SURGICAL PATHOLOGY

[redacted]

Surgical Pathology Report
Diagnosis:
A: Left tonsil, anterior margin, biopsy.
- No tumor seen.

B: Left tonsil, posterior margin, biopsy.
- No tumor seen.

C: Left tonsil, superior margin, biopsy.
- No tumor seen.

D: Left tonsil, inferior margin, biopsy.
- No tumor seen.

E: Left tonsil, deep superior margin, biopsy.
- No tumor seen.

F: Left tonsil, deep inferior margin, biopsy.
- No tumor seen.

G: Left tonsil, excision of tumor.
- Invasive poorly differentiated squamous cell carcinoma with overlying surface squamous cell carcinoma in situ, tumor size 1.6 cm in greatest dimension, involving lateral and inferior surgical margins of this specimen (these positive specimen margins may be superseded by the frozen sections).

H: Uvula, excision.
- No tumor seen.

I: Lymph nodes, left neck Level I, excision.
- No tumor seen in four lymph nodes (0/4).
- Submandibular gland present with no tumor seen.

J: Lymph nodes, left neck Level II, excision.
- Submandibular gland present with no tumor seen.
- No lymph nodes present in this specimen, specimen was submitted entirely for pathologic evaluation.

K: Lymph nodes, left neck Level III, excision.
- No tumor seen in one lymph node (0/1), the majority of the specimen is benign adipose tissue, specimen was submitted entirely for pathologic evaluation.

L: Lymph nodes, left neck Level IV, excision.
- Metastatic poorly differentiated squamous cell carcinoma in 2 of 6 lymph nodes (the positive nodes may each represent a mass of matted noes), size of largest node/matted node is 2.9 cm in greatest dimension, with extracapsular extension of tumor identified.

M: Lymph nodes, left neck Level V, excision.
- Metastatic poorly differentiated squamous cell carcinoma in 2 of 14 lymph nodes (the largest involves node may actually be a mass of matted nodes), size of largest metastasis 1.6 cm in greatest dimension, with extracapsular extension of tumor identified.

Intraoperative Consult Diagnosis:
Intraoperative consultation was requested by Dr.

FSA1: Left tonsil, anterior margin, biopsy
- Negative for carcinoma

FSB1: Left tonsil, posterior margin, biopsy
- Negative for carcinoma

FSC1: Left tonsil, superior margin, biopsy
- Negative for carcinoma

FSD1: Left tonsil, inferior margin, biopsy
- Negative for carcinoma

FSE1: Left tonsil, deep superior margin, biopsy
- Negative for carcinoma

FSF1: Left tonsil, deep inferior margin, biopsy
- Negative for carcinoma

Frozen Section Pathologist:

Clinical History:
left tonsil, poorly differentiated invasive squamous cell carcinoma.

Gross Description:
Specimen A is received fresh for frozen section and is a 0.5 x 0.4 x 0.3 cm red/tan soft tissue fragment, which is totally submitted as FSA1, NTR.

Specimen B is received fresh for frozen section and is a 1 x 0.4 x 0.3 cm red/tan soft tissue fragment, which is totally submitted as FSB1, NTR.

Specimen C is received fresh for frozen section and is a 0.7 x 0.3 x 0.2 cm fatty pink/tan soft tissue fragment, which is totally submitted as FSC1, NTR.

Specimen D is received fresh for frozen section and is a 0.6 x 0.5 x 0.2 cm fatty pink/tan soft tissue fragment, which is totally submitted as FSD1, NTR.

Specimen E is received fresh for frozen section and is a 1.3 x 0.3 x 0.2 cm red/tan soft tissue fragment, which is totally submitted as FSE1, NTR.

Specimen F is received fresh for frozen section and is a 0.3 x 0.2 x 0.2 cm red/tan soft tissue fragment, which is inked black and totally submitted as FSF1, NTR.

Specimen G is received in formalin. The specimen label states "left tonsil, stitch superior" and consists of an 8.8 gram 4.3 x 2.5 x 0.8 cm segment of left tonsil. The overlying mucosa has a 2.3 cm x 0.5 cm central defect with underlying tan/brown soft tissue. There is a long suture, indicating superior. The specimen is inked as follows: superior blue, inferior black, medial red, lateral yellow, deep green. On cut section, there is a diffuse tan/white thickening and nodular area consistent with probable tumor. This measures 1.3 x 1.2 x 2.3 cm. A portion of normal and tumor is given to tissue procurement. Full thickness cross sections are submitted as G1-G4. Perpendicular sections of the blue inked superior margin are submitted as G5 and G6. Perpendicular sections of the black inked inferior margin are submitted as G7 and G8. The specimen is entirely submitted, NTR.

Specimen H is received in formalin. The specimen label states "uvula" and consists of an unremarkable edematous 2.1 x 0.8 x 0.5 cm pink/tan soft tissue fragment, which is bisected to reveal a soft edematous pink/tan cut surface. The specimen is entirely submitted as H1, NTR.

Specimen I received is one appropriately labeled container with the specimen is received in formalin. The specimen label states "left neck Level I". The specimen consists of a 5.4 x 4.0 x 1.4 cm fatty soft tissue fragment. There is an ill-defined 4.5 x 2.0 x 1.3 cm submandibular gland with a tan external surface and a tan cut surface is grossly unremarkable. There are a few small lymph node candidates palpated in the remainder of the specimen. A representative section of submandibular gland is submitted as I1. The remainder of the adjacent fatty soft tissue is submitted as I2-I6.

Specimen J received is one appropriately labeled container with the specimen is received in formalin. The specimen label states "left neck LN Level II". The specimen consists of a 5.2 x 4.1 x 0.5 cm fatty soft tissue fragment. A few small lymph node candidates are palpated. A 2.1 x 0.5 x 0.5 cm portion of possible submandibular gland is included in this specimen. This is submitted as J1. The specimen is entirely submitted as J1-J10, NTR.

Specimen K received is one appropriately labeled container with the specimen received in formalin. The specimen label states "left neck LN Level III". The specimen consists of a 4.5 x 3.3 x 0.5 cm fatty soft tissue fragment. A few small lymph node candidates are palpated. The specimen is entirely submitted as K1-K9, NTR.

Specimen L received is one appropriately labeled container with the specimen received in formalin. The specimen label states "left neck LN Level IV". The specimen consists of a 4.8 x 4.2 x 1.5 cm fatty soft tissue fragment. Within the specimen is a 2.5 x 2.0 x 1.5 cm tan-brown cystic structure. The specimen has yellow clear fluid on cut section as well as variable yellow-tan areas. A representative section is submitted as L1 and L2. There is an additional 2.1 x 1.0 x 0.8 cm variably solid and cystic lymph node as well this is submitted as L3. The remainder of the specimen is submitted as L4-L8.

Specimen M received is one appropriately labeled container with the specimen received in formalin. The specimen label states "left neck LN Level V". The specimen consists of a 5.2 x 3.5 x 0.8 cm fatty soft tissue fragment. A few small lymph node candidates are palpated. In addition there is a 2.3 x 1.0 x 0.5 cm cystic area with hemorrhagic fluid. This specimen is bisected and submitted as M1. The remainder of the specimen is submitted as [redacted] NTR.

Grossing Pathologist
Light Microscopy:
Light microscopic examination is performed by Dr.

Signature
Resident Physician:
Attending Pathologist: I have personally conducted the evaluation of the above specimens and have rendered the above diagnosis(es).