

(Pre-2007 multiple primary/histology rules are used for all sites except CNS)

Case 1: Breast

Physical Examination

6/1 Right Breast: 5 x 3 cm mass noted on physical exam by family physician. No pain or tenderness; no nipple discharge; no skin changes. Slight nipple retraction. Freely movable mass. Left breast: no masses palpated. No enlarged lymph nodes

Imaging

6/1 Chest X-ray: Within normal limits.

6/1 Mammogram: Right breast mass, UOQ, possible malignancy

6/8 Bone scan: No evidence of skeletal disease. Thoracic and lumbar spine; negative for metastases.

Laboratory

SMA 12: within normal limits

Estrogen receptor assay: positive for estrogen receptors

Procedures

6/8 Needle aspiration of right breast

6/15 Biopsy and right modified radical mastectomy

Pathology Reports

6/8 Aspiration cytology: Adenocarcinoma of right breast.

6/15 Biopsy and right mastectomy: Infiltrating ductal carcinoma, tubular type, of right breast with dermal invasion; tumor is attached to fat; tumor size is 7.0 x 4.0 x 4.0 cm; lesion is located at 12:00; grade is Bloom Richardson intermediate. No evidence of tumor in 32 regional lymph nodes. Immunohistochemistry shows isolated tumor cells (< 0.2 mm in size) in two low axillary lymph nodes.

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Answers

Case 1 Breast	Answer	Rationale
Date of Dx	6/8	Needle aspiration; <i>FORDS</i> , p. 89
Primary Site	C50.8	Mastectomy path, 12 o'clock, overlapping lesion; path takes precedence when there's conflict in medical record info (12 o'clock per path vs. UOQ per mammogram); <i>SEER Program Coding and Staging Manual (PCSM) 2004</i> , Appendix C, p. C-470
Laterality	1	PE; <i>FORDS</i> , p. 92
Histology	8211/32	<i>SEER PCSM 2004</i> , p. 87, histology coding rules for single tumor #6 Mastectomy path; breast grading conversion table, <i>SEER PCSM 2004</i> , p. 94; <i>FORDS</i> p. 14
CS Extension	20	Mastectomy path, dermal invasion; <i>Collaborative Staging (CS) Manual</i> , p. 458
CS Lymph Nodes	00	Mastectomy path; <i>CS Manual</i> , p. 460, note 5
CS Mets at Dx	00	Bone scan negative; <i>CS Manual</i> , p. 462
Surg Primary Site	51	Op report; <i>FORDS</i> p. 269
Scope Reg Ln Surg	5	Modified radical mastectomy op report, <i>FORDS</i> , p. 138
Surg Proc/Other Site	0	<i>FORDS</i> , p. 142
Rad Reg Treatment Mod	00	<i>FORDS</i> , p. 155
Chemotherapy	00	<i>FORDS</i> , p. 171
Hormone Therapy	00	<i>FORDS</i> , p. 175
Immunotherapy	00	<i>FORDS</i> , p. 179
Hem Tsplt & End Proc	00	<i>FORDS</i> , p. 183
Other Treatment	0	<i>FORDS</i> , p. 186

Case 2: Breast

Physical Examination

4/12 Right breast: 4 x 3 cm firm, irregular mass at 1:00 position. No skin changes, no dimpling, no nipple discharge. Freely movable mass. Left breast: no masses palpated. Palpable lymph nodes in right axilla, clinically suspicious for involvement.

Imaging

4/12 Mammogram: Suspected malignant lesion in right breast. Faint calcifications at mirror image position in left breast.

4/12 Chest X-ray: Within normal limits.

Laboratory

SMA 12: fasting blood sugar elevated.
Estrogen/progesterone receptors: ER mildly positive, PR negative.

Procedures

4/15 Bilateral breast biopsies

8/1 Right modified radical mastectomy

Pathology Report

4/15 Biopsies: Right breast, extensive intraductal carcinoma. Left breast; fibrocystic disease.

8/1 Right modified radical mastectomy: Extensive intraductal comedocarcinoma. Ten level I axillary lymph nodes negative for metastases. Tumor size = 2.1 cm.

Oncology

Three courses of Cytoxan and Adriamycin (adjuvant) beginning in May.

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Answers

Case 2 Breast	Answer	Rationale
Date of Dx	4/12	Mammogram; <i>FORDS</i> , p. 3, ambiguous terms that constitute diagnosis
Primary Site	C50.2	PE; <i>SEER Program Coding and Staging Manual (PCSM) 2004</i> , Appendix C, C-470, breast clock
Laterality	1	PE; <i>FORDS</i> , p. 92
Histology	8501/39	Mastectomy path, comedocarcinoma; <i>SEER Program Coding and Staging Manual (PCSM) 2004</i> , histology coding rules for single tumor #5, p. 86 <i>Collaborative Staging (CS) Manual</i> , note 4, p. 458, if extension code is 10, behavior code must be 3
CS Extension	10	<i>CS Manual</i> , p. 29, instructions for coding CS extension #9, don't code extension in situ if there is evidence of nodal involvement, use localized NOS if no better info
CS Lymph Nodes	60	PE; <i>CS Manual</i> , p. 460, note 4, if pre-surgical therapy was given and there is clinical evaluation of nodes, use 60 for clinically positive axillary nodes
CS Mets at Dx	00	Chest X-ray normal, <i>CS Manual</i> , P. 462
Surg Primary Site	51	Mastectomy op report; <i>FORDS</i> , p. 269
Scope Reg Ln Surg	5	Modified radical mastectomy op report; <i>FORDS</i> , p. 138
Surg Proc/Other Site	0	<i>FORDS</i> , p. 142
Rad Reg Treatment Mod	00	<i>FORDS</i> , p. 155
Chemotherapy	03	Multi-agent chemotherapy; <i>FORDS</i> , p. 171
Hormone Therapy	00	<i>FORDS</i> , p. 175
Immunotherapy	00	<i>FORDS</i> , p. 179
Hem Tsplt & End Proc	00	<i>FORDS</i> , p. 183
Other Treatment	0	<i>FORDS</i> , p. 186

Case 3: Breast

Physical Examination

6/21 Palpable lump in LOQ, right breast. No adenopathy in right or left axilla.

Imaging

6/21 Chest X-ray: within normal limits

Laboratory

ER/PR study results are not currently available.

Procedures

6/28 Stereotactic biopsy of right breast

7/9 Right breast lumpectomy

7/9 Sentinel lymph node biopsy

Pathology Reports

6/28 Right breast biopsy: Ductal carcinoma in situ

7/9 Lumpectomy: Fibrofatty tumor measuring 1.5 x 1.0 x 0.9 cm. Ductal carcinoma in situ with microinvasive apocrine adenocarcinoma and focal associated central necrosis present in multiple microscopic foci. No tumor seen at or approaching surgical resection margins.

7/9 Sentinel node biopsy: GROSS: A: Right axillary lymph node, sentinel lymph node measuring 3.5 x 2.0 x 1.0 cm. B: Second sentinel lymph node measuring 2.0 x 1.0 x 0.5 cm. C: Axillary node right breast reveals multiple potential lymph nodes ranging in size from 0.6 to 1.1 cm in greatest dimension. D: Supraclavicular node measuring 1.2 x 1.0 x 0.6 cm. FINAL DIAGNOSIS: A: Right axillary sentinel node excision: Metastatic carcinoma consistent with breast primary, present in one of one identified lymph node (1/1); no extranodal invasion identified. B: Second right axillary sentinel lymph node, excision: 1 lymph node w/no tumor identified (0/1). C: Axillary node right breast, excision: metastatic carcinoma consistent with breast primary, present in 2 of 3 lymph nodes (2/3); extracapsular invasion in fibroadipose tissue is present. D: Supraclavicular node right breast excision: metastatic carcinoma consistent w/ breast primary, present in one identified lymph node (1/1); extracapsular invasion into adipose tissue is present.

Oncology

The patient had a consult with an oncologist who recommended post-operative chemotherapy.

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Answers

Case 3 Breast	Answer	Rationale
Date of Diagnosis	6/28	Breast biopsy; <i>FORDS</i> , p. 89
Primary Site	C50.5	PE; <i>FORDS</i> , p. 91
Laterality	1	PE; <i>FORDS</i> , p. 92
Histology	8401/39	Lumpectomy path; <i>SEER Program Coding and Staging Manual (PCSM) 2004</i> , p.86, histology coding rules for single tumor #2
CS Extension	10	Lumpectomy path; <i>Collaborative Staging (CS) Manual</i> , p. 458
CS Lymph Nodes	80	LN dissection path; <i>CS Manual</i> , p. 4
CS Mets at Dx	00	Chest X-ray; <i>CS Manual</i> , p. 462
Surg Primary Site	22	Lumpectomy op & path; <i>FORDS</i> , p. 269
Scope Reg Ln Surg	6	Path; <i>FORDS</i> , p. 139, code 6 = 2 (sentinel LN biopsy) + 5 (4 or more LNs dissected)
Surg Proc/Other Site	0	<i>FORDS</i> , p. 142
Rad Reg Treatment Mod	00	<i>FORDS</i> , p. 155
Chemotherapy	88	<i>FORDS</i> , p. 172
Hormone Therapy	00	<i>FORDS</i> , p. 175
Immunotherapy	00	<i>FORDS</i> , p. 179
Hem Tsplt & End Proc	00	<i>FORDS</i> , p. 183
Other Treatment	0	<i>FORDS</i> , p. 186

Case 4: Breast

Physical Examination

12/31 The patient is a 73-year-old female and presents with suspicious calcification of the right breast discovered on routine screening mammogram. Physical exam revealed no palpable mass in the breast and negative axillary and supraclavicular adenopathy. All other systems are normal.

Imaging

12/10 Mammogram, right breast: Calcifications in the upper outer quadrant, some prominent right axillary lymph nodes, less likely metastatic.

Laboratory

ER/PR: Negative

P53/CERB-2: Positive

Procedures

12/31 Stereotactic needle core biopsy, right breast

1/13 Ultrasound needle guided biopsy, right breast

2/19 Modified radical mastectomy, right breast

Pathology

12/31 Stereotactic biopsy: Ductal carcinoma in situ, grade 3 of 3.

1/13 Ultrasound needle guided biopsy: Infiltrating mammary carcinoma with duct and tubular differentiation. Duct carcinoma in situ.

2/19 Mastectomy: Infiltrating poorly differentiated mammary carcinoma, nuclear grade 2 of 3, measuring 9.9 cm in largest diameter, duct and tubular features with mass-like lymphatic invasion in central duct regions and three quadrants. Extensive lymphatic invasion including nipple and dermal lymphatics. Metastatic carcinoma to 24 of 33 lymph nodes.

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Answers

Case 4 Breast	Answer	Rationale
Date of Dx	12/31	Breast biopsy; <i>FORDS</i> , p. 89
Primary Site	C50.4	Mammogram; <i>FORDS</i> , p. 91
Laterality	1	Mammogram; <i>FORDS</i> , p. 92
Histology	8523/32	Mastectomy path; <i>SEER Program Coding and Staging Manual (PCSM) 2004</i> , p. 86, histology coding rules for single tumors #4 <i>SEER PCSM 2004</i> , p. 94 and <i>FORDS</i> , p. 14, breast grade conversion table; <i>SEER PCSM 2004</i> , p. 94 and <i>FORDS</i> , p. 13, nuclear grade takes precedence over terminology when coding grade
CS Extension	20	Mastectomy path; <i>Collaborative Staging (CS) Manual</i> , p. 458
CS Lymph Nodes	25	Modified radical mastectomy path, axilla removed including its nodes; <i>CS Manual</i> , p. 460; SEER Inquiry System (SINQ) 20051018, movable is involved node not described as fixed or matted
CS Mets at Dx	00	PE, systems normal; <i>CS Manual</i> , p. 462
Surg Primary Site	51	Modified radical mastectomy; <i>FORDS</i> , p. 269
Scope Reg Ln Surg	5	Modified radical mastectomy; <i>FORDS</i> , p. 138
Surg Proc/Other Site	0	<i>FORDS</i> , p. 142
Rad Reg Treatment Mod	00	<i>FORDS</i> , p. 155
Chemotherapy	00	<i>FORDS</i> , p. 171
Hormone Therapy	00	<i>FORDS</i> , p. 175
Immunotherapy	00	<i>FORDS</i> , p. 179
Hem Tsplt & End Proc	00	<i>FORDS</i> , p. 183
Other Treatment	0	<i>FORDS</i> , p. 186

Case 5: Breast

Consultation 11/4/Xx

Reason for Referral: Breast cancer, clinical stage I.

Chief Complaint: Breast cancer, s/p lumpectomy.

History of Present Illness: This is the first visit to me for this 64-year-old woman, referred for consultation regarding evaluation and management of early stage breast cancer. She was in her usual state of health until a lesion was found on routine mammogram. Needle-localized breast biopsy revealed infiltrating ductal carcinoma, Grade I, 9-10 mm in size. Margins were close. She is referred here for consultation regarding evaluation and management, specifically for sentinel lymph node biopsy. She has had some preliminary discussion about this and is knowledgeable on the topic.

Family History: Maternal great aunt developed breast cancer in her mid 60s. Maternal uncle had throat cancer (smoked). Paternal uncle had lung cancer (smoked).

Social History: Hairdresser and worked at a pen company. Ex-smoker quit 30 years ago. No ETOH.

Past Medical History: Hypertension. Coronary artery disease. CHF. "Heart valve leak" per patient. Diverticulosis and diverticulitis. Diabetes.

Past Surgical History: VGB, complicated by infection, requiring VBG take down in 1993. Lumbar spine fusion in 1991. Right rotator cuff repair. Open cholecystectomy and appendectomy in 1965.

Review of Systems

Gyn: Menarche age 11, G5P4, did not breast feed. Went through natural menopause in 1990, no HRT. No fever or chills, no weight loss. No chest discomfort. She gets SOB with walking, but her walking distance is very limited by her back problems. She has to use cane. No abdominal pain, but occasional constipation.

Physical Exam: Moderately obese white female, alert and oriented, in NAD. Breasts symmetric with nicely healing circumareolar incision on the right. Nipples and areolae normal; axillae and supraclavicular regions negative. Induration under biopsy site, no other masses noted.

Heart: Regular rhythm, no murmur. Chest: CTAB. Abdomen: bowel sounds present, soft distended, non-tender, several large parallel abdominal scars with large ventral hernia. Extremities: well perfused, no edema.

Results Reviewed: Chart, mammograms viewed, outside reports reviewed.

Impression: Breast cancer, clinical stage 1.

Plan: Re-excision and SLN, with AND if SLN is positive. I discussed with patient and she understands and agrees. Given patient's associated medical problems, she will need cardiology evaluation and clearance prior to surgery.

Pathology Report Consultation (Case 5 Breast)

Collected: 11/04/xx

Surgical Pathology Examination

Diagnosis

Breast, right, biopsy. Infiltrating ductal carcinoma, Elston-Ellis histologic grade I, no capillary-lymphatic space invasion identified. Largest size identifiable on microscopic slide 0.9 x 0.4 cm. No capillary-lymphatic space invasion identified. Tumor is less than 1mm from apparent resection margins. Ductal carcinoma in situ, low grade is present and within 1.0 mm of resection margin.

Comment

Estrogen receptor and progesterone receptors were done. The estrogen and progesterone receptors are positive, Her-2 neu by florescence in situ hyalinization is not amplified. The DNA index is diploid with a 2.3 % S-phase.

History

Outside slides: Right breast biopsy revealing breast cancer. Please interpret.

Outside Pathology Report, Transmittal Form, Surg Path Consult Gross

OSS Case

Microscopic

One surgical pathology case and its accompanying pathology report are reviewed. We concur with the referring diagnosis. As the primary pathologist on this case, I have personally reviewed this case and edited the report as necessary.

Surgery Report (Case 5 Breast)

Surgical Service—General Surgery

Surgery/Procedure Date: 11/22/XX

Anesthesia: Block, with general anesthesia.

Pre-Operative Diagnosis: Right breast infiltrating ductal carcinoma.

Operation/Procedure: Re-excision of right breast infiltrating ductal carcinoma. Right axillary sentinel lymph node biopsy times 2.

Post-Operative Diagnosis: Same.

Indications: Patient is a 64-year-old female who underwent lumpectomy for right breast infiltrating ductal cancer at an outside hospital. Clear margins were less than 1 mm. She presents here for re-excision of cancer, as well as axillary re-staging.

Findings: Excellent localization to two right axillary sentinel lymph nodes, negative for cancer cells on touch prep. No unusual findings on re-excision.

Complications: None.

Description of Operation/Procedure: After injection of radioactive tracer in the Radiology Department, the patient was brought to the operating room. Under general endotracheal anesthesia, she was prepped and draped in the usual sterile fashion. Lymphazurin blue dye 5 cc was injected along the lateral side of previous lumpectomy incision. This area was massaged with sterile towel for 5 minutes. The patient was prepped and draped in the usual fashion. A 4 cm transverse skin incision was made in the axilla in the area of projection of sentinel lymph nodes as marked by Radiology team. Dissection was further continued with electrocautery until axillary fascia was opened. Dissection was further continued sharply and bluntly until, using the Gamma probe, sentinel lymph nodes were localized. They had a slight blue hue. They were excised and sent for touch prep. Touch prep was negative for cancer cells. Ex vivo counts for the two sentinel lymph nodes were respectively, 571 and 233. Bed count after the second lymph node excision was 37. No additional blue or palpable nodes were noted. This was considered to be adequate sentinel lymph node biopsy. The wound was irrigated with normal saline and inspected for hemostasis. Excellent hemostasis was achieved. Axillary fascia was closed with interrupted 3-0 Vicryl to dermis. Running 4-0 Monocryl subcuticular stitch. Sterile dressing was applied.

Attention was then turned to the right breast. Skin incision was made along lumpectomy incision. Dissection was further continued with electrocautery until the seroma cavity was entered. Scant serous drainage. Dissection was continued around the capsule of post-lumpectomy seroma until the specimen was completely excised with at least 1 cm breast tissue around the previous lumpectomy site. Post-lumpectomy capsule was never entered during the re-excision. The specimen was oriented and sent to Pathology. Upon examination of the wound, no other abnormalities were palpated. The wound was thoroughly irrigated with normal saline and inspected for hemostasis. Interrupted 3-0 Vicryl to dermal layer, running 4-0 Monocryl subcuticular stitch. Sterile dressing was applied. The patient tolerated the procedure well, with no complications.

Pathology Report (Case 5 Breast)

Collected: 11/22/XX

Surgical Pathology Examination

Diagnosis:

- A. Lymph node, sentinel #1, excision: No tumor identified.
- B. Lymph node, sentinel #2, excision: No tumor identified.
- C. Breast, right, lumpectomy: No evidence of residual invasive carcinoma; focus of lobular carcinoma in situ at anterolateral margin. Multifocal ductal hyperplasia without atypia. Extensive fat necrosis; biopsy cavity identified.

History: Patient with right ductal carcinoma of breast. Not with good margins, for re-excision and sentinel lymph node.

Tissue Submitted:

- A. Lymph node #1 "touch prep"
- B. Lymph node #2 "touch prep"
- C. Re-excision lumpectomy, short stitch superior, long stitch lateral

Frozen Section:

- A. Lymph node #1: FS: No tumor cells identified. TPx2 KAK FAM
- B. Lymph node #2: FS: No tumor cells identified. TPx1 KAK FAM

Gross

- A. Received fresh for frozen section is a 4.4 x 2.1 x 1.1 cm mass of yellow, lobulated adipose tissue containing a 1 x 0.7 x 0.6 cm pink lymph node. A touch preparation is made. The remnant is submitted in A1. A1, lateral margin, perpendicular section; A2-A18, biopsy cavity is submitted in its entirety; A19, medial margin, perpendicularly sectioned.
- B. Received fresh for frozen section is a 3 x 2.5 x 0.7 cm aggregate of adipose tissue containing three lymph nodes, ranging in size from 1 to 1.6 cm in greatest dimension. Touch preparations are made. The remnants are submitted 100% in B1-B3.
- C. Received in formalin is a 7.5 x 5.5 x 4.1 cm mass of yellow, lobulated adipose tissue with a short stitch denoting the superior aspect and the long stitch denoting the lateral aspect of the specimen. The superior aspect is inked blue, the inferior aspect is inked green, the anterolateral aspect is inked orange, and the posteromedial aspect is inked black. The specimen is sectioned serially from lateral to medial. Sectioning reveals yellow, lobulated adipose tissue and a cavity with a white fibrous rim and surrounding white, firm tissue, possibly consistent with fat necrosis, scar or carcinoma. Sections submitted: C1, lateral margin; C2-C18, entire biopsy cavity; C19, medial margin. More tissue later submitted: C20, level 3, superior; C21, level 3, anterolateral; C22, level 4, superoposterior medial; C23, level 4, superoanterolateral; C24-25, level 5, superoanterolateral; C26-27, level 5 superoposteromedial; C28-29, level 6, posteromedial; C30, level 6, inferoanterolateral; C31, level 6, inferior; C32, level 7, superoanterolateral; C33, level 7, superoposteromedial; C34, level 7, inferoposteromedial; C35, level 7, inferoanterolateral; C36, level 8, superoanterolateral; C37, level 8, inferior. LATC.

Microscopic:

- A. Sections reveal a lymph node with no evidence of metastatic carcinoma.
- B. Sections reveal a lymph node with no evidence of metastatic carcinoma.
- C. Sections of biopsy cavity, lateral and medial margins, reveal no evidence of residual invasive adenocarcinoma. Sections reveal extensive fat necrosis with granulomatous foreign body inflammation. There are multiple focal areas of ductal hyperplasia. There is focal lobular carcinoma in situ some at the anterolateral margin (C6). Mucicarmine stain shows intracytoplasmic lumina.

Consultation Note – Radiation Oncology (Case 5 Breast)

12/1/xx

Primary Site: Right Breast

Histopathology: Infiltrating ductal carcinoma.

Chief Complaint: Evaluate for radiation therapy.

History of Present Illness: This patient is a 64-year-old female who had an abnormal mammogram. A needle localization biopsy was performed in August. This was reviewed and showed infiltrating ductal carcinoma, Elston-Ellis grade 1, and no papillary space invasion. The tumor was 0.9 x 0.4 cm. Ductal carcinoma in situ low grade was present within 1 mm of the resection margin. Estrogen and progesterone receptors are positive; HER-2/neu is not amplified. The patient was seen in Medical Oncology on 11/xx/xx. The doctor recommended axillary surgery. On 11/22/xx she had a sentinel lymph node procedure. No tumor was identified in sentinel lymph nodes. She had a right lumpectomy, and there was no evidence of residual invasive carcinoma. The patient has been seen by XXXX who recommended tamoxifen times five years. She was referred for consideration of breast radiation therapy. Currently she is feeling well. She has some fatigue. Prior to her surgery she has been active swimming at the YMCA and exercising at home.

Past Medical History: Past medical history is positive for hypertension, diabetes, congestive heart failure, diverticulosis, and diverticulitis. She is status post back surgery with hardware placement secondary to injury and bad disc. She had vertical band gastroplasty, eye surgery, hernia surgery, and has sleep apnea.

Family History: Family history is positive for a great aunt who had breast cancer in her late 60s. According to the patient her aunt did not seek treatment until this tumor was quite advanced. Patient's sister had adenoid cystic carcinoma of the neck. She had an uncle with throat cancer and an uncle with lung cancer.

Social History: She is married. She smoked for 15 years, but quit at age 30. She does not use alcohol. She is apparently quite active socially and swims on a regular basis.

Allergies: No reported drug allergies.

Review of Systems: Review of systems is negative, aside from items mentioned.

Physical Exam: Physical exam reveals a pleasant, well-appearing female. HEENT is within normal limits. Lymph Nodes: There is no palpable cervical, supraclavicular, or axillary adenopathy. Lungs are clear. Heart: normal sinus rhythm. Abdomen is soft, non-tender, and protuberant, with multiple scars. The patient has a ventral hernia. Breast Exam: Left breast is without dominant masses. Right breast has a healed excisional biopsy scar in the upper outer quadrant. There is mild erythema and bruising surrounding the scar, but no sign of active infection at this time. Extremities are without edema.

Results Reviewed: Pathology results from 11-4-xx and 11-22-xx reviewed.

Impression: Infiltrating ductal carcinoma of the right breast, T1N0. Tamoxifen has been recommended for systemic treatment. I recommend postoperative irradiation to reduce her risk of recurrence in the breast. If the patient decides to be treated here, we will proceed with CT-based planning, treat the breast to 50.4 Gy followed by a boost of 10 Gy to the site of the excised tumor. She has not decided if she would like to be treated here or at a center closer to home. She will inform us of her decision.

Clinical Notes – Surgery (Case 5 Breast)

2/1/yy

Chief Complaint: Follow-up breast cancer.

History of Present Illness: Patient is a 64-year-old female status post right needle localization excisional right biopsy locally with pathology revealing infiltrating ductal carcinoma, Elston-Ellis Grade I/III, no capillary lymphatic invasion, tumor measuring 0.9x 0.4 cm with DCIS within 1 mm of nearest margin. She subsequently underwent repeat excision with sentinel lymph node on 11/22/xx. Final pathology showed no residual carcinoma with 0/2 nodes and presence of LCIS in the excisional margin. She has completed radiation therapy and has done well. She has just begun Tamoxifen. She has no complaints referable to the breast; no lumps, bumps, nipple discharge. No problems with arm.

Family History: Sister (age 70) just diagnosed with breast cancer. She has daughters.

Social History: Unchanged from previous visit.

Past Medical History: Unchanged from previous visit.

Past Surgical History: Unchanged from previous visit.

Review of Systems: Unchanged from previous visit.

Physical Exam: Moderately obese white female, alert and oriented, in NAD. Breasts are symmetric with slight deformity (dimpling) of lumpectomy site. Nipples and areolae are normal; axillae and supraclavicular regions are negative.

Impression: Doing well.

Plan: RTC four months, unilateral post-treatment mammograms to be done outside, sooner prn.

Radiological Consultation Report (Case 5 Breast)

Chest X-Ray

11/04/xx

History: Breast cancer and history of CHF. Rule out metastases.

Findings: PA and lateral views of the chest without prior comparison show normal cardiac silhouette. Pulmonary vascular is within normal limits. There are no focal infiltrates or effusions. There are multiple surgical staples below the diaphragm. There are several perihilar calcified granulomas bilaterally. There are no masses seen.

Impressions:

1. No acute cardiopulmonary process.
2. Multiple calcified granulomas in the perihilar region.
3. No evidence of metastases.

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Answers

Case 5 Breast	Answer	Rationale
Date of Diagnosis	8/99/xx	Consultation note-rad onc, biopsy in August showed infiltrating duct ca; <i>FORDS</i> , p. 89
Primary Site	C50.4	Consultation note-rad onc, PE, biopsy scar in UOQ; <i>FORDS</i> , p. 91
Laterality	1	Path consult 11/4; <i>FORDS</i> , p. 92
Histology	8522/31	Lumpectomy path & re-excision path; <i>SEER Program Coding and Staging Manual (PCSM) 2004</i> , p. 86, histology coding rules for single tumors #4, Appendix C, p. C-471, if dx is both lobular & ductal (in situ or invasive or combination of in situ and invasive) use code 8522 11/4 path report; <i>SEER PCSM 2004</i> , p. 92, general coding rule #2, if more than 1 path report, code highest grade
CS Extension	10	Re-excision path; <i>Collaborative Staging (CS) Manual</i> , p. 458
CS Lymph Nodes	00	SLN biopsy path; <i>CS Manual</i> , p. 460
CS Mets at Dx	00	Chest X-ray; <i>CS Manual</i> , p. 462
Surg Primary Site	23	Re-excision op report; <i>FORDS</i> , p. 269
Scope Reg Ln Surg	2	SLN biopsy op report; <i>FORDS</i> , p. 138
Surg Proc/Other Site	0	<i>FORDS</i> , p. 142
Rad Reg Treatment Mod	20	Clinical notes surgery, HPI; <i>FORDS</i> , p. 155
Chemotherapy	00	<i>FORDS</i> , p. 171
Hormone Therapy	01	Clinical notes surgery, HPI; <i>FORDS</i> , p. 175
Immunotherapy	00	<i>FORDS</i> , p. 179
Hem Tsplt & End Proc	00	<i>FORDS</i> , p. 183
Other Treatment	0	<i>FORDS</i> , p. 186