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

Case 1: Melanoma

History and Physical Examination

The patient is a 70-year-old white female who has had a longstanding, pigmented nevus over her left forearm. Recently she noticed some change with pruritus and increase in size. The lesion was an irregular, flat, brown 2 x 2 cm lesion over the left forearm. The remainder of the exam was negative.

Laboratory

None

Procedures

3/5 Shave biopsy of skin of left forearm

3/16 Wide excision of skin of left forearm

Pathology

3/5 Biopsy: Malignant melanoma.

3/16 Wide excision: Malignant melanoma, nodular type, Clark's level III, Breslow's depth 1.0 mm radial and vertical growth phase present, papillary dermis invaded. No regression, microsatellites, angiolymphatic or perineural invasion identified. Margins of resection were free, but within less than 2 mm.

Answers

Case 1 Melanoma	Answer	Rationale
Date of Dx	3/5	Shave biopsy; *FORDS,* p. 89
Primary Site	C44.6	PE; *FORDS,* p. 91
Laterality	2	PE, left forearm; *FORDS,* p. 92
Histology	8721/39	WE path; *SEER Program Coding and Staging Manual (PCSM) 2004,* p. 87, histology coding rules for single tumors #6
CS Extension	20	WE path; *Collaborative Staging (CS) Manual,* p. 436, note 1
CS Lymph Nodes	00	PE, remainder of exam negative; *CS Manual,* p. 437
CS Mets at Dx	00	PE, remainder of exam negative; *CS Manual,* p. 440
Surg Primary Site	31	WE path, margins < 2mm; *FORDS,* p. 268
Scope Reg LN Surg	0	*FORDS,* p. 138
Surg Proc/Other Site	0	*FORDS,* p. 142
Rad Reg Treatment Mod	00	*FORDS,* p. 155
Chemotherapy	00	*FORDS,* p. 171
Hormone Therapy	00	*FORDS,* p. 175
Immunotherapy	00	*FORDS,* p. 179
Hem Tsplt & End Proc	00	*FORDS,* p. 182
Other Treatment	0	*FORDS,* p. 186

Case 2: Melanoma

Physical Examination

White male presents with a new, small ulcerated and irritated lesion on his left ear. No other abnormalities were identified.

Imaging

5/10 CT scan head/neck: Probably malignant involvement of occipital lymph nodes.

Laboratory

None

Procedures

5/15 Excision of skin lesion of left ear with flap advancement: A portion of the earlobe was utilized and advanced superiorly to the lateral helix.

Pathology

5/15 Excision of lesion: Malignant melanoma, 0.5 cm, ulcerated lesion, Clark's level III-IV, Breslow's depth 3 mm, focally present within 1 mm from the deep inked margins of resection. Regression or satellite nodules were not noted. The inferior and lateral margins revealed melanoma in situ (lentigo maligna).

Oncology

7/1 Began interferon regimen.

Answers

Case 2 Melanoma	Answer	Rationale
Date of Dx	5/15	Excision; *FORDS,* p. 89
Primary Site	C44.2	PE; *FORDS,* p. 91
Laterality	2	PE; *FORDS,* p. 92
Histology	8742/39	Path; *SEER Program Coding and Staging Manual (PCSM) 2004,* p. 86, histology coding rules for single tumor #2, exception
CS Extension	30	Path; *Collaborative Staging Manual,* p. 436
CS Lymph Nodes	10	CT scan; *CS Manual,* p. 437
CS Mets at Dx	00	PE, no other abnormalities; *CS Manual,* p. 440
Surg Primary Site	27	Path, margins involved; *FORDS,* p. 268
Scope Reg LN Surg	0	*FORDS,* p. 138
Surg Proc/Other Site	0	*FORDS,* p. 142
Rad Reg Treatment Mod	00	*FORDS,* p. 155
Chemotherapy	00	*FORDS,* p. 171
Hormone Therapy	00	*FORDS,* p. 175
Immunotherapy	01	*FORDS,* p. 179
Hem Tsplt & End Proc	00	*FORDS,* p. 182
Other Treatment	0	*FORDS,* p. 186

Case 3: Melanoma

Physical Examination

Patient is a 62-year-old male who presented with a small, pigmented lesion involving the skin on the right side of his neck. This was locally excised at an outside facility. Wide re-excision was performed at this facility. The rest of the physical exam was normal.

Laboratory

None

Procedures

2/1 Excision of skin lesion on the right side of neck (outside facility report)

2/21 Wide re-excision of lesion of right neck

Pathology

2/1 Excision of lesion: The specimen was 1.5 x 0.8 x 0.5 cm and irregularly shaped. A pigmented area, which measured 0.4 x 0.3 cm, was consistent with malignant melanoma in situ with regressive changes, extending to the margins of excision. No vascular and/or lymphatic invasion. (outside facility report)

2/21 Wide re-excision: Inflammation and organizing granulation tumor, negative for any residual melanoma, margins of resection negative.

Answers

Case 3 Melanoma	Answer	Rationale
Date of Dx	2/1	Excision; *FORDS,* p. 89
Primary Site	C44.4	PE; *FORDS,* p. 91
Laterality	0	*FORDS,* p. 92
Histology	8720/29	Excision; *FORDS,* p. 93
CS Extension	00	Excision path; *Collaborative Staging (CS) Manual,* p. 436
CS Lymph Nodes	00	*CS Manual,* p. 34, rule 2
CS Mets at Dx	00	PE, remainder of PE normal; *CS Manual,* p. 440
Surg Primary Site	45	Wide re-excision, negative margins; *FORDS,* p. 268
Scope Reg LN Surg	0	*FORDS,* p. 138
Surg Proc/Other Site	0	*FORDS,* p. 142
Rad Reg Treatment Mod	00	*FORDS,* p. 155
Chemotherapy	00	*FORDS,* p. 171
Hormone Therapy	00	*FORDS,* p. 175
Immunotherapy	00	*FORDS,* p. 179
Hem Tsplt & End Proc	00	*FORDS,* p. 182
Other Treatment	0	*FORDS,* p. 186

Case 4: Melanoma

History and Physical Examination

This 27-year-old white female presented with a surgical incision that did not heal after surgery for hammertoes by a podiatrist. Excisional biopsy was performed followed by wide re-excision including grafts. No lymphadenopathy.

Imaging

4/10 Chest X-ray: Normal.

4/10 CT of abdomen: No abnormalities.

Laboratory

None

Procedures

3/31 Excisional biopsy of skin of plantar ulceration and granuloma of right foot

4/17 Wide re-excision with skin graft of plantar aspect of right foot

Pathology

3/31 Excisional biopsy: Ulcerated malignant melanoma, epithelioid and spindle cell types, overlying the skin of the 3rd metatarsal, Clark's level IV, Breslow's thickness 5.0 mm, regression not identified, ulceration present, no vascular invasion. Satellitosis identified 1 cm from lesion, melanoma. Deep and peripheral margins were involved and special immunostains for S100 and HMB-45 were positive.

4/17 Wide re-excision: No residual melanoma.

Answers

Case 4 Melanoma	Answer	Rationale
Date of Dx	3/31	Excisional biopsy; *FORDS,* p. 89
Primary Site	C44.7	Excisional biopsy; *FORDS,* p. 91
Laterality	1	Excisional biopsy; *FORDS,* p. 92
Histology	8770/39	Excisional biopsy; *SEER Program Coding and Staging Manual (PCSM) 2004,* p. 86, histology coding rules for single tumor #4
CS Extension	30	Excisional biopsy; *Collaborative Staging (CS) Manual,* p. 436
CS Lymph Nodes	13	Excisional biopsy, satellite nodules without regional LN involvement – per PE, no lymphadenopathy; *CS Manual,* p. 438
CS Mets at Dx	00	Normal CT of abdomen and chest X-ray; *CS Manual,* p. 440
Surg Primary Site	45	Wide re-excision, no residual melanoma; *FORDS,* p. 268
Scope Reg LN Surg	0	*FORDS,* p. 138
Surg Proc/Other Site	0	*FORDS,* p. 142
Rad Reg Treatment Mod	00	*FORDS,* p. 155
Chemotherapy	00	*FORDS,* p. 171
Hormone Therapy	00	*FORDS,* p. 175
Immunotherapy	00	*FORDS,* p. 179
Hem Tsplt & End Proc	00	*FORDS,* p. 182
Other Treatment	0	*FORDS,* p. 186

Surgical Pathology Report (Case 5: Melanoma)

Date of Service: 11/8/XX

Date Reported: 11/9/XX

Surgical Pathology Examination

Diagnosis: Skin, back, punch biopsy: Malignant melanoma, Breslow depth 1.1 mm, Clark level 4.

History: 53-year-old female with enlarging irritated lesion on back. 8 mm black papule with scale and erythema. Irritated nevus vs seb K vs other. Punch 6 mm back.

Tissue Submitted Gross: Received in formalin is a 0.7 cm punch biopsy with an eccentric 0.5 cm dark brown papule. Bisected and submitted 100% in A1.

Microscopic: Sections demonstrate nests of nevomelanocytes at the dermal-epidermal junction and within the dermis. The nests contain large atypical appearing melanocytes with increased nuclear cytoplasmic ratio. Rare mitotic figures are found including within the reticular dermis. Margins are not involved.

Histologic Subtype: Nodular melanoma

Clark's Level: IV

Breslow Thickness: 1.1 mm

Ulceration: No

Regression: No

Mitotic Rate: 1/mm2

Vascular/Lymphatic Invasion: No

Neurotropism: No

Microsatellites: Yes No

Margins: Uninvolved

Primary Tumor: T2a

Regional Lymph Nodes: NX

Distant Metastasis: MX

The pathologic stage based on available pathologic material is: T2a, NX, MX

Operation Record (Case 5: Melanoma)

Surgery Date: 12/2/XX

Preoperative Diagnosis: Malignant melanoma, left back

Operation/Procedure

1. Wide local excision of malignant melanoma
2. Sentinel lymph node biopsy times 2

Postoperative Diagnosis: Same

Indications: 53-year-old female who noticed some irritation of a mole on her left back. She was seen by Dermatology on 11/8/XX and had a punch biopsy. This returned as nodular malignant melanoma. This was reviewed by Pathology and had a Breslow depth of 1.1 mm and a Clark's level of IV. She was thus indicated for a wide local excision with 2 cm margins, as well as a sentinel lymph node biopsy.

Description of Operation/Procedure

After informed consent was obtained, the patient first was seen by Nuclear Medicine where the primary site on her left back was injected with technetium-labeled sulfur colloid. Images were then taken with areas lighting up in the left axilla. The patient was then brought to the operating room and laid supine on the operating room table. General endotracheal anesthesia was obtained by the Anesthesia Services. Once this was adequate, the patient was carefully rolled up onto her right side. A beanbag was underneath her for support. Her left arm was placed in a Ming sling. An axillary roll was placed under her right axilla. All pressure points were appropriately padded and she was safely secured. Next, the primary site was injected with Lymphazurin blue in all 4 quadrants. This was done intradermally. Next, the patient's left back and left axilla was prepped and draped in the standard sterile fashion. Next, we used the gamma probe to identify the area of highest count in the left axilla. This was slightly more superior than that marked by Nuclear Medicine. A 3 cm incision was made, using a scalpel. This was carried down through the subcutaneous tissues, using electrocautery. Next, using the gamma probe, we took the first in situ count. This was 3381. Next, with the aid of the gamma probe, we carefully dissected and identified the lymph node. This was dissected free circumferentially, using electrocautery. Once it was dissected free completely, an ex vivo count was taken, which was 2691. This was then passed off the table as a specimen labeled "sentinel lymph node #1." The post excision count was still 1404. Using the gamma probe once again, we probed the entire area, both in the incision and the surrounding area. Once again, a second lymph node was identified and dissected free. This count had an ex vivo count of 1638. The post excision count was now 751. We then surveyed the entire area and did not find any counts to suggest further nodes, except much more proximally along the axillary vein. This area was then closed. The deep tissues were closed with 3-0 Vicryl suture in an interrupted fashion. The skin was closed, using 4-0 Monocryl suture in a subcuticular fashion. Steri-strips were then placed over this incision.

We then turned our attention to the primary site on her left back. An elliptical outline was made surrounding this going with the direction of the lines of Langer. We made sure there were at least 2 cm margins circumferentially. Next, using a scalpel, the incision was made circumferentially around the ellipse. This was carried down until the fascia was encountered. The entire ellipse was then dissected free from the fascia circumferentially. Once it was dissected free, it was appropriately marked for Pathology to maintain orientation. A long stitch was placed on the lateral aspect and a short stitch on the superior aspect. This was then passed off the table as a wide local excision. We next raised some skin flaps both superiorly and inferiorly until there was no undue tension when the skin was brought together. The deep layer of tissues was re-approximated, using 2-0 Vicryl suture in an interrupted fashion. Next, the skin was re-approximated, using interrupted 3-0 nylon sutures in a vertical mattress fashion. Once this was complete, the area was washed and dried. Gauze and silk tape was placed over the incision. A sterile dressing was then also placed over the axillary incision. The patient tolerated the procedure well. There were no apparent complications. The patient was extubated and brought to recovery room in good condition.

Surgical Pathology Report (Case 5: Melanoma)

Date of Service: 12/2/XX

Date Reported: 12/6/XX

Surgical Pathology Examination

Diagnosis:

A. Lymph node, sentinel #1, biopsy: One lymph node negative for metastatic melanoma (0/1)

B. Lymph node, sentinel #2,biopsy: Metastatic melanoma in one lymph node, 0.1 cm in greatest dimension (1/1), with no extranodal extension

C. Skin, left upper back, excision: Scar with no residual melanoma

History: None provided.

Tissue Submitted:

A. Sentinel node #1

B. Sentinel node #2

C. L upper back lesion long stitch lateral short stitch superior

Gross:

A. Received in saline and placed in formalin is a single tan-white soft tissue piece measuring 2.5 x 0.5 cm. Specimen is bisected and entirely submitted in A1-A2.

B. Received free floating in formalin is a tan-brown soft tissue piece measuring 1.3 x 1.1 x 0.4 cm. Specimen is entirely submitted in B1.

C. Received fresh is a 6.0 x 4.0 x 2.5 cm skin ellipse with subcutaneous fat. On the surface of the skin there is a 0.8 x 0.5 cm scar. The scar is located 1.4 cm from the superior resection margin, 3.0 cm from the medial resection margin, 1.4 cm from the inferior resection margin, and 2.4 cm from the lateral resection margin. Orientation, designated by the surgeon: the long stitch denotes the lateral, short stitch denotes the superior; superior surface of the subcutaneous fat is inked black, the inferior surface is inked orange. Sections submitted: C1, lateral tip; C2, medial tip; C3-C10, portions of skin, soft tissue and subcutaneous tissue including the scar and 0.5 cm on either side, moving from lateral to medial and alternating superior and inferior.

Microscopic:

A. Sections reveal one lymph node, negative for metastatic melanoma.

B. Sections reveal one lymph node, with a focus of subcapsular metastatic melanoma measuring 0.1 cm in greatest dimension.

C. Sections of skin reveal hyperkeratosis and dermal fibrosis with giant cells. No residual is identified.

Operation Record (Case 5: Melanoma)

Surgery Date: 1/3/XX

Preoperative Diagnosis: Known metastasis of melanoma

Operation/Procedure: Left axillary node dissection

Postoperative Diagnosis: Same

Indications: 53-year-old woman who was found to have a melanoma to the left of the midline on her back. On 12/2/XX she underwent wide local excision and sentinel node biopsy. Her sentinel node showed evidence of microscopic spread to the lymph nodes and she now requires node dissection of the left axilla.

Description of Operation/Procedure

After obtaining written informed consent, the patient was brought to the operating room, placed in a supine position, and underwent general anesthesia. The site of surgery was confirmed and the left axilla was prepped and draped in a sterile fashion. The area of the old biopsy site was included in the excision. The margins on her previous back excision were clear of tumor. Therefore no re-excision was required of the back. An approximately 6 cm skin incision was made in the left axilla following a just below the hair-bearing area of the skin extending from the lateral edge of the pectoralis major to the anterior edge of the latissimus dorsi muscle. Flaps were raised cephalad and caudad to the estimated level of the axillary vein superiorly and the edge of the pectoralis major medially. The clavipectoral fascia was then incised along the edge of the pectoralis major and the pectoralis major and minor were freed from surrounding fat and nodal tissue. Dissection continued under the pectoralis major and then under the pectoralis minor muscle. The pectoralis muscles were then retracted medially and the level 2 nodes deep to the pectoralis minor were included in the dissection. The axillary vein was then identified and cleared of the overlying fat. The thoracodorsal branch of the axillary vein was identified. The long thoracic nerve was identified along the edge of the serratus anterior on the chest wall. This was preserved throughout the case and stimulated well at the end of the case. The thoracodorsal nerve was then identified deep to the vessels. This was also preserved and stimulated well at the end of the case. The nodal tissue between the nerves was carefully removed, taking care to avoid any injury to the nerves. The subscapularis muscle was identified posteriorly. The nodal tissue was then removed from the axilla and sent to Surgical Pathology. The wound was then irrigated and hemostasis was assured. A closed suction drain was brought through a separate stab incision and secured to the skin with a nylon suture. The wound was then closed once hemostasis was assured. It was closed in two layers with interrupted 3-0 Vicryl and a subcuticular layer of Monocryl suture. Steri-strips were placed. A sterile dressing was applied. The patient tolerated the procedure well with no apparent complications. She was extubated and transferred to the post-anesthesia care unit in good condition.

Surgical Pathology Report (Case 5: Melanoma)

Date of Service: 1/3/XX

Date Reported: 1/6/XX

Surgical Pathology Examination

Diagnosis:

A. Lymph node, left axillary, dissection: Fat necrosis and foreign body giant cell reaction. No metastatic melanoma identified in eight lymph nodes (0/8).

B. Lymph node, level I, excision: No diagnostic abnormality. No metastatic melanoma identified in five lymph nodes (0/5).

C. Lymph node, level II, excision: No diagnostic abnormality. No metastatic melanoma identified in four lymph nodes (0/4).

History: 53-year-old female status-post sentinel lymph node biopsy in left axilla with wide excision of malignant melanoma of left back on 12/2/XX. Biopsy came back positive for one of the lymph nodes so presents for lymph node dissection. Stitch marks apex of axilla.

Tissue Submitted:

A. L axillary lymph node dissection, stitch marks apex of axilla

B. Additional level 1 node

C. Level 2 nodes

Gross

A. Received in formalin is a 9.1 x 9.0 x 2.7 cm yellow-tan fatty soft tissue, with a 5.0 x 0.9 x 0.1 cm pink-tan section of attached skin. There is a black stitch designating the apex. Nine possible lymph nodes are identified, ranging from 0.5 to 2.0 cm in greatest dimension. Two possible lymph nodes are both bisected and submitted entirely in A1. Two possible lymph nodes, both bisected, submitted in A2. Two lymph nodes, both bisected in A3. One lymph node bisected in A4. One lymph node bisected in A5. One lymph node serially sectioned and submitted entirely in A6 and A7.

B. Received in formalin is a 5.3 x 3.0 x 1.0 cm aggregate of yellow-tan fatty soft tissue. Five possible lymph nodes are identified, ranging from 0.4 to 1.0 cm in greatest dimension. Three lymph nodes are submitted in B1. Two lymph nodes, both bisected are submitted in B2.

C. Received in formalin is a 4.0 x 2.0 x 1.0 cm yellow-tan fatty soft tissue fragment. Four possible lymph nodes are identified ranging from 0.6 to 1.4 cm in greatest dimension. Two possible lymph nodes bisected in C1 and two lymph nodes, bisected in C2.

Microscopic

A. Sections show lymphoid tissue with germinal centers, and focal acute inflammation. There is evidence of fat necrosis and multinucleate giant cells. No metastatic melanoma is identified.

B. And C: Sections show lymphoid tissue with germinal centers. No metastatic melanoma is identified.

Radiological Consultation Report (Case 5: Melanoma)

Exam: Chest – PA and Lateral

Exam Date: 11/19/XX

Report

History: New diagnosis of melanoma

Findings: PA and lateral views without prior comparison show normal cardiac silhouette. Pulmonary vasculature appears normal. There are no focal infiltrates or pleural effusions. There is no mediastinal lymphadenopathy. There is no evidence of any bony nodules or masses. The bony structures appear normal.

Impression: Negative chest.

Radiological Consultation Report (Case 5: Melanoma)

Exam: NM, Lymphoscintigraphy TC99M SC

Exam Date: 12/2/XX

Report

History: 53-year-old female with recently diagnosed malignant melanoma of upper back.

Radiopharmaceuticals and Procedure: The superficial excisional biopsy site was localized in the mid-left back area and prepped in standard fashion. 1% lidocaine was injected intradermally immediately adjacent to excision site on opposite sides. 2.2 mCi (approximately 1.1 mCi each) of Tc-99m filtered sulfur colloid was injected intradermally at previous two site of lidocaine injection. Dynamic images of the chest were then acquired in the posterior projection with patient laying prone for approximately 15 minutes. An additional static image of the chest region was acquired in the anterior projection with patient laying supine with cobalt source in background. The patient tolerated the procedure well.

Findings: There is prompt tracer flow along a lymphatic channel superolateral from site(s) of injection with localization of tracer in a sentinel node in the inferior left axilla. There is subsequent tracer localization in multiple lymph nodes superior to sentinel node in left axilla most likely along same nodal chain. There are no lymphatic drainage patterns or lymph nodes demonstrated in the right axilla or groin during imaging. In the left lateral position, the skin immediately overlying the sentinel node was marked with pen and depth of lesion was calculated to be approximately 1.5 cm.

Impression: Sentinel node localization in inferior left axilla from primary left mid-back melanoma site.

Clinical Notes – Oncology Consultation (Case 5: Melanoma)

Date: 1/28/XX

History of Present Illness: The patient is a 53-year-old female who is nurse and in August XX noticed some irritation of a mole along her bra line. She was then seen by dermatology and on 11/8/XX, she had a punch biopsy of the area. This returned as a nodular, malignant melanoma, Breslow depth 1.1 mm, Clark level 4. There was no evidence of ulceration, regression, and it also had a low mitotic rate with no lymphovascular invasion. This was treated by wide local excision and sentinel lymph node biopsy on 12/2/XX where there were negative margins, but 1 node was microscopically positive. Therefore, the patient underwent left axillary dissection on 1/3/XX. Pathology from this revealed 17 negative lymph nodes.

She denies any cough, shortness of breath, weight loss, or other complaints. She has not noticed any nodularity in her neck, axillae, or groin. She has no other moles of concern. She is here today for a medical oncology recommendation for the same.

Past Medical History: None significant.

Allergy Notes: None known.

Medication Notes: Multivitamin.

Family History: She has a paternal aunt that had a melanoma and a paternal uncle with breast cancer. Her parents both have hypertension.

Social History: She is divorced and lives alone. She does not smoke and drinks alcohol only on occasion. She works as a nurse at this facility.

Review of Systems: On review of systems, she denies any fevers, chills, nausea, vomiting, shortness of breath, cough, chest pain, palpitation, or abdominal pain. All other review of systems are negative.

Physical Exam: Awake and oriented lady very comfortable and cheerful. Her vitals are stable. HEENT was unremarkable including no palpable lymph nodes in the neck. Heart had normal tones and lungs were clinically clear on auscultation. Left axillary incision was well healed. The left upper back incision was well healed. Abdomen was soft, NT, BS+. No other masses palpable. Lower extremities were without any pedal edema. Neurologically non-focal exam.

Impression: 53-year-old woman with a T2N1aM0, stage IIIA malignant melanoma and is s/p wide excision of malignant melanoma on her back and sentinel lymph node biopsy and axillary dissection on the left.

Plan: We discussed various options including adjuvant high dose interferon, clinical trials, and observation only. She is currently not eligible for the trial open here and is not keen to pursue interferon route. She herself has gone through some of the Internet search and understands the outcome of those interferon based adjuvant trials. She wants to be on observation mode and we do feel comfortable in her decision at this time. However, she does need to keep her close dermatology f/u as well. We will follow as needed.

Answers

Case 5 Melanoma	Answer	Rationale
Date of Dx	11/8	Punch biopsy; *FORDS,* p. 89
Primary Site	C44.5	PE; *FORDS,* p. 91
Laterality	2	Op record, left back; *FORDS,* p. 92
Histology	8721/39	Punch biopsy; *FORDS,* p. 93
CS Extension	30	Punch biopsy & excisional biopsy; *Collaborative Staging (CS) Manual,* p. 436
CS Lymph Nodes	10	Path, sentinel node biopsy; *Collaborative Staging (CS) Manual,* p. 437
CS Mets at Dx	00	PE, remainder of exam normal; *CS Manual,* p. 440
Surg Primary Site	46	Wide re-excision, 12/2 op record “at least 2 cm margin”; *FORDS,* p. 268
Scope Reg LN Surg	7	Sentinel node biopsy & ALND at different times; *FORDS,* p. 139
Surg Proc/Other Site	0	*FORDS,* p. 142
Rad Reg Treatment Mod	00	*FORDS,* p. 155
Chemotherapy	00	*FORDS,* p. 171
Hormone Therapy	00	*FORDS,* p. 175
Immunotherapy	00	*FORDS,* p. 179 (discussion is not recommendation)
Hem Tsplt & End Proc	00	*FORDS,* p. 182
Other Treatment	0	*FORDS,* p. 186