CALIFORNIA TUMOR TISSUE REGISTRY
HUNTINGTON MEMORIAL HOSPITAL
PROTOCOL
FOR
MONTHLY STUDY SLIDES
NOVEMBER 1990
GASTROINTESTINAL TUMORS
CONTRIBUTOR: Jozef Kollin, M. D.  
Long Beach, California

Tissue FROM: Jejunum  
ACCESSION NO. 25887

Clinical abstract:

History: This 65-year-old Black male presented in July 1986 with g.i. bleeding secondary to gastric ulcer. Ten months earlier, he had an 8 x 8 cm. adenocarcinoma of the lung resected and was treated with radiation therapy. He subsequently underwent radiation treatment to the left ischial tuberosity for presumed metastatic tumor. In the past (1961) he had a pheochromocytoma resected and had multiple other medical problems. Despite treatment for his gastric ulcer, bleeding persisted and an exploratory laparotomy was undertaken.

Laboratory report: Albumin 3.0; protein 5.6; alkaline phosphatase 141. Hct 11; WBC 12; 80% pmn; 5 bands. O2 57; HCO2 23; CO2 32.

Radiograph: Upper G.I. series showed a persistent filling defect at the ligament of Treitz. Preoperative endoscopy demonstrated a gastric ulcer.

Surgery: (July 23, 1986)

At surgery, a gastric ulcer was biopsied. In addition, a 3.0 cm. friable exophytic proximal jejunal mass near the ligament of Treitz was identified, biopsied, and resected.

Gross pathology:

The specimen received was 10 cm. length of bowel. Protruding from the serosal surface was a 3.5 x 3.5 x 2.0 cm. purple-brown, roughly nodular mass of soft tissue. The central portion showed disruption and necrosis with possible perforation of bowel. On opening the bowel, the lumen was filled with mucus, but the mucosa appeared relatively intact suggesting ingrowth from the mesentery. Adjacent lymph node (?S) was involved.
CONTRIBUTOR: Nelson Quigley, M. D. 
Anaheim, California 

TISSUE FROM: Small bowel 

ACCESSION NO. 26868

CLINICAL ABSTRACT:

History: This 55-year-old Caucasian female presented in September 1990 with a history of heavy prolonged vaginal bleeding for two months. After a D&C and ultrasound, a tumor mass of unstated dimension was found behind the uterus. A right adrenal mass was also identified and fine needle biopsy suggested carcinoma.

Past medical history: A long history of chronic alcoholism and chronic obstructive pulmonary disease.

SURGERY: (September 12, 1990)

A low midline incision was made and the pelvic cavity was explored. The uterus and ovary were normal. A prominent tumor of unstated dimension was present in the proximal portion of the ileum. The bowel was resected and wedge biopsies of both the adrenal and a node from the area were done.

GROSS PATHOLOGY:

The specimen received was an 8 cm. length of bowel with a 4.5 x 4.0 cm. nodule projecting from the serosal surface - a Meckel's diverticulum. On opening the bowel, a protruding mass projected into the lumen. Bisecting the nodule revealed a gray-tan, grossly encapsulated tumor measuring 5.5 x 3.5 cm. on cross section. The adrenal mass consisted of a metastatic signet ring carcinoma.
CLINICAL ABSTRACT:

History: This 65-year-old white male presented with sharp pain, intermittent in nature, with radiation to the umbilicus. Pain was also present in the infrascapular region when the patient was lying down. The patient had lost 5 lb. in the past 2-3 weeks.

Past medical history: Long history of chronic obstructive lung disease and alcoholism.

Physical examination was essentially normal, including prostate. There was no supraclavicular, femoral, epitrochlear or cervical adenopathy present except for a 4 cm. right axillary lymph node which was poorly movable.

Endoscopy: A midesophageal polypoid lesion at 30 cm. was found. The lesion was 2 cm. at its longest length and had an irregular ulcerated surface.

Radiograph: Barium swallow showed a small lesion in the superficial 1/3 of the esophagus.

SURGERY: (February 10, 1983)

Following a short course of radiation, the patient underwent an esophago-gastrectomy.

GROSS PATHOLOGY:

A 10 cm. length of distal esophagus and a 6 cm. length of proximal stomach was received. A tumor was present in the proximal esophagus. The tumor measured 2.5 cm. in length and involved 2.5 cm. of internal circumference. The cut surface showed a pink-tan tumor, extending 1 cm. in depth nearly reaching the soft tissue margin.
CLINICAL ABSTRACT:

History: This 58-year-old male presented in February 1985 with a 15 days' history of intermittent epigastric pain unaccompanied with vomiting or bleeding. The pain became worse on the day of admission and was accompanied by vomiting. Familial history of flu.

Physical examination. There was diffuse tenderness throughout the abdomen accompanied by increasing bowel sounds and moderate distension.

Radiograph (AP view) revealed a markedly distended bowel.


SURGERY: (February 21, 1985)

At exploratory laparotomy, there was found to be complete bowel obstruction 3 feet from the ileocecal valve. A round 3-4 cm. intraluminal tumor was present and was associated with a 1° intussusception. A segmental small bowel resection with end-to-end anastomosis was done.

GROSS PATHOLOGY:

A 15 cm. in length and 4 cm. in maximum diameter length of small bowel was received. A polypoid mass with a sessile base measured 3.5 x 2.5 x 3.5 cm. On section, the tumor exhibited a gray-yellow homogenous glistening appearance.
CLINICAL ABSTRACT:

History: This 77-year-old woman presented with a 3 months' history of emesis, fever, and chills. There was also weight loss and diarrhea.

Physical examination: No abdominal masses were noted. Colonoscopy was negative.

Radiographs: Upper G.I. and barium enema were negative. CT scan of abdomen showed a 4.5 cm. mass between the stomach and the pancreas.

SURGERY: (May 24, 1988)

At laparotomy, a 4½ cm. solid mass was identified attached to the posterior wall of the body of the stomach. The mass appeared to be exophytic with its base measuring 2½ cm. in width. The lesion was wedged out in a triangular fashion.

GROSS PATHOLOGY:

The tumor was 4 cm. in diameter, circumscribed and had an attached strip of pinkish-tan mucosa. On sectioning, the nodule was hemorrhagic and had a slightly golden tan color.
CLINICAL ABSTRACT:

History: This 68-year-old alcoholic white male with a known history of liver dysfunction was admitted because of rectal bleeding of three days' duration.

Physical examination revealed ascites and peripheral edema. Verrucous hyperplasia of the skin of the lower extremities was noted. There was tachycardia and atrial fibrillation considered to be secondary to "beri-beri" heart disease.

Colonoscopy revealed ulceration of the cecum and a tumor of the ileocecal valve region.

Laboratory reports: Hemoglobin 8 grams. Blood ETOH 162 mg/dl.

SURGERY: (January 29, 1990)

At exploratory laparotomy, a markedly nodular liver and a cecal tumor were the only observations noted. A right hemicolecctionomy was performed.

GROSS PATHOLOGY:

The ileocecal specimen measured 38 cm. in length with attached appendix, measuring 7 cm. in length. The opened specimen revealed a 3.1 x 2.3 x 1.5 polypoid nodule attached by a pedicle to the cecal side of the ileocecal valve 1 cm. from the appendiceal orifice. There were erosions of the adjacent colonic mucosa. The colonic mucosa overlying the tumor was intact. Two of eleven regional nodes appeared to contain tumor.
CONTRIBUTOR: DeBose Dent, M. D.  
Glendale, California

TISSUE FROM: Stomach

ACCESSION NO. 24799

CLINICAL ABSTRACT:

History: This 65-year-old male was admitted to the hospital for epistaxis, anemia, and hypotension. While in the hospital he developed hematemesis. There was a longstanding history of heavy alcohol use. He had one previous episode of upper gastrointestinal hemorrhage 13 years ago. He was told he had peptic ulcer disease and recently noted increasing abdominal girth.

Physical examination: The patient was tremulous. Spider telangiectasia was noted. The liver was felt several cm. below the right costal margin. There was modest ascites.

Laboratory reports: Hemoglobin was 8.4 gm%. Bilirubin was 1.4; SGOT and SGPT were normal. Prothrombin time was increased to 16 seconds over a control of 12.

Endoscopy revealed esophageal and gastric varices and a small gastric ulcer with active bleeding.

Radiographs: Upper G.I. showed a deformed distal 2/3 of stomach and a ulcer crater in the posterior gastric wall.

Surgery: (January 21, 1983)

Because of continuing g.i. hemorrhage, the patient underwent partial gastrectomy.

GROSS PATHOLOGY:

The stomach specimen measured 10 cm. along the lesser curvature and 16 cm. along the greater curvature. The gastric rugae were thickened up to 1.5 cm. in width and lesser curvature erosions were noted. The wall of the stomach measured up to 1.5 cm. in thickness in some areas. The pyloric ring was noted and was also thickened.
CONTRIBUTOR: Howard Otto, M. D.
Cheboygan, Michigan

NOVEMBER 1990 - CASE NO. 8

TISSUE FROM: Rectum

ACCESSION NO. 26669

CLINICAL ABSTRACT:

History: This 60-year-old woman with a 20 years' history of ulcerative colitis was admitted for a D&C and during the course of the procedure a perforation of the uterus was suspected prompting a laparotomy. The sigmoid colon was noted to be firm and biopsies of the sigmoid colon were taken showing inflammation and ulceration of the mucosa, focal dysplastic epithelial cells and mucin production.

Laboratory report: Hemoglobin 10.4; hematocrit 30.7; WBC 6,100; platelet count 547,000. Patient exhibited microcytic hypochromic indices.

Radiograph: Barium enema 1½ years previously apparently showed no obstructive lesions.

SURGERY: (November 14, 1989)

Because of evidence of bowel obstruction, a total colectomy with ileostomy and a total hysterectomy were performed 6 days after the laparotomy.

GROSS PATHOLOGY:

The bowel specimen included the colon, rectum and distal ileum. The mucosa of the cecum was granular throughout. A 20 cm. segment of the distal colon had severe ulceration of the mucosa. A 15 cm. segment of the rectosigmoid was thickened, indurated and measured up to 1.3 cm. in thickness. The lumen was narrowed to 2 cm. The mucosa, although ulcerated, showed no gross tumor. Regional lymph nodes were replaced by neoplasm.
CONTRIBUTOR: Lars W. Kleppe, M. D. NOVEMBER 1990 - CASE NO. 9 Petoskey, Michigan

TISSUE FROM: Duodenum ACCESSION NO. 26796

CLINICAL ABSTRACT:

History: This 65-year-old patient was first seen in 1968. She was referred because of the presence of multiple colonic polyps. A diagnosis of familial polyposis was made and a total colectomy with ileostomy was performed. In 1980 she had a hysterectomy for multicentric carcinoma of the endometrium with mural invasion. About three months before admission she had an onset of nausea and epigastric pain. She only vomited once.

Radiograph: An upper gastrointestinal study approximately three months before admission was interpreted as negative.

Endoscopic examination revealed an annular duodenal lesion which was biopsied.

SURGERY: (November 7, 1989)

A Whipple procedure was performed.

GROSS PATHOLOGY:

Located 7.0 mm. below the pylorus, there was a 1.2 x 0.2 cm. area of coalescence of small polyps. Approximately 1.5 cm. after that there was an 11.0 x 5.5 x 1.2 cm. protruding cauliflower-like neoplasm. The ampulla of Vater entered the duodenum through the distal aspect of the neoplasm and showed little evidence of obstruction.
CLINICAL ABSTRACT:

History: This 60-year-old carpenter was admitted with a one week history of anorectal pain and 2 days' history of diarrhea and blood streaking of the stool.

Digital anorectal examination showed marked narrowing of the anterior wall of the anal canal for 3 cm. This felt like a firm abscess, but when opened no pus was encountered. Biopsy was performed.

SURGERY: (August 5, 1960)

A combined abdominoperineal resection of the rectum was performed.

GROSS PATHOLOGY:

There was a 32 cm. length of sigmoid colon and rectum with a 9.5 cm. attached rectum and a peri-anal skin cuff. Surrounding the anorectal junction anteriorly and laterally was a horseshoe-shaped mass of neoplastic tissue, measuring 95 mm. circumferentially, 25 mm. wide in the midline anteriorly, and 12 mm. in thickness. The lesion lacked 2.5 cm. of being completely circumferential. Sections showed a hard, granular tan-pink tumor which infiltrated perirectal and peri-anal fat and muscle. Rectal mucosa overlying the tumor was not ulcerated or distorted.
CONTRIBUTOR: William Wedemeyer, M. D.
Martinez, California

NOVEMBER 1990 - CASE NO. 11

TISSUE FROM: Stomach

ACCESSION NO. 26673

CLINICAL ABSTRACT:

History: The chief complaints of this 60-year old black female were melena, nausea, weakness, constipation and anorexia for a few days preceding admission. Past history included g.i. bleeding, the last episode a few months prior to admission. There was also history of a right cerebrovascular accident 12 years previously. Peptic ulcer disease dated back 17 years ago. Monoclonal IgM gammopathy with mild lymphoplasmacytic proliferation and positive rheumatoid factors were documented in the past.

Esophagogastroduodenoscopy on February 1988 revealed 5 ulcers, one which measured 1.5 cm. in diameter. Repeat done on July 7, 1988 showed a 2.5 cm. incisural ulcer with irregular margins.


Laboratory report: Hemoglobin 6 gm.%; platelets 594,000; WBC 8,400. Electrolytes, BUN, creatinine and glucose were within normal limits. Hemoccult positive.

SURGERY: (July 20, 1988)

There was a gastric tumor involving the lesser curvature as well as large hepatic metastases to the left lobe. A partial gastrectomy with a Billroth reconstruction and liver biopsy were performed.

GROSS PATHOLOGY:

The specimen consisted of gastric segment, 11 cm. in length, along the lesser curvature and 18.5 cm. along the greater curvature. A 2 x 6 cm. ulcer was noted 2.5 cm. from the distal margin. Sections through the ulcer bed revealed yellow to white tumor up to 1.5 cm. in thickness extending into serosal fat. Needle biopsy of liver 2 cm. in length was noted.
CLINICAL ABSTRACT:

History: This 63-year-old woman gave a history of several months of abdominal bloating and constipation. There was no rectal bleeding. Her sister died of colon cancer at the age of 56.

Physical examination: Abdomen was soft; the left lobe of the liver was palpable and tender. Anorectal digital examination was negative. Sigmoidoscopy was normal to 35 cm.

Laboratory report: WBC 13,800; hgb 13.9 gm%; SGOT 121 (10-42); SGPT 254 (10-16); alkaline phosphatase 307 (26-88).

Radiograph: Barium enema revealed 13 cm. length of narrowed colon at the junction of the distal colon and sigmoid colon. This had the appearance of involvement from an extrinsic lesion from pelvis (a possible 10 cm. pelvic mass was seen on preliminary film). Possible 1.5 cm. polypoid mass located on the medial wall of the cecal pouch (adherent fecal material or an inverted appendiceal stump may also cause this appearance).

SURGERY: (May 17, 1988)

There was a large sigmoid colon tumor extending through full thickness of bowel with adhesions to the left lateral abdominal wall. Extensive liver metastases were noted.

GROSS PATHOLOGY:

The specimen consisted of a 17 cm. segment of large bowel which contained an 8.5 x 8.5 x 5 cm. multilobulated gray-white tumor. No mucosal ulcerations were noted. Sections showed neoplasm infiltrating bowel wall and attached mesentery. Foci of necrosis were seen. There were several effaced regional nodes.
STUDY GROUP CASES
FOR
NOVEMBER 1990

CASE NO. 1 - ACCESSION NO. 25887

LOS ANGELES: Anaplastic carcinoma with trophoblastic differentiation - 7

LONG BEACH: Poorly differentiated adenocarcinoma with choriocarcinomatous elements (Beta HCG positive) - 9

SAN BERNARDINO (INLAND): Metastatic carcinoma of lung to jejunum - 5; metastatic pheochromocytoma - 4

OAKLAND: Primary small bowel anaplastic carcinoma - 14

MARTINEZ: Metastatic bronchial adenocarcinoma - 5

SAN DIEGO: Metastatic poorly differentiated carcinoma - 19

NORTH DAKOTA: Anaplastic adenocarcinoma - 1

GRASS VALLEY: Metastatic pheochromocytoma - 1

ARIZONA: Metastatic choriocarcinoma from gastric primary - 1

FOLLOW-UP:
Post-operatively the patient developed hepatic insufficiency, a paralytic ileus, and respiratory insufficiency. He died with ventricular arrhythmias on the 14th post-operative day.

DIAGNOSIS:
Choriocarcinoma, jejunum

REFERENCE:


CASE NO. 2 - ACCESSION NO. 26868

NOVEMBER 1990

LOS ANGELES: Leiomyosarcoma - 7

LONG BEACH: Leiomyoma - 7; cellular leiomyoma - 1; leiomyoma of uncertain malignant potential - 1

SAN BERNARDINO (INLAND): Smooth muscle tumor of indeterminate malignant potential - 4; low-grade leiomyosarcoma - 3; leiomyoma - 2

OAKLAND: Stromal sarcoma, low grade - 15

MARTINEZ: Leiomyoma - 5

SAN DIEGO: Leiomyoma - 4; smooth muscle tumor undetermined malignant potential - 12; leiomyosarcoma - 3

NORTH DAKOTA: Smooth muscle tumor of undetermined malignant potential - 1

GRASS VALLEY: Leiomyoma - 1

ARIZONA: Leiomyoma - 1

FOLLOW-UP:

Patient is presently receiving chemotherapy and is doing well.

DIAGNOSIS:

Leiomyosarcoma (Meckel's ?), ileojejunal junction

REFERENCES:


CASE NO. 3 - ACCESSION NO. 24826

NOVEMBER 1990

LOS ANGELES: Squamous cell carcinoma - 7

LONG BEACH: Squamous cell carcinoma - 9

SAN BERNARDINO (INLAND): Squamous cell carcinoma - 9

OAKLAND: Poorly differentiated squamous cell carcinoma - 11; moderately differentiated squamous cell carcinoma - 2

MARTINEZ: Squamous cell carcinoma - 5

SAN DIEGO: Poorly differentiated squamous cell carcinoma - 19

NORTH DAKOTA: Adenosquamous cell carcinoma - 1

GRASS VALLEY: Moderately differentiated squamous cell carcinoma - 1

ARIZONA: Squamous cell carcinoma of GE junction - 1

CORRECTED GROSS PATHOLOGY:

The specimen consisted of 16 cm. of esophagus and upper stomach. The esophagus measured 10 cm. and the proximal stomach 6 cm. in length at the proximal margin as indicated on the attached drawing which appeared to involve the surgical margin. The tumor measured 2.5 cm. in length and involved 2.5 cm. of internal circumference. The cut surface showed a pink-tan tumor, extending 1 cm. in depth precariously close to the soft tissue margin.

SPECIAL STAINS:

Keratin and Mucin: Positive (by contributor)

FOLLOW-UP:

He expired August 1983 at home of recurrent tumor. No autopsy was performed.

DIAGNOSIS:

Squamous cell carcinoma, mid esophagus

REFERENCES:


CASE NO. 3 - ACCESSION NO. 24826

Gross Description:

Esophago-gastrectomy specimen:
(Part E)
Proximal Margin,
Tumor E1-E9

Distal Margin
15.0 E12

Gastroesophageal Junction

E10

E11

E12

Resident in Pathology
Pathologist
Date Completed
CASE NO. 4 - ACCESSION NO. 25419

NOVEMBER 1990

LOS ANGELES: Inflammatory fibroid polyp - 7

LONG BEACH: Inflammatory fibroid polyp (Vaneck polyp or inflammatory pseudotumor) - 9

SAN BERNARDINO (INLAND): Inflammatory fibroid polyp - 9

OAKLAND: Inflammatory fibroid polyp - 15

MARTINEZ: Inflammatory fibroid polyp - 5

SAN DIEGO: Inflammatory fibroid polyp - 19

NORTH DAKOTA: Inflammatory fibroid polyp - 1

GRASS VALLEY: Inflammatory pseudotumor - 1

ARIZONA: Inflammatory fibroid polyp - 1

FOLLOW-UP:

Patient has not been seen by physician in 5 years.

DIAGNOSIS:

Inflammatory fibroid polyp, small bowel

REFERENCE:

LOS ANGELES: Leiomyoblastoma - 7
LONG BEACH: Leiomyoma - 9
SAN BERNARDINO (INLAND): Neurilemoma - 6; leiomyoma - 3
OAKLAND: Stromal tumor of uncertain malignant potential - 15
MARTINEZ: Neurilemoma - 5
SAN DIEGO: Epithelioid leiomyoma (leiomyoblastoma) - 18; schwannoma - 1
NORTH DAKOTA: Leiomyoma - 1
GRASS VALLEY: Epithelioid leiomyoma - 1
ARIZONA: Neurofibroma - 1

SPECIAL STAIN:

Vimentin: Positive (by contributor)

FOLLOW-UP: (October 19, 1990)

Post-operative course was unremarkable with respect to her tumor and she has had no symptoms referable to the gastro-intestinal tract.

DIAGNOSIS:

Leiomyoblastoma, stomach

REFERENCES:


CASE NO. 6 - ACCESSION NO. 26708

NOVEMBER 1990

LOS ANGELES: Carcinoid - 7

LONG BEACH: Carcinoid - 9

SAN BERNARDINO (INLAND): Carcinoid tumor - 9

OAKLAND: Carcinoid - 15

MARTINEZ: Carcinoid - 5

SAN DIEGO: Carcinoid tumor - 19

NORTH DAKOTA: Carcinoid - 1

GRASS VALLEY: Malignant carcinoid tumor - 1

ARIZONA: Adenocarcinoid - 1

FOLLOW-UP:

He had an uneventful recovery. He was last seen in July of 1990 without any clinical evidence of neoplasm.

DIAGNOSIS:

Carcinoid, ileocecal valve

REFERENCES:


LOS ANGELES: Poorly differentiated adenocarcinoma (linitis plastica) - 7

LONG BEACH: Poorly differentiated adenocarcinoma - 9

SAN BERNARDINO (INLAND): Diffusely infiltrating carcinoma, linitis plastica type - 9

OAKLAND: Gastric adenocarcinoma, linitis plastica type - 15

MARTINEZ: Linitis plastica - 5

SAN DIEGO: Diffuse adenocarcinoma - 19

NORTH DAKOTA: Signet ring cell carcinoma - 1

GRASS VALLEY: Poorly differentiated adenocarcinoma - 1

ARIZONA: Poorly differentiated adenocarcinoma - 1

FOLLOW-UP:

The patient expired 3 days after surgery without benefit of an autopsy.

DIAGNOSIS:

Poorly differentiated adenocarcinoma (linitis plastica), stomach

REFERENCES:


CASE NO. 8 - ACCESSION NO. 26669

NOVEMBER 1990

LOS ANGELES: Mucinous carcinoma (signet ring cell type) - 7

LONG BEACH: Mucinous (colloid) adenocarcinoma - 8; signet ring cell carcinoma - 1

SAN BERNARDINO (INLAND): Mucinous adenocarcinoma - 9

OAKLAND: Adenocarcinoma, mucinous type - 15

MARTINEZ: Signet ring carcinoma - 5

SAN DIEGO: Mucinous adenocarcinoma - 19

NORTH DAKOTA: Signet ring cell carcinoma - 1

GRASS VALLEY: Poorly differentiated adenocarcinoma (signet ring cell adenocarcinoma) - 1

ARIZONA: Signet ring cell adenocarcinoma - 1

SPECIAL STAIN:

S-100: Negative

FOLLOW-UP:

The patient expired on August 10, 1990 without benefit of an autopsy.

DIAGNOSIS:

Mucinous carcinoma (signet ring cell type), rectosigmoid

REFERENCES:


CASE NO. 9 - ACCESSION NO. 26796

LOS ANGELES: Villous adenoma with focal adenocarcinoma in situ - 7

LONG BEACH: Villous adenoma with marked cytologic atypia in a patient with Gardner's syndrome - 9

SAN BERNARDINO (INLAND): Tubulovillous adenoma with focal intramucosal adenocarcinoma - 9

OAKLAND: Tubulovillous adenoma with severe dysplasia/CIS; adenomatous hyperplasia in adjacent mucosa - 15

MARTINEZ: Villoglandular polyp with focal CIS - 5

SAN DIEGO: Tubulovillous adenoma with intramucosal adenocarcinoma - 4; tubulovillous adenoma with severe dysplasia - 5; tubulovillous adenoma with carcinoma in situ - 10

NORTH DAKOTA: Adenocarcinoma in situ - 1

GRASS VALLEY: Moderately dysplastic tubulovillous adenoma - 1

ARIZONA: Ampullary villous adenoma with severe atypia - 1

FOLLOW-UP:

Patient is doing well as of October 17, 1990.

DIAGNOSIS:

Villous adenoma with intramucosal carcinoma, duodenum

REFERENCES:


CASE NO. 10 - ACCESSION NO. 12662

LOS ANGELES: Poorly differentiated squamous cell carcinoma, cloacogenic type - 8

LONG BEACH: Poorly differentiated squamous cell carcinoma (basaloid) - 9

SAN BERNARDINO (INLAND): Cloacogenic carcinoma - 9

OAKLAND: Squamous cell carcinoma, non-keratinizing - 10; Squamous cell carcinoma, basaloid type - 5

MARTINEZ: Keratinizing carcinoma - 5

SAN DIEGO: Cloacogenic carcinoma (basosquamous type) - 14; squamous cell carcinoma - 4; anal carcinoma - 1

NORTH DAKOTA: Squamous cell carcinoma - 1

GRASS VALLEY: Basaloid squamous cell carcinoma - 1

ARIZONA: Non-keratinizing squamous cell carcinoma (basaloid) - 1

FOLLOW-UP:

He expired on March 14, 1962 of carcinomatosis without benefit of an autopsy.

DIAGNOSIS:

Cloacogenic carcinoma (basosquamous), anus

REFERENCES:


CASE NO. 11 - ACCESSION NO. 26673
NOVEMBER 1990

LOS ANGELES: Lymphoplasmacytoid lymphoma - 7

LONG BEACH: Malignant lymphoma, poorly differentiated lymphocytic - 9

SAN BERNARDINO (INLAND): Gastric lymphoma, small cleaved cell type - 6; plasmacytoid lymphoma - 3

OAKLAND: Malignant lymphoma, diffuse, small lymphocytic with plasmacytoid features, low grade - 15

MARTINEZ: Malignant lymphoma - 5

SAN DIEGO: Malignant lymphoma, low grade, small lymphocytic - 19

NORTH DAKOTA: Malignant lymphoma - 1

GRASS VALLEY: Non-Hodgkin's malignant lymphoma, small lymphoid type (low grade) - 1

ARIZONA: Malignant lymphoma, small lymphocytic type - 1

FOLLOW-UP:

Patient completed a course of chemotherapy with no resolution or progression of disease. Biopsy of right upper lung in June 1989 revealed same neoplasm as the stomach. As of September 1990 he was alive but bedridden.

Immunohistochemistry of gastric tumor by contributor showed most of cells were positive for IgM. Kappa and Lambda were "unrevealing".

DIAGNOSIS:

Lymphoplasmacytoid lymphoma, stomach

REFERENCES:


CASE NO. 12 - ACCESSION NO. 26257

NOVEMBER 1990

LOS ANGELES: Neuroendocrine tumor (carcinoma) - 7

LONG BEACH: Poorly differentiated carcinoma - 6; neuroendocrine carcinoma - 3

SAN BERNARDINO (INLAND): Neuroendocrine carcinoma of colon - 9

OAKLAND: Poorly differentiated adenocarcinoma, metastatic - 15

MARTINEZ: Undifferentiated small cell neuroendocrine carcinoma - 3; undifferentiated carcinoma - 2

SAN DIEGO: Small cell neuroendocrine carcinoma - 19

NORTH DAKOTA: Small cell carcinoma - 1

GRASS VALLEY: High grade malignant carcinoid tumor/small cell undifferentiated carcinoma - 1

ARIZONA: Malignant lymphoma, small non-cleaved (Burkitt's type) - 1

SPECIAL STAINS:

Keratin, chromogranin, and NSE - Positive (by contributor)

FOLLOW-UP:

Lost to follow-up following her surgery in 1988.

DIAGNOSIS:

Neuroendocrine carcinoma, rectosigmoid

REFERENCE: