Malignancy, General

Concept

Make sure you understand the common nature of spread of the cancer (hematogenous—papillary/thyroid; peritoneal—ovarian; lymphatic—breast). All cancers need to be addressed with regard to:

Staging,
Surgical treatment,
Neoadjuvant/adjuvant therapies.

Way Question May be Asked?

About half the time will be clearly cancer from the outset. The other half, you will get the diagnosis after a long, exhaustive work-up.

How to Answer?

As with everything else, be methodical
Don't leave out of history: important systemic symptoms like change in bowel habits, dysphagia, weight loss, anorexia, jaundice, last mammograms, family history of malignancies.

Don't leave out of physical exam: important information like abdominal masses, examination of important lymphatic basins, complete skin exam in someone with melanoma.

Make sure you do everything you can to work-up pt pre-op both in:

(1) Determining a diagnosis—FNA, U/S, mammogram in breast CA
(2) Appropriate staging—(don't go overboard with ordering tests!)
    (a) LFTs, CXR for breast cancer
    (b) PFTs, CT scan chest to adrenals in lung cancer, +/– mediastinoscopy
    (c) CT scan abd/pelvis, angio, tumor markers, ERCP in pancreatic CA
(3) Make sure to determine if lesion is resectable or if pt needs pre-op chemo/XRT
    (a) rectal CA Stage II or above gets pre-op XRT
    (b) inflammatory breast CA gets pre-op chemo

In the OR, if you don't have a dx yet (as in case of pancreatic mass), must do frozen section
Frozen section also appropriate after resection to check margins in gastric, esophageal, lung CA
Examination of lymph node basins when appropriate
Frozen section of SLNs (controversial—careful here in any CA but melanoma and breast! Not necessarily a right answer, but know your answer and stick to it!)
Be able to describe common lymph node dissections
Don't forget to ask for pathology report—size, margins, lymph nodes, tumor type, nuclear grade (receptor status for breast cancer)
Don't forget to discuss post-op chemo/XRT management

Common Curveballs

Cancer diagnosis unable to determine pre-op (common with pancreatic/cholangioCA)
Margins positive in gastric/breast cancer
Mediastinoscopy positive
Post-op 1 yr with local recurrence or rising tumor markers in first year of post-op follow-up
Post-op 1 yr with metastatic lesion (resect in sarcoma if primary site controlled and in melanoma if single organ met)
Post-op discussion of chemo/XRT regimen
"Scenario switch" where you were working up one diagnosis and find a malignancy (bloody nipple d/c after resection, path reveals small focus ductal carcinoma)
Pt will have synchronous tumor in colon CA
Pt will have post-op leak after GI resection

Pt will want to preserve their breast with advanced breast CA
Pt will have positive SLN on permanent/frozen section
Pt will have non-diagnostic FNA or percutaneous biopsy
Asked to describe your technique for performing SLN biopsies

Strikeouts

Failure to check old CXR if suspect lung CA
Failure to check old mammogram/or order mammogram in breast CA
Failure to complete lymph node dissection for positive SLN (don't get into discussion about most recent NSABP trials randomizing pts to not have complete ALND for + SLN in breast CA)
Failure to know chemo/XRT regimen after resection for breast CA
Failure to check margins after GI resection
Aggressive resection of metastatic lesions in breast CA
Failure to do FNA on palpable thyroid nodule/breast lesion
Failure to get pre-op lymphoscintigraphy if performing SLN for trunk melanoma (can go to at least four different lymph node basins)
Failing to use pre-op XRT in rectal CA stage II or above
Failing to evaluate adrenal glands in evaluation of lung CA
Failing to determine resectability pre-op in pt with pancreatic neoplasm
Failing to examine lymph node basins on pre-op H&P
Failing to ask about prior hx malignancy in pre-op H&P