PIPADOR REVISION

MRCOG Part 1 Revision Notes

CGIN

PATHOLOGY • LECTURE 343

VISUAL EXAMINATION REVISION NOTES

2026 Edition

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MRCOG PART 1 REVISION NOTES | PATHOLOGY

CGIN

Cervical glandular intraepithelial neoplasia — pathology, detection and management

Glandular	HPV 18	Skip lesions	Clear margins
Endocervical epithelium	Most associated type	Multifocal	Key aim of excision

■ KEY FACTS: Learning objectives

- Define cervical glandular intraepithelial neoplasia (CGIN) and describe its pathology.
- Describe detection and differences from CIN.
- Describe management including fertility-sparing excision and follow-up.

343.1 Pathology

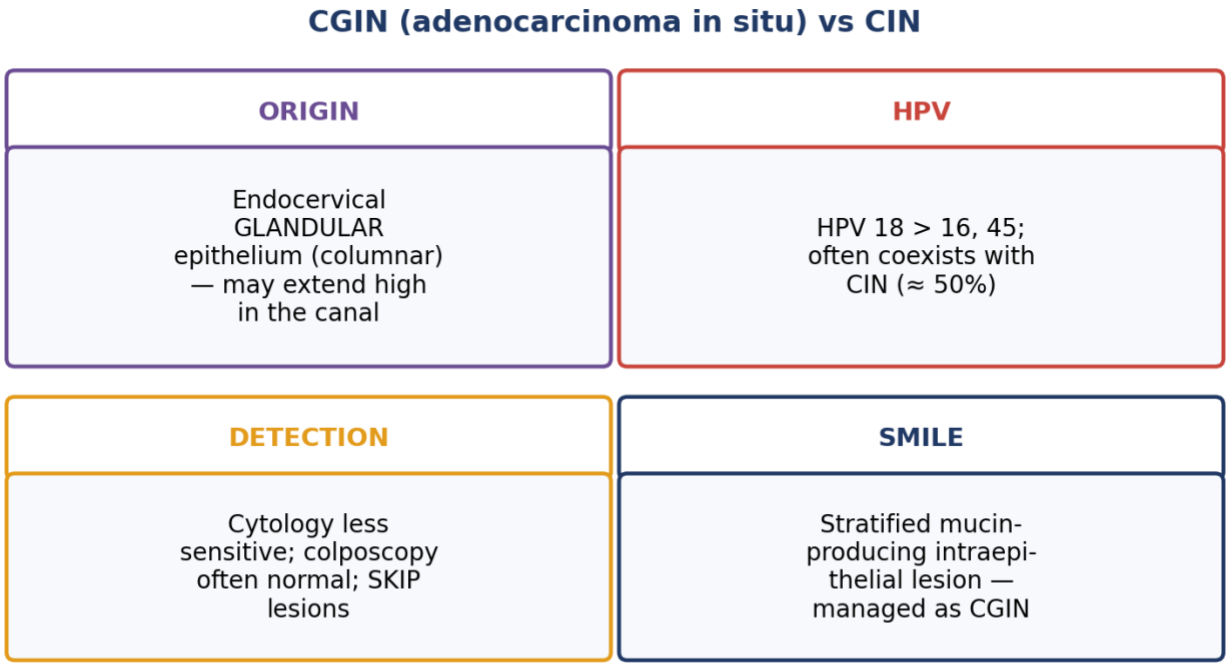


Figure 343.1 — CGIN vs CIN

- Histology: endocervical glands with crowded, stratified, hyperchromatic nuclei, mitoses and apoptotic bodies
  - Normal gland architecture retained (no stromal invasion) — **adenocarcinoma in situ (AIS)**.
- High-grade CGIN is the precursor of HPV-associated **adenocarcinoma** (rising proportion of cervical cancers in screened populations).
- Immunohistochemistry: p16 block-positive, high Ki-67
  - Differential — tubal/endometrioid metaplasia, endometriosis, Arias-Stella reaction, endometrial adenocarcinoma extending down.

343.2 Management

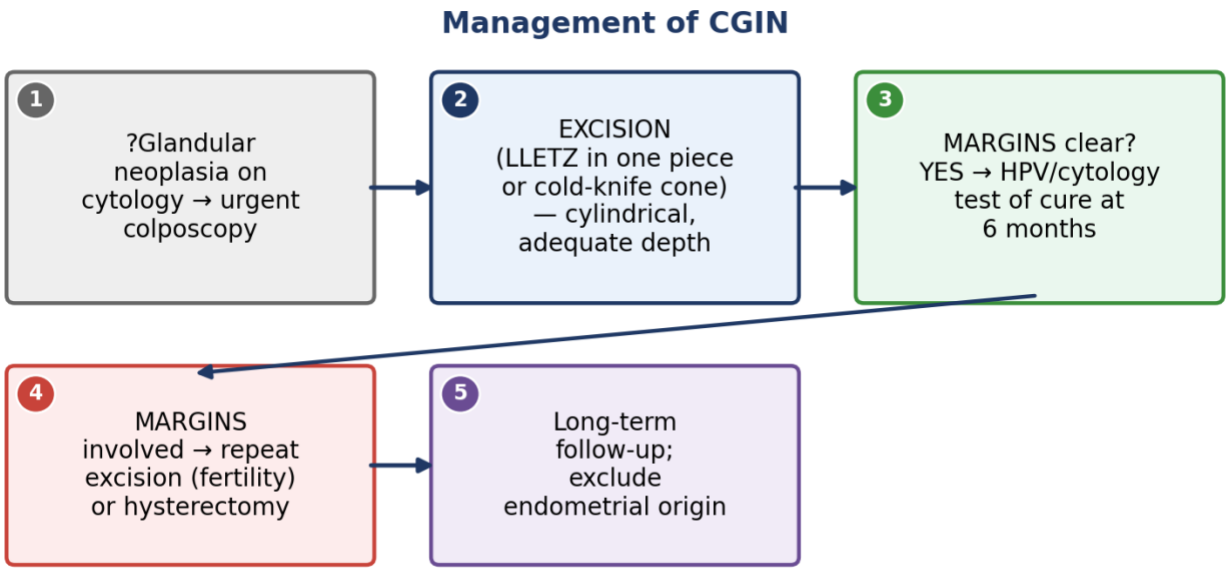


Figure 343.2 — Management of CGIN

- Excision should be **cylindrical and extend ≥ 1 cm into the canal** (or deeper if TZ not visible) — fragmented samples hamper margin assessment.
- Women who have completed childbearing may choose hysterectomy (especially with involved margins or inadequate follow-up).
- Glandular lesions may coexist with endometrial pathology — consider endometrial sampling, especially in older women.

343.3 Must-know summary

■ EXAM TIP

- CGIN/AIS = glandular precursor of adenocarcinoma; HPV 18.
- Hard to detect (cytology, colposcopy); skip lesions.
- Excise in one piece with clear margins; re-excise if involved; HPV test of cure at 6 months.
- Exclude endometrial origin.

■ MNEMONIC / MEMORY AID

CGIN — 'Glands Go High (in the canal), Get clear margins'.