Cytology report for cancer

I'm not robot!

DEPT OF RADIODIAGNOSIS AND IMAGING
BASE HOSPITAL DELHI CANTT
Mammography Report

Regn No: 247 /2011 *Date: 18/11 /2011*
Patient's Name:M/o Sep Praveen Kumar *Age: 51 yrs*
Clinical Diagnosis: Lump left breast
Referring Clinician:Lt Col Savita *WARD/OPD: S OPD*

Bilateral Mammogram

PROTOCOL:
Bilateral cranio-caudal and medio-lateral oblique.

FINDINGS:
1. Both breasts are composed of mixed fibroglandular & fatty tissue. (ACR 1).
2. Skin, nipples, areola and subareolar area normal.
3. A well defined round to oval smoothly marginated mass lesion measuring 3.36 x3.54 cms is seen in supero medial quadrant of left breast is seen.
4. Multiple discrete amorphous Microcalcifications spread over inferomedial quadrant of right breast are seen.
5. Normal breast architecture preserved.
6. Visualised portions of axillae are normal.

On Corroborative USG:
1. Bilateral breast parenchyma is normal.
2. A well circumscribed round to oval hetero echoic lesion with distal acoustic enhancement is seen in supero medial quadrant of left breast.
3. No duct ectasia.
4. Bilateral axillae are clear.

IMPRESSION: Cystic SOL- left breast
Pleomorphic segmental Microcalcifications-right breast
BIRADS-IV.
Suggest FNAC correlation

(Sqn Ldr D Diwakar)
Resident Radiodiagnosis

(RS Negi)
Lt Col
Cl Spl Radiodiagnosis

ROENTGENOLOGICALLY OCCULT LUNG CANCER DIAGNOSED BY CYTOLOGY

Report of 12 Cases

MYRON R. MELAMED, M.D., LEOPOLD G. KOSS, M.D., AND EUGENE E. CLIFFTON, M.D.

CYTOLOGICAL STUDY OF SPUTUM OR BRONchial aspirate provides an accurate and effective means of diagnosing carcinoma of the lung. This technique finds widest application in the investigation of patients clinically suspected of having lung cancer, usually with radiological abnormalities. It is not generally appreciated that cytological examination will sometimes identify lung carcinoma in the absence of any detectable roentgenographic change and occasionally when unsuspected clinically. A few such cases have been reported,[2-5] but they are still a novelty. The increasing availability and use of skilled cytological diagnosis will continue to uncover many more. Because of the practical importance of exploiting this method of diagnosis and the problems arising in localizing and treating carcinomas diagnosed cytologically but not evident roentgenographically, it was felt that a report of our experience with 12 cases would be of interest.

REVIEW OF CASES

Pertinent clinical and pathological data of 12 patients with roentgenographically occult cancer diagnosed cytologically at Memorial Hospital for Cancer and Allied Diseases or James Ewing Hospital, New York, N.Y., are summarized in Tables 1 and 2. The illustrations of roentgenograms, cytological material, and pathological specimens are identified according to the case numbers used in the tables and text. Cases 3, 4, and 5 were briefly noted in a previous publication by one of us[2] and the reader is referred to it for additional illustrations.

All patients had lung carcinoma diagnosed cytologically at a time when routine posteroanterior and lateral chest roentgenograms were essentially normal. The initial radiological diagnoses were confirmed on review by Dr. Robert Sherman, Chief of the Department of Diagnostic Radiology of Memorial Hospital.

All patients were men. Their ages ranged from 39 to 67 years. Their occupations were quite varied but were unassociated with any exposure to known carcinogens. Only 1 man (case 4) was a nonsmoker; 2 others (cases 6 and 11) had stopped smoking 4 years previously and 6 months previously, respectively.

The 12 patients can be conveniently considered in 3 groups. The first (cases 1 to 4) is made up of patients with lesions that were localized and treated quickly. They all had anatomically very early carcinoma, mostly in situ with only focal invasion and still confined to the bronchial wall. The second group of patients (cases 5 to 8) had long delay in localization and treatment of the cancers after cytological diagnosis. They had advanced disease when finally treated. The third group (cases 9 to 12) also had advanced cancer even though localization following cytological diagnosis was fairly prompt.

Following are illustrative case reports from each of these groups.

GROUP 1

Case 1. J.P. This 50-year-old man was found to have epidermoid carcinoma in sputum ex-

From the Cytology Service, Department of Pathology, and Thoracic Service, Memorial Hospital for Cancer and Allied Diseases and the James Ewing Hospital of the City of New York, 444 E. 68th St., New York 21, N.Y.

The authors particularly wish to thank Dr. Robert Sherman, Chief of the Department of Diagnostic Radiology of Memorial Hospital, for reviewing the roentgenograms of the patients in this report. They also wish to thank Dr. Patrick Fitzgerald, Professor of Pathology at the Downstate Medical Center, Brooklyn, N.Y., for allowing us to review the bronchoscopic biopsy in case 7; Dr. C. G. Burn, Pathologist at Samaritan Hospital, Troy, N.Y., for providing us with the autopsy findings in case 10 and allowing us to review the histological sections; and Dr. R. L. Yeager, Medical Director of Summit Park Sanatorium, Pomona, N.Y., for supplying us with follow-up clinical data and roentgenograms of case 12.

Cytological examinations in cases 6 and 12 were performed and reported by the late Dr. G. Papanicolaou. The initial routine examination in case 1 was carried out at the Strang Clinic, Memorial Center for Cancer and Allied Diseases, New York, N.Y., in co-operation with Dr. E. Day and Dr. W. Cahan.

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Cervical and vaginal cytology: Interpretation of results (Pap test report)

Authors: Christopher P Crum, MD; Warner K Huh, MD
Section Editor: Barbara Goff, MD
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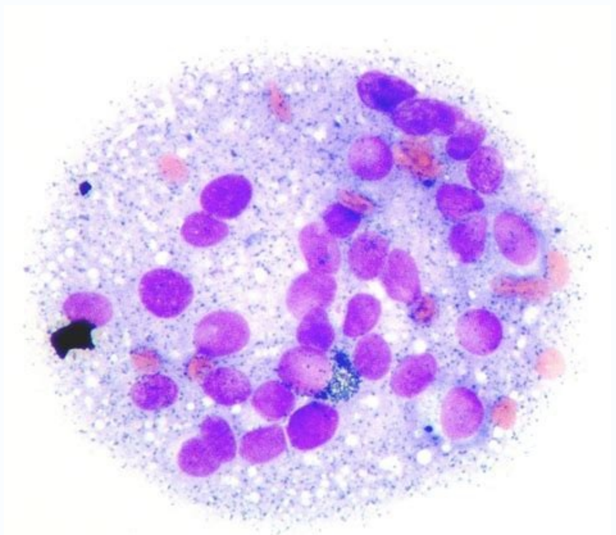
INTRODUCTION — Cervical cytology became the standard screening test for cervical cancer and premalignant cervical lesions with the introduction of the Papanicolaou (Pap) smear in 1941 [1]. Liquid-based, thin layer preparation of cervical cytology specimens was a subsequent modification in technique. Terminology for reporting cervical cytology was standardized by the Bethesda System in 1988 [2]. This system has been revised several times, and the current system was developed in 2014 (table 1) [3-6]. Human papillomavirus (HPV) testing has now been incorporated into cervical cancer screening. (See "Screening for cervical cancer" and "Cervical cancer screening tests: Techniques for cervical cytology and human papillomavirus testing".)

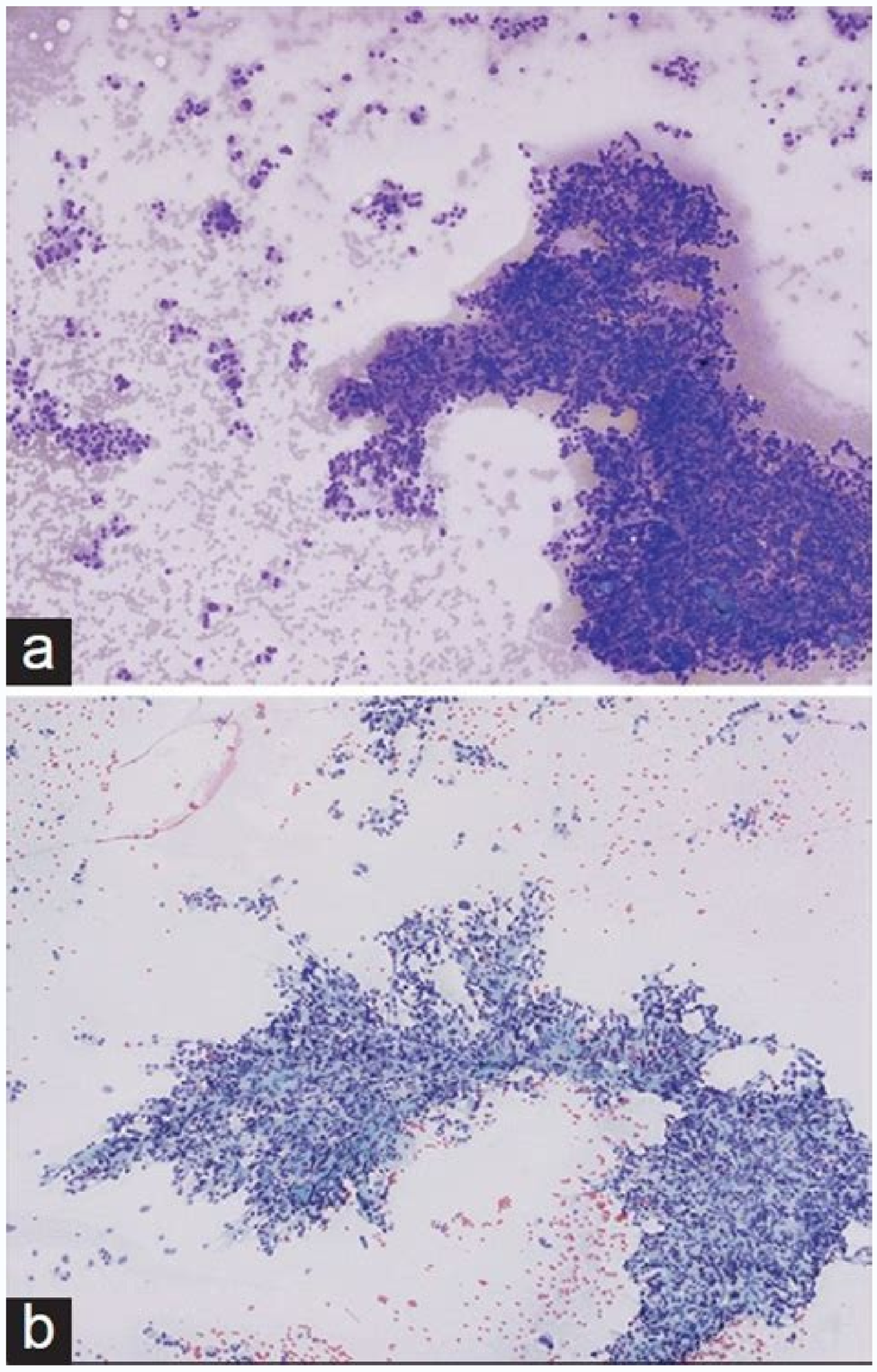
The cervical cytology report is presented in a standard format. Interpretation of cervical cytology results will be reviewed here. Cervical cancer screening strategies and techniques, as well as the follow-up of abnormal cytology results and treatment of cervical intraepithelial neoplasia (CIN), are reviewed separately:

- (See "Screening for cervical cancer".)
- (See "Cervical cancer screening tests: Techniques for cervical cytology and human papillomavirus testing".)
- (See "Cervical cytology: Evaluation of atypical squamous cells (ASC-US and ASC-H)".)
- (See "Cervical cytology: Evaluation of low-grade squamous intraepithelial lesions (LSIL)".)
- (See "Cervical cytology: Evaluation of high-grade squamous intraepithelial lesions (HSIL)".)
- (See "Cervical cytology: Evaluation of atypical and malignant glandular cells".)
- (See "Cervical intraepithelial neoplasia: Management of low-grade and high-grade lesions".)

ROLE OF CERVICAL CYTOLOGY — Cervical cytology can be used in combination with testing for high-risk human papillomavirus (HPV) for cervical cancer screening. The results of cervical cytology cannot be used to make a definitive diagnosis or initiate treatment, with the exception of high-grade squamous intraepithelial lesion (HSIL). Rather, the test functions solely to screen for cellular abnormalities that are associated with an increased risk for the development of cervical cancer. The results are used to guide further evaluation, such as colposcopy and/or cervical biopsy. Treatment decisions are then made based upon diagnostic results from histologic examination, usually from colposcopically directed biopsies. (See "Cervical intraepithelial neoplasia: Management of low-grade and high-grade lesions".)

TERMINOLOGY FOR SQUAMOUS CELL ABNORMALITIES — There have been frequent modifications in the nomenclature used for classifying cytologic and histologic cervical changes associated with human papillomavirus (HPV) infection and precancerous lesions. The major shifts in terminology apply to squamous cell abnormalities. The current classification system in the United States for cervical cytology was introduced with the Bethesda 1988 System [3]. This system has been updated several times, as Bethesda 1991, Bethesda 2001, and Bethesda 2014 [4-





Can cytology detect cancer. Is a cytology report a pathology report. Cytology of cancer cells. Does biopsy confirm cancer.

Diagnosing diseases by looking at single cells and small clusters of cells is called cytology or cytopathology. It’s an important part of diagnosing some types of cancer. Compared with tissue biopsy, a cytology specimen usually: Is easier to get Causes less discomfort to the patient Is less likely to result in serious complications Costs less The disadvantage is that, in some cases, a tissue biopsy result is more accurate, but in many cases the cytology fluid may be just as accurate. Cytology tests may be used for diagnosis or for screening: A diagnostic test is only used for people who have signs, symptoms, or some other reason to suspect that they might have a particular disease (like cancer). A diagnostic test finds out if a disease is present and, if so, it precisely and accurately classifies the disease. A screening test is used to find people who might have a certain disease even before they develop symptoms. A screening test is expected to find nearly all people who are likely to have the disease, but a screening test doesn’t always prove that the disease is present. Often, a diagnostic test is used if a screening test result is positive (that is, if something is found on the screening test). Some cytology tests, such as the Pap test, are mainly used for screening, while others can accurately identify cancers (see “Scrape or brush cytology” below). When cytology results show cancer, often a biopsy is also done to be sure before treatment is started. Fine needle aspiration Fine needle aspiration (FNA) is sometimes considered a cytology test and is sometimes considered a biopsy. It’s discussed in Types of biopsies used to look for cancer. Cytology tests on body fluids Fluids taken from cavities (spaces) in the body can be tested to see if cancer cells are present. Some of the body cavity fluids tested in this way include: Urine Sputum (phlegm) Spinal fluid, also known as cerebrospinal fluid or CSF (from the space surrounding the brain and spinal cord) Pleural fluid (from the space around the lungs) Pericardial fluid (from the sac that surrounds the heart) Ascitic fluid, also called ascites or peritoneal fluid (from the space in the belly) Scrape or brush cytology Another cytology technique is to gently scrape or brush some cells from the organ or tissue being tested. The best-known cytology test that samples cells this way is the Pap test. A small spatula and/or brush is used to remove cells from the cervix (the lower part of the uterus or womb) for a Pap test. Other areas that can be brushed or scraped include the esophagus (swallowing tube), stomach, bronchi (breathing tubes that lead to the lungs), and mouth. A cytology report recorded as suspicious is not considered as diagnostic of cancer and unless supported by a positive biopsy (as reported on a pathology report) or by a clinical impression of cancer, these cases should not be abstracted. The Papanicolaou classification of cells for the detection of malignancy ("Pap" smear) used in the past is as follows: Class Interpretation No evidence of a malignant neoplasm, no atypical cells Atypical cells present but no evidence of malignant neoplasm Cells present causing suspicion of malignant neoplasm Fairly conclusive evidence of malignant neoplasm Conclusive evidence of malignant neoplasm Some medical records will contain more than one cytology report. If there are multiple reports on the same type and source of specimen, record the findings on the first positive report. If they are based on different types and sources of specimens, summarize all pertinent findings. According to the National Cancer Institute Workshop on Terminology for Cervical and Vaginal Cytology, December 12-13, 1988, "While the Papanicolaou Classes have a significant historical association with the early development of cytology, it can no longer be relied upon to communicate clinically relevant information. In particular, the Papanicolaou Classes do not reflect current understanding of cervical neoplasia, do not provide for the diagnosis of non-cancerous entities, and as a result of numerous idiosyncratic modifications over the years, no longer reflect uniform diagnostic interpretations. Accordingly, it is our conclusion that the Papanicolaou Class System is not acceptable in the practice of diagnostic cytology". Their organization of the new terminology and classifications is a follows: a STATEMENT ON ADEQUACY OF THE SPECIMEN, a GENERAL CATEGORIZATION of the diagnosis (within normal limits or other), and the DESCRIPTIVE DIAGNOSIS For Squamous Cell the following terminology is used: III.A.1 Atypical squamous cells of undetermined significance (specify recommended follow-up and /or further investigative procedures) III.A.2 Squamous intraepithelial lesions (Comment on presence or absence of cellular changes consistent with Human papillomavirus (HPV) infection III.A.2a Low grade squamous intraepithelial lesion encompassing: Cellular changes consistent with HPV infection Mild dysplasia/CIN 1 III.A.2b High grade squamous intraepithelial lesion encompassing: Moderate dysplasia/CIN 2 Severe dysplasia/CIN 3 Carcinoma in situ/CIN 3 III.A.3 Squamous carcinoma At first you may find it somewhat disconcerting to discover that more than one type of form may be used to report similar findings. However, as you study Examples G12-G15, you will find that they contain similar information. For example: The source of the specimen is recorded by checking one of the blocks on the left of the report. This report is of special interest to the new tumor registrar because it lists the major sources of material used as specimens for a cytologic examination. At the top left of the report, the clinical diagnosis may be summarized. This need not be recorded on the abstract. In many cases the laboratory study was ordered on the basis of a previously suspicious Pap smear. The findings of the examination will be recorded by checking one of the blocks

listed in the section describing the tissue status on the lower right. « Previous (Cytology and Its Procedures)Next (Practical Examples) » Aside from tissue biopsy, cytology serves as an indispensable tool in screening and diagnosing cancer. In this technique, a cytological material is obtained from the patient, spread onto glass slides for microscopic examination, stained, screened for abnormalities and assessed prior to the issuance of a final report. Cytology differs from histology in that the sample usually consists of a suspension of cells whereas histology samples are usually sections of actual tissue. For example; a Gill's hematoxylin single strength formulation would be much better suited for cytology, whereas a triple strength formulation would be better for tissue sections. Cytology examinations can be performed using the following specimen: Body fluids including urine, sputum or phlegm, cerebrospinal fluid (CSF), pleural fluid, pericardial fluid and ascetic or peritoneal fluid Cells that are scraped or brushed from the tissue or organ being tested (e.g., cells from the cervix, esophagus, stomach, bronchi and mouth) Palpable and non-palpable lesions Cytological samples from palpable and non-palpable lesions from the area of interest can be obtained through a technique known as fine needle aspiration or FNA. Basically, this technique uses a fine needle (usually a 21-25 French gauge needle) to aspirate cellular material from the lesion and use it as a basis for making a diagnosis. Processing Cytology Materials In preparing cytology specimen, the material is smeared on glass slides and dipped in a series of stains (Diff Quick, Romanowsky, Papanicolaou, Hematoxylin and Eosin stain) before being examined under the microscope. However, since body fluids are too diluted, they are concentrated first before staining. Samples are then analyzed by a pathologist. As required by federal law, clinical slides are kept in the lab for at least five years. This means that should a patient require a second opinion from a different doctor, the same sample can still be used (provided there is enough material available). Cytological materials can be subjected to a number of ancillary studies including simple special stains, immunohistochemistry, flow cytometry, cytogenetic analysis, electron microscopy and molecular pathology studies. Importance of Cytology Cytological examinations have numerous applications. They can be used for: Cytological tests such as Pap smears serve as an effective screening tool since they can be used to detect abnormalities and other changes in the cervix which may develop into cervical cancer. Routine follow-up procedure. This technique is also used as routine follow-up procedure after an initial diagnosis. For example, patients who were previously diagnosed with pulmonary carcinoma may be required to provide sputum, bronchial brushings, discharge samples and body cavity fluids (e.g., pleural, peritoneal and CSF) during the follow-up period. Diagnostic test. Cytological examinations can help clinicians and pathologists reach a definitive diagnosis that can help them provide an effective treatment plan for the patient. Cytology vs. Biopsy: Weighing the Differences While cytology and biopsy can both be used to effectively and safely diagnose cancer, there is a world of difference between these two. Here are some of their major differences: Specimen used. Biopsy uses body tissues while cytological tests use cellular materials. The collection of cytological specimen is less invasive and does not even leave a scar. In addition, the procedure does not cause any significant discomfort to the patient and has extremely low risk of resulting in serious complications. Specimen collection for cytology tests costs less since the procedure is extremely simple. It usually does not require the use of general anesthesia or any elaborate equipment. Due to the invasiveness associated with biopsies, they are often not performed unless there is sufficient suspicion or risk of a certain condition. While cytological procedures can sometimes be less accurate, they are much more suited for screening in a preventative manner. There may be times when biopsy results are more accurate. This usually happens when cytology collection does not provide representative specimens or does not provide an easily recognizable abnormality for testing. Cytology often relies on certain cells being dislodged from a tissue and then collected. Thus, it makes perfect sense for a biopsy of that specific tissue to be much more accurate and informative than using the fluid that surrounds it. Cytology also fails to provide any structural information about how the cells are arranged within a tissue - something that is often useful when looking at early stages of tumorigenesis. However, diseases such as cancer are known for having a prognosis that is directly related to the stage when it was diagnosed. Many cancer forms known for having poor prognosis, such as colon or prostate are also associated with late detection. While taking biopsies without a certain degree of suspicion of a condition is not advisable, this is where cytology shines. Procedures such as pap-smears are routinely used as to screen patients in a preventative manner. Until now, many of these routine checkup procedures where based on visual input as is the case for colonoscopies. However, advances in immunology and other diagnostic procedures are leading to less invasive procedures that have the potential to detect aberrances before the human eye can. Making screening procedures less invasive is a very important goal since it could lead to more frequent checkups and thus earlier diagnosis. Related Blogs Key Differences of H&E and Special Stains for Immunohistochemistry

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