ICD-O-3
Carcinoma, infiltrating ductal, NOS 8500/3
Site: breast, NOS C50.9 1/24/11 lw

UUID:24D42292-B875-4FAF-8C3A-9834414C3A01
TCGA-A2-A04T-01A-PR Redacted

PATHOLOGY REPORT

Patient:
FMP/SSN:
DOB/Age/Sex:
Location:
Physician(s):

Race: **WHITE**

Specimen #:
Taken:
Received:
Reported:

SPECIMEN:
A: SENTINEL LYMPH NODE #1 B: SENTINEL LYMPH NODE #2
C: LEFT BREAST TISSUE

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FINAL DIAGNOSIS:

A. SENTINEL LYMPH NODE #1, LEFT AXILLA, EXCISION:
- TWO LYMPH NODES, NEGATIVE FOR METASTATIC CARCINOMA BY HEMATOXYLIN AND EOSIN AND IMMUNOHISTOCHEMICAL STAINING.

B. SENTINEL LYMPH NODE #2, LEFT AXILLA, EXCISION:
- ONE LYMPH NODE, NEGATIVE FOR METASTATIC CARCINOMA BY HEMOTOXYLIN AND EOSIN AND IMMUNOHISTOCHEMICAL STAINING.

C. BREAST, LEFT, EXCISIONAL BIOPSY:
- POORLY-DIFFERENTIATED ADENOCARCINOMA CONSISTENT WITH INFILTRATING DUCTAL CARCINOMA, HIGH GRADE (SEE COMMENT).
- TUMOR SIZE = 2.2 CM.
- THE TUMOR IS ONE CENTIMETER FROM THE SUPERIOR POSTERIOR AND SUPERIOR ANTERIOR MARGINS OF RESECTION.
- BIOPSY SITE CHANGES.
- FIBROCYSTIC CHANGES.

COMMENT:
This tumor was graded using the modified Bloom and Richardson scheme with a score as follows: mitoses = 3, tubules = 3, nuclei - 3; for a total score of 9/9, high grade. No in situ carcinoma is identified.

** Report Electronically Signed Out **

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CLINICAL DIAGNOSIS AND HISTORY:
-year-old white female with left infiltrating ductal carcinoma of breast.

SURGICAL PATHOLOGY REPORT

Patient:

Specimen #:

PRE-OPERATIVE DIAGNOSIS:
Left breast cancer.

POST-OPERATIVE DIAGNOSIS:
Left breast cancer.

GROSS DESCRIPTION:
A. The specimen is received in formalin, labeled with the patient's name, is designated as "SENTINEL LYMPH NODE #1". It consists of multiple fragments of pink to yellow/tan, irregularly shaped tissue, which measure 2.5 x 2.0 x 1.0 cm in loose aggregate. The specimen is submitted entirely. 1CF

B. The specimen is received fresh, labeled with the patient's name, and is designated as "SENTINEL LYMPH NODE #2". It consists of a 3.5 x 2.5 x 1.3 cm piece of fatty tissue containing a 2.5 x 1.3 x 1.2 cm lymph node. The node is bisected, revealing extensive fat infiltration. One half of the node is submitted for CBCP protocol; the remaining half is submitted for paraffin section in cassette B2. 2CF

C. The specimen is received fresh, labeled with the patient's name, and is designated "LEFT BREAST TISSUE - ONE STITCH MEDIAL, TWO STITCHES SUPERIOR, THREE STITCHES ANTERIOR". It consists of a 210 gm portion of fatty tissue,which measures 11.5 x 8.5 x 2.7 cm. The specimen is oriented with sutures (long single medial, two stitches superior, three stitches anterior). Ink code: blue superior posterior, orange, superior anterior, black inferior posterior, green inferior anterior. Sectioning reveals a well circumscribed, slightly lobulated tan tumor in the lateral portion of the specimen, measuring 2.2 x 1.8 x 1.5 cm. On cut section, the tumor has a centrally placed hemorrhage filled cavity, consistent with prior biopsy. The tumor is at least 1.0 cm from the near margin (black, orange). The remaining tissue is predominantly fatty with a 1.0 cm area of fibrous tissue punctuated with yellow flecks about 3.0 cm medial to the tissue abutting the green inked margin. Multiple sections are submitted for CBCP protocol with matching paraffin sections as follows:

C1: grossly normal fibrofaty tissue, approximately 5.0 cm medial to tumor.
C2: fibrous area with yellow flecks.
C3: tumor.
C4: tumor.

Additional sections are submitted.

C5 and C6: lateral margin.

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SURGICAL PATHOLOGY REPORT

Patient:

Specimen #:

GROSS DESCRIPTION (continued):

C7: section adjacent to C4.
C8 and C9: well defined mass in section medial to section containing C4 and C7.
C10-C15: fibrous areas submitted lateral to medial.
C16 and C17: medial margin. 17CF

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:	

End of Report