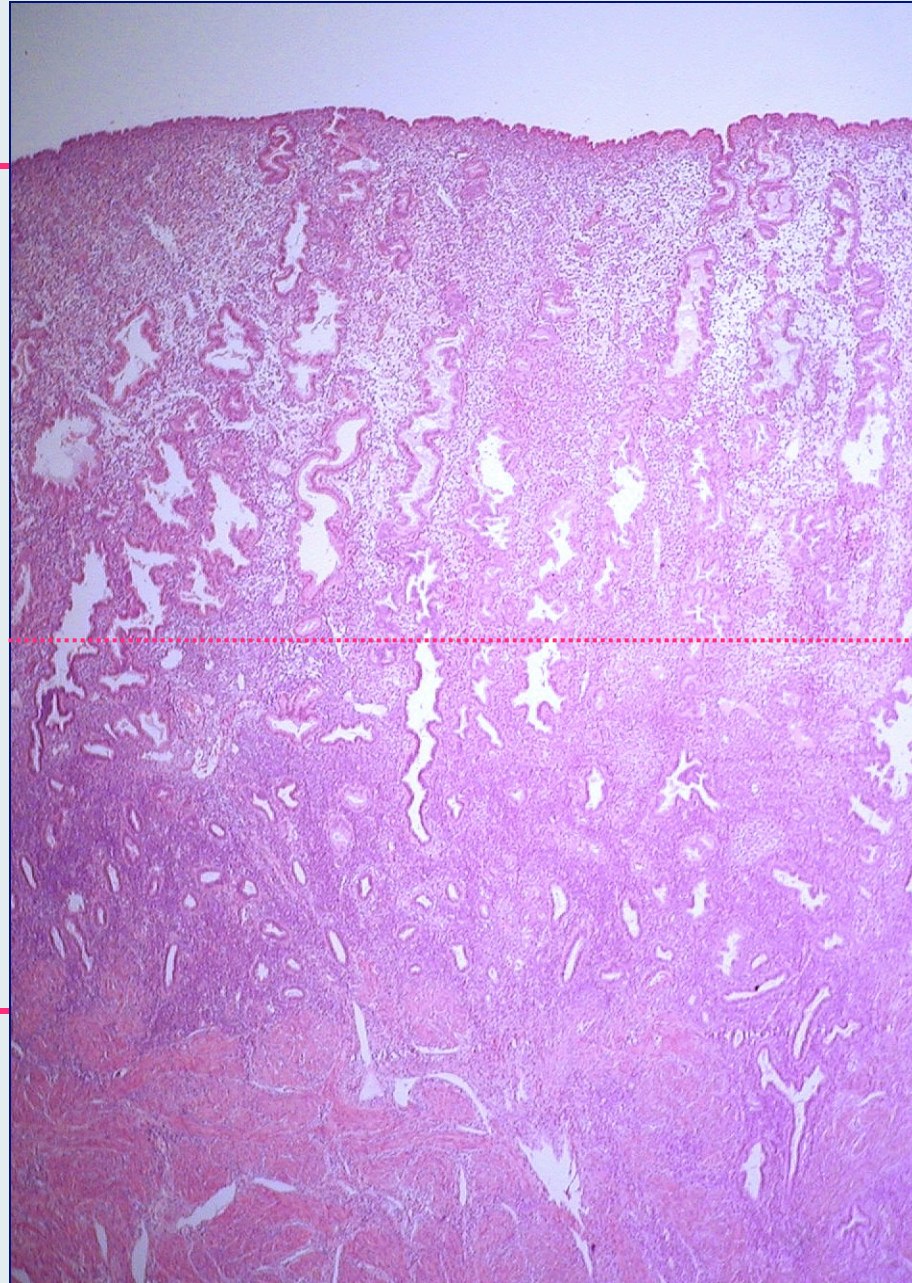
PATOLOGIA ENDOMETRIAL



MUCOSA ENDOMETRIAL

ENDOMETRIO

MIOMETRIO



COMPACTA

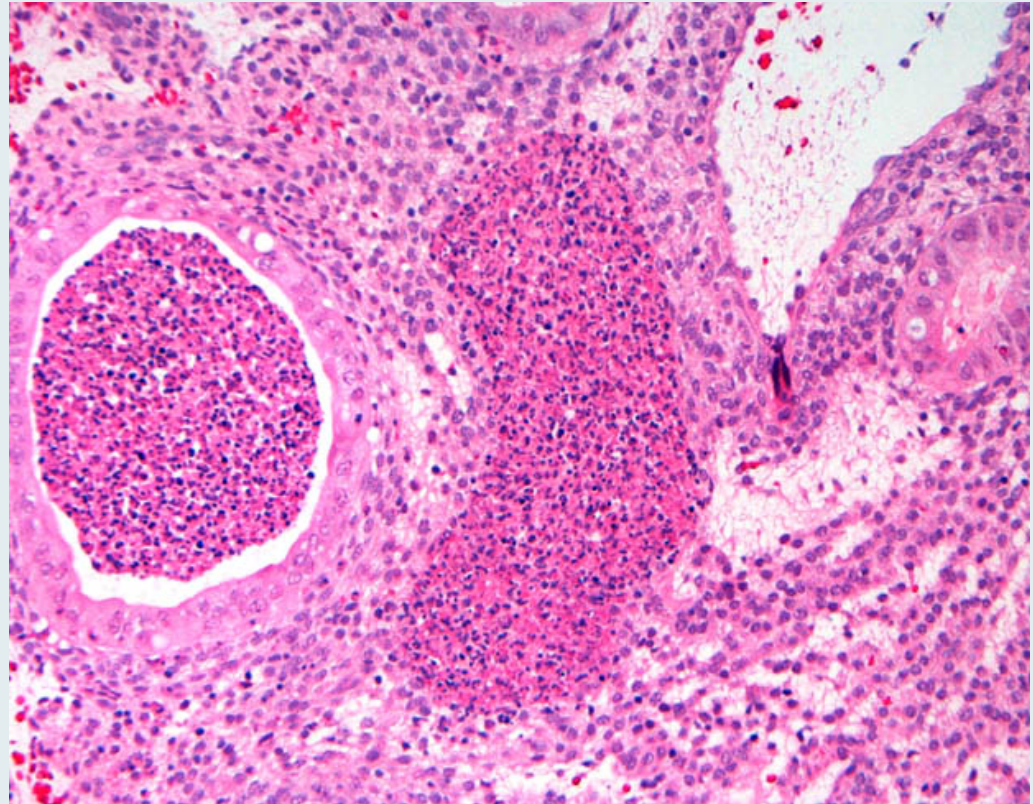
ESPONJOSA

BASAL

PATOLOGÍA DEL ENDOMETRIO

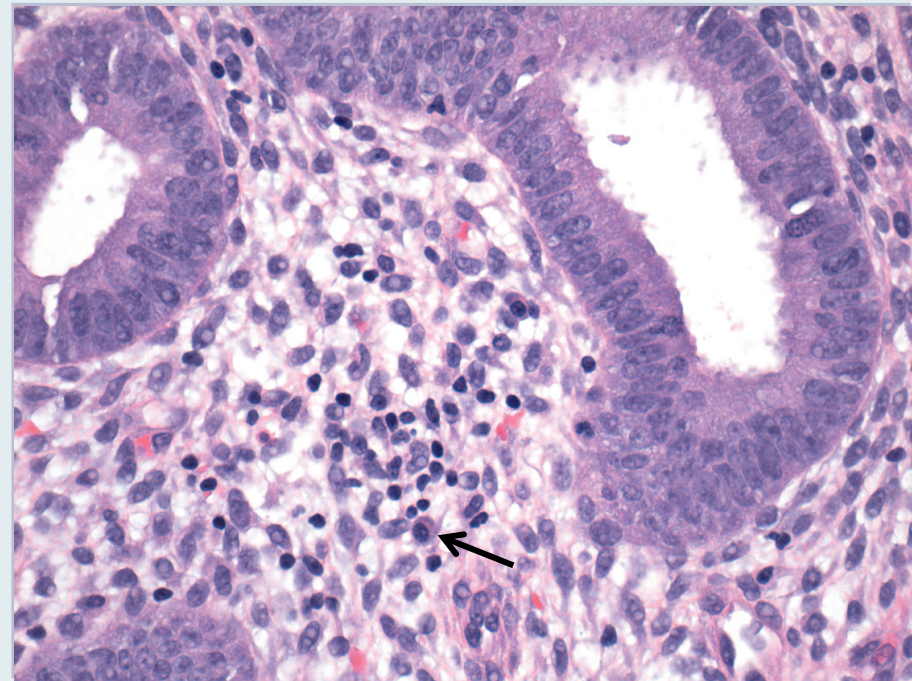
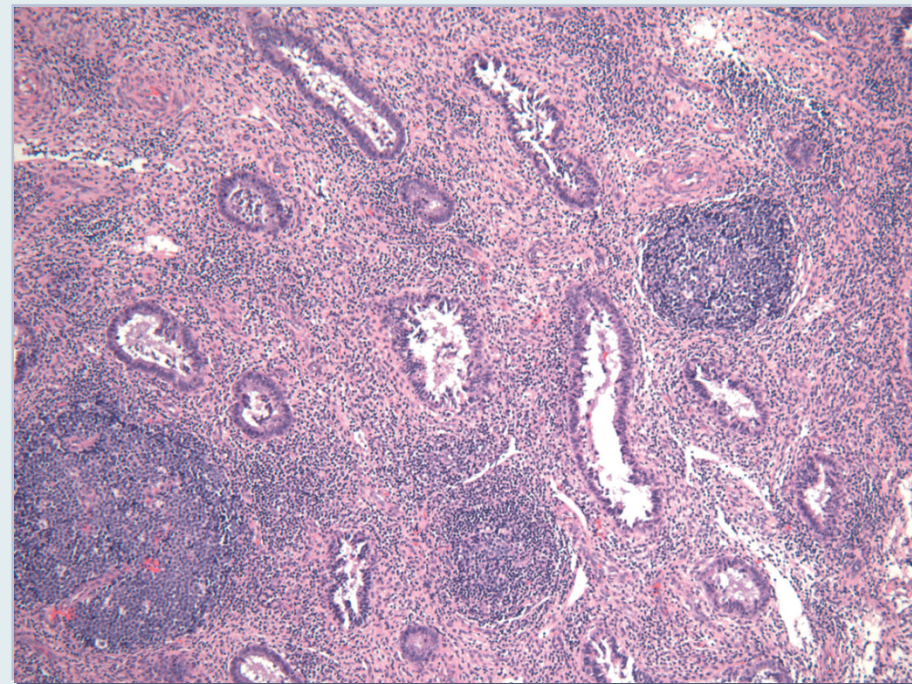
ENDOMETRITIS AGUDA

- ALTERACIÓN BARRERA
 - MENSTRUACIÓN
 - PARTO
 - ABORTO
 - INSTRUMENTACIÓN (CURETAJE, BIOPSIA, INSERCIÓN DIU)
 - CONIZACIÓN
 - RASPADO TERAPÉUTICO
 - CUERPO EXTRAÑO



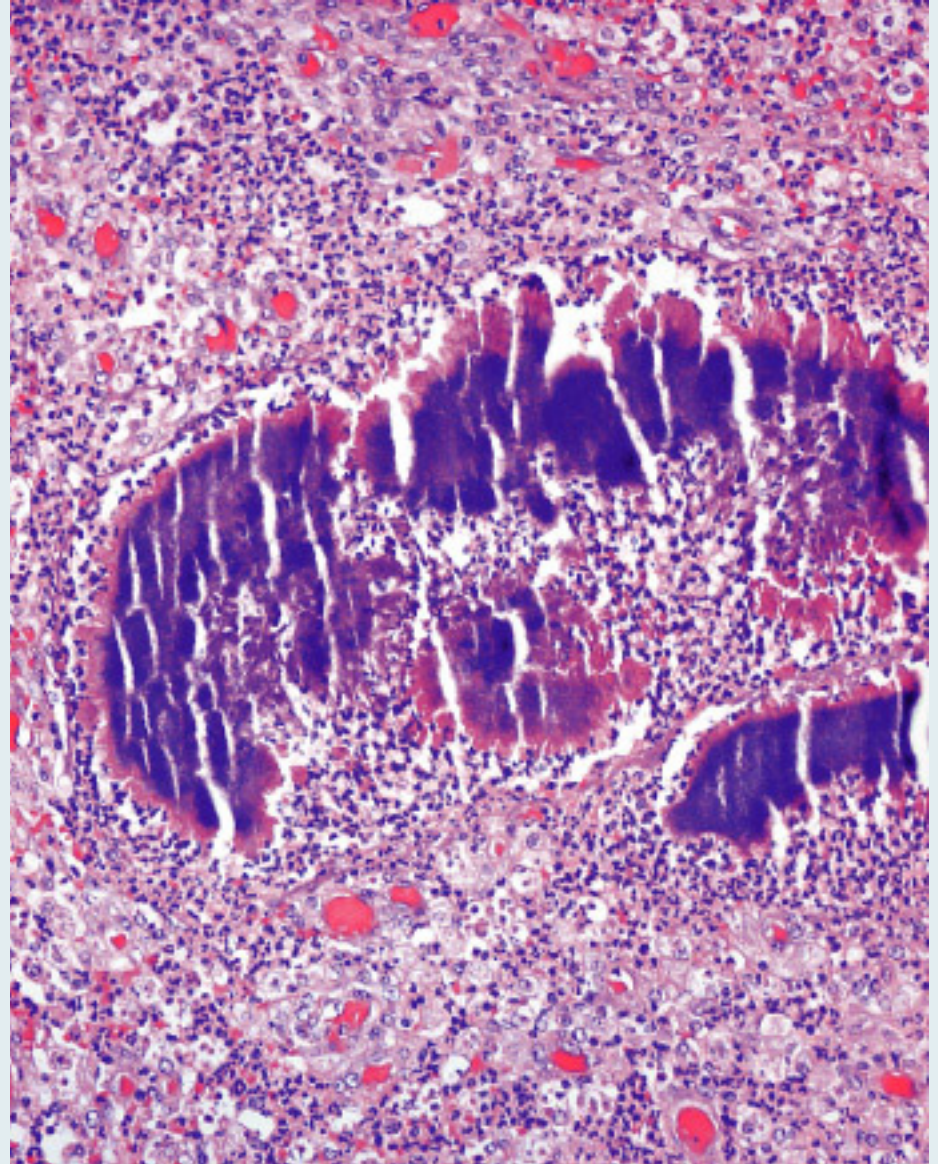
ENDOMETRITIS CRÓNICA

- INESPECÍFICA
 - Edad reproductiva
 - Metrorragia y dolor pélvico
 - Asociado a enfermedad inflamatoria pélvica
 - 1 al 10% de todas las muestras por metrorragia
 - Agentes: Chlamydias, N. Gonorrhea, Streptococos, Mycoplasma y virus
 - Otras causas: DIU, intervenciones uterinas.



- **ESPECÍFICA**

- TBC (luego de salpingitis por diseminación hematógica desde pulmón)
- MYCOPLASMA
- HONGOS
- HERPES, CMV (causa aborto espontáneo, se dg por inclusión y halo nuclear, necrosis)
- GRANULOMATOSA (cuerpo extraño: talco, material de contraste, presencia de DIU)



ACTINOMYCES

ABNORMAL UTERINE BLEEDING (AUB)

TABLE 1.1. Clinical terms for abnormal uterine bleeding.

Amenorrhea	Absence of menstruation
Hypermenorrhea	Uterine bleeding occurring at regular intervals but increased in amount. The period of flow is normal
Hypomenorrhea	Uterine bleeding occurring at regular intervals but decreased in amount. The period of flow is the same or less than the usual duration.
Menorrhagia	Excessive uterine bleeding in both amount and duration of flow occurring at regular intervals
Metrorrhagia	Uterine bleeding, usually not heavy, occurring at irregular intervals
Menometrorrhagia	Excessive uterine bleeding, usually with prolonged period of flow, occurring at frequent and irregular intervals
Oligomenorrhea	Infrequent or scanty menstruation. Usually at intervals greater than 40 days
Abnormal uterine bleeding (AUB)	A term that describes any bleeding from the uterus. Menorrhagia, metrorrhagia, menometrorrhagia, and postmenopausal bleeding are all forms of AUB.
Dysfunctional uterine bleeding (AUB)	Abnormal uterine bleeding with no organic cause. The term implies bleeding caused by abnormalities in ovulation or follicle development and is a disorder of premenopausal women.
Postmenopausal	Abnormal uterine bleeding that occurs at least 1 year after menopause (the cessation of menses)

Patología endometrial en sangrado uterino anormal

Table 2 Distribution of cases of AUB with isolated endometrial lesions according to age group

Age groups	<20 years	21–30 years	31–40 years	41–50 years	51–60 years	61–70 years	71–80 years	Total
Normal cyclical patterns	2 1.7%	9 7.8%	42 36.2%	48 41.4%	12 10.3%	3 2.6%		116 100%
Disordered proliferative pattern		5 6%	28 33.3%	40 47.6%	10 11.9%	1 1.2%		84 100%
Hyperplasia			2 8%	17 68%	6 24%			25 100%
Atrophic pattern		1 10%		3 30%	4 40%	2 20%		10 100%
Benign endometrial polyp		5 10.9%	13 28.3%	18 39.1%	6 13%	4 8.7%		46 100%
Chronic endometritis		2 11.8%	5 29.4%	6 35.3%	3 17.6%	1 5.9%		17 100%
Endometrial carcinoma				5 27.8%	4 22.2%	7 38.9%	2 11.1%	18 100%
Complications of pregnancy	4 4.3%	63 67.7%	26 28%					93 100%
Total	6 1.5%	85 20.8%	116 28.4%	137 33.5%	45 11%	18 4.4%	2 0.4%	409 100%

CAUSAS DE SANGRADO UTERINO ANORMAL

TABLE 1.3. Causes of abnormal uterine bleeding in the reproductive years.

Common	Uncommon
Complications of pregnancy ^a	Hyperplasia
Endometritis	Neoplasia
Dysfunctional bleeding	Endometrial carcinoma
Anovulatory cycles	Cervical carcinoma
Inadequate luteal phase	Clotting disorders
Irregular shedding	
Organic lesions	
Leiomyomas	
Polyps (endometrial, endocervical)	
Adenomyosis	
Exogenous hormones	
Birth control	
Progestin therapy	

TABLE 1.4. Causes of abnormal uterine bleeding in perimenopausal years.

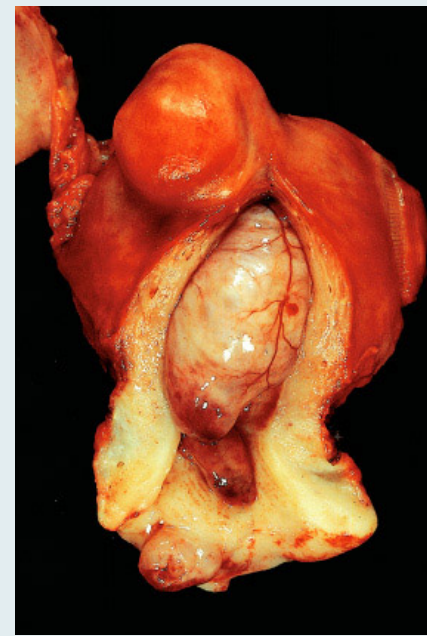
Common	Uncommon
Dysfunctional bleeding	Complications of pregnancy ^a
Anovulatory cycles	Endometritis
Organic lesions	Adenomyosis
Hyperplasia	Neoplasia
Polyps (endometrial, endocervical)	Cervical carcinoma
Exogenous hormones	Endometrial carcinoma
Birth control	Sarcoma
Estrogen replacement	Clotting disorders
Progestin therapy	

METRORRAGIA

- **ORGÁNICA:**
 - ADENOMIOSIS
 - LEIOMIOMA, LEIOMIOSARCOMA
 - PÓLIPOS (15-20% DE LAS METRORR.)
 - CANCER (ADENOCA, 15-20%, postmenop.)
 - EMBARAZO
 - DIU
- **DISFUNCIONAL**

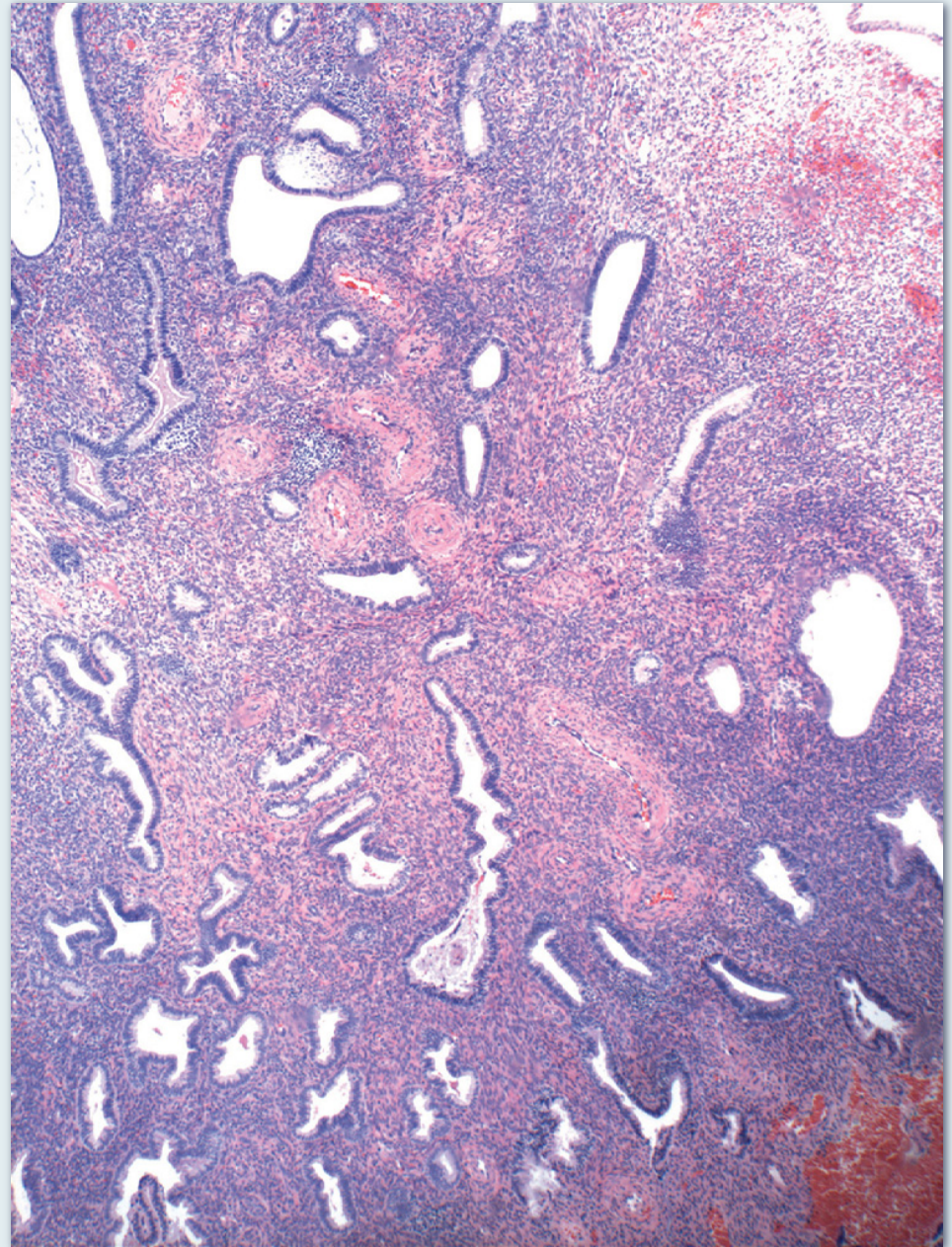
POLIPO ENDOMETRIAL

- Localizado generalmente en fondo uterino
- Lesión frecuente, 25% de las mujeres
- Mayores de 40 años (asintomático)
- Metrorragia es síntoma más común
- Solo 5% se asocia a neoplasia (postmenopáusicas)



POLIPO ENDOMETRIAL

- Arquitectura glandular alterada con quistes y glándulas irregulares
- Estroma fibroso
- Presencia de vasos gruesos



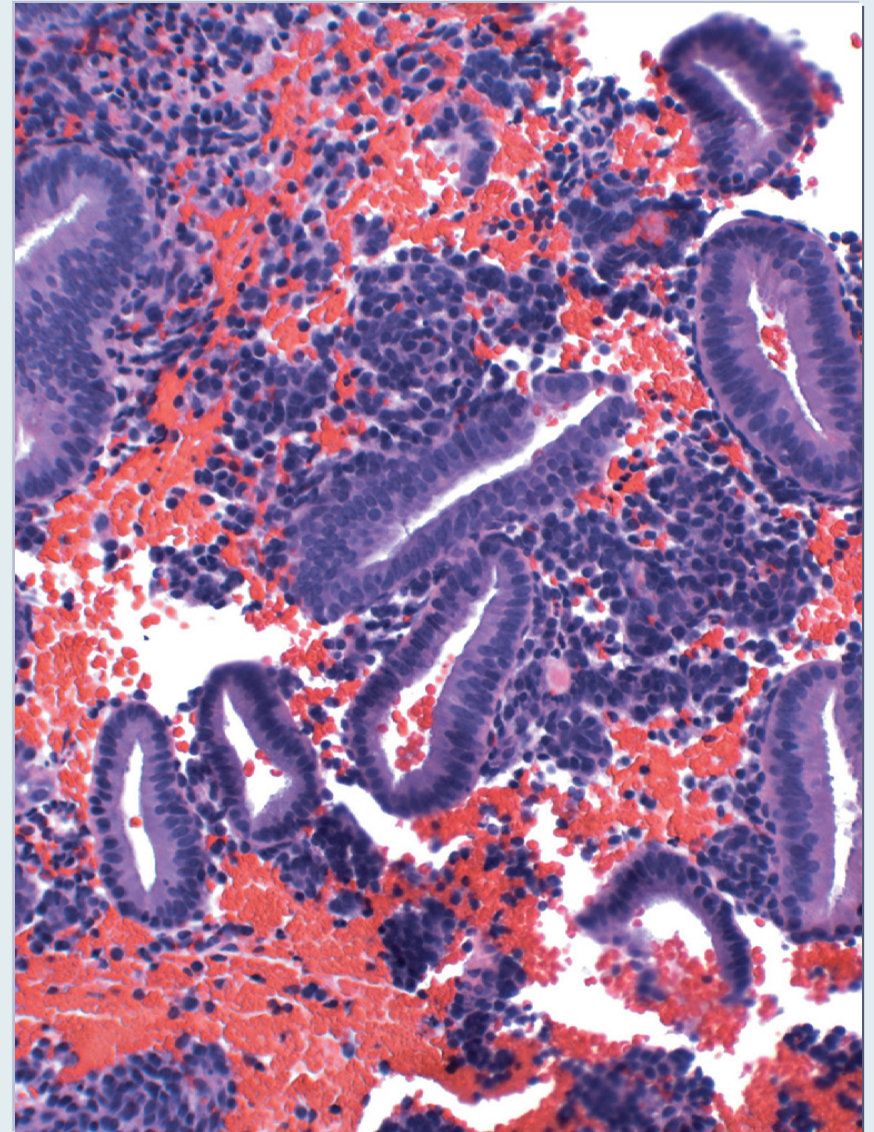
HALLAZGOS EN BIOPSIA ENDOMETRIAL EN PACIENTES CON SANGRAMIENTO ANORMAL SEGÚN LA EDAD

Finding in endometrial specimen ^d	Age					
	Premenopausal ^a <40 years (n = 460)		Perimenopausal ^a 40–55 years (n = 748)		Postmenopausal ^b >55 years (n = 226)	
	No.	(%)	No.	(%)	No.	(%)
Carcinoma	0	(—)	3	(0.4)	15	(7)
Atypical hyperplasia	0	(—)	5	(0.7)	NK ^c	
Hyperplasia	6	(1)	41	(6)	34	(15)
Atrophy	7	(2)	51	(7)	127	(56)
Polyp	6	(1)	13	(2)	19	(8)
Proliferative	139	(29)	273	(36)	31	(14)
Secretory	241	(50)	287	(38)	0	(—)

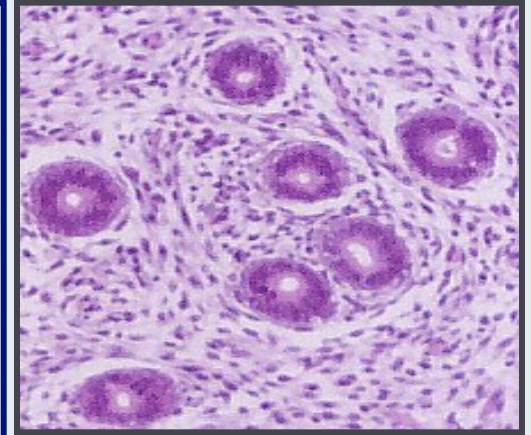
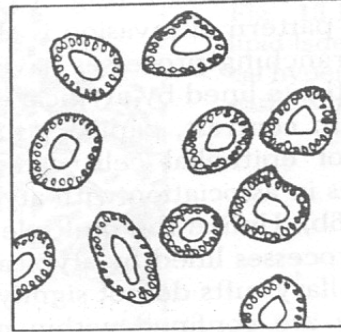
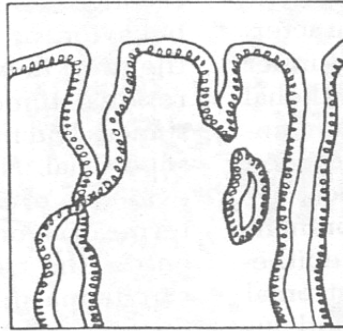
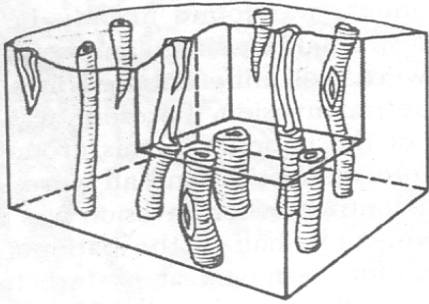
METRORRAGIA DISFUNCIONAL

ANOVULACIÓN

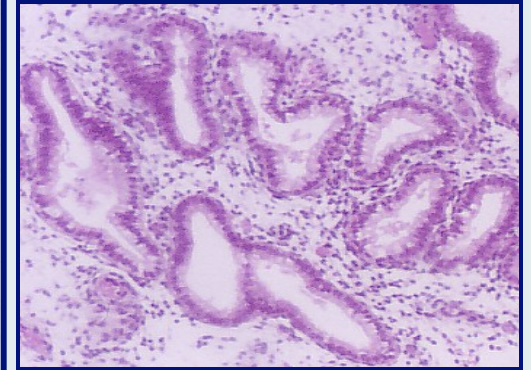
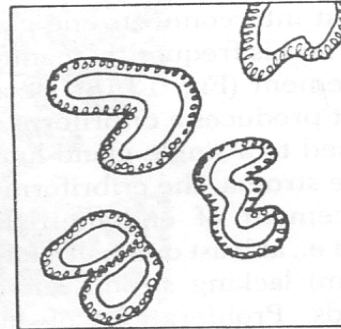
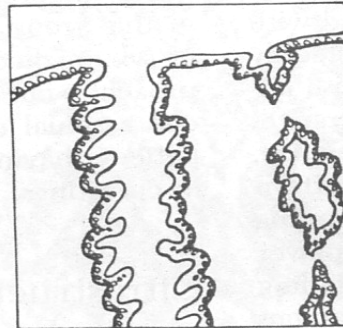
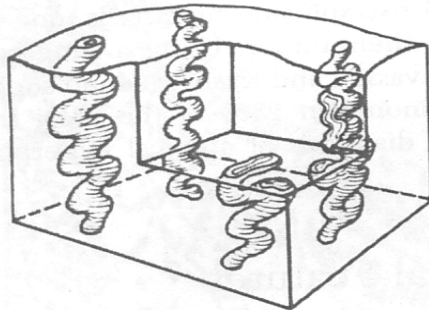
- Causa más frecuente
- Generalmente en la perimenopausia
- Glándulas tubulares de tipo proliferativo, estroma disgregado, sangre y fibrina.
- No se observan cambios secretores



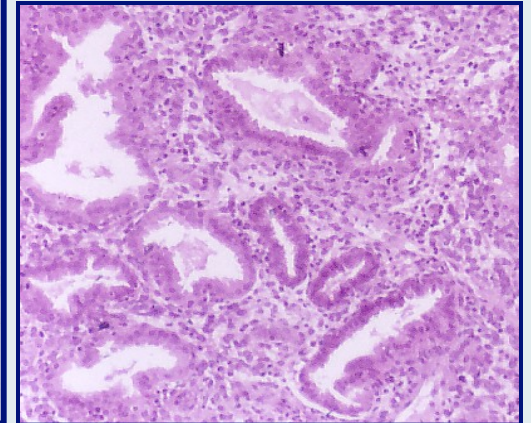
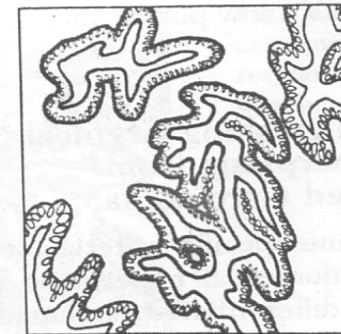
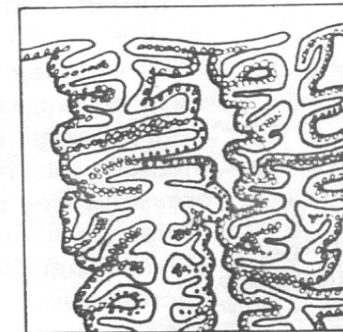
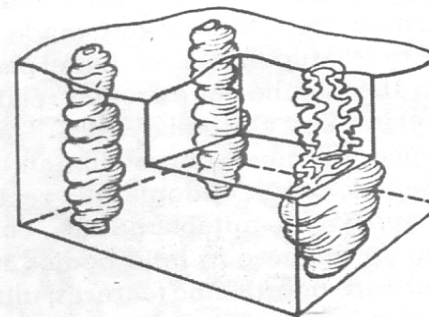
ESQUEMA TRIDIMENSIONAL DE LA ARQUITECTURA ENDOMETRIAL NORMAL



A.- ENDOMETRIO PROLIFERATIVO

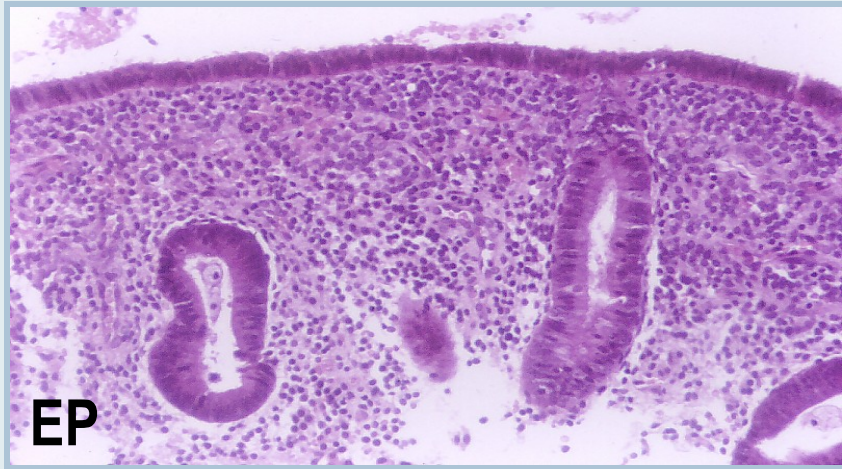


B.- ENDOMETRIO SECRETOR INICIAL

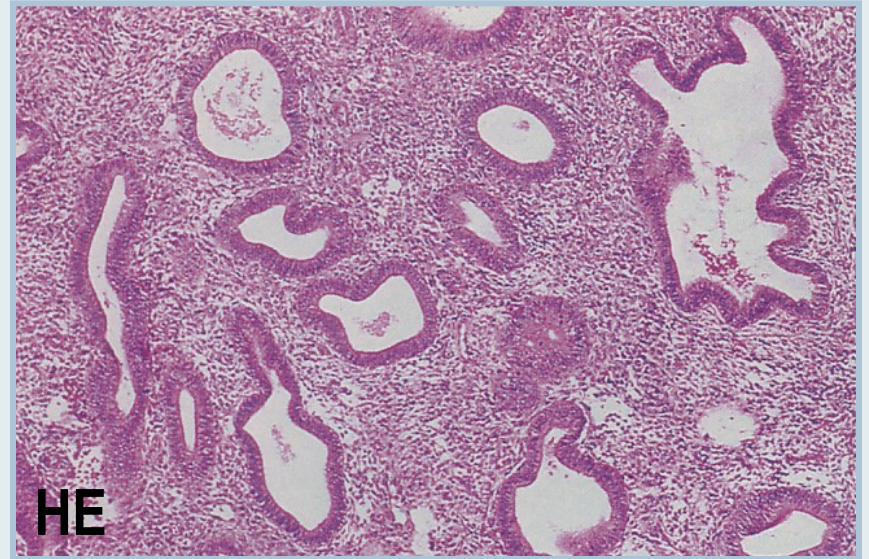
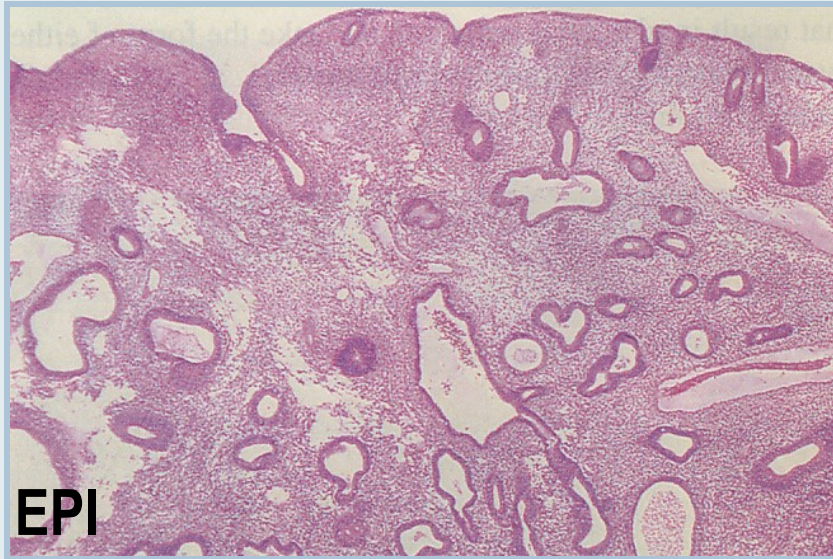


C.- ENDOMETRIO SECRETOR TARDIO

ENDOMETRIO PROLIFERATIVO IRREGULAR (ENDOMETRIO SOBREESTIMULADO POR ESTROGENOS)



Lesión focal con glándulas aumentadas de tamaño e irregulares, con signos de hiperplasia, entremezcladas con glándulas proliferativas normales



HIPERPLASIA ENDOMETRIAL

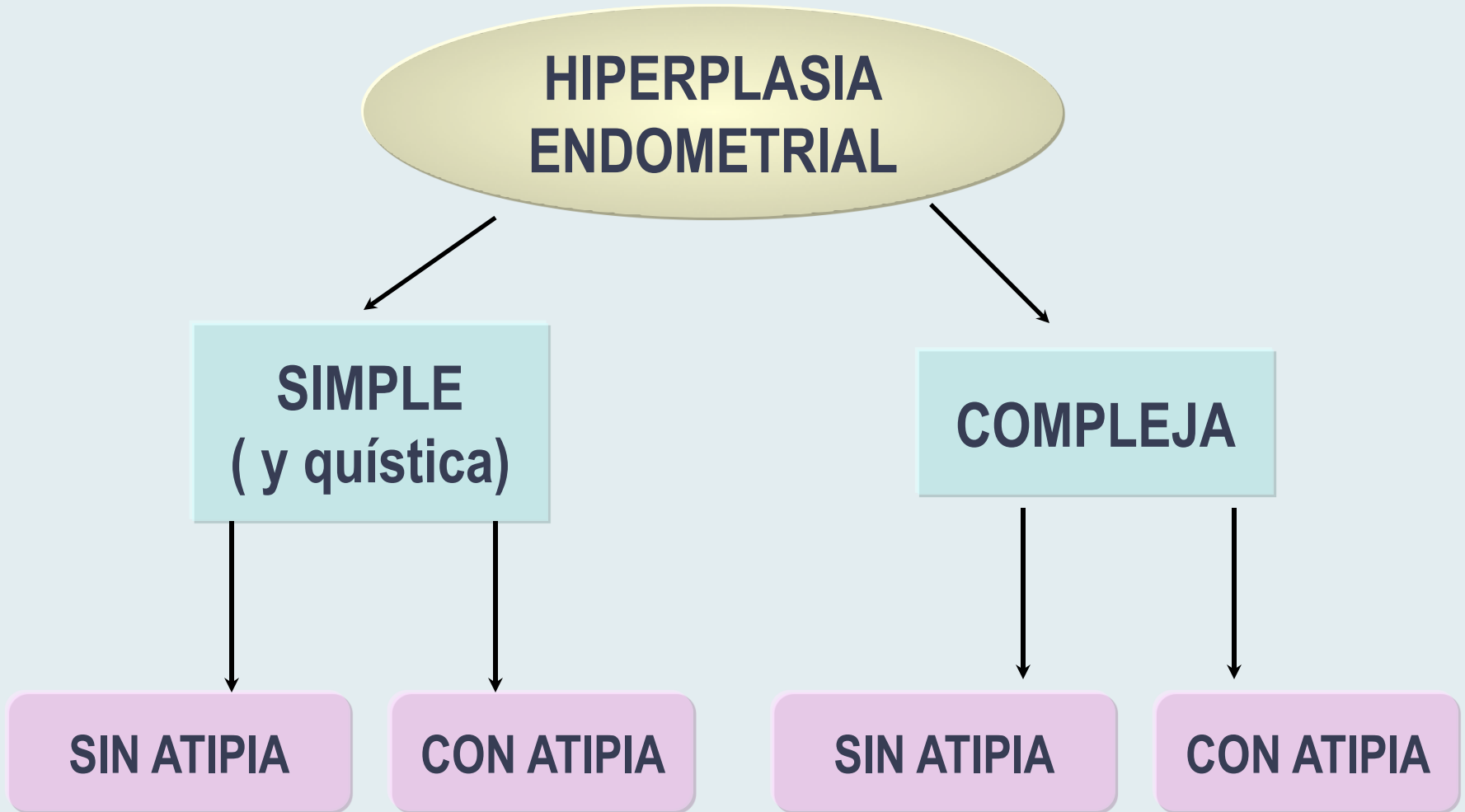
Espectro de alteraciones morfológicas que van desde lesiones benignas a premalignas, causadas por un ambiente hormonal anormal

*Proliferación **difusa** de glándulas endometriales, de tamaño y forma irregular con un aumento de la relación glándula-estroma, comparado con el endometrio proliferativo*

Hallazgos clínicos generales:

- Asintomática: hallazgo
- Sangramiento moderado a severo
- Más frecuente en pacientes perimenopáusicas
- Asociadas a ciclos anovulatorios
- En mujeres jóvenes están asociadas a SOP

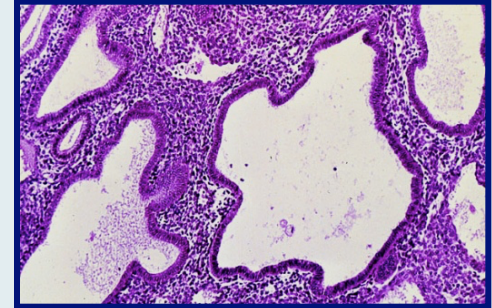
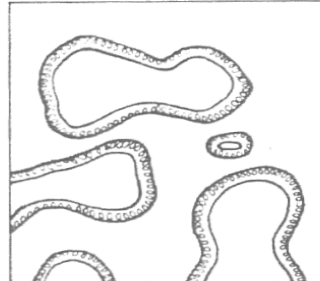
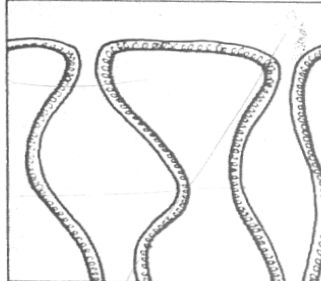
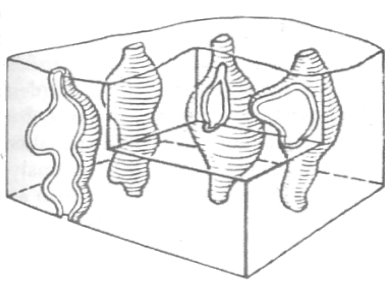
CLASIFICACION DE LAS HIPERPLASIAS



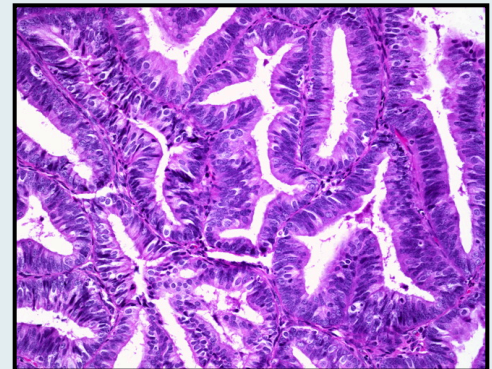
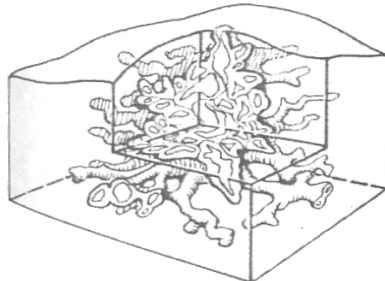
Diagnostic Entities and Terminology (WHO, 2014)

Nomenclature*	Topography	Functional Category	Cancer Risk	Treatment
Hyperplasia without Atypia	Diffuse	Prolonged estrogen effect	2–4× ^{18–21}	Hormonal therapy, symptomatic
EIN (atypical hyperplasia)	Focal progressing to diffuse	Precancerous	45× ¹⁴	Hormonal or surgical
Endometrioid adenocarcinoma	Focal progressing to diffuse	Malignant	—	Surgical stage-based

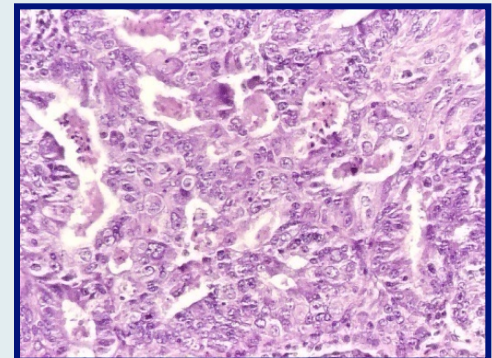
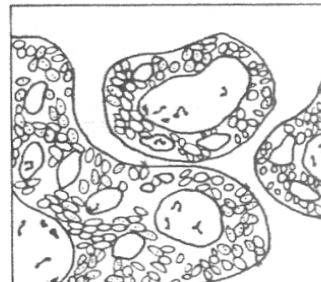
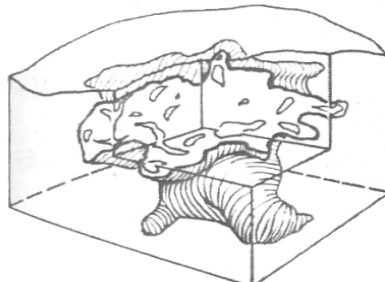
MORFOLOGÍA EN PATOLOGÍA ENDOMETRIAL



C.- HIPERPLASIA ENDOMETRIAL SIMPLE



D.- HIPERPLASIA ENDOMETRIAL COMPLEJA

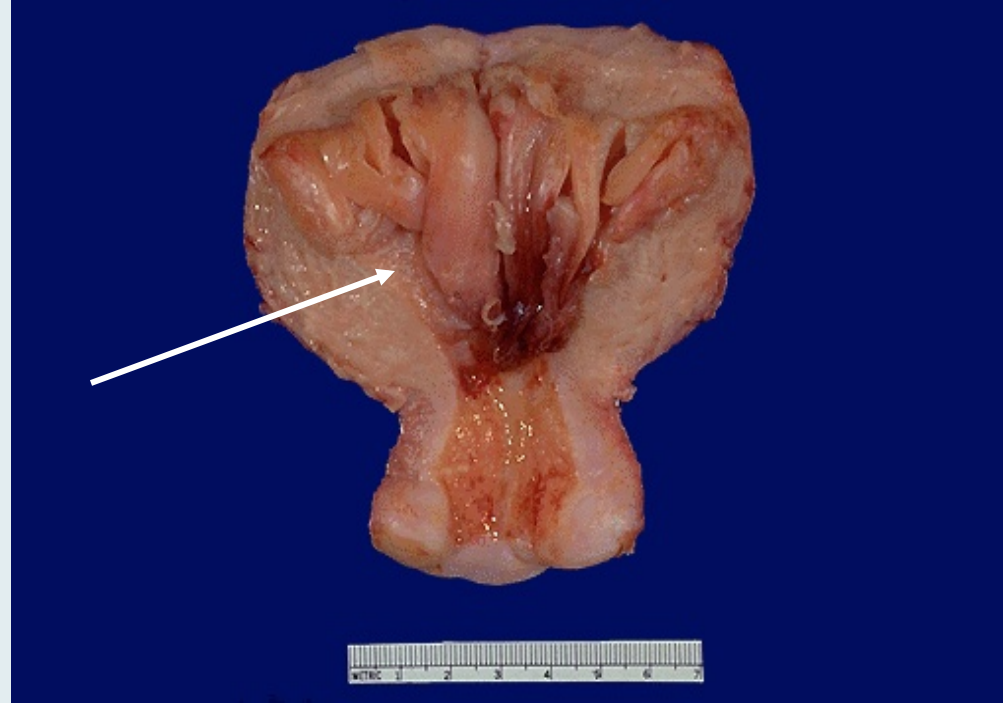
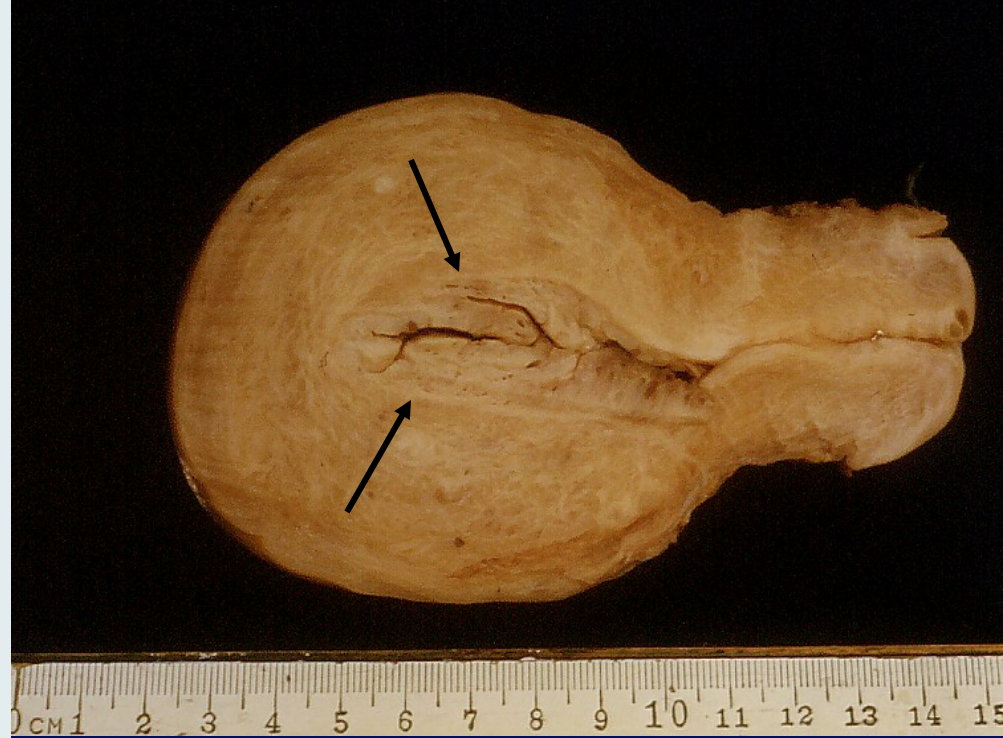


E.- ADENOCARCINOMA ENDOMETRIAL

HIPERPLASIA ENDOMETRIAL

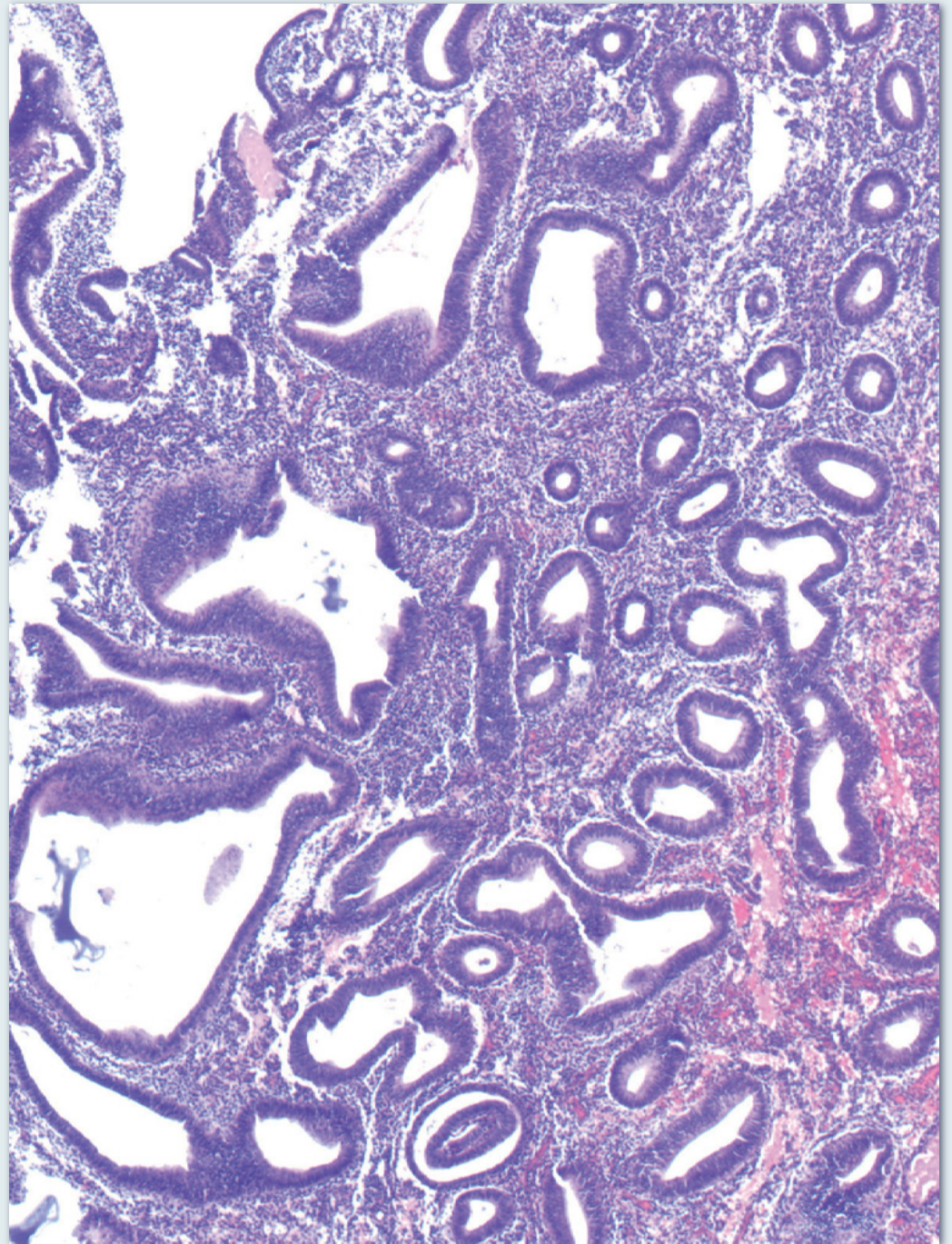
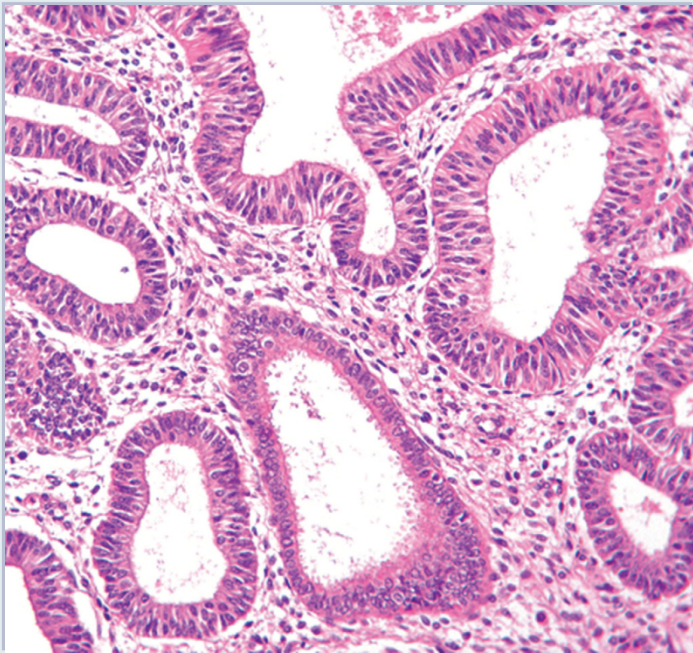
MACROSCOPIA

Endometrio engrosado, superficie aterciopelada y suave, puede protruir al lumen en digitaciones gruesas, no afecta endocérnix

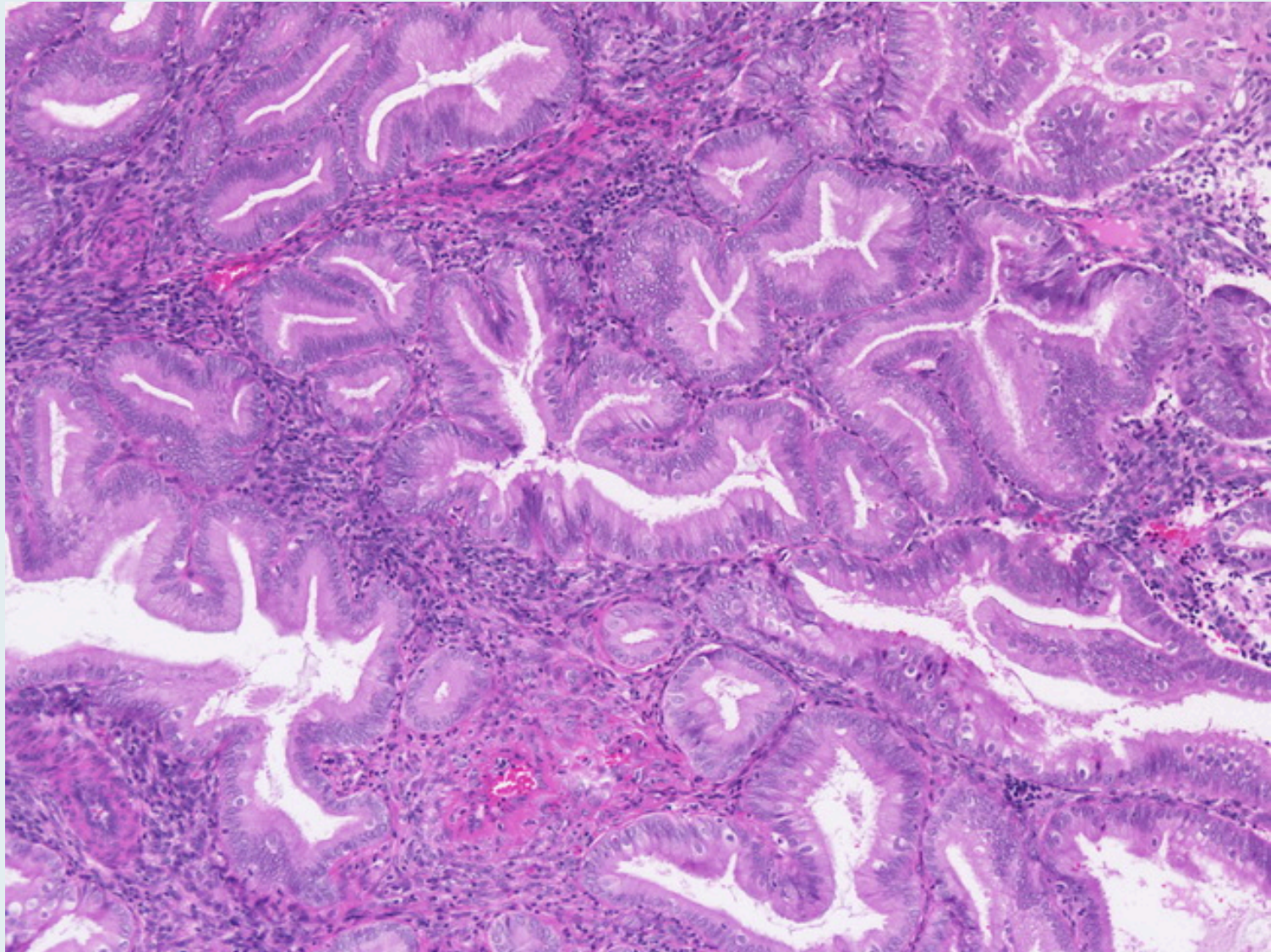


HIPERPLASIA SIMPLE SIN ATIPIA

- Aumento de la relación glándula estroma por proliferación glandular y estromal
- Glándulas de forma y tamaño variable
- Dilatación y yemaciones
- Abundante estroma celular, denso y compacto

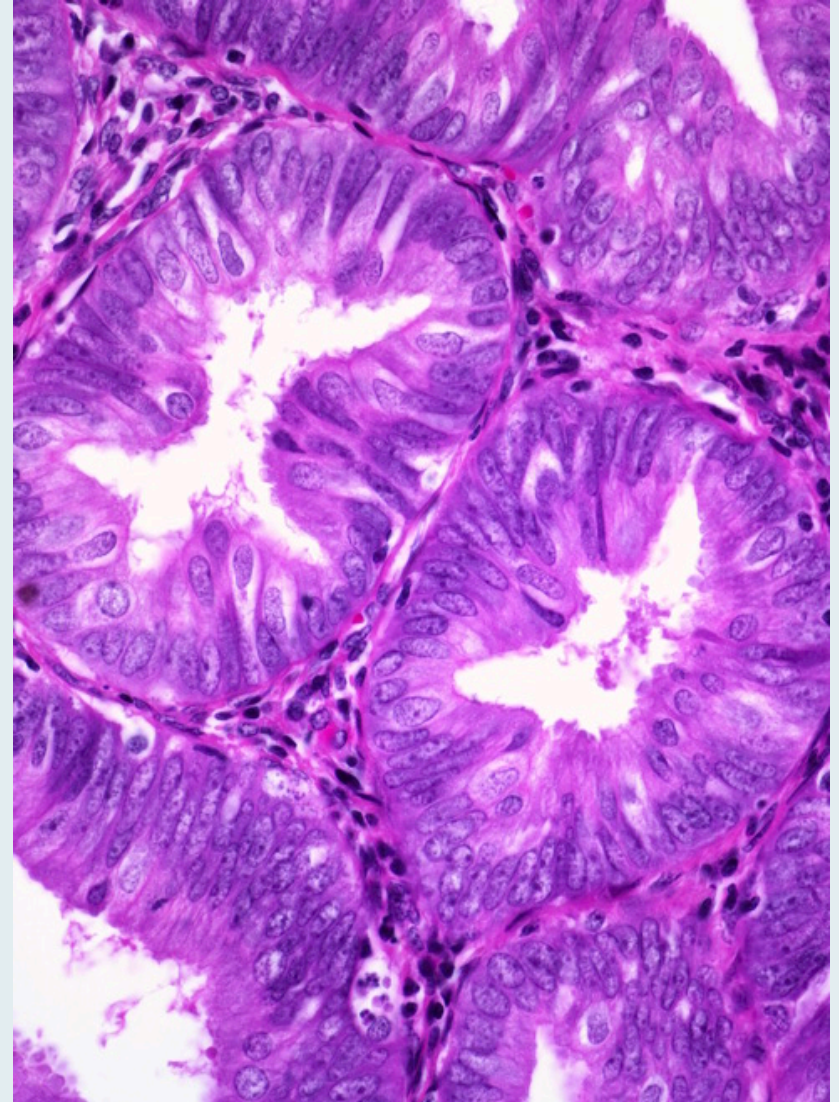
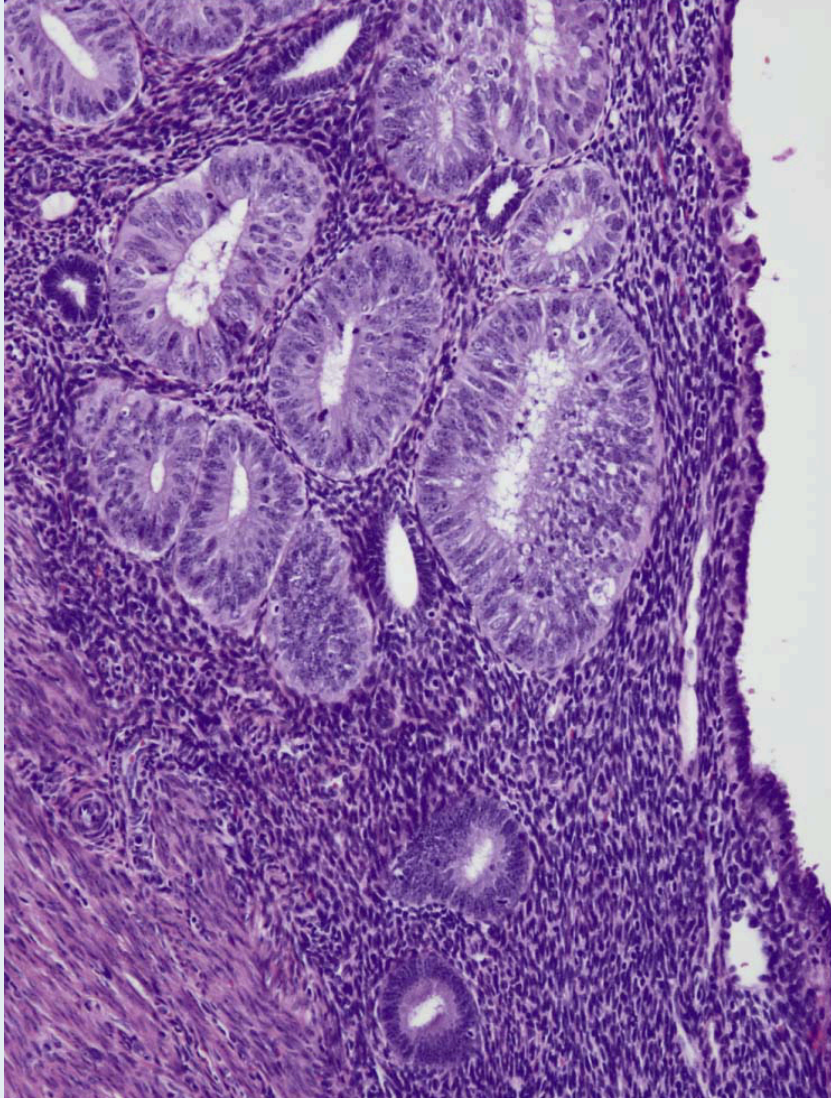


HIPERPLASIA COMPLEJA



ARQUITECTURA CON PATRON GLANDULAR COMPLEJO SIN ATIPIA NUCLEAR

HIPERPLASIA ENDOMETRIAL CON ATIPIA



NUCLEOS OVOIDES, PÉRDIDA DE POLARIDAD Y PRESENCIA DE NUCLÉOLO

SEGUIMIENTO DE HIPERPLASIAS ENDOMETRIALES EN 170 PACIENTES

<i>Type of hyperplasia</i>	<i>No. of patients</i>	<i>Regressed</i>		<i>Persisted</i>		<i>Progressed to carcinoma</i>	
		<i>No.</i>	<i>(%)</i>	<i>No.</i>	<i>(%)</i>	<i>No.</i>	<i>(%)</i>
Hyperplasia	122	97	(80)	23	(19)	2	(2)
Atypical hyperplasia	48	29	(60)	8	(17)	11	(23)

<i>Type of hyperplasia</i>	<i>No. of patients</i>	<i>Regressed</i>		<i>Persisted</i>		<i>Progressed to carcinoma</i>	
		<i>No.</i>	<i>(%)</i>	<i>No.</i>	<i>(%)</i>	<i>No.</i>	<i>(%)</i>
Simple	93	74	(80)	18	(19)	1	(1)
Complex	29	23	(80)	5	(17)	1	(3)
Simple atypical	13	9	(69)	3	(23)	1	(8)
Complex atypical	35	20	(57)	5	(14)	10	(29)

ADENOCARCINOMA ENDOMETRIAL

INTRODUCCION

- El cáncer de endometrio constituye la neoplasia maligna invasora más frecuente de la pelvis femenina.
- 13% de los cánceres que se presentan en la mujer, siendo el cuarto en frecuencia en países desarrollados.
- Su incidencia se ha incrementado
- Es el más curable de los cánceres de causa ginecológica y de los 10 cánceres más frecuentes en el sexo femenino.

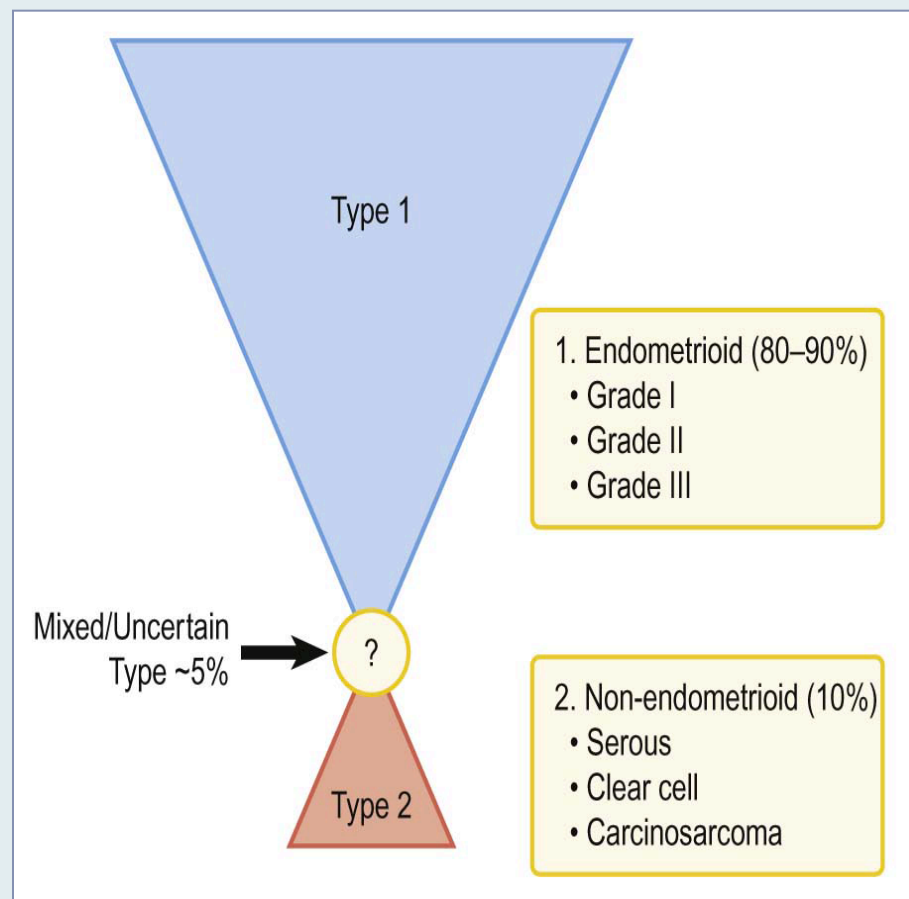
El 97% de los cánceres de útero se originan del epitelio glandular y se denominan *adenocarcinomas endometriales*.

El 3 % afecta al estroma endometrial y a la pared muscular del útero y se llaman *sarcomas*.

TIPOS CLINICOPATOLOGICOS DE LOS CARCINOMAS ENDOMETRIALES

Feature	Endometrioid (Type 1)	Non-Endometrioid (Type 2)	Refs
Histologic pattern(s)	Endometrioid, mucinous, adenosquamous, secretory	Serous	51,167 ↗
Grade	1–3	Not applicable	
Behavior	Indolent	Aggressive	
Average age	59	66	8,168 ↗
Risk factors	Endocrine (unopposed estrogen)	Unknown	
Precursor lesion	EIN	Serous EIC	169 ↗
p53 mutation	5–10%	>90%	164,168,170 ↗
PTEN inactivation	55%	11%	164 ↗
KRAS mutation	13–26	0–10%	171,172 ↗
PIK3CA mutations	24–39%	12%	
PIK3CA amplification	–	Frequent	
CTNNB1 (β-Catenin mutation)	25–38%	Rare	170 ↗
MLH-1 inactivation	17%	5%	68 ↗
ARID1A mutation	29–39%	18–26%	
Loss of estrogen and progesterone receptors	27–30%	76–81%	

Note: Clear cell carcinoma and carcinosarcoma are non-endometrioid tumors by exclusion, but are non-equivalent to serous carcinomas.



ESTUDIO ANATOMO-PATOLÓGICO

BIOPSIA ENDOMETRIAL:

Cucharilla de Randall, Novak o cánula aspirativa Pipelle
Legrado uterino tiene rendimiento superior al 90 a 95%.

HISTEROSCOPIA MÁS BIOPSIA:

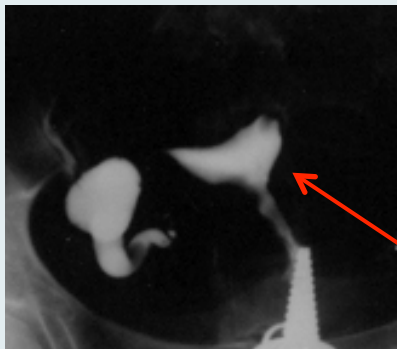
Se observa el estado del endometrio
Permite evaluar extensión de la lesión.
Se realiza cuando la biopsia es negativa



PAPANICOLAU

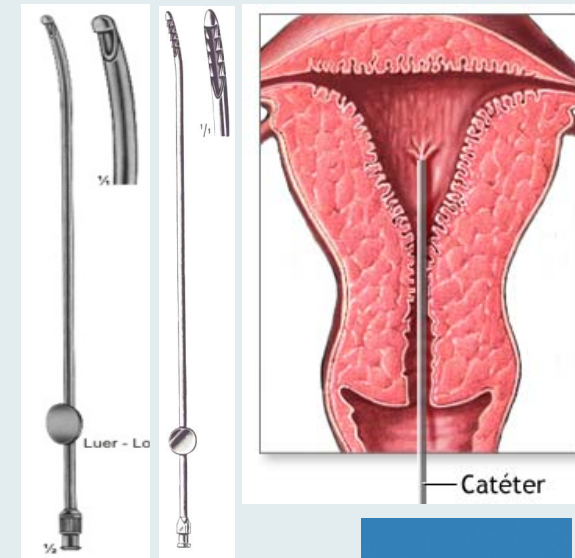
CITOLOGÍA ENDOMETRIAL CON TÉCNICA DE CEPILLADO O LAVADO

HISTEROGRAFÍA:



Cavidad Endometrial

El rol del screening para este cáncer no se ha establecido y su uso no está aún recomendado.



CLASIFICACION HISTOPATOLOGICA DE LOS ADENOCARCINOMAS ENDOMETRIALES

Endometrioid adenocarcinoma

 Variants

 Endometrioid adenocarcinoma with squamous differentiation

 Mucinous adenocarcinoma

 Secretory adenocarcinoma

 Ciliated cell adenocarcinoma

 Villoglandular adenocarcinoma

 Endometrioid carcinoma with sertoliform differentiation

Serous carcinoma

Clear cell adenocarcinoma

Carcinosarcoma (MMMT)

Undifferentiated carcinoma

Neuroendocrine carcinoma

Small cell carcinoma

Squamous cell carcinoma

Miscellaneous types

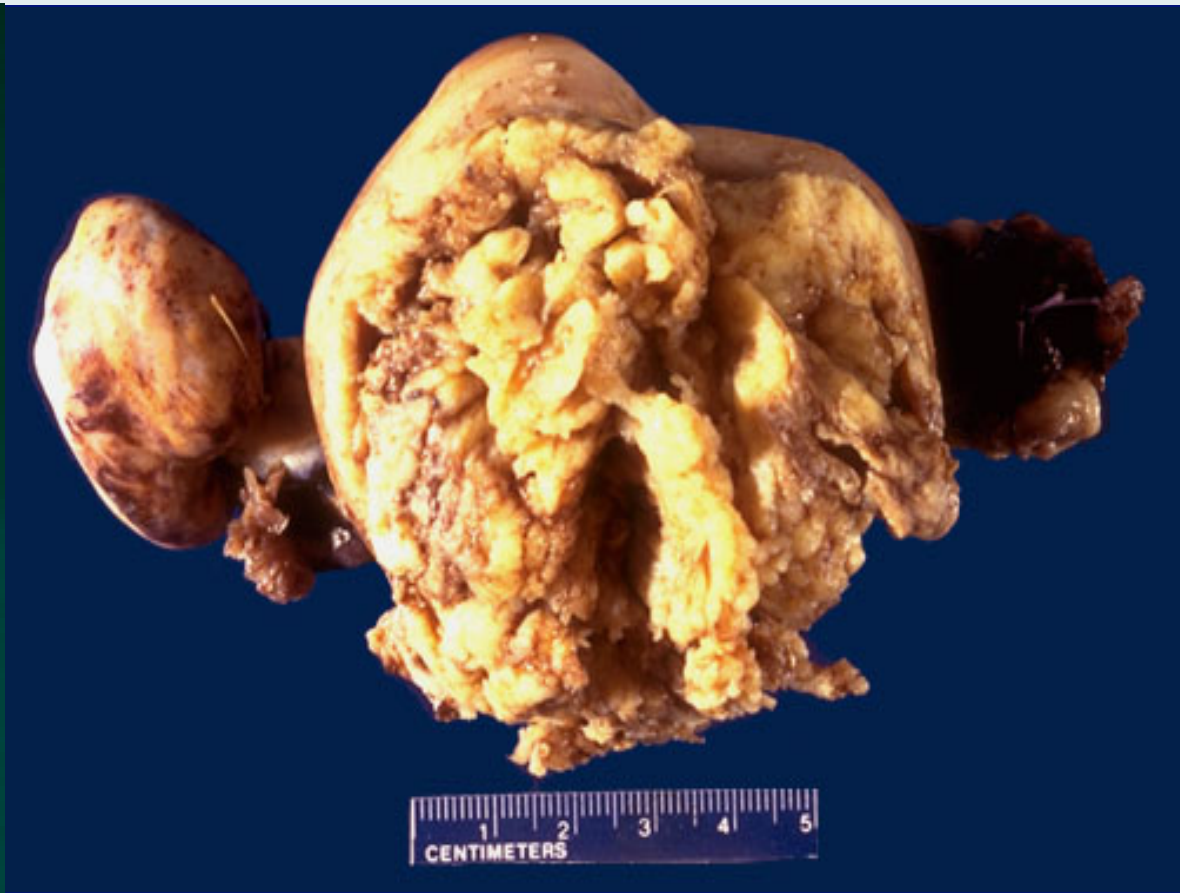
ADENOCARCINOMA ENDOMETRIOIDE (TIPO I)

- **75 % de todos los carcinomas endometriales**
- **Referido por su semejanza con el endometrio proliferativo**
- **Afecta a mujeres pre y post menopáusicas**
- **Promedio de edad 59 años (2da a 8a década)**
- **Neoplasia poco frecuente en mujeres jóvenes (solo el 1-8% ocurre en < 40 años)**
- **Asociado en estas pacientes a SOP**
- **Puede ser asintomático (20-31 en 10000 fallecidas sin síntomas endometriales)**

MACROSCOPIA

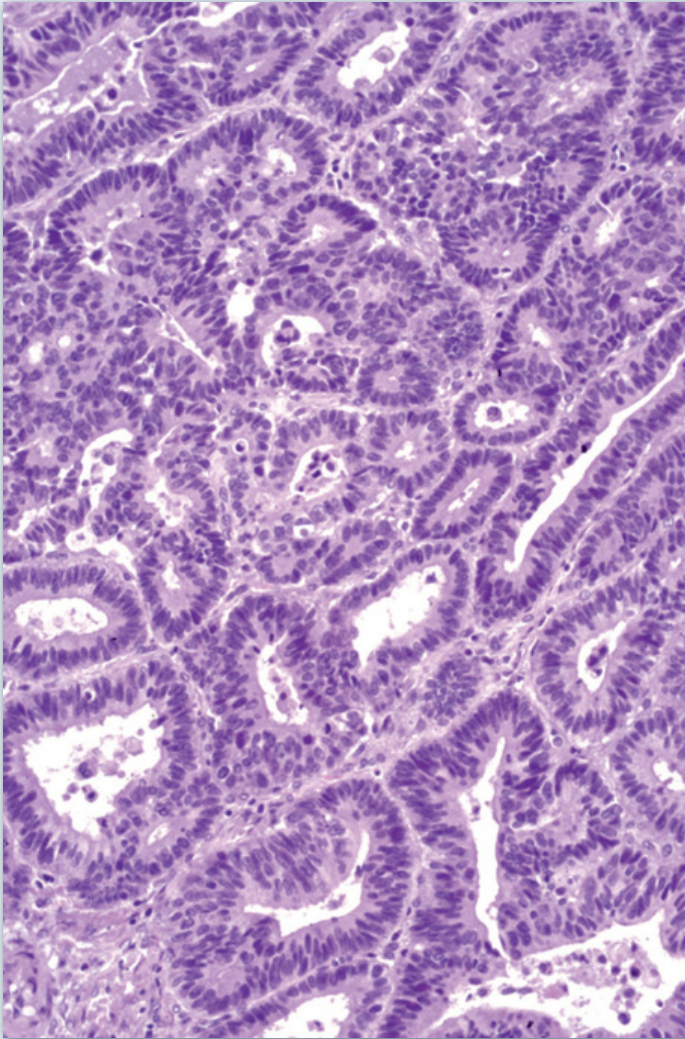


**Adenocarcinoma endometrial
con invasión mayor de 50% de la
pared uterina**

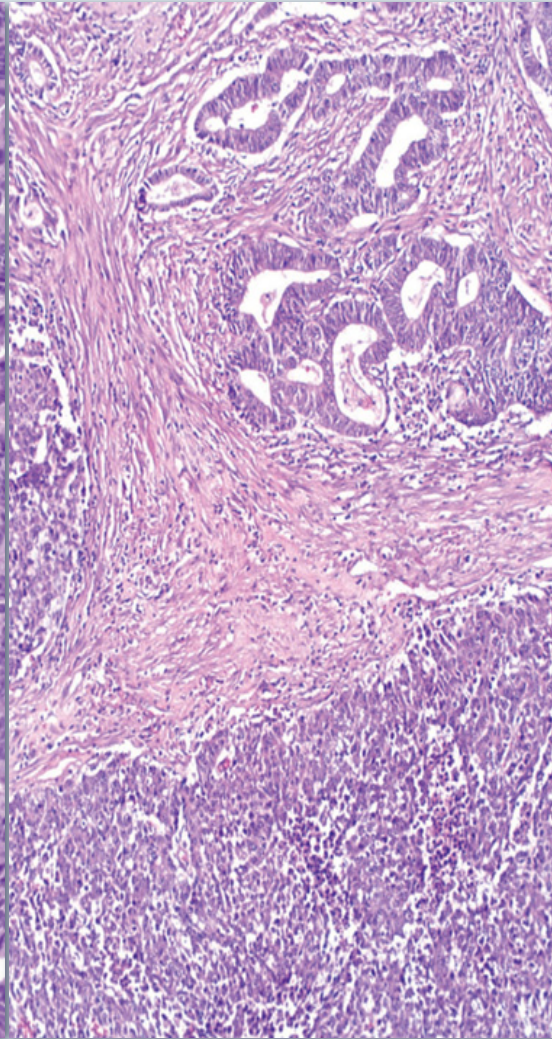


Gran lesión neoplásica que compromete todo el útero

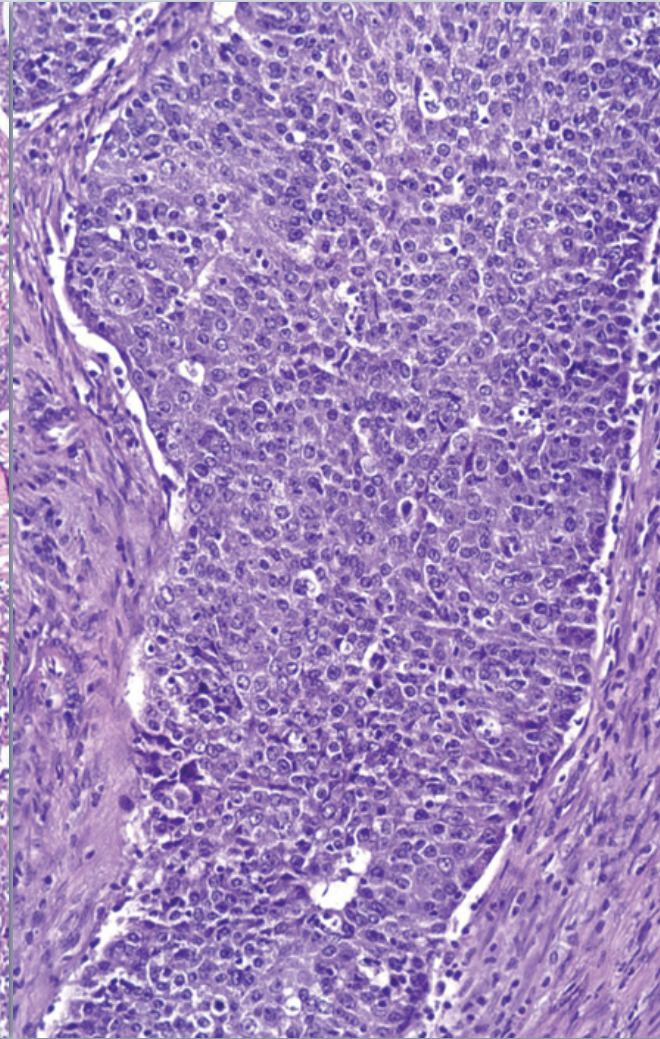
ADENOCARCINOMA ENDOMETRIOIDE



GRADO I
< 5% COMPONENTE SOLIDO

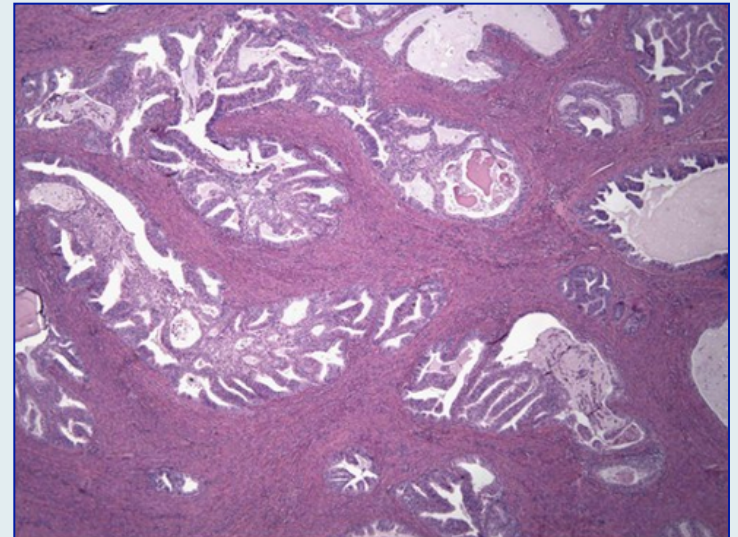
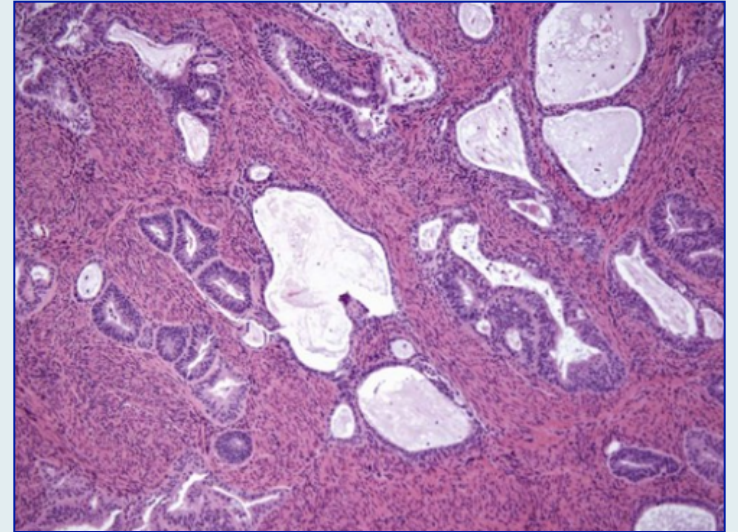
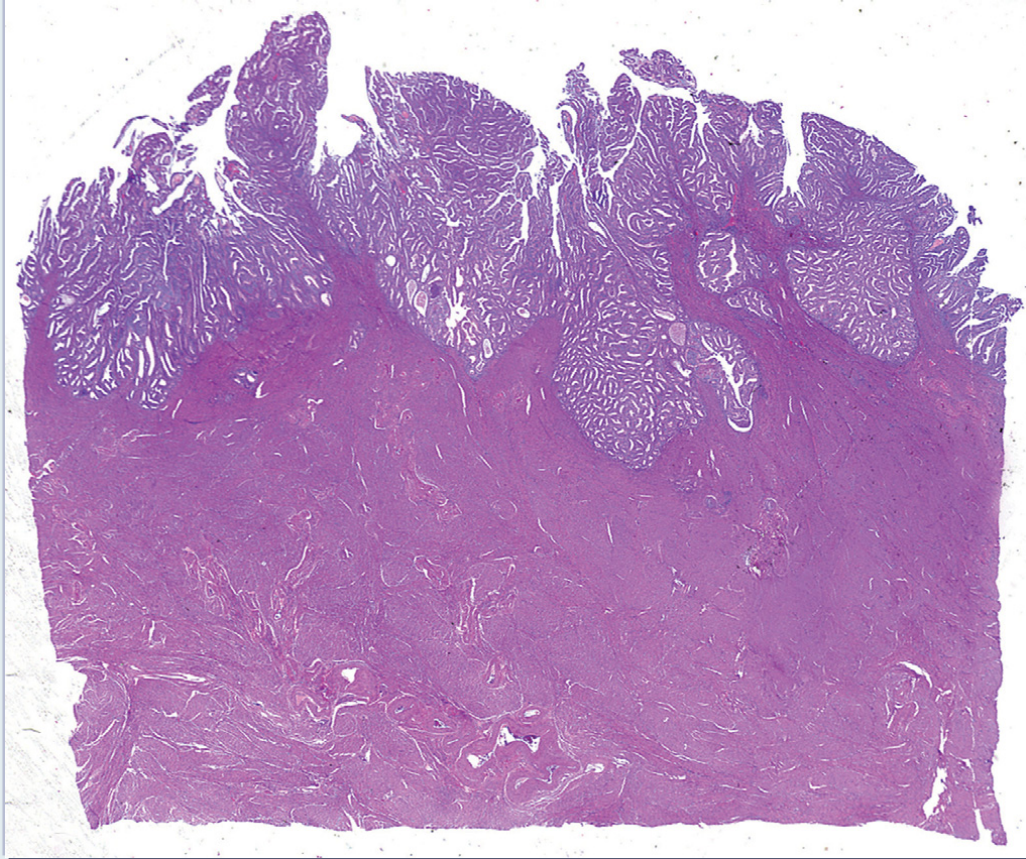


GRADO II
6 – 50% COMPONENTE SOLIDO



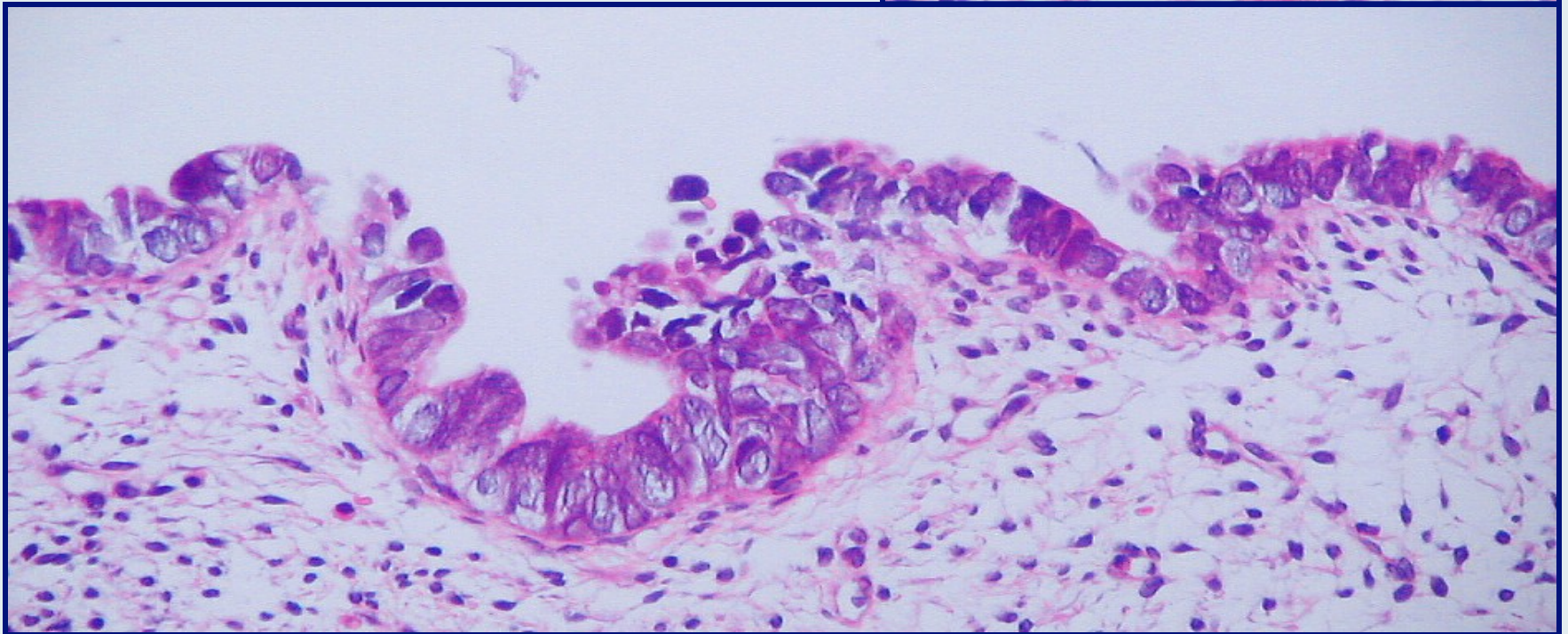
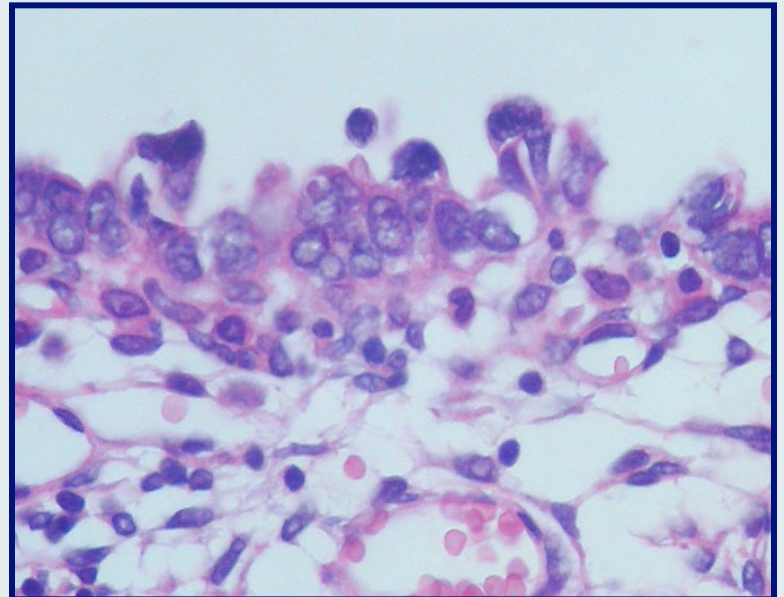
GRADO III
>50% COMPONENTE SOLIDO

INVASIÓN DEL MIOMETRIO



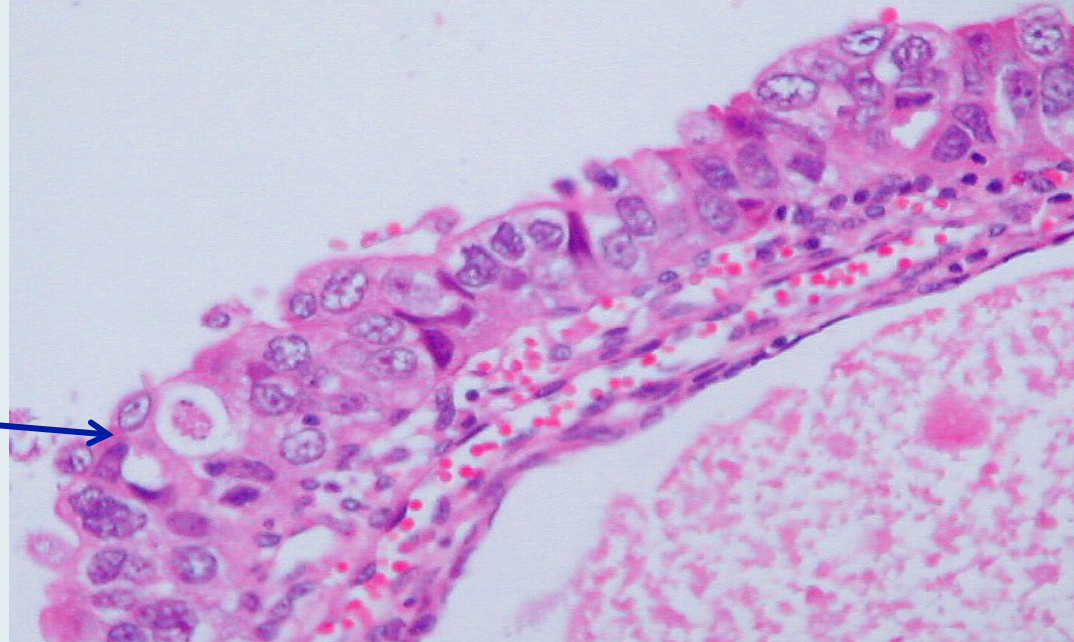
PRECURSOR DE CARCINOMAS ENDOMETRIALES TIPO II

CARCINOMA ENDOMETRIAL INTRAEPITELIAL

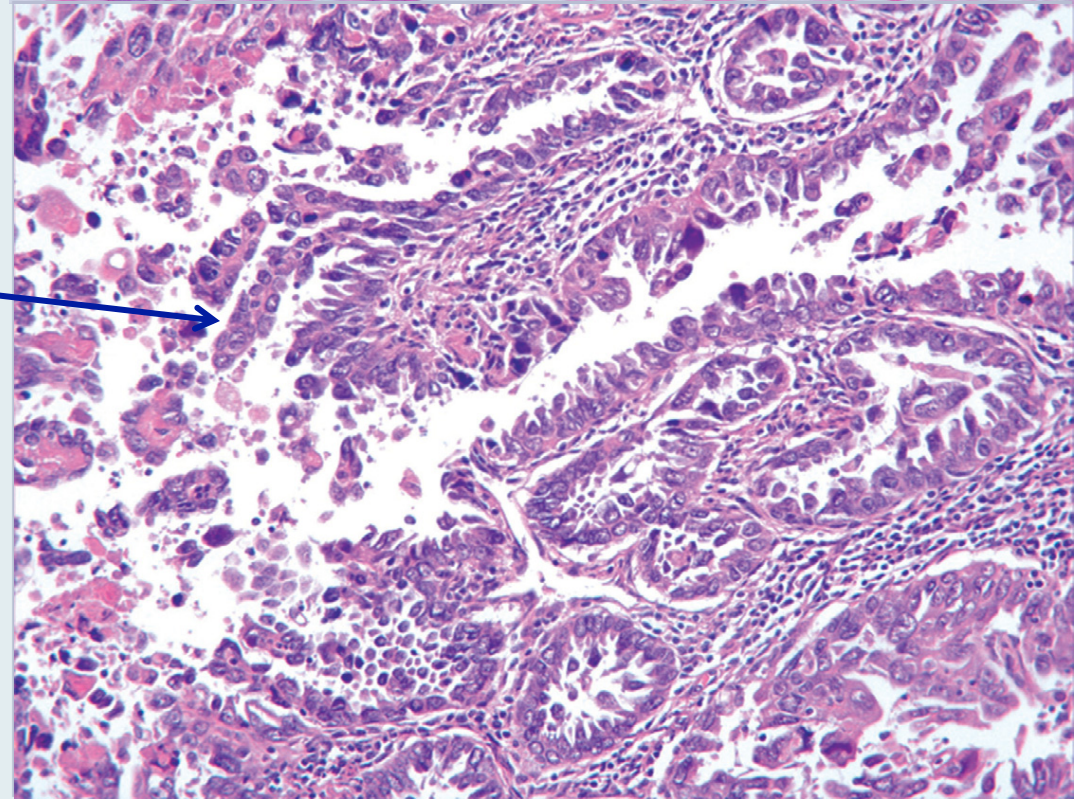


**CARCINOMA SEROSO
DEL ENDOMETRIO
(TIPO II)**

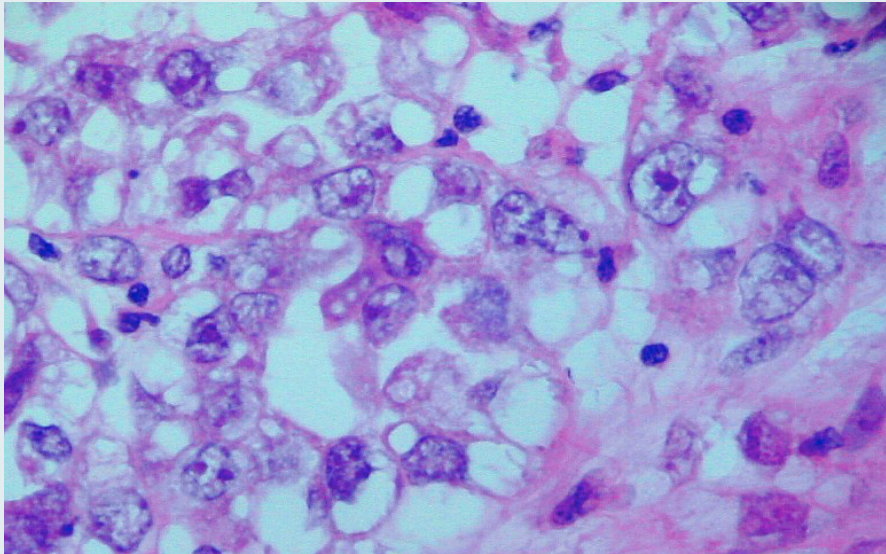
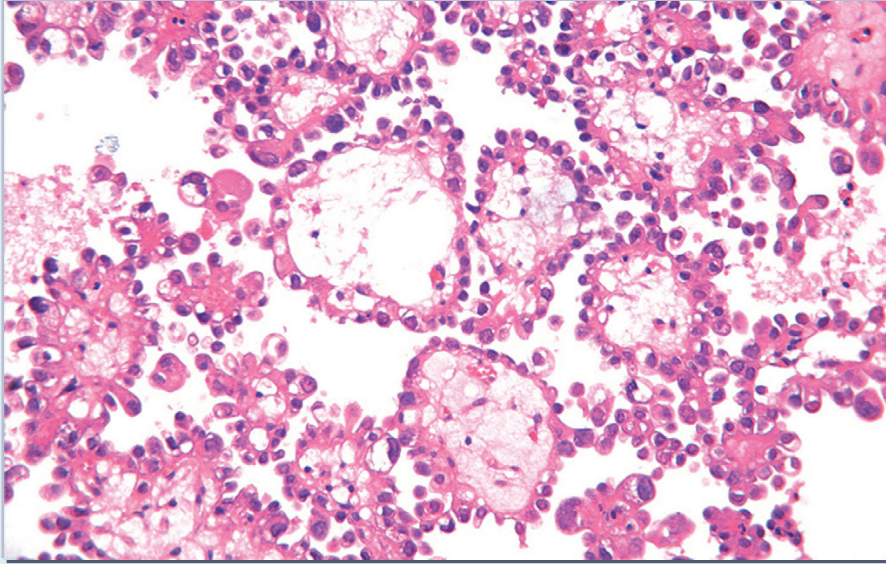
**CARCINOMA SEROSO
INTRAEPITELIAL**



**CARCINOMA
SEROZO INFILTRANTE**



Adenocarcinoma de Células Claras (TIPO II)



ETAPIFICACION FIGO 2009

Stage I	Tumor confined to the corpus uteri
IA	No or less than half myometrial invasion
IB	More than half myometrial invasion
Stage II	Tumor invades cervical stroma, but does not extend beyond the uterus
Stage III	Local and/or regional spread of the tumor
IIIA	Tumor invades the serosa of the corpus uteri and/or adnexa ^a
IIIB	Vaginal and/or parametrial involvement ^a
IIIC	Metastases to pelvic and/or para-aortic lymph nodes ^a
IIIC1	• Positive pelvic nodes
IIIC2	• Positive para-aortic lymph nodes with or without positive pelvic lymph nodes
Stage IV	Tumor invades bladder and/or bowel mucosa, and/or distant metastases
IVA	Tumor invasion of bladder and/or bowel mucosa
IVB	Distant metastases, including intra-abdominal metastases and/or inguinal lymph nodes

Table 12.8. Sites of metastasis from endometrial carcinoma at autopsy

<i>Organ site</i>	<i>Relative frequency (%)</i>
Lung	41
Peritoneum and omentum	39
Ovary	34
Liver	29
Bowel	29
Vagina	25
Bladder	23
Vertebra	20
Spleen	14
Adrenal	14
Ureter	8
Brain or skull	5
Vulva	4
Breast	4
Hand	Rare
Femur	
Tibia	
Pubic bone	
Skin	

From Hendrickson E (1975) The lymphatic dissemination in endometrial carcinoma. A study of 188 necropsies. Am J Obstet Gynecol 123:570.

12. Endometrial Carcinoma

Table 12.7. Sites of lymph node metastasis from endometrial carcinomas at autopsy

<i>Lymph nodes</i>	<i>Relative frequency (%)</i>
Para-aortic	64
Hypogastric	61
External iliac	48
Common iliac	40
Obturator	37
Sacral	22
Mediastinal	18
Inguinal	16
Supraclavicular	12

From Hendrickson E (1975) The lymphatic dissemination in endometrial carcinoma. A study of 188 necropsies. Am J Obstet Gynecol 123:570.

FACTORES PRONÓSTICOS

El carcinoma endometrial es una enfermedad heterogénea

Sobrevida a 5 años de 36% a un 95% (estadios I)

Pronóstico depende de los hallazgos quirúrgicos – patológicos

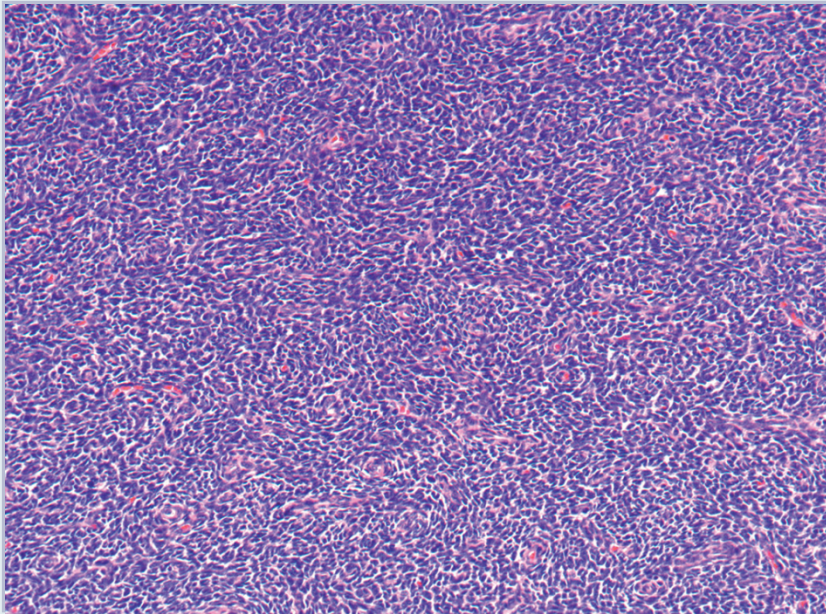
- Tipo histológico
- Diferenciación histológica
- Estadio de la enfermedad
- Invasión miometrial
- Citología peritoneal
- Metástasis a ganglios linfáticos
- Metástasis en anexos.

GRADO	INDICE DE SUPERVIVENCIA
1	79.8 %
2	73 %
3	57.9 %

TIPO HISTOLOGICO	PORCENTAJE	SOBREVIDA A 5 AÑOS
ADENOCARCINOMA ENDOMETRIOIDE	60 %	80 %
CARCINOMA DE CÉLULAS CLARAS	6 %	44 %
CARCINOMA PAPILAR SEROSO	4.7%	68 %

TUMORES DEL ESTROMA ENDOMETRIAL

NODULO ESTROMAL

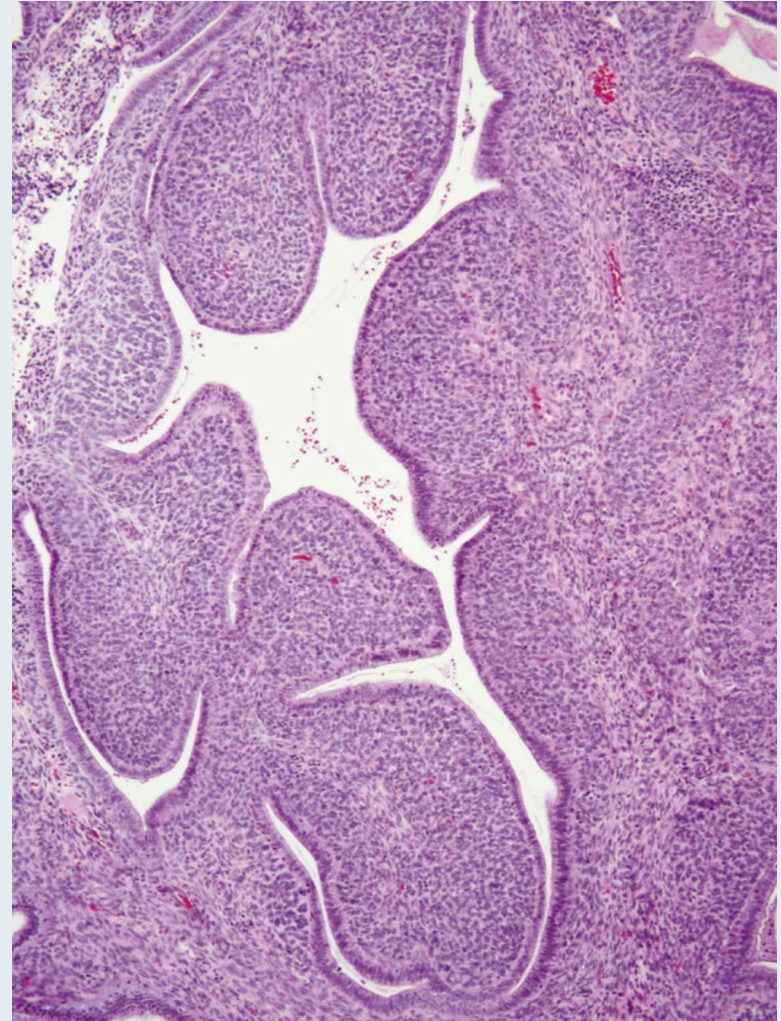


- NÓDULO ESTROMAL Y SARCOMA DEL ESTROMA ENDOMETRIAL (BAJO Y ALTO GRADO)
- SE ORIGINAN EN LÁMINA PROPIA DE LA MUCOSA ENDOMETRIAL
- CÉLULAS PEQUEÑAS CON ESCASO CITOPLASMA
- EL GRADO SE MIDE EN N° DE MITOSIS
- BENIGNOS SON EXPANSIVOS, PUEDEN RECURRIR
- MALIGNOS
 - INFILTRATIVOS
 - DISEMINAN X VÍA HEMATÓGENA
 - ATIPIA NUCLEAR
 - INVADEN LINFÁTICOS
 - RECURRENCIA ALTA,

TUMORES MÜLLERIANOS MIXTOS DEL UTERO



ADENOFIBROMA



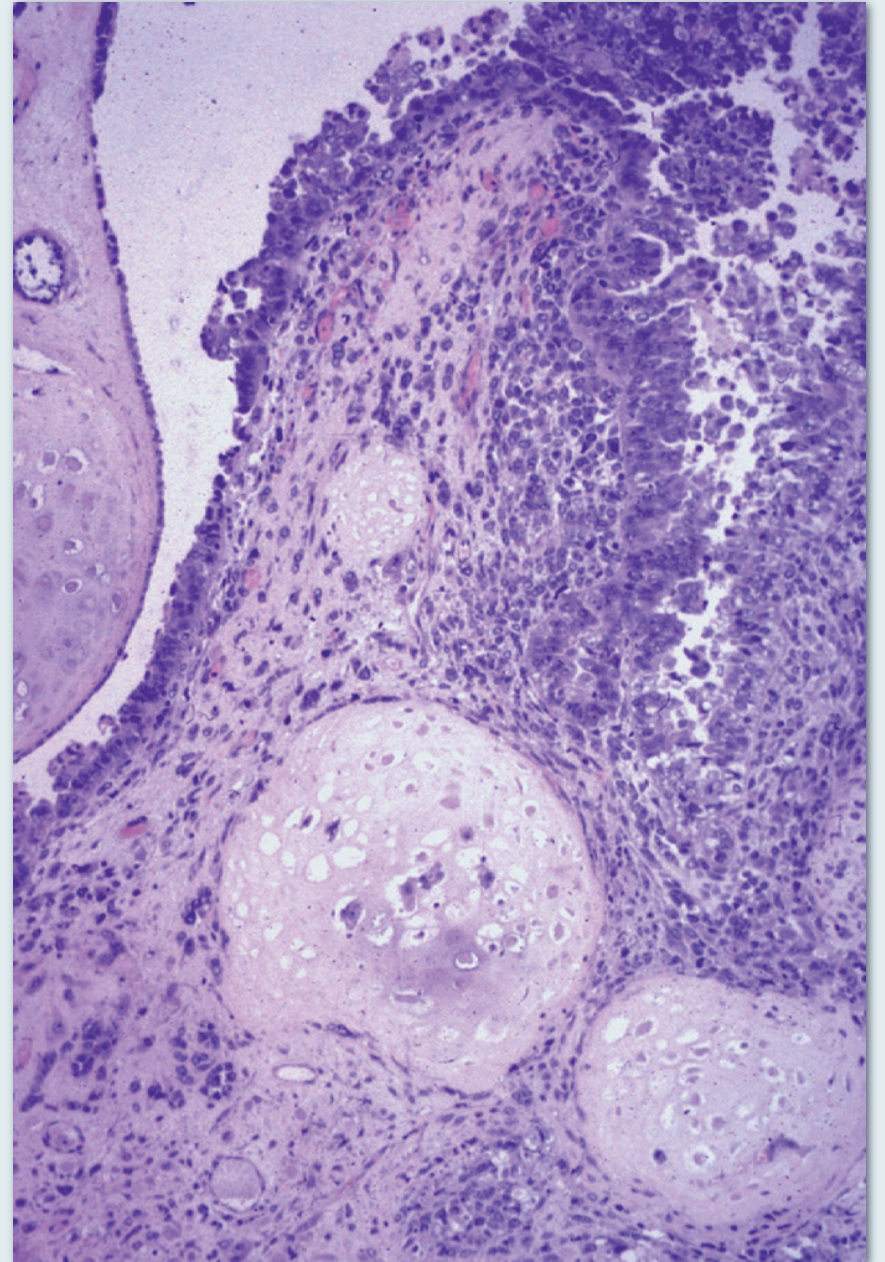
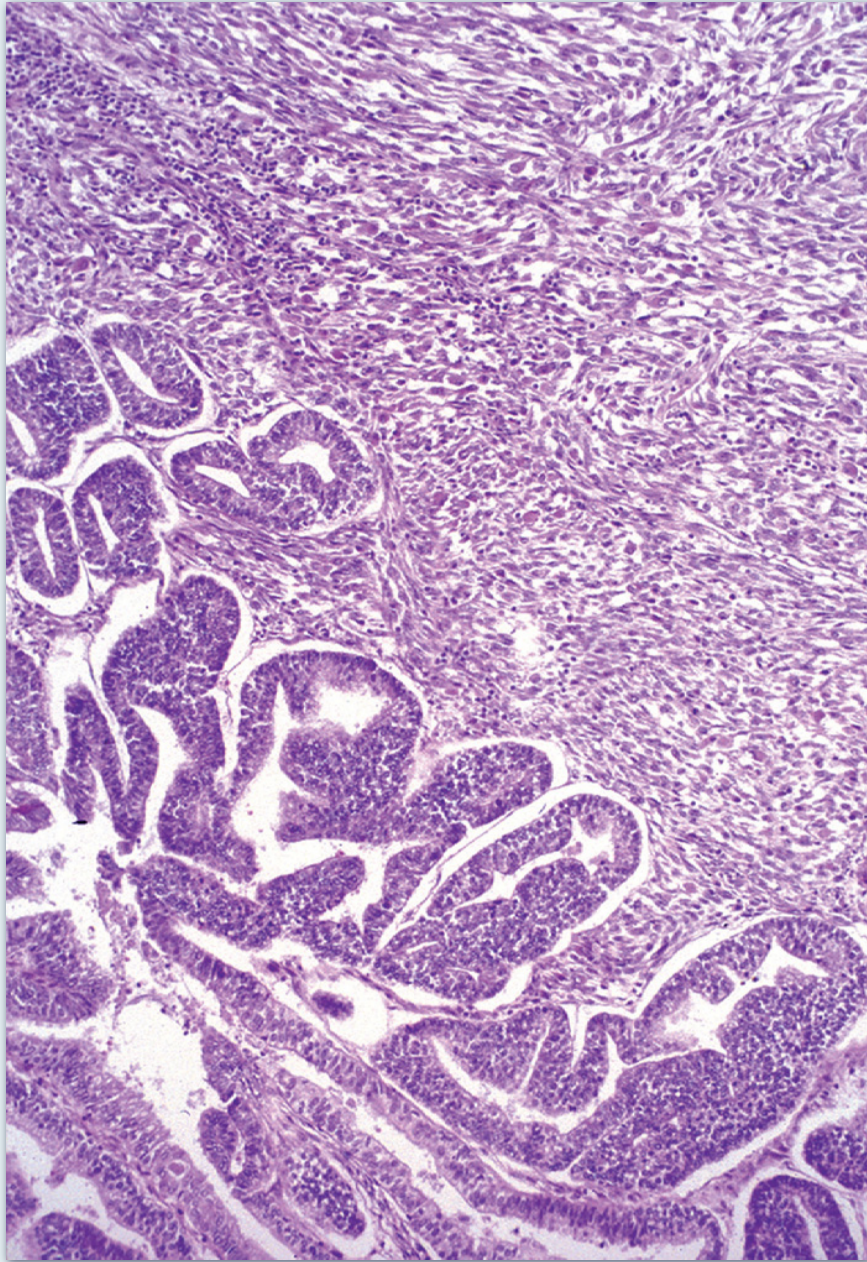
ADENOSARCOMA

TUMOR MIXTO MULLERIANO MALIGNO

CARCINOSARCOMA

- TIENEN ELEMENTOS EPITELIALES Y MESENQUIMATICOS MALIGNOS
 - ADENOCARCINOMA ENDOMETRIAL
 - COMPONENTE MESENQUIMÁTICO:
 - HOMÓLOGO: SARCOMA DEL ESTROMA
LEIOMIOSARCOMA
 - HETERÓLOGO: LIPOSARCOMA
CONDROSARCOMA
RABDOMIOSARCOMA, ETC.
- HETERÓLOGOS MÁS AGRESIVOS
- SON EL 1.5% DE LOS CANCERES UTERINOS
- SUS METASTASIS SON DE ADENOCARCINOMAS
- 25-30% DE SOBREVIDA A 5 AÑOS



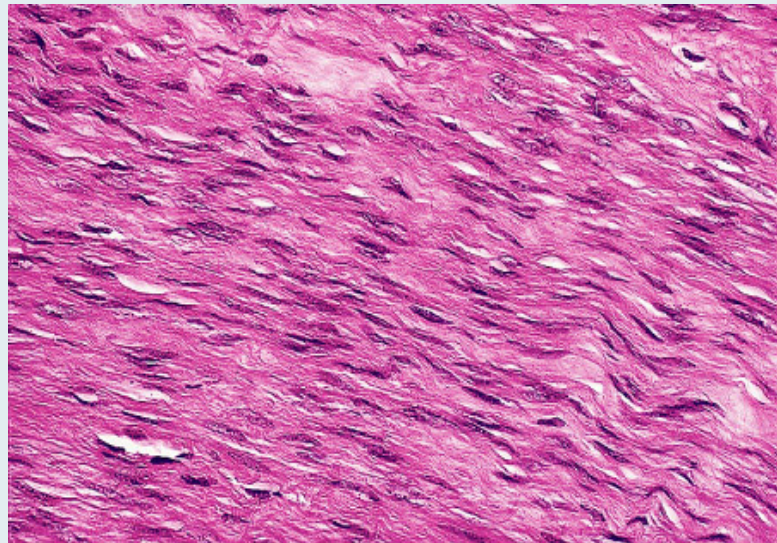
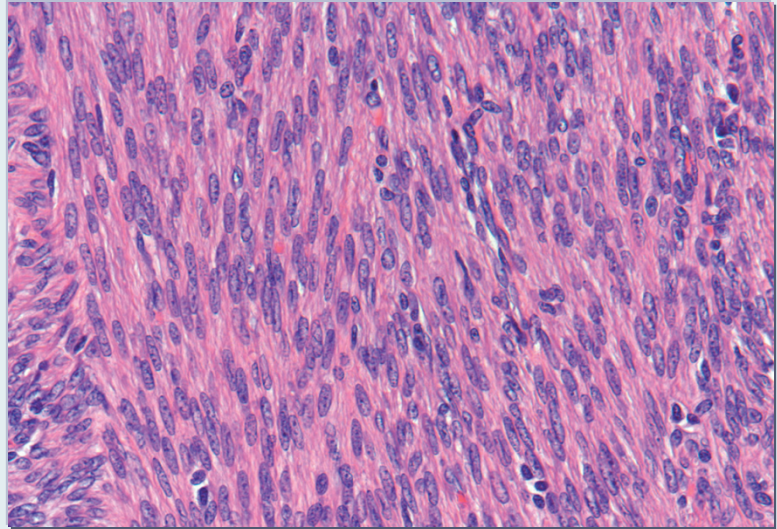
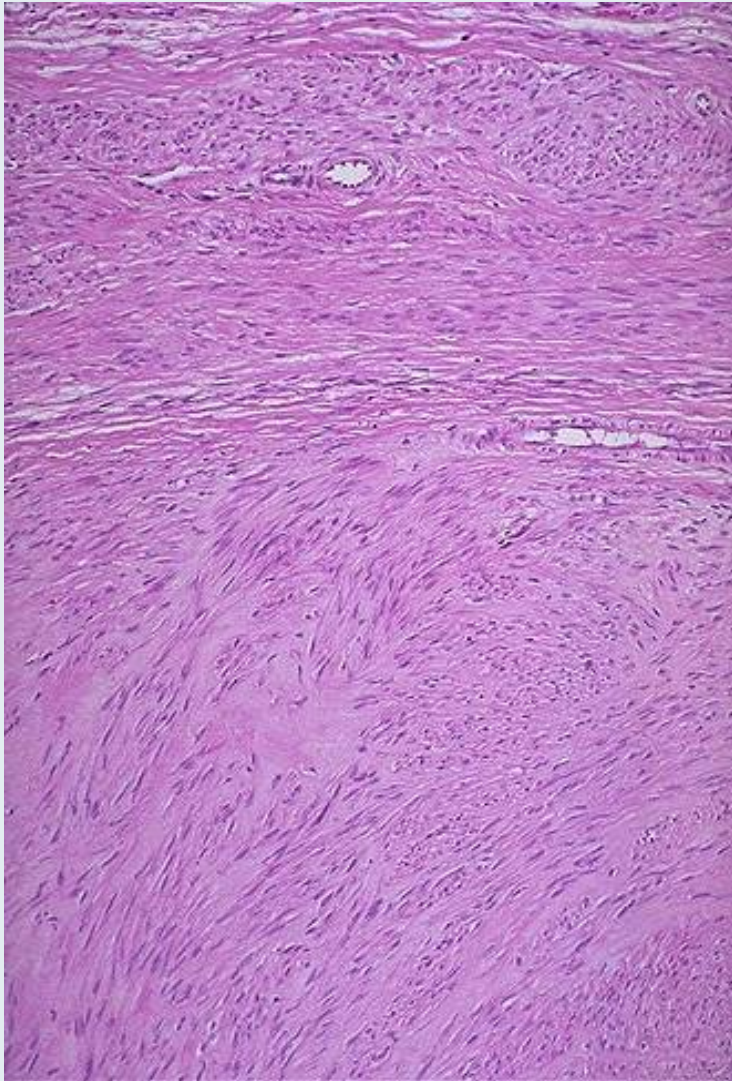


PATOLOGÍA MIOMETRIAL

- LEIOMIOMA
 - EN $\frac{1}{4}$ DE MUJERES EN EDAD FÉRTIL
 - TUMOR UTERINO MÁS FRECUENTE
 - AUMENTO TAMAÑO EN EMBARAZO
 - DISMINUYEN TAMAÑO EN MENOPAUSIA
 - 2/3 MÚLTIPLES



LEIOMIOMA



NÚCLEOS UNIFORMES, SIN ATIPIA NUCLEAR, MUY ESCASAS MITOSIS

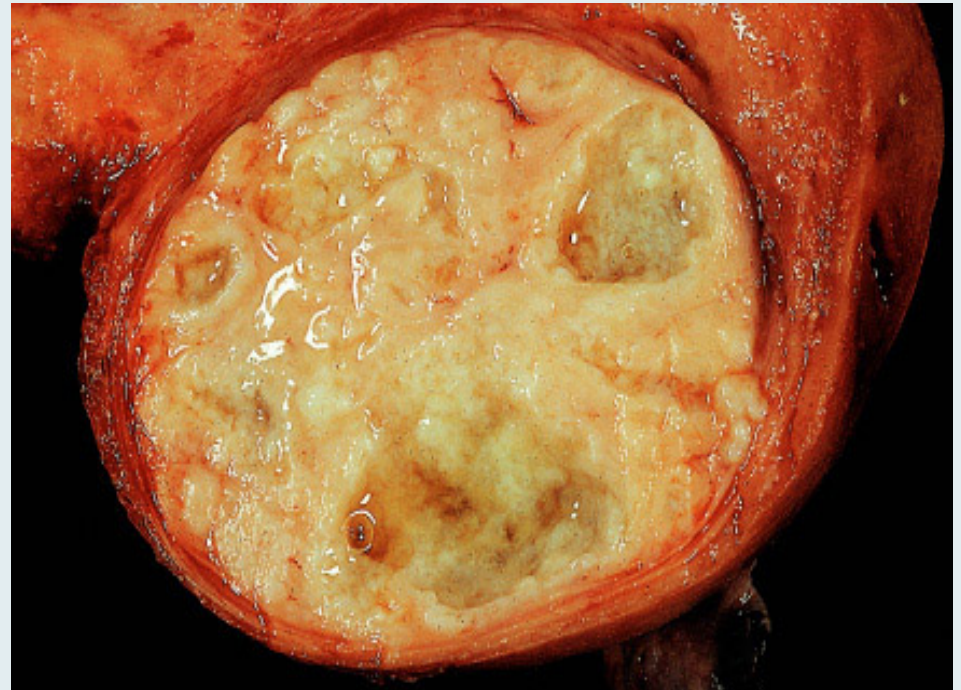
PUEDEN SUFRIR:

DEGENERACIÓN ROJA (INFARTO ROJO)

DEGENERACIÓN HIALINA

DEGENERACIÓN MIXOIDE

CALCIFICACIÓN



LEIOMIOSARCOMA

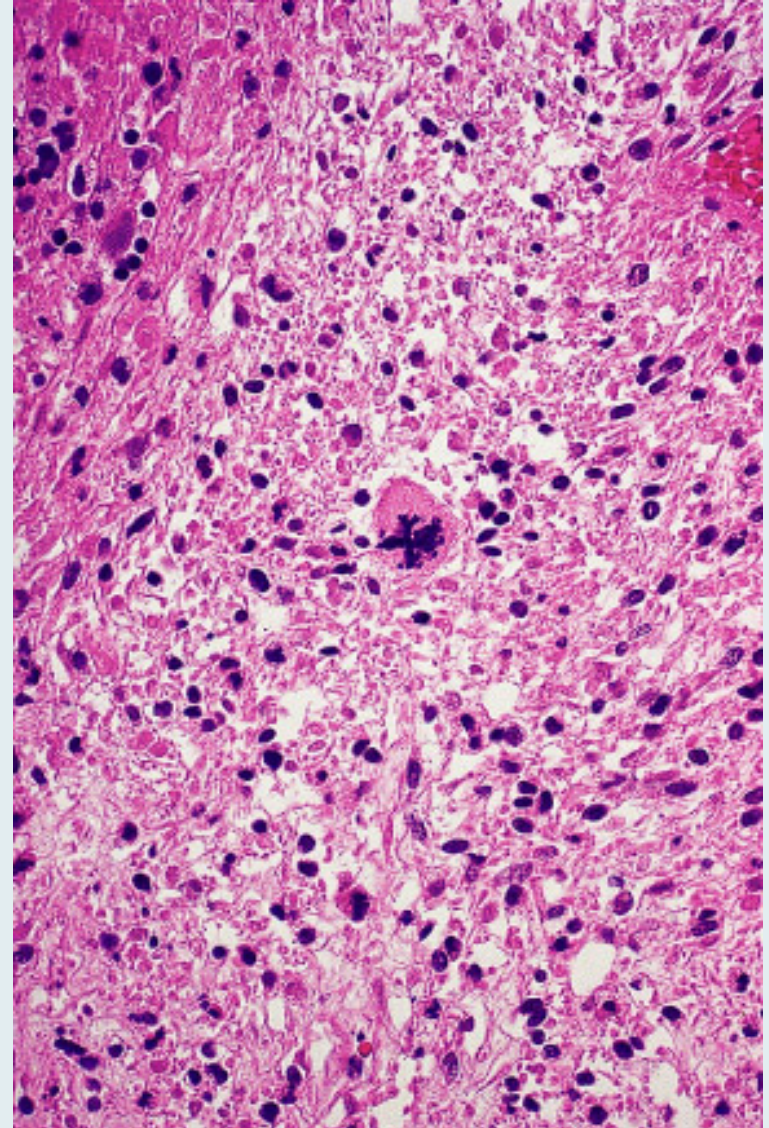
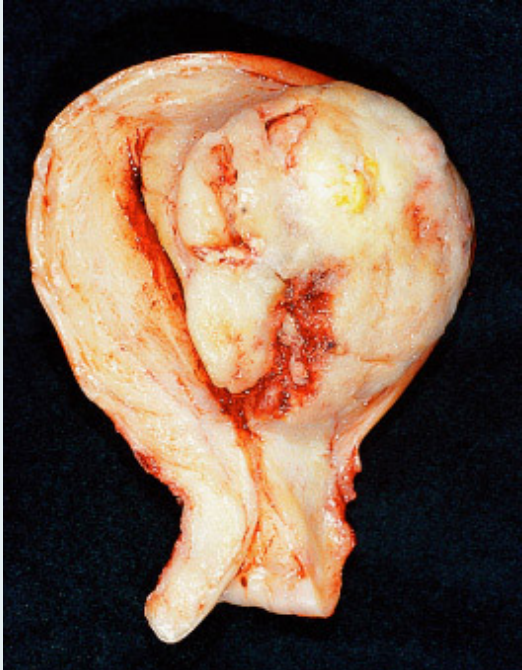
1/800 miomas

1,3 % de los cánceres de útero

Mujeres mayores

Muy malignos

Pronóstico depende del índice mitótico



LEIOMIOSARCOMA

