ICD-0-3
Carcinoma, squamous cell NOS 8070/3
Site Tonsil NOS C09.9
JW 8/9/13

CASE: RECEIVED:

CLINICAL DATA:
Squamous cell carcinoma composite resection.

GROSS DESCRIPTION:
A) Received in formalin as right upper level 2 node is a 3.2 x 1.9 x 0.5 cm firm lobular piece of tan soft tissue. Sectioning reveals a mixed tan and hemorrhagic parenchyma consistent with lymph node with one pole that has a solid uniform white appearance. The specimen is sectioned and submitted entirely in cassettes A1 - A3.

B) Received in formalin as left lowest cervical node is a 0.7 cm greatest dimension firm tan nodule surrounded by small amounts of fibrofatty tissue. Sectioning reveals a uniformly tan parenchyma. The bisected specimen is submitted entirely in cassette B1.

C) Received fresh as left neck dissection is an unoriented complex 10 x 8 x 3 cm specimen consisting of muscle and fibrofatty tissue and a large vein. It is divided into levels 2 - 5. Anteriorly and immediately adjacent to a major vein is a 7 x 4 x 3 cm white mass that is 80-90% necrotic grossly and is present throughout levels 2 - 4. Very little of the mass appears viable. It lies next to a major vein but does not appear to invade the lumen of the vessel grossly. Multiple nodules are dissected from each level and submitted entirely. Cassette summary: C1 - C4 - 7 cm necrotic mass with relation to vessel - level 2; C5 - five level 2 nodules; C6 - three level 2 nodules; C7 - three level 2 nodules; C8 - C9 - two level 3 nodules in each; C10 - four level 4 nodules; C11 - two level 5 nodules; C12 - five level 5 nodules; C13 - three level 5 nodules; C14 - five level 5 nodules.

D) Received fresh as left level 1 is a 4 x 2.5 x 1.5 cm aggregate of tan/yellow soft tissue that has a minimally lobular appearance. It is diffusely thick and firm. No definite lymph nodes are identified. Representative sections are submitted in D1 - D5 (approximately 75% submitted).

E) Received in formalin as proximal lingual nerve is a 0.5 cm irregular shaped piece of tan-white tissue with a minimally exophytic appearance on one surface. The entire specimen is submitted in cassette E1.

F) Received in formalin as left sublingual gland is a 4.5 x 2 x 1 cm tan lobular piece of soft tissue. Sectioning reveals approximately half the specimen is composed of a lobular tan tissue consistent with salivary gland. At one end is a 1.6 cm firm nodule composed of similar lobular tan tissue. The entire specimen is submitted in F1 - F4.

G) Received fresh as left tonsil mass is an ovoid piece of red soft tissue with a pink shiny mucosal surface measuring 4.6 x 3.5 x 2.2 cm consistent with tonsil. At one pole the structure is a short stitch designated inferior. Attached to this is a 4.5 x 3 x 0.5 cm triangular piece of red soft tissue that appears to be skeletal muscle with a suture designating medial pterygoid. The medial edge of the tonsil is inked blue and lateral black. In the center of the mucosa is a 1.5 cm ovoid hole that appears to contain a yellow-tan exophytic mass. Sectioning reveals a 4.5 x

3.5 x 2 cm mass grossly extending through the majority of the specimen. The medial pterygoid muscle does not appear to be involved. Grossly the mass extends to medial margin and is less than 0.1 cm from the lateral margin at the inferior tip. The mass grossly approaches both lateral and medial margins within 0.1 cm at the superior tip. The inferior and superior tips are sectioned perpendicularly then into parallel sections.
Cassette summary: G1-G2 - inferior tip; G3-G4 - superior tip; G5-G8 - complete cross sections from medial to lateral direction from inferior to superior pole (one complete cross section in G6 -G7 and G8-G9); G10 - representative skeletal muscle.

H) Received in formalin as left level 5 lymph node is a 3 x 2 x 1 cm aggregate of fibrofatty tissue containing approximately nine nodules ranging from 0.3 to 1.1 cm. Three nodules are submitted in each cassette: H1 - H3.

I) Received in formalin as left low level 4 node is a 2 x 1.5 x 0.5 cm aggregate of tan fibrofatty tissue containing two nodules measuring 0.2 and 1.3 cm. The entire specimen is submitted in cassettes I1 - I2 (I1 one intact and one bisected nodule).

J) Received in formalin as left facial node is a 1.2 cm greatest dimension firm tan nodule that is submitted entirely in cassette J1.

FINAL DIAGNOSIS:
A) Lymph node (right upper level 2 node), biopsy: There is no evidence of malignancy in one lymph node (0/1).

B) Lymph node (left lowest cervical node), biopsy: There is no evidence of malignancy in one lymph node (0/1).

C) Lymph node (left neck) dissection:
Level II: Squamous cell carcinoma involving matted lymph nodes with extensive extracapsular spread measuring 7 cm in greatest extent. Fifteen additional
level II nodes with no evidence of malignancy.
Level III: No evidence of malignancy in four lymph nodes (0/4).
Level IV: No evidence of malignancy in six lymph nodes (0/6).
Level V: No evidence of malignancy in twelve lymph nodes (0/12).

D) Labeled left level 1 : Seromucinous salivary gland with no diagnostic abnormality including no evidence of malignancy.

E) Labeled proximal lingual nerve : Peripheral nerve with no evidence of malignancy.

F) Labeled left sublingual gland : Seromucinous salivary gland and peripheral nerve with no diagnostic abnormality including no evidence of malignancy.

G) Labeled left tonsil mass :
1. Squamous cell carcinoma, moderately to poorly differentiated, invasive of tonsil and adjacent pharyngeal skeletal muscle.
2. Size: 4.5 x 3.5 x 2.0 cm
3. Margins: Inked margins are free of malignancy. Carcinoma measures <0.1 cm (<1 millimeter) from the blue inked inferomedial soft tissue margin.
4. Medial pterygoid muscle appears free of malignancy.

5. Consistent with pathological stage pT3, pN3, MX.

H) Lymph node (left level 5 lymph node), biopsy: No evidence of malignancy in ten lymph nodes (0/10).

I) Lymph node (left low level 4 node), biopsy: No evidence of malignancy in three lymph nodes (0/3).

J) Lymph node (left facial node), biopsy: No evidence of malignancy in one lymph node (0/1).

Procedures used to establish the diagnosis:
Routine

Per TSS diagnostic discrepancy form, TCGA tumor is squamous cell carcinoma, basaloid type

Criteria	JW 7/29/13	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	Date Reviewed: 7/29/13		

TCGA Pathologic Diagnosis Discrepancy Form 4.05

Study Subject ID:			**Person ID:**	N/A
Study/Site:	TCGA Head and Neck squamous cell carcinoma - squamous cell carcinoma)	(Head and Neck	**Age:**	N/A
Event:	PathDiscrepancy		**Date of Birth:**	
Interviewer:			**Sex:**	M

Tumor Identifier Provided on Initial Case Quality Control Form		Provide the tumor identifier documented on the initial case quality control form for this case.
Pathologic Diagnosis Provided on Initial Pathology Report	moderately to poorly differentiated squamous cell carcinoma	Provide the diagnosis/ histologic subtype(s) documented on the initial pathology report for this case. If the histology for this case is mixed, provide all listed subtypes.
Histologic features of the sample provided for TCGA, as reflected on the CQCF	Head & Neck squamous cell carcinoma Basaloid type	Provide the histologic features selected on the TCGA Case Quality Control Form completed for this case.

Discrepancy between Pathology Report and Case Quality Control Form

Provide the reason for the discrepancy between the pathology report and the TCGA Case Quality Control Form	The use of basaloid type for head and neck cancer was not in use back at the time of this case being accessioned	Provide a reason describing why the diagnosis on the initial pathology report for this case is not consistent with the diagnosis selected on the TCGA Case Quality Control Form.
Name of TSS Reviewing Pathologist or Biorepository Director		Provide the name of the pathologist who reviewed this case for TCGA.