IRD-0-3
Carcinoma, squamous cell, NOS 8070/3
Site Code Cervix, NOS C53.9 12/29/10 mr

OF SURGICAL PATHOLOGY

Name: [redacted]
Address: [redacted]
MR No.:
Service: GYNECOLOGY
Surgeon: [redacted]

Surg. Path. No.: [redacted]
DOB: [redacted]
Sex/Race: F UNKNOWN
Location:
Hosp. No.: [redacted]
Taken/Received: [redacted]

DIAGNOSIS

UTERUS, CERVIX, BIOPSY - INVASIVE SQUAMOUS CELL CARCINOMA

[redacted]

By this signature, I attest that the above diagnosis is based upon my personal examination of the slides (and/or other material indicated in the diagnosis), and that I have reviewed and approved this report.

[redacted]

[redacted]

SPECIMEN(S) SUBMITTED

CERVIX

HISTORY

The patient is a year old woman who has a high grade squamous lesion on a PAP smear of Operative procedure: Cervical biopsy.

GROSS

The specimen is received in a container of formalin, labelled with the patient's name and "cervical biopsy." It consists of multiple soft, friabl fragments of tan to tan-brown tissue that in aggregate measure 1.1 x 0.6 x 0.3 cm. The largest tissue fragment has a greatest dimension of 0.3 cm. Wrapped in tissue paper. Jar 0.

COMMENT

Sections show a well differentiated invasive squamous cell carcinoma. Focal areas of keratinization are present. A prominent eosinophilic infiltrate accompanies the tumor.

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TCGA-C5-A1BF-01B-PR Redacted

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 [redacted] Date Reviewed: 12/29/10		