CALIFORNIA TUMOR TISSUE REGISTRY
HUNTINGTON MEMORIAL HOSPITAL
PROTOCOL
FOR
MONTHLY STUDY SLIDES
APRIL 1990
LUNG TUMORS
CONTRIBUTOR: Jay W. Carson, M. D. 
Martinez, California 

TISSUE FROM: Lung 

ACCESSION NO. 26661 

CLINICAL ABSTRACT:

History: This 62-year-old male presented with complaint of productive cough of yellow sputum, malaise, low grade fever, and night sweats. He had a history of smoking 40-pack-year, as well as asbestos exposure from sheet rock work.

Physical examination: Decrease breath sounds in the right lung field.

Laboratory report: Leukocytosis at 34,000 (It was felt that this was a reactive leukocytosis, not representing a leukemoid reaction).

Radiograph: Bone scan of rib and spine were negative as well as thoracic CT scan.

SURGERY: (March 30, 1987)

A right thoracotomy with right lower lobectomy was performed. The tumor grossly appeared metastatic with attachments to the right ribs and vertebra as well as the spinal column.

GROSS PATHOLOGY:

The lung segment was received in torn state. The entire specimen measured 25 x 15 x 10 cms. The pleural surface showed multiple white nodules throughout the majority of the pleural surface. The tumor was ragged and white with a huge area of central necrosis. The tumor itself, upon reconstruction, measured approximately 18 x 9 x 11 cms.
History: This 65-year-old female was admitted to the hospital with complaint of sore throat of 2 weeks' duration. She had a history of smoking one pack of cigarette a day for some 45 years.

Physical examination: There was a nodule in the left cervical chain. Lung: Slight increase present in the inspiratory phase, with end inspiratory and expiratory rhonchi.

She underwent a laryngoscopy and biopsy which was later diagnosed as squamous carcinoma, base of tongue. A bronchoscopy was done because of the radiographic finding of a left lung nodule.

SURGERY: (February 5, 1987)

A left thoracotomy with left lower pulmonary lobectomy was performed. Findings: There was a mass 5 to 6 cms., in the lower lobe that had puckered the pleura. The hilar lymph nodes were small and benign looking.

GROSS PATHOLOGY:

The specimen consisted of the left lower lobe of lung, weighing 220 grams and measuring 16 x 7.5 x 7.5 cms. Along the anterior and lateral surfaces of the lower portion of the lobe, involving the posterior and lateral basal segments, was a crescent-shaped depression surrounded by an irregular, somewhat lobulated, well-defined area, having a bulging, glistening, pink-purple appearance. The area had a firm to rubbery consistency and measured 10 x 4 cms. Section through this area revealed a tumor, 6 x 6 x 5 cm., which had a bosselated, glistening, mucoid, gray-pink cut surface with a central granular area, yellow-tan and mottled black, containing many cystic spaces. Adjacent to the pleural surface, corresponding with the crescentic-shaped depression, was a glistening, milky white scar surrounded by anthracotic pigment. The tumor did not appear grossly to violate the pleura. The tumor had scalloped, well-defined edges and was well-demarcated from the surrounding lung parenchyma which was pink-tan and showed focal anthracotic pigmentation.
CLINICAL ABSTRACT:

History: This 69-year-old Cambodian female presented 3-4 weeks ago with complaint of small amount of hemoptysis, 3 months' duration. She denied fever, chills, weight loss or night sweats.

Radiographs: Chest x-ray showed a poorly defined lesion in the area of the right cardiophrenic angle. CAT scan confirmed lesion in the right lower lobe as well as possible mediastinal node involvement.

Mediastinoscopy and bronchoscopy were performed and reported as negative for malignancy.

SURGERY: (February 28, 1990)

Exploratory right thoratocomy with right lower lobectomy was performed. Findings: A large, 3 x 4 cm. mass was present in the right lower lobe which was umbilicated and irregular in shape.

GROSS PATHOLOGY:

The specimen consisted of resected right lower lobe of lung, measuring 17 x 11 x 9 cms. and weighing 148 grams. Pleural surfaces were generally smooth and glistening, ranged in coloration from light tan with a focal anthracotic stippling to deep red. Centrally, at the base of the resected lobe, was an area of pleural opacification and puckering measuring 1.5 x 1.5 cms. in maximal diameter. Immediately adjacent pulmonary parenchyma was firm, light-tan-fleshy with focal anthracotic stippling. This measured 2.7 x 1.8 x 1.9 cm. and had smooth pushing margins. The mass was intimately associated with a small peripheral bronchus, but origin within the bronchus was not demonstrated. The bronchial tree which was open from the hilum of the resected lobe was unremarkable.
CONTRIBUTOR: Jozef Kollin, M. D.  
Long Beach, California

TISSUE FROM: Lung

CLINICAL ABSTRACT:

History: This 50-year-old white male with long standing hypertension complained of left apical pain when he raised his shoulder. Past history indicated known left apical lung mass since 1983 followed by periodic chest x-rays showing no significant change. He was diagnosed several years ago as small cell carcinoma, left upper lobe.

Radiographs: CT scan in 4-86 did not show intrapulmonary parenchymal lesion but it showed a left apical paraspinal process. CT of chest and abdomen on 9-16-86 showed a left apical paramediastinal mass, about 4 cms. in size. Abdominal CT was normal.

Needle biopsy on 8-29-86 showed atypical cells suspicious but not diagnostic of small cell carcinoma. On 9-23-86, a supraclavicular approach and biopsy of the mass was performed. A diagnosis of a neoplasm was made, the origin of which was uncertain, but lymphoma and small cell carcinoma was excluded. On the basis of suggested possible etiology of the tumor I-131-MIBG whole body scan was obtained showing focal uptake in the known primary lesion in the left parapical location.

SURGERY: (October 14, 1986)

Exploratory thoracotomy with subtotal removal of the parapical tumor was performed.

GROSS PATHOLOGY:

The specimen was received in fragments: "B" - Reddish-purple piece of viable tissue, 1.2 x 0.5 x 0.3 cms; "C" - Multiple fragments of red-purple soft friable tumor, 6.5 x 3 x 1.5 cm; "D" - Section of tumor with capsule consisted of soft, friable, red-purple tissue, 2 x 1 x 0.5 cms.
CONTRIBUTOR: Thomas J. Bassler, M. D.
Inglewood, California

TISSUE FROM: Pleura and Lung (Case 5)
Axilla (Case 6)

CLINICAL ABSTRACT:

History: This 56-year-old white male was seen on July 15, 1985 with complaint of tightness in the chest. He admitted to daily productive cough of a small amount of phlegm. He was exposed to asbestos for six month period at age 19 while doing industrial installation. He smoked on to two packs of cigarettes daily for 36 years.

Skin testing for tuberculosis and coccidiodomycosis were negative. An x-ray revealed a large mass in the anterior segment of the left upper lobe. A needle aspiration was done with the findings of a fibromatous lesion with chronic inflammatory cells, compatible with a pulmonary inflammatory pseudotumor.

Repeat radiograph of chest revealed what appeared to be an extrapleural lesion in the region of the anterior superior chest wall; CT scan on 7-30-85 demonstrated a left apical extrapleural mass with possible pleural plaques and diaphragmatic calcifications.

SURGERY: (August 5, 1985) - Case 5

A left thoracotomy with excision of chest wall tumor, left anterior chest and partial wedge resection of left upper lobe was performed. Findings: A mass was found in the area of the anterior second and third ribs which extended into the upper lobe of the lung. After removal of mass in the lung, it was found that there was extension of the tumor between the second and first ribs, extending like a sheet into the apex, making this portion of the tumor non-resectable.

GROSS PATHOLOGY: (Case 5)

The specimen received were in two parts: "A" - the specimen consisted of one large and two small hard white tissue fragments. The specimen consisted of a rubbery glistening gray, well circumscribed fibrotic mass with small amount of attached red lung parenchyma, 6 x 6 x 2 cms. in diameter and 84 grams in weight. The portion of the lung measured 7 x 6 x 2 cms. "B" - the specimen consisted of a hard white tissue fragment, 3 x 1 cm. The center was calcified.

COURSE:

Further evaluation failed to reveal a primary site outside of the chest such as a malignant hypernephroma. Because of the surgical findings and his constitutional symptoms, local radiation therapy was recommended and he was treated initially with 5,040 rads and an ultimate dose of 6,300 rads to the area of tumor involvement. Despite his radiation on March 4, 1986, he developed a mobile 4 cms. left axillary mass.
SURGERY: (March 18, 1986) - Case 6

Resection of left axillary lymph node, measuring 5 x 3 cms. was performed.

GROSS PATHOLOGY:

Despite resection of the axillary node a recurrence occurred, which was a fixed 4 cms. mass, with a new 3 cms. mobile subcutaneous mass beneath his left scapula. Multiple tumor nodules were noted in the chest x-ray. Because of the progressive nature of his disease, he was treated with Adriamycin, total dose of 170 mg. He subsequently developed stomatitis for which he was hospitalized as well as for severe leukopenia. The symptoms resolved and he received a second course of Adriamycin. Despite his chemotherapy, chest x-ray showed progression of disease and the left axillary mass continued to grow.
CLINICAL ABSTRACT:

History: This 72-year-old Caucasian male was seen in November 1980 for an ill-defined mass, right upper lobe. Bronchoscopy was negative. In early 1982, the mass had become definitely, larger, and denser. He remained asymptomatic except for shortness of breath on exertion. He was admitted to the hospital on April 27, 1982 for surgical procedure.

Radiograph of chest revealed a tumor in the right upper lobe of the right lung.

SURGERY: (April 28, 1982)

A right thoracotomy with upper lobectomy was performed.

GROSS PATHOLOGY:

The specimen consisted of the upper lobe of the right lung, 14 x 12 x 7 cms. in dimension and 135 grams in weight. Along the anterior surface at a level that was approximately 5 cms. beneath the apical portion of the lung was a depressed area in the pleura that measured 2 cms. in greatest dimension. Dissection of the lung revealed in a primary branch of the upper lobe bronchus, at a level that was 2 cms. distal to the margin of resection, an irregular eroded area, 1.5 cm in greatest dimension. This proved to be overlying an irregular firm yellowish-white lesion, 3.5 cms. in greatest dimensions. Sections revealed the lesion to have a rather variegated appearance. The peripheral margin of the lesion extended to the pleural surface.

Further dissection of the lung revealed the tissue to be pinkish-white in color and to be normally crepitant. In the peribronchial area there were found a total of 8 small nodal structures, the largest of these 0.8 cm. in size. These node were grayish-black in color, soft in consistency.
CONTRIBUTOR: Peter L. Morris, M. D. 
Santa Barbara, California

TISSUE FROM: Lung

CLINICAL ABSTRACT:

History: This 76-year-old white male underwent check-up examination between 11-15-85 and 11-19-85, during which time a routine chest x-ray revealed the presence of a right lower lobe mass, characterized as a "nodular lesion", which had not been observed at the time of prior radiologic studies (7-11-84). Needle aspiration biopsy was consistent with malignancy.

SURGERY: (December 16, 1985)

A thoracotomy with wedge excision of nodule, right lower lobe, was performed. Findings: The radiographically visualized nodule was seen to lie on the pleural surface of the anterior basilar segment of the lower lobe.

GROSS PATHOLOGY:

The specimen consisted of partially expanded 10 gram wedge-shaped lung segment, 7.0 x 5.5 x 2.5 cm. in greatest dimensions. The transected margin was pink, with slightly anthracotic parenchyma and covered a distance of 5.5 x 2.2 cm. The pleural surface was smooth and glistening except for a raised, firm gray nodule, 2.0 cms. in diameter, which occurred 2.1 cm. from the transected margin. Sections through this nodule showed a glistening gray appearance and sharply separated from the surrounding parenchyma. It was 2.0 cm. in diameter. Sections through the remainder of the lung showed a spongy pink parenchyma with a few areas of faint ill-defined nodularity but no discrete lesions.
CONTRIBUTOR: David Hoblit, M. D.  
Norman Cadman, M. D.  
Pomona, California

TISSUE FROM: Lung  
ACCESSION NO. 24914

CLINICAL ABSTRACT:

History: This 81-year-old male was admitted on March 20, 1983 with chief complaint of a coin lesion in the right lung. He had a recent hospitalization for congestive failure with pulmonary edema. As part of his evaluation, chest x-ray revealed a lesion, 2½ cms., in the right lower lung field, that had not been present on chest film taken a year prior. He had a sixty pack year smoking history.

SURGERY: (March 21, 1983)

A bronchoscopy with biopsy of right middle lobectomy was performed. Findings: At bronchoscopy the right upper lobe take-off had some reddening and some thickening of the mucosa. At thoracotomy there was a 3 cm. indentation of the visceral pleura in the lower portion of the right middle lobe. There were no apparent pathologically involved hilar or mediastinal lymph nodes.

GROSS PATHOLOGY:

The specimen received was a right middle lobe of lung, weighing 125 grams. Cut section through this lung showed a single discrete mass adjacent to the pleural surface measuring 2.4 x 2.1 x 1.9 cms. It was adherent to the pleural surface. In the area adjacent to the bronchus. There was an additional tumor which appeared to be large matted nodes, measuring upwards to 1.5 cm. Additional sections of the peripherally located mass was taken with involved nodes, adjacent lung tissue, and bronchus.
CLINICAL ABSTRACT:

History: This 67-year-old white male was in "perfect" health until 8 months ago when he developed a dry cough which became progressively worse. He was in the San Joaquin Valley where a chest x-ray showed a pleural effusion. This was aspirated on two occasions which was negative on culture and cytologic studies.

Laboratory data: SMAC panel was within normal limits. The WBC was 8,500 with 9% lymphocytes. Postoperative electrophoresis: Normal total protein with increased gamma globulin to 1.4 gms (24.1%) with pattern suggesting a monoclonal protein in the gamma region. Serum immunoelectrophoresis showed normal IGG, IGA with IGM decreased. Kappa and Lambda light chains were normal.

Radiograph: A large right pleural effusion was noted.

SURGERY: (August 20, 1981)

A right exploration revealed 1300 ml. of bloody turbid fluid. There were multiple palpable nodular opacities of pleura over the lower lobe and medial aspect of the middle lobe. A pleural peel debulked the major portion of the parietal pleura. A wedge-shaped portion of the middle lung was removed.

GROSS PATHOLOGY:

The specimen received was an 8.0 x 5.5 x 3.0 cm. wad of pleural peel, consisting of four separate ragged strips, varying from 13.3 x 4.0 to 30.0 x 5.5 cms. The pleural surface of each portion contained multiple soft, velvety, discrete, and confluent diffuse plaques up to 4.0 cms. in diameter and no more than 3 mm. in thickness. When sectioned the surfaces made were homogeneous, crisp-glistening tan.

The second specimen received was an approximately 20 gm. wedge-shaped portion of lung, 7.0 x 1.7 cms. in greatest dimensions across the transection and up to 2.5 cms. in length. The pleural surface had discrete and confluent plaques of mossy finely papillary light pink-tan tissue, similar to that seen on the parietal pleura. The sectioned surfaces appeared to be up to 7 mm. and infiltrated the pulmonary parenchyma. A calcific irregular yellow nodule, 9 mm. in diameter, shelled out easily, leaving a mantle of neoplasm about the periphery.
CONTRIBUTOR: Bill Pettross, M. D.  
Los Angeles, California  
APRIL 1990 - CASE NO. 11

TISSUE FROM: Lung  
ACCESSION NO. 25643

CLINICAL ABSTRACT:

History: This 8 month-old-male infant was seen on November 6, 1985 for upper respiratory infection symptoms and noted to have left lung density. He was treated with penicillin but one week later he still presented with the mass. He was admitted to the hospital on December 2, 1985 for diagnostic work-up.

Raiograph of chest revealed a 5 cm. round mass in left mid chest.

SURGERY: (December 4, 1985)

A left lower lobectomy was performed.

GROSS PATHOLOGY:

The specimen consisted of the left lobe weighing 50 grams. The entire specimen measured 4 x 6 x 8.5 cms. within the lung parenchyma, in mid posterior location, there was a light tan, firm nodule, measuring 3 x 3 x 4 cms. Gritty areas were noted centrally within the tumor. The tumor was not encapsulated but was well circumscribed and demarcated from the surrounding lung tissue and appeared to be easily shelled out. No involvement of the hilar area or lymph nodes was noted. The tumor bulged on the pleural surface. The pleural surface was uniformly dusky red. The cut surface of the lung was soft and red brown.
CLINICAL ABSTRACT:

History: This 76-year-old white female was admitted to the hospital on January 17, 1989 for bilateral pneumonia. For many years she suffered with idiopathic lung disease, associated with pulmonary fibrosis and low PAO2. She developed increased shortness of breath in the second week of December 1988 due to an upper respiratory infection. At her office visit, an ABGs revealed, on room air, a pO2 of 48, pCO2 of 37 and a pH of 7.47. Chest x-ray revealed diffuse bilateral infiltrates. Sputum culture was taken and patient was started on Cipro, 750 mg. po.bid. A week later sedimentation rate was 98. A repeat chest x-ray at patient's request was not done. She continued on medication.

On 1-3-89, she returned complaining of burping up large amounts of dark sputum. Culture returned only normal flora. Patient was on continuous O2 at home. A culture was taken and additional medication prescribed to be taken at home.

She returned to the office because of a sudden increase in her shortness of breath. After chest x-ray revealed an extensive bilateral lower lobe pneumonia, she was admitted to the hospital. Patient was not a smoker or consumer of alcohol.

Physical examination: Lungs - markedly decreased breath sounds. There was decreased diaphragmatic excursion. There were fine rales at both bases.

Flexible bronchoscopy was done on 1-18-89 and cultures obtained from pus out of the left lower lobe bronchus was submitted for sensitivity, routine acid fast bacilli, fungus, smears and cytology. Nocardia asteroides was positive.

SURGERY: (January 20, 1989)

A major left upper and lower pulmonary decortication with wedge resection of left lingula, upper and basilar lower lobes, drainage of lingular pulmonary abscess, and closed chest tube pleural drainage were performed. Findings: There were extensive empyema involving the left pleural space and areas of adhesions densely adhered to the parietal wall. A firm indurated mass involved the lingular segments of the left lower lobe with microabscesses on the parenchymal surface. An abscess was broken into with resultant purulent drainage.

GROSS PATHOLOGY:

The specimen consisted of multiple biopsies from pleura and lung which were friable, gray-white, fibrinous focally hemorrhagic and shaggy. Sectioning revealed necrotic cavities, measuring up to 1 cm. in greatest dimension.
CASE NO. 1 - ACCESSION NO. 26661

LOS ANGELES: Giant and spindle cell carcinoma - 7

LONG BEACH: Poorly differentiated carcinoma, NOS - 7; large cell carcinoma - 1

FRESNO: Malignant fibrous mesothelioma - 6; spindle cell carcinoma vs. sarcoma - 1

SACRAMENTO: Large cell carcinoma - 4; giant cell carcinoma - 5

MARTINEZ: Spindle cell carcinoma - 9

BAKERSFIELD: Sarcoma, NOS - 1; pleomorphic sarcoma - 1; fibrous malignant mesothelioma - 1; carcinomatous abscess - 1

SAN BERNARDINO (INLAND): Malignant mesothelioma - 6; sarcoma, NOS - 5; rhabdomyosarcoma - 2; malignant Triton tumor - 1

OAKLAND: Large cell nonkeratinizing carcinoma - 5; poorly differentiated adenocarcinoma with sarcomatoid features - 3

NORTH DAKOTA: Malignant mesothelioma - 1

GRASS VALLEY: Malignant mesothelioma - 1

CONSULTATION:

AFIP: Pleomorphic carcinoma with spindling. Special stains (PAS without and with diastase predigestion) showed the tumor cells contained neither glycogen nor mucin. Immunostains for keratin positive while S-100 protein and desmin were negative. The morphology of the tumor as well as the results of the special stains and immunostains were most consistent with the above diagnosis and did not support malignant fibrous histiocytoma.

FOLLOW-UP:

The patient died on May 9, 1987 without benefit of an autopsy.

DIAGNOSIS:

Giant cell adenocarcinoma, lung

REFERENCES:


TABLE 2 - Classification of bronchogenic carcinoma observed in autopsy series (Hadley & Bullock)

<table>
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<tr>
<td>Anaplastic</td>
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<td>(Undifferentiated)</td>
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<tr>
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<td>5</td>
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<tr>
<td><strong>Total</strong></td>
<td><strong>64</strong></td>
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</table>
Los Angeles: Well differentiated adenocarcinoma, bronchioalveolar type - 7

Long Beach: Bronchioloalveolar cell carcinoma - 8

Fresno: Bronchoalveolar carcinoma - 5; metastatic adenocarcinoma vs. adenocarcinoma - 1; papillary mucinous carcinoma - 1

Sacramento: Well differentiated adenocarcinoma - 5; bronchoalveolar carcinoma - 4

Martinez: Adenocarcinoma - 9

Bakersfield: Bronchioloalveolar carcinoma - 4

San Bernardino (Inland): Bronchioloalveolar carcinoma - 6; mucinous (colloid) carcinoma - 8

Oakland: Bronchioloalveolar tumor - 7; mucinous carcinoma - 1

North Dakota: Bronchoalveolar cell carcinoma - 1

Grass Valley: Adenocarcinoma - 1

Follow-up:

She had a stormy course after discharge from the hospital with a laryngeal squamous carcinoma which was radiated and laryngectomized with right neck dissection. She did well until September 1988 when a right squamous cell carcinoma of the kidney was diagnosed by fine needle aspiration but because of extensive retroperitoneal spread resection was not possible. She expired in October 1988.

Diagnosis:

Bronchoalveolar carcinoma, lung

References:


LOS ANGELES: Scar adenocarcinoma - 5; bronchioalveolar carcinoma - 2

LONG BEACH: Adenocarcinoma - 8

FRESNO: Well differentiated adenocarcinoma - 6; atypical bronchiolar proliferation around scar - 1

SACRAMENTO: Bronchoalveolar carcinoma - 9

MARTINEZ: Adenocarcinoma - 6; bronchioloalveolar - 3

BAKERSFIELD: Scar carcinoma - 2; adenocarcinoma in interstitial fibrosis - 1; adenocarcinoma, NOS - 1

SAN BERNARDINO (INLAND): Adenocarcinoma - 14

OAKLAND: Adenocarcinoma, NOS with bronchioloalveolar tumor - 8

NORTH DAKOTA: Adenocarcinoma - 1

GRASS VALLEY: Bronchiolar alveolar carcinoma - 1

FOLLOW-UP:

   Patient is alive and well as of 4/5/90.

DIAGNOSIS:

   Bronchoalveolar carcinoma, lung

REFERENCES:


LOS ANGELES: Intrathoracic paraganglioma - 7
LONG BEACH: Paraganglioma - 8
FRESNO: Carcinoid tumor with oncocytic features - 3; granular cell myoblastoma - 1; Hurthle cell adenoma (or medullary) - 1; alveolar cell carcinoma scar cancer - 1; large clear cell carcinoma, R/O renal metastasis - 1
SACRAMENTO: Paraganglioma - 9
MARTINEZ: Paraganglioma - 9
BAKERSFIELD: Paraganglioma - 4
SAN BERNARDINO (INLAND): Paraganglioma - 14
OAKLAND: Paraganglioma - 7
NORTH DAKOTA: Metastatic pheochromocytoma - 1
GRASS VALLEY: Paraganglioma - 1

FOLLOW-UP:

He is being followed in hematology and endocrinology clinics. As of February 5, 1990 he is alive and well, with no evidence of recurrence. Blood pressure under control.

DIAGNOSIS:

Para-apical paraganglioma, lung

REFERENCES:


LOS ANGELES: Malignant mesothelioma - 6; malignant fibrous histiocytoma - 1
LONG BEACH: Malignant mesothelioma - 8
FRESNO: Large cell spindle carcinoma vs. sarcoma, HFS. - 1; malignant mesothelioma - 4; malignant fibrous histiocytoma - 2
SACRAMENTO: Malignant fibrohistiocytoma involving pleura and axillary node - 9
MARTINEZ: Mesothelioma - 9
BAKERSFIELD: Malignant fibrous mesothelioma - 4
SAN BERNARDINO (INLAND): Malignant mesothelioma - 14
OAKLAND: Mesothelioma - 5; malignant fibrous histiocytoma - 4
NORTH DAKOTA: Malignant mesothelioma - 1
GRASS VALLEY: Carcinosarcoma - 1

CONSULTATIONS:

Michael Koss, M. D. - LAC-USC Med. Ctr.: Malignant fibrous mesothelioma or sarcoma of lung such as malignant fibrous histiocytoma.

Louis P. Dehner, M. D. - University of Minnesota: Immunohistochemical stains were performed on both the pulmonary and soft tissue lesions for fibrohistiocytic markers. Alpha-1 antichymotrypsin positive (lung and axilla); vimentin weakly reactive (axilla). The myofibroblastic inflammatory pseudotumor has not been found to possess histiocytic markers and these stains further supported the diagnosis of a malignant fibrous histiocytoma, lung, ? metastatic to axilla.

FOLLOW-UP:

See case 6

DIAGNOSIS:

Malignant fibrous histiocytoma, pleura vs. lung.

REFERENCES:


LOS ANGELES: Malignant mesothelioma - 6; malignant fibrous histiocytoma - 1
LONG BEACH: Metastatic malignant mesothelioma - 8
FRESNO: Malignant mesothelioma - 2; metastatic tumor - 1; malignant fibrous histiocytoma - 2
SACRAMENTO: Malignant fibrohistiocytoma involving pleura and axillary node - 9
MARTINEZ: Mesothelioma - 9
BAKERSFIELD: Malignant fibrous mesothelioma - 4
SAN BERNARDINO (INLAND): Malignant mesothelioma - 14
OAKLAND: Mesothelioma - 5; malignant fibrous histiocytoma - 4
NORTH DATKOTA: Malignant mesothelioma - 1
GRASS VALLEY: Metastatic carcinomsarcoma - 1

CONSULTATIONS:

Michael Koss, M. D. - LAC-USC Med. Ctr.: Malignant fibrous mesothelioma or sarcoma of lung such as malignant fibrous histiocytoma.

Louis P. Dehner, M. D. - University of Minnesota: Immunohistochemical stains were performed on both the pulmonary and soft tissue lesions for fibrohistiocytic markers. Alpha-1 antichymotrypsin positive (lung and axilla); vimentin weakly reactive (axilla). The myofibroblastic inflammatory pseudotumor has not been found to possess histiocytic markers and these stains further supported the diagnosis of a malignant fibrous histiocytoma, lung, ? metastatic to axilla.

FOLLOW-UP:

Despite resection of the axillary node, a recurrence occurred, which was a fixed 4 cms. mass, with a new 3 cms. mobile subcutaneous mass beneath his left scapula, and multiple tumor nodules were noted in the chest x-ray. Because of the progressive nature of his disease, he was treated with Adriamycin, total dose of 170 mg. He subsequently developed stomatitis for which he was hospitalized as well as for severe leukopenia. The symptoms resolved and he received a second course of Adriamycin. Despite his chemotherapy, chest x-ray showed progression of disease and the left axillary mass continued to grow. He expired on 9/21/86.

DIAGNOSIS:

Metastatic malignant fibrous histiocytoma, axilla. Primary pleura or lung.

REFERENCES:


CASE NO. 7 - ACCESSION NO. 24546

LOS ANGELES: Squamous cell carcinoma, bronchus, with bronchoalveolar carcinoma - 7

LONG BEACH: Mixed adenocarcinoma and squamous cell carcinoma - 8

FRESNO: Biphasic carcinoid (adenosquamous vs. second separate primary) - 1; mixed adenosquamous - 3; adenocarcinoma, bronchoalveolar - 2; second lesion = atypical bronchiolar proliferation around scan and squamous cell carcinoma - 1

SACRAMENTO: Adenosquamous carcinoma - 4; combined bronchoalveolar carcinoma and squamous carcinoma - 5

MARTINEZ: Combined collision tumor (adenocarcinoma and squamous cell carcinoma) - 9

BAKERSFIELD: Collision tumor (squamous cell carcinoma and adenocarcinoma) - 4

SAN BERNARDINO (INLAND): Mixed adenocarcinoma and squamous cell carcinoma - 8; adenosquamous carcinoma - 6

OAKLAND: Adenosquamous carcinoma - 7; squamous carcinoma - 1

NORTH DAKOTA: Squamous cell carcinoma and bronchoalveolar cell carcinoma - 1

GRASS VALLEY: Combined squamous cell and adenocarcinoma - 1

FOLLOW-UP:

About 4 days postoperatively, he developed fever with whiteout of the remaining lobes on the right side. Staphylococcus aureus was cultured and he was treated appropriately. At the same time he developed atrial fibrillation on and off. Despite therapy he spiked a high fever and expired on 5-27-82.

DIAGNOSIS:

Squamous cell carcinoma, bronchus
Bronchoalveolar carcinoma, lung

REFERENCE:

CASE NO. 8 - ACCESSION NO. 25635  

APRIL 1990

LOS ANGELES: Malignant spindle cell tumor, unclassified - 3; malignant schwannoma - 4

LONG BEACH: Malignant fibrous histiocytoma - 4; leiomyosarcoma - 3; metastatic sarcoma - 1

FRESNO: No tumor just emphysema and bronchitis in my slide - 1; sarcoma primary vs. secondary - 1; malignant fibrous histiocytoma - 2; atypical peripheral carcinoid - 2; sarcomatous carcinoma - 1

SACRAMENTO: Malignant Schwann cell tumor - 6; malignant fibrous histiocytoma - 3

MARTINEZ: Malignant fibrous histiocytoma - 9

BAKERSFIELD: Malignant fibrous histiocytoma - 2; fibrosarcoma - 2

SAN BERNARDINO (INLAND): Malignant fibrous histiocytoma - 5; fibrosarcoma - 3; leiomyosarcoma - 2; malignant mesothelioma - 1; sarcoma, NOS - 3

OAKLAND: Sarcomatoid mesothelioma - 7; malignant fibrous histiocytoma - 1

NORTH DAKOTA: Squamous cell carcinoma, spindle cell type - 1

GRASS VALLEY: Malignant fibrous histiocytoma - 1

CONSULTATION:


FOLLOW-UP:

He was admitted to the hospital in November 1988 for a transurethral prostatic resection for obstructive uropathy. The tissue removed was benign. A chest film done at that time revealed no evidence of pulmonary nodules.

ELECTRON MICROSCOPY REPORT:

Most consistent with a malignant schwannoma or neurofibrosarcoma.

SPECIAL STAINS:

Submittor's S-100 was positive; CTTR S-100: Negative

DIAGNOSIS:

Malignant Schwannoma, lung.

REFERENCES:


CASE NO. 9 - ACCESSION NO. 24914

Los Angeles: Intermediate small cell carcinoma - 7

Long Beach: Intermediate small cell carcinoma - 7; undifferentiated large cell carcinoma - 1

Fresno: Malignant carcinoid, oat cell type - 1; oat cell carcinoma - 2; undifferentiated small cell carcinoma, polygonal variant - 1; poorly differentiated carcinoma, large spindle cell - 2; atypical carcinoid tumor - 1

Sacramento: Poorly differentiated carcinoma - 3; small cell carcinoma, intermediate type - 5; possible metastatic tumor - 1

Martinez: Atypical carcinoid - 3; malignant neuroendocrine - 6

Bakersfield: Small cell carcinoma, intermediate cell - 2; spindle cell carcinoid - 1; bronchial adenoma - 1

San Bernardino (Inland): Neuroendocrine carcinoma (atypical carcinoid) - 14

Oakland: Malignant lymphoma, small lymphocytic - 8

North Dakota: Neuroendocrine carcinoma - 1

Grass Valley: Small cell undifferentiated carcinoma, intermediate cell type - 1

Consultation:

Michael Koss, M. D. - USC-LAC Med. Ctr.: Intermediate small cell carcinoma

Special Stains: (Contributor)

PAS & Mucicarmine were unremarkable. Silver: Negative

Follow-up:

He expired on the third post operative day (3/24/83) of cardiac arrest.

Diagnosis:

Intermediate small cell carcinoma, lung.

References:


CASE NO. 10 - ACCESSION NO. 25010

APRIL 1990

LOS ANGELES: Plasmacytoid lymphocytic lymphoma - 7

LONG BEACH: Well differentiated lymphocytic lymphoma - 8

FRESNO: Lymphoma, non-Hodgkin's - 3; lymphoma vs. leukemia infiltrate, small cell type - 1; WDLL/CLL - 2; pseudolymphoma - 1

SACRAMENTO: Well differentiated lymphocytic lymphoma - 9

MARTINEZ: B-cell lymphocytic lymphoma - 9

BAKERSFIELD: Malignant lymphoma, diffuse, small cell - 3; pseudolymphoma - 1

SAN BERNARDINO (INLAND): Lymphoma, well differentiated, with plasmacytoid areas - 14

OAKLAND: Malignant lymphoma, small lymphocytic - 8

NORTH DAKOTA: Small cell lymphocytic lymphoma - 1

GRASS VALLEY: Non-Hodgkin's malignant lymphoma, small cleaved cell type - 1

FOLLOW-UP:

Not available.

DIAGNOSIS:

Malignant well differentiated non-cleaved small cell lymphocytic lymphoma, lung.

REFERENCES:

CASE NO. 11 - ACCESSION NO. 25643

APRIL 1990

LOS ANGELES: Plasma cell granuloma - 9

LONG BEACH: Inflammatory pseudotumor (plasma cell granuloma)- 6; benign fibrous histiocytoma - 2

FRESNO: Plasma cell granuloma - 4; hamartoma - 2; inflammatory reaction - 1

SACRAMENTO: Hamartoma - 2; inflammatory pseudotumor - 2

MARTINEZ: Inflammatory pseudotumor - 7; adenomatoid hamartoma - 2

BAKERSFIELD: Inflammatory pseudotumor - 3; hamartoma - 1

SAN BERNARDINO (INLAND): Inflammatory or fibrous pseudotumor - 14

OAKLAND: Inflammatory pseudotumor - 8

NORTH DAKOTA: Inflammatory pseudotumor - 1

GRASS VALLEY: Pulmonary hamartoma - 1

FOLLOW-UP:

Not available.

DIAGNOSIS:

Inflammatory pseudotumor, lung.

REFERENCES:


Los Angeles: Chronic pneumonitis with reactive squamous cell metaplasia - 7

Long Beach: Abscess with atypical epithelial reaction, no organisms identified on gram stain - 8

Fresno: Large cell carcinoma, squamous - 2; abscess - 1; adenocarcinoma with necrosis - 3; pulmonary adenomatosis - 1

Sacramento: Poorly differentiated adenocarcinoma with inflammation - 2; epithelial hyperplasia with severe inflammation - 7

Martinez: Wegner's nocardiosis - 8

Bakersfield: Bronchocentric granulomatosis - 4

San Bernardino (Inland): Abscess with reactive inflammatory changes in lung - 14

Oakland: Nocardiosis - 8

North Dakota: Squamous cell carcinoma - 1

Grass Valley: Bronchiolitis obliterans - 1

Follow-up:
Patient died in the postoperative interval. No autopsy was obtained.

Diagnosis:
Pneumonitis, acute and chronic, with squamous cell metaplasia, lung.