با نام پروردگار
تومور برد مرکز تحقیقات سرطان
CRC
آبان ۱۴۰۰
پیمار خانم ۴۰ ساله متاهل، بدون سابقه خانوادگی بیماری‌های پستان که از دی ماه ۹۹ با شکایت لمس توده و سفتی بافت پستان همراه با یوست قرمز و گرم به همکار جراح در همدان مراجعه می‌کند و در تشخیص آبیسه پستان تحت قرار می‌گیرد.
پاتولوژی:
FCC with active chronic inflammation, florid ductal hyperplasia
P-1657-99
SURGICAL PATHOLOGY REPORT

SPECIMEN: Breast mass resection, side is not specified
CLIN. DATA: Work up breast mass

MACROSCOPIC:
Specimen received in fixative solution including breast mass; consists a piece of yellowish elastic fibrofatty tissue measuring (2x1x0.8 cm), on section cream-whitish, elastic area with fibrocystic pattern is obvious. Totally specimen submitted in one block

MICROSCOPIC:
Microscopic observation of serial sections preparation revealing mammary parenchyma with fibrocystic changes including cystic ducts, ductal hyperplasia without atypia, glandular adenosis, and sclerosing adenosis that all of them composed of epithelial and myoepithelial layers without atypical cytoarchitectural feature.

DIAGNOSIS:
Breast mass resection, side is not specified:
- Fibrocystic changes of breast parenchyma with active chronic inflammation, florid usual ductal hyperplasia and sclerosing adenosis
- Evidences of malignancy is not seen in this specimen
- Evidences of granulomatous inflammation in favor of lobular granulomatous mastitis is not seen in this specimen.
شروع درمان با ۵۰ میلی گرم پردونیزولون و مراجعه به کلینیک پستان مرکز تحقیقات و تایید تشخیص از نظر کلینیکال مبنا بر IGM و ادامه درمان با کورتون که در پیگیری همراه با کاهش علائم که منجر به درمان با ۱۲.۵ میلی گرم پردونیزولون شد و در ارتباط‌های ۱۴۰۰ با taper بزرگی و شعله ور شدن مجدد علائم و با توجه به معانی بالینی تصمیم به بررسی مجدد و core bx و گرفته شد.
با توجه به معاینه بالینی و نتیجه بیوبیسی و تشخیص کارسینوم پستان چپ، جهت بیماری کمترایی نفوذ جوانت و inflammatory plan جهت بیماری MRM گذاشته شده.
توموز برد آبیان

1400

اسلام وقت

اسام رحیم
Adobe Reader Updater has not been able to check for updates recently.
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خانم ۵۰ ساله خرداد ۱۳۹۸ با شکایت توده پستان چپ مراجعه داشته و با تشخیص جهت نتایج جراحات ارجاع می‌شود IDC

انجام می‌شود BCS + ALND

۸ جلسه نتایج جراحات شده و سپس جراحی
PATHOLOGY REPORT

Clinical data
Pre-operative neoadjuvant chemotherapy has been performed for left breast cancer

Specimen
1- Left breast upper inner quadrant mass, lumpectomy, in fresh state for intra-operative pathology consult
2- Left breast mass superior margin re-excision, in formalin
3- Left breast mass deep margin re-excision, in formalin
4- Left axillary lymph nodes, dissection, in formalin

Macroscopy
Received specimens labeled as above in four containers (all samples and the specimens were transferred into 10% buffered formalin in lab, and the samples were fixed overnight with cold ischemia time of less than 1hr) and consist respectively as follows:
1- Part of breast tissue without skin or nipple, or skeletal muscle strip attached, and the following gross description:
   • Size and description of specimen: Breast tissue measures 7x6.5x4 cm, marked by single, double and triple stitches at medial, superior and superficial margins, respectively. There are multiple irregular areas of fibrosis in different parts of the specimen without definite mass lesion.
   • Distance of suspicious fibrotic areas from surgical margins grossly: Superior margin = 0.1 cm; Inferior margin = 1.5 cm; Medial margin = 1.5 cm; Lateral margin = 1.3 cm; Superficial margin = 1.3 cm; Deep margin = 0.1 cm;
   • Description of blocks: Suspicious fibrotic areas: A1-4: Superior (inked black) and inferior (inked green) margins: A5: Medial (inked black) and lateral (inked green) margins: A6: Superficial (inked black) & deep (inked green) margins: A7: Repeated superficial margin (inked green): A8: FS1: Deep margin; FS2: Superior-superficial margin (FS= frozen section)

Frozen section diagnosis: The deep margin and superior-superficial margins intercept are very close to DCIS (much less than 0,1cm away); other surgical margins are free

2- A piece of fatty tissue measuring 3.5x3x2 cm, containing a fibrotic area with maximum diameter of 1 cm, marked by single stitch at one aspect as the surgical margin, and separated piece of skin tissue measuring 3x1.5x0.5 cm: B1= Fibrotic lesion; B2= Margin; B3= Separated skin tissue
3- A piece of fatty tissue measuring 4.5x4x1.5 cm, marked by single stitch at one aspect as the surgical margin; SOS 1/1; & C
4- Multiple fatty tissue pieces totally measuring 7x5x2 cm, containing 9 lymph nodes, 0.5-2.5 cm, embedded totally in six blocks: D1,2= One lymph node slice; D3= One lymph node slice; D4= One lymph node slice; D5,6= Other lymph nodes

Microscopy
See the diagnosis please.
Dx:

1. Left breast upper inner quadrant mass, lumpectomy (FS/PS):
   - A single focus of invasive ductal carcinoma NOS, besides multiple foci of high-grade comedo type ductal intra-epithelial neoplasia (DIN); DCIS nuclear grade 3
   - Maximum diameter of invasive carcinoma: 0.2 cm
   - Histologic grade according to Nottingham system: Grade II/III (Tubule formation: 3, Nuclear grade: 3, Mitotic activity: 1; Total score: 7/9)
   - Extensive lymph-vascular invasion is identified in multiple sections examined
   - Perineural invasion not identified in the sections examined
   - Calcification identified in DCIS and invasive carcinoma
   - Surgical margins status:
     ➢ Superior surgical margin is involved by DCIS
     ➢ Deep surgical margin is less than 0.1 cm away from DCIS and intravascular tumor emboli
     ➢ Medial surgical margin is less than 0.1 cm away from intravascular tumor emboli
     ➢ All other surgical margins are free

2. Left breast mass superior margin re-excision:
   - Single focus of high grade ductal carcinoma in situ (0.2 cm in diameter)
   - Surgical margin and skin are free

3. Left breast mass deep margin re-excision:
   - Free of tumor

4. Left axillary lymph nodes, dissection:
   - Eight out of all nine found lymph nodes are involved by metastatic carcinoma
   - Maximum diameter of metastatic focus is 1.6 cm
   - Extramural extension present

ICD-O: C50.9, M8500/3; C77.3, M8500/6

Pathologic staging (based on information available to the pathologist): ypT1a, ypN2a, pMX
IMMUNOHISTOCHEMISTRY REPORT

Clinical data
See our ref. No. P-98-6226

Specimen
Paraffin block No. P-98-6226/A8

Immunohistochemistry
Using appropriate buffered formalin (10%) fixed [6-48 hours fixation time, and cold ischemia time of <1 hour (time between tissue removal and initiation of fixation)] paraffin tissue block #A8 with following interpretation.

HER2 (SP3): Negative (1+), Incomplete, faint/barely perceptible membrane staining within >10% of the invasive tumor cells.

ER (Clone SPI): Moderate/Strong positive reaction in 100% of tumor cells

PR (RTU-PGR-312): Moderate/Strong positive reaction in 70% of tumor cells

Note: Report format based on “template for reporting results of biomarker testing of specimens from patients with carcinoma of the breast” (college of American pathologists, January 2018).

Clinical & Surgical Pathologists:
Lymph 8/9 + Cm

• باقی مانده تومور ۲.۰ + Cm
  • سپس بیمار رادیوتراپی شده و تحت هورمون درمانی قرار می‌گیرد

مرداد ۱۴۰۰

انجام می‌شود FDG-PET/CT
Technique:

Blood Sugar at Injection Time: 83mg/dl
Injection Dose: 1.8ml of $^{18}$FDG
Field of View: Total Body
Above mention dose of $^{18}$FDG was administered intravenously. To allow for distribution and uptake of radiotracers, the patient was allowed to rest quietly for 60 min in a shielded room. Imaging was performed on an integrated 16-slice PET/CT scanner. CT scanning was performed for attenuation correction and localization purposes. 3D emission scan was acquired. Images were reviewed in the transaxial, coronal, and sagittal planes.

Diagnosis: Breast cancer
Indication: Restaging

Findings:

Brain:
Physiologic FDG uptake is noted throughout the brain

Head and Neck:
The nasopharynx, oropharynx and oral cavity appear normal. The larynxes, including true and false vocal cords are normal. The major salivary glands are intact. The thyroid gland appears normal. Bilateral level I subcentimeter cervical lymph nodes up to 11mm without abnormal metabolic activity are noted.

Thorax:
Lungs: Post radiation changes in LUL are seen.
Mediastinum: Normal FDG uptake is noted within the myocardium and mediastinum without any pathologic adenopathy.

Chest wall: Patient is post left breast lumpectomy with evidence of post surgical changes and mild hypermetabolic skin thickening (SUVmax = 3.28).

Axillary: Multiple hypermetabolic right sided level I and II axillary lymphadenopathies (measuring up to 15mm with SUVmax = 4.58). There is also left sided axillary lymphadenopathies (measuring 12mm with SUVmax = 3.39) with evidence of post surgical changes.
Liver and biliary system: The liver is normal in size and metabolic activity without focal hepatic lesions. No intra or extra hepatic ductal dilation is seen.

Spleen: Spleen is normal in size and metabolic activity without focal activity.

Pancreas: The pancreas is normal in size and metabolic activity.

Adrenal glands: The Adrenal glands are normal in appearance and metabolic activity.

Gastrointestinal/Peritoneal/Retroperitoneal: No intra/retroperitoneal lymphadenopathy is demonstrated. Physiologic uptake is seen throughout the GI tract.

Genitourinary system: Physiologic activity is noticed within kidneys, ureters and bladder.

Pelvis:
Bilateral inguinal lymph nodes without abnormal metabolic activity are noted.

Musculoskeletal system:
Evidence of degenerative changes is noticed along the spine.

Impression:
- Mildly hypermetabolic left breast skin thickening (SUVmax = 3.2); dedicated breast imaging is advised.
- Hypermetabolic metastatic right level I and II and left level I axillary lymphadenopathies (SUVmax up to 4.5)
Clinical data: 50 Y/O with personal history of left breast CA and BCT 2 years ago

Mammography is not available for correlation.

Sonography and color Doppler exam of both breasts and axillary regions:

In the ultrasonic evaluation which was performed by 5 to 13 and 5 to 18 MHZ multi frequency probes:

- The pattern of the breast parenchyma is heterogeneous fibroglandular.
- There is no evidence of suspicious mass in either breast.

- At right breast 10 O’clock far zone hypoechoic cyst 8 x 6 mm and 4.5 mm is seen (B3).
- Post treatment changes are seen in left breast.
- Hypoechoic prominent lymph nodes are seen in both axillae with maximum 6 mm cortical thickness is right axilla and 4 mm in left axilla.
- Hypoechoic irregular structure contains vascularity measured about 21 x 16 mm is seen in left axilla (B4a-b). Tissue exam is recommended.

MRM correlation is also helpful before tissue sampling.
CLINICAL DATA:
Left axillary irregular structure 21x16 (BIRADs4a)

MACROSCOPIC:
Received specimen in formalin consist of four pieces of creamy yellow core biopsy from 0.5 to 1.6 cm in length and 0.2 cm in diameter.
SOS: 4/1 E: 100%

MICROSCOPIC:
See the diagnosis please

DIAGNOSIS:
Left axillary lymph node, Core Needle Biopsy:
- Invasive ductal carcinoma nuclear grade 2 with micropapillary component

NOTE 1: For confirmation of micropapillary component IHC for EMA is recommended.
NOTE 2: Because of high probability of lymph node metastasis in micropapillary carcinoma evaluation of lymph node is recommended

ICDO  M: 8500.3
C: 50.9
Specimen

Clinical data
- Left axillary prominent lymph node (BIRADS 4a)
- Right axillary prominent lymph node (BIRADS 4a)

Macroscopy
- Right axillary lymph node: Received 7 unstained smears of right lymph and 5 unstained of left axilla which stained by PAP and Geimsa method
- Left axillary lymph node: Received 5 unstained smears of lymph node which stained by PAP and Geimsa method

Microscopy
- A, B) Smears are hypercellular show numerous cluster cohesive high N/C ratio tumoral cells mixed with numerous varigated of lymphoid cells set in the hemorrhagic background

Diagnosis
- A) Right axillary lymph node, Fine Needle Aspiration - Positive for malignant cell.
- B) Left axillary lymph node, Fine Needle Aspiration - Positive for malignant cell.
IHC REPORT:

Clinical data:
See our ref No. P-1400-1800

Specimen:
Paraffin block No. P-1400-1800

ER (Clone SP1): Strong nuclear staining in about 90% of tumoral cell (Positive)
PR (RTU-PGR-312): Moderate nuclear staining in about 5% of tumoral cell (Positive)
HER2 (RTU-CB11):
Equivocal (2+), intense complete circumferential membrane staining <10% of invasive tumor cells. HER2 FISH or CISH is recommended. (Her2 CISH or FISH is available in this lab) (2+)

Ki67 (SP6): Nuclear staining in about 35-40% of tumoral cells

EMA: Inside out pattern are seen so micropapillary carcinoma is confirmed

NOTE: Report format based on template for reporting result of biomarker testing of specimens from patients with carcinoma of the breast (collage of American pathologists, December 2014)
Breast MRI With and Without Contrast

COMPARISON: With 1400 sonography

HISTORY:
- Left breast cancer and BCT

FINDINGS:
The breasts are composed of scattered fibroglandular tissue.
Breast composition: b
Background parenchymal breast tissue enhancement is mild.
Background parenchymal enhancement is symmetric

RIGHT BREAST:
7mm cyst is seen at 9 o'clock
- There is no abnormal mass, non-mass enhancement, or fluid collection.
- Prominent right axillary lymph nodes are seen. No abnormal internal mammary chain lymph node is present.

LEFT BREAST:
Post treatment changes are seen in left breast
- There is no abnormal mass, non-mass enhancement, or fluid collection.
- Left axillary lymph nodes are not enlarged. No anomalous internal mammary chain lymph node is present.

IMPRESSION:
Benign finding

RECOMMENDATION:
- Annual screening mammogram and breast MRI unless earlier examination is clinically indicated.

BI-RADS CATEGORY:
2 - Benign

Please note that MRI is not a substitute for careful mammographic and sonographic evaluation.
خانم ۶۳ ساله ۷ ماه قبل تحت جراحی بی سی سی لب بالا قرار گرفتند. با مارژین نرمال و بی‌پاسی انجام شده است. از پنجم ماه بعد جراحی دیگر عود در محل جراحی لب بالا می‌شود.
Diagnosis: Upper lip, excisional biopsy:
- Skin tissue involved by malignant epithelial neoplasm (involving full thickness dermis and subcutaneous tissue).
- Surgical margins are tumor free.
- Other pathologic findings: focal granulomatous reaction

Comment: Dear colleague; According to morphologic findings and IHC study results both primary sweat gland carcinoma and metastatic breast carcinoma are in differential diagnosis, both of them are GATA3 and ER positive. GCCFP15 and HER2/neu were negative which is in favor of sweat gland carcinoma more clinical investigation is recommended.
سی تی اسکن ریه و مدياستن با و بدون تزریق

انفجار پانی متعدد می‌دانستی به حداکثر sad = 7mm در بارا آتور دیده می‌شود.

شواهد Dd یا ستون فقرات تو راسیک و اسکلرون end plate می‌دانست تختانی دیده می‌شود که در درجه اول به علت تغییرات دانریتی می‌باشد. تصویر دور ندول به ابعاد ترنس آگرال می‌دانست کلسفیکاسیون با فاقد اینتسلمنت واضح در تصاویر با تزریق دیده می‌شود. با توجه به سابقه ی به خدمی در صورت شک با پیش اسکن CT یا PET بالینی فالو آپ توصیه می‌شود.
سونوگرافی نشان نژم سطحی گردن:

در بررسی فضای سرویکال، سباب منتال و پوست‌بری اوریکولا در سوزن اکلاویکولا دو گروه دارای هیلوم و non significant طرف تصویر لنف نوده‌های متعدد خوانسای دهنده در هیلوم روبت می‌شود.

wider

ایزی‌گو به ابعاد 25x19mm در لوب راست تیرولید yافته اتفاقی: تصویر ندول

solid-cystic

پایه‌ای اتفاقی: تصویر ندول با حدود مشخص روبت می‌شود. (TIRADS: 2) than taller

wider

ایزی‌گو به ابعاد 15x14mm در لوب چپ تیرولید Mostly solid با حدود مشخص و Follow up

تیزی‌گو به ابعاد 20x22mm در لوب سمت چپ TIRADS: 3: Sonoگرافی روبت می‌شود. (3: TIRADS: 3) than taller
HISTORY: Cancer of Unknown Primary (Upper Lip Squamous Cell Carcinoma)

QUESTION: Metastatic Evaluation

TECHNIQUE:
Sixty minutes following administration of 370 MBq of FDG intravenously a partial body integrated PET-CT scan from vertex to proximal thighs was acquired. Sections were reconstructed in three standard orthogonal planes. For anatomic referencing and for transmission correction purposes an unenhanced low dose CT was acquired and fused images were also generated.

BRAIN:
There is no midline shift or intracranial hemorrhage. The lateral ventricles are normal. The cerebellum and brainstem are intact. The basal cisterns are patent. The skull is intact. Physiological FDG-uptake of the brain is seen.

NECK:
Hypermetabolic soft tissue in upper lip is seen (SUV max= 3.3), which may represent recurrent tumoral lesion. Hypermetabolic soft tissue density in right submandibular region is detected, which may represent metastatic lymph node. Hypermetabolic thyroid gland is seen. Clinical correlation is recommended. The major salivary glands of the neck are normal. The epiglottis & aryepiglottic folds, true & false vocal cords, and supra & subglottic airways are intact.

CHEST:
Right paratracheal and prevascular space lymph nodes are seen with no metabolic activity. Diffuse fine micronodularity of both lung fields are seen. Clinical correlation is recommended. Tiny peripheral subpleural hypermetabolic nodule is seen in anterior segment of left upper lobe, measuring 10mm (SUV max= 1.3). No mass lesion is detected. No evidence of pleural effusion is seen. Chest wall is unremarkable. Heart size is normal. Physiological FDG-uptake of the heart is noted.
Skin, lip, excisional biopsy.

History of malignant epithelial neoplasm, now presented with tumor recurrence. DDx: BCC.

Specimen is received in formalin and consists of a piece of skin tissue measuring 0.3x0.2x0.1 cm. Totally submitted in one block.

Sections show skin tissue involved by malignant epithelial neoplasm involving dermis mostly located in intravascular spaces composed of atypical epithelial cells with vesicular nuclei, inconspicuous nucleoli, clear to scant amphophilic cytoplasm and increased mitotic activity arranged in small and large nests and scattered individual cells with extensive lymphovascular invasion.

Skin, lip, excisional biopsy:
- Skin tissue involved by malignant epithelial neoplasm involving dermis with extensive lymphovascular invasion, incomplete excision.

Dear colleague; According to morphologic findings and IHC study results both primary sweat gland carcinoma and metastatic breast carcinoma are in differential diagnosis, both of them are GATA3 and ER positive. More clinical evaluation is recommended.
Skin lesion, upper lip, excision:
- Skin tissue involved by malignant epithelial neoplasm (involving full thickness dermis and subcutaneous tissue) with extension to underlying skeletal muscle tissue.
- Deep margin (skeletal muscles) is involved by tumor, peripheral surgical margins are tumor free.
- Other pathologic findings: Disorganized proliferation of nerve fascicles, fibroblasts and Schwann cells (post traumatic neuroma).

Dear colleague; According to morphologic findings and IHC study results both primary sweat gland carcinoma and metastatic breast carcinoma are in differential diagnosis, both of them are GATA3 and ER positive. More clinical evaluation is recommended.
Sweat Gland Carcinoma

Grading

- Low grade
  - Ductal adenocarcinoma, aggressive digital papillary adenocarcinoma, acrosiopcarcinoma

- High grade
  - Porocarcinoma, clear cell acrosiopcarcinoma

Afshin moradi

https://t.me/PN_Links
Sweat Gland Carcinoma

Grading

- Low grade
  - Microcystic carcinoma, adenoid cystic carcinoma, mucinous carcinoma, extramammary Paget’s disease, mucoepidermoid carcinoma
- Intermediate grade
  - Ductal adenocarcinoma, aggressive digital papillary adenocarcinoma, acrospiromesenchymoma
- High grade
  - Porocarcinoma, clear cell acrospiromesenchymoma

Afshin moradi

https://t.me/PN_Links
Sweat Gland Carcinoma

- Those with well-developed ductal differentiation simulate metastatic carcinoma, particularly from the breast

- They can exhibit IR for GCDF-15 and ER protein (although usually not for HER2/neu)
CRC TUMOR BOARD

آبان 29
1400