

Result

PET TUMOR IMAG W/ CONC CT SKULL BASE TO MID-THIGH (ExID# [REDACTED]) (Order# [REDACTED])

Patient Demographics

Patient Name	Sex	DOB	Address	Phone
Cervantes, Miguel	Male	[REDACTED]	[REDACTED] MANTECA CA 95337	[REDACTED]

Entry Date

6/7/2011

Header:

REASON FOR EXAM: MALIGNANT NEOPLASM PAROTID GLAND

EXAMINATION: PET/CT SKULL TO MID THIGH - (CPT/0055) -

HISTORY: 67-year-old man with rapidly enlarging left neck mass. He was previously treated for possible parotid abscess. This mass has been biopsied 05/17/11 with pathology showing atypical cyst content. The patient is scheduled to have this mass excised. PET/CT is requested for evaluation of possible metastatic disease.

COMPARISON: Report of outside neck CT 4/27/2011 and 05/11/11.

RADIOPHARMACEUTICAL: 11.2 mCi 18-F deoxyglucose IV.

PROCEDURE: The patient's fasting blood glucose was 90 mg/dl at the time of injection. The patient was positioned on a dedicated high resolution full-ring PET scanner 79 minutes after intravenous injection of the radiopharmaceutical. An emission /16 detector CT transmission scan was obtained from the top of the skull to the midthighs. The images were corrected for tissue attenuation and reviewed in the transaxial, coronal and sagittal planes.

BRAIN No suspicious hypermetabolic foci. This evaluation is limited by high normal physiologic uptake of FDG throughout the cortical gray matter and basal ganglia.

HEAD AND NECK: There is a somewhat lobulated left neck mass which extends from the inferior aspect of the left parotid gland more inferiorly into the submandibular space. This mass is in close proximity to the left submandibular gland and also abuts the left sternocleidomastoid muscle posteriorly. The mass measures approximately up to 4.5 cm in maximal axial dimension and demonstrates abnormal FDG activity (max SUV 9.8). A small focus of increased FDG uptake is also noted in the skin overlying this mass may be related to ulceration of the overlying skin.

No hypermetabolic cervical lymph nodes identified. There is otherwise normal physiologic FDG uptake throughout the lymphoid tissues. The thyroid gland appears grossly unremarkable.

CHEST: No hypermetabolic mediastinal or hilar lymph nodes. No axillary lymphadenopathy. Status post median sternotomy. Status post aortic valve repair or replacement. A pacemaker is seen. Right-sided PICC line is present. Mild bibasilar atelectasis. No suspicious lung nodules or focal areas of airspace consolidation.

ABDOMEN AND PELVIS: Normal physiologic FDG activity is noted in the

2

Cervantes, Miguel

DOB: [REDACTED]

Age: 67 yrs Male

Enc Date: 05/19/2011

gastrointestinal and urinary tracts. The liver is grossly unremarkable and does not demonstrate abnormal focal uptake. The gallbladder, spleen, pancreas, and kidneys are unremarkable. No adrenal masses. The bladder is slightly thick walled but may not be completely distended. The bowel is unremarkable. No hypermetabolic mesenteric, retroperitoneal, or pelvic lymph nodes.

MUSCULOSKELETAL: Multilevel degenerative changes are seen in the axial skeleton. No suspicious hypermetabolic osseous lesions.

IMPRESSION:

Hypermetabolic left neck mass in the region of the left parotid gland concerning for malignancy. No findings to suggest regional nodal or distant metastatic disease.

UT: (p) RC: (n)

INTERPRETED BY: NHAN T. NGUYEN MD

Imaging Facility Information

Name	Address	Phone
SUNQUEST SAC SIERRA REGION-RAD		

Result Release

Released to My Health Online by Benzion G Goldwyn at Wed Jun 8, 2011 9:22 AM
Results have not been viewed by patient.

Reviewed by List

GOLDWYN MD, BENZION G on Wed Jun 8, 2011 9:22 AM

Imaging Exam Information

Imaging Exam Information

LMRP (CPT or other procedure code) and Procedure Comments

Procedure comments:

Status of Other Orders

Order	Result Status	Result Date	Provider Status
PATHOLOGY SF [PATHO Custom] Order #: [REDACTED]	Final result	5/19/2011	Reviewed Thu May 19, 2011 4:03 PM

Order

PET TUMOR IMAG W/ CONC CT SKULL BASE TO MID-THIGH [REDACTED] (Order [REDACTED])

Patient Demographics

Patient Name	Sex	DOB	Address	Phone
Cervantes, Miguel	Male	[REDACTED]	[REDACTED] MANTECA CA 95337	[REDACTED]

Additional Information

Associated Reports

View Encounter

Priority and Order Details

2

SURGICAL PATHOLOGY SF (ExtID#Status: **Final result**

Results

7/5/2011 7:35 PM

Patient Demographics

Patient Name	Sex	DOB	Address	Phone
Cervantes, Miguel	Male	[REDACTED]	[REDACTED] MANTECA CA 95337	[REDACTED]

Result Information

Collected Date and Time	Lab Received Date and Time	Filed in EpicCare Date and Time
6/30/2011 12:00 AM	6/30/2011 2:59 PM	7/5/2011 7:35 PM

Pathology Laboratory

DIAGNOSTIC PATHOLOGY MEDICAL GROUP, INC
3301 C ST SUITE 200E, Sacramento, CA 95816 (916)446-0424
Fax: (916)446-9330

Medical Director: Robert W. Ghiselli, MD

Results

CLINICAL HISTORY **Final**
CLINICAL DATA:
PRE-OP DIAGNOSIS: LEFT PAROTID TUMOR

SPECIMEN:

- A. LEFT PAROTID LYMPH NODE
- B. LEFT PAROTID TUMOR
- C. R/O TUMOR, LEFT SUBMANDIBULAR TISSUE
- D. ADDITIONAL TUMOR
- E. LEFT PAROTID TUMOR
- F. DERMAL MASS LEFT NECK

FROZEN SECTION DIAGNOSIS:

A. LEFT PAROTID LYMPH NODE (FROZEN SECTION AND TOUCH PREP): FRAGMENT OF LYMPH NODE AND SKELETAL MUSCLE, NEGATIVE FOR CARCINOMA. (KAM, ZEK; 06/30/11)

B. LEFT PAROTID TUMOR (FROZEN SECTION): LOOSE FIBROCONNECTIVE TISSUE WITH PROBABLE HEMATOLYMPHOID CELLS, NO DEFINITE CARCINOMA SEEN. (KAM, ZEK, DVC; 06/30/11)

C. LEFT SUBMANDIBULAR TISSUE (FROZEN SECTION AND TOUCH PREP): LYMPHOHISTIOCYTIC INFILTRATE, **NO DEFINITE MALIGNANCY SEEN.** (ZEK, KAM; 06/30/11)

D. ADDITIONAL TUMOR (FROZEN SECTION AND TOUCH PREP): LYMPHOHISTIOCYTIC INFILTRATE WITH MULTINUCLEATE GIANT CELLS AND ASSOCIATED SKELETAL MUSCLE, **NO DEFINITE MALIGNANCY SEEN.** (ZEK; 06/30/11)

F. LEFT NECK DERMAL MASS (FROZEN SECTION): LYMPHOHISTIOCYTIC INFILTRATE, **NO DEFINITE MALIGNANCY IS SEEN.** (ZEK; 06/30/11)

GROSS DESCRIPTION:

JW:wb

- A. Received fresh labeled with the patient's name and "A. left parotid lymph node" is an approximate 1.1 x 1.0 x 0.5 cm aggregate of soft tissue. One lymph node is identified. A touch prep is prepared, stained

and interpreted during the operating room consultation. The specimen is frozen. The frozen section residue, which is the entire specimen, is submitted in cassette A.

B. Received fresh labeled with the patient's name and "B. left parotid tumor" are two pieces of tissue measuring 0.3 x 0.2 x 0.2 cm and 0.2 x 0.1 x 0.1 cm. The smaller is inked blue. The specimen is frozen. The frozen section residue, which is the entire specimen, is submitted in cassette B.

C. Received fresh labeled with the patient's name and "C. rule out tumor left submandibular tissue" is a 0.4 x 0.3 x 0.2 cm aggregate of soft tissue. Two touch preps are stained and interpreted during the operating room consultation. The remaining specimen is frozen. The frozen section residue, which is the entire specimen, is submitted in cassette C.

D. Received fresh labeled with the patient's name and "D. additional tumor" is a 1.3 x 0.7 x 0.2 cm fragment of gray-yellow to dark red tissue. Touch preps are prepared, stained and interpreted during the operating room consultation. The specimen is frozen. The frozen section residue, which is the entire specimen, is submitted in cassette D.

E. Received in formalin labeled with the patient's name and "E. left parotid tumor" is a 9.0 x 5.2 x 3.2 cm pad of soft tissue which is surfaced by a 6.3 x 2.3 cm elliptical portion of light pink-brown skin. The specimen weighs 37 g. No orientation is provided. The margin is inked black. The skin surface displays a slightly eccentric deep umbilication. On sectioning, subjacent to the umbilication, the cut surfaces vary from gray-white to red-pink to golden yellow with interspersed abscesses noted. The above findings span a total distance of approximately 5.5 cm and diffusely extend to the surrounding soft tissue margins. On continued sectioning, within the opposite half of the specimen, approximately 2.0 cm from the above-described process, there is a 1.3 cm golden yellow area at the periphery. Also noted are several lymph node candidates measuring up to 0.7 cm. The remainder of the tissue has coarsely lobulated yellow to yellow-pink cut surfaces. Representative sections are submitted as follows: E1-E5 - sections taken from skin to include umbilication and above-described changing involving underlying tissues to include involvement of surgical margins; E6 - section demonstrating golden yellow are at opposite half of the specimen; E7 - four lymph node candidates submitted in toto.

F. Received fresh labeled with the patient's name and "F. dermal mass (left neck)" are two pieces of tissue averaging 0.2 x 0.2 x 0.2 cm. The specimen is frozen. The frozen section residue, which is the entire specimen, is submitted in cassette F.

MICROSCOPIC DIAGNOSIS:

A. LYMPH NODE, LEFT PAROTID, EXCISION: ONE BENIGN LYMPH NODE.

B. PAROTID TUMOR, LEFT, BIOPSY: SOFT TISSUE INVOLVED BY CHRONIC INFLAMMATION.

C. SUBMANDIBULAR TISSUE, LEFT, BIOPSY: FRAGMENTS OF SOFT AND FIBROADIPOSE TISSUE INVOLVED BY HISTIOCYTIC REACTION AND CHRONIC INFLAMMATION, **NEGATIVE FOR MALIGNANCY.**

D. PAROTID, ADDITIONAL TUMOR: FRAGMENTS OF SOFT AND FIBROADIPOSE TISSUE INVOLVED BY HISTIOCYTIC REACTION AND CHRONIC INFLAMMATION, **NEGATIVE FOR MALIGNANCY.**

E. PAROTID, LEFT, SUPERFICIAL PAROTIDECTOMY:

1. SKIN AND UNDERLYING SOFT TISSUE INVOLVED BY;
 - a. CHRONIC INFLAMMATION AND HISTIOCYTIC REACTION.
 - b. NO OVERT GRANULOMAS IDENTIFIED.
 - c. FOCAL GIANT CELL REACTION.
- d. NO EVIDENCE FOR FUNGAL ELEMENTS (GMS STAIN) OR ACID-FAST BACILLI (AFB STAIN).
 2. ASSOCIATED HISTOLOGICALLY UNREMARKABLE PAROTID GLAND.
 3. ONE BENIGN LYMPH NODE.
 4. SKELETAL MUSCLE WITH ISCHEMIC CHANGE.
5. INFLAMMATORY CHANGES EXTENDING TO MULTIPLE SURGICAL MARGINS.
6. **NEGATIVE FOR MALIGNANCY.**

F. DERMAL MASS, LEFT NECK, EXCISION: FRAGMENTS OF SOFT AND FIBROADIPOSE TISSUE INVOLVED BY HISTIOCYTIC REACTION AND CHRONIC INFLAMMATION, **NEGATIVE FOR MALIGNANCY.**

NOTE:

The patient reportedly has a history of a large parotid mass. A recent fine needle aspiration (Outpatient Pathology Associates, AV11-2630) demonstrated atypical cyst contents, where degenerated cellular material was identified and some nuclear atypia was seen.

The findings within the current parotidectomy specimen demonstrate chronic inflammatory changes and a histiocytic and focal giant cell reaction that involves the soft tissue. The changes include erosion into the superficial skin. No discrete granulomas are identified. The inflammation is predominantly centered on the subcutaneous soft tissue and appears to secondarily involve the parotid gland, at least in this material evaluated. However, we cannot entirely exclude more prominent inflammatory changes involving unsampled salivary gland.

The findings here suggest a chronic inflammatory reaction. There is no evidence of overt malignancy identified within this material.

Immunohistochemical stains are performed and confirm the histiocytic nature of the infiltrate by positivity for CD68, as well as a mixture of CD3-positive T cells and CD20-positive B cells. A stain for cytokeratin KC3 demonstrates no malignant epithelial cells. Additionally, vessels are highlighted by CD34. A special stain for acid-fast bacilli (AFB stain) and fungal elements (GMS stain) are negative.

The findings here appear to represent a chronic inflammatory process. An acute inflammatory component is not a prominent feature of the biopsies and excision. As histologic special stains performed on tissue sections are of low sensitivity, correlation with the pending microbiologic cultures is recommended.

While no malignancy is identified within this biopsy, clinical correlation is recommended. Additionally, close clinical followup is recommended. If the parotid / soft tissue mass does not resolve or continues to grow, a repeat evaluation may be worth while, as clinically indicated.

Dr. Kimberly A. Monnin has reviewed this case and concurs with the diagnosis and impression.

The tests that are reported here were developed and the performance characteristics determined by Central Histology Facility of Diagnostic Pathology Medical Group, Inc. They may not have been cleared or approved by the U.S. Food and Drug Administration (FDA). However, the FDA has

determined that such clearance or approval is not necessary. These tests are used for clinical purposes. They should not be regarded as investigational or for research. This laboratory is certified under the Clinical Laboratory Improvement Amendments of 1988 (CLIA) as qualified to perform high complexity clinical laboratory testing. The appropriate positive and negative controls were used for each immunohistochemical and/or ISH stain.

ZEK:rad; 88331 x5, 88305 x5, 88307, 88342 x5, 88312 x2; 785.6

SPECIMEN(S): A LEFT PAROTID LYMPH NODE
SPECIMEN(S): B LEFT PAROTID TUMOR
SPECIMEN(S): C R/O TUMOR, LEFT SUBMANDIBULAR TISSUE
SPECIMEN(S): D ADDITIONAL TUMOR
SPECIMEN(S): E LEFT PAROTID TUMOR
SPECIMEN(S): F DERMAL MASS LEFT NECK
CLINICAL HISTORY: PRE-OP DIAGNOSIS LEFT PAROTID TUMOR

Diagnostician: Zarir E. Karanjawala M.D.
 Pathologist
 Electronically Signed 07/05/2011

Lab and Collection

SURGICAL PATHOLOGY SF (Order # [REDACTED]) on 7/5/2011 - Lab and Collection Information

Order Providers

Authorizing Provider Benzion G Goldwyn, MD	Encounter Provider Benzion G Goldwyn, MD
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Reviewed by List

GOLDWYN MD, BENZION G on Wed Jul 6, 2011 7:46 AM

Original Encounter

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Results Encounter

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Order

SURGICAL PATHOLOGY SF [EASURGICALSF]
 (Order # [REDACTED])

Patient Demographics

Patient Name	Sex	DOB	Address	Phone
Cervantes, Miguel	Male	[REDACTED]	[REDACTED] MANTECA CA 95337	[REDACTED]

Additional Information

Associated Reports
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OPERATIVE REPORT

DATE OF PROCEDURE: 06/30/2011

PREOPERATIVE DIAGNOSIS: Left parotid mass.

POSTOPERATIVE DIAGNOSIS: Left parotid mass.

OPERATION: (1) Left superficial parotidectomy. (2) Excision of skin lesion. (3) Adjacent tissue transfer closure (4 x 3 cm defect). (4) NIM facial nerve monitoring x2 hours.

SURGEON: Benzion G. Goldwyn, M.D.

CO-SURGEON:

ASSISTANT SURGEON: Roseanne E. Pevec, M.D., F.A.C.S.

ANESTHESIA: General by endotracheal tube.

ESTIMATED BLOOD LOSS: 100 mL.

COMPLICATIONS: None.

DRAINS: 1/4-inch Penrose.

OPERATIVE INDICATIONS: This is a 67-year-old gentleman with an enlarging parotid mass, also became acutely infected with significant purulence. This did erode the skin. Multiple biopsies have been taken, some indicating but not entirely consistent with malignancy, now presents for the above procedures. Risks and benefits have been discussed with the patient through an interpreter in detail, including but not limited to anesthesia, infection, bleeding, temporary or permanent damage to the facial nerve, Frey syndrome, ear numbness, possibility of malignancy, need for further surgeries. He does understand, wishes to proceed. All questions were answered.

OPERATIVE TECHNIQUE: Patient taken to the operating room, placed in the supine position on the operating room table. After satisfactory anesthesia was obtained the patient was registered to the facial nerve monitor, a shoulder roll was placed to facilitate neck extension, patient then prepped and draped in the usual sterile fashion. He did have an area of skin erosion in the neck, and this is circled off for an approximately 4 x 3 cm defect, incorporated into the incision line. A modified Blair incision was then marked out and infiltrated with 1% lidocaine with epinephrine 1:100,000. Incision was then created with

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Page 1 of 3

PATIENT NAME: CERVANTES, MIGUEL
MR#: [REDACTED] ACCT#: [REDACTED]
BENZION G. GOLDWYN, M.D.

I RM: MACU
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OPERATIVE REPORT

15-blade, taking the skin flap up in the immediate subcutaneous plane, leaving the skin on with the main specimen. The parotid gland was then mobilized posteriorly with dissection with the electrocautery. Skin flaps were then sutured out of the operative field and the tragal pointer was identified and skeletonized. This allowed access to the tympanomastoid suture and the facial nerve was then found. The pes was then immediately found as well and the tumor was well away from the upper branches and these were not dissected. The lower branches were then dissected out using a McCabe dissector with bipolar electrocautery and a 12-blade. This was also accomplished with a Harmonic device. The nerve was then skeletonized and identified until it was free. The tumor mass was identified. As we do not have an adequate diagnosis, a large frozen section was then taken. Unfortunately this came back with some atypia, inflammation and giant cells without any discrete malignancy noted. Multiple other biopsies were taken, again with similar findings. As such, it was determined not to do a total parotidectomy or a neck dissection as this may be atypical mycobacteria, which is what the pathologist was leaning towards. The remainder of the parotid gland was then taken up off the sternocleidomastoid muscle. There was some inflammation and adherence to the muscle, muscle fibers were then taken with the specimen with the electrocautery. The specimen was also adherent to the anterior facial vein and this was then divided and ligated with 2-0 silk tie and 3-0 silk suture ligature. This vein was quite large. The remainder of the dissection was taken off the underlying fibrotic tissue with some difficulty because of the significant inflammation. This was accomplished with sharp and blunt dissection. Once the entire specimen was removed, the wound was then irrigated and hemostasis was achieved with the bipolar electrocautery. The flaps were then further undermined. Because of the significant skin defect, primary closure could not be accomplished. This was then closed in a V-to-Y fashion based inferiorly. This was accomplished with a 3-0 Vicryl. A large Burow's triangle was then taken out of the inferior limb and then remainder of the incision closed with interrupted 3-0 Vicryl, running interlocking 4-0 Prolene. A 1/4-inch Penrose drain was placed prior to closure and brought out through a separate stab incision. This was secured with 3-0 silk. The wounds were then cleaned. Bacitracin was applied as well as a pressure dressing. The patient tolerated the

SUTTER MEMORIAL HOSPITAL
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Page 2 of 3

PATIENT NAME: CERVANTES, MIGUEL
MR#: [REDACTED]
BENZION G. GOLDWYN, M.D.

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OPERATIVE REPORT

procedure well. He was discharged to PAR in satisfactory condition. Sponge and instrument counts were correct.

Physician: Benzion G. Goldwyn, M.D.

BGG/MEDQ/ [REDACTED] D:06/30/2011 12:10:10 T:06/30/2011 14:58:14

CC: Roseanne E. Pevec, M.D., F.A.C.S.
Fax: 916-262-9460

Dr. Gautami Agastya
Tracy, CA

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Page 3 of 3

PATIENT NAME: CERVANTES, MIGUEL
MR#: [REDACTED]
BENZION G. GOLDWYN, M.D.

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