

BREAST PATHOLOGY DIAGNOSTIC TEMPLATE

- Breast; Right vs. Left; *(Other/specify)* _____; Ultrasound-Guided Core Needle Biopsy;
 Stereotactic Core Needle Biopsy;
 Core Needle Biopsy;
 Lumpectomy/Excisional Biopsy;
 Mastectomy;
 (Other/specify) _____:

(PRIMARY MALIGNANT LESIONS)

- Infiltrating mammary carcinoma (see Comment) *(use for samples too small for meaningful subtyping/grading)*
 Infiltrating "ductal" carcinoma of no special type; with lobular vs. tubular vs. mucinous vs. medullary features
 Infiltrating "lobular" carcinoma; classical subtype vs. variant subtype
 Infiltrating "tubular" carcinoma; classical subtype vs. variant subtype
 Infiltrating "mucinous" carcinoma; classical subtype vs. variant subtype
 Infiltrating "medullary" carcinoma; classical subtype vs. variant subtype
 Microinvasive carcinoma (largest focus < 1 mm); focal vs. multifocal

(additional information needed for all infiltrating carcinomas...except microinvasive carcinoma)

- Greatest (gross vs. microscopic) dimension = _____ mm vs. cm *(microscopic dimension preferred)*
 Not directly measurable (identified in _____ of _____ total slides)
 Estimated size = _____ mm vs. cm *(use when not directly measurable)*
 Histological grade = ____/3 (score = ____/9) by ESBR criteria
 Mitotic index = _____ average mitoses /HPF (low vs. intermediate vs. high) *(count 10 HPF when possible)*
 Surgical margins positive (focal vs. multifocal; microscopic vs. extensive; location: _____)
 Surgical margins negative (nearest = _____ mm vs. cm)
 Invading angiolymphatic spaces (in breast parenchyma; in dermal lymphatics)
 Invading the skin (with vs. without ulceration)
 Invading the nipple (with vs. without ulceration)
 Intraepithelial involvement of nipple (Paget's disease)

- Lobular carcinoma in situ (LCIS);
 Focal vs. Multifocal
 Surgical margins negative vs. positive

- Ductal carcinoma in situ (DCIS)

(specify size of pure DCIS)

- Greatest (gross vs. microscopic) dimension = _____ mm vs. cm *(microscopic dimension preferred)*
 Not directly measurable (identified in _____ of _____ total slides)
 Estimated size = _____ mm vs. cm

(specify extent of DCIS combined with invasive carcinoma)

- Comprising _____% of carcinoma in sample *(considering in situ and invasive components combined)*

(additional information needed for all DCIS)

- Nuclear grade = ____/3 by SBR criteria
 Growth Pattern (s): Cribriform, Solid, Micropapillary, Papillary, Mixed
 _____% central "comedo" necrosis *(refers to cross-sectional area of DCIS on slides)*
 Intraepithelial involvement of nipple (Paget's disease)
 Surgical margins positive (focal vs. multifocal; microscopic vs. extensive; location: _____)
 Surgical margins negative (nearest = _____ mm vs. cm)

- (Other/specify)*: _____

BREAST PATHOLOGY DIAGNOSTIC TEMPLATE

(COMMON BENIGN AND MISCELLANEOUS DIAGNOSES)

- Insufficient tissue for meaningful diagnostic evaluation
- Histologically normal breast tissue
- No residual carcinoma
- Healing wound consistent with recent core needle biopsy vs. excisional biopsy
- Atypical ductal hyperplasia (ADH)
- Atypical lobular hyperplasia (ALH)
- Usual ductal hyperplasia (UDH) (mild vs. moderate vs. florid and focal vs. multifocal)
- Hyperplastic unfolded lobules (HUL) (focal vs. multifocal)
- Radial scar (RS)
- Sclerosing adenosis (SA) (mild vs. florid and focal vs. multifocal)
- Intraductal papilloma (small/peripheral subtype)
- Intraductal papilloma (large/central subtype)
- Fibroadenoma (FA)
- Stromal fibrosis (Mild vs. Diffuse)
- Microcysts with apocrine change
- Duct ectasia
- Fat necrosis
- Microcalcifications (associated with _____) (specify if possible)
- Microcalcifications not identified
- No malignant findings
- (Other/specify): _____

Lymph Nodes; Sentinel; Right vs. Left Axilla; Excision:

- Negative for metastatic carcinoma (0/____ total nodes)
- Positive for metastatic carcinoma (____/____ total nodes)
- Positive for micrometastatic (foci >0.2 mm but < 2.0 mm) carcinoma (____/____ total nodes)
- Positive for isolated tumor cells (<0.2mm; stage = pN0i+)
- Extranodal extension
- Matting of adjacent nodes
- (Other/specify): _____

MICROSCOPIC DESCRIPTION:

- Microscopic evaluation performed (See Diagnosis vs. See Diagnosis and Comment).
- (Other/specify): _____

COMMENT:

- The sample is too small for meaningful detailed evaluation (e.g. histological subtyping and grading).
- Core needle biopsies are relatively small and certain histological characterizations of invasive carcinomas (e.g. histological subtype and grade) may not be representative of the entire lesion in the breast.
- A diagnosis of DCIS in a core needle biopsy, which is relatively small, may be a marker of more advanced disease (e.g. invasive carcinoma) remaining in the breast.
- A diagnosis of ADH in a core needle biopsy, which is relatively small, may be a marker of more advanced disease (e.g. DCIS) remaining in the breast.
- All outside materials are being returned to the originating hospital.
- (Other/specify): _____

Patient Name: JANE DOE
Referring Physician: Dr. C.K. Osborne
Date Reported: August 11, 2003

MATERIALS AND METHODS

The following materials were received for histopathological evaluation from St. Elsewhere Medical Center, Houston, Texas: H&E-stained slides labeled S03-10000 (A-E) and corresponding pathology report.

RESULTS

BREAST, RIGHT, "MASS", STEREOTACTIC CORE NEEDLE BIOPSY:

- Infiltrating "ductal" carcinoma of no special type (see Comment)
 - Histological grade = 2/3 (score 7/9) by ESBR criteria
 - Mitotic index = 2.4 average mitoses/HPF (high)
- Ductal carcinoma in situ (DCIS)
 - Comprising 25% of carcinoma in sample
 - Nuclear grade = 2/3 by SBR criteria
 - Solid growth pattern
 - 50% central "comedo" necrosis
- Stromal fibrosis (diffuse)
- Microcysts with apocrine change
- Microcalcifications (associated with DCIS and fibrocystic changes)

COMMENT

Core needle biopsies are relatively small and certain histological characterizations of invasive carcinomas (e.g. subtype and grade) may not be representative of the entire lesion in the breast. All outside materials are being returned to the originating hospital.

Pathologist: _____
D. Craig Allred, M.D.