**CASE #1**

**Physical exam**

4 cm lesion on left base of tongue. Palpable cervical lymph node on the left side. No other abnormal findings reported.

**X-Rays and Scans**  CXR: negative

**Scopes** Laryngoscopy: negative

**Pathology**

Base of tongue: moderately differentiated non-keratinizing squamous cell carcinoma, completely resected. Tumor size: 3\*2cm. No muscle invasion. Metastatic squamous cell carcinoma in 2 (size 2 cm) of 8 submental lymph nodes and 0 of 12 upper cervical lymph nodes.

**Primary Site** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Morphology** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**CASE #2**

**Physical exam**

48 year old male smoker complaining of hoarseness. 2 cm firm lymph node in left upper jugular region.

**X-Rays and Scans** Chest X-ray: negative

**Laryngoscopy** Lesion of left false cord visualized. Vocal cords fixed.

**Operative Report** Supraglottic laryngectomy and left radical node dissection

**Pathology**

Squamous cell carcinoma of the supraglottic larynx. Tumor size, 2.5cm. Metastases present in 2 of 5 prelaryngeal lymph nodes, 1 of 7 parapharyngeal nodes and 1 of 3 middle deep cervical nodes. Largest node measures 5.3cm. None of the involved lymph nodes demonstrate evidence of extracapsular extension.

**Primary Site** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Morphology**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CASE #3**

**Physical exam**

Oropharynx showed presence of granular lesion involving lateral aspect of uvula creeping towards edge of soft palate and onto posterior pillar on the left side. No palpable nodes in the neck or supraclavicular area.

**X-Rays and Scans**  CXR: Question of nodule in right lower lobe.

**Scopes**

Direct laryngoscopy with biopsy of soft palate and uvula. Finding; granular lesion of soft palate appears to be involving uvula.

**Surgical findings**

Excision of palatal carcinoma, tonsillectomy, palatal pharyngoplasty. Findings: Palatal carcinoma involving uvula extending along left-edge of soft palate onto anterior and posterior pillar with no direct infiltration of tonsil.

**Pathology**

Infiltrating moderately to poorly differentiated focally keratinizing squamous cell carcinoma arising from epithelium of uvula. Deep margins free. Epithelial margins show onw margin negative and the opposite involved microscopically by malignant process. Tumor size 1.0cm.

**Primary Site** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Morphology** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CASE #4**

**Physical exam**

Tobacco chewer for 50 years. Large fungating tumor of right floor of mouth involving retromolar trigone and lowere alveolar ridge. No palpable nodes or masses.

**X-Rays and Scans** Chest X-ray: negative

**Triple Endoscopy**

No additional lesions visualized in pharynx, larynx, esophagus or bronchi.

**Operative Report**

Extensive leukoplakia, healing ulcer right floor of mouth

**Pathology**

Resection of tongue, mandible and floor of mouth, right radical neck dissection: 2.8cm moderately differentiated squamous cell carcinoma, right floor of mouth. No metastases to 35 lymph nodes in levels I through IV.

5-6-2004 to 6-20-2004 5400 gray to right retromolar trigone and lower alveolar ridge.

**Primary Site** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Morphology** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CASE #5**

**Physical exam**

4/8/CCXX 1.5-2cm mass in tail of left breast confirmed by outpatient mammogram.

 Right breast and bilateral axillae negative.

**X-Rays and Scans**

4/15/CCXX Chest X-ray: Essentially normal.

 Bone scan: Normal

 Liver/spleen scan: Negative

**Laboratory**

4/25/CCXX Estrogen receptor and progesterone receptor assays: Both within positive range

**Surgical findings**

5/1/CCXX Mastectomy: Several enlarged nodes, all appear benign.

**Pathology**

4/25/CCXX Excisional biopsy: 2.0cm poorly-differentiated infiltrating ductal carcinoma;

 Surgical margins are microscopically involved with tumor.

5/1/CCXX Mastectomy: Rim of tumor tissue in former biopsy site (size not recorded)

 which contains ductal carcinoma; 3 of 21 lymph nodes positive for metastases.

 Surgical margins are clear.

**Treatment**

4/25/CCXX Excisional biopsy

5/1/CCXX Left modified radical mastectomy

**Primary Site** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Morphology** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CASE #6**

**Physical exam**

Right breast 5\*3cm 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**

4/12/CCXX Chest X-ray: within normal limits

4/14/CCXX Thoracic and lumbar spine: negative for metastases

**Laboratory**

4/14/CCXX Blood work: within normal limits

4/15/CCXX Estrogen receptor assay: positive for estrogen receptors

**Surgical findings**

3/13/CCXX Needle aspiration of right breast

4/15/CCXX Biopsy and right modified radical mastectomy

**Pathology**

3/13/CCXX Grade IV adenocarcinoma of right breast

4/15/CCXX Infiltrating ductal carcinoma of right breast with vascular and lymphatic invasion;

 no evidence of tumor in 32 regional lymph nodes; tumor is attached to fat; tumor

 size is 7.0\*4.0\*4.0 cm; lesion is located at 12:00; differentiated is grade II

**Primary Site** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Morphology** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CASE #7**

**Chief complaint**

Patient came to her doctor after finding a hard mass in her left breast. Did not perform breast self examination on a regular basis. No nipple discharge or nipple retraction. Postmenopausal. smoker.

**Physical exam**

Physical exam: 4\*4cm hard mass, upper inner quadrant left breast. On examination skin was dimpled with evidence of edema and peau d’orange

Axillary examination: palpable suspicious nodes in lower axilla

Remainder of exam: No organomegaly or enlarged lymph nodes other than in axilla

Chest: Clear

**Imaging** Chest X-ray: Normal

**Laboratory report**

Breast biopsy: Estrogen and progesterone receptors: positive

**Surgical procedures**

6/21/CCXX Needle biopsy, left breast

7/06/CCXX Left modified radical mastectomy

**Operative report**

7/06/CCXX Skin tightly adherent to 3.5cm gritty mass, left upper inner quadrant in fatty breast

 tissue just below dermis. Careful dissection of axilla. Thorough examination of chest

 wall to midline showed no suspicious masses.

**Pathology reports**

6/21/CCXX Core needle biopsy: poorly differentiated infiltrating duct carcinoma

7/06/CCXX Modified radical mastectomy: 3\*3cm poorly-differentiated infiltrating ductalcarcinoma with infiltration of dermis but no ulceration of skin surface. Areas of ductal carcinoma in situ not seen. 04/17 axillary lymph nodes involved. Size of largest metastasis within a lymph node: 8 mm

**Further treatment**

Post-operative radiation therapy to axilla. Referred for consideration of adjuvant chemotherapy times 3 cycles.

**Primary Site** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Morphology** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CASE #8**

**History**

Chest pain, productive cough hoarseness with partial vocal cord paralysis. One pack per day cigarette smoker \* 40 years

**Physical exam**

Lungs, slight wheezing on expiration in both lungs. Otherwise no abnormal findings.

**Laboratory**

11/19/CCXX Laboratory tests: Within normal limits

**Imaging**

11/29/CCXX Chest x-ray: 6 cm. right upper lobe mass: incomplete atelectasis same lung.

 Pneumonitis and pleural effusion apparent. Separate mediastinal mass noted.

**Surgical observations**

11/30/CCXX Bronchoscopy with biopsy: Right upper lobe mass noted with extension along

 lateral wall of main stem bronchus involving trachea.

12/1/CCXX Scalene node biopsy

**Pathology**

11/30/CCXX Squamous cell carcinoma. poorly differentiated, lung biopsy. Bronchial washings and

 brushings positive for malignant cells.

12/1/CCXX Scalene node biopsy: Metastatic squamous cell carcinoma.

**Primary Site** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Morphology** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CASE #9**

**History and physical exam**

Patient admitted for progressive weakness and weight loss.

Neck: supple, no palpable nodes

Abdomen: liver down a finger breath

Remainder of exam consistent with cachectic elderly male.

**Imaging techniques**

9-15-CCXX Chest x-ray: Right suprahilar soft tissue subpleural mass with extension into

 superior mediastinum. Mass measures 6.0\*3.0 cm. No evidence of hilar or

 mediastinal nodal metastases. Left lung and hilum are essentially within normal

 limits

**Laboratory**

None

**Endoscopic procedures**

None

**Surgical observations**

9-18-CCXX Needle biopsy, right suprahilar mass; no observation recorded

**Pathology**

9-18-CCXX Needle biopsy, right lung: Poorly differentiated non-keratinizing squamous cell

 carcinoma

Patient referred to radiation oncology for consultation and probable treatment.

**Primary Site** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Morphology** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CASE #10**

**History and physical exam**

Patient complained of cough of 12 months duration. Recent development of pleuritic chest pain aggravated by deep breathing.

Lungs: Wheezing on expiration in both lungs. Remainder of physical exam shows elderly male in moderate distress. No organomegaly or adenopathy.

**Imaging techniques**

11-09-CCXX Chest x-ray: subpleural-based right upper lobe mass extending through pleura.

11-11-CCXX Chest tomograms: Solitary 4cm mass at inner edge of lung extending through

 pleura and into intercostal muscles of chest wall. Enlarged subcarinal lymph nodes.

**Laboratory**

CBC and differential normal. CPK and Alkaline phosphatase elevated.

**Endoscopic procedures**

11-12-CCXX Mediastinoscopy and biopsy: tumor mass extending from right upper lobe involving

 pleura and soft tissues of chest wall but not ribs.

**Surgical observations**

No surgery

**Pathology**

11-02-CCXX Thoracoscopy biopsy: poorly differentiated large cell carcinoma in muscle fibers of

 chest wall

Patient referred for consideration of concurrent radiation and chemotherapy.

**Primary Site** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Morphology** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CASE #11**

**Physical exam**

10-27-CCXX Abdomen reveals liver edge palpable on deep inspiration but not firm. Patient

 exhibits tenderness in epigastric region. No palpable masses, but some firmness.

**X-rays and scans**

10-5-CCXX CT abdomen: Left retroperitoneal mass in para-aortic position behind the stomach

 and retroperitoneal nodes enlarged.

10-12-CCXX Upper GI and Barium Enema: applecore lesion right proximal stomach.

10-28-CCXX Chest x-ray: fibrotic changes Left hilar areas.

**Laboratory**

10-27-CCXX Alkaline phosphatase: 337 (45-110); CA: 9.8 (8.8-11.5)

**Endoscopy**

Prior to admission: Indirect laryngoscopy: distal esophageal lesion

**Surgical findings**

10-27-CCXX Esophagogastrectomy: exploration showed carcinoma at the esophagogastric

 junction, mainly in the esophageal section.

**Pathology report**

10-27-CCXX Stomach and esophagus, Gastroesophageal junction biopsy: invasive moderately

 differentiated adenocarcinoma in Barrett’s esophagus.

 Esophagogastrectomy: esophagus and stomach: moderately differentiated

 adenocarcinoma, involving entire thickness of esophageal wall and through the

 adventitia and periesophageal fatty tissue with intraluminal spread to stomach.

 1 of 6 perigastric lymph nodes contains metastatic adenocarcinoma.

**Primary Site** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Morphology** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CASE #12**

**Physical exam**

Two month history of being unable to swallow liquids. Coughs when eating. Some night cough.

Physical exam essentially normal.

**X-rays and scans**

5-31-CCXX Chest x-ray: Normal

5-18-CCXX CT Chest/abdomen: Bulky mass mid thoracic esophagus. No liver metastases.

 Small paratracheal nodes. 5mm nodule rt chest—small granuloma vs. metastases.

5-4-CCXX Barium swallow: long segment narrowing of esophagus caused by lobulated filling

 defect highly suggestive of esophageal carcinoma approximately 10 cm long.

**Laboratory**

5-12-CCXX CEA: 156(<2.3); Alk Phos 97 (45-110); LDH 347 (297-537)

**Endoscopy**

5-7-CCXX Upper endoscopy: Large, fungating and ulcerated mass at 20-cm level, almost

 complete occlusion of lumen

**Surgical findings**

No surgery due to cardia status.

**Pathology report**

5-7-CCXX Esophageal biopsy: suspicious for squamous cell carcinoma

5-7-CCXX Gastric brushing: few highly atypical cells suspicious for malignancy.

**Primary Site** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Morphology** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CASE #13**

**Physical exam**

10-28-CCXX Epigastric mass

**X-rays and scans**

11-2-CCXX Chest X-ray: Negative

 Upper GI: Partial obstruction in antrum and pylorus

11-6-CCXX Liver scan: No definite focal defects.

**Laboratory**

11-7-CCXX CEA: 8.2 (within normal limits)

**Endoscopy**

11-4-CCXX Gastroscopy: Findings consistent with carcinoma

**Surgical findings**

11-8-CCXX Total gastrectomy with esophagojejunostomy and jejunojejunostomy: Entire stomach

 involved with tumor. Extensive involvement of regional lymph nodes and metastatic

 seeding in cul-de-sac. No palpable liver involvement.

**Pathology report**

11-4-CCXX Gastric washings and brush biopsy: Mucinous adenocarcinoma consistent with

 gastric origin.

11-8-CCXX Total stomach: Infiltrating mucinous adenocarcinoma of stomach, grade 3.

 Metastatic undifferentiated adenocarcinoma in 9/20 perigastric lymph nodes.

 Proximal esophagus and distal duodenum free of tumor. Tumor infiltrates entire

 wall of stomach to involve serosa.

**Primary Site** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Morphology** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CASE #14**

**Physical exam**

02-15-CCXX Neck: no adenopathy. Abdomen: a 4\*4 cm firm nodular slightly tender and

 movable mass in the epigastric region. Rest of abdomen non-tender. No mention

 of lymph nodes.

**X-rays and scans**

2-17-CCXX Upper GI: Suggestive of carcinoma of the stomach. No size mentioned.

2-19-CCXX Chest: No active disease.

**Laboratory**

2-19-CCXX Alkaline phosphatase: within normal limits.

**Endoscopy**

None

**Surgical findings**

2-21-CCXX Palliative subtotal gastrectomy: large mass of carcinoma in distal stomach, which

 seems to stop sharply at the pylorus. Tumor occupying approximately lower 1/3 of

 stomach. Umbilicated relatively good-sized metastasis in dome of liver, probably

 4-5 cm in diameter. Regional nodal metastases and direct extension to the gastric

 antrum’s adjacent omentum.

**Pathology report**

2-21-CCXX Stomach: irregularly shaped fungating lesion measuring 5.0 cm in greatest

 dimension. At one point erodes through serosa. Tumor has infiltrated laterally

 through the pylorus to involve the subserosa and muscularis of duodenum. Tumor

 present in lymphatics. Adenocarcinoma, poorly to moderately differentiated with

 penetration of serosa, metastases to lymph nodes of greater and lesser omentum.

**Primary Site** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Morphology** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CASE #15**

**Chief Complaint**

Sudden onset of rectal bleeding. Patient reported pencil-thin stools for 6 weeks and difficulty with bowel movements.

**Physical exam**

HEENT essentially negative

Chest Positive for diminished breath sounds; no wheezing.

Abdomen Bowel sounds present, soft, nontender.

Liver-kidney-spleen not palpated: no rebound guarding.

Rectal Bright red blood, small amount. Non-circumferential lesion palpable at about 7cm from

anal verge.

Extremities Within normal limits

**Imaging**

Chest x-ray Congestive heart failure. No masses or nodules.

Liver/spleen scan : No abnormalities.

**Laboratory**

Routine CBC normal.

11-12-CCXX CEA: 10.1 (Normal<3.0)

**Colonoscopy**

11-9-CCXX Sigmoidoscopy: Ulcerated, constricting lesion from 7 to 9cm. Scope was able to pass beyond lesion. Multiple biopsies taken.

**Operative report**

11-13-CCXX Low anterior resection: Exploration of pelvic cavity revealed a normal male urinary tract. No visible extramural tumor extension from rectal lesion.

 Abdominal exploration showed no palpable abnormalities or gross evidence of tumor.

**Pathology report**

11-9-CCXX Biopsies of lesion in rectum: Poorly differentiated adenocarcinoma

11-13-CCXX Low anterior resection, rectum, rectosigmoid and sigmoid: Invasive, moderately differentiated (Broders Grade II of IV) adenocarcinoma, upper rectum. Tumor penetrates through muscularis propria and into perirectal fat. Tumor size 2.3cm. Two small perirectal lymph nodes: metastatic adenocarcinoma.

**Primary Site** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Morphology** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CASE #16**

**Chief Complaint**

Anorexia over past 5 months with 50 Ib. wt loss. More recently, patient developed extreme listlessness and weakness.

**Physical exam**

Pale-appearing elderly male in wheelchair.

Chest Clear to auscultation and percussion

Abdomen Marked hepatomegaly to 7 cm below right costal margin spanning flank to umbilicus.

No other masses.

Distal rectal examination: No masses palpated.

**Imaging**

2-2-CCXX Chest x-ray: No masses or infiltrates. Skeletal system demonstrates spinal degenerative

 changes.

2-8-CCXX Barium Enema: Elongated adjacent annular constricting lesion in proximal sigmoid

 colon, highly suspicious for malignancy. Impending obstruction. Barium passed with

 some difficulty beyond the stricture sufficiently to rule out any additional lesions at

 least to level of hepatic flexure.

**Laboratory**

Severe anemia. Liver function studies highly abnormal.

2-2-CCXX CEA 162.5 (normal<3.0)

**Operative report**

2-10-CCXX Exploratory laparotomy: biopsies of liver; left hemicolectomy: diffuse nodularity in

 liver, left lobe more involved than right lobe. Frozen section shows metastatic

 adenocarcinoma compatible with a colorectal primary. Large nearly-obstructing,

 invasive tumor in upper sigmoid colon.

**Pathology report**

2-10-CCXX Left hemicolectomy and liver biopsies:

 Liver: Metastatic adenocarcinoma, consistent with colon primary.

 Left hemicolectomy: Perforated adenocarcinoma, Grade III, measuring 6.6\*5.3 cm, in

 proximal sigmoid colon with extension to the serosal surface. Proximal, distal and

 redial margins free of tumor. Metastatic adenocarcinoma in 7 of 10 mesocolic and

 sigmoidal lymph nodes.

**Follow-up** Patient referred for chemotherapy.

**Primary Site** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Morphology** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CASE #17**

**Chief Complaint**

6/25/CCXX Passage of blood in stool of one-year duration, worse in last 2 months.

 Progressive difficulty in evacuating her bowels.

**Physical exam**

This is 1 52-year-old white female in no acute distress.

Lungs: Clear.

Heart: Regular.

Abdomen Soft, nontender, and nondistended with no evidence of masses.

Perineal exam External skin tags consistent with external hemorrhoids.

Digital rectal exam: Within normal limits.

**X-rays and Scans**

6/25/CCXX Chest: Normal

**Scopes**

6/27/CCXX Colonoscopy: Fungating lesion involving 75% circumference of bowel,

 mid-transverse colon

**Laboratory**

6/27/CCXX Alk phos: within normal limits

**Surgical findings**

6/30/CCXX Transverse colectomy: Apple core lesion at mid-transverse colon without evidence

 of gross adenopathy.

**Pathology report**

6/30/CCXX Gross: Section of bowel. Micro: Moderately differentiated mucinous adenocarcinoma

 showing transmural extension to serosa and metastases to 3/10 mesocolic lymph

 nodes. Duke’s C2. Tumor size 4.5cm. Liver biospy benign.

**Treatment**

6/30/CCXX Transverse colectomy

**Primary Site** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Morphology** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CASE #18**

**Physical exam**

11/12/CCXX Endocervical lesion with no parametrial or vaginal extension.

No inguinal adenopathy.

**X-rays and Scans**

11/15/CCXX Chest X-ray: No evidence of disease.

11/13/CCXX CT scan abdomen and pelvis: No evidence lymphadenopathy or local extension

**Scopes**

None

**Laboratory**

None

**Pathology report**

11/12/CCXX Endocervical biopsy: infiltrating poorly differentiated squamous cell carcinoma

11/15/CCXX Hysterectomy: moderately differentiated squamous cell carcinoma of cervix with

 invasion half-way through cervical wall.

**Treatment**

11/15/CCXX Modified radical hysterectomy

2/11/CCYY High dose radiation (intracavitary)

**Primary Site** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Morphology** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CASE #19**

**Physical exam**

Presented with dizziness, shorthness of breath and vaginal discharge. Examination showed tumor involving the right side of the bladder wall and bilateral ureteral obstruction.

**X-rays and Scans**

All performed prior to admission. Summary: large cervical mass involving the right side of the bladder, extending into the upper third of the vagina with right parametrial area involvement. Tumor extends to pelvic wall and causes hydronephrosis.

**Scopes**

Cystoscopy: bullous edema of bladder wall.

**Pathology report**

Prior to admission: Cervical biopsy: moderately differentiated squamous cell carcinoma

Prior to admission: Bladder biopsy: squamous cell carcinoma

**Treatment**

3600 rads to A/P pelvis.

**Primary Site** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Morphology** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CASE #20**

**Physical exam**

1/23/CCYY Exam under anesthesia: vagina was somewhat shortened considering radical

 hysterectomy. Well healed. Minimal induration above the cuff. No evidence of

 disease rectovaginal.

**X-rays and Scans**

1/21/CCYY Chest x-ray: normal

1/23/CCYY CT scan of pelvis: two applicators, overlying the lower pelvis with residual contrast

 in the rectum.

**Laboratory**

1/21/CCYY CA-125: <6.3 (nl 0-35)

**Pathology report**

10/10/CCXX (Prior to admission) Radical hysterectomy and bilateral salpingooophorectomy with

 pelvic node dissection: poorly differentiated squamous cell carcinoma of the cervix. Tumor size 3.5\*4.0 cm. Pelvic nodes positive for metastatic disease; number of lymph nodes not recorded.

**Treatment**

10/10/CCXX (Prior to admission) Radical hysterectomy and bilateral salpingooophorectomy with

 pelvic lymph node dissection

1/23/CCYY Intracavitary cesium 127 implant to cervix

**Primary Site** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Morphology** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CASE #21**

**History and Physical examination**

Patient reported difficulty urinating; in bathroom 3-4 times per nigh with minimal output.

Symptoms of frequency, hesitancy, intermittence, and sensation of incomplete bladder emptying. Admitted for transurethral resection of prostate to relieve symptoms.

Rectal exam: Prostate 3+ enlarged, nontender. No nodularity or induration

**Imaging techniques**

7-1-CCXX Chest x-ray: Unremarkable

**Laboratory**

PSA 5.0 (normal 0-4.0)

**Endoscopic procedures**

7-10-CCXX Cystoscopy and transurethral resection of prostate: Significant obstruction by

 enlarged prostate

**Surgical procedures and observations**

None

**Pathology report**

7-10-CCXX Transurethral resection of prostate: Grade II (Gleason 2+2 =4)

 adenocarcinoma present in 5 of 20 chips from TURP specimen.

Patient returned to home post-operatively with improvement of symptoms.

**Primary Site** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Morphology** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CASE #22**

**History and Physical examination**

Patient came in for routine physical exam. complained of fatigue and generalized malaise.

Rectal exam: Prostate large, hard and fixed

Physical exam: no obvious reasons for symptomatology. No organomegaly of lymphadenopathy.

**Imaging techniques**

8-22-CCXX CT Abdomen: Enlarged left iliac lymph nodes probably secondary to metastatic

 disease from carcinoma of prostate. Apparent periprostatic extension of tumor.

**Laboratory**

8-22-CCXX Prostate specific antigen elevated at 29.0 (normal 0-4.0)

**Endoscopic procedures**

9-25-CCXX Cystoscopy and transurethral resection of prostate

**Surgical procedures and observations**

9-20-CCXX Transrectal prostate biopsy

**Pathology report**

9-20-CCXX Needle biopsy: diffuse moderately differentiated adenocarcinoma, Gleason score

 6(3+3)

9-25-CCXX Transurethral resection of prostate: Prostate curettings: adenocarcinoma, moderately

 differentiated, multifocal (present in 12 of 17 chips). Gleason 6

**Treatment**

11-8-CCXX Completed 6660 cGys delivered in 37 fractions

**Primary Site** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Morphology** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CASE #23**

**History and Physical examination**

Patient is a 63 year old worker in a tanning factory who suddenly developed gross hematuria and presented to the emergency department.

Physical exam: No abdominal masses. Prostate not enlarged. No abnormal findings.

**Imaging techniques**

1-10-CCXX Chest x-ray: No evidence of metastatic tumor infiltrates.

 Intravenous pyelogram(IVP): 2.5 cm bladder tumor arising from the right ureteral

 orifice.

**Laboratory**

Blood chemistries: norma. CBC: normal

**Endoscopic procedures**

1-27-CCXX Transurethral resection of bladder tumor: polypoid bladder tumor on right side of

 bladder involving the right ureteral orifice, somewhat bulky.

 Remainder of bladder examination: essentially normal.

**Surgical procedures and observations**

None

**Pathology report**

1-27-CCXX Transurethral resection of bladder tumor: Multiple fragments of well differentiated

 noninvasive papillary transitional cell carcinoma, grade I. Areas of ulceration around base. Deep smooth muscle fibers: no evidence of invasion by tumor.

**Primary Site** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Morphology** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CASE #24**

**History and Physical examination**

53 year old woman complaining of fatigue and pain on urination. Treated for urinary tract infection with no relief.

Physical exam: No abdominal masses. No breast masses. Gynecologic exam: No abnormal findings.

**Imaging techniques**

2-28-CCXX Chest x-ray: Normal; no infiltrates.

3-5-CCXX CT scan of abdomen and pelvis: thickening of anterior wall of bladder.

 Enlarged left pelvic lymph nodes suspicious for metastases.

**Laboratory**

WBC and platelets: platelets high; anemic.

**Endoscopic procedures**

2-28-CCXX Upper GI endoscopy within normal limits. No evidence of bleeding.

3-6-CCXX Cystoscopy and biopsy: inflamed area on low anterior wall of bladder.

 Biopsies and cytologies taken.

**Surgical procedures and observations**

3-17-CCXX Radical cystectomy and left pelvic lymphadenectcomy: frozen sections of pelvic

 lymph nodes positive for metastatic bladder carcinoma.

 Cystectomy canceled.

**Pathology report**

3-6-CCXX Biopsies of anterior bladder: undifferentiated malignant neoplasm.

 Urine cytology: undifferentiated malignant neoplasm.

3-17-CCXX Left pelvic lymph node dissection: 4 of 5 lymph nodes from left obturator fossa

 contain foci of metastatic malignant neoplasm.

**Further treatment**

4-2-CCXX Chemotherapy, multiple agents

**Primary Site** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Morphology** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_