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ANATOMIC PATHOLOGY CONSULTATION REPORT

Order Number:	**OC-20-119**	**Referred by:**
First Name:	JACK	DR. BAKER
Last Name:	SMITH	GENERAL HOSPITAL
MRN:	1234567890	123 MAIN ST
Gender:	Male **Age:** 60 Y **DOB:** 11/1/1960	ANYWHERE, MI 48000
Date Received:	01/03/2020	
Date Completed:	01/06/2020	

DIAGNOSIS:

Pericardium, partial excision (window) (SN19-20166, A1-A3; 12/30/2019): Organizing fibrinous pericarditis with reactive mesothelial hyperplasia.

Immunohistochemical stains were positive for pancytokeratins (AE1/AE3 and CAM5.2) and calretinin (patchy, nuclear and cytoplasmic) in reactive mesothelial cells with no evidence of invasion. These results are consistent with reactive mesothelial hyperplasia.

Dear Dr. Baker,

This report confirms our telephone conversation concerning findings in the pericardial window excised from Jack Smith, a 60 - year-old man who is status post cardiac pacemaker placement in November 2019. He was recently discovered to have a circumferential large 3 cm pericardial effusion without tamponade. Pericardial fluid cytology was negative. As I indicated over the telephone, I reviewed these slides and completely agree with your assessment and conclusion.

The main change in sections of the pericardial window is a dramatic organizing fibrinous pericarditis localized to the pericardial surface. At higher magnification, organizing spindle cells are affiliated with a relatively scant infiltrate of predominantly mononuclear inflammatory cells and scattered atypical epithelioid cells with enlarged nuclei and prominent nucleoli. Cytologically similar epithelioid cells are arranged in a linear fashion at the interface between the inflammatory process and the underlying pericardial connective tissue without evidence of invasion. I completely agree that all of these findings are consistent with atypical mesothelial hyperplasia in the context of pericarditis. I performed a couple of immunostains primarily to document the absence of invasive behavior as well as a mesothelial phenotype.

As always, I appreciate the opportunity to participate in review of this unusual problem. Please do not hesitate to contact me directly if I can be of any further assistance.

Sincerely,

Jeffrey L. Myers, M.D.

Clinical History:

Outside slide(s) submitted for review.

Materials Received:

A **Outside Case Number:** **SN19-20166**

Materials Received:

Number of prepared slides: 5
Number of unstained slides: 0
Number of blocks: 1

CPT Codes:

Specimen	CPT Code	Number of Charges
A	88321	1
A	88341	1
A	88342	1

Laboratory Accrediting Agency Compliance Statement:
If immunostain testing was performed on this case, the testing was developed and the performance characteristics were determined by the University of Michigan Clinical Immunoperoxidase Laboratory. It has not been cleared or approved by the U.S. Food and Drug Administration. (The FDA has determined that such clearance is not necessary. This test is used for clinical purposes. It should not be regarded as investigational or for research.) Appropriate negative and positive controls were run and demonstrated expected results. Most antibodies (including ER, PR, and HER2/neu) were not validated on decalcified tissues; negative staining on decalcified specimens should therefore be viewed with discretion, as a falsely negative result cannot be excluded. The Coreo ACIS instrument (if used for any test on this case) is FDA approved.

Performing site:

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CLIA Director: RICCARDO VALDEZ , M.D.

CLIA Number: 23D0366712
