

ICD-O-3  
Carcinoma, infiltrating ductal, NOS 8500/3  
Site: breast, NOS C50.9  $\mu$

FOR OFFICIAL USE ONLY - PERSONAL DATA - PRIVACY ACT OF 1974

## SURGICAL PATHOLOGY REPORT

Patient: Specimen #: .  
FMP/SSN:  
DOB/Age/Sex: Race: WHITE Taken:  
Location: Received:  
Physician(s): Reported:

### SPECIMEN:

A: LEFT BREAST LUMPECTOMY B: LEFT AXILLARY CONTENTS  
C: SENTINEL NODE #1

### FINAL DIAGNOSIS:

#### A. BREAST, LEFT, LUMPECTOMY:

- TUMOR TYPE: INFILTRATING DUCTAL CARCINOMA
- NOTTINGHAM GRADE: POORLY DIFFERENTIATED (Grade 3)
- NOTTINGHAM SCORE: 9 OF 9 (Tubules= 3, Nuclei= 3, Mitoses= 3; mitotic count 24 per 10 high power fields at 40x power)
- TUMOR SIZE: MULTIFOCAL, LARGEST CONTIGUOUS FOCUS 1.3 CM (Gross measurement)
- MICROCALCIFICATIONS: NONE IDENTIFIED
- VENOUS/LYMPHATIC INVASION: PRESENT
- MARGINS:
  - INFILTRATING CARCINOMA 0.8 MM FROM ANTERIOR MARGIN (Slide A10)
  - FOCI OF ANGIOLYMPHATIC INVASION 0.2 MM FROM POSTERIOR MARGIN (Slide A2)
- INTRADUCTAL COMPONENT: DCIS, FOCAL, HIGH GRADE
- LYMPH NODES: NEGATIVE (See parts B and C)
- NIPPLE: NOT SAMPLED
- SKIN: NOT SAMPLED
- HORMONE RECEPTOR AND HER2 STUDIES: PREVIOUSLY REPORTED
- PATHOLOGIC STAGE: pT1 N0 MX (AJCC Stage I)

#### B. AXILLARY CONTENTS, REMOVAL:

- BENIGN FIBROADIPOSE TISSUE

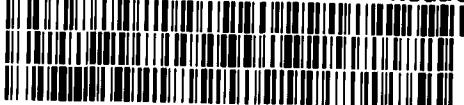
#### C. SENTINEL LYMPH NODE, REMOVAL:

- NEGATIVE FOR TUMOR BY H&E AND IMMUNOHISTOCHEMISTRY

\*\* Report Electronically Signed Out \*\*

===== UID:63F76D85-8433-4FFE-9054-6C04F065DF2D  
TCGA-A2-A0SX-01A-PR =====

Redacted



b 1

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===== ALL DATA - PRIVACY ACT OF 1974 =====

**SURGICAL PATHOLOGY REPORT**

Patient:

Specimen #:

**CLINICAL DIAGNOSIS AND HISTORY:**

year old with diagnosis of left breast cancer

**PRE-OPERATIVE DIAGNOSIS:**

left breast cancer

**GROSS DESCRIPTION:**

A. Received fresh is an 8 x 7 x 2.5 cm unoriented irregular piece of soft tissue with embedded localization wire. The radiograph accompanies the specimen. The external surface is composed of focally disrupted lobulated yellow tan adipose tissue. A 3 x 1 cm irregular portion of red brown muscle is denoted on one surface which is smooth and consistent with a deep fascia margin. This surface is inked black and the remainder of the specimen is inked blue. Serial sections reveal a 1.3 x 1.2 x 1.2 cm soft ink tan Mammomark plug with embedded clip. This lesion comes to within 0.2 cm of both inked margins. The remainder of the specimen is composed of unremarkable adipose tissue admixed with scant fibrous tissue. No additional lesions are identified. Representative sections submitted as follows:

A1: lesion

A2-A3: margins of A1

A4: adjacent normal

A5: margin (blue ink)

A6-A15: representative sections

Matched sections of A1 and A4 are submitted in for CBCP protocol.

B Received in formalin labeled with the patient's name

designated "AXILLARY CONTENTS LEFT" consists of a single fragment of pink tan tissue measuring 2.5 x 1.9 x 0.9 cm which is grossly unremarkable. The entire specimen is submitted whole. There are no lymph nodes identified.

C. Received fresh labeled with the patient's name

designated "SINGLE NODE #1" is a 1 x 0.7 x 0.3 cm lymph node. The specimen is bisected to reveal a fatty hilum with a hemorrhagic rim of lymphoid tissue. The specimen is entirely submitted in C1. No tissue is taken for protocol.

Criteria	Yes	No
Diagnosis Discrepancy		
Primary Tumor Site Discrepancy		
HIPAA Discrepancy		
Prior Malignancy History		
Dual/Synchronous Primary Noted		
Case is (circle):	QUALIFIED	DISQUALIFIED
Reviewer Initials	JW	
	10/22/10	