Mammogram, Screening
11/09/2007

Mammogram, Screening, Bilateral

The present examination has been compared to imaging studies dated 07/27/2005 and 07/22/2003.

Findings: The breast tissue is heterogeneously dense. This may lower the sensitivity of mammography.

There are punctate calcifications seen in the anterior region of the left breast at 2 o'clock.

Impression: Calcifications in the left breast require additional evaluation. Magnification mammography is recommended.

ACR BI-RADS Category 0: Incomplete: Need additional imaging evaluation.

Mammogram, Diagnostic
11/14/2007

Mammogram, Diagnostic, Left

The present examination had been compared to prior imaging studies.

Findings: Additional evaluation was performed for the calcifications in the anterior region of the left breast at 2 o'clock seen on 11/09/2007. On the present examination, there are coarse heterogeneous calcifications in the anterior region of the left breast at 2 o'clock.

Impression: Calcifications in the left breast are suspicious. Histology using core biopsy is recommended.

Patient was informed of the need for biopsy at the time of study. The patient should be off aspirin for one week prior to biopsy.

ACR BI-RADS Category 4: Suspicious abnormality

Operative Report
12/04/2007

Preoperative Diagnosis: High grade ductal carcinoma in situ of the left breast

Postoperative Diagnosis: High grade ductal carcinoma in situ of the left breast

Procedures:
1. Injection of radial colloid for sentinel lymph node identification
2. Left axillary sentinel lymph node biopsy x 2
3. Left breast wire localization partial mastectomy (lumpectomy)

Procedure: This black female was brought to the Breast Center in the morning, where she underwent left breast wire localization. The wire localization films showed that the wire essentially travels from a superior to inferior direction, slightly medial and anterior, out anteriorly along the skin surface; but essentially from a superior to inferior direction in the left upper outer region, with the wire extending inferiorly. She was brought to the operating room. She underwent a general endotracheal anesthesia. The left breast, chest, anterior arm and axilla were prepped and draped in a sterile fashion with a Betadine solution. A scant hot spot was noted in the left axilla. A small 3-4 cm transverse inferior axillary incision was made. The subcutaneous tissue was dissected with electrocautery. The clavipectoral fascia was opened. A lymph node was clinically palpable, which was excised. This had a scant amount of radioactivity, but was labeled as a clinical sentinel lymph node. There were some other smaller lymph nodes attached to it, and it was submitted to pathology as a clinical lymph node. The radioactivity was noted further medial in level I, where a small 5 mm node showed radioactivity with counts of greater than 50. The background count, once this was removed, was approximately 5 or less, indicating adequate sentinel lymph node sampling. The first clinically palpable node was shown to have some cells, at the time of intraoperative pathologic evaluation, that were possibly suspicious of metastatic carcinoma. The second sentinel lymph node was classified as negative. Given the fact that this was ductal carcinoma in situ, and not confirmed to be malignant cells, but only suspicious; the axillary sampling was completed, and an axillary lymph node dissection would be deferred, if necessary, to permanent histopathologic sectioning and/or immunohistochemical stains. With this, the axillary incision was closed. The subdermal subcutaneous tissue was approximated with interrupted 3-0 Vicryl suture, and the skin was closed with a running 4-0 Monocryl subcuticular suture.

Attention was then turned to left breast. A periareolar oblique incision was made in the upper outer aspect of the left breast, approximately 1 cm from the areolar margin. The skin incision was made. The wire was dissected into the lumpectomy cavity from the superior skin flap to allow introduction of the wire into the wound. The dissection was carried anteriorly and inferiorly along the subdermal region, as the area of hematoma was very anteriorly located in the inferior skin flap near the lateral areolar margin. The entire hematoma cavity was circumferentially excised. Hemostasis was achieved within the biopsy bed with electrocautery. Because the anterior aspect of the hematoma cavity was essentially at the skin, this was further marked for specimen orientation with 3 hemoclips. A short stitch was placed superior, and a long stitch was placed lateral, and we also placed 1 clip on the short stitch superiorly and 2 clips on the long stitch laterally, as well as the 3 clips along the anterior margin where the hematoma

had been dissected from the subdermal tissue of the skin. Specimen radiograph confirmed that the clip was in the specimen near what would be the inferior lateral aspect. Since the anterior margin would be close, and the clip deemed to be within the specimen, the procedure was completed. Hemostasis was achieved electrocautery. The subdermal subcutaneous tissue was approximated with interrupted 3-0 Vicryl suture and the skin was closed with a running 4-0 Monocryl subcuticular suture. Steri-Strips and dry sterile gauze dressings were applied. The patient was turned over to anesthesia in satisfactory condition. All needle, instrument, and sponge counts were correct. All further pathology will be deferred to permanent sectioning.

Pathology Report
12/04/2007

Clinical Diagnosis: Left breast calcifications

Specimen:
Left breast calcifications (16 cores):
1. Cores with calcification
2. Other cores

Gross Description:
1. Received in formalin are four breast core biopsy fragments that range from 0.6 to 2.2 cm. Entirely submitted in a single cassette.
2. Received in formalin are four breast core biopsy fragments that range from 0.4 to 2 cm. Entirely submitted in a single cassette.

Microscopic Description:
1. There are several areas of high grade intraductal carcinoma. The ducts are partially filled with a proliferation of atypical cells with central necrosis. There are some mild fibrocystic alterations including stromal sclerosis, ductal dilatation and incipient sclerosing adenosis. There is some foci of dystrophic calcification of the stroma.
2. Fibrocystic alterations include stromal sclerosis, ductal dilatation and incipient sclerosing adenosis. There is a focus of high grade intraductal carcinoma, similar to that seen in specimen #1.

Final Pathologic Diagnosis:
1 and 2. Core biopsies from left breast: High grade intraductal carcinoma.

Supplemental: 12/11/2007
1. The cells of the intraductal carcinoma are nuclear estrogen* and nuclear progesterone* receptor negative by immunocytochemical assay. The controls stained appropriately.

Clinical Diagnosis/Information: DCIS

Specimen:
1. Sentinel lymph node #1
2. Sentinel lymph node #2
3. Left breast

Final Pathologic Diagnosis:
1. Sentinel lymph node #1, excision:
   One benign lymph node identified; negative for metastatic carcinoma on H&E stained step sections and sentinel lymph node protocol immunostained sections (0/1).
2. Sentinel lymph node #2, excision:
   One benign lymph node identified; negative for metastatic carcinoma on H&E stained step sections and sentinel lymph node protocol immunostained sections (0/1).

3. Left breast, oriented lumpectomy:
   Ductal carcinoma in situ, solid and cribriform types, high nuclear grade 3, with focal necrosis and calcification.
   No invasive carcinoma identified.

   Additional Findings:
   Biopsy site changes and fibrocystic changes.
   Immunohistochemical stains for hormone receptors pending with supplemental report to follow.

Radiation Oncology Completion of Therapy Note
02/14/2008

On 12/28/2007 patient was brought to the CT simulator and an alpha cradle fashioned to support the upper extremities in the treatment position. Images in this position were obtained. The breast and excision cavity were outlined. A 3D conformal treatment plan was devised.

Diagnosis: 1. Malignant neoplasm of breast. 174.9. ductal carcinoma in situ

Stage: Tis

Dates of Treatment: 01/08/2008 - 02/08/2008
Number of Treatments: 23
Area Treated: Left Breast
Field Size and Arrangement: Tangents, 9x17 cm
Beam Energy: 6mev photons
Depth of Calculation: Plan
Total Tumor Dose: 46 Gy at 2 Gy per fraction

Dates of Treatment: 02/08/2008 - 02/14/2008
Number of Treatments: 7
Area Treated: Excision Cavity
Field Size and Arrangement: Appositional
Beam Energy: 9mev Electrons And 12mev Electrons
Depth of Calculation: Plan
Total Tumor Dose: 14 Gy at 2 Gy per Fraction

Developed mild skin reaction by end of course. Returns 03/08/2008.