ARTHUR PURDY STOUT SOCIETY
OF
SURGICAL PATHOLOGISTS

ANNUAL SLIDE SEMINAR

LESIONS OF THE MEDIASTINUM & LUNG

1977

Dominion Ballroom South, Sheraton Centre
Toronto, Ontario
Business Meeting - 12 Noon
Slide Seminar - 2-6 P.M.

Tuesday, March 15, 1977

(Please bring to meeting.)

CASE #1 (76-5784)
Gerald D. Levine, M.D.

History

Patient was 30 years-old at time of presentation on April 30, 1976. She had experienced chest and back pain for one month and shortly before admission developed a non-productive cough and gradual onset of dyspnea. A chest x-ray in November 1975 was interpreted as normal. X-ray in April 1976 revealed a very large anterior mediastinal mass with left main stem bronchial narrowing. Physical examination revealed no lymphadenopathy or hepato-splenomegaly. A mediastinoscopy was performed and diagnostic tissue obtained. 4,576 rads were given to the mediastinum and this resulted in marked shrinkage of the mediastinal mass.

Diagnosis: Histiocytic lymphoma with sclerosis —

Contributor's Diagnosis: Histiocytic lymphoma
(Levine)

Discussants' Diagnoses:

A. Byrne = absent —

B. Abell = absent —

Isaacson = Flymphoma

CASE #2

Frederick Kraus, M.D.

History

A 51 year old woman was admitted for diagnosis and treatment of mediastinal mass and rounded density in lower lobe of left lung. Occupation: beautician.

Past history: Rheumatoid arthritis (hands, shoulders, neck, knees) with response to prednisone, 10mgm on alternate days for 15 years. Sjogren's syndrome moderate-mild - 5 years. Hysterectomy for leiomyomas - 3 years PTA. A heavy smoker with severe chronic bronchitis and emphysema, she also had many gastrointestinal symptoms thought to represent peptic ulcer and irritable colon syndrome. Other medications: Probanthine, Bellergal, Butisol, Valium, Darvon, Premarin. Abnormal laboratory findings: include Rheumatoid factor 1:160,000, ANA 1:1024. Serologic testing for toxoplasma, histoplasma and microsomal antibodies: within normal limits. After scalene lymph node biopsy the mediastinal mass (wt. 83 gm) and the intrapulmonary mass (1.6 cm diameter) were resected.

The seminar slide is from the mediastinal mass; the scalene lymph node (3.1 cm diameter) had the same pattern. Current status of patient (Jan., 1977, 10 mo. post-op): Alive, in her usual state of compensated chronic ill-health.

Diagnosis: M. lymphocytic, intermediate, with plasmacytoid diff

Contributor's Diagnosis: Reactive lymphadenopathy
(Kraus)

Discussants' Diagnoses:

A. Cervical = ? reactive (pseudolymphoma)
lymphoid infiltrate -

B. Rappaport = absent -

CASE #3

James M Woodruff, M.D.

History

This 45-year-old man was found at autopsy to have a multifocal tan-white rubbery tumor which involved the anterior mediastinal soft tissues, anterior and apical epicardium of the heart, right and left visceral pleurae, and the left hemidiaphragm. Other relevant findings included a systemic cytomegaloviral infection and necrotizing pneumonitis due to Aspergillus. A diagnosis of myasthenia gravis had been made seven years earlier.

Diagnosis: Malignant lymphoma

Contributor's Diagnosis: Malignant lymphoma

Discussants' Diagnoses:

A. Joachim = Malignant lymphoma

B. Rosai = Malignant lymphoma

CASE #4

Saul Kay, M.D.

History

The case concerns a 60-year-old white man who was admitted to the hospital for evaluation of a mass in the left lung and persistent temperature elevation to 103°, generalized weakness, weight loss and cachexia. He also had edema of both lower extremities which was unexplained. The patient was explored with removal of a rib exposing the mass just within the pleural space. The mass was slightly encapsulated and rubbery in consistency. Dissection was carried out in order to totally remove the entire mass which did not seem to invade the lung parenchyma at all but seemed to be encapsulated in the fissure planes and in the pleural space adjacent to the lung tissue.

Diagnosis: [redacted] Mal. Histiocytoma

Contributor's Diagnosis: Inflammatory histiocytoma (Kay)

Discussants' Diagnoses:

A. Fine = itishiocytoma

B. Lattes = Histiocytoma

CASE #5

Richard B. Marshall, M.D.

History

A two and one half year-old male had acute onset of chest pain on 7/2/76, with a diagnosis of pneumonia. This was treated with clinical response; however, persistant left upper lobe atalectasis was seen on chest x-ray. Bronchoscopy one month later failed to demonstrate obstruction or a foreign body. The biopsy was interpreted as chronic bronchitis. The bronchoscopist noted an apparently extrinsic pulsatile mass beyond the scope. At surgery, a 7.8 x 4.5 x 2.5 cm mass with a central small cyst was resected with the surrounding thymus.

Diagnosis: Benign teratoma

Contributor's Diagnosis: Benign teratoma (Marshall)

Discussants' Diagnoses:

A. [redacted] Abell = absent -

B. Eggleston = Benign teratoma

CASE #6

Dale Bennett, M.D.

History

This 38-year-old male was in good health until two weeks prior to admission when he noted the onset of chest pain. Chest x-rays showed a large anterior mediastinal mass extending into the left upper lung field. The mass on tomograms showed no calcification. Physical examination was unremarkable as was bronchoscopy. At thoracotomy, a partially encapsulated 140 Gm., 11 cm. tumor was removed from the anterior mediastinum. This tumor was soft with a fish-flesh consistency and showed focal areas of necrosis and hemorrhage.

Diagnosis:

Contributor's Diagnosis: (Bennett) Primitive germ cell tumor — embryonal ca with areas of anaplastic seminoma

Discussants' Diagnoses:

A. Silverberg = Agree

B. Leggs = Embryonal carcinoma

CASE #7

Artemis Nash, M.D.

History

A 51 year-old man was referred for evaluation of an anterior mediastinum mass noted on a chest x-ray taken as part of a routine medical check-up. A chest film taken a year previously had been reported as normal. The patient had occasional twinges of pain in the left presternal area, unrelated to activity or position, but was otherwise well and free of any other symptoms. He smoked 20 cigarettes daily.

Physical examination revealed a robust male with a BP of 150/90 and was otherwise within normal limits. At exploration a 10 x 7 x 6 cm. encapsulated firm mass was found in the anterior mediastinum, attached to thymic remnant and extending laterally to the superior vena cava.

Diagnosis:

Contributor's Diagnosis: Neuroblastoma (Nash)

Discussants' Diagnoses:

A. Assoc = Agree

B. Fine = Agree

CASE #8

William H. Hartmann, M.D.
George Kandzie, M.D.
Matthew C. Patterson, M.D.

History

This is a posterior mediastinal mass from a 48-year-old man who presented with ulnar paresthesias of the right arm of some weeks duration. A chest x-ray revealed a 4.5 cm mass projecting just below the level of the right hilus (this and other x-rays will be shown). A 4.5 cm, well-circumscribed, gray-white mass was resected from the right, posterior chest wall. The tumor was highly vascular and the parenchyma was gelatinous, cystic and red-purple. Sections submitted are from the mass.

Diagnosis: Paraganglioma

Contributor's Diagnosis: ganglioneuroma
(Hartmann)

Discussants' Diagnoses:

A. Lieberman = Hemangioblastoma

B. Enzinger = Paraganglioma - the round epithelial-like cells in typical glomus jugulare tumors and aortic body tumors -

TO: Members Participating in the March 15th Program of the Arthur Purdy Stout Society of Surgical Pathologists

FROM: William H. Hartmann, M.D.
Secretary

As you know, our March 15th Program will deal with diseases of the mediastinum. Drs. Rosai and Eggleston's lectures will be followed by a Slide Seminar on Tumors of the Mediastinum. Eight cases have been selected by Dr. Azorides R. Morales from those submitted to him during the last six to eight months. In order to encourage a more lively participation from the audience, following the contributor's presentation, two additional members of the Society are being asked to comment on each case. Contributors will be alloted a maximum of twelve minutes for their presentations and two minutes each to discussants #2 and #3.

I am distributing the enclosed list of cases only to the members whose cases have been selected and those members who are being invited to participate in the discussion. Those of you who are unwilling or unable to participate, please communicate promptly with Dr. Morales in order to find a suitable substitute as soon as possible. Contributors are also asked by means of this memo to prepare 130 slides, label them according to the number shown on the attached list, and to mail them to me with a brief clinical summary. I would appreciate receiving this material by the last week of January, so as to be able to distribute the cases to the entire membership of the Society by the first week of February.

CASE NUMBER	CONTRIBUTOR'S DIAGNOSIS	CONTRIBUTOR & DISCUSSANT #1	DISCUSSANT #2	DISCUSSANT #3
1 (76-5784)	Lymphoma	Levine	Byrne	Abell
2 (76-2646	Rheumatoid adenopathy	Kraus	Levine	Rappaport
3 (76-15373)	Thymoma	Woodruff	Ioachim	Rosai
4 (76-3046)	Inflammatory histiocytoma	Kay	Fine	Lattes
5 (8723)	Benign teratoma	Marshall	Abell	Eggleston
6 (10932-76)	Embryonal carcinoma with seminomatous elements	Bennett	Silverberg	Legg
7 (66-4987)	Neuroblastoma	Nash	Assor	Fine
8 (76-8475)	Ganglioneuroma	Hartmann	Lieberman	Enzinger

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DIAGNOSES

	Contributor's Diagnosis	Discussants' Diagnoses
Case #1	Histiocytic lymphoma	
Case #2	Reactive adenopathy	Lymphoid infiltrate (wait & see)
Case #3	Malignant thymoma	a) Malignant thymoma b) Malignant thymoma
Case #4	Inflammatory fibrous histiocytoma	a) Histiocytoma b) Malignant xanthogranuloma (fibrous histiocytoma)
Case #5	Adult teratoma	Adult teratoma
Case #6	Embryonal carcinoma with anaplastic seminoma	a) Agree b) Agree but no seminoma
Case #7	Differentiated neuroblastoma	Agree
Case #8	Ganglioneuroma	a) Benign vascular tumor resembling a capillary hemangioblastoma b) Paraganglioma