

Breast Case #1

SITE	
CS Tumor Size	
CS Exten	
CS TS/Ext Eval	
CS LN	
CS LN Eval	
CS Reg LN Pos	
CS Reg LN Exam	
CS Mets @ Dx	
CS Mets Eval	
SSF 1	
SSF 2	
SSF 3	
SSF 4	
SSF 5	
SSF 6	

BREAST #1

7/11/xx HISTORY: 51-year-old Caucasian female with an abnormal left routine screening mammogram. Sonogram reveals a 1.2-centimeter mass

PE: BREASTS: There is no dominant mass in either breast. There are no skin changes and no nipple changes. Axilla and supraclavicular areas are clear.

7/11/xx OP: DESCRIPTION OF OPERATION: Needle localization was at approximately 11 to 12 o'clock. This area was excised with a margin of breast tissue. With the incision open with palpation, there was a very firm area noted at 4 o'clock in the left breast. This was a second area and was separate from the original tumor. A separate incision was therefore made over the 4 o'clock area and the mass was excised.

7/11/xx Needle localized left breast biopsy, left breast Path:

- 1) BREAST, LEFT, BIOPSY: Moderately differentiated infiltrating ductal carcinoma, 1 cm in maximum dimension, extending to within 2 mm of the medial margin.
- 2) BREAST, LEFT, BIOPSY: Moderately differentiated infiltrating ductal carcinoma, 1.6 cm in maximum dimension extending to inked margin.

7/11/ xx PATH: (Specimen #2): 1.6 cm largest size, Invasive ductal carcinoma, Grade 2; ER 55%, PR 97%, Her2 1+, FISH Negative

8/18/xx She has decided to proceed with mastectomy and first stage reconstruction with expanders for this probable T1 breast cancer.

8/18/xx PATHOLOGY

- 1) LYMPH NODE, LEFT AXILLA, BIOPSY: Metastatic moderately infiltrating ductal carcinoma involving 1 lymph node. No extracapsular extension is noted.
- 2) BREAST, LEFT, MODIFIED RADICAL MASTECTOMY: Residual moderately differentiated infiltrating ductal carcinoma 1.5 cm in cross diameter adjacent to previous biopsy site. Margins free. 2 of 2 axillary lymph nodes with metastatic tumor.
 SIZE OF INVASIVE COMPONENT: 1.6 cm from initial biopsy and an additional 1.5 cm residual tumor, total 3.1cm aggregate
 MARGINS: Margins uninvolved by tumor

9/26/xx Adria, Cytoxan x 4 followed by Taxol x 4
 3/20/xy Tamoxifen

Breast Case #2

SITE	
CS Tumor Size	
CS Exten	
CS TS/Ext Eval	
CS LN	
CS LN Eval	
CS Reg LN Pos	
CS Reg LN Exam	
CS Mets @ Dx	
CS Mets Eval	
SSF 1	
SSF 2	
SSF 3	
SSF 4	
SSF 5	
SSF 6	

BREAST #2

1/27/xx HISTORY: 42-year-old female with a history of a spontaneous left nipple discharge containing blood. A sonogram revealed dilated ductal tissue. A ductogram revealed filling defects in a distal duct just behind the nipple complex.

PHYSICAL: BREASTS: Diffuse fibrocystic changes. Compression on the left nipple elicits a grossly bloody nipple discharge. No adenopathy.

1/27/xx OP: A central duct excision was performed. The ductal tissue was amputated from behind the nipple, this was straight down into the breast, and removed.

1/27/xx PATH: Breast, deep subareolar tissue: Low grade intraductal carcinoma, nuclear grade 1 (cribriform and micropapillary patterns), extending to inked margin.

3/11/xx OP: Skin sparing left simple mastectomy with First stage left breast reconstruction using tissue expander with expected saline implants to be performed later this year.

3/11/xx PATH: Breast, left, simple mastectomy: Infiltrating ductal carcinoma, grade I.

- Extensive low and focal high grade ductal carcinoma in situ (cribriform and micropapillary patterns, nuclear grades 1 & 3).
- Size: Largest invasive component measures 5 mm with multiple smaller foci of microinvasion less than 3 mm (as measures microscopically).
- Lymphovascular invasion not specifically identified.
- Margins free of involvement.

ER/PR positive, Her2 negative

3/30/xx OP: Left axillary dissection due to finding of invasive carcinoma

3/30/xx PATH: Left axillary lymph nodes, final count: One of ten lymph nodes contains metastatic adenocarcinoma.

5/13/xx Patient begun on Adria & Cytoxan followed by Taxotere and Xeloda

10/29/xx Patient begun on Arimidex

BREAST #3

SITE	
CS Tumor Size	
CS Exten	
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CS LN	
CS LN Eval	
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CS Mets @ Dx	
CS Mets Eval	
SSF 1	
SSF 2	
SSF 3	
SSF 4	
SSF 5	
SSF 6	

BREAST #3

02/09/xx H&P: 49 year old female with quickly changing right breast in past four months. Mammogram and ultrasound revealed 2.5-3cm lesion. Generous biopsy at this clinic last week revealed infiltrating ductal carcinoma. Punch biopsy of skin showed dermal lymphatic involvement. She is here today to begin her chemotherapy of Adriamycin and Cytoxan for inflammatory breast cancer, ER/PR positive, Her2 negative. CT scan abdomen, Bone scan negative.

6/15/xx H&P: Patient has had moderate response to neoadjuvant chemotherapy and is now here for MRM. The mass has shrunk from 3.2 to 1.7cm per mammogram. By physical exam, there is a mass with induration that is approximately 10 cms including all of the induration. The left side reveals no dominant mass and no supraclavicular, cervical or axillary adenopathy is palpable.

6/15/xx Right MRM Pathology:

SPECIMEN SIZE: 17 x 13.5 x 7 cm.

LATERALITY: Right.

TUMOR SITE: Upper outer quadrant.

SIZE OF INVASIVE COMPONENT: 7 cm in greatest dimension.

HISTOLOGIC TYPE: Invasive ductal carcinoma, grade 3

LYMPH NODES: 7 in 14 lymph nodes positive

MARGINS: The inked deep margin of resection is focally contiguous with tumor.

ADDITIONAL PATHOLOGIC FINDINGS: A small mucinous component is present in the axillary tissue and in the dermis.

12/16/xx RADIATION END OF TREATMENT NOTE: Patient received further adjuvant chemotherapy of Taxol x 4 and began Arimidex 10/07/xx. She underwent a CT simulation with a three dimensional isodose plan with dose volume histograms.

SITE: Right chest wall, Right supraclavicular

ENERGY: 6 MV

DOSE PER FRACTION: 1.8 Gy

TOTAL FRACTIONS: 28

TOTAL DOSE: 50.4 Gy

SITE: Mastectomy scar

ENERGY: 6 MeV electrons

DOSE PER FRACTION: 2.0 Gy

TOTAL FRACTIONS: 7

TOTAL DOSE: 14 Gy

TREATMENT START: 10/17/xx TREATMENT END: 12/16/xx

RECTAL

SITE	
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SSF 1	
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SSF 4	
SSF 5	
SSF 6	

RECTAL

10/18/XX Colonoscopy The patient is a 67-year-old gentleman recently discovered to have a large soft posteriorly based rectal polyp. Previous colonoscopy had shown tubulovillous adenoma, high-grade dysplasia with no evidence of cancer. This is a posteriorly based tumor; about four centimeters in diameter, with its lower edge ten centimeters from the anal verge and the upper edge 13 to 14 centimeters from the anal verge.

PATH: RECTAL LESION, DEEP CENTRAL, BIOPSY:
Adenocarcinoma originating in a villous adenoma, high grade.

RADIATION THERAPY NOTE: Low-lying adenocarcinoma with high-grade features originating in a villous adenoma. Ultrasound showed complete penetration through the rectal wall. He has now received combined concurrent chemotherapy of continuous infusion 5-FU and radiation preoperatively. Clinically T3, N0, M0 via ultrasound.

Treatment Dates: 10/28 /xx – 01/13/xy

Site: Pelvis

Mode/Energy: 6 MV photons

Daily Dose per Fraction: 1.8Gy

Total Dose: 50.4 Gy

3/2/xy OP: Exploratory laparotomy, rigid sigmoidoscopy, proctectomy with low rectal stump, creation of permanent end-sigmoid colostomy. The specimen was opened showing a 4-cm polypoid lesion of the low rectum with approximately a 3-cm margin. The residual anorectal stump measured only approximately 4 cm long. It was my surgical judgment at the time of the operation that the patient would be ill served by extremely low anastomosis due to his age and radiation effect with possibility of impaired continence. Decision was therefore made to perform an end-sigmoid colostomy.

3/2/xy PATH: COLON, SIGMOID AND RECTUM, RESECTION:
Tubulovillous adenoma with high grade atypia and intramucosal carcinoma. Margins are free of tumor. See CAP checklist.

TUMOR SIZE: Polyp measuring 3.7 cm in greatest dimension with focal high grade atypia and intramucosal carcinoma.

HISTOLOGIC TYPE: Adenocarcinoma

HISTOLOGIC GRADE: Low grade

PRIMARY TUMOR: pTIS, carcinoma in situ, intraepithelial (no invasion).

Regional lymph nodes: pN0, number examined 3.

MARGINS: Uninvolved by tumor

Colon #1

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SSF 6	

Colon #1

11/01/xx H&P: Very pleasant lady age 78. She has been sick for about 9-10 days. She started with some lower abdominal discomfort, which has been intermittent and somewhat crampy. She saw me in the office one week ago today on 10/25. At that time, we went over her history and she was noted to have an elevated white blood cell count. She had a CT scan of the abdomen which showed a large amount of stool in the colon, possible ileus, versus early small bowel obstruction.

ASSESSMENT:

1. Probable small bowel obstruction, possibly colonic mass. Could not exclude some other inflammatory lesion, or complication related to her previous radiation cystitis.

SECONDARY DIAGNOSES:

1. Uterine cancer in 1983, status post hysterectomy.
2. Status post radiation seed implantation in 1984.
3. Severe radiation cystitis.

11/01/xx OP: Exploratory lap, right colectomy

FINDINGS: The cecum was identified. This had a large intraluminal mass, which appeared to be obstructing the terminal ileum as well. The cecum itself was densely adherent to the lateral parietal peritoneum. This was freed using sharp and cautery dissection ... On exam by pathology it was felt to be an 8 cm. primary malignancy. A functional end-to-end anastomosis was then performed between terminal ileum and transverse colon

11/01/xx PATH: COLON, RIGHT, RESECTION:

Moderately differentiated adenocarcinoma, 8 cm in maximum dimension exhibiting transmural invasion involving pericolonic adipose tissue.

8 pericolonic lymph nodes all negative for metastatic tumor.

Margins free. .

COLON #2

SITE	
CS Tumor Size	
CS Exten	
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CS LN	
CS LN Eval	
CS Reg LN Pos	
CS Reg LN Exam	
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CS Mets Eval	
SSF 1	
SSF 2	
SSF 3	
SSF 4	
SSF 5	
SSF 6	

Colon #2

5/11/xx H&P: 39 year old male with history of schizophrenia and epilepsy. He reports increasing fatigue and lab work showed Hgb of only 5. Patient denies hematemesis, melena, or hematochezia.

5/11/xx Colonoscopy: Obstructed area in the distal transverse colon that looks like a mass there with submucosal spread, status post biopsy.
 PATH: COLON MASS BIOPSY AT 80 CM: Colon mucosa showing minimal histologic change.

CEA 5.2 (Normal high 3.0)

5/12/xx CT: Two liver lesions, question neoplasm versus cystic. Possible adenopathy.

5/24/xx OP: Resection of transverse colon, splenic flexure with colon; anastomosis and biopsy of mesenteric lymph node. The colon was normal with the exception of the large mass at the splenic flexure consistent with tumor.

5/24/xx: PATH Diagnosis
 1) COLON, TRANSVERSE, LEFT, RESECTION: Poorly differentiated mucinous adenocarcinoma, 6 cm in maximum dimension, exhibiting transmural invasion to involve pericolic adipose tissue and approaching the serosal margin to within 2 mm. All other margins are free of tumor.
 13 of 15 pericolic lymph nodes with metastatic mucinous adenocarcinoma.
 2) LYMPH NODES AND ANASTOMOTIC RINGS: Two of three pericolic lymph nodes with metastatic adenocarcinoma.
 Anastomotic rings, no sections.
 Comment: The tumor is comprised of greater than 50% mucinous adenocarcinoma with areas of poorly differentiated and moderate differentiated nonmucinous adenocarcinoma present.

5/30/xx Hepatic Ultrasound: Two subtle liver solid lesions, not considered cysts.

6/14 PET: Findings are compatible with hypermetabolic lesions and suspicious for but not diagnostic of metastases with SUV of 10 and 12.7.

6/25 Oncology Office Note: Patient seen briefly. Would not stay for full consultation. Acknowledged diagnosis but stated adamantly would not accept chemotherapy for metastatic colon cancer.

Lung Case #1

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CS LN	
CS LN Eval	
CS Reg LN Pos	
CS Reg LN Exam	
CS Mets @ Dx	
CS Mets Eval	
SSF 1	
SSF 2	
SSF 3	
SSF 4	
SSF 5	
SSF 6	

Lung #1

3/16/xx H&P: 60 year old farmer with six week symptoms of cough and flu-like symptoms. Outside CT shows persistent infiltrate RLL , question pneumonia. Sputum and bronchoscopy have not yielded malignant diagnosis.

3/16/xx OP: Bi-lobectomy RLL and RML.

Findings: The lung was basically fused with the diaphragm, and there were almost no planes here. We were able to mobilize this and the inferior pulmonary ligament. The middle and lower lobe had become confluent. There were multiple large lymph nodes.

Diagnosis

- 1) LEVEL 12 LYMPH NODE: Follicular lymphoid hyperplasia, negative for neoplasm.
- 2) RIGHT LOWER LOBE: Bronchioloalveolar carcinoma.
- 3) RIGHT LOWER LOBE, EXCISION: Bronchioloalveolar carcinoma with acute and chronic inflammation.
Bronchial margin of excision negative for negative.
Three peribronchial lymph nodes with follicular and paracortical lymphoid hyperplasia, negative for neoplasm.

TUMOR SIZE: 12 cm in greatest dimension.

HISTOLOGIC TYPE: Bronchioloalveolar carcinoma.

HISTOLOGIC GRADE: Well differentiated.

MARGINS: Bronchial margin of excision negative for neoplasm.

ONC CONSULTATION: When I saw him I talked to him and his family about adjuvant treatments. He had no positive lymph nodes and this particular type of lung cancer is not very response to chemotherapy. Patient chose close observation.

LUNG #2

SITE	
CS Tumor Size	
CS Exten	
CS TS/Ext Eval	
CS LN	
CS LN Eval	
CS Reg LN Pos	
CS Reg LN Exam	
CS Mets @ Dx	
CS Mets Eval	
SSF 1	
SSF 2	
SSF 3	
SSF 4	
SSF 5	
SSF 6	

Lung #2

4/13/xx H&P: 84 year old female with chief complaint of incoordination.

CT HEAD: Densities in right parietal and frontal region

CT CHEST: 1.5 spiculated mass is present in the left mid lung involving the left upper lobe highly suspicious for bronchogenic carcinoma with associated mediastinal/hilar adenopathy.

ONC CONSULT: IMPRESSION: Bronchogenic carcinoma.

ONC RECOMMENDATIONS: The patient and her family are currently considering palliative radiation therapy and they seem to be rather disinterested in chemotherapy at this point.

RT: TREATMENT:

SITE: Whole brain

TECHNIQUE: Laterals

ENERGY: 6 MV photons

DOSE PER FRACTION: 300 cGy

NUMBER OF FRACTIONS: 10

TOTAL DOSE: 30 Gy

TREATMENT DATES: 04/20/xx – 05/03/xx

LUNG #3

SITE	
CS Tumor Size	
CS Exten	
CS TS/Ext Eval	
CS LN	
CS LN Eval	
CS Reg LN Pos	
CS Reg LN Exam	
CS Mets @ Dx	
CS Mets Eval	
SSF 1	
SSF 2	
SSF 3	
SSF 4	
SSF 5	
SSF 6	

Lung #3

10/16/xx H&P: 58 year old male admitted with chest pain and history tobacco abuse. Cardiac workup negative.

PE: Palpable 2-3cm supraclavicular node

CT CHEST: large confluent paratracheal and mediastinal mass suspicious for adenopathy with enlarged anterior and superior mediastinal lymph nodes. Lymph nodes are seen in the subcarinal region and AP window. Leading differential consideration is lymphoma. Trace pericardial effusion. Small amount of patchy density right upper lobe which may reflect infiltrate.

CT HEAD and ABDOMEN negative.

10/18/xx MEDIASTINOSCOPY: Paratracheal mediastinal lymph nodes were extensively biopsied. They appeared much larger than usual and were quite friable.

PATH: 1) RIGHT PARATRACHEAL LYMPH NODE: Small cell carcinoma.

2) RIGHT PARATRACHEAL LYMPH NODE: Small cell carcinoma.

10/21/xx Carbo, VP16 begun while in hospital.

RT SITE: Right supraclavicular mediastinum

ENERGY: 6 MV

DOSE PER FRACTION: 1.8 Gy

TOTAL FRACTIONS: 30

TOTAL DOSE: 54 Gy

TREATMENT START: 10/31/xx TREATMENT END: 12/14/xx

Prostate #1

SITE	
CS Tumor Size	
CS Exten	
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CS LN	
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CS Reg LN Exam	
CS Mets @ Dx	
CS Mets Eval	
SSF 1	
SSF 2	
SSF 3	
SSF 4	
SSF 5	
SSF 6	

Prostate #1

61-year-old, rather healthy, white male with a prostate specific antigen of up to 11.5. He underwent transurethral ultrasound of the prostate and needle biopsy revealing adenocarcinoma in five out of five needle biopsies on the right side with Gleason score 3+4 and seven out of seven needle core biopsies on the left side with a Gleason score of 4+3. He had a CT scan of the abdomen and pelvis and a bone scan that was negative for metastatic disease. Prior to workup and final treatment decision, he was given Lupron in the office. He now presents for bilateral pelvic lymph node dissection with radical retropubic prostatectomy.

Path Diagnosis

1) RIGHT PELVIC LYMPH NODE:

Three lymph nodes identified, negative for neoplasm.

2) LEFT PELVIC LYMPH NODE:

Two lymph nodes identified, negative for neoplasm.

3) PROSTATE: Moderate to poorly differentiated adenocarcinoma involving left and right lobes, Gleason primary grade 4, Gleason histologic score 7 with perineural invasion, see comment.

Glandular and stromal hyperplasia.

RIGHT SEMINAL VESICLE: Negative for neoplasm.

LEFT SEMINAL VESICLE: Positive for adenocarcinoma.

Proximal periurethral margin of excision: negative for neoplasm.

Distal periurethral margin of excision: negative for neoplasm.

Perineural invasion is present close to the distal periurethral margin of excision.

Comment: The observable inked pseudocapsular margin of excision is negative for neoplasm. However, the carcinoma is close to the inked pseudocapsular margin of excision of the right and left lobes focally.

Prostate #2

SITE	
CS Tumor Size	
CS Exten	
CS TS/Ext Eval	
CS LN	
CS LN Eval	
CS Reg LN Pos	
CS Reg LN Exam	
CS Mets @ Dx	
CS Mets Eval	
SSF 1	
SSF 2	
SSF 3	
SSF 4	
SSF 5	
SSF 6	

Prostate #2

CHIEF COMPLAINT: BPH with obstruction.

HISTORY OF PRESENT ILLNESS: This is a 77-year-old white male who had a transurethral microwave thermotherapy of the prostate done by a urologist on May 20, 2004. The patient did not have achieve a good result from the surgery according to him. He has been on Flomax 0.4 mg daily since then. He was cystoscoped recently and found to have BPH with obstruction. He wanted to see me and did in the office and I offered him a transurethral resection of the prostate or KTP laser of the prostate. The patient wants a regular operation on her prostate, so he enters the hospital at this time for a transurethral resection of the prostate.

Diagnosis

PROSTATE TISSUE: Prostatic adenocarcinoma, see checklist.

HISTOLOGIC TYPE: Prostatic adenocarcinoma

HISTOLOGIC GRADE: Gleason grades 2 and 3 (Gleason score 5, moderately well differentiated).

TUMOR QUANTITATION: Tumor involves 2 of 79 chips or approximately 2.5% of the specimen.

EXTENT OF INVASION: T1a

Prostate #3

SITE	
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CS LN	
CS LN Eval	
CS Reg LN Pos	
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CS Mets Eval	
SSF 1	
SSF 2	
SSF 3	
SSF 4	
SSF 5	
SSF 6	

Prostate #3

This patient is a 64-year-old white male with an elevated PSA of 6.30. On rectal exam, he has an enlarged prostate without specific nodularity. On prostate ultrasound, he has a very large prostate with a very large median lobe. Twelve ultrasound-guided biopsies were taken of the prostate gland. The biopsies were positive at the left apex. After discussion of the different treatment options, he has decided on radical prostatectomy with bilateral pelvic lymph node dissection.

Diagnosis

- 1) LEFT PELVIC LYMPH NODES:
Multiple lymph nodes. There is no evidence of malignancy.
- 2) RIGHT PELVIC LYMPH NODES:
Multiple lymph nodes. There is no evidence of malignancy.
- 3) PROSTATE, RADICAL RESECTION:
Prostatic adenocarcinoma, see comment.

HISTOLOGIC TYPE: Adenocarcinoma

HISTOLOGIC GRADE: Primary pattern, grade: 3; secondary pattern grade: 3. Total Gleason score: 6

PATHOLOGIC STAGING

PRIMARY TUMOR: pT2A (tumor involves right prostatic lobe)

REGIONAL LYMPH NODES: pN0. No regional lymph nodes, see specimens 1 and 2.

DISTANT METASTASIS: pMX, cannot be assessed

MARGINS: Uninvolved (Tumor is less than 1 mm. from distal prostatic urethral margin, extraprostatic extension absent, seminal vesicle invasion absent. Surgical margin free of tumor, however, tumor involves pseudocapsule.)

ANSWER SHEET

Breast Cancer #1
SITE: C509
CS Tumor Size 031
CS Exten 10
CS TS/Ext Eval 3
CS LN 25
CS LN Eval 3
CS Reg LN Pos 03
CS Reg LN Exam 03
CS Mets @ Dx 00
CS Mets Eval 0
SSF 1 010 SSF 4 888
SSF 2 010 SSF 5 888
SSF 3 003 SSF 6 000

Breast Cancer #2
SITE: C501
CS Tumor Size 005
CS Exten 10
CS TS/Ext Eval 3
CS LN 25
CS LN Eval 3
CS Reg LN Pos 01
CS Reg LN Exam 10
CS Mets @ Dx 00
CS Mets Eval 0
SSF 1 010 SSF 4 888
SSF 2 010 SSF 5 888
SSF 3 001 SSF 6 020

Per I&R, skin-sparing
mastectomy = SIMPLE,
not mod even though
LNs removed
BUT SING states axillary
dissection is what should
make this 55, not 45

Breast Cancer #3
SITE: C509
CS Tumor Size 998
CS Exten 71
CS TS/Ext Eval 6
CS LN 25
CS LN Eval 6
CS Reg LN Pos 07
CS Reg LN Exam 14
CS Mets @ Dx 00
CS Mets Eval 0
SSF 1 010 SSF 4 888
SSF 2 010 SSF 5 888
SSF 3 007 SSF 6 000

Rectum
SITE: C209
CS Tumor Size 999
CS Exten 40
CS TS/Ext Eval 6
CS LN 00
CS LN Eval 5
CS Reg LN Pos 00
CS Reg LN Exam 03
CS Mets @ Dx 00
CS Mets Eval 0
SSF 1 999
SSF 2-6 888

Colon #1
SITE: C180
CS Tumor Size 080
CS Exten 45
CS TS/Ext Eval 3
CS LN 00
CS LN Eval 3
CS Reg LN Pos 00
CS Reg LN Exam 08
CS Mets @ Dx 00
CS Mets Eval 0
SSF 1 000
SSF 2-6 888

Colon #2
SITE: C185
CS Tumor Size 060
CS Exten 45
CS TS/Ext Eval 3
CS LN 30
CS LN Eval 3
CS Reg LN Pos 15
CS Reg LN Exam 18
CS Mets @ Dx 40
CS Mets Eval 0
SSF 1 010
SSF 2-6 888

Lung #1
SITE: C343
CS Tumor Size 120
CS Exten 10
CS TS/Ext Eval 3
CS LN 00
CS LN Eval 3
CS Reg LN Pos 00
CS Reg LN Exam 04
CS Mets @ Dx 00
CS Mets Eval 0
SSF 1-6 888
PER SING: Tumor that
crosses fissure into
another lobe = 10 if no
other involvement.

Lung #2
SITE: C341
CS Tumor Size 015
CS Exten 10
CS TS/Ext Eval 0
CS LN 40
CS LN Eval 0
CS Reg LN Pos 98
CS Reg LN Exam 00
CS Mets @ Dx 00
CS Mets Eval 0
SSF 1-6 888

Lung #3
SITE: C348
CS Tumor Size 000
CS Exten 95
CS TS/Ext Eval 0
CS LN 60
CS LN Eval 0
CS Reg LN Pos 02
CS Reg LN Exam 02
CS Mets @ Dx 00
CS Mets Eval 0
SSF 1-6 888

Prostate #1
SITE: C619
CS Tumor Size 999
CS Exten 15
CS TS/Ext Eval 6
CS LN 00
CS LN Eval 6
CS Reg LN Pos 00
CS Reg LN Exam 05
CS Mets @ Dx 00
CS Mets Eval 0
SSF 1 115 SSF 4 550
SSF 2 010 SSF 5 043
SSF 3 023 SSF 6 007

Prostate #2
SITE: C619
CS Tumor Size 999
CS Exten 13
CS TS/Ext Eval 1
CS LN 00
CS LN Eval 0
CS Reg LN Pos 98
CS Reg LN Exam 00
CS Mets @ Dx 00
CS Mets Eval 0
SSF 1 000 SSF 4 550
SSF 2 000 SSF 5 023
SSF 3 097 SSF 6 005

Prostate #3
SITE: C619
CS Tumor Size 999
CS Exten 15
CS TS/Ext Eval 4
CS LN 00
CS LN Eval 3
CS Reg LN Pos 00
CS Reg LN Exam 97
CS Mets @ Dx 00
CS Mets Eval 0
SSF 1 063 SSF 4 350
SSF 2 010 SSF 5 033
SSF 3 021 SSF 6 006

