Highly Configurable & Flexible Software
With more than 25 years of LIS experience, the scalability and flexibility of Orchard’s laboratory information systems facilitates an advanced level of configurability that enables Orchard to support a diverse client base. More than 1,500 laboratories across the country have turned to Orchard Software—including all types and sizes of multi-site and multi-specialty clinics and physician office laboratories, hospitals, regional reference labs, fertility clinics, veterinary labs, university student health services, research laboratories, toxicology and pain management clinics, and public health organizations.

Decorated Product Suite Empowers Laboratories
Our award-winning laboratory information systems utilize process automation, robust interface and integration tools, and rules-based technology to simplify laboratory workflow and expertly address regulatory and integration issues.
## PATIENT INFORMATION

Patient Name: **Patient, John**  
M, Age 34 | DOB: 4/12/1979  
Phone: (123) 555-1234  
EMR: (123) 555-1234  
CLINICAL INFORMATION:  
8.6; Oct. 2012 / Elevated PSA

## PHYSICIAN INFORMATION

**James Provider, MD**  
ABC Medical  
400 Royal Drive  
Anytown USA, 12345  
Phone: (123) 555-4321  
Fax: (999) 555-4322

## PROSTATE BIOPSY DIAGRAM AND MICROSCOPIC IMAGES

![Prostate Biopsy Diagram](image)

## ACCESSION NUMBER

**12XX0002**  
COLLECTION DATE: 2/15/2013  
RECEIVED DATE: 2/15/2013  
REPORT DATE: 2/17/2013  
TAT: [26 hours]

## FINAL DIAGNOSIS

<table>
<thead>
<tr>
<th>Site</th>
<th>Gleason Score</th>
<th>Diagnosis</th>
<th>Tumor %</th>
<th>Tumor Length (mm)</th>
<th>Core Length (mm)</th>
<th># Cores</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Left Base</td>
<td>3+4=7</td>
<td>ADENOCARCINOMA</td>
<td>60</td>
<td>6</td>
<td>10</td>
<td>1</td>
</tr>
<tr>
<td>2 Left Mid</td>
<td>Benign</td>
<td></td>
<td>0</td>
<td>10</td>
<td>10</td>
<td>1</td>
</tr>
<tr>
<td>3 Left Apex</td>
<td>Benign</td>
<td></td>
<td>0</td>
<td>10</td>
<td>10</td>
<td>1</td>
</tr>
<tr>
<td>4 Right Base</td>
<td>Benign</td>
<td></td>
<td>0</td>
<td>10</td>
<td>10</td>
<td>1</td>
</tr>
<tr>
<td>5 Right Mid</td>
<td>Benign</td>
<td></td>
<td>0</td>
<td>10</td>
<td>10</td>
<td>1</td>
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<tr>
<td>6 Right Apex</td>
<td>HGPIN</td>
<td></td>
<td>0</td>
<td>10</td>
<td>10</td>
<td>1</td>
</tr>
</tbody>
</table>

**John Pathologist**

Electronically Signed on 2/17/2013 at 11:42 am

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**CLIA ID#: 01D0000XXX000**  
END OF REPORT (FINAL)  
Page 1 of 1
Surgical Pathology Report

FINAL DIAGNOSIS

A. Soft Tissue, Left Supraclavicular, Core Needle Biopsy:
   MALIGNANT LYMPHOMA, LARGE CELL ANAPLASTIC TYPE,
   ALK-1 NEGATIVE

B. Skin, Upper Back, Incisional Biopsy:
   MALIGNANT LYMPHOMA, LARGE CELL ANAPLASTIC TYPE,
   ALK-1 NEGATIVE

Specimen: Left Supraclavicular Skin, Upper Back

Preoperative Diagnosis Probable malignancy. History of recent
left supraclavicular mass of rapid onset with an upper back skin
nodule. CT scan shows mediastinal adenopathy without other organ
masses.

Gross Examination
Received are two formalin filled containers labeled “Jane Patient”

A. Container A is labeled “Needle biopsy left supraclavicular area” and holds 2
cylindrical shaped fragments measuring 2 mm in diameter and 10 and 13 mm in
length. The specimen is poured into a filter bag and entirely submitted in cassette
A.

B. Container B is labeled “Skin Upper Back” and holds a wedge-shaped fragment of
skin measuring 8.0 x 10.0 x 6.0 cm. The specimen is dissected and entirely
submitted in cassette B.

Performed by: A. Tech

Microscopic Examination
The Final Diagnosis for each specimen is based on a microscopic examination of the tissues or preparation from these
tissues.
Comment:
Both of these biopsies show similar neoplastic cell infiltrates that have the characteristic isolated large poorly differentiated (anaplastic) cells with oval to reniform nuclei with large single nucleoli and a flocculent eosinophilic cytoplasm. In the supraventricular space there is necrosis and inflammation with the neoplastic cells oriented around vessels. The skin lesion is earlier involvement with infiltrates in the deep and superficial dermis. A panel of immunohistochemical stains was done that show a pattern consistent with this type of lymphoma (see below), which includes a strong CD 30 positive pattern.

<table>
<thead>
<tr>
<th>Special Stains Performed</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>CD30</td>
<td>Positive</td>
</tr>
<tr>
<td>CD45</td>
<td>Weakly Positive</td>
</tr>
<tr>
<td>CD3</td>
<td>Negative</td>
</tr>
<tr>
<td>CD4</td>
<td>Positive</td>
</tr>
<tr>
<td>CD20</td>
<td>Negative</td>
</tr>
<tr>
<td>ALK-1</td>
<td>Negative</td>
</tr>
</tbody>
</table>

John Pathologist

John Pathologist, MD
Electronically signed: 10/03/2013 09:13

GPT Codes: 88305(x2), 88342(x14)

ICD8 Codes: 202.88
Patient Name: Patient, John C.  
Sex: M  
DOB: 04/12/1979  
Patient ID: 54321-6  
Collection Date: 10/15/2013 17:45  
Received Date: 10/15/2013 18:52  
Reported: 10/16/2013 10:44  

Provider: James Provider, MD  
Account Number:  
Client: ABC Medical  
Client Address: 1234 Anystreet; Anytown, USA 12345  
Telephone: (123) 555-1234  
Accession #: S-01-543210-6  

Surgical Pathology Report

FINAL DIAGNOSIS

A. Ascending Colon  
SESSILE SERRATED ADENOMA (POLYP) WITH LOW-GRADE ADENOMATOUS DYSPLASIA.

B. Sigmoid Colon  
TUBULAR ADENOMA

COMMENT:
Patients with sessile serrated adenomas, especially with cytologic dysplasia, are at increased risk for the development of adenocarcinoma showing microsatellite instability. This progression may occur at a more rapid rate than with traditional adenomas. Complete endoscopic excision is recommended if clinically appropriate. If unresectable, repeat colonoscopy at a shortened interval (1 year), with sampling of suspicious areas or surgical resection possibly warranted.

Specimen: 2 cm polyp ascending colon 2 mm polyp in sigmoid colon

Clinical History: Screening colonoscopy. Maternal hx of adenocarcinoma of colon age 57

Gross Examination
A. The first container is labeled “ascending colon.” It contains a polypoid piece of tan mucosal tissue measuring 2.0 cm in greatest dimension. The polyp margin is inked, sectioned, and submitted in cassettes A1 and A2.

B. The second container is labeled “sigmoid colon.” It contains one piece of light tan mucosal tissue 0.2 cm in greatest dimension. Entirely submitted in cassette B.

Microscopic Examination
Microscopic Examination performed supportive of the Final Diagnosis above.

John Pathologist

John Pathologist, MD  
Electronically signed: 10/16/2013 10:44  

Case number: S-01-543210-6  
END OF REPORT  
Reviewed by: _____
Bone Marrow Pathology Report

FINAL DIAGNOSIS

WHO Acute Myeloid Leukemia Not Otherwise Specified: FAB Acute Myelomonocytic Leukemia (M4)

Bone Marrow Biopsy, Aspirate and Particle Preparation:
1. Acute Myeloid Leukemia with marked hypercellularity, numerous blasts (67%), and eosinophilia (21%).
2. Reduced Trilineage Hematopoesis.

Peripheral Blood:
1. Acute Myeloid Leukemia with leukocytosis including numerous blasts (40%), monocytosis (25%), and eosinophilia (16%).
2. Anemia and thrombocytopenia.

Flow Cytometry Interpretation
Flow cytometric immunophenotyping studies performed on bone marrow demonstrated numerous CD34 positive/CD117 positive myeloid blasts (14.22% positive); these cells coexpressed the myeloid markers CD13/33. Many expressed HLA-DR and TdT, also markers of myeloid immaturity. Also, there was a distinct population of cells that expressed the monocytoid marker, CD14.

Clinical History: A 58-year-old female without any significant past medical history, developed symptoms of sinus pressure and headache for approximately three weeks. These were thought to be sinusitis and treated with oral antibiotics (Bactrim) and antihistamines. Subsequently she developed gingival hyperplasia and was found to have a white blood cell count of over 70 x 10^9/L.

Microscopic Examination
Bone Marrow biopsy and aspirate were performed with the following remarkable and abnormal differential counts:

<table>
<thead>
<tr>
<th>Component</th>
<th>Percentage</th>
<th>Normal Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blasts</td>
<td>67.0%</td>
<td>0.0-2.0</td>
</tr>
<tr>
<td>Eos Myelo/Meta</td>
<td>15.0%</td>
<td>1.0-4.0</td>
</tr>
<tr>
<td>Eos Band</td>
<td>3.7%</td>
<td>1.0-2.0</td>
</tr>
<tr>
<td>Eos Seg</td>
<td>2.3%</td>
<td>1.0-2.0</td>
</tr>
</tbody>
</table>

The marrow was markedly hypercellular (approximately 100%). The predominant cells were blasts but eosinophils also appeared markedly increased. The blasts in the marrow were generally large with many having a moderate amount of
Patient Name: Patient, Jane A.  
Patient ID: 12345-6  
Date of Birth: 06/22/1955  Age: 58  Sex: F  
Provider: James Provider, MD

Case number: B08-0006  
Collection Date: 08/12/2013 08:40  
Received Date: 08/12/2013 08:40  
Reported: 08/16/2013 10:02

Bone Marrow Pathology Report

FINAL DIAGNOSIS

WHO Acute Myeloid Leukemia Not Otherwise Specified: FAB Acute Myelomonocytic Leukemia (M4)

Bone Marrow Biopsy, Aspirate and Particle Preparation:
1. Acute Myeloid Leukemia with marked hypercellularity, numerous blasts (67%), and eosinophilia (21%).
2. Reduced Trilineage Hematopoiesis.

Peripheral Blood:
1. Acute Myeloid Leukemia with leukocytosis including numerous blasts (40%), monocytosis (25%), and eosinophilia (16%).
2. Anemia and thrombocytopenia.

Flow Cytometry Interpretation
Flow cytometric immunophenotyping studies performed on bone marrow demonstrated numerous CD34 positive/CD117 positive myeloid blasts (14/22% positive); these cells coexpressed the myeloid markers CD13/33. Many expressed HLA-DR and TdT, also markers of myeloid immaturity. Also, there was a distinct population of cells that expressed the monocytoid marker, CD14.

Clinical History: A 58-year-old female without any significant past medical history, developed symptoms of sinus pressure and headache for approximately three weeks. These were thought to be sinusitis and treated with oral antibiotics (Bactrim) and antihistamines. Subsequently she developed gingival hyperplasia and was found to have a white blood cell count of over 70x10^9/L.

Microscopic Examination
Bone Marrow biopsy and aspirate were performed with the following remarkable and abnormal differential counts:

- Blasts: 67.0% (normal 0.0-2.0)
- Eos Myelo/Meta: 15.0% (normal 1.0-4.0)
- Eos Band: 3.7% (normal 1.0-2.0)
- Eos Seg: 2.3% (normal 1.0-2.0)

The marrow was markedly hypercellular (approximately 100%). The predominant cells were blasts but eosinophils also appeared markedly increased. The blasts in the marrow were generally large with many having a moderate amount of...
medium-to-light blue cytoplasm. The nuclear chromatin was dispersed, or partially dispersed, but usually without a
nucleolus. Immunohistochemistry was performed and findings were as follows: Approximately 10% of the young cells
appeared to be reactive for peroxidase, a histochemical marker for myeloid differentiation. Approximately 10% of the
blasts were weakly positive for nonspecific esterase (NSE), a histochemical marker for monocytoid differentiation. Greater
than 50% of cells were positive for CD68, an immunohistochemical marker for myeloid cells and especially macrophages.
Approximately 30% of cells were positive for lysozyme, another immunohistochemical marker for myeloid and particularly
monocytoid lineage cells.

**Cyogenetics/FISH:**

Conventional karyotypic analysis suggested initially that one cell line represented by most of the examined cells showed a
translocation between the long arms of chromosomes 5 and 22. Specifically 46XX t(5;22)(q31,q11.2). However, FISH
studies performed subsequently suggested a more complex three-way translocation involving chromosomes 12, 5, and 22:
[15;12,22)(p33;q13)]. FISH studies utilized the ERG1(5q31), the telomeric DNA probes for 5q and 22q, and the TEL
DNA (12p13) probes to further elucidate the breakpoints. These studies showed that one 5q tel signal was translocated from
the der(5) to the der(22) (Seimon5q.tif) and one 22q tel signal was translocated form the der(22) to the short arm of
chromosome 12 (Seimon22q.tif), and one TEL signal was translocated from the short arm of der(12) to the long arm of
der(5). The FISH findings confirmed a complex three-way translocation involving the short arm of chromosome 12 in
addition to the long arms of chromosomes 5 and 22 as was detected by classical cytogenetics. The ERG1(5q31) probe
showed that the EGR1 gene locus was preserved on the der(5) suggesting that the breakpoint was distal to the ERG1 locus
therefore modifying the karyotype to be 46,XX,t(5;12;22)(q33;p13;q13)

**Laboratory Findings**

<table>
<thead>
<tr>
<th>Test</th>
<th>Result</th>
<th>Normal Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>WBC</td>
<td>78 x 10^9/L</td>
<td>(normal 3.8 - 10.6 x 10^9/L)</td>
</tr>
<tr>
<td>RBC</td>
<td>2.69 x 10^12/L</td>
<td>(normal 3.7 - 4.8 x 10^12/L)</td>
</tr>
<tr>
<td>Hemoglobin</td>
<td>9.0 g/dL</td>
<td>(normal 11.6 - 14.6 g/dL)</td>
</tr>
<tr>
<td>Hematocrit</td>
<td>25.6 %</td>
<td>(normal 34.1 - 43.3 %)</td>
</tr>
<tr>
<td>MCV</td>
<td>95.4 fl</td>
<td>(normal 82.6 - 97.4 fl)</td>
</tr>
<tr>
<td>MCH</td>
<td>33.5 pg</td>
<td>(normal 27.8 - 33.4 pg)</td>
</tr>
<tr>
<td>MCHC</td>
<td>35.1 g/dL</td>
<td>(normal 32.7 - 35.5 g/dL)</td>
</tr>
<tr>
<td>RDW</td>
<td>14.6 %</td>
<td>(normal 11.8 - 15.2 %)</td>
</tr>
<tr>
<td>PLT</td>
<td>43 x 10^11/L</td>
<td>(normal 156 - 369 x 10^11/L)</td>
</tr>
<tr>
<td>POLYS</td>
<td>1 %; ABS 0.8</td>
<td>(normal 2.24 - 7.68)</td>
</tr>
<tr>
<td>LYMPH</td>
<td>13 %; ABS 10.0</td>
<td>(normal 0.80 - 3.65)</td>
</tr>
<tr>
<td>MONOS</td>
<td>25 %; ABS 23.3</td>
<td>(normal 0.30 - 0.90)</td>
</tr>
<tr>
<td>EOS</td>
<td>16 %; ABS 10.6</td>
<td>(normal 0.00 - 0.40)</td>
</tr>
<tr>
<td>BLASTS</td>
<td>40 %; ABS 29.2</td>
<td></td>
</tr>
<tr>
<td>PRO</td>
<td>1 %; ABS 0.8</td>
<td></td>
</tr>
<tr>
<td>MYELO</td>
<td>2 %; ABS 1.60</td>
<td></td>
</tr>
<tr>
<td>META</td>
<td>2 %; ABS 1.60</td>
<td></td>
</tr>
</tbody>
</table>

**John Pathologist**

John Pathologist, MD
Electronically signed: 08/16/2013 09:44

Case number: B08-0006/2
END OF REPORT (Preliminary)
Molecular Pathology Report

Specimen Type: Voided Urine
Indication for Study: Bladder Cancer
FISH Probes: Centromeres of 3, 7 and 17. Locus p16 at 9p21
Interphase Nuclei Scored: 200

Results: POSITIVE for the 3, 7, and 17 centromeres. Normal for the 9p21 probe.

Molecular Interpretation

Molecular detection of aneuploidy for chromosomes 3, 7, 17, and the loss of locus 9p21 is performed by fluorescence in situ hybridization (FISH) using the Vysis UroVysion bladder cancer recurrence commercial assay. This assay is performed according to modification of the FDA approved method, which has been validated by Orchard Pathology Laboratories.

Support for the interpretation of this case may have included the use of immunohistochemistry, and/or in situ hybridization tests that were performed by Orchard Pathology Laboratories. These tests have not been cleared or approved by the U.S. Food and Drug Administration. The FDA has determined that such clearance or approval is not necessary. These tests are used for clinical purposes and 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.

Patient Result: FISH POSITIVE (POLYSOMY)

(A positive result indicates a gain of more than one chromosome in 4 or more cells, or the homozygous loss of locus 9p21 in 12 or more cells.)

Comment: "The Vysis UroVysion FISH kit for the diagnosis and monitoring of bladder cancer has been approved by the FDA. This kit is designed to detect aneuploidy for chromosomes 3, 7, and 17 and the loss (deletion) of the 9p21 locus via FISH in urine specimens. The performance of the probes in this kit has been determined by Premier Laboratories and this test is utilized for clinical purposes.

John Pathologist

John Pathologist, MD
Electronically signed: 2/21/2013 09:44

Reviewed by: _______
Surgical Pathology Report

FINAL DIAGNOSIS

A. GE Junction: ADENOCARCINOMA of the esophagus.

B. Antrum: Non-neoplastic gastric antral mucosa, negative for inflammation. Stain for Helicobacter pylori microorganisms is negative.

Gross Examination

A. Received in formalin and labeled “Patient, Michael E.” and “EG Junction” are multiple fragments of tan tissue measuring 0.7 x 0.4 x 0.2 cm in aggregate. The specimen is entirely submitted in one cassette labeled “A.”

B. Received in formalin and labeled, “Patient, Michael E.” and “Antrum” are two fragments of pink-tan tissue measuring 0.2 x 0.2 x 0.2 cm. The specimen is entirely submitted in one cassette labeled “B.”

John Pathologist

John Pathologist, MD
Electronically signed: 03/30/2013 09:44
Patient Name: Julie B.
Patient ID: 444222
Date of Birth: 09/05/1968
Age: 45
Sex: F

Case number: G07-0062
Collection Date: 06/13/2013 21:14
Received Date: 06/13/2013 21:14
Reported: 06/14/2013 02:43

Final Cytology GYN Report

Interpretation/Result: Epithelial Cell Abnormalities:
ASCCH - Atypical squamous cells cannot exclude HSIL

Organisms: Normal Findings

Specimen Adequacy: Satisfactory for Evaluation - Presence of
Endocervical Transformation Zone Component

CLINICAL INFORMATION

Date Last Pap Feb 2012
GYN Source: Cervical/endocervical
Date LMP/Menopause: 05/22/2013
Clinical Impressions: Oral contraceptives
Previous Treatment: None
Previous Pap: Atypical; ASCUS

*The Pap smear is a screening test, not a diagnostic procedure and should not be used as the sole means of detecting cervical cancer.
Both false-positive and false-negative reports do occur.

Human Papilloma Virus HPV Assay by in-situ hybridization
16, 18, 31, 33, 35, 39, 45, 51, 52, 56, 58, 66 ...... NOT DETECTED

Laboratory Findings

Historical Diagnosis:
Thin Prep PAP Test Case Number: G06-42-01 Issued: 06/12/07
INTERPRETATION/RESULT: Epithelial Cell Abnormalities: ASCUS-Atypical squamous cells of undetermined significance

Screened by: M Jones, CT

John Doctor

John: Doctor, MD
Electronically signed: 06/14/2013 02:31

Reviewed by: _______
Cytology GYN Report

General Categorization:
Epithelial cell abnormality (See Interpretation)

Interpretation:
Atypical squamous cells of undetermined significance (ASCUS)
Atypical koilocytosis, cytoplasmic and nuclear change consistent with HPV effect
HPV, High Risk - Positive; HPV, Type 16 - Positive; HPV, Type 18 - Negative
Chlamydia (CT) - Positive; Gonorrhoeae (GC) - Negative

The Pap smear is a cancer screening test that has an overall 3-25% false negative rate. For this reason, an annual Pap smear is recommended. Please discuss this with your patients.

CLINICAL INFORMATION
Type of test: High Risk Screening
Date LMP: 5/5/10
Clinical diagnosis: None given
Clinical history: None given
Previous Smears: Unknown

Specimen type: Liquid based
Specimen source: Cervical, Endocervical
Specimen Adequacy: Smear is satisfactory for evaluation

Comment: The Thin Prep Imaging System from Hologic, Inc. was used to pre-screen this Pap smear. Primary screening reported Pap abnormalities. Pathologist review was required to interpret the primary screener review.

Pap screening performed by: Breakthrough Cytology Services, 527 Joanne Lane, Dekalb, IL 60115.
Interpretation required by undersigned pathologist at Orchard Pathology Laboratories, 701 Congressional Blvd, Carmel, IN 46032.

09/16/2013
Cy Totech, CT, ASCP

09/16/2013 Authenticated by:

John Doctor
John Doctor, MD
Electronically signed: 06/14/2013 02:31

Case number: P07-6824
END OF REPORT (Final)
DERMATOPATHOLOGY REPORT

FINAL DIAGNOSIS

1) SKIN, RIGHT ANTERIOR MEDIAL SHOULDER, EXCISION:
   -INVASIVE MALIGNANT MELANOMA, NODULAR TYPE WITH ULCERATION, BRESLOW’S
   DEPTH 7 MM, CLARK’S LEVEL IV, MARGINS NARROWLY CLEAR (SEE MELANOMA SUMMARY AND
   COMMENT).

GROSS EXAMINATION
SKIN, RIGHT ANTERIOR MEDIAL SHOULDER: Labeled “right ant med shoulder” is a 2.6 x 2.0 cm ovoid gray-tan irregular
skin excised to a depth of 0.8 cm. The skin surface displays an eccentric 1.5 x 1.4 cm white-tan to dark brown nodule. No orienta-
tion provided. Inked, sectioned. ES (4) as follows:

1A:   Tips
1B-ID: Remainder of Specimen

Specimen: Right shoulder

MELANOMA CANCER SUMMARY

| [MACROSCOPIC]                      |                  |
| SPECIMEN TYPE:                    |                  |
| MACROSCOPIC TUMOR:                |                  |
| TUMOR SITE:                       |                  |
| LESION SIZE:                      |                  |
| SATELLITE NODULES:                |                  |
| [MICROSCOPIC]                     |                  |
| HISTOLOGIC TYPE:                  |                  |
| ULCERATION:                       |                  |
| DEPTH OF INVATION/BRESLOW’S DEPTH:|                  |
| CLARK’S LEVEL:                    |                  |
| GROWTH PHASE:                     |                  |
| REGRESSION:                       |                  |
| MITOTIC INDEX:                    |                  |
| ANGIOLYMPHATIC INVASION:          |                  |
| NEUROTROPISM:                     |                  |
| TUMOR INFILTRATING LYMPHOCYTES:  |                  |
| MICROSCOPIC SATELLITES:           |                  |
| MARGINS:                          |                  |
| LYMPH NODES:                      |                  |
| PATHOLOGIC STAGING (PTNM)         |                  |

Excision, ellipse
Present
Right anterior medial shoulder
1.5 x 1.4 cm in greatest dimension
Absent
Nodular melanoma
Present
7mm
IV
Vertical
Absent
High (Greater than 20 mitotic figures per mm squared)
Absent
Absent
Present (non-brisk)
Not present in tissue submitted
Invasive melanoma within 2 mm of peripheral margin
Not submitted
pT4b, pNX, pMX
IMMUNOHISTOCHEMISTRY

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>HMB45</td>
<td>Positive</td>
</tr>
<tr>
<td>S100</td>
<td>Positive</td>
</tr>
<tr>
<td>MELANA</td>
<td>Positive</td>
</tr>
</tbody>
</table>

John Pathologist

John Pathologist, M.D.
Board Certified in Anatomic and Clinical Pathology
Authenticated by Pathologist: 09/16/2013 10:31

Case number: S07-6825/2
END OF REPORT (Preliminary)