

History & Physical
Outpatient Services
Memorial General Hospital
Anytown, FL 99999
04/16/2007

CC: Abnormal mammogram

Mrs. Smith is a 63 y/o black female who had an abnormal screening mammogram on March 20, 2007, which showed multiple areas of microcalcifications and an ill-defined mass right breast, lower outer quadrant, BIRAD 5. A screening mammogram March 2006 had been normal. Follow-up ultrasound on March 29 revealed a 3.5 cm partially cystic mass at the 6:00 o'clock position right breast. The patient is here today for stereotactic core needle biopsy.

PE: Examination of the right breast reveals a palpable firm area approximately 4.0 cm in size at the six o'clock position consistent with the ultrasound. An area of erythema of the skin of the breast was present. It was approximately 3.5 x 3.0 cm. Skin, nipple and areola were otherwise negative. Palpation of the axilla was negative.

Medical History: Patient reports she had a small melanoma removed from her left shoulder about 15 years ago without recurrence. No other surgeries. Gravida two, para two. Patient is post-menopausal.

Family History: No family history of malignancies. Mother and father both living. Two sisters and one brother also living. Patient is married and has two adult children.

Assessment: Approximately 4.0 cm palpable mass in lower right breast with microcalcifications and possible neoplasm seen on mammogram. Partially cystic mass also demonstrated on ultrasound.

Plan: CT-guided stereotactic core needle biopsy

Pathology Report
04/16/2007

Clinical History: Abnormal mammogram

Operative Procedure: Rt breast stereotactic needle core biopsy

Specimen:
Breast, right, needle cores

Gross Description:

Four core breast needle biopsies received in compartmentalized Petri. Accompanying the dish is an X-ray of the dish which shows circled calcifications in 12:00, 3:00, 6:00 and 9:00 sites.

Microscopic Diagnosis:

Breast, right, stereotactic needle core biopsies:

- 12:00 site Ductal carcinoma in situ (DCIS), high grade with features of comedonecrosis. Micro-calcifications are evident.
- 3:00 site Ductal carcinoma in situ (DCIS) and lobular carcinoma in situ (LCIS), intermediate to high grade. Microcalcifications are evident.
- 6:00 site Infiltrating duct carcinoma, high grade, arising in a background of ductal carcinoma in situ (DCIS) with features of comedonecrosis. Microcalcifications are evident.
- 9:00 site Ductal carcinoma in situ (DCIS) and lobular carcinoma in situ (LCIS), intermediate to high grade. Microcalcifications are evident.

Comment:

Immunoperoxidase stains for ERA/PRA and HER2 will be performed on sections of the needle biopsy. A supplemental report will follow when results are received.

Patient MR# 999905
Patient Name: Jane Smith

Breast Advanced Case #5
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Pathology Report Addendum
04/20/2007

Clinical History: Abnormal mammogram

Operative Procedure: Rt breast stereotactic needle core biopsy

This addendum is based upon the results of the immunohistochemical stains:

Pancytokeratin (AE1/AE3) Positive in tumor cells

Estrogen Receptor Protein (ER)
Positive in tumor cells (approximately 80% of tumor nuclei stain)

Progesterone Receptor Protein (PR)
Positive in tumor cells (approximately 90% of tumor nuclei stain)

HercepTest (HER2/neu)
Negative for HER2 protein overexpression (0+ membranous staining intensity)

Operative Report
04/30/2007

Preoperative Diagnosis: Ductal carcinoma right breast with DCIS & LCIS

Postoperative Diagnosis: Ductal carcinoma right breast with DCIS & LCIS

Operations:

1. Sentinel lymph node mapping of right breast
2. Modified Radical Mastectomy right breast

Findings: Touch preps for sentinel lymph nodes are positive.

Drains: Two 15 mm rounded, soft, Silastic Jackson-Pratt drains, one in the right axilla and the other one under the flap at mastectomy site on right side.

Procedure: The right breast subareolar area was prepped. I injected 3 cc of Lymphazurin in the subareolar area. Then the right breast, chest wall, both sides of the neck and the entire area were prepped with Betadine solution and draped in the usual fashion. I made a marking and then made an elliptical skin excision. The superior flap was raised more into the clavicle. I identified two areas of sentinel lymph nodes in the lower axilla. Two highly active lymph nodes were identified with the probe and dissected out. I secured the first flap's undersurface with cautery and sutures. I dissected the inferior flap to the upper rectus abdominis, the lateral flap to the anterior border of the latissimus dorsi and medially dissected to the lateral border of the sternum.

By that time the report came from pathology that the two sentinel lymph nodes were positive. I then proceeded with the axillary lymph node dissection and carried the dissection into the axilla. The breast was dissected easily from the underneath fascia and removed along with the fatty tissue, the subareolar tissue, the skin and the axillary contents. I then irrigated the skin flaps thoroughly with antibiotic solutions and warmed saline. I then inserted the two soft Jackson-Pratt drains, one in the axilla and the other in the anterior surface of the pectoralis major muscle, and anchored them to the skin. We closed the skin and subcutaneous tissue with monofilament sutures and applied a dressing.

The sponge, needle and instrument counts were correct.

The patient tolerated the procedure well and was transferred to the recovery room in good condition.

Pathology Report
04/30/2007

Clinical History: Breast cancer

Procedure: Sentinel lymph node biopsy & right breast mod rad mastectomy

Specimen:

- 1) Lymph Node, Sentinel #1, Biopsy, Rt Breast
- 2) Lymph Node, Sentinel #2, Biopsy, Rt Breast
- 3) Lymph Nodes, Dissection, Rt Axillary, Rt Breast
- 4) Mastectomy, Rt Breast

Intraoperative Consultation:

Touch Prep And Gross:

- 1) Sentinel Lymph Node #1: Positive for Malignancy
- 2) Sentinel Lymph Node #2: Positive for Malignancy

Gross Description:

Specimen #1 is received in a container labeled with the patient's name and appropriate accession number. It consists of a 2.0 x 1.5 x 1.3 cm firm, focally fatty lymph node. The specimen is sectioned and entirely submitted in cassette 1A through 1C.

Specimen #2 is received in a container labeled with the patient's name and appropriate accession number. It consists of a 2.1 x 1.4 x 1.3 cm firm, focally fatty lymph node. The specimen is sectioned and entirely submitted in cassette 2A through 2B.

Specimen #3 is received in a container labeled with the patient's name and appropriate accession number. It consists of a 8.0 x 7.1 x 2.6 cm fragment of adipose tissue. Sectioning through the specimen reveals several probably lymph nodes which are submitted as follows: 3A – one bisected lymph node, 3B – 5 probable lymph nodes, 3C – 5 possible lymph nodes, 3D – 5 possible lymph nodes.

Specimen #4 is received in a container labeled with the patient's name and appropriate accession number. It consists of a 20.0 x 18.0 x 7.5 cm right breast mastectomy specimen with an attached 15.0 x 6.0 x 2.5 cm axillary tail. No orientation is provided. The specimen is covered by an ellipse of skin. At 6.5 cm from the nipple an erythematous area in the skin which is submitted separately in cassette 4A. Nipple and areola are submitted in cassette 4B. The axillary tail is sectioned. Possible lymph nodes are submitted in cassettes 4C – 4F. A fragment of adipose tissue with a possible lymph node is submitted in cassette 4G. Sectioning through specimen several areas of white fibrous parenchyma are identified. A 2.5 x 1.3 x 1.3 cm white, ill-defined firm nodular mass is present 3.5 cm from skin and 3.0 cm from nearest inked lateral margin and 3.5 cm from deep margin. A 2.0 cm cystic, hemorrhagic area is adjacent to the white nodular mass.

Microscopic Diagnosis:

1. Right sentinel lymph node #1: Metastatic ductal carcinoma in one of one lymph node. (1/1)
2. Right sentinel lymph node #2: Metastatic ductal carcinoma in one of one lymph node. (1/1)
3. Right axillary contents: Metastatic ductal carcinoma in two lymph nodes out of 12. (2/12)
4. Right breast, modified radical mastectomy: Invasive ductal carcinoma, poorly differentiated, (2.5 x 1.3 x 1.3 cm) with lymphovascular space involvement. High grade ductal carcinoma in situ, solid and comedo type with necrosis, and lobular carcinoma in situ. Background breast parenchyma with fibrocystic changes, fibroadenomatous hyperplasia. Nipple and areola skin, no malignancy identified. Lymphovascular space involvement identified, multiple areas. Benign lymph nodes (12)

Key Pathological Findings:

Invasive Ductal Carcinoma

Tumor size:	2.5 x 1.3 x 1.3 cm
Histologic type	Ductal, invasive
Margins involved by DCIS	Negative
Margins involved with invasive Ca	Negative
Distance from closest margin	3.0 cm
Final histologic grade	III/III
Nuclear Grade of DCIS	III/III
Extent of Associated DCIS	Moderate
Skin/nipple involvement	Negative
ER/PR	Positive/Positive (based on biopsy)
HercepTest (HER2/neu)	Negative (based on biopsy)
Regional lymph nodes	Positive 4/26
Pathologic staging	pT2N2aMX

Medical Oncology Consult
05/01/2007

Mrs. Smith is a very pleasant 63 y/o woman who was evaluated for an abnormal screening mammogram that showed multiple microcalcifications in several areas of her right breast. Her right axilla was negative to palpation. Sonography showed a 4.0 cm mass at the 6 o'clock position. Stereotactic breast core needle biopsy was done. Four cores were removed. Three of the cores were significant for intermediate to high grade DCIS and LCIS. A fourth core also showed infiltrating ductal carcinoma. Analysis showed the tumor is ER/PR positive and HER2 negative. She was admitted yesterday for modified radical mastectomy and sentinel lymph node mapping. Two of two sentinel lymph nodes in the axilla were positive for ductal carcinoma. Modified radical mastectomy was positive for two additional axillary lymph nodes of 26 total lymph nodes examined. A 2.5 cm white hard nodule was found to be high grade invasive ductal carcinoma. Adjacent to the white nodule was a 2.0 cm cystic, hemorrhagic area that had no malignant cells. The patient is referred for adjuvant chemotherapy for a HER2-negative tumor. The patient is scheduled for a radiation oncology consult after discharge.

Assessment:

Patient has an invasive 2.5 cm high grade ductal carcinoma, with 4/26 positive lymph nodes, that is HER2 negative, ER/PR strongly positive. A MUGA scan will be done two weeks after discharge in preparation for chemotherapy. After the surgical incisions have been given time to heal, about four to six weeks, a staging PET scan and abdominal/pelvic CT will be scheduled. At that time a port will be placed. Assuming no metastases are found, the patient is pT2N2AM0 stage 3A.

Plan:

The AC+T regimen is recommended for this patient, to start immediately after the PET scan. The regimen consists of four cycles of doxorubicin and cyclophosphamide followed by four cycles of paclitaxel. Trastuzumab is not thought to be helpful for this HER2 negative tumor. It is expected that the patient will have radiation to the mastectomy site and lymph node bearing areas when chemotherapy is completed. At that time the patient will be started on Tamoxifen for five years at which time an aromatase inhibitor, probably letrozole, will be initiated.

Mrs. Smith was asked to call my office immediately after discharge to schedule an office visit.

Radiology Report
05/30/2007

PET Scan

Diagnosis: s/p Rt breast mastectomy and axillary lymph node dissection

Assessment: Low-level activity is seen in the areas of the absent right breast and right axilla consistent with recent surgery. There is no other activity indicating chest or cervical lymph nodes. Mediastinum is negative. The liver, pancreas and spleen are within normal limits. There is no evidence of abdominal or pelvic lymph node activity. There is no abnormal uptake in the bones or soft tissue.

Impression: Negative for metastatic activity

Medical Oncology Progress Report
Office Visit
11/15/2007

Mrs. Smith completed her last chemotherapy last week. She returns today to begin Tamoxifen. She is doing well and has tolerated the AC+T regimen even better than expected. Her blood counts remain strong. There is no reason she cannot continue with her therapy for stage 3A breast cancer. She is started on Tamoxifen today. She was provided with education and written materials on what to expect from Tamoxifen. All her questions were answered. It is expected she will stay on Tamoxifen for five years followed by five years of letrozole.

She had a radiation oncology consult midway through her chemotherapy at the end of the AC portion. She will be starting adjuvant radiation therapy the Monday after Thanksgiving. The plan is to radiate the right chest wall with a boost to the mastectomy scar. The node bearing areas will also be treated, including the right axilla, right supraclavicular area and the ipsilateral internal mammary area.

Both her radiation oncologist and I will monitor her progress closely.