***** please note that the operation date in the medical record and the date that tumor was collected for the study are the same but the date in the pathology report was The name of patient, DOB, and the MRN in the path report are correct and there is no other path report for this patient. The content in path report corresponds to the content in the operative report (in term of resected specimen sent to pathology. *****

ICD-O-3
Carcinoma, squamous cell NOS 8070/3
Site ⓒ Tonsil C09.9
QW 8/9/13

CASE: RECEIVED:

CLINICAL DATA:
This is a -year-old man with a clinical history of left tonsil tumor. Procedure is a left common TC resection with left radial F.F.

GROSS DESCRIPTION:
A) Received in formalin designated "left neck dissection DL level III, DS level II" is a 9 cm x 2.8 cm x 1.5 cm yellow fibrofatty tissue with two long sutures on one side designated as superior surface , and two short sutures on one side designated as inferior portion . There are no apparent masses identified. The specimen is separated in the mid portion. The superior portion represents leveI II soft tissue, while the inferior portion represents level III soft tissue. There are multiple lymph nodes identified. Representative sections are submitted as follows: A1, A2 - level II lymph nodes (A1- twelve (12) potential lymph nodes, A2- two (2) potential lymph nodes), A3, A4 - level III lymph nodes (A3- thirteen (13) potential lymph nodes and A4 - three (3) potential lymph nodes).

B) Received in formalin designated "left level IA" are two tissue irregular soft yellow fatty tissue, measuring 2.0 x 1.0 x 0.9 cm and 1.0 x 0.5 x 0.4 cm in greatest dimensions. There are four potential lymph nodes identified. All are submitted in cassette B1.

C) Received fresh designated "composite resection" is an irregular piece of soft tissue and bone, measuring 7.0 x 6.0 x 4.0 cm in greatest dimension. The bone is grossly consistent with a portion mandible, including part of the ramus and posterior part of the body. On the medial aspect of the bone, there is a irregular soft tissue partially covered with pink mucosa. On the anteroinferior aspect, a round lobule of normal appearing salivary gland is seen. Located in the center, there is an irregular ulcer identified, measuring 3.5 cm (anteroposterior plane) x 3 cm (superoinferior plane) x 1.3 cm (mediolateral plane). The ulcer extends to within 0.5 cm of the anterior mucosal margin, 0.8 cm of the superolateral margin, 1.0 cm of the posterior margin and 0.3 cm of the inferomedial resection margins. No apparent intact tonsil is identified. The attached salivary gland measures 3 x 1.9 x 1.5 cm in maximal dimension and appears grossly unremarkable. The soft tissue margins are composed predominantly of irregular tissue including muscle and connective tissue as well as occasional fat. The tumor is not identified on the surgical margins. There appears to be a small hemorrhagic polyp that is 0.4 cm x 0.3 cm extending off of the posterolateral surface of the tonsil. No other gross abnormalities are identified. The specimen is inked as follows: Anterior soft tissue margin - blue, inferomedial soft tissue margin - yellow, posterior soft tissue margin - black, and superolateral soft tissue margin - orange. Serial sections of the specimen demonstrate grayish white, firm tumor mass extending to within approximately 0.3 cm of the inferior

(yellow) soft tissue margin, 0.7 cm from the superolateral (orange), and 0.1 cm of the anterior soft tissue margin.

Representative sections are submitted as follows: C1, C2 - anterior resection margin (perpendicular to the inked margin); C3, C4 - one complete cross section of the tumor (C3 is inferior to C4); C5, C6 - one complete cross section of the tumor (posterior to C3 and C4; C5 is inferior to C6); C7, C8 and C11 - posterior resection margin (perpendicular to the inked margin; C7 is superior to C8); C9 - salivary gland; C10 - cross section of the mandible (tissue submitted for decalcification).

D) Received in formalin designated "left level III" is one piece of fatty tan-brown tissue measuring 1.2 x 1.2 x 1.3 cm. One potential lymph node is identified, serially sectioned, and submitted entirely in D1.

E) Received in formalin designated "level V node" is a single tan and yellow 1.7 x 1.3 x 0.9 cm piece of tissue. Five potential lymph nodes are identified and are submitted in E1.

FINAL DIAGNOSIS:
A) Lymph nodes, designated left neck dissection (level II and III), excision: Metastatic carcinoma to one of 26 lymph nodes (1/11 level II lymph nodes and 0/15 level III lymph nodes).
No evidence of extracapsular soft tissue extension.

B) Lymph nodes, designated left, level IA , excision: No evidence of metastatic carcinoma in 4 lymph nodes (0/4).

C) Tonsillar bed, portion of mandible and salivary gland, left, composite resection:
Invasive squamous cell carcinoma, with the following features:
1. Size: 3.5 cm in greatest dimension.
2. Moderately differentiated.
3. Carcinoma invades the underlying skeletal muscle, with very focal invasion of minor salivary gland tissue; the submandibular salivary gland is free of carcinoma.
4. Foci of angiolymphatic and perineural space invasion are identified.
5. The inked surgical margins are free of carcinoma. See comment. Invasive carcinoma extends to within 0.1 cm of the anterior soft tissue resection margin (C2), 0.1 cm of the cauterized inferomedial soft tissue resection margin (C3),0.2 cm of the deep soft tissue resection margin (C1), 0.4 cm of the posterior soft tissue mucosal resection margin (C11), and 0.9 cm of the superolateral soft tissue resection margin (C6).
6. No gross bony invasion is identified; pending decalcification.
7. No gross involvement of bony margins is seen; pending decalcification.
8. See comment.

D) Soft tissue, designated left, level III , excision: Benign fibroadipose tissue; no lymph nodes are identified.

E) Lymph nodes, designated level V , excision: No evidence of metastatic carcinoma in 5 lymph nodes (0/5).

COMMENT:

Carcinoma approximates inked margins in C7 and C8, however, on correlation with gross appearance these foci are interpreted as tissue tear-distortion with ink run-off and not as true inked margins.

The minimal pTNM classification is pT2, pN1, pMx (AJCC staging manual, 6th edition, 2002). Assessment of bony invasion and bony margins is currently pending (decalcification). The results will be reported as addendum.

Procedures used to establish the diagnosis:
Submit tissue for decalcification

ADDENDUM REASON:
This addendum is issued to report the histologic findings in the decalcification specimens. Additional representative bony margins are submitted in cassettes C12 and C13. The overall diagnosis remains unchanged.

ADDENDUM FINAL DIAGNOSIS:
A) Lymph nodes, designated left neck dissection (level II and III), excision:
Metastatic carcinoma to one of 26 lymph nodes (1/11 level II lymph nodes and 0/15 level III lymph nodes).
No evidence of extracapsular soft tissue extension.

B) Lymph nodes, designated left, level IA , excision: No evidence of metastatic carcinoma in 4 lymph nodes (0/4).

Tonsillar bed, portion of mandible and salivary gland, left, composite resection:
Invasive squamous cell carcinoma, with the following features:
Size: 3.5 cm in greatest dimension.
Moderately differentiated.
Carcinoma invades the underlying skeletal muscle, with very focal invasion of minor salivary gland tissue; the submandibular salivary gland is free of carcinoma.
Foci of angiolymphatic and perineural space invasion are identified.
The inked surgical margins are free of carcinoma. See comment. Invasive carcinoma extends to within 0.1 cm of the anterior soft tissue resection margin(C2), 0.1 cm of the cauterized inferomedial soft tissue resection margin (C3),0.2 cm of the deep soft tissue resection margin (C1), 0.4 cm of the posterior soft tissue mucosal resection margin (C11), and 0.9 cm of the superolateral soft tissue resection margin (C6).
No bony invasion is identified.

Bone margins with cellular marrow exhibiting trilineage maturation; no evidence of carcinoma.

D) Soft tissue, designated left, level III , excision: Benign fibroadipose tissue; no lymph nodes are identified.

E) Lymph nodes, designated level V , excision: No evidence of metastatic carcinoma in 5 lymph nodes (0/5).

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:	

LW. 7/29/13