LUNG CANCER CASE #1

Patient was admitted with dyspnea, cough and hemoptysis, as well as right hilar mass, postobstructive pneumonia, atelectasis, mediastinal adenopathy, supraclavicular adenopathy, left lower lobe nodularity.

CT scan chest showed a large right hilar mass (4.6cm) with right middle lobe postobstructive pneumonia. This appears to occlude the right mainstem bronchus with complete atelectasis of RML. There is also some infiltrate at the left base. There is significant hilar and superior mediastinal adenopathy, as well as right supraclavicular adenopathy of 2.6cm.

PET: HEAD/NECK: At the base of the neck on the right, just lateral to the right lobe of the thyroid gland an enlarged lymph node is present in the right paratracheal region. This has a maximal SUV of 4.82. This lymph node measures approximately 2.1 x 1.9 cm.
LUNGS: There is a rim of mildly hypermetabolic activity noted in the right midlung corresponding to a region of dense consolidation. This has a maximal SUV of 1.81 and could be secondary to an inflammatory process such as pneumonia. Direct tumor involvement could not be excluded but thought less likely.
MEDIASTINUM/HILA: The ill-defined right hilar mass appears hypermetabolic with a maximal SUV of 5.23. Multiple enlarged right paratracheal and azygous lymph nodes are present with maximal SUVs ranging between 4.8 and 5.59. A large subcarinal lymph node is a maximal SUV of 4.40. Suspicious approximate 2.4 x 1.6 cm.
PET CONCLUSION: 1. Hypermetabolic activity is seen in the right hilar mass with suggestion of metastatic involvement of multiple mediastinal lymph nodes.

3/14 PROCEDURE PERFORMED: Bronchoscopy with biopsy, brushing and washing. The oropharynx, larynx and trachea were normal. The left lung was inspected. The left upper lobe lingula and left lower lobe were normal. The right lung was inspected. The right upper lobe and right lower lobe were normal. At the takeoff the right midlung there was a significant endobronchial lesion obstructing the right middle lobe orifice. Several biopsies were taken in that area as well as brushing. Washing was done with approximately 50 mL of sterile saline with return of bloody fluid.

3/14 CYTOLOGY: 1) RIGHT MIDDLE LOBE BRUSHING: Small cell carcinoma
2) RIGHT MIDDLE LOBE WASHING: Atypical cells present

314 PATH: RIGHT MIDDLE LOBE OF LUNG, NEEDLE BIOPSY: Small cell carcinoma

SEER SUMMARY STAGE: _____
cT _____ cN _____ cM _____ Stage _____
pT _____ pN _____ pM _____ Stage _____
LUNG CASE #2

CT CHEST: Spiculated masslike process right middle lobe measuring nearly 3 cm which appears to be adherent to the pleura. Additional spiculated area of infiltrate/mass right lower lung field measuring 3.2 cm. Additionally there is mixed interstitial and alveolar infiltrate identified in the base of the right lower lobe and right middle lobe. There are suspicious mediastinal lymph nodes which measure up to nearly 15 mm in the right paratracheal and precarinal spaces. PET scan recommended by not completed.

PALLIATIVE CARE CONSULT: He has the lung masses, which were felt to be probably cancer, but there has been no biopsy for diagnosis.

DISCHARGE SUMMARY:
CAUSE OF DEATH: Sepsis syndrome.

OTHER DIAGNOSES: Include:
1. Non-ST elevation myocardial infarction.
2. Diffuse coronary artery disease.
3. Cardiogenic shock.
4. Septic shock.
5. Probable underlying malignancy with inability to diagnose due to multiple comorbidities.
6. Chronic obstructive pulmonary disease.
7. Pulmonary fibrosis.
8. Bronchiectasis.

SEER SUMMARY STAGE: ______
cT _____ cN _____ cM _____ Stage _____
pT _____ pN _____ pM _____ Stage _____
Patient is a 52-year-old who has a recent diagnosis of breast cancer. She had a palpable abnormality of the right breast, which was evaluated by mammogram and ultrasound. This demonstrated a 4.7 x 3 x 3.8 cm right breast mass with second adjacent smaller area on ultrasound underlying nipple. Biopsy demonstrated invasive ductal carcinoma that was ER/PR positive, HER-2 positive. Patient planned to initiate neoadjuvant chemotherapy with carboplatin, Taxotere and Herceptin. Subsequently, she had a PET CT scan for initial staging which demonstrated a right lower lobe lung nodule. A lung biopsy demonstrated this to be adenocarcinoma with mucinous features, well differentiated, likely of a second primary from her breast cancer.

CT CHEST/PET: 5.7 x 3.3 cm pulmonary mass involving the posterior medial right lung base which extends to the pleura surface. This is hypermetabolic on today’s PET/CT scan and suspicious for malignancy. This likely represents a primary lung carcinoma or, less likely, mets.

10/2 Tumor Conference: Mucinous adenocarcinoma suspected to be what was formerly called bronchoalveolar, now called in situ adenocarcinoma. But that can’t be proven without resection because there could be microinvasion found. Recommended lobectomy.

10/8 OPERATION PERFORMED: Video-assisted thoracoscopic on the right with thoracoscopic right lower lobectomy.

10/8 PATH - LUNG, RIGHT LOWER LOBE, LOBECTOMY: Bronchioloalveolar carcinoma, mucinous type, no definitive invasion identified, see CAP checklist and comment.
- Margins free of tumor.
- Lymph node: Calcified peribronchial lymph node negative for malignancy.

SPECIMEN: Lung
PROCEDURE: Lobectomy
SPECIMEN INTEGRITY: Intact
SPECIMEN LATERALITY: Right
TUMOR SITE: Lower lobe
TUMOR SIZE GREATEST DIMENSION: 6 cm
ADDITIONAL DIMENSIONS: 4.9 x 3.3 cm
TUMOR FOCALITY: Unifocal
HISTOLOGIC TYPE: Bronchioloalveolar, mucinous
HISTOLOGIC GRADE: G1, well-differentiated
VISCERAL PLEURAL INVASION: Not identified
TUMOR EXTENSION: Not identified
MARGINS: All margins uninvolved by invasive carcinoma
LYMPH-VASCULAR INVASION: Not identified
- Number of lymph nodes examined: 1
- Number of lymph nodes involved: 0

SEER SUMMARY STAGE: ______
cT _____ cN _____ cM _____ Stage _____
pT _____ pN _____ pM _____ Stage _____