PATIENT HISTORY:

Electronic medical record: previous left thyroid lobectomy for benign disease (not reviewed). Thyroid nodule was found incidentally on a CT scan performed for pneumonia. Family history of thyroid nodules, goiter, and Hashimoto thyroiditis. No risk factors for thyroid malignancy (no history of head and neck radiation).
CHIEF COMPLAINT/PRE-OP/POST-OP DIAGNOSIS: Thyroid nodule
PROCEDURE: Not answered
SPECIFIC CLINICAL QUESTION: Not answered
OUTSIDE TISSUE DIAGNOSIS: Not answered
PRIOR MALIGNANCY: Not answered
CHEMOTHERAPY: Not answered
ORGAN TRANSPLANT: Not answered
IMMUNOSUPPRESSION: Not answered
OTHER DISEASES: Not answered

ICD-O-3
Carcinoma, papillary, follicular variant 8340/3
Site: thyroid, NOS C73.9 hw 11/27/11

FINAL DIAGNOSIS:

THYROID GLAND, RIGHT LOBE AND ISTHMUS, COMPLETION LOBECTOMY (26 GRAMS) -

- **A. ENCAPSULATED PAPILLARY THYROID CARCINOMA (3.0 CM), FOLLICULAR VARIANT, CONFINED TO THE RIGHT THYROID LOBE (See comment).**
- **B. INVASION INTO TUMOR CAPSULE AND VASCULAR INVASION ARE ABSENT.**
- **C. MARGINS ARE FREE OF CARCINOMA.**
- **D. MULTINODULAR THYROID.**
- **E. PARATHYROID TISSUE IS ABSENT.**
- **F. C-CELL HYPERPLASIA (See comment).**
- **G. PATHOLOGIC STAGE T2.**

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COMMENT:

Molecular studies were previously performed on the right thyroid fine needle aspiration material and demonstrated PAX8/PPARg rearrangement. PPARg immunostain was done on the current material and is positive.

Incidentally, there are areas of C-cell hyperplasia. C-cell hyperplasia may be seen in a variety of reactive, physiologic and neoplastic (sporadic and hereditary) conditions. There are no histologic features that reliably distinguish reactive C-cell hyperplasia from neoplastic C-cell hyperplasia. Most cases are not neoplastic, but if clinically appropriate, further workup (family history, serum calcitonin, RET mutation screening) may be more definitive.

MICROSCOPIC:

Immunohistochemical stains were focally positive for Galectin-3 and PPAR gamma. Immunohistochemical stain was negative for HBME-1. Positive calcitonin and CEA confirm the presence of C-cell hyperplasia.

The following statement applies to all immunohistochemistry, insitu hybridization (ISH & FISH), molecular anatomic pathology, and immunofluorescence testing:

The testing was developed and its performance characteristics determined by the , as required by the CLIA '88 regulations. The testing has not been cleared or approved for the specific use by the U.S. Food and Drug Administration, but the FDA has determined such approval is not necessary for clinical use. Tissue fixation ranges from a minimum of 2 to a maximum of 84 hours.

This laboratory is certified under the Clinical Laboratory Improvement Amendments of 1988 ("CLIA") as qualified to perform high-complexity clinical testing. Pursuant to the requirements of CLIA, ASR's used in this laboratory have been established and verified for accuracy and precision. Additional information about this type of test is available upon request.

CASE SYNOPSIS:

SYNOPTIC DATA - PRIMARY THYROID TUMORS

SPECIMEN TYPE:	Other: Completion lobectomy, right
TUMOR SITE:	Right Lobe
TUMOR FOCALITY:	Unifocal
TUMOR SIZE (largest nodule):	Greatest Dimension: 3 cm
HISTOLOGIC TYPE:	Papillary carcinoma, follicular variant
PATHOLOGIC STAGING (pTNM):	pT2 pNX pMX
MARGINS:	Margins uninvolved by carcinoma
VENOUS/LYMPHATIC (LARGE/SMALL VESSEL) INVASION (V/L):	Absent
ADDITIONAL PATHOLOGIC FINDINGS:	None Identified

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 / Date Reviewed: 11/27/11		

hw 11/27/11