MEDGENOME
CAP ACCREDITED
258/A, 3rd Floor, Narayana Nethralaya Building, Narayana Health City,
Hosur Road, Bommasandra, Bangalore, Karnataka, India – 560 099
(Toll Free) 1800 103 3691 techsupport@medgenome.com
www.medgenome.com customersupport@medgenome.com

Sample Receipt Details:

POD :_____ Temp :_____

Date & Time :_____ Sample Type :_____

CS Name & Sign: _____ Logistics Name & Sign : _____

Prenatal Sample ☐Yes ☐No Bill type MOU Retail Research

TEST REQUISITION FORM

Disease Segment* _____

Each sample must be accompanied by this completed requisition. * Fields are mandatory

Test Details

ESR1 gene testing by NGS -Liquid Biopsy (Hot Spot Mutations)
Tumour HRR (Homologous Recombination Repair) pathway genes analysis by NGS

Test Name:* Test Code:* MGM2732 , MGM1623

Sample type:

- ☐ Blood (in EDTA tube)
- ✱ Blood (in streck tube)
- ☐ DNA, Specify Source:_____
- ☐ Buccal swab
- ☐ Amniotic Fluid
- ☐ CVS
- ☐ Cultured CV
- ☐ Cultured amniocytes
- ☐ Fetal Blood (PUBS)
- ☐ Maternal blood for MCC (please send for prenatal studies)
- ☐ Products of Conception (POC), specify tissue:_____
- ✱ FFPE tissue Block (Block no. .....)
- ☐ DBS/FTA
- ☐ Fresh Frozen Tissue
- ☐ Saliva
- ☐ Other sample type (specify site) _____

XL17538F
XL17538G
XL17538H
XL17538J

Whole Blood in Streck Tubes 2x 10ml

Patient had a blood transfusion ☐Yes ■No Date of last transfusion___/___/___(minimum 3 days of wait time is required for genetic testing)

Has he/she undergone allogenic bone marrow transplant: ☐Yes ☐No.

Patient Details

Name:* Mrs. T. Tharushi C D Peris (In Capital Letters) D.O.B. DD MM YY Age:* 42Y/F Gender:* M / F

Address: .....

Phone:..... E-mail I.D: .....

Clinician Details

Clinician's Name:* Dr. Mahendra Perera Hospital Affiliation: Aegle Omics Pvt Ltd

Address: ..... Phone : .....

..... Email id : .....

Date of sample collection* 14/12/2025 YY Blood Sample 15/1/2025

I understand that the current analysis is limited to variants which co-relate with disease phenotype/symptoms/terms as mentioned in the clinical details provided by me. Incidental findings which may or may not be actionable are not routinely reported. They can however be provided on request after informed consent from the patient/guardian. As disease phenotype may evolve over time, the appearance of new symptoms/signs may alter test results or their significance: MedGenome laboratories cannot be held responsible for this. A re-analysis or a re-test may be required due to the former; this will be performed (if deemed necessary) at an additional cost. I am authorised to order the above tests as I am the treating physician/consulting physician in this case. I confirm that the patient/guardian (in case of minors) has been provided complete information regarding the test, including its limitations in a language of their understanding.

Dr. MAHENDRA PERERA
MBBS (Cey), MD (Col), Dip RT
Consultant in Clinical Oncology
& Radiotherapy

Medical Professional Signature* Date: Place:

Clinical notes/diagnosis:

Disease affection status Yes NO Parental consanguinity present Yes NO Age of manifestation:_____

Affected Siblings Yes NO Details:_____

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COLLEGE of AMERICAN PATHOLOGISTS

GOVERNING LAW, JURISDICTION AND DISPUTE RESOLUTION

These Terms and Conditions and this Test Requisition Form shall be governed by and construed in accordance with Indian law and the courts in Bangalore shall have exclusive injunctive jurisdiction. In the event of any dispute, controversy or claim whatsoever arising from these Terms and Conditions and/or this Test Requisition Form, the parties shall undertake to make every effort to reach an amicable settlement within fifteen (15) days upon reference of the dispute by any party through discussions among the concerned representatives of parties, failing which the dispute, controversy or claim shall be settled by Arbitration by a Sole Arbitrator appointed by the 'President-Arbitration Centre-Karnataka', Bangalore as per Indian Arbitration and Conciliation Act, 1996 as amended from time to time. The venue of arbitration shall be Bangalore and it shall be conducted in English language. The award passed by the Sole Arbitrator shall be final and binding upon the parties.

NOTICE

All notices, statements or other communication required or permitted to be given or made shall be in writing and in English language. Such notices will deliver by hand or sent by prepaid post with recorded delivery, or facsimile transmission addressed to the intended recipient at the address mentioned in this Test Requisition Form.

INDEPENDENT PARTIES

All parties effected hereunder are independent entities and neither of the parties are an agent, employee or joint venture of the other and they shall not represent themselves as such to any third parties.

REFUND

Refund of fees for any reason has to be claimed by the Patient or the guardians of the Patients within 90 days from the date of delivery of report.

Patient/Guardian Authorization

By my signature below I attest to the following:

I have read and I understand the information provided on this form.

Patient Consent (sign here or on the consent document)

☐ I have read the Informed Consent document and I give permission to MedGenome to perform genetic testing as described. I also give permission for my specimen / genetic data to be used in (de-identified) studies at MedGenome to improve genetic testing for other patients.

By agreeing to this informed consent below, I am confirming that I understand the benefits, risks and limitations associated with genetic testing. Furthermore, I am affirming that I recognize the seriousness of conditions for which {I am/my child} being tested, and that disease descriptions, prognoses, and treatment options have been made available to me by {my/my child's} health care provider. Finally, if I have the legal authorization to provide this informed consent on behalf of another person, I am attesting that the sample provided belongs to that person.

Patient/Guardian Name Mrs. T. Tharushi C D Peris

First Name | Middle Name | Last Name | Date of Birth: mm/dd/yyyy

Patient/Guardian Signature* | Date: | Place:

Father Name | Mother Name

Signature* | Date and time | Signature* | Date and time

Relationship with the proband

Note :

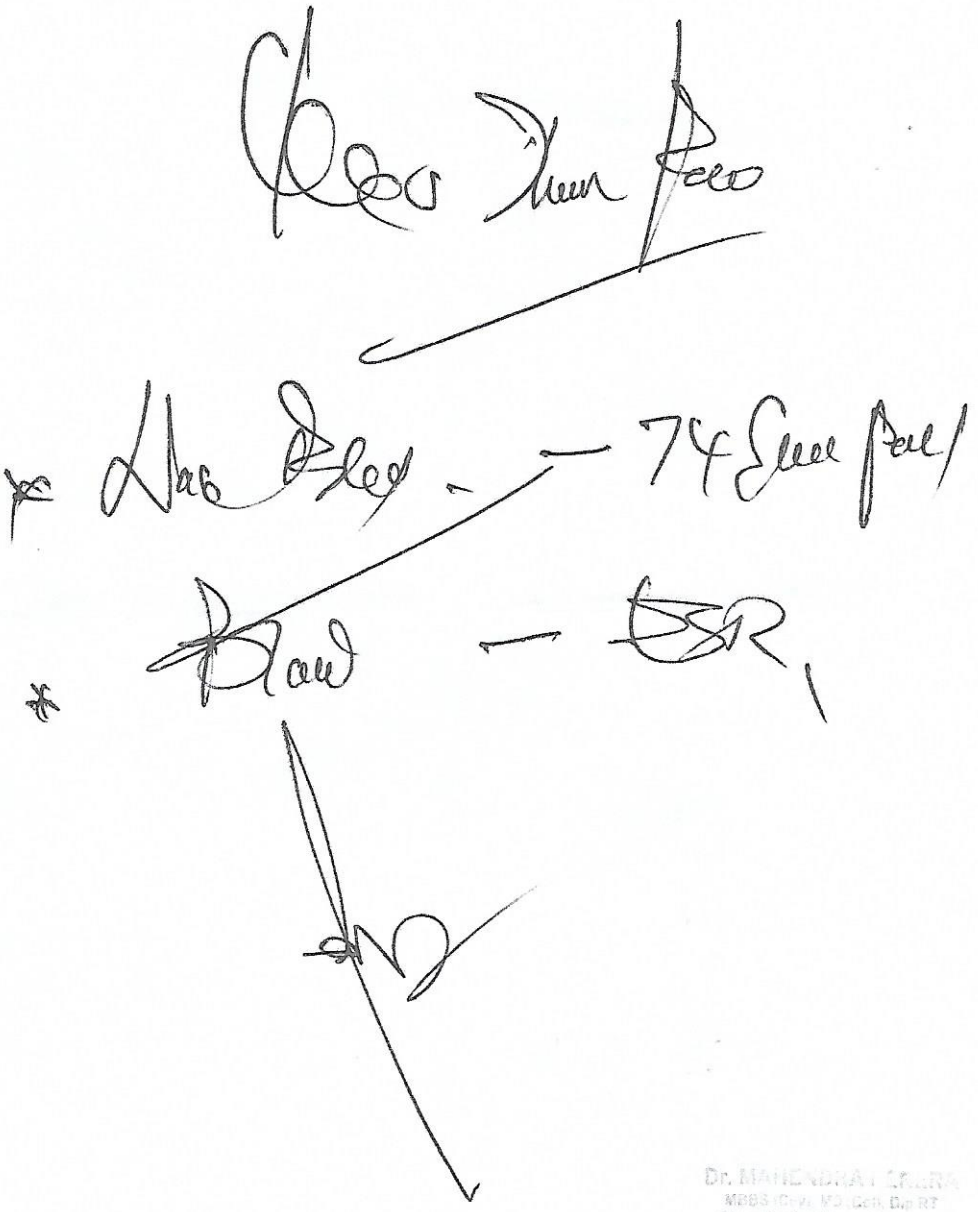
Signature of both parents is requested for prenatal testing.

For trio testing, each parent should provide separate informed consent for the sequencing of his or her sample.

MeGenome may reserve the right to send you communications on genetics / genomics periodically. The team may also connect with you to seek consent for your active participation in certain programs & communications.

*Fields are mandatory

02 JAN 2025



Dr. MAHENDRA [illegible]
MBBS (Ceyl), M.D. (Col), Dip RT
Consultant Clinical Oncology
& Radiotherapy
Principal Investigator - Clinical Trials

CLIENT CODE : C000000208

CLIENT'S NAME AND ADDRESS :
LANKA HOSPITALS - IPD
COLOMBO - 05
SRI LANKA
IPD

LANKA HOSPITALS DIAGNOSTICS PVT LTD.
LHD REFERENCE LAB - COLOMBO
7TH FLOOR, LANKA HOSPITAL, NO. 578, ELVITIGALA MAWATHA,
NARAHENPITA, COLOMBO 5
Tel : +94 11 5430000 , Fax : +94 11 5439032
Email : info@lhd.lk Web : www.lhd.lk

PATIENT NAME : Mrs. T THARUSHI D C PEIRIS
ACCESSION NO : 6001XL017538
AGE : 42 Years SEX : Female
DATE OF BIRTH :
REFERRING DOCTOR : Dr Lanka Hospital Doctor
CLINICAL INFORMATION :
OP2400003836/IPC1.0299414 IPD-OPERATION THEATRE 8043

PATIENT ID : LHC1.0001098517
COLLECTED : 14/12/2024 09:41
RECEIVED : 14/12/2024 09:41
REPORTED : 26/12/2024 15:04

Test Report Status Final Results

HISTOPATHOLOGY

LARGE SPECIMEN OTHERS

LARGE SPECIMEN OTHERS

SPECIMEN: Right axillary lymphnodes

CLINICAL DETAILS:
MRI- Enlarged right axillary nodes. R/breast 7o'clock BIRADS IV
USS- No suspicious lesion on R/breast
CECT-? R/parotid adenocarcinoma
IHC-ER Positive, PR Positive, Her 2 Negative

MACROSCOPY:
Multiple pieces of fibrofatty tissue together measuring 100x90x40mm.
Twenty three lymphnodes are dissected measuring 7-30mm in diameter.
The largest node is 30x20x15mm.

MICROSCOPY:
Sections show 23 lymphnodal tissue and some breast tissue.
Eight out of twenty three nodes show metastatic tumour deposits.
The tumour is composed of cords and tubules of cells with pleomorphic nuclei having prominent nucleoli. There is eosinophilic cytoplasm.
Increased mitotic activity is seen. There is lymphovascular invasion.
Extra nodal tumour is not seen. Some nodes show reactive lymphoid follicular hyperplasia. Small amount of breast tissue present in the specimen are histologically unremarkable.

CONCLUSION:
Right axillary lymphnodes:
Lymphnodal deposits of a carcinoma is present.
Appearances favour nodal metastasis of invasive carcinoma of breast.
Eight out of twenty three nodes show metastatic tumour deposits (8/23).
Lymphovascular invasion is present.

COMMENT:
Performance of Immunohistochemical stains ER/PR (Previousely performed) confirms breast origin.

Note -
Specimen -10% neutral buffered formal saline fixed and paraffin embedded

Dr. L. N. Wijethunga informed to issue
F, G, H, J wax blocks.

CLIENT CODE : C000000208

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COLOMBO - 05
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Email : info@lhd.lk **Web :** www.lhd.lk

PATIENT NAME : Mrs. T THARUSHI D C PEIRIS
ACCESSION NO : **6001XL017538**
AGE : 42 Years SEX : Female
DATE OF BIRTH :
REFERRING DOCTOR : Dr Lanka Hospital Doctor
CLINICAL INFORMATION :
OP2400003836/IPC1.0299414 IPD-OPERATION THEATRE 8043

PATIENT ID : **LHC1.0001098517**
COLLECTED : 14/12/2024 09:41
RECEIVED : 14/12/2024 09:41
REPORTED : 26/12/2024 15:04

Test Report Status **Final**	Results

End Of Report

Dr. L. N. Wijetunge
MBBS, Dip.Path, MD
(Histopathology)
Consultant Histopathologist

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Melsta Hospitals
A Member of Melstacorp PLC
No. 43, Mahabage Road, Ragama, Sri Lanka.
Tel: +94 11 5 714 714. www.melstahospitals.com
Business Registration No. PV 77421

NAME:- Mrs. T Priya AGE:- 42 y

DEPARTMENT OF MEDICAL IMAGING

Melsta Hospitals

Adi No:- 732460 DATE: 24/11/2024

REFFER BY:-Dr. Ajith Arthanayake (Consultant Surgeon)

Pre contrast axial scan followed by intravenous contrast axial scan of the neck and chest were performed

CT SCAN NECK CHEST AND ABDOMEN

Findings: There is 1.2 x 1.9 cm lesion identified in the superficial lobe of left parotid salivary gland. It show low density in non contrast images and show enhancement with intravenous contrast.

Multiple enhancing lymphnodes identified in the right axilla, largest one measuring 2.7 x 1.3 cm. No left axillary lymphadenopathy.

Left parotid and submandibular glands on both sides are normal in size and shows normal density , no focal lesions within them.

There are no cervical lymphadenopathy . No mass lesions are identified in the pharynx ,larynx or both sides of the neck.
Epiglottis and both vallecula are normal. Hyoid bone appear normal.
Both vocal cords are normal. Piriformis fossae and aryepiglottic fold on both side are normal. No evidence of erosions or destruction in the thyroid cartilage.
Thyroid gland appear normal

Both lungs are normally aerated except small bullae in the left upper lobe . There are no focal parenchymal nodules , areas of consolidations or atelectasis .No pneumothorax or pleural effusion is present .
The hilar regions on each sides and main bronchi appear normal. No hilar masses or enlarged lymphnodes .
The mediastinum is centered and of normal width. There is no evidence of mediastinal masses or lymphadenopathy seen.
Cardiac chambers and the major intra thoracic vessels appear normal.
The thoracic skeleton and thoracic soft tissues show no abnormalities.

2.1 x 2.6 cm well defined lesion identified in the right supra renal gland. No contrast enhancement identified.

Liver is normal in size , smooth outline and shows uniform parenchymal enhancement .There are no focal lesions .Intrahepatic and extrahepatic ducts are not dilated . Portal vein , hepatic veins and their branches appear normal.

Gall bladder is well distended and wall thickness appear normal . No gall stones
Pancreas is normal in size ,shape and attenuation pattern .Spleen is normal in size and there are no focal lesions .
Both kidneys are normal. Urinary bladder is shows smooth contour and no intravesical masses
Urinary bladder shows smooth contour and normal mural thickness . No intravesical mass lesions or calculi are present .
There are no evidence of para aortic , mesenteric or iliac lymphedenopathy .

No free fluid . Opacified bowel appear normal.

IMPRESSION: Right parotid tumour and right axillary lymphadenopathy ? right parotid adenocarcinoma with right axillary lymph node metastasis.

Incidental finding of right adrenal adenoma.

DATE: 26/11/2024

Dr M B S N Mandawala
MBBS,MD(Radiology)
Consultant Radiologist

Dr. M. B. S. N. Mandawala
MBBS , MD Radiology
Consultant Diagnostic and Interventional Radiologist
Colombo North Teaching Hospital
Ragama

...KY REPORT
...IDENTIAL

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...IENT CODE : C000002746

CLIENT'S NAME AND ADDRESS :
LHD - KADAWATHA
NO 161/1 RAGAMA RD,KADAWATHA

E - GAMAPAHA
SRI LANKA
0742024610

LANKA HOSPITALS DIAGNOSTICS PVT LTD.
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Tel : +94 11 5430000 , Fax : +94 11 5439032
Email : info@lhd.lk, Web : www.lhd.lk

PATIENT NAME : MRS. THARUSHI PIERIS
ACCESSION NO : **6001XK032783**
AGE : 42 Years SEX : Female
DATE OF BIRTH :
REFERRING DOCTOR : DR SUJEEWA SIYABALAPITIYA

PATIENT ID : **THARF261649110**
COLLECTED : 23/11/2024 17:05
RECEIVED : 23/11/2024 23:37
REPORTED : 29/11/2024 14:40

Test Report Status **Final** **Results**

HISTOPATHOLOGY

IHC - CYTOKERATIN 07

INTERPRETATION

ADDENDUM REPORT - 28/11/2024

Specimen TRUCUT BIOPSY OF RIGHT AXILLARY LYMPH NODE

Immunohistochemistry

Mammaglobin - Positive (cytoplasmic and membrane staining in > 80 % of cells; moderate intensity)

CK7 - Negative (control - positive)

CK20 - Negative (control - positive)

WT-1 - Negative (control - positive)

TTF1 - Negative (control - positive)

Comment **TRUCUT BIOPSY OF RIGHT AXILLARY LYMPH NODE**

* **Metastatic carcinoma; Unknown primary**
Tumour cells are positive for Mammaglobin which is a marker for mammary tissue origin.
(all other markers - negative)

* Comment - It is advisable to combine with another marker of similar lineage.
Recommend - GCDFP15
Contact the lab / 7th floor.

Note-

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LIENT CODE : C000002746

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PATIENT ID : THARF261649110
COLLECTED : 23/11/2024 17:05
RECEIVED : 23/11/2024 23:37
REPORTED : 29/11/2024 14:40

Test Report Status Final Results

IHC marker - CK7
IHC clone - OV-TL 12/30
IHC method - Manual
Detection system - Envision two step polymer based (Non Avidin-Biotin) system
Specimen - 10% neutral buffered formal saline fixed and paraffin embedded

IHC marker - CK20
IHC clone - KS20.8
IHC method - Manual
Detection system - Envision two step polymer based (Non Avidin-Biotin) system
Specimen - 10% neutral buffered formal saline fixed and paraffin embedded

IHC marker - TTF1
IHC clone - 8G7G3/1
IHC method - Manual
Detection system - Envision two step polymer based (Non Avidin-Biotin) system
Specimen - 10% neutral buffered formal saline fixed and paraffin embedded

IHC marker - WT1
IHC clone - 6F-H2
IHC method - Manual
Detection system - Envision two step polymer based (Non Avidin-Biotin) system
Specimen - 10% neutral buffered formal saline fixed and paraffin embedded

QUALITY CONTROL RESULTS (INTERNAL OR EXTERNAL AS APPROPRIATE)
Positive controls show appropriate positive immunostaining
Negative controls do not show immunostaining

ASR DISCLAIMER
This test was developed and its performance characteristics were determined by LHD. It has not been cleared or approved by the US Food and Drug Administration. This test is used for clinical purposes. It should not be regarded as investigational or for research.

IHC - CYTOKERATIN 20

INTERPRETATION

See above

IHC - TTF1

INTERPRETATION

See above

IHC - WT1 (6F-H2)

INTERPRETATION

See above

RY REPORT

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LIENT CODE : C000002746

CLIENT'S NAME AND ADDRESS :
LHD - KADAWATHA
NO 161/1 RAGAMA RD,KADAWATHA

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ACCESSION NO : **6001XK032783**
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PATIENT ID : **THARF261649110**
COLLECTED : 23/11/2024 17:05
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Test Report Status **Final** **Results**

IMMUNOHISTOCHEMISTRY MAMAGLOBIN

INTERPRETATION

See above

****End Of Report****

Prof.Bimalka Seneviratne
(MBBS, Dip. Path, MD, FCPSL)
Consultant Pathologist
Dept.Of Pathology

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See reverse for list of ISO 15189 accredited tests

Report Format, GN-FM-20, Issue 05, Issue Date: 01.05.2022, Rev. No.- , Rev. Date-, Prepared by Ex QA, Reviewed by QAM, Approved by HOL; Page 01 of 02

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Participant of External Quality Assurance Programmes of : RIQAS BIO-RAD EQAS CAP SLAB ACCREDITED CAP ACCREDITED

CLIENT CODE : C000000209

CLIENT'S NAME AND ADDRESS :
LANKA HOSPITALS - OPD
578, ELVITIGALA MAWATHA
NARAHENPITA
OPD
COLOMBO SRI LANKA

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Email : info@lhd.lk, Web : www.lhd.lk

PATIENT NAME : Mrs THARUSHI PIERIS
ACCESSION NO : 6001XL006494
AGE : 42 Years SEX : Female
DATE OF BIRTH :
REFERRING DOCTOR : Dr Lanka Hospital Doctor
CLINICAL INFORMATION :
BI2400093496/CS24471767 OPD-BILLING 3RDFL

PATIENT ID : LHSP.0002477450
COLLECTED : 05/12/2024 20:09
RECEIVED : 05/12/2024 20:09
REPORTED : 10/12/2024 16:25

Test Report Status **Final** Results

HISTOPATHOLOGY

IHC - ER

INTERPRETATION

ADDENDUM REPORT - 10/12/2024

Specimen TRUCUT BIOPSY OF RIGHT AXILLARY LYMPH NODE

Immunohistochemistry

ER - Positive ; Proportion score - 4/5
Intensity score - 2/3
Total score - 6/8

PR - Positive; Proportion score - 5/5
Intensity score - 3/3
Total score - 8/8

Her2/neu - Negative / 1+ (> 10% of cells show weak, incomplete membrane staining).

Ki67 - 8 - 10 % proliferative index

Comment Molecular subtype : Luminal A.

Note-

IHC marker	- ER, PR, Her2, Ki-67
IHC clone	- ID5, PGR636, c-erbB-2 Oncoprotein, MIB-1
IHC method	- Manual
Detection system	- Envision two step polymer based (Non Avidin-Biotin) system
Specimen	- 10% neutral buffered formal saline fixed and paraffin embedded
Fixation time	- Unknown
Cold ischemis time	- Specimen was placed in fixative within an hour of removal
Scoring method	- Allred scoring system / ASCO/CAP guidelines
Scoring Guidelines	- ALLRED SCORING SYSTEM FOR ER & PR

CLIENT CODE : C000000209

CLIENT'S NAME AND ADDRESS :
LANKA HOSPITALS - OPD
578, ELVITIGALA MAWATHA
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Test Report Status **Final** Results

Score for Proportion of Staining (PS)
0 = No nuclear Staining
1 = < 1% Nuclear Staining
2 = 1 - 10% Nuclear Staining
3 = 11 - 33% Nuclear Staining3 =
4 = 34 - 66% Nuclear Staining
5 = 67 - 100% Nuclear Staining

Score for Staining Intensity (IS)
0 = No staining
1 = Weak Staining
2 = Moderate Staining
Strong Staining

A total score of 3 or more is taken as Positive

- ASCOP/CAP GUIDELINES FOR ER

Positive	- ≥ 10% of the tumour cells are immunoreactive
Low positive	- 1-10% of tumour cells are immunoreactive
Negative	- < 1% of the tumour cells are immunoreactive in the presence of positive internal control
Uninterpretable	- If the sample is inadequate, if external and internal controls do not stain appropriately or if pre-analytical variables interfered with assay's accuracy.

- ASCOP/CAP GUIDELINES FOR PR

Positive	- ≥ 1% of the tumour cells are immunoreactive
Negative	- < 1% of the tumour cells are immunoreactive in the presence of positive internal control
Uninterpretable	- If the sample is inadequate, if external and internal controls do not stain appropriately or if pre-analytical variables interfered with assay's accuracy.

- ASCOP/CAP GUIDELINES FOR HER-2/NEU

Negative (Score 0)	- No staining observed or Incomplete, faint/barely perceptible membrane staining in ≤10% of invasive tumor cells
Negative (Score 1+)	- Incomplete, faint/barely perceptible membrane staining in >10% of invasive tumor cells
Equivocal (Score 2+)	- Incomplete and/or weak to moderate circumferential membrane staining in >10% of invasive tumor cells or Complete, intense, circumferential membrane staining in ≤10% of invasive tumor cells
Positive (Score 3+)	- Complete, intense, circumferential membrane staining in >10% of invasive tumor cells*

QUALITY CONTROL RESULTS (INTERNAL OR EXTERNAL AS APPROPRIATE)
Positive controls show appropriate positive immunostaining
Negative controls do not show immunostaining

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Test Report Status **Final**	Results

IHC - HER 2

INTERPRETATION

See above

IHC - KI 67

INTERPRETATION

See above

IHC - PR

INTERPRETATION

See above

****End Of Report****

Prof.Bimalka Seneviratne
(MBBS, Dip. Path, MD, FCPSL)
Consultant Pathologist
Dept.Of Pathology

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ASIRI SURGICAL HOSPITAL | AOI AMERICAN ONCOLOGY INSTITUTE PRECISION CANCER CARE

Comprehensive Cancer Care Centre

Department of Nuclear Medicine

Whole body PET-CT Report

Name : Mrs.T.T.D.Chamika Peiris	Age/Sex:42Y/F	Ref. No : RC00015043
Referred By:Dr.Sujeewa Siyabalapitiya	PET CT No:976/24	Date: 29.11.2024

Whole body F-18 Fluorodeoxyglucose (FDG) PET CT imaging was performed from the vertex to lower-thigh 60 minutes following intravenous administration of 6.38 mCi of F18 FDG using GE Optima 560 dedicated 8 slice/sec PET-CT system without breath holding instruction. Intravenous contrast enhanced CT scan was performed for anatomical localization and attenuation correction. The images were reviewed in axial, coronal and sagittal projections. A semi quantitative analysis of FDG uptake was performed by calculating SUV max value corrected for dose administered and patient body weight. The blood sugar level was 93 mg/dl at the time of injection of tracer.

Indication: A patient with metastatic right axillary lymphadenopathy from a poorly differentiated adenocarcinoma of unknown primary. Images were reviewed with previous CT scan of the neck, chest, abdomen and pelvis done on 24.11.2024.

FINDINGS

Head and Neck

No FDG avid or non FDG avid focal parenchymal lesions are identified in the cerebral or cerebellar hemispheres or in the brain stem, which maintain it's normal CT morphology, attenuation characteristics and normal distribution of metabolic activity. The ventricular system, basal cisterns and cortical sulci are within normal limits. There are no areas of infarctions, intra axial or extra axial mass lesions. No metabolic abnormality is detected in the skull vault or base.

There is a moderate degree of FDG avid, uniformly enhancing, well marginated solid mass lesion in the superficial lobe of right parotid gland inferiorly, encroaching upon the deep lobe too, measuring 1.50x1.45cm in size with SUV max of 6.04. No cystic areas of calcifications are identified within it.

No similar lesions or other FDG avid or non FDG avid mass lesions are identified in rest of the right parotic gland or in the left parotid gland which maintain it's normal size, shape, attenuation pattern and normal distribution of metabolic activity.

No FDG avid or non FDG avid focal lesions are identified in the submandibular glands which maintain it's normal size, shape, attenuation pattern and normal distribution of metabolic activity.

Mild to moderate degree of increased FGD uptake is observed in bilateral lingual and palatine tonsils and are more in favour of inflammatory in origin.

The pharynx, larynx and para pharyngeal spaces maintain it's normal CT morphology and otherwise normal distribution of metabolic activity.

There are minimally FDG avid prominent and minimally enlarged lymphnodes with preservation of it's normal fatty hila in the level 2A of upper neck bilaterally and are most likely of inflammatory in origin. Largest lymphnode is in left side measuring 13.6mm in diameter with SUV max of 2.28 and relatively larger lymphnode in the right sided level 2A group measure 12.8mm in diameter with SUV max of 1.83.

Additionally, there are few prominent non FDG avid lymphnodes with preservation of it's normal fatty hila in the upper neck bilaterally and are more in favour of reactive hyperplasia. Relatively larger lymphnodes in the right and left sided level 1A groups measure 6.5mm and 6.0mm in diameters respectively. Relatively larger lymphnodes in the right and left sided level 1B groups measure 8.0mm and 9.6mm in diameters respectively.

No prominent, enlarged or FDG avid lymphnodes are identified in rest the neck or supraclavicular region.

No significant mucoperiosteal thickening, fluid levels or retention cysts are observed in the paranasal sinuses which are clear bilaterally.

The orbits, globes, optic nerves and extra ocular muscles maintain it's normal CT morphology and normal distribution of metabolic activity.

There is minimal diffuse increased FDG uptake (SUV max of 2.70) in the thyroid gland which is not enlarged and maintains it's normal parenchymal attenuation pattern. No definite focal or diffuse attenuation abnormalities are identified in the thyroid gland.

Chest:

Two minimally FDG avid smooth walled soft tissue density ovoid mass lesions are identified in the axillary tail of right breast measuring 2.02x1.34 and 1.55x1.23cm in sizes with SUV max of 3.54 and 2.65. No calcific foci are identified within. Few non FDG avid fat strandings are identified in the immediately around axillary tail. No similar lesions or other FDG avid or non FDG avid mass lesions or abnormal calcifications are identified in rest of the right breast or in the left breast.

Mild to moderate degree of FDG avid, few prominent and enlarged lymphnodes with loss of it's normal fatty hila are identified in the right axilla and largest measures 2.61x1.34cm in size with SUV max of 4.15.

Few prominent and enlarged non FDG avid lymphnodes with thickened cortices and obliteration of it's normal fatty hila are observed in the left axilla and largest measures 1.80x0.71cm in size.

Minimally enlarged, non FDG avid lymphnode with loss of it's normal fatty hilum is identified in the para aortic group of the mediastinum measuring 1.04cm in diameter.

No prominent, enlarged or FDG avid lymphnodes are identified in the subpectoral, internal mammary or rest of the mediastinal groups or in the hila. Great vessels of the mediastinum are within normal limits and mediastinal blood pool shows SUV max of 2.03.

There are no suspicious or FDG avid focal parenchymal nodules, areas of collapse or consolidations in the lungs which are clear bilaterally.

There is no pleural or pericardial effusion.

Abdomen and Pelvis

No FDG avid or non FDG avid focal lesions are identified in the liver which is enlarged and shows diffuse and heterogeneous reduction in parenchymal attenuation pattern. Normal smooth regular hepatic contour and normal distribution of parenchymal metabolic activity are maintained (SUV max of 2.68). Intrahepatic and extra hepatic ducts are not dilated. Portal venous and hepatic venous radicles are within normal limits. Main portal vein is normal in caliber and no filling defects are present within. Gall bladder maintains it's normal distensibility and mural thickness. No calculi are present within it.

A non FDG avid smooth walled low attenuated mass lesion measuring 1.83x1.49cm in size is identified in the body of right suprarenal gland, most likely representing a suprarenal adenoma. No similar lesions are identified in left adrenal gland. Rest of the right suprarenal gland and the left adrenal gland maintain it's normal size, shape, normal attenuation pattern and normal distribution of metabolic activity.

No FDG avid or non FDG avid lesions are identified in the pancreas, spleen or kidneys, which maintain it's normal CT morphology, attenuation characteristics and normal distribution of metabolic activity.

Uterus is absent and is post surgical. A non FDG avid smooth walled cyst measuring 1.85x1.61cm in size is identified in the left ovary and is more in favour of a functional cyst. A small developing follicle measuring 0.8cm in diameter is identified in right ovary. No FDG avid lesions are identified in the ovaries which are otherwise normal in size, shape and attenuation pattern for the age of the patient.

No prominent, enlarged or FDG avid lymphnodes are identified in the para aortic, para caval, iliac or mesenteric groups.

No FDG avid or other non FDG avid mass lesions are identified in the abdomen or pelvis. No localized fluid collection or free peritoneal fluid is present.

Normal distribution of the tracer in the small and large bowel are observed.

Few prominent and enlarged non FDG avid lymphnodes with preservation of it's normal fatty hila are identified in the inguinal groups bilaterally and are most likely representing reactive hyperplasia. Largest lymphnode is in the right inguinal group measuring 1.83cm in diameter and relatively larger lymphnode in the left inguinal group measures 1.62cm in diameter.

Musculoskeletal & Miscellaneous

Few small non FDG avid dense foci are identified in the femoral heads bilaterally and in the right iliac bone and are most likely representing benign bone islands.

No other sclerotic or lytic lesions or FDG avid osseous lesions are identified in the scanned region.

IMPRESSION

Two minimally FDG avid smooth walled soft tissue density ovoid mass lesions in the axillary tail of right breast could represent hypermetabolic intra-mammary lymphnodes too.

However, presence of few hypermetabolic prominent and enlarged lymphnodes in the right axilla and in the absence of any other hypermetabolic lesions in right breast, the possibility of primary lesion in the axillary tail has to be excluded. Image guided biopsy of the axillary tail lesions are advised.

Moderate degree of FDG avid, uniformly enhancing well marginated solid mass lesion in the right parotid gland is more in favour of a parotid neoplasm. Image guided biopsy would be helpful in definitive tissue diagnosis.

No other hypermetabolic lesions are identified in the scanned region to suggest primary or metastatic lesions.

There is no pulmonary metastases.

Hypometabolic prominent and enlarged lymphnodes in left axilla and para aortic group are non specific findings.

Evidence of diffuse fatty infiltration of the liver.

Incidentally noted a right suprarenal adenoma.

The non FDG avid smooth walled cyst in the left ovary is more in favour of a functional cyst. Follow up with US scan is advised.

Dr. S. H. Munasinghe
Consultant Radiologist

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Name : Mrs Tharushi Peiris

Age , Sex 42 Yrs/F

Ref. by: Dr M B S N Mandawala

Bill No : SPR 18410801

Specimen No: **SFH 531/24**

Date received - 15/11/2024

Date issued - 21/11/2024

HISTOPATHOLOGY REPORT

SPECIMEN	:	Right axillary lymph node tru cut biopsy
U S SCAN	:	Multiple enlarged lymph nodes in right axilla. No central echogenic fatty hilum identified to suggest benign lymph nodes.
MACROSCOPY	:	Received one core measuring 10mm in length.
MICROSCOPY	:	Sections reveal a core of lymph node tissue partly replaced by cohesive nests of atypical cells with monomorphic nuclei and moderate eosinophilic cytoplasm. Very occasional gland formation is noted.
CONCLUSION	:	Right axillary lymph node: Tru cut biopsy: Histology: Metastatic poorly differentiated adenocarcinoma.
COMMENT	:	Please exclude primaries in the breast and the vicinity. If a primary can be detected on radiology, immunohistochemistry is not required. If otherwise paraffin block can be provided for CK 7, CK 20, TTF 1, WT 1, Mammaglobin etc.

Dr Shanika Fernandopulle
Consultant Histopathologist

Authorized by

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HISTOPATHOLOGY

UHID	: 120453179	
REFERENCE No.	: 01 0223 12/12/24	/
SAMPLE DATE & TIME	: 12/12/2024 09:38	AGE : 42 Y/F 13/11/1982
REPORT DATE & TIME	: 13/12/2024 10:07	AHH2099810 / ASH2106653
PATIENT	: MRS. THARUSHI PEIRIS	
REFERRED BY	: DR ERANGA PERERA	

TEST : CYTOLOGY

.

SPECIMEN : Ultra Sound Guided FNAC- Left axillary lymphnodes

CLINICAL DETAILS : Right axillary lymphnodes- Biopsy showed metastatic poorly differentiated adenocarcinoma

MACROSCOPY : Five H&E stained smears examined.

MICROSCOPY : Smears reveal a polymorphous population of small and medium sized lymphocytes. There are no large atypical lymphocytes, granuloma formation or metastatic deposits of a carcinoma.

CONCLUSION : US Guided FNAC- Left axillary lymphnodes:

- Cells from a reactive lymphnode.
- No metastatic deposits of a carcinoma.

LNH-223
(S.C.T - 12/12/2024 at 09.18 am)

DR L N WIJETHUNGE
MBBS,Dip(Path),MD (Histopathology)
Consultant Histopathologist