Patient [redacted]

AP Surgical Pathology: Additional Info

Surg Path

Criteria	Yes	No
Diagnosis Discrepancy		X
Primary Tumor Site Discrepancy		X
HIPAA Discrepancy		X
Prior Malignancy History		X
Dual/Synchronous Primary Noted		X

Case is (circle): QUALIFIED / DISQUALIFIED
Reviewer Initials: KMT Date Reviewed: 6/22/12

6/23/12

CLINICAL HISTORY:
Not provided.

GROSS EXAMINATION:
A. "Sentinel node #1, hot (AF1-3)", received for frozen section are three lymph node candidates. One lymph node is bisected and submitted for frozen section as AF1-AF2, and the remnant sections are submitted in blocks A1-2. Two additional lymph nodes are submitted for frozen section as AF3, and the remnant is submitted as block A3.

B. "Axillary fat", received in formalin is a 11.3 x 4 x 1.5 cm fragment of yellow-tan adipose tissue which is dissected to reveal one lymph node candidate measuring 0.8 x 0.7 x 0.5 cm, which is submitted entirely in block B1.

C. "Left breast cancer, two clips medial, one clip inferior, long stitch lateral, short stitch superior", received in formalin is a 8 cm medial to lateral, 7 cm superior to inferior, 2.7 cm anterior to posterior lumpectomy specimen inked as follows: superior-yellow, inferior-red, anterior-blue and posterior-black. The specimen is sectioned from medial to lateral to reveal a 2.0 x 1.5 x 1 cm mass lesion located 0.4 cm from the posterior margin, 0.7 cm from the anterior margin, 2.7 cm from the medial margin, 2.7 cm from the lateral margin, 1.3 cm from the superior margin and 3.2 cm from the superior margin. The remainder of the breast tissue demonstrates fibrofatty lobulated adipose tissue that is otherwise grossly unremarkable. Sections are submitted as follows per the block diagram:

BLOCK SUMMARY:

C1- medial edge
C2-4 representative medial breast
C5-28 mass submitted entirely
C29-31 representative lateral breast
C32-34 lateral edge

ICD-O-3
Carcinoma, infiltrating ductal NOS 8500/3
Site: breast, NOS C50.9
7-2-12 CD

D. "Superior medial margin", received in formalin is a 7.2 x 6.4 x 2.3 cm fragment of adipose tissue with a stitch marking final margin. The final margin is inked blue and the opposite margin is inked black. Every other section is submitted in blocks D1-10.

E. "Medial and superior margin", received in formalin is a 5.5 x 3.5 x 2.2 cm fragment of yellow-tan adipose tissue with a stitch in place marking the final margin. The stitched margin is inked blue, and the opposite margin is inked black. The specimen is sectioned to reveal no focal lesions. Every other section is submitted in blocks E1-12.

F. "Inferior to lateral margin", received in formalin is a 6.5 x 5.2 x 2.1 cm fragment of yellow-tan adipose tissue with a suture marking the final margin. The final margin is inked blue and the opposite margin is inked black. The specimen is sectioned to reveal no focal lesions. Every other section is submitted in blocks F1-11.

G. "Anterior skin", received in formalin is a 7.5 x 5 x 2 cm unoriented aggregate of brown skin with subcutaneous tissue that is grossly unremarkable. Representative sections are submitted in blocks G1-3.

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INTRA OPERATIVE CONSULTATION:
A. "Sentinel node #1, hot and blue":

AF1-2 (one lymph node candidate, bisected)-positive for carcinoma.
AF3 (two lymph node candidates)-negative for malignancy

MICROSCOPIC EXAMINATION:
Microscopic examination is performed.

PATHOLOGIC STAGE:
PROCEDURE: Partial mastectomy, sentinel lymph node biopsy.

PATHOLOGIC STAGE (AJCC Edition): pT1c pN1a(sn) pMX

NOTE: Information on pathology stage and the operative procedure is transmitted to this Institution's Cancer Registry as required for accreditation by the Commission on Cancer. Pathology stage is based solely upon the current tissue specimen being evaluated, and does not incorporate information on any specimens submitted separately to our Cytology section, past pathology information, imaging studies, or clinical or operative findings. Pathology stage is only a component to be considered in determining the clinical stage, and should not be confused with nor substituted for it. The exact operative procedure is available in the surgeon's operative report.

DIAGNOSIS:
A. "SENTINEL LYMPH NODE #1" (BIOPSY):

METASTATIC ADENOCARCINOMA IN ONE OF THREE LYMPH NODES (1/3).
SIZE OF METASTASIS: 5 MILLIMETERS
EXTRANODAL INVASION: ABSENT.

B. "AXILLARY FAT" (EXCISION):

ONE LYMPH NODE, NO EVIDENCE OF MALIGNANCY (0/1).
SEE COMMENT.

COMMENT: The specimen is re-examined and only one lymph node is identified.

C. "LEFT BREAST CANCER" (PARTIAL MASTECTOMY):

INVASIVE ADENOCARCINOMA OF THE BREAST.
HISTOLOGIC TYPE: DUCTAL.
NOTTINGHAM COMBINED HISTOLOGIC GRADE: 3 OF 3.
TUBULE FORMATION SCORE: 3
NUCLEAR PLEOMORPHISM SCORE: 3
MITOTIC RATE SCORE: 2
GROSS TUMOR SIZE: 2 X 1.5 X 1 CM.
SIZE OF INVASIVE COMPONENT: 2.0 CM.
LYMPHATIC/VASCULAR INVASION: ABSENT.
MULTIFOCAL TUMOR: ABSENT.

IN-SITU CARCINOMA: PRESENT.
TYPE OF IN-SITU CARCINOMA: CRIBRIFORM.
NUCLEAR GRADE OF IN-SITU CARCINOMA: 3 OF 3.
NECROSIS: ABSENT.
DCIS EXTENDING OUTSIDE INVASIVE TUMOR MASS: ABSENT.
SIZE OF IN-SITU CARCINOMA: NOT APPLICABLE.

STATUS OF NON-NEOPLASTIC BREAST TISSUE: INTRADUCTAL PAPILLOMA, RECENT NEEDLE CORE BIOPSY SITE.
SIZE OF BIOPSY: 8 X 7 X 2.7 CM.
MICROCALCIFICATIONS: ABSENT.
SURGICAL MARGIN STATUS: NEGATIVE (GREATER THAN 2 MM).

ESTROGEN/PROGESTERONE RECEPTOR, CELL CYCLE, EGFR AND HER2/NEU ANALYSIS: PENDING.

PARAFFIN BLOCK NUMBER: C14.
RESULTS WILL BE ISSUED IN SEPARATE REPORT FROM

D. "SUPERIOR MEDIAL MARGIN, LEFT BREAST" (RE-EXCISION):

BREAST TISSUE, NO EVIDENCE OF MALIGNANCY.
FINAL MARGIN FREE OF TUMOR.

E. "MEDIAL AND SUPERIOR MARGIN, LEFT BREAST" (RE-EXCISION):

BREAST TISSUE, NO EVIDENCE OF MALIGNANCY.
FINAL MARGIN FREE OF TUMOR.

F. "INFERIOR TO LATERAL" (RE-EXCISION):

BREAST TISSUE, NO EVIDENCE OF MALIGNANCY.
FINAL MARGIN FREE OF TUMOR.

G. "ANTERIOR SKIN" (BIOPSY):

SKIN AND SUBCUTANEOUS TISSUE, NO EVIDENCE OF MALIGNANCY.
FINAL MARGIN IS NEGATIVE FOR MALIGNANCY.

I certify that I personally conducted the diagnostic evaluation of the above specimen(s) and have rendered the above diagnosis(es).

[redacted]

Electronically signed: [redacted]

ADDENDUM 1:
Please see for results of supplementary tests.

I certify that I personally conducted the diagnostic evaluation of the above specimen(s) and have rendered the above diagnosis(es).

Electronically signed: [redacted]

Performed by: [redacted]