

Capitolo 7

*Esame istologico: la biopsia mirata ed il
cono cervicale*

P. dalla Palma, S. Privitera, B. Ghiringhello

Problema CIN 2

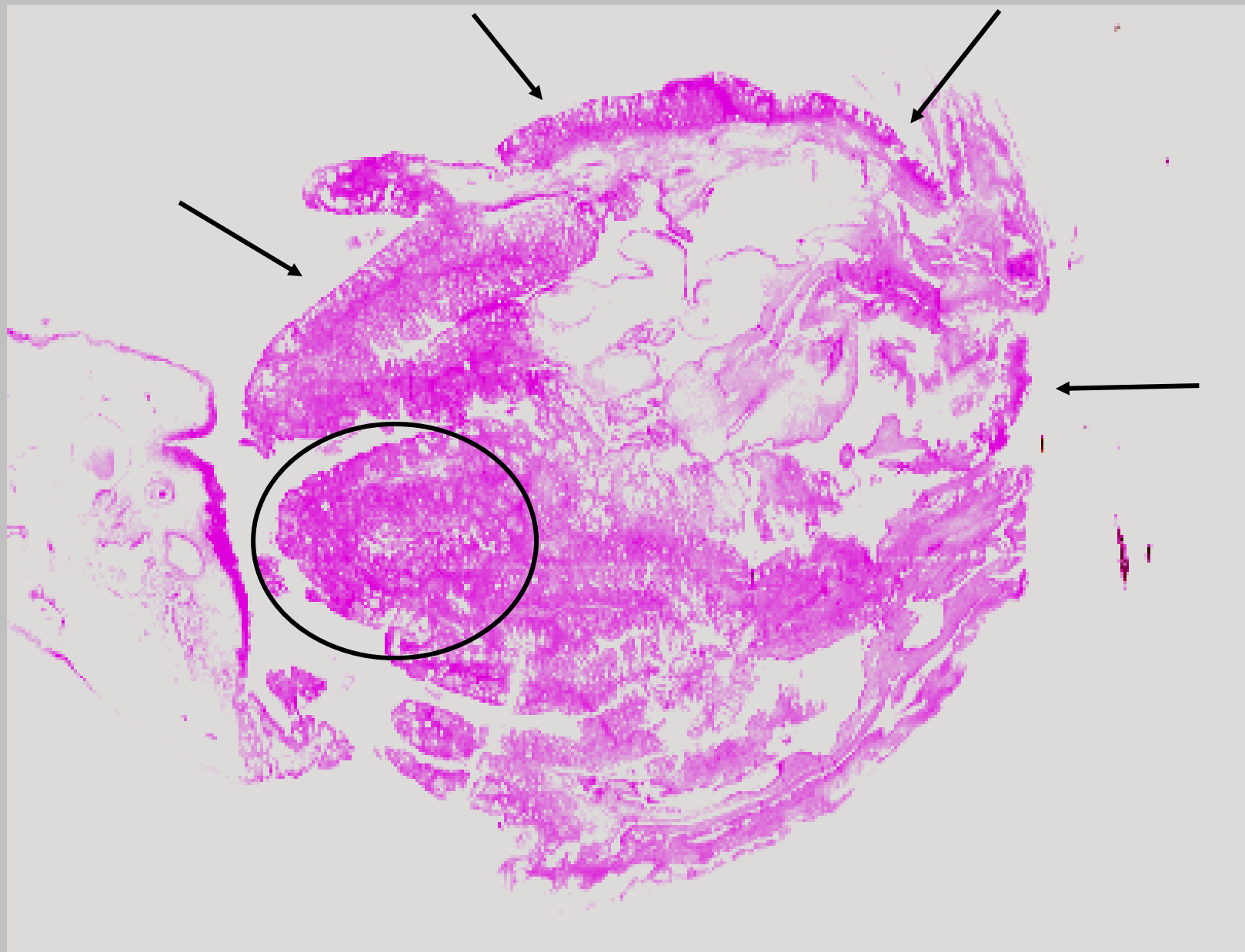
Classificazione in 3 gradi

MIB 1 e p16



M.M. aa 38

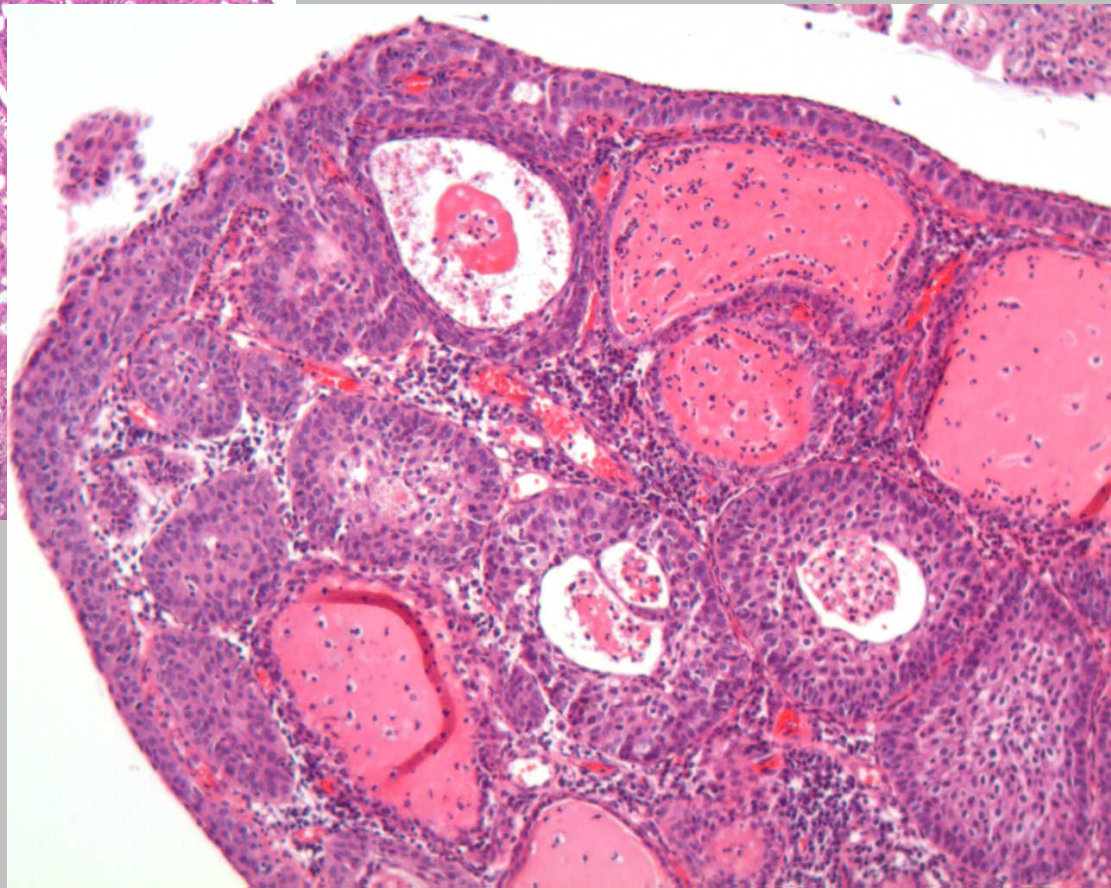
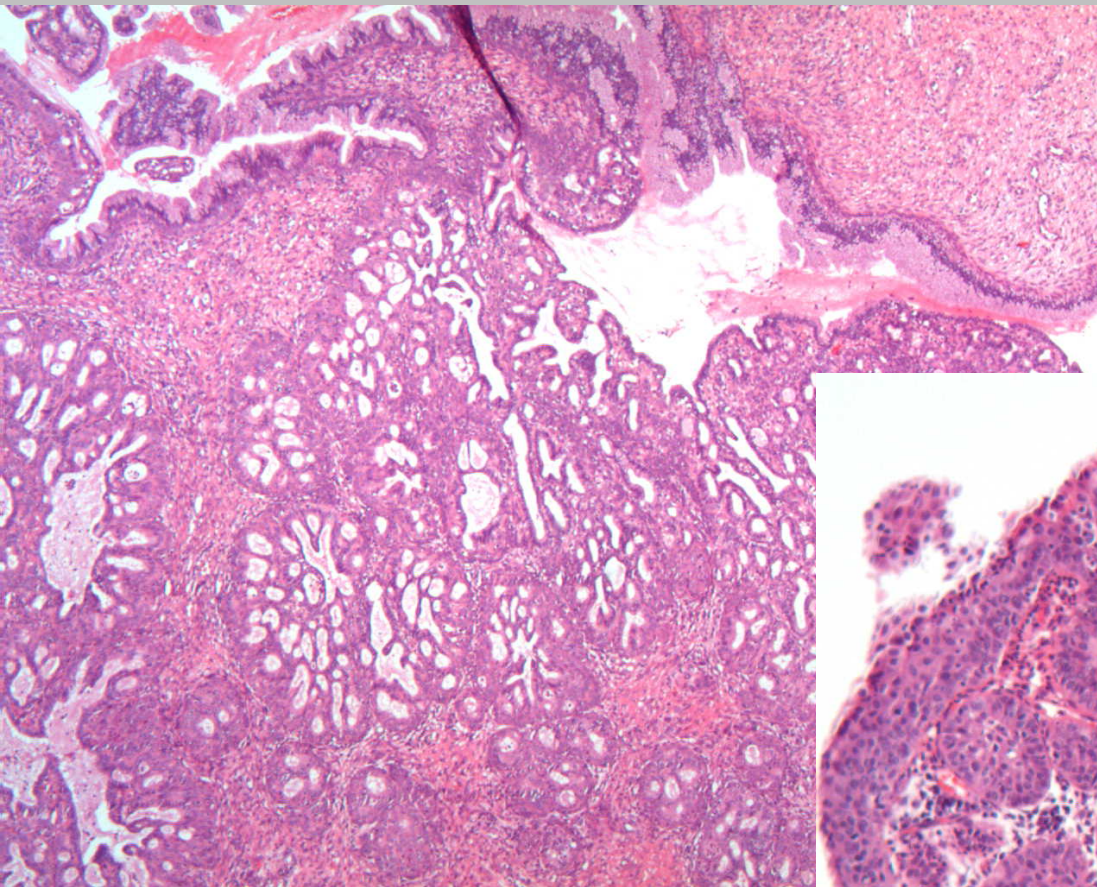
Giu 2007: escissione polipo cc

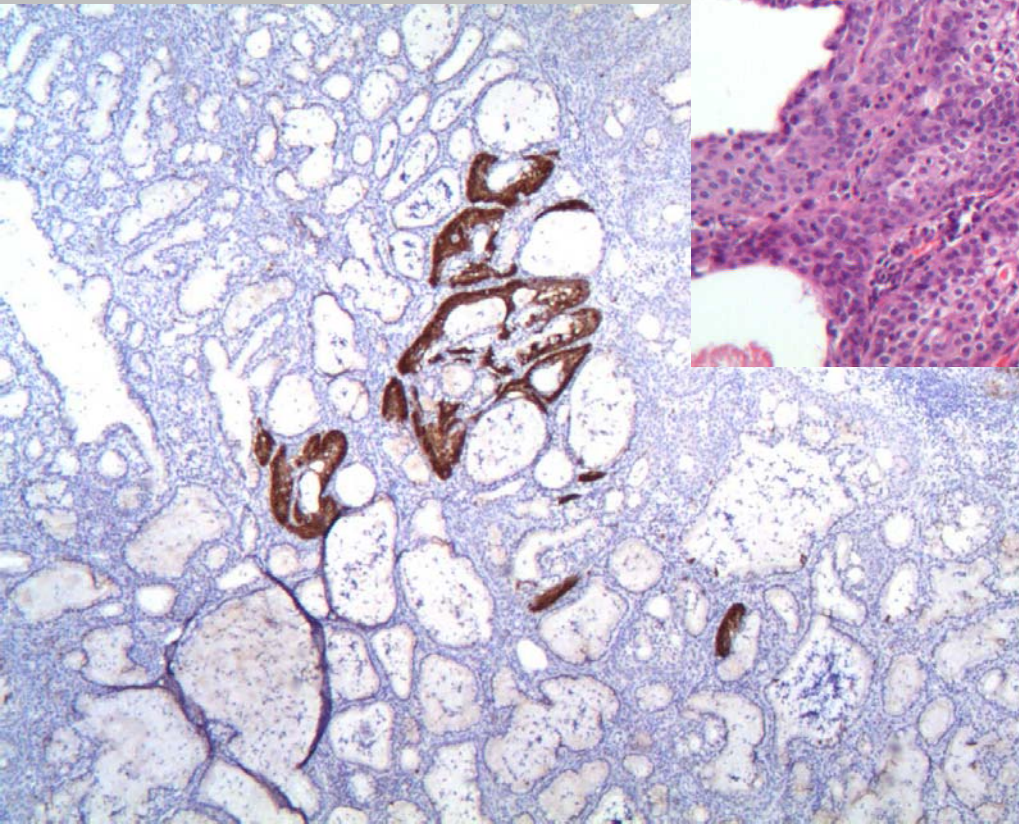
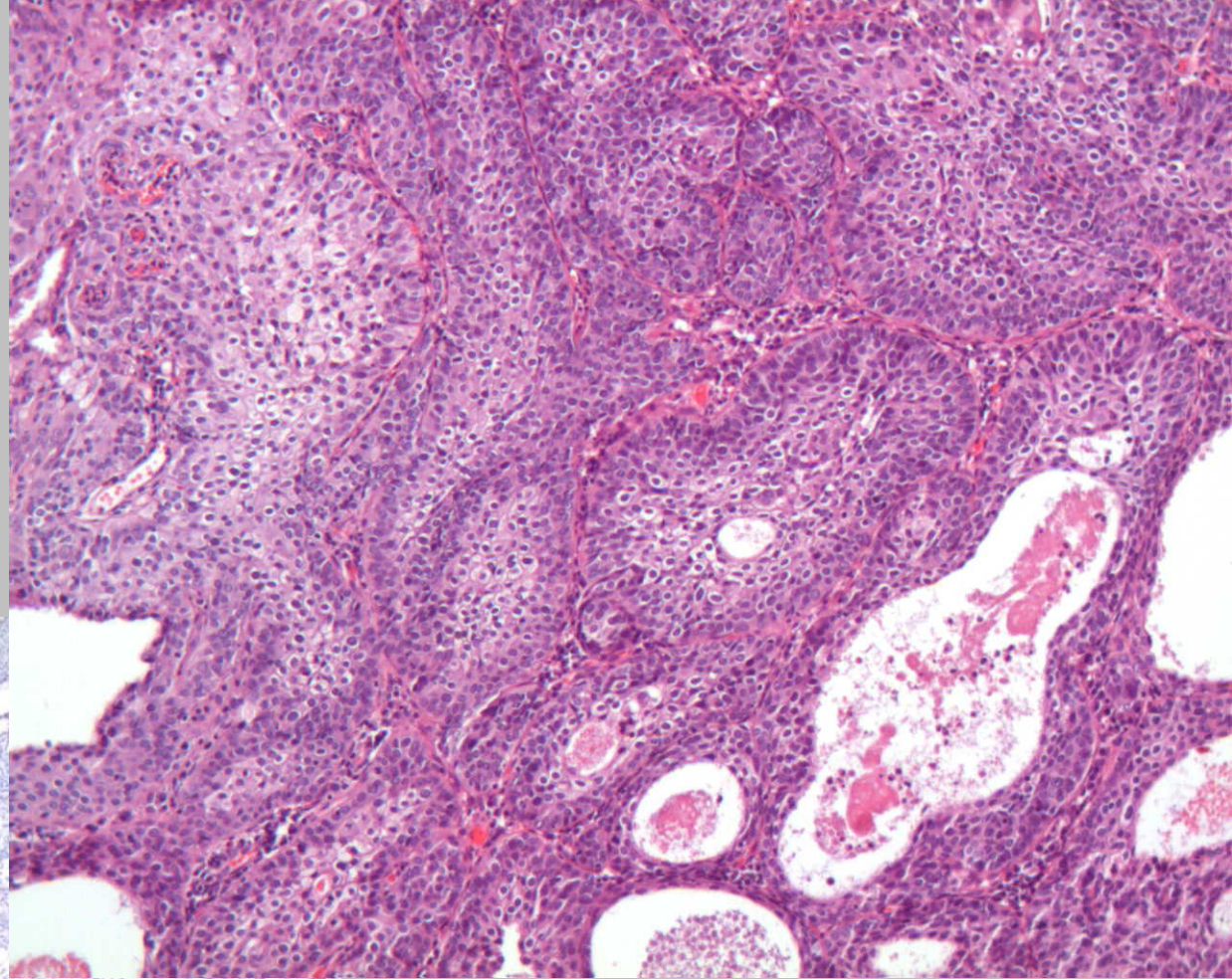


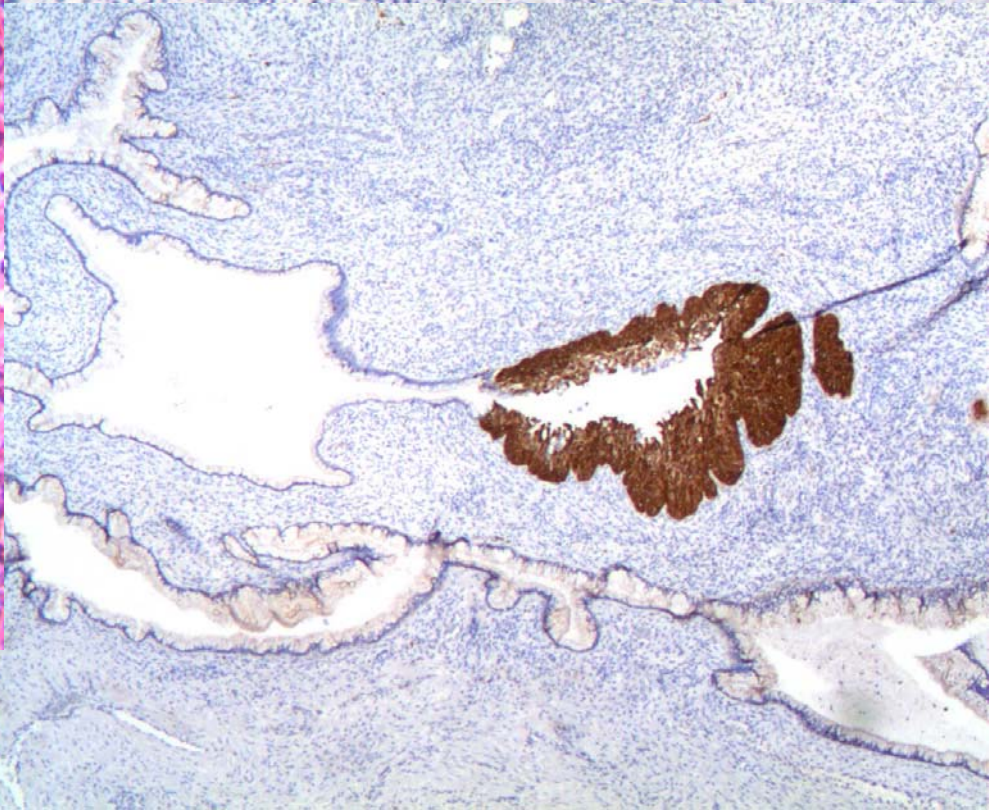
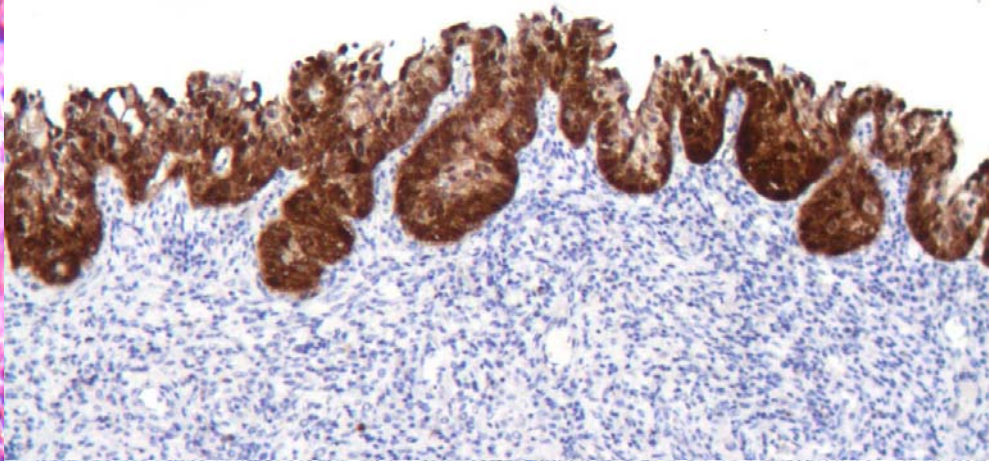
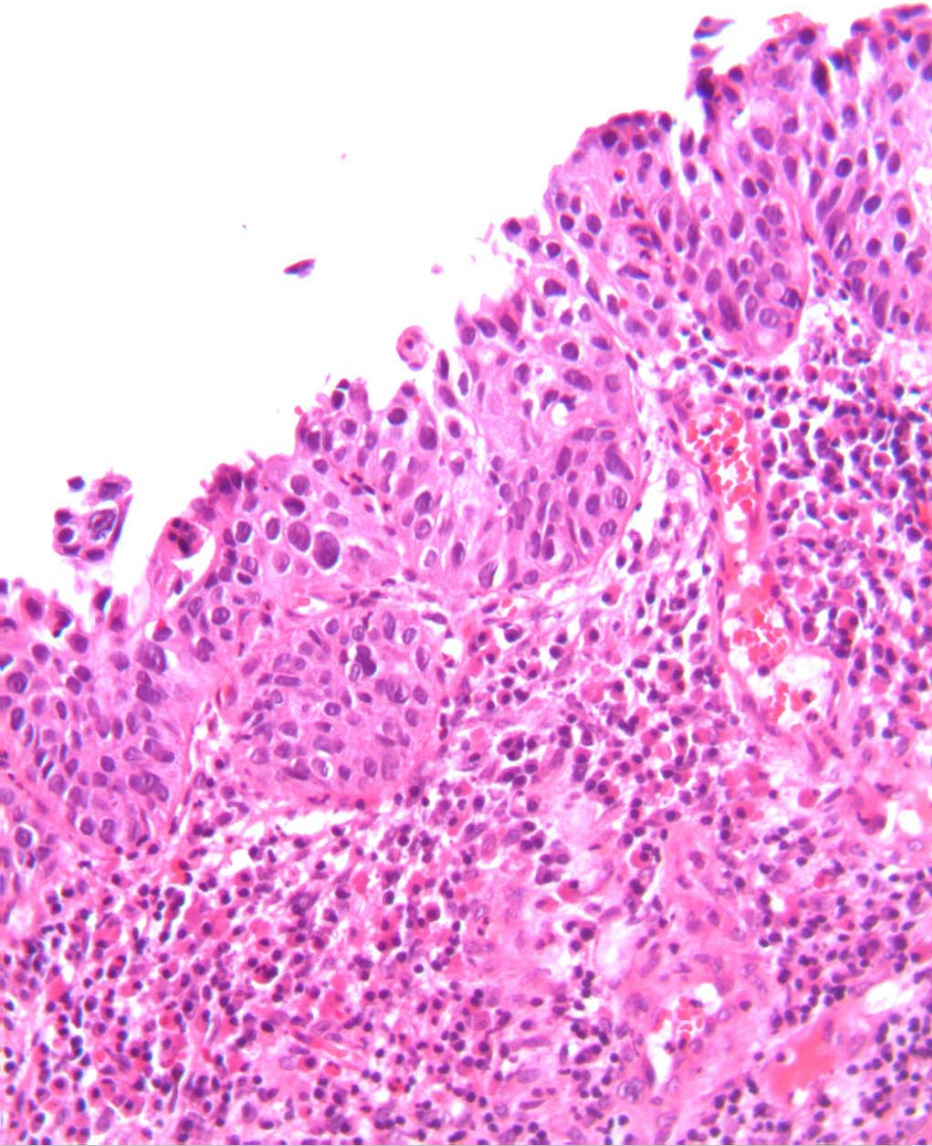


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Giu 2007: escissione polipo cc







CGIN vs AIS

Microinfiltrante vs infiltrante

Biopsia diagnostica

Biopsia escissionale

The histological report should include:

- Tissue type
- Absence or presence and type of neoplastic lesions
- Grade of identified lesions:
- Squamous lesions: cervical intraepithelial neoplasia 1-3 (CIN1-3), invasive cancer
- Glandular lesions: high-grade and low-grade cervical glandular intraepithelial neoplasia (CGIN) invasive adenocarcinoma or adenosquamous carcinoma
- Presence of HPV-associated changes (koilocytes, dyskeratosis)
- Size of the lesion (in mm)
- Characterization of non-neoplastic lesions
- Stromal reaction: presence and extent of inflammation or desmoplastic reaction
- In case of invasive cancer, depth of invasion, presence of lymphovascular involvement and the degree of differentiation should be documented.

5.3 Punch biopsies 5.3.4 Histological diagnosis

.....In small biopsies it may occasionally be necessary to report CIN as “ungraded” but where possible diagnoses such as CIN1-2 should be avoided.

5.4 Excision biopsies

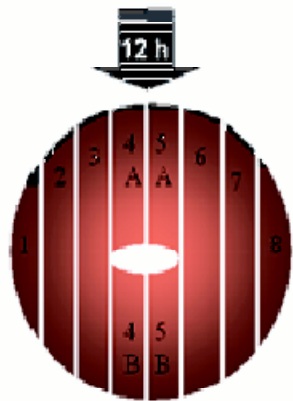
5.4.2 Macroscopic description

Description should include the size of the specimen (length and diameter), localisation of the cervical canal (central, paracentral or marginal), any visible lesion, and the position of any markings and sutures for orientation of the specimen (Horn et al., 1999).



Radial cutting

includes opening longitudinally and pinning. Sequential identification of each section allows accurate mapping of the lesion.



Parallel antero-posterior cutting from left to right (or vice versa)

should include ink application of one margin in minimum, application of multiple colour inks simplifies proper identification of various margins. If divided into an anterior and posterior fraction numbering of the posterior part should follow the same order as the anterior part.



Division into two equal halves

along the axis of the cervical canal. Each half should be marked by colour inking of one margin as a minimum, and is then embedded in separate deep (1 cm) cups followed by complete step (0.1 mm) serial sectioning.

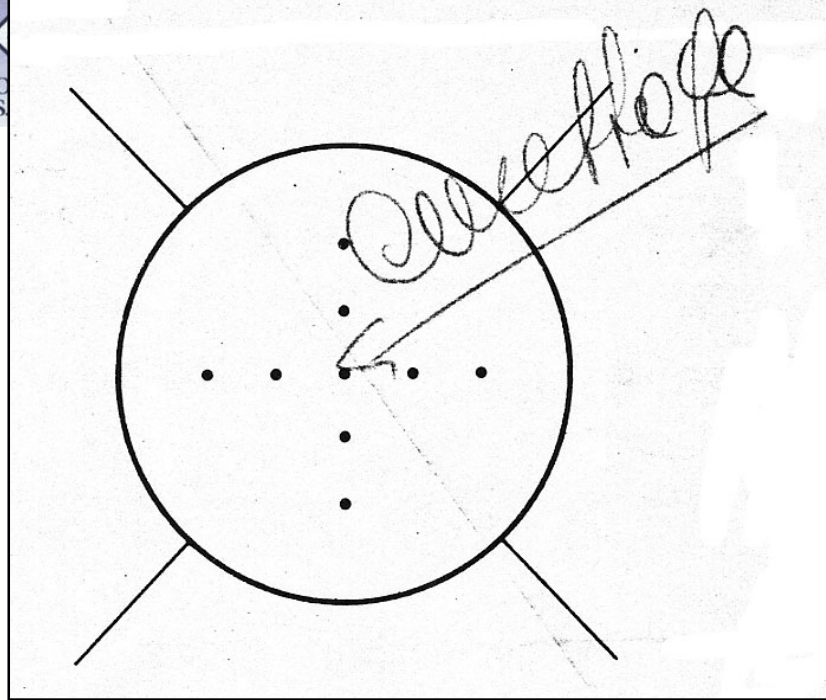
Fig. 1. Examples of techniques for sectioning exision biopsies (graphics created by H. G. Wiener)

5.4 Excision biopsies 5.4.4 Histological diagnosis

Histological reports on an excision biopsy should provide a well defined pathological diagnosis as summarized below. The diagnosis should also be in concordance with the WHO histological classification of tumours of the uterine cervix

In addition to a precise description of the histological type of the lesion the report should include information concerning the

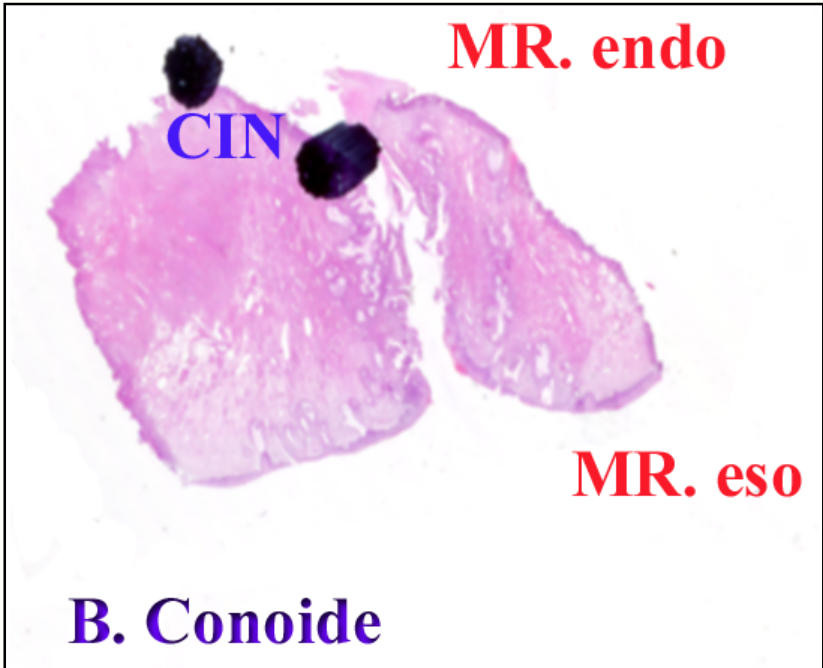
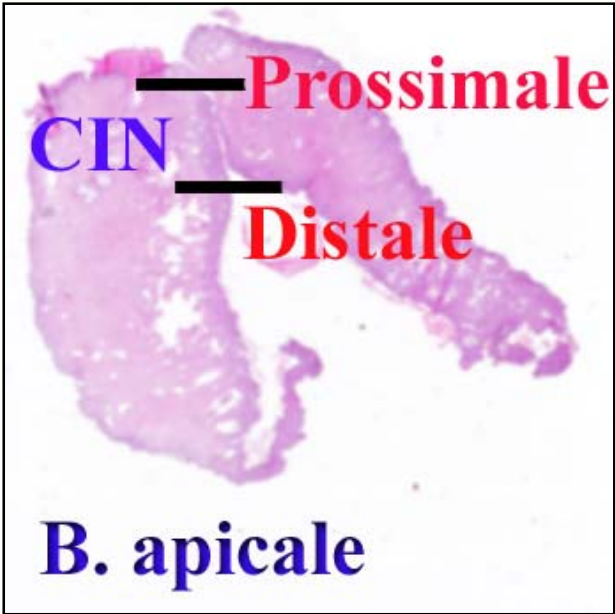
- Grade of neoplastic lesion
- Localization of the lesion within the excision biopsy
- Uni/multifocality of the lesion
- Extent of the lesion (in cases of microinvasive and invasive cancer, measurement of vertical and horizontal diameters is crucial for adequate staging).
- Stromal reaction
- Involvement of microvessels
- Relation of tumor tissue to all resection margins (distance)
- Description and characterization of additional non-neoplastic lesions (tuboendometroid metaplasia, microglandular hyperplasia, endometriosis, regenerative and repair changes)



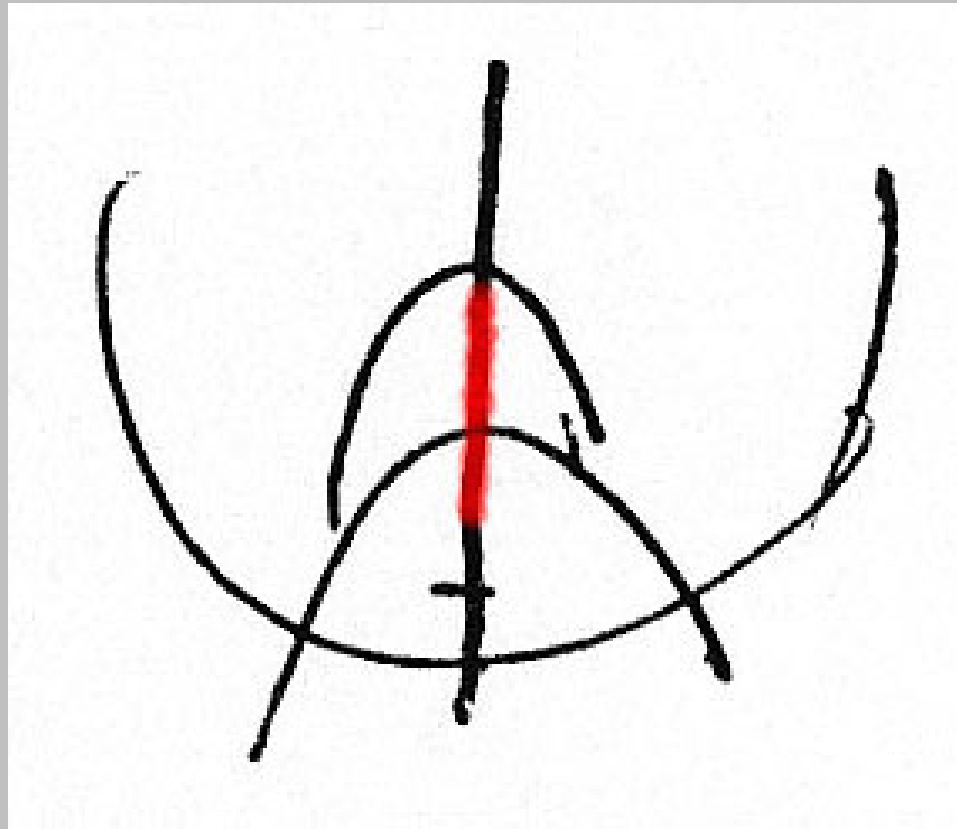
**BIOPSIA CONOIDE CERVICALE
(O MULTIPLE) A R F Q A SCOPO
DIAGNOSTICO ED EVENTUALMENTE
TERAPEUTICO**

(CURETTAGE PREINTERVENTO POSITIVO)

- ~~X~~ BIOPSIA CONOIDE
- 2 BIOPSIA APPROFONDIMENTO PROSSIMALE
- ~~X~~ BIOPSIA APICALE
- 4 CURETTAGE (ESEGUITO CURETTAGE DOPO ASPORTAZIONE APICALE)
- 5 LABBRO ANTERIORE CERVICA
- 6 LABBRO POSTERIORE CERVICALE



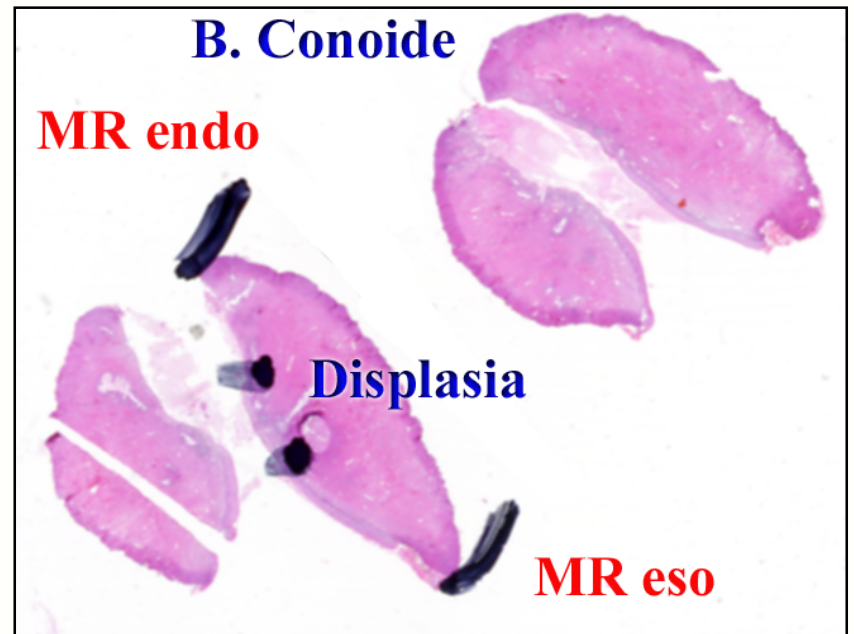
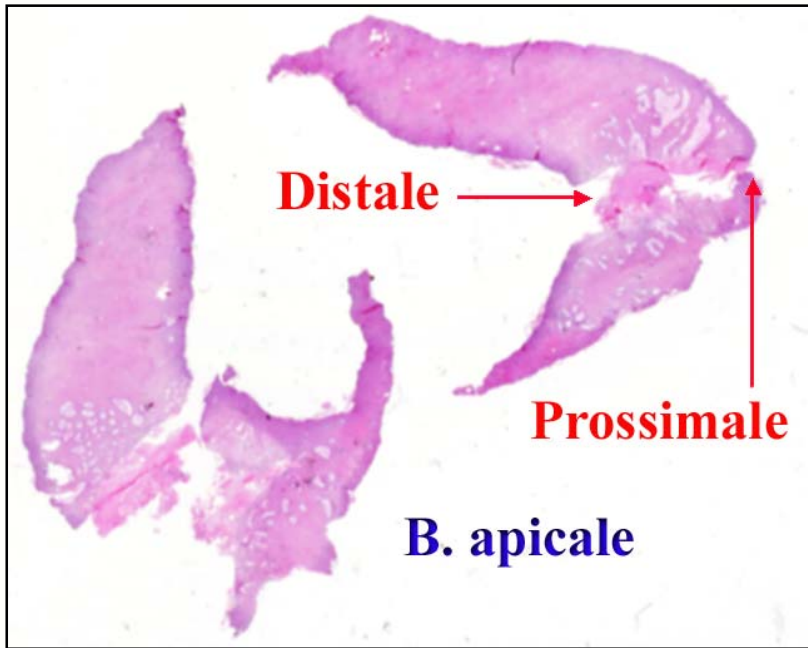
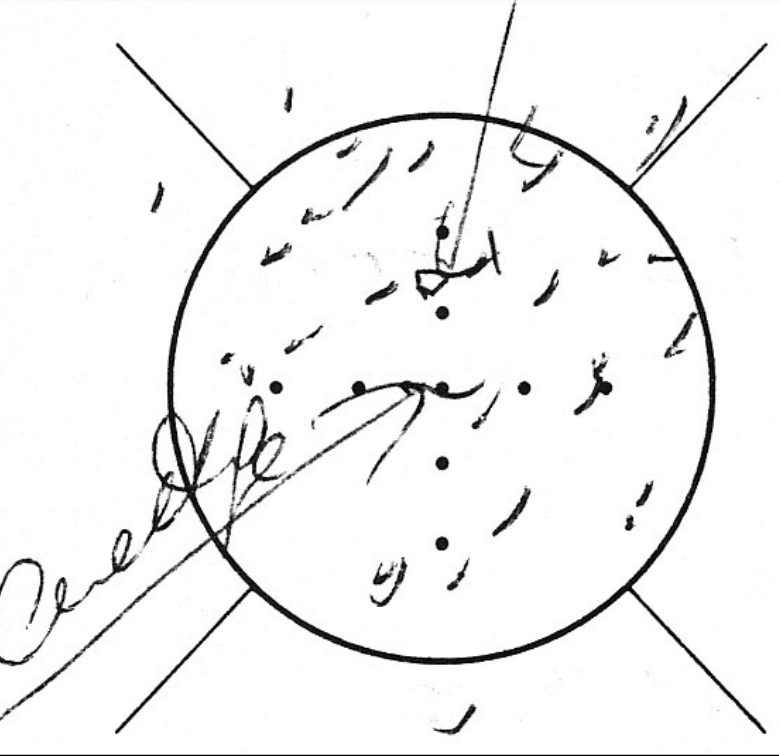
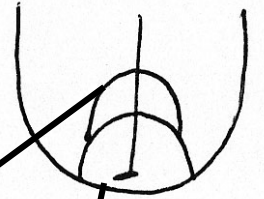
Displasia grave (CIN III) con associato HPV.
Sede endocervicale su biopsia conoide e apicale
con estensione complessiva di 6 mm. Margine di
resezione esocervicale indenne. Margine di
resezione endocervicale a ridosso della lesione
sulla biopsia apicale.



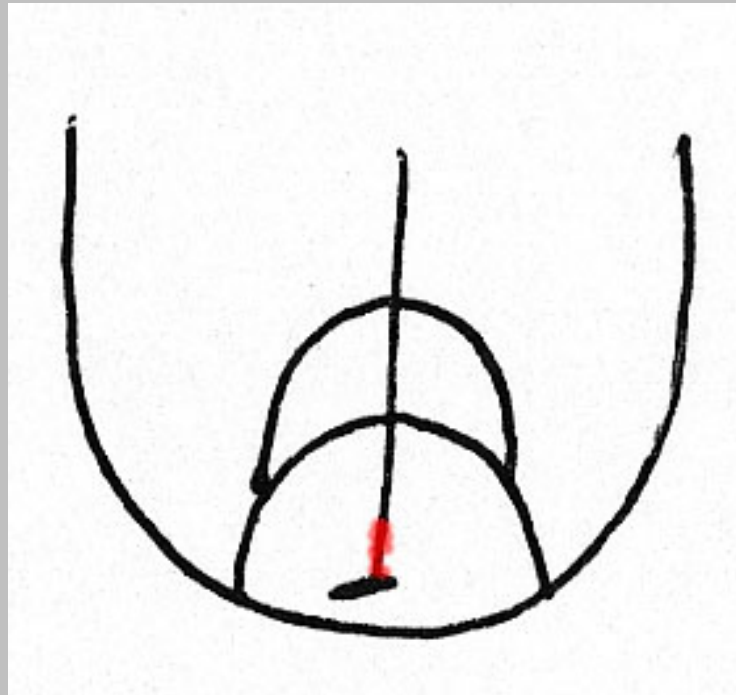
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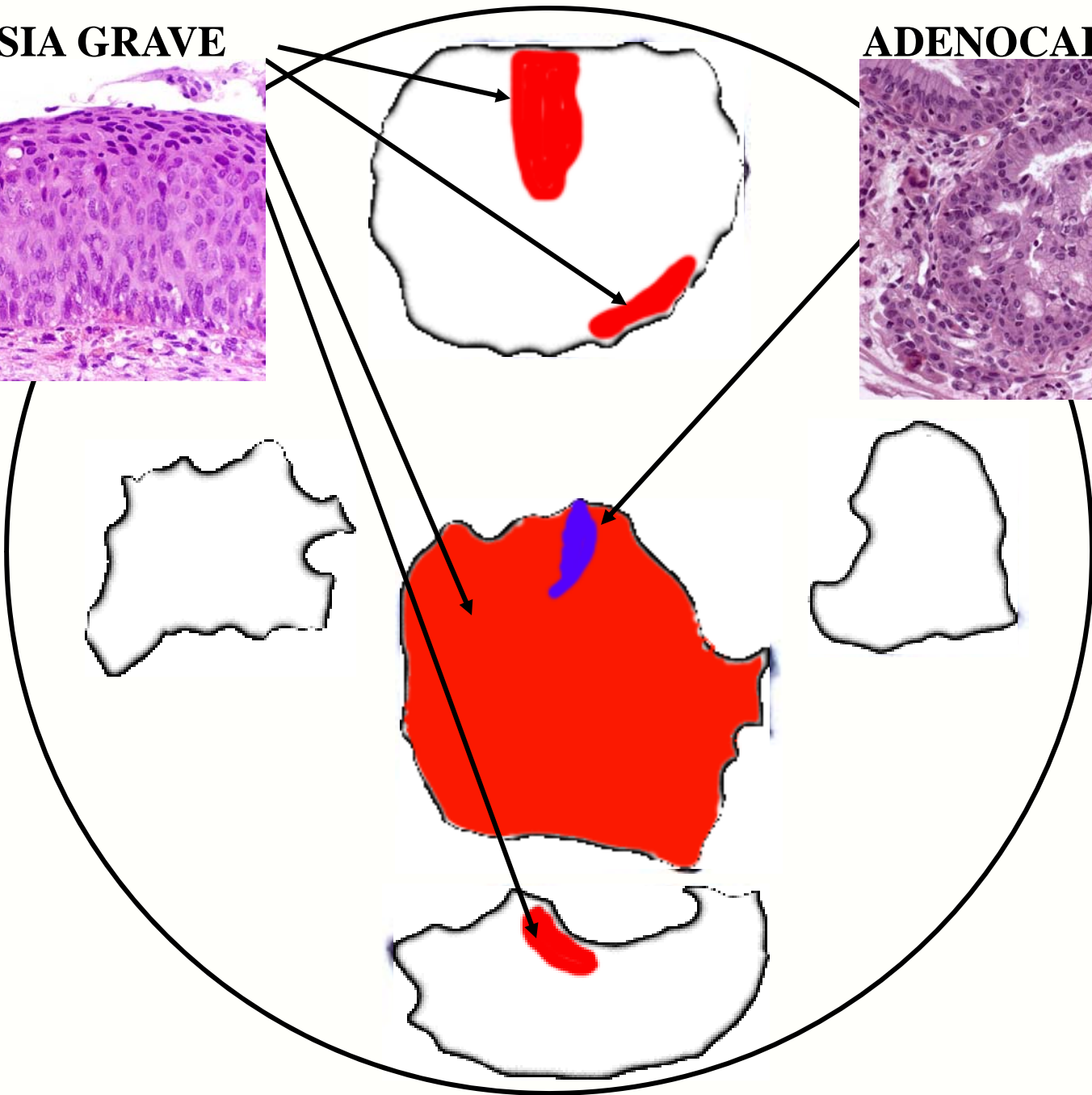
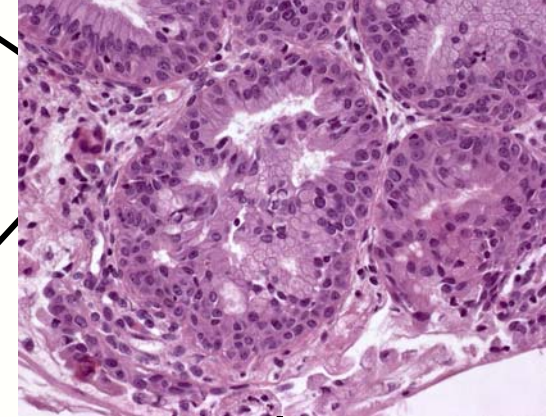
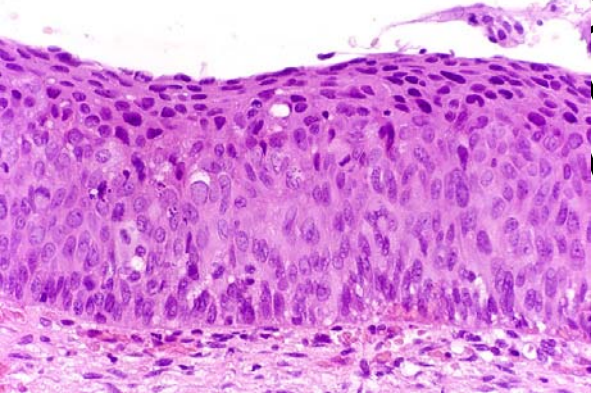
- Displasia moderata grave (CIN II-III) con associato HPV. Sede giunzionale con estensione di 2 mm sulla biopsia conoide. Margini di resezione indenni.





DISPLASIA GRAVE

ADENOCARCINOMA



Curettage endocervicale:

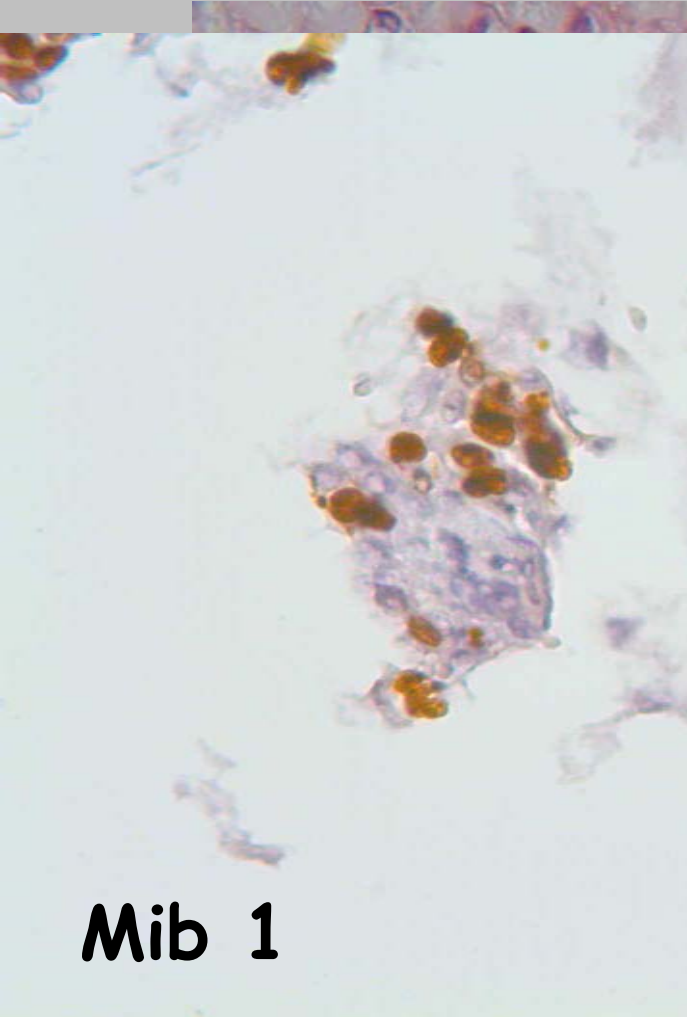
- aspetto e consistenza macroscopica
 - utile la centrifugazione

Referto istologico:

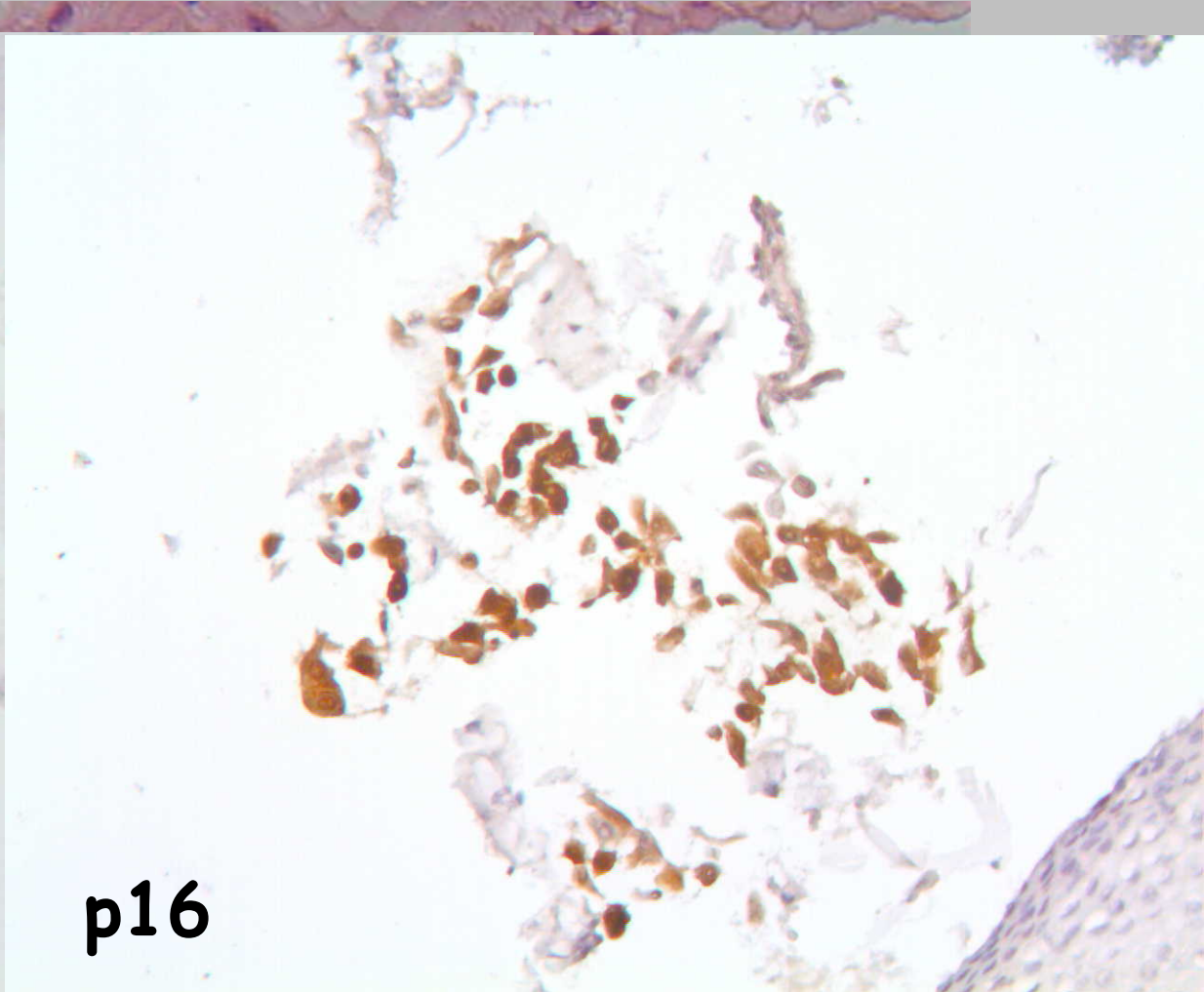
- tipo di epitelio
 - fondo
 - lesione
 - ev. invasione
- evitare inadeguatezza
- displasia non graduabile

B.A. 65 aa

FEB 2007 istologia curettage: sospetto ADK



Mib 1



p16

Controllo di qualità

42 CASI \geq 35 ANNI

COLPOSCOPIA	CITOLOGIA	ISTOLOGIA			TIPO PREL.
		NEG	L-SIL	H-SIL	
G0+ G 0/X (15 CASI)	NEG	4	0	0	1B, 3C
	L-SIL	8	2	0	10C
	L-SIL+	1	0	0	1C
G 1+G 1/X (23 CASI)	NEG	6	2 (1 L-SIL+)		2B, 2B+C, 4C
	L-SIL	6	6	1 (VAIN)	6B, 6B+C, 1C
	H-SIL	0	0	2 (CIN 2)	2B
G X (3 CASI)	NEG	0	0	0	
	L-SIL	3	0	0	3C
	H-SIL	0	0	0	
G 2 (1 CASO)	NEG	0	0	0	
	L-SIL	1	0	0	1C

15 CASI < 35 ANNI

COLPOSCOPIA	CITOLOGIA	ISTOLOGIA			TIPO PREL.
		NEG	L-SIL	H-SIL	
G 0+ G 0/X (8 CASI)	NEG	3	0	0	3C
	L-SIL	4	1	0	1 B+C. 4C
		NEG	L-SIL		
G 1 (7 CASI)	NEG	3	1	0	2B, 1C, 1B+C
	L-SIL	0	1	0	1B
	H-SIL	0	1	1	1B, 1B+C

VPP (CIN 2+)

≥ 35 aa: 9,3%

< 35 aa: 9,0%

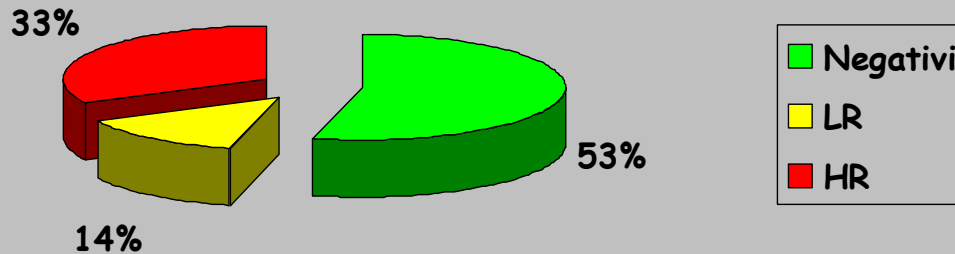
VPP (cit +)

≥ 35 aa: 65%

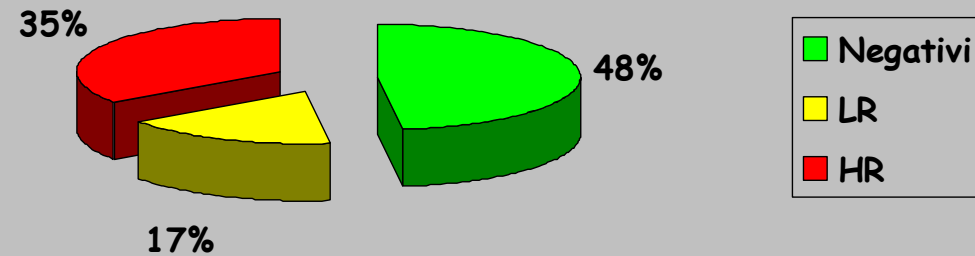
< 35 aa: 40%

ASCUS vs LSIL (1999-2003)

ASCUS

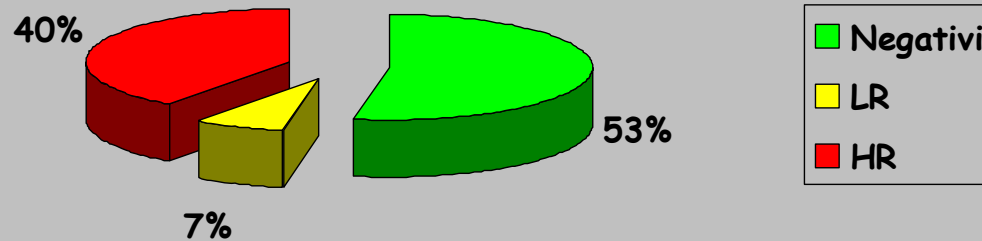


LSIL



ASCUS vs LSIL (2006)

ASCUS



LSIL

