Radiology Report
06/05/2007

Diagnostic Digital Mammography Left Breast Ultrasound

Clinical History: Palpable lesion within the upper outer quadrant of the left breast

Bilateral MLO and CC views were obtained, as well as ML, SPOT compression CC, SPOT compression MLO and rolled MLO views of the left breast. This screening mammogram was read using the assistance of R2 Computer Aided Detection Software Version 5.3.

Additionally, ultrasound examination of the left breast was performed.

Examination demonstrates heterogeneous glandular tissue within bilateral breasts. There is asymmetric glandular tissue on MLO imaging of the left breast within the superior aspect of the breast. However, this does not definitely correspond to the site of the palpable abnormality and it does not persist as a discrete lesion on additional mammographic views. No dominant mass, architectural distortion or suspicious calcifications are identified.

Sonographic imaging of the left breast was then performed which demonstrated no discrete abnormality at the site of the palpable abnormality.

Impression: Birads III/probably benign left mammogram. No discrete lesion to correspond to the palpable abnormality within the left breast is identified by mammography or breast ultrasound. Therefore, clinical management of this finding is recommended. Additionally, an asymmetry is noted within the superior aspect of the left breast but this does not definitely correspond to the palpable abnormality and does not persist as a discrete lesion on additional views. Therefore, 6 month follow-up mammographic evaluation to document stability of this finding is recommended.

General Surgery Office Note
07/25/2007

History of Present Illness: Patient was seen in the office today. This is a very pleasant 34-year-old female who has reported massive enlargement in her left breast over the last three months. She was seen by her physician who noticed this asymmetry. She had mammograms and ultrasounds performed, both of which were basically unremarkable with no significant objective radiographic findings of abnormality. She was put on a short course of antibiotics, which had some improvement possibly in the breast swelling, but the breast size itself and the general skin changes have not really changed significantly. She has not had any recent trauma to this breast. She denies any recent suckling or other issues on the nipple-areolar complex, which are related to these issues or complications other than taking birth control pills. She has not other significant history of breast issues, and she at this time only has maternal grandparents that have had breast cancer in the past.

Physical Examination: Just by clinical inspection, the right breast is probably one or two cup sizes smaller than the left. The left has some peau d'orange changes around the nipple-areolar complex. This is unusual discoloration of the skin in the inframammary fold extending up the lateral part of the breast. It is not blue, but more of a reddish discoloration, which does not blanch with examination. I do not appreciate any skin dimpling and the nipple itself is not retracted. The right breast shows no masses or abnormalities with no primary or secondary signs of malignancy. Left breast is very firm to palpation with the skin overlying the nipple-areolar complex being very firm and the peau d'orange changes as described. She is reporting some tenderness to the exam but nothing in the way heat or cellulitic changes that I can appreciate. The axillary exam does not show adenopathy.

Impression/Plan: I am quite concerned given current clinical course to rule out the possibility of inflammatory breast cancer, which I think will be very unusual in 34 year old. Certainly this could be a strange variant of cellulitis and mastitis, but I do not think that is likely given current presentation. Mondor disease also comes to mind as a possibility given the presentation, but this is a rule out or exclusion in my opinion. I will offer her nipple-areolar skin biopsies with associated deep breast biopsies at some point in the near future so we can rule out an inflammatory cancer, and from here we will work down a diagnostic sequela to reach a diagnosis. The patient will not continue birth control pills after today, and I have stated to her very clearly the need to avoid her getting pregnant in the next month or two until this problem is resolved.

Operative Report
07/26/2007

Preoperative Diagnosis: Massive enlargement of the left breast with peau d'orange changes on the skin

Postoperative Diagnosis: Inflammatory breast cancer

Operative Procedure: Periareolar nipple and deep breast biopsy left breast

Complications: None

Procedure: Following general anesthetic, the patient was prepped and draped in the usual sterile fashion. A diamond-shaped incision was made involving the nipple areolar complex, with deep dissection into subcutaneous tissue also being performed, with a marked amount of breast tissue being removed with the skin excision itself. This nipple alreolar and deep breast biopsy were sent to pathology and returned malignant tissue within the lymphatics, suggestive of inflammatory breast cancer. Deep core biopsies of the breast performed in multiple locations, some of which were sent under separate cover for ER-PR receptors and diagnosis.

Following irrigation the wound was closed with interrupted 3-0 Vicryl and 4-0 Vicryl nylon. Sterile dressings were applied. The patient was taken to recovery.

Pathology Report
07/26/2007

Clinical History: R/O inflamed breast cancer, left breast

Specimen:
1. Breast, left breast biopsy
2. Breast, left breast core biopsy

Frozen Section Diagnosis:
1. Lymphatic tumor consistent with inflammatory carcinoma
2. None specified

Gross Description:
1. Specimen labeled “Left breast biopsy” and consists of a segment of skin and some underlying soft tissue. It measures approximately 4.0 x 1.5 x 1.5 cm. Portions submitted for frozen section. Frozen section diagnosis: Lymphatic tumor consistent with inflammatory carcinoma. Frozen section and additional sections submitted as “A” through “C”.
2. Specimen labeled “Left breast core biopsy” and consists of multiple needle biopsies of white tissue that measures approximately 1.5 x 0.2 cm. It is totally submitted in a single cassette.

Microscopic Diagnosis:
1. Examination of sections of skin and soft tissue show dermal lymphatic involvement by malignancy. It shows an adenocarcinoma consisting of tumor cells with pleomorphic, vesiculated nuclei with prominent nucleoli. It is within dermal lymphatic spaces with chronic inflammation. Epithelial involvement is not definitely identified. In the sections of subcutaneous tissue on sections “A” show nets of intralymphatic tumor foci.
2. Specimen two shows needle biopsies of breast parenchyma. It also shows foci of infiltrating carcinoma as well as intralymphatic carcinoma. It has a similar appearance as that above and it consistent with a breast primary. The tumor is in only one of the needle core biopsies and measures .2 cm in diameter with lighter tumor present to include the intralymphatic spaces. ER/PR will be attempted on this specimen.

Final Diagnosis:
1. Left breast biopsy: Intralymphatic carcinoma consistent with inflammatory breast carcinoma
2. Left breast biopsy: Infiltrating carcinoma

Immunohistochemistry Evaluation:

| Test | Interpretation | Intensity | % Tumor Staining | Comments |
|---|---|---|---|---|
| ER | Positive | 3+ | 90% | Favorable |
| PR | Positive | 3+ | 90% | Favorable |
| HER-2 | Positive | 3+ | 80% | Unfavorable |
| Ki-67 | N/A | N/A | 30% | Unfavorable |

General Surgery Note
07/28/2007

Patient was seen in the office today. Her path has indeed confirmed inflammatory breast cancer with lymphatic involvement of the skin being present on biopsy. The patient is already prepared for the pathology, and she and I have had a very lengthy discussion today regarding the diagnosis. We had a conversation already and she has been scheduled for a bunch of tests next week to complete her staging workup. MediPort will be placed on Wednesday, and hopefully, chemotherapy can be started some time latter part of next week. Obviously, a quite aggressive tumor for a person this age. Risk of local breakdown and systemic disease is quite high for which I have been quite frank with her at the end of the day and discussed this in detail. I will place MediPort on Wednesday and above-forementioned test will be scheduled.

Radiology Report
07/31/2007

CT Chest, Abdomen/Pelvis with Contrast

Indication: Inflammatory breast carcinoma

Technical Information: Informed written consent was obtained prior to the examination. Helical computerized tomograms from the apex of the lungs to the inferior costophrenic angles were obtained during the rapid, uneventful IV administration of 125 cm of OptiRay -320. Images were reconstructed in 5 mm increments.

Axial 5 mm computerized tomograms were obtained in a spiral fashion from the dome of the diaphragm to the superior iliac wings. Oral contrast was administered prior to the examination. Delayed 5 mm spiral computerized tomograms through the kidneys were performed.

Cluster axial 5 mm computerized tomograms were obtained from the superior iliac wings through the inferior ischial rami immediately following the contrast bolus performed for the abdominal CT examination. Oral contrast wad administered prior to the examination. There are no old studies available for comparison.

Findings: There is skin thickening and ill-defined soft tissue density associated with the left breast in this patient with known recently diagnosed inflammatory breast carcinoma. This likely reflects a combination of postsurgical change and/or residual disease. Left axillary lymph nodes are present which measure up to 17 x 10 mm in size.

Evaluation of the lung parenchyma demonstrates a nonspecific 2 mm nodule within the right lower lobe of image 29 of series 5. There are additional faint dependent opacities within bilateral lungs. Lungs are otherwise clear. No pneumothorax of pleural fluid collection is identified. No pathologically enlarged mediastinal or hilar adenopathy is noted. There is no pericardial effusion.

The liver demonstrates a 6 mm hypodensity within the medial segments of the left hepatic lobe and an additional 4 mm hypodensity within the hepatic dome. These lesions are too small to further characterize on this examination. No adrenal mass is identified. The spleen, kidneys and pancreas are within normal limits. The gallbladder is present and unremarkable in appearance by CT evaluation.

There is no evidence of bowel obstruction, free intraperitoneal space or free abdominal fluid. No pathologically enlarged adenopathy is noted within the mesentery or retroperitoneum.

Evaluation of the pelvis demonstrates a 2.3 cm fluid density structure associated with the right adnexa. No additional adnexal mass, free pelvic fluid or pelvic adenopathy is identified.

Impression:
1. Skin thickening and ill-defined soft tissue density within the left breast likely reflecting a combination of postsurgical change and/or residual disease in this patient with recently

diagnosed inflammatory breast carcinoma. Prominent left axillary lymph nodes are present which measure up to 17 x 10 mm in size, suspicious for axillary lymph node involvement.

2. There is a nonspecific 2 mm noncalcified nodule within the right lower lobe. Continued follow-up of this finding is recommended, as both potential benign and malignant etiologies exist. There are additional subtle dependent opacities within bilateral lungs, most likely reflecting depending atelectasis and/or scarring.
3. Subcentimeter hypodensities within the liver which measure 6 mm within the medial segment of the left hepatic lob and 4 mm within the hepatic dome. These lesions are too small to further characterize on this examination.
4. 2.3 cm fluid density structure within the right adnexa which, in patient this age, likely reflects a functional ovarian cyst. However, follow-up sonographic evaluation of the pelvis could be performed to evaluate for resolution or further characterization of this finding.

Radiology Report
07/31/2007

NM Bone Scan

Clinical History: Inflammatory breast CA

Technique: Following injection of 21.2 mCi of Te99m MDF multiple delayed views of bony structures were obtained.

Findings: There is good uptake of the radiopharmaceutical by the bony structures. There is a single area of increased activity in the right foot. No other focal areas of increased or decreased activity are demonstrated in the bony structures. There appears to be some increased soft tissue activity in the region of the left breast.

Impression: Bone scan demonstrates a focal area of increased activity in the right foot. This is of unknown etiology but is probably second to some degenerative change. The bony structures are otherwise unremarkable. No metastatic disease is identified. Incidentally noted is some increased soft tissue activity in the region of the left breast. The bone scan is otherwise unremarkable.

Department of Hematology/Oncology
08/01/2007

Chief Complaint: Inflammatory breast cancer of the left breast

History of Present Illness: The patient has noticed an abnormal area on her left breast on 05/25/2007. She was evaluated soon after that by her OB/GYN physician ordered ultrasound and mammograms, which did not demonstrate any specific abnormality. About two weeks following these tests, she noticed that her left breast was enlarging and becoming tender. She was reevaluated at this point and treated with antibiotics, but was told that if she failed to improve that she would be referred to general surgery. Seen in consultation on 07/25/2007 and scheduled for a biopsy on the following day which confirmed inflammatory breast cancer with lymphatic involvement of the skin being present. She is here in the office today accompanied by her mother and her best friend to discuss her diagnosis and treatment recommendations.

Past Medical History: Includes history of migraines, history of narcolepsy, and history of endometriosis

Past Surgery History: Includes ACL repair on both knees from basketball injuries

Medications: She is on no routine medications. She has two more doses of penicillin to complete her round of antibiotics.

Allergies: She has no known drug allergies.

Social History: She is a special needs teacher. She is a nonsmoker and a nondrinker. She is married. She has two children ages 4 and 7 years old.

Family History: Her maternal great grandmother was diagnosed with breast cancer in her 80s. Diabetes, hypertension, coronary artery disease all run in her family, and her mother has a diagnosis of sarcoid.

Review of Systems: Generally, her weight is stable. She denies fevers or night sweats. Her energy level is good. She sleeps well at night. Has minimal pain from her breast biopsy. HEENT: No nosebleeds, sore throat, mucositis, or other problems. Respiratory: She has a dry cough which she has had since being put to sleep for her biopsy. No hemoptysis. Cardiovascular: No history of heart problems. No chest pain, heart palpitations, or other cardiac symptoms. GI: No nausea or vomiting. She had an episode of diarrhea, which she attributed to all the contrast materials that she had to consume for her CT scan. GU: No hematuria, dysuria, or other urinary tract problems. Musculoskeletal: No acute areas of bone pain or joint swelling. Neurologic: As mentioned previously history of migraine headaches. These occur rarely. Skin: She has redness and skin changes on her left breast. She also has suture, tram her recent biopsy. No other skin rashes, lesions, or abnormalities.

Physical Exam: Vital Signs: Her weight is 177 pounds and blood pressure 128/78. She is afebrile. General appearance: A well-nourished fema1e, alert and oriented and in no acute distress. She is tearful at times during the interview and examination process. HEENT: Moist mucous membranes. Neck: Supple. No thyromegaly. Cardiopulmonary: Normal to auscultation.

Breasts: Right breast is unremarkable. Left breast has erythema and peau d'orange changes with sutures in place from her recent biopsy procedure. Abdomen: Soft and nontender. Positive bowel sounds with no organomegaly. Musculoskeletal: No tenderness in bone or ribs. Neurologic: Nonfocal.

Laboratory: White count 6100, hemoglobin 13.4, hematocrit 40, and platelet count 233,000. A chemistry panel and CA 15-3 are pending.

Pathology Results: Left breast biopsy shows internal lymphatic carcinoma consistent with inflammatory breast cancer and infiltrating carcinoma. She has had CT scan of the chest, abdomen, and pelvis completed. There are small nonspecific noncalcified nodules in the lung and also a subcentimeters hypodensity in the liver. Both these are too small for PET evaluation and will be monitored closely. Her bone scan has been completed, but not read yet.

Impression: Inflammatory breast cancer

Recommendations: We spent a long time in discussion with patient, her mother, and her friend. We explained that our treatment recommendations involve aggressive multiple layers of treatment. She is planning to have a MediPort placed tomorrow morning at 07:30. Our plan is for her to come directly here following port insertion. We recommend chemotherapy treatment with four cycles of Adriamycin/Cytoxan every two weeks followed by four cycles of Taxol every two weeks. We explained the goal is to shrink the left breast disease as small as possible. Once chemotherapy is completed, we will proceed to surgery. Once she has recovered from the surgical procedure, we would then refer her to our radiation oncology colleagues for radiation. Because of her ER, PR, and HER-2 positive status, we would also include treatment with tamoxifen with a goal of five years of treatment and also Herceptin, which would be given every three weeks for one year. We explained the risks, benefits, and side effects of all the treatment recommendations. She and her family are anxious for her to begin treatment right away.

We have given her verbal and written information about the chemotherapy drugs, but we have encouraged her to call back if she has any questions or concerns prior to her appointment tomorrow.

History & Physical
Hospital Short Stay Record
08/02/2007

Admission Diagnosis: Breast CA

Plan: MediPort insertion

Chief Complaint: Breast CA – patient recently diagnosed with left breast cancer (Inflammatory) needs port for chemotherapy.

Past Medical History: Otherwise healthy

Past Surgical History: Left ACL; Right ACL; Arthroscopy

Allergies: No known allergies

Social History: Nonsmoker

Physical Examination: WDWN White female in NAD
HEENT: WNL
Neck: Supple
Lungs: Clear to auscultation
Heart: RRR
Abdomen: Negative
Extremities: Negative

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Operative Report
08/02/2007

Preoperative Diagnosis: Left breast cancer

Postoperative Diagnosis: Left breast cancer

Operative Procedure: MediPort insertion

Anesthesia: General

Department of Hematology/Oncology
08/16/2007

The patient is back in the office today to be evaluated for cycle two of her chemotherapy, for inflammatory breast cancer of her left breast. She reports that she had some problems with nausea and vomiting following her treatment. She also developed some mucositis, and a vaginal yeast infection, which have now resolved with treatment. She reports that her left breast has decreased tenderness since last week. She states the redness does not appear to have decreased any in her opinion. She also reports that she has lost approximately fifty percent of her hair.

Physical Examination: Her weight is 176 pounds. Her blood pressure is 132/74. She is afebrile.
General Appearance: Well nourished female, alert, oriented, and in no acute distress.
HEENT: Moist mucous membranes, no oral lesions or thrush. Neck is supple; Pupils are equal and reactive to 1ight.
Cardiopulmonary Examination: Normal to auscultation
Breasts: Left breast has continued erythema and peau d'orange changes, with little appreciable change from the previous examination two weeks ago. She continues to have fullness in her left axilla.

Laboratory: White count is 6.500. Hemoglobin is 13. Hematocrit 38.8. Platelet count is 219,000. Chemistry panel is pending.

Impression: Inflammatory left breast cancer currently on chemotherapy.

Plan: We plan to proceed with today's treatment. She will return in two weeks to be evaluated for her next cycle. We will make adjustments to her nausea regimen in hopes of controlling her symptoms with this cycle. She has been instructed to call, if she has problems prior to her next scheduled appointment.

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General Surgery Note
08/23/2007

Patient is in the office today. All the peau d’orange changes have disappeared from the breast. No mass affect is appreciated at this time. Her wound was healed nicely. Her MediPort is in good position and is being utilized. Although she has lost her hair, which is anticipated she is having excellent chemotherapeutic response at this juncture. Our preference would be that she get four rounds of therapy, have mastectomy, complete four rounds of therapy, get radiation, and then long-term follow-up is to be planned at the juncture. I have discussed this with the patient, and we will discuss it with her physician when she sees him next Wednesday. Currently, I am quite pleased with progress.

Department of Hematology/Oncology
08/30/2007

Chief Complaint: Inflammatory breast cancer

The patient is back in the office today to be evaluated for cycle number three of her chemotherapy. She reports that the changes made to her antiemetic regimen worked very well last time. She reports that she has been evaluated and that her physician was very pleased with the improvement of the inflammatory appearance of the left breast. She states that the breast itself is less tender, less heavy, and although she still has some redness on the breast itself, the dimpled texture has resolved. She states she has returned to school, and is now back to teaching.

Physical Examination: Her weight, blood pressure, and temperature are all recorded and stable.
General Appearance: Well nourished female, alert, oriented, and in no acute distress.
HEENT: Moist mucous membranes. No oral lesions or thrush. Neck is supple. Pupils are equal and reactive to light.
Cardiopulmonary Examination: Normal to auscultation
Breasts: Left breast has some erythema. Peau d'orange changes of the skin have now resolved. She continues to have some palpable fullness in the left axilla.

Laboratory: CBC is completely normal

Impression: Inflammatory breast cancer

Plan: We plan to proceed with today's cycle number three of AC. She will return in two weeks for cycle number four. We will confer about the sequencing of chemotherapy and surgery before her next appointment here. She has been instructed to call if she has problems prior to her scheduled appointment.

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Department of Hematology/Oncology
09/13/2007

Chief Complaint: Inflammatory breast carcinoma

Patient is back today for her fourth cycle of Cytoxan and Adriamycin. She states that she has done well since we started her on Emend. She has not had any significant nausea.

Physical Examination: She is afebrile today.
HEENT: Unremarkable
Nodes: No palpable nodes
Cardiovascular: Regular rates and rhythm, without murmurs, rubs or gallops
Lungs: Clear

Impression: Patient is doing well, and her counts look good

Plan: We will go ahead with her next cycle of therapy. She will return in two weeks to begin Taxol.

General Surgery Note
09/26/2007

Patient is in the office today. This woman has had tremendous response to chemotherapy with most of the inflammatory component of the breast cancer completely resolved. No palpable masses appreciated. Most of the peau d'orange are completely resolved and the patient from my perspective is having an excellent response to chemotherapy at this juncture. Question now is going to be the timing of the mastectomy in this patient. I suspect based upon our initial discussion that therapy in terms of eight rounds of chemotherapy will be offered prior to completion mastectomy in this young woman, but given her excellent response, there may be a place to slip in between chemotherapies, do her mastectomy, and have them completed on the back end. I will have her see physician to discuss this with her further and then notify me as to exact timing of the mastectomy. I will sample low-lying nodes but given the inflammatory nature of her cancer, she has been treated already as a stage IV disease.

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Department of Hematology/Oncology
09/27/2007

Chief Complaint: Inflammatory breast carcinoma

Patient is back today to begin Taxol. She is doing well today.

Physical Examination: Her weight is 178 pounds. Blood pressure is 132/80. She is afebrile.
HEENT: Reveals alopecia
Nodes: No palpable nodes
Cardiovascular: Regular rate and rhythm, without murmurs, rubs or gallops
Lungs: Clear
Abdomen: Soft and nontender with no masses or hepatosplenomegaly

Laboratory: White count is 7,800. Hemoglobin is 11.1. Platelets are 178,000.

Impression: Patient is doing well

Plan: We will go ahead with four cycles of Taxol, surgeon will then take her to surgery. She will then receive radiation and Herceptin.

Department of Hematology/Oncology
10/11/2007

Chief Complaint: Inflammatory breast carcinoma

Patient is back today for her second course of Taxol. She did well with the first cycle, except for some leg cramps and joint pain, which she states happened about two or three days afterwards, otherwise, she is doing well without new complaints.

Physical Examination: Her weight is stable. She is afebrile.
HEENT: Unremarkable, except for alopecia
Nodes: No palpable nods
Cardiovascular: Regular rate and rhythm
Lungs: Clear
Abdomen: Soft and nontender

Impression: Patient is doing well. Her laboratory studies look good.

Plan: We will go ahead with her next cycle of chemotherapy. She will return in two weeks. She will use anti-inflammatories and Lorcet for her leg pain.

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Department of Hematology/Oncology
10/25/2007

Chief Complaint: Inflammatory breast carcinoma

Patient is back today for her third Taxol. She did well with the second cycle, and states she is feeling good today.

Physical Examination: Her weight is 182 pounds. Blood pressure is 132/87. She is afebrile.
HEENT: Unremarkable
Nodes: No palpable nodes
Cardiovascular: Regular rates and rhythm, without murmurs, rubs or gallops
Lungs: Clear
Abdomen: Soft and nontender with no masses or hepatosplenomegaly

Laboratory: White count is 10,000. Hemoglobin is 11.8. Platelets are 179,000.

Impression: Patient is doing well, and her counts look good.

Plan: We will go ahead with her next cycle of chemotherapy. She will return in two weeks.

General Surgery Note
10/30/2007

Patient has one more chemotherapy prior to doing her mastectomy for inflammatory breast cancer. The patient will be scheduled in two weeks from now since her next therapy is nxt week, and then mastectomy would be offered. Risks and benefits were discussed with her in detail today, and surgery will be planned as described.

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Department of Hematology/Oncology
11/08/2007

Chief Complaint: Inflammatory breast carcinoma

Patient is back today for her last cycle of Taxol. She continues to do well with her therapy. She has had some fevers after each treatment, but we think that may be from the Neulasta. She has had a good response and will be taken to surgery on 11/20/2007.

Physical Examination: Her weight is 181 pounds. Blood pressure is 135/88. She is afebrile.
HEENT: Unremarkable, except for alopecia
Nodes: No palpable nodes
Cardiovascular: Regular rates and rhythm, without murmurs, rubs or gallops
Lungs: Clear
Abdomen: Soft and nontender with no masses or hepatosplenomegaly

Laboratory: White count is 10,700. Hemoglobin is 12.4. Platelets are 219,000.

Impression: Patient is doing well

Plan: We will go ahead with her next cycle of treatment today. She will have her surgery on the 20th, and we will see her back after that to begin Herceptin.

History & Physical
Hospital Short Stay Record
11/20/2007

Admission Diagnosis: Left Breast CA

Plan: Left Modified Radical Mastectomy

Chief Complaint: Left breast cancer – patient with inflammatory breast carcinoma currently receiving chemo and now presents for mastectomy

Past Medical History: Within normal limits

Past Surgical History: Left ACL; Right ACL; Arthroscopy

Medications: Taxol

Allergies: No known allergies

Social History: Nonsmoker

Physical Examination: WDWN White female in NAD
HEENT: WNL - alopecia
Neck: Supple
Lungs: Clear to auscultation
Heart: RRR
Abdomen: Negative
Extremities: Negative

Operative Report
11/20/2007

Preoperative Diagnosis: Inflammatory breast cancer post chemotherapy

Postoperative Diagnosis: Inflammatory breast cancer post chemotherapy

Operative Procedure: Modified radical mastectomy with only low lying axillary nodes removed

Anesthesia: General

Complications: None

Drains: Two 10 milligram Jackson-Pratt drains

Procedure: Following a general anesthetic, the patient was prepped and draped in the usual sterile fashion. An elliptical incision now utilized with dissection down to the subcutaneous tissue. Flaps now produced superiorly to the clavicle, medial to the sternum, inferiorly to the costal margin, laterally to the latissimus dorsi muscle.

The breast then was removed to include removal of the pectoralis fascia itself off the overlying muscle. Dissection was continued laterally to the latissimus dorsi muscle where the breast was then removed. Dissection of the axilla was carried out and low lying level 1-2 nodes were dissected and subsequently removed with the nodes being sent separately. Following irrigation and hemostasis, two 10 millimeter Jackson-Pratt drains were placed, one in the axilla and one to the chest wall. The skin was then reapproximated with staples. Sterile dressings applied and the patient was taken to recovery.

Pathology Report
11/20/2007

Clinical History: Left breast cancer

Specimen:
1. Breast, left breast
2. Breast, low lying axillary nodes

Gross Description:
1. The first specimen is labeled "Left breast" and consists of a mastectomy specimen measuring 24 x 28 x 6.7 cm partially covered by an ellipse of light tan skin measuring 21 x 8.6 cm. Central is a nipple and areola with a partially healed 1.5 cm linear scar within the areola complex. The adjacent skin shows some blue ink staining but no additional masses are noted. The deep margin of the breast is inked in black. The breast is serially sectioned to reveal largely unremarkable adipose tissue. There are no discrete masses noted. There is some blue dye noted within the breast tissue, beneath the previously described scar adjacent to the areola. This area of blue is located approximately 4 cm from the deep inked surgical margin. Representative sections submitted in nine cassettes. Section code:

   | | |
   |---|---|
   | 1A and B | Nipple and areola with scar |
   | 1C thru H | Left breast tissue with areas of fibrosis |
   | 1I | Deep inked surgical margin |

   Also received in the same container is an ovoid portion of soft rubbery yellow tan adipose tissue measuring 7.1 x 4.3 x 1.4 cm. The specimen is serially sectioned to reveal unremarkable yellow adipose tissue with no areas of firmness or fibrous tissue noted. Representative sections submitted in a single cassette. Additional sections are submitted in five additional cassettes.
2. The second specimen is labeled "Low lying axillary nodes" and consists of an ovoid portion of soft rubbery yellow tan adipose tissue, measuring 3.9 x 3.4 x 1.7 cm. The specimen is serially sectioned and carefully dissected for lymph nodes with all possible lymph nodes submitted. Representative sections are submitted in four cassettes "2A" through "2D".

Microscopic Diagnosis:
1. Examination of sections shows multiple fragments of breast parenchyma. It shows on sections "A" and "B" segments of benign epithelium with no evidence of tumor involvement of the epithelium. Intralymphatic ducts do not show evidence of tumor involvement. There is no evidence of nipple involvement by malignancy. Residual inflammatory carcinoma is not identified. Sections of the breast parenchyma show areas of atypical duct epithelial hyperplasia. Sections "D" show a focus of carcinoma in situ with areas of calcifications identified. It shows markedly atypical glands with no definitive evidence of residual invasive carcinoma or evidence of intralymphatic involvement of malignancy. The glands show atypical enlarged nuclei with macronucleoli present. Remaining breast parenchyma shows fibrosis without evidence of residual tumor identified.
2. Second specimen labeled "Low axillary lymph nodes" reveal seven lymph nodes. No evidence of metastatic tumor is identified.

Final Diagnosis:

1. Left Mastectomy: Residual invasive cancer: Absent. Residual in-situ cancer: Present. Constitutes approximately 100% of tumor. Intraductal carcinoma is of the cribriform type of high nuclear grade and has no central necrosis. Estimated maximum invasive tumor dimensions: current specimen measures .3 cm and .2 cm in prior biopsy findings. Nipple/areola: No evidence of Paget's disease. No nipple involvement. No evidence of dermal lymphatic embolization. Deep margin: Negative. Axillary lymph node status: 0 of 7 positive lymph nodes for metastatic carcinoma.
2. Low axillary lymph nodes: Seven lymph nodes negative for metastatic carcinoma.

TNM Staging Form

| | |
|---|---|
| Primary Tumor (T): | T4 Tumor of any size with direction extension |
| Regional Lymph Node (N): | pN1 Metastasis in 1 to 3 axillary lymph nodes, and/or in internal mammary nodes with microscopic disease detected by sentinel lymph node dissection but not clinically apparent |
| Distant Metastasis: | M0 No distant metastasis |
| Stage Grouping: | IIIB T4 N0 M0 |
| Grade: | G3 High combined histologic grade (unfavorable) |
| Residual Tumor (R) | R0 No residual tumor |

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General Surgery Note
12/15/2007

Patient is in the office today. This woman is doing tremendously well since her mastectomy. She is node negative and is on the heels of neo-adjunctive therapy for her cancer. Mastectomy site is healing quite nicely. She is to be back for Herceptin next week and consideration for her chest wall XRT to be considered in the coming month. I will see her back in six weeks.