Instructions: *code topography, morphology, cTNM and pTNM (if applicable). Note the primary consecutive treatments.*

CASE #l

CASE HISTORY
Female (64 years) came to her doctor after finding a hard mass in her left breast. No nipple discharge or nipple retraction.

PHYSICAL EXAMINATION
Breast: 4 cm hard mass, lower outer quadrant of the left breast. On examination the skin was dimpled with signs of oedema and peau d'orange. Axilla left: palpable suspicious nodes in the lower axilla. No hepatomegaly or enlarged lymph nodes other than in left axilla.

DIAGNOSTIC PROCEDURES
18/06/20XX Mammography: suspect lesion in lower outer quadrant of the left breast
18/06/20XX Chest X-ray: normal
21/06/20XX Needle biopsy, left breast

PATHOLOGY
21/06/20XX Needle biopsy: poorly differentiated infiltrating duct carcinoma. Oestrogen and progesterone receptors positive.

SURGERY
06/07/20XX Modified radical mastectomy

OPERATIVE REPORT
06/07/20XX Skin tightly adherent to 3.5 cm gritty mass, left upper inner quadrant in fatty breast tissue just below dermis. Dissection of axilla.

PATHOLOGY
06/07/20XX Modified radical mastectomy: poorly differentiated infiltrating ductal carcinoma with infiltration of dermis, but no ulceration of the skin surface, largest diameter 3 cm. Second lesion of 0.8 cm in diameter in lower inner quadrant, infiltrating lobular carcinoma. No areas of ductal carcinoma *in situ*. 6 out of 17 axillary lymph nodes involved (ductal carcinoma).

FURTHER TREATMENTS
Post-operative radiation therapy to axilla. Referred for adjuvant chemotherapy and hormonal treatment.

Topography _____ Code _____

Morphology and grade _____ Code _____

Clinical TNM T _____ N _____ M _____

Pathological TNM T _____ N _____ M _____

Treatment(s) _____

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CASE #2

CASE HISTORY
Male, 56 years. Patient lost 5 kg of weight during the last year. Chest pain , productive cough hoarseness with partial vocal cord paralysis. Smoker for over 30 years. Chest X-ray performed by GP shows as suspect lesion in the right lung.

PHYSICAL EXAMINATION
19/11/20XX Lungs, slight wheezing on expiration in both lungs. Tumour palpable supraclavicular right. Patient visibly lost weight, otherwise no abnormal findings.

DIAGNOSTIC PROCEDURES
19/11/20XX Laboratory tests: within normal limits
19/11/20XX CT-scan chest: 6 cm tumour mass in right upper lobe, incomplete atelectasis of the right lung. Pleural effusion apparent. Large mediastinal mass (both left and right).
20/11/20XX Supraclavicular biopsy
26/11/20XX Bronchoscopy with bronchial washing and biopsy: right upper lobe mass noted with extension along lateral wall of main bronchus into the trachea.

PATHOLOGY
20/11/20XX Supraclavicular node biopsy: Metastatic squamous cell carcinoma.
26/11/20XX Squamous cell carcinoma, poorly differentiated. Bronchial washings and brushings positive for malignant cells.

TREATMENT
Patient receives palliative radiotherapy

Topography _____ Code _____

Morphology and grade _____ Code _____

Clinical TNM T _____ N _____ M _____

Treatment(s) _____

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CASE #3

CASE HISTORY
Female, 74 years. Passage of blood in stool of one-year duration , worse in last months. Progressive difficulty in evacuating bowels.

PHYSICAL EXAMINATION
Abdomen: Soft, non tender, and non distended with no evidence of masses. Digital rectal exam: no abnormalities.

DIAGNOSTIC PROCEDURES
25/08/20XX CT-scan chest and abdomen: no abnormalities.
27/08/20XX Colonoscopy: Fungating lesion involving more than 50% of the circumference of bowel at the splenic flexure of the colon. Biopsy.
27/08/20XX Liver enzymes: within normal limits .

PATHOLOGY
27/08/20XX Biopsy: adenocarcinoma

SURGERY
30/08/20XX Left hemicolectomy: lesion at the splenic flexure without evidence of gross lymphadenopathy. A suspicious lesion at the liver surface is biopsied.

PATHOLOGY
30/08/20XX Left hemicolectomy. Microscopy: Moderately differentiated mucinous adenocarcinoma showing extension into the subserosa and metastases in 6/10 mesocolic lymph nodes. The visceral peritoneum is intact. Tumour size 5 cm. Liver biopsy: no evidence of tumour.

FUTHER TREATMENT
Patient receives adjuvant chemotherapy

Topography _____ Code _____

Morphology and grade _____ Code _____

Clinical TNM T _____ N _____ M _____

Pathological TNM T _____ N _____ M _____

Treatment(s) _____

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CASE #4

CASE HISTORY
Male, 76 years, in good condition, no comorbidity. Progressive difficulty urinating, especially starting and stopping while urinating. Decreased flow.

PHYSICAL EXAMINATION
Digital rectal examination: Enlargement of prostate bilaterally. Nodule in lower half of right lobe, protruding slightly more than right lobe and somewhat irregular.

DIAGNOSTIC PROCEDURES

19/03/20XX	PSA: 43.4 (normal = 10)
22/03/20XX	Chest X-ray: Normal; Pelvic CT scan: no of evidence of pelvic lymph node metastases
22/03/20XX	Bone scan: Increased uptake in right ankle and right knee, felt to be due to arthritic changes. No clear signs of distant metastasis.
26/03/20XX	Bilateral needle biopsies of the prostate.

PATHOLOGY

26/03/20XX	Needle biopsies: left 3 out of 6 are positive, right 6 out of 6 are positive. Moderately differentiated adenocarcinoma. Gleason grade 3 + 4.

SURGERY

01/04/20XX	Pelvic lymph node dissection. The urologist finds an enlarged suspicious lymph node and the pathologist is consulted intraoperatively for a frozen section procedure.

PATHOLOGY

01/04/20XX	Frozen section procedure: one lymph node with metastatic adenocarcinoma, largest diameter 12 mm.

TREATMENT
Because of the discovery of the positive lymph node, the planned prostatectomy is abandoned and the patient receives radiotherapy and also starts with anti-androgen hormone therapy.

Topography _____ Code _____

Morphology and grade _____ Code _____

Clinical TNM T _____ N _____ M _____

Pathological TNM T _____ N _____ M _____

Treatment(s) _____

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