

1039

PATHOLOGISTS' CLUB OF NEW YORK



comp ← (new case)

MEETING

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WINTHROP UNIVERSITY HOSPITAL
222 STATION PLAZA NORTH, SUITE 618
MINEOLA, NY 11501

DATE: Thursday, December 3, 1998

PLACE: North Shore University Hospital
300 Community Drive
Manhasset, New York 11030

HOST: Steven Hajdu, M.D.

INFORMATION: (516) 562-3250

RECEPTION: 5:30 P.M.

DINNER: 6:00 - 7:00 P.M.

SCIENTIFIC SESSION: 7:00 - 9:00 P.M.

DIRECTIONS

Take Long Island Expressway to Exit 33. Follow Community Drive to Entrance #3 to the hospital. Follow this to the parking garage.

Cross to the main entrance (Monti Pavilion), inside which signs will direct you to the meeting.

PATHOLOGY CLUB

December 3, 1998

CASE 1. (Case of Alain C. Borczuk, M.D.)

Case History:

The patient is a 78 year old man, with a history of Crohn's Disease in the past (recently inactive, no recent steroid therapy) who presented to his physician after a complaint of weight loss. He was a heavy smoker. A chest x-ray revealed a mass in the left lower lobe, confirmed by CAT scan. A lower lobe resection was performed, and an endobronchial mass, 1.5cm. from the bronchial margin was identified.

Discussant: Kathleen Whitney, M.D.
Montefiore Medical Center, Albert Einstein College of Medicine

CASE 2. (Case of Peter M. Farmer, M.D.)

Case History:

An 82 year old woman had no significant past medical history. She lived alone, was independent and able to look after herself. She was discovered on the floor of her apartment by a building superintendent who called EMS. On admission, she was awake but mute and did not respond to commands. Imaging studies demonstrated a hematoma in the left cerebral convexity.

Discussant: Chandrakant Rao, M.D.
Attending Neuropathologist
Clinical Associate Professor of Pathology
State University of New York - Downstate Medical Center

CASE 3. (Case of Carlos D. Urmacher, M.D.)

Case History:

A 51 year old woman presented with a neck mass of several months duration. No constitutional symptoms. No significant past medical history.

Discussant: Daniel Filippa, M.D.
Attending Pathologist
Memorial Sloan-Kettering Cancer Center

CASE 4. (Case of Albert E. Stanek, M.D.)

Case History:

The patient is a 72 year old woman who presented with vaginal bleeding. She had no other symptoms. The physical examination showed no significant abnormalities. Following endometrial curettage, a hysterectomy was performed.

Discussant: Lora Hedrick Ellenson, M.D.
Assoc. Prof. of Pathology, Weill Medical College of Cornell University
Director of Gynecological Pathology, The New York Hospital

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MINUTES OF MEETING December 3, 1998 North Shore University Hospital

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A sizeable turnout was no doubt due to the extremely interesting cases presented, although the balmy spring-like weather was certainly a plus! Dr. Broome hosted and Dr. Haidu moderated the scientific session.

Case #1

78 year old man with lung mass.

Guest discussant: Kathleen Whitney, Montefiore Medical Center, AECOM.

Host: Alain C. Borczuk.

Diagnosis: Sebaceous carcinoma

Dr. Whitney began with a histologic description of the lesion, the relevant features of which include a heterogeneity of the tumor cells, squamous differentiation with keratin, and a population of cells with basophilic to clear, bubbly cytoplasm. There is no associated CIS. The histologic features suggest sebaceous differentiation. Mucoepidermoid carcinoma is excluded by mucicarmine negativity. The tumor cells are CAM 5.2 neg, CK7 neg, CK20 neg, CK903 pos, and polyCEA pos. A literature review discloses cases of sebaceous lesions in salivary gland but not in lung. Sebaceous carcinoma has also been reported in the ocular adnexa, thought to arise from Meibomian glands. Poor prognostic features include pagetoid spread, multicentric origin, and poor sebaceous differentiation.

Dr. Borczuk's conclusion was essentially the same; his diagnosis was primary squamous carcinoma of the lung with sebaceous differentiation vs. metastatic sebaceous carcinoma. He showed electron microscopic data, mentioned the old red O positivity and mucicarmine negativity, and emphasized the unique aspect of this case, with a case report in the works!

Case #2

87 year old woman without dementia, with left cerebral hemorrhage.

Guest discussant: Chandrakant Rao, SUNY New York - Downstate Medical Center

Host: Peter M. Farmer

Diagnosis: Cerebral amyloid angiopathy (CAA)

Dr. Rao began with a presentation of the major causes of intracerebral hemorrhage: hypertensive, vascular malformation, neoplasm, and hematologic disease, all of which were excluded in the current case, either due to location of the hemorrhage (subcortical white matter), or other clinical factors. He drew attention to the homogeneous pink material within the vessel walls, with "double barrel" lumens. Congo red stain is positive with apple green birefringence. Thus, this is a case of cerebral amyloid angiopathy (CAA). Dr. Rao next established this as a case of beta A4 amyloid, ruling out other biochemical amyloid forms (AA, AL, cystatin, beta-2-microglobulin, transthyretin, apolipoprotein A1, prior protein). He then presented a differential diagnosis which included Alzheimer's disease with CAA, Down's, D. Pugilistia, AVM, Dutch type hereditary cerebral hemorrhage with amyloid, and non-familial CAA. He concluded that the current case is one of CAA, non-familial, non-Alzheimer's-related, sporadic, age-related. Dr. Farmer concurred.

Case #3

51 year old woman with neck mass

Guest discussant: Daniel Filippa, Memorial Sloan-Kettering Cancer Center

Host: Carlos D. Urmacher

Diagnosis: Tumor of fibroblastic reticulum cells (stromal cell tumor of lymph node).

Dr. Filippa illustrated the lesion as a diffuse proliferation of large irregular cells percolating through residual lymphocytes. The differential diagnosis encompasses metastatic carcinoma, Langerhan cell granulomatosis, follicular dendritic cell tumor, interdigitating dendritic cell tumor, thymoma, meningioma, mesothelioma, epithelioid sarcoma, and large cell lymphoma. Most of these entities are excluded by histology and/or immuno results. The cells of interest are AE1/AE3 positive, but negative for everything else, including other kerating markers (CAM 5.2, 7, 20), lymphoid markers including CD30, S100, HMB45, vimentin, and CD21 (dendritic reticulum cells). Dr. Filippa then presented a nice table contrasting the site, antigenic markers, and clinical course of Langerhans cell lesions (S100+, CD1a+), follicular dendritic cell lesions (CD21+, CD35+), and interdigitating dendritic cell lesions (S100+, CD4+, CD1A+, HLA-DR+). He concluded that the tumor is a stromal cell tumor of lymph node.

Dr. Urmacher mentined that the patient had three lymph node biopsies over 15 months, all of which were in the same neck area and similar histologically. Of interest, EBV expression was found by PCR. The nasopharyngeal area was investigated and found to be negative. The cells are negative for S100, CD21, CD35, vimentin, SMA, desmin. HMW CK903, CAM5.2, EMA, and AE1/AE3 are positive. The differential diagnosis includes metastatic carcinoma, Rosai-Dorfman, and follicular dendritic cell neoplasm. Fibroblastic reticulum cells of the mantle zone are PAS+, CK+, desmin +, vimentin +, SMA+, and S100-. Electron microscopy showed desmosomes, and microfilaments. Dr. Urmacher's final diagnosis is **metastatic carcinoma (unknown primary) vs. Tumor of fibroblastic reticulum cells.**

Case #4

72 year old woman with vaginal bleeding

Guest discussant: Lora Hedrick Ellenson

Host: Albert E. Stanek

Diagnosis: Endometrial adenocarcinoma, endometrioid, and mucinous, with interstitial differentiation and signet ring cells.

Dr. Ellenson described the lesion as an infiltrating gland-forming tumor with heterogeneous features, with glands lined by tall columnar cells with mucinous differentiation, both endocervical and intestinal types, with areas of solid growth and a vague nesting pattern, and with abundant extracellular mucin and signet ring cells. The differential diagnoses is among and endometrial primary with mucinous differentiatin, an endocervical primary with endometrial extension, and a GI primary metastatic to the uterus. "Histologic hints" include the presence of an in situ lesion (complex atypical hyperlasia), squamous differentiation, and central necrosis, all of which favor an endometrial primary. Further, the tumor cells are CK7+/CK20-, consistent with Mullerian origin and not GI origin. Dr. Ellenson concluded by pointing out the genetic and histologic similarities between GI and Mullerian tumors that mimic GI features.

Dr. Stanek concurred, extended the theme of histologic overlap, and drew attention to the presence of enteric O-acylated sialomucins in some endometrioid adenocarcinoma.