SEMINAR

SOFT TISSUE TUMORS

Moderated by

Juan Rosai, M.D.
Professor and Director
Anatomic Pathology
University of Minnesota
Minneapolis, Minnesota

April 16, 1977
2:00 - 5:00 P.M.

At a Meeting of
The Wisconsin Society of Pathologists, Inc.

held at
MECCA Convention Center
Milwaukee, Wisconsin
This 18 year old girl had been aware of some pain and discomfort on the lateral aspect of her left thigh for several years. There was no recollection of what may have started this pain. There was no known injury or fall. About a year before her hospitalization, her pain and discomfort increased with dancing and increased activity. The area involved was the outer aspect of the left thigh just below the greater trochanter. About four months prior to admission, a small swelling was noted. The x-rays of the extremity were not available. The consultant's report described an ill-defined soft tissue swelling with some speckling in the tissues, indicative of calcification. There was no bone involvement. Pelvis and chest x-rays were negative. The mass was excised. It was oval, encapsulated, lobular and creamy tan to light red with vascular markings. Lab Data - normal.

The history is that of a 39 year old white male school teacher who first noticed a tumor beneath the left eye in January of 1976. In November of 1976 the lesion was estimated to measure 0.75 cm in diameter. At the time of excision, in December 1976, it measured 1 cm in diameter. The lesion was located beneath the orbicularis oculi muscle and was described by the surgeon as being attached to the periosteum. There has been no evidence of recurrence to the present date.
This 80 year old white male had a lesion excised from the right lower extremity with subsequent skin grafting in May 1974. He again underwent surgery in September 1975, with wide excision and split thickness skin grafting. Tumor was found at the margins and he underwent chemosurgical excision in October 1975. Since then he has had recurrence of his tumor and now enters for further treatment. Pertinent physical findings: This is a well-developed, well-nourished male who appears younger than his stated age and is in no acute distress. Examination of the lower extremity reveals a well-healed donor site on the left thigh and a healed split-thickness skin graft on the distal aspect of the right gastrocnemius. There is a large skin defect in this area which is covered by a well-healed graft. The contour of the calf is somewhat distorted. There is a firm mass in this area which does not appear to be adherent to the underlying bony structures. Because of several recurrences, an above-knee amputation was recommended. However, the patient preferred to risk a below-knee amputation which was performed. The patient is also on estrogen Rx for an adenocarcinoma of prostate.

This 80 year old white male underwent excision of a right upper lateral chest wall mass in May 1976. His past medical history includes chronic obstructive pulmonary disease and status several years post thoracotomy (histoplasmosis). Three months after excision the tumor recurred and at that time he underwent wide excision of the chest wall tumor. Radiotherapy was then recommended, however, the patient decided to postpone treatment. He expired in December 1976. (No autopsy was done.)
A 25 year old Negro male with large subcutaneous masses measuring 2 x 3 cm in the left inferior aspect of the scrotum, 2 x 1 cm just inferior to the umbilicus slightly to the right of midline, and 3 x 2 cm on the left flank approximately 6 cm inferior to the posterior axillary line. At surgery, the masses were firm and fairly adherent to underlying tissues.

This is a 23 year old white female who first noted a mass in the left upper arm over the area of the triceps muscle in late 1973. It gradually increased in size and was somewhat tender. She underwent local excision on 5/74 in another hospital with a final report of pleomorphic fibroma with areas of sarcomatous degeneration. Her course was uneventful until April of 1975, when she noted recurrent nodularity in the scar. This also had gradually increased in size and was re-excised on 7/2/75. The patient had a left thoracotomy at age 9 for apparent empyema following pneumonia. Laboratory studies showed HGB, 14; HCT, 42; WBC, 7,600; Platelets 7,000. Urinalysis was negative. Chest x-ray was clear.
A 68 year old female admitted for diarrhea. On physical examination a grapefruit sized mass was present on left lower thigh, clinically thought to be lipoma. By history, however, it was present only six months and had grown steadily in size. The lesion was resected.

A large lung tumor from a man who is 66 years old. The first manifestation of this tumor was a subcutaneous osseous producing malignant tumor located in the tissues of the upper arm. No other tumor was present in any of his bones.

A 22 year old male who noted discomfort in Achilles tendon for approximately two years. A nodule was noted on exam and was resected.
R.B. Hilar or mediastinal mass. This 25 year old male was seen by his physician for chest pain. Chest x-ray revealed a left hilar infiltrated. There was no improvement with antibiotic therapy.

Lab Data: WBC - 9,800  Hb - 16.1 gm crit 48.7%
Seg. 56 Lymph 29 Mono 6 Eos. 4 Stab 5
Sed. rate 31 mm.
Skin test neg. for PPD - Blasto, Coccidio- histoplasmosis
SMA- LDH - slightly elevated
Cultures of sputum - normal flora  Acid fast- neg.
Fungus cultures- neg.
Cytology studies - neg.

Chest x-ray showed enlargement of the mass which appeared within the anterior segment of the left upper lobe. It was well defined and measured 6 cm in diameter. A thoracotomy was done.

This 21 year old male had acute abdominal pain. Flat plate of the abdomen and IVP revealed a mass. Two months previously, a left inguinal herniorrhaphy was performed. Left lower quadrant pain was present prior to the herniorrhaphy. GI, gallbladder and IVP x-rays were negative. The pain was more intense in the upright position than lying down. The SMA was normal. The patient was explored. A large retroperitoneal mass was present on the left side. The mass was removed, including spleen, left kidney, adrenal (L), tail of pancreas.

This 49 year old woman had been seen in consultation for her vascular problem (thrombophlebitis of the right leg). Examination revealed a swelling in the right posterior thigh. Angiograms and excisional biopsy was done. The area involved was indurated, tender, and there was brawny discoloration of the skin. The peripheral arterial pulses were good. Lab Data: WBC - 6,100  Seg. 59% Lymph 39 Mono 3%
Hb - 13.9 gm. crit - 40.5%
SMA - normal
CASE 1: SOFT TISSUE, THIGH - SYNOVIAL SARCOMA


CASE 2: SOFT TISSUE, INFRAORBITAL REGION - REACTIVE FIBROBLASTIC PROLIFERATION (CONSISTENT WITH NODULAR FASCIITIS)


CASE 3: SOFT TISSUE, LEG - PLEOMORPHIC SARCOMA (CONSISTENT WITH MALIGNANT FIBROUS HISTIOCYTOMA, MYXOID VARIANT)

See under Case 4.
CASE 4 - SOFT TISSUE, CHEST WALL - MALIGNANT FIBROUS HISTIOCYTOMA


CASE 5 - SOFT TISSUE (SCROTUM, ABDOMINAL WALL AND FLANK) - GRANULAR CELL TUMORS (MULTIPLE)


CASE 6 - SOFT TISSUE, ARM - MUSCULOAPONEUROTIC FIBROMATOSIS (EXTRA-ABDOMINAL DESMOID)


CASE 7 - SOFT TISSUE, THIGH - MALIGNANT FIBROUS HISTIOCYTOMA


CASE 8 - SOFT TISSUE, ARM - EXTRASKELETAL OSTEOSARCOMA


CASE 9 - SOFT TISSUE, ANKLE - SARCOMA (CONSISTENT WITH MONOPHASIC SYNOVIAL SARCOMA)


CASE 10 - MEDIASTINUM - GERMINOMA (SEMINOMA)


CASE 11 - SOFT TISSUE, RETROPERITONEUM - LIPOSARCOMA, MYXOID


CASE 12 - SOFT TISSUE, THIGH - LIPOSARCOMA, MYXOID

Mass from the left thigh 18 year old female

**#1.** The specimen consists of an oval encapsulated lobular mass, creamy tan to light red with vascular markings along the periphery. The cut surface is creamy tan with focal gray and yellow tan areas. The specimen weighs 34 grams and measures 4.6 x 3.8 x 3.0 cm. The tissue is firm, resilient and cuts with uniform resistance.

**#2.** The specimen consists of lobulated blood stain masses measuring 8.6 x 5 x 2 cm. It is soft, moist and yellow tan on the cut surface. There is a dark red membranous area that is gritty and bony in consistency at the periphery.

**Diagnosis**  
1. Synovial cell sarcoma  
2. Tumor with foci of ossification.
February 18, 1977

Robert F. Lipo, M.D.
Director of Laboratories
Family Hospital
2711 W. Wells Street
Milwaukee, Wisconsin 53208

Dear Bob:

Enclosed are the unstained slides of the case submitted for the WSP seminar (F 27597-76).

The history is that of a 39 year old white male schoolteacher who first noticed a tumor beneath the left eye in January of 1976. In November of 1976 the lesion was estimated to measure 0.75 cm. in diameter. At the time of excision in December 1976 it measures 1 cm. in diameter. The lesion was located beneath the orbicularis oculi muscle and was described by the surgeon as being attached to the periosteum. There has been no evidence of recurrence to the present date.

Sincerely,

William J. Pier, Jr., M.D.
WJP:m

Muscle from amputation level - Frozen Section

Right leg

Recurrent pleomorphic fibrous histiocytoma.

Prem. surg.: VS75-1475, C-590, VS75-1654

Proximal margins appear to be free of tumor.

Diagnosis: No evidence of malignancy at muscle margin.

Frozen Section: Gross: A 2.3x1.4x0.5 cm, red-brown muscle with attached fascia or tendon. Section taken at margin of attachment.

Diagnosis: No evidence of malignancy at muscle margin.

Frozen Section: Gross: A 2.3x1.4x0.5 cm, red-brown muscle with attached fascia or tendon. Section taken at margin of attachment.

Diagnosis: No evidence of malignancy at muscle margin.

Gross Description:

- See Frozen Section description (1 piece, all tissue used). AA - Remainder.
- Specimen is a right leg amputated below the knee. The foot measures 24 cm from the heel to the great toe and the leg measures 35 cm from the heel to the proximal surgical margin across the tibia and fibula. On the lower right aspect of the calf above the malleolus there is an extensive area of induration and scarring with an 11 cm, approximately oval site of skin grafting. There is a 3 cm incision scar in

(Continue on reverse side)
the first metatarsal space. On incising the leg over the lateral aspect and extending the excision into the foot, there is a fairly well demarcated multilobulated tumor mass lying in the muscle planes between fascial sheaths. Overall this lobulated tumor mass measures 15x6 cm at its greatest axes. The attachment to the fascial planes is fairly loose and much of the tumor can be shelled out, particularly in the upper portion although there are direct attachments along blood vessels into the muscle and attachments to the muscle. The lobulated tumor masses measure respectively 6, 5.5 and 4 cm. On incising into these, the two lower masses are firm, gray-white and the upper is hemorrhagic and yellowish gray. There is an indentation on the posterolateral border of the fibula at a point 9 cm above the head of the fibula. There is no direct tumor attachment to bone. The muscle close to the proximal surgical margin and the vessels on this plane are free of visible tumor. Elsewhere in the lower part of the leg, there is extensive fibrosis and scarring involving the subcutaneous fat with attachments to the interosseous membrane. The fibula, the complete tumor, the proximal muscles and the area of skin scarring are removed from the remainder of the specimen and these are fixed for later processing. Sections:


Microscopic Description:

1 and A1 - Sections of muscle at proximal margin in which there is focal mild atrophy. No evidence of malignancy.

1 - Two skin sections are examined. In one there is dermal and subcutaneous fibrous reaction with no evidence of malignancy. In the other the grafted skin is hyperkeratotic with complete loss of appendages. There is neovascularity in the upper dermis. In the underlying subcutis there is a large tumor mass made up of loosely-arranged fibroblastic and myxomatous cells. The tumor is infiltrative. At its margins, there are 1-3 mitoses/HPF. B2 - Similar tumor of variable cellularity with fibrosarcomatous and myxosarcomatous areas. There are many blood vessels with cellular proliferations adjacent to the wall, including plasma cells. Tumor giant cells are scattered through the neoplasm. The tumor is invasive at its margins. B3 - Sections of a cellular fibrosarcoma directly invading striated muscle. B4 - Sections contain a large elastic artery with medial calcification as well as two large veins, surrounding nerves, connective tissue and smaller vessels. There is no evidence of malignancy in these sections. B5 - Section of cortical and cancellous bone. There is no evidence of any bony invasion with tumor and the surrounding connective tissue and muscle also appear free of tumor.
## CLINICAL RECORD

### TISSUE EXAMINATION

<table>
<thead>
<tr>
<th>SPECIMEN SUBMITTED BY</th>
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<tr>
<td>Dr. Kotynek</td>
<td>5/19/76</td>
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<tr>
<th>SPECIMEN</th>
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<tr>
<td>A - Right chest wall tumor - Frozen Section</td>
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<td>B - Right chest wall tumor</td>
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### BRIEF CLINICAL HISTORY

- Include duration of lesion and rapidity of growth, if a neoplasm
- Right thoracotomy 1961 for histoplasmosis.

### PREOPERATIVE DIAGNOSIS

### OPERATIVE FINDINGS

### POSTOPERATIVE DIAGNOSIS

### SIGNATURE AND TITLE

J.G. Kotynek, M.D.

### PATHOLOGICAL REPORT

<table>
<thead>
<tr>
<th>NAME OF LABORATORY</th>
<th>ACCESSION NO(S).</th>
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<td>VS76-937</td>
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**DIAGNOSIS:** Malignant mesenchymal tumor, right chest wall (possible malignant fibrous histiocytoma).

**NOTE:** No cross striations are evident; there is negligible collagen production. Possible origin of tumor would include nerve sheath and fascial tissue. Material will be submitted to the AFIP for opinion.

**Frozen Section:** Gross: Tissue consists of a 2x1x1 cm, gray, firm nodule.

**Diagnosis:** Malignant tumor probably sarcoma; suggest muscle or nerve origin.

**Gross Description:**

- A - See Frozen Section description (1 section taken).
- B - Specimen consists of two pieces of tissue, the larger measuring 2.5x2x3.5 cm and having a cut surface. The tissue feels firm and on cutting, it is gray-white. The smaller piece measures 2.8x1.5x1 cm and is firm and gray. Two sections from the larger and one piece from the smaller taken.

**Microscopic Description:**

- A and B - Sections consist of nodule with a definite capsule. It is made up of

**SIGNATURE OF PATHOLOGIST:** J.H. Turner, M.D., Asst Chief, Laboratory Service

**DATE:** 5/24/76

### PATIENT'S IDENTIFICATION

- For typed or written entries give: Name—last, first, middle; grade, date, hospital or medical facility
- Need 12/13/76

- VAH, Madison, Wisconsin
spindle-shaped cells which are arranged in a bizarre pattern and few whorls seen. Nuclei are very bizarre with multinucleation and hyperchromatism. Mitoses are abundant. Few lymphocytes and slit-like spaces are present. Tumor blood vessels, thin walled and lined by non-proliferative endothelium.
CONSULTATION REPORT ON CONTRIBUTOR MATERIAL

AFIP DIAGNOSIS:  Malignant fibrous histiocytoma, chest wall.

The staff agrees with your diagnosis in this case. This is indicated by the cellular morphology, prominent storiform pattern, multinucleated giant cells and atypical xanthoma cells. Tumors of this type frequently recur if not widely excised and in our experience approximately thirty to forty percent developed metastases.

Follow-up information would be appreciated.

JAMES L. HANSEN, M.D.
Colonel, MC, USA
The Director

Examing and Reporting Pathologist:

F. M. EHZINGER, M.D./JLK
CLINICAL RECORD

Tissue Examination

SPECIMEN SUBMITTED BY
Dr. Manly

DATE OBTAINED
4/30/76

SPECIMEN

A - Left scrotal subcutaneous mass (FS)
B - Nodule near margin (FS)
C - Sebaceous cyst of back

BRIEF CLINICAL HISTORY (Include duration of lesion and rapidity of growth, if a neoplasm)
Has been present for four years.

REOPERATIVE DIAGNOSIS
Sebaceous cyst?

OPERATIVE FINDINGS

PATHOLOGICAL REPORT

NAME OF LABORATORY

ACCESSION NO(S).

R. J. MANLY, M.D.

Gross description, Metabolic examination and diagnosis)

DIAGNOSES: Granular cell myoblastomas, multiple, scrotum x2, back x1. 216, 215

Frozen Section: Gross: A - Nodular mass 1.7x1.2x1.5 cm with yellowish white cut surface which is firm (1 central section).
B - Specimen consists of a 1.5x2x1 cm, soft to firm nodule. Cut surface is yellowish white.

Diagnoses: A - Granular cell myoblastoma. (Dr. Turner)
B - Granular cell tumor extending to near the margin--suggest further removal of adjacent tissue. (Dr. Bloodworth)

Gross Description:
(Continue on reverse side)

Microscopic Description:
A - Connective tissue nodule surrounded by fat, vessels, nerve and cremaster muscle. The nodule consists of poorly defined fibrous tissue with strands and collections of large cells with small nuclei and prominent, slightly basophilic granules.

SIGNATURE OF PATHOLOGIST
J. H. TURNER, M.D., Asst Chief, Laboratory Service

DATE
5/4/76

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; date; hospital or medical facility)

DOB 8/5/51
VAH, Madison, Wisconsin

Tissue Examination
Standard Form 515

GENERAL SERVICES ADMINISTRATION AND
INTERAGENCY COMMITTEE ON MEDICAL RECORDS
EFRR 101-11-656-8
OCTOBER 1975
315-107
cyologic evidence of malignancy. There are a few foci of lymphocytes. Excision appears to be incomplete.

- Similar, rather poorly-defined tumor which appears to be subcutaneous and just deep to dermal sweat glands. The lesion extends close to surgical margins.

- Similar subcutaneous tumor which appears to be completely excised.
PATHOLOGICAL FINDINGS:

The specimen is composed of skin together with its underlying subcutaneous tissue and skeletal muscle. It has a somewhat rectangular shape and measures 13 x 8.5 x 3 cm. It shows a well-healed scar on the surface which measures 7.8 cm. in length. There are two masses which are firm and poorly circumscribed. These are seen in the subcutaneous tissue and extends into the underlying muscle. These masses have pinkish tan cut surfaces and a somewhat lobular appearance. These nodules are connected with each other with rather dense tan-pink, somewhat indurated tissue. The masses measure 3 x 2 x 1.5 and 4 x 3 x 2 cm. The margins and base of the specimen show grossly normal tissue. From one end of resection the margin is approximately .8 cm. from the tumor. The base shows a .7 cm. of muscle and fascia that appears to be grossly normal. Sections of the bases are labelled "A". Sections of the margins are labelled "B". 

7/3/75 - 7/5/75

Microscopic (AD): Micro sections of the nodules alluded to grossly, reveal these to consist of spindle cells that are seen to invade the subcutaneous tissue, as well as the deeper skeletal muscle bundles. The spindle cells are arranged in haphazard fashion in some areas, while in others they are seen in fascicles or bundles. The different areas vary in cellularity with some being more cellular while others a more collagenous appearance predominates. The cells have nuclei that vary from oval to short-spindled with tapered ends. The cells have fibrillar cytoplasmic extensions that merges in many areas with abundant collagenous tissue. Islands of skeletal muscle fibers are entrapped by the proliferating lesion in some areas. There are scattered capillaries and rare clusters of round cells encountered. Mitotic figures are very rare. Margins are adequate. 

Diagnosis:

Aggressive fibromatosis involving subcutaneous tissue and skeletal muscle

7/7/75 - 7/7/75
The specimen comes in two parts, one of which is a markedly irregular shaped oval mass of soft tissues measuring 3.0 x 2.8 x 2.0 cm. On section, the specimen consists of mottled grey hemorrhagic violet and pale yellow non-descript mass of tissue which appears to be focally necrotic. Representative sections of this mass are submitted. Accompanying this mass of tissue there is a larger mass of tissue measuring 5.0 x 5.0 x 1.5 cm. The majority of the specimen appears to consist of skeletal muscle but at one point there is a rather discrete homogenous firm grey opaque mass measuring 3.0 x 1.6 x 1.4 cm. Representative sections of the opaque white tissue will be submitted.

Microscopic examination:

Microscopic sections through the tumor masses are remarkable in that there are the distinct but probably related histologic appearances one of which that is the discrete homogenous white nodule tissue consists of spindle shaped cells with elongate oval rounded nuclei which are markedly anaplastic and pleomorphic with marked hyperchromatism with irregular membranes, densely clumped and irregularly distributed chromatin and brilliant large pink and often multiple nucleoli. The other pattern is far more disorganized consisting of such larger cells many of which are multinucleate all of which are very irregular in outline. The nuclei however are quite comparable to those described above in the spindle shaped portion of the tumor. Associated with these large giant cells which are multinucleate in character is a small amount of fibrillar intracellular substance which appears to be more collagenous in nature than osteoid. Associated with the multinucleate cells are numerous uninucleate cells which are also strikingly malignant. Distributed in large numbers throughout both forms of the tumor there are numerous mitotic figures many of which are quite atypical in configuration. The margins of the tumor extend to the borders of the resected tissues and seem to infiltrate the surrounding more normal muscular tissues in a rather diffuse and random fashion.

Diagnosis: Giant cell sarcoma of probable fascial origin. See consultation from Armed Forces Institute of Pathology dated 4.15.70.

LJC/nms

PATHOLOGICAL REPORT

DOCTORS HOSPITAL
WAUKEE, WISCONSIN
705-18

PATHOLOGICAL REPORT
Department of Pathology
January 25, 1977

Dr. Robert Lipo
Family Hospital
2711 West Wells Street
Milwaukee, Wisconsin 53208

Dear Dr. Lipo:

In response to your request for soft tissue tumors, I am submitting a slide from a large lung tumor from a man who is 66-years-old. The first manifestation of this tumor was a subcutaneous osseous producing malignant tumor located in the tissues of the upper arm. No other tumor was present in any of his bones. The metastatic lesion in the arm contained considerable more osteoid and sections of this lesion would be available from the Fort Atkinson Hospital.

We have some gross pictures, x-rays, etc. of this case if you are interested.

Sincerely,

[Signature]
Donald J. Stevenson, M.D.
Associate Pathologist

Enclosure
January 17, 1977

Robert Lipo, M.D.
Family Hospital
West Wells at North 28th Street
Milwaukee, WI 53208

Dear Bob:

This is a case that you may wish to consider for Dr. Rosai's soft tissue seminar.

If you need any more cases, please let us know.

Warmest regards . . .

Sincerely,

Enid Gilbert, M.D.
Director, Surgical Pathology

EG: cj

Dr. Enid Gilbert, Univ. of Wisconsin, Madison
22 y/o male who noted discomfort to appear 2 yrs. A module was noted on exam and was resected
REPORT

GROSS: Three previous frozen sections have been performed and have been read and interpreted as follows; "F-1" - biopsy of mass of right Achilles tendon, sarcoma favor clear cell sarcoma NOTE: We cannot exclude synovial sarcoma, "F-2" - 7 cm. piece of tendon with a 2 cm. brownish lesion 1.5 cm. away from the proximal margin, no evidence of malignancy, "F-3" - Achilles tendon sheet, no evidence of malignancy.

The specimen consists of a 7 cm. piece of tendon with grayish, soft to firm, 2 cm. nodule which is 1.5 cm. away from one margin and 3.5 cm. away from the other margin. There is a piece of muscle attached to the tendon.

One section of the lesion and another from the lower margin is labeled "X".

A photograph of the specimen has been taken. (Dictated by Dr. Chandrashekar Padmalatha) ss

MICROSCOPIC: Sections consist of a tendon which has a tumor composed of compact nests and fascicles of spindle-shaped cells with pale-staining eosinophilic cytoplasm. Cell borders are not prominent with a centrally placed vesicular nucleus with prominent nucleoli. Cells appear uniform. Mitoses are rare. The stroma consists of thin connective tissue.

PAS stains reveal a borderline positivity. Reticulin stains the intervening trabeculae, but do not stain the individual tumor cells. Resected margins are free of malignancy.

DIAGNOSIS: Clear cell sarcoma of the Achilles tendon.

REFERENCE: Cancer, Volume 18, No. 9, September, 1965.
A portion of tissue was fixed in glutaraldehyde and further processed for electron microscopy. Sections contain polyhedral cells which frequently abut on a basement membrane. The nuclei are irregularly spindle-shaped. Nucleoli are large and dense. The cytoplasm contains abundant polysomes. Golgi vesicles and mitochondria are present. The cells occasionally surround intercellular clefts. Intercellular attachments or pigmented granules were not observed.

The ultrastructural features of these cells are similar to those reported for clear cell sarcoma of tendon. The features are also similar to glandular component of synovial cell sarcoma and suggest a similar origin of the two tumors.

Clear cell sarcoma of tendon.


Bearman et al, Cancer 36, 977, 1975.
Specimen consists of the left lung with pericardium adherent to the medial surface.

There is a dark red/hemorrhagic area in the upper lobe firm.

On the cut surface, the mass measures 7 x 6 cm, it is creamy white, necrotic and involves the medial portion of the upper lobe. The mass is extrinsic to the lung and surrounded by fibrous tissue. A small/nodule, measuring 1.4 cm. is in the thickened pleura. White

There is no communication between tumor and bronchi.

Diagnosis: Seminoma

CHEST: In the interval of 11 days since our previous examination there has been progression of the previously described mass in the left lung which appears not to arise from the hilum, but rather to be contained anteriorly within the anterior segment of the left upper lobe. At present it measures approximately 6 cm. in diameter and appears to be well defined.

In the absence of inflammatory signs one had to suspect the possibility of tumor with hemorrhage to account for the rapid growth.

TOMOGRAPHY OF LEFT LUNG: Tomograms of the left/lung reveal to our advantage the above described mass lesion which appears to be well defined and bosselated. The patient underwent fluoroscopy of the area which revealed that a fleck of calcifications laterally and inferiorly. Pulsations were identified but whether these were transmitted pulsations or intrinsic ones could not be elucidated by fluoroscopy.

The possibility that this could be a vascular mass a pulmonary angiogram has been suggested.
S 1866-74

Retroperitoneal tumor

Several small segments of tissue were submitted in the fresh state, measuring 3.5 x 3 x 2.0 cm and 3.7 x 3.0 x 2.5 cm. The tissue is homogenous, myxomatous and pinkish tan to dark red with hemorrhagic areas.

The second portion consists of a large mass of tumor, which includes the spleen, kidney, omentum, and adrenal gland. The entire mass measured 23 x 15.5 x 12 cm. The tumor is creamy tan to yellow, with red hemorrhagic areas. It is very mucoid in consistency and has a myxomatous appearance.

The spleen has multiple infarcts. The kidney and adrenal were surrounded by tumor.

Diagnosis: Liposarcoma
Specimen consists of two large separate masses, one of which weighed 813 gms. and measured 36 x 33 x 4 cm. The second mass weighed 500 gm. and measures 19 x 16 x 7.5 cm.

Both masses are similar. On the cut surface, the tissue to tan is multilobulated, yellow gray/and mucinous. The tissue is speckled with red hemorrhagic streaks. In some areas, the homogenous lobules are firm/and reddish tan.

Diagnosis: Well differentiated liposarcoma
RIGHT LEG VENOGRAPH:
Serial films of the right lower extremity have been obtained during injection of contrast material into one of the veins of the dorsum of the foot during the application and after the release of a tight tourniquet above the ankle.

There is complete occlusion of the deep venous system distal to the significant incompetence of the perforators. The only venous return identified is via the saphenous system. A definite filling defect is not identified but one suspects that this is the result of long standing phlebothrombosis.

Incidentally, there is a soft tissue mass of approximately 12 cm. in diameter overlying the junction of middle and distal thirds of right femur. This is not associated with osseous abnormalities or calcifications.

RIGHT FEMORAL ARTERIOGRAPH:
Serial films of the right lower extremity have been obtained during manual injections of contrast material into the right common femoral artery.

Both deep and superficial femoral arteries are well identified and show no evidence of atherosclerosis or occlusions.

There is displacement of the arterial vessels at Hunter's level at the site of the above described soft tissue mass. The mass in question appears avascular and has produced outstretching of the corresponding vessels. There is no evidence of early venous return or arterial venous malformation.

VESICAL ANGIOGRAPH:
Serial films of the abdomen have been obtained during manual injections of contrast material into the superior mesenteric and celiac trunks respectively.

There is normal size and distribution of the corresponding arterial tree. Both of the superior and inferior pancreatic arches are identified and appear normal.

The venous return is relatively well identified particularly at the splenoportal system and no indentations or areas of occlusion are identified.

The above findings referable to the leg probably represent benign tumor of the fibrous or muscular origin but malignant degeneration is not excluded. A lipoma is less likely possibility.