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<td>39</td>
<td>28463</td>
<td>Malignant melanoma, small bowel mesentery</td>
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ACCESSION 18592

CLINICAL ABSTRACT: The patient was a 57-year-old, Caucasian male who underwent workup for "headaches".

GROSS PATHOLOGY: The specimen consisted of several irregular fragments of hemorrhagic and dark gray tissue containing nodular masses up to 3 cm in diameter. There was adherent fibrous membrane.

ACCESSION 18888

CLINICAL ABSTRACT: This 69-year-old Caucasian female presented with a left thigh mass of one year's duration. There was no preceding history of infection or trauma. A radiograph revealed a soft tissue mass which did not involve adjacent bone. The patient was otherwise in excellent health. A local resection was performed.

GROSS PATHOLOGY: The tumor was fusiform and measured 10 x 7 x 6 cm. Bisection revealed a variegated yellow-tan surface.

FOLLOW-UP: The patient did well for two years, when radiographs revealed extensive metastatic disease. Chemotherapy and radiotherapy were unsuccessful. The patient expired the following year, with metastatic disease to the right maxillary sinus, palate, and lungs, as well as recurrent tumor in the left thigh.

ACCESSION 19278

CLINICAL ABSTRACT: A 55-year-old Caucasian female experienced progressive thyroid enlargement over many years which she described as a goiter, though the exact function of her thyroid gland was not known to her. She had been placed on thyroid medication for a month prior to her thyroidectomy. She admitted to intermittent episodes of palpitation, nervousness and apprehension for many years. A mass appeared recently in the left side of the neck associated with intermittent choking-like sensations and fullness in her throat, which had suddenly become worse just prior to admission. Positive physical findings included a moderately enlarged thyroid gland with the left lobe appearing larger than the right, and a small palpable nodule in the left lobe. Her blood pressure was midly elevated. A thyroidectomy was performed.

GROSS PATHOLOGY: The specimen was received in three sections. The first consisted of a 6 gram portion of thyroid tissue measuring 5 x 2.5 x 1.5 cm. It was partially encapsulated and showed meaty red thyroid tissue which was finely lobulated in a uniform fashion, showing no discrete nodules except for a small pale area near one end of the lobe. The next consisted of a 1.0 x 0.6 x 0.2 cm portion of pink-white parenchyma. The final specimen consisted of a 34 gram portion of tissue measuring 5.5 x 4.0 x 3.0 cm. It was firm and showed pale gray-pink to pink-white fascicular tissue throughout, with a scattering of honey-colored small translucent foci which were oval to spherical and measured up to 4 mm in diameter scattered in the parenchyma. Some muscular tissue was attached externally.
CLINICAL ABSTRACT: An 83-year-old female complained of intermittent pain with swelling in the right lower quadrant of the abdomen of two months' duration. The pain was present after meals and prior to the movement of her bowels. Bowel movements sometimes relieved the pain slightly, but the distress was more or less constant. Patient had lost six pounds in two months. Physical examination confirmed tender mass in the right lower quadrant. A salpingo-oophorectomy, para-ovarian cystectomy and cholecystectomy were performed.

GROSS PATHOLOGY: The specimen consisted of approximately 800 grams of mucinous, amorphous yellow-white tissue. The left ovary weighed 650 grams and measured 15 x 15 x 10 cm. It contained multiple 0.5 to 0.8 cm cystic spaces filled with myxomatous white material. The para-ovarian cyst measured 4 cm in greatest dimension. The gallbladder showed a smooth mucosa and multiple stones.

NOTE: The abdominal mass noted clinically and on physical examination apparently was due to the large amount of "gelatinous" material that also caused the patient's pain.

SPECIAL STUDIES: PAS - positive for mucin.

CLINICAL ABSTRACT: The patient was a 38-year-old Caucasian male presented with a lump in his throat of four months duration. Physical examination revealed a midline fungating polypoid tumor of the posterior tongue just anterior to the epiglottis. A supraglottic laryngectomy with removal of the tumor and base of the tongue was performed.

GROSS PATHOLOGY: The specimen consisted of one piece of tissue containing the epiglottis, hyoid bone, thyroid cartilage and base of tongue with a fungating lesion. The tumor measured 6.0 x 5.5 x 2.0 cm, and was attached to the base of the tongue by a pedicle which measured 3.0 cm in diameter. Upon bisection, the tumor varied from pink to tan in color, and the base of the tumor had a distinct margin with no gross evidence of infiltration into the tissue beneath.

FOLLOW-UP: The patient underwent radiotherapy. The patient required further surgery to remove a stricture which developed at the site of the original surgery. One year post-operatively, the patient had no evidence of recurrent or metastatic tumor.

CLINICAL ABSTRACT: A 59-year-old female was found to have bilateral thyroid nodules and an ectopic thyroid gland on workup.

GROSS PATHOLOGY: The specimen consisted of a 10 gram piece of dark reddish-brown to pale yellow tissue which measured 6.5 x 4.5 x 1.2 cm. The architecture was practically obliterated by multiple soft pale white nodules varying in size from 0.3 to 1.4 cm in diameter. Focally these nodules were speckled with fine calcification.
CLINICAL ABSTRACT: A 43-year-old Hispanic female had been experiencing neck pain for five years. There was associated nervousness and insomnia. Patient denied any recent weight loss. On physical examination, a hard and movable nodule was palpated in the left lobe of thyroid. A partial thyroidectomy was performed.

GROSS PATHOLOGY: The specimen weighed 55 grams. Cut sectioning revealed a whitish, homogenous nodule, 4.5 cm in diameter. Other smaller nodules were noted in the remaining glandular tissue.

CLINICAL ABSTRACT: This 18-year-old, vigorously health Caucasian male noted a fullness in his right groin of one month's duration. Physical examination revealed a firm, 3.0 cm mass in the right inguinal region, in the space between the inguinal ligament and femoral fossa. There was not adjacent or other adenopathy. The liver and spleen were not palpable. The testicles were carefully examined and found to be normal. Both testicles were present. A CBC revealed a relative lymphocytosis which had persisted. Chest x-ray and routine laboratory studies were normal. An excisional biopsy was performed.

GROSS PATHOLOGY: The specimen consisted of 30 grams of tissue containing multiple nodular aggregates which measured from 1.0 cm to a large mass measuring 3 x 3.5 x 2.5 cm. The masses were poorly-encapsulated. Sectioning showed a relatively homogeneous, glistening, relatively soft tissue with a focus of necrosis or hemorrhage focally.

FOLLOW-UP: The patient was seen in Tumor Board and numerous diagnostic procedures were recommended. These included an intravenous pyelogram, Gallium scan, lymphangiogram, human chorionic gonadotropin titer, alpha-1 fetoprotein and CEA determinations. All of these were negative or normal, except for the lymphangiogram which showed para-aortic nodal enlargement diagnostic of involvement by metastatic tumor.

CLINICAL ABSTRACT: This 52-year-old Caucasian female presented with a pelvic mass. Workup revealed a right ovarian tumor. Hysterectomy with bilateral salpingo-oophorectomy were performed.

GROSS PATHOLOGY: The specimen measured 6 x 5 x 4 cm and weighed 35 grams. Sectioning revealed two separate lesions replacing portions of the ovary. One lesion was a solid, slightly nodular and roughly ovoid mass that measured 2.5 cm in greatest dimension. This mass was a yellowish-white in color, and rubbery in consistency. The other lesion measured 4 cm in greatest dimension and on sectioning was partially cystic. This cystic area contained a yellowish-white, semi-solid material that had a "greasy" consistency. The remainder of the structure in the ovary was more solid and was of a reddish-brown color with the cut surface suggesting the gross appearance of thyroid tissue.
ACCESSION 23347  CASE 10

CLINICAL ABSTRACT: A 59-year-old male complained of intermittent gross hematuria for one year. He gave the history that after an abdominal exploratory operation he was told he had pancreatic cancer. No biopsy was obtained. He was treated with cytoxan which was continued on an intermittent basis for five years. After five years of treatment, another doctor told him it must have been a pancreatic cyst. Hematuria and symptoms of bladder irritation began five years after that. X-ray examination revealed a cystic, partially calcified structure in the region of the pancreas, and highly anaplastic malignant cells were detected on urine cytologic examination. Cystoscopy revealed diffuse, edematous and erythematous raised granular areas throughout the lower half of the bladder, and multiple biopsies were performed.

GROSS PATHOLOGY: Unavailable.

ACCESSION 23669  CASE 11

CLINICAL ABSTRACT: This 64-year-old female presented with mass in the pelvic area. Workup revealed a large ovarian mass. A hysterectomy and bilateral salpingo-oophorectomy were performed.

GROSS PATHOLOGY: The specimen consisted of a lobulated ovoid tumor mass which weighed 323 grams and measured 12 x 8 x 8 cm. The serosal surface was pink-tan to purple with multiple cystic lobulations and fibrous adhesions. Cross sectioning revealed a soft tan-yellow fibrous tissue with multiple irregular cystic cavities ranging from 0.1 to 2.3 cm in diameter, filled with clear yellow serous fluid. The lining of the larger cystic cavities contained papillary projections measuring 0.2 cm in greatest dimension.

ACCESSION 24020  CASE 12

CLINICAL ABSTRACT: This 58-year-old female had a four-month history of an enlarging mass in the right inguinal femoral region. Physical examination revealed a 3.5 x 4.0 x 3.0 cm mass in the right femoral region which was resected. Twenty-three years earlier she had a hysterectomy with bilateral salpingo-oophorectomy. Three years ago she had a right thigh skin lesion removed by electrodessication.

GROSS PATHOLOGY: The 6.0 x 4.0 x 3.5 cm portion of fat and connective tissue included a fairly well-circumscribed, 5.5 x 3.8 x 3.0 cm mass. It had yellow-gray, friable parenchyma with areas of hemorrhage and cyst formation.

SPECIAL STUDIES: HMB-45 = negative, S-100 = positive.

FOLLOW-UP: After surgery, the patient was lost to follow-up.
ACCESSION 24147  CASE 13

CLINICAL ABSTRACT: This 74-year-old female presented with atypical symptoms of appendicitis. During surgery, the surgeon thought he was dealing with an acute appendicitis, perforated, with a walled-off abscess.

GROSS PATHOLOGY: The specimen was a sausage veriform appendix which measured 7 cm long and 2 cm in diameter with a roughened, patchily hemorrhagic serosa. Cut surfaces showed mucinous to gelatinous material replacing almost the entire wall, with focal extension into adjacent mesoappendiceal fat.

ACCESSION 24856  CASE 14

CLINICAL ABSTRACT: This 46-year-old Caucasian male presented with a neck mass. Physical examination revealed a thyroid tumor.

GROSS PATHOLOGY: Unavailable.

ACCESSION 25067  CASE 15

CLINICAL ABSTRACT: The patient was a 73-year-old male. No further history is available.

GROSS PATHOLOGY: Unavailable.

ACCESSION 25100  CASE 16

CLINICAL ABSTRACT: This 60-year-old female had a mass in the right hip which reportedly had not changed in size for eighteen years. Recently there had been vague pain in the hip. X-rays suggested that the mass was lateral to the ilium without bony involvement. The mass was located deep in the buttock and seemed to be attached to gluteal fascia by a stalk. It was not connected to the joint capsule or space.

GROSS PATHOLOGY: The mass measured 6.0 x 5.5 x 4.5 cm and appeared encapsulated. Cut surfaces were glistening and white with yellow streaks.

FOLLOW-UP: Post-operatively, the tumor bed was irradiated with 6000 rads. There had been no recurrence of the thigh lesion. Approximately one year post-operatively she developed back pain. A bone scan showed multiple labelling defects in the cervical, thoracic and lumbar vertebrae, ribs and lesser trochanter, with fractures of the right femur and rib. These were clinically thought
CLINICAL ABSTRACT: This 40-year-old male presented with a huge mass the size of a large apple in the right neck, near the posterior triangle. No adenopathy was noted on physical examination. The mass was quite firm and attached, with no pulsations or bruit noted. There was anesthesia over the right ear, neck, and onto the mandibular area of the face. No apparent weakness to the trapezius muscle area or the spinal accessory innervates at this time. The thyroid was not enlarged.

GROSS PATHOLOGY: The specimen consisted of a soft tan-white tissue that measured in aggregate approximately 2.5 x 2.5 x 1.5 cm. Additionally, an elliptical skin segment measured 4.0 x 0.8 cm, which presumably represented a cutaneous scar.

ACCESSION 25417 CASE 17

CLINICAL ABSTRACT: This 40-year-old male presented with a huge mass the size of a large apple in the right neck, near the posterior triangle. No adenopathy was noted on physical examination. The mass was quite firm and attached, with no pulsations or bruit noted. There was anesthesia over the right ear, neck, and onto the mandibular area of the face. No apparent weakness to the trapezius muscle area or the spinal accessory innervates at this time. The thyroid was not enlarged.

GROSS PATHOLOGY: The specimen consisted of a soft tan-white tissue that measured in aggregate approximately 2.5 x 2.5 x 1.5 cm. Additionally, an elliptical skin segment measured 4.0 x 0.8 cm, which presumably represented a cutaneous scar.

ACCESSION 25451 CASE 18

CLINICAL ABSTRACT: The patient was a 34-year-old gay, white male with "gay lymph node syndrome", who presented with a left neck mass. Within a couple of weeks a right neck mass developed. Patient's serum calcitonin was negative. A total thyroidectomy was performed. Because of the histology of the tumor, a radical neck dissection was not performed, and the patient remained with cervical and supraclavicular adenopathy which continued to increase in size. Patient was treated with a low dose of Adriamycin.

GROSS PATHOLOGY: The specimen consisted of a 48 gram total thyroidectomy specimen. The right lobe was markedly larger than the left, and measured 7.0 x 3.0 x 4.0 cm in greatest dimension. This lobe contained a 4.3 cm in greatest dimension encapsulated nodule which bulged from the cut surface. The parenchyma of this nodule was rubbery and centrally soft, and had a variegated yellow-orange-white and hemorrhagic appearance. Irregular nodules up to 0.4 cm in diameter with a white, rubbery, soft appearance extended throughout the proximal portion of the right thyroid lobe, as well as across the isthmus and into the medial portion of the left lobe of the thyroid. A 1.5 cm in diameter lymph node completely replaced by soft white, similar-appearing tumor tissue was located beneath the isthmus.

OUTSIDE CONSULTATION: Harry Evans, M.D., University of Texas in the Anderson Hospital: Poorly differentiated invasive follicular carcinoma of the thyroid extending into extrathyroid tissue.

ACCESSION 25704 CASE 19

CLINICAL ABSTRACT: An 80-year-old female presented with a cyst in the right hip area which had been increasing in size. She had increased her Thiosulfil during this time, which seemingly reduced the size of the cyst. Physical examination revealed a 7-8 cm mass with a projection. Ultrasound showed a non-cystic subcutaneous mass. An excisional biopsy was performed.

GROSS PATHOLOGY: The specimen was received in multiple sections. The first consisted of multiple pieces of neoplastic tissue, 0.5 x 0.8 x 0.8 cm in diameter. The second specimen weighed 150 grams and measured 12 x 25 x 8 cm. One surface was covered by a thick leathery fascia; the other by lobulated fat. Cut sections were fleshy with areas of necrosis and yellowish discoloration interspersed. The third specimen consisted of a 1.5 x 3.0 x 2.8 cm strip of glistening, pearly white fascia. The final specimen measured 0.5 x 1.8 x 2.0 cm and consisted of a strip of fascia with muscle adherent to it.
CLINICAL ABSTRACT: A 38-year-old female noted a mass in her left buttock that was rapidly enlarging. MRI scan revealed a large gluteal mass, neither invading nor involving bone, measuring 12 x 14 cm. After radiation therapy, the patient returned for resection of the buttock tumor.

GROSS PATHOLOGY: The specimen consisted of skin, subcutaneous tissue and muscle from the left buttock, measuring 21 x 18 x 14 cm and weighing 2300 grams. A healed biopsy area is noted in the skin, which appeared to be elevated 5-8 mm above the adjacent skin. Sectioning revealed an irregular, multinodular tumor mass extending over an area measuring 17 x 8 x 7 cm. The tumor was noted as irregularly nodular, and presented for the most part fish-flesh in appearance. It extended wo within 1 cm of the skin but did not appear to be attached to skin. It appeared to arise in underlying fatty tissue which was involved extensively. The underlying musculature was involved with tumor, extending into the muscle to a depth of 2.5 and 3.0 cm in two areas. Focal areas of yellow-gray necrosis were seen within the tumor. The tumor extended to the inferior lateral margin of resection. The closest margin from the edge of resection from the tumor was 3.0 cm. The maximum tumor dimensions were 17 x 8 x 7 cm.

CLINICAL ABSTRACT: This 43-year-old Asian male was found to have a mediastinal mass during workup.

GROSS PATHOLOGY: The specimen consisted of a well-circumscribed mass weighing 376 grams and measuring 15 x 10 x 7.5 cm. The mass had a wedge-shaped appearance with a serosal surface that was well-encapsulated and lobulated with a reddish brown color with areas of cream-colored parenchyma below the capsule. On one surface of the mass a smooth, sac-like structure was attached which was smooth and glistening. There was also adherent adipose tissue. Cross sectioning of the tumor revealed focal areas of necrosis. The areas of firmness were well-circumscribed lobular structures with fibrous septae extending throughout the tumor mass. The tumor itself was pale yellow in the lobulated regions. There were some pale yellow lesions on the periphery of the tumor mass that had a different color than the majority of the tumor mass, measuring 1.0 cm in diameter.

CLINICAL ABSTRACT: This 55-year-old male presented with a seven month history of a rapidly expanding mass on the right buttock with local ulceration and bleeding. Patient states that before the lesion became obvious, he noticed a "red-streak" over the area. An excisional biopsy was performed.

GROSS PATHOLOGY: The specimen consisted of an ovoid portion of skin measuring 15.5 x 12.5 cm. Present on the skin surface was a large, nodular, firm, centrally ulcerating, flat lesion which measured 4.5 cm and arose from the skin surface at a height of 1.4 cm. The skin surface was markedly distorted by several additional lumps which measured 3.0, 1.5 and 0.5 cm. No ulcerations were seen on these lesions. Cut sectioning revealed a rather well-defined, heterogenous, somewhat mucoid, light pink-white lesion of 4.0 cm. Adjacent and apparently non-contiguous with this larger lesion was an additional, similar-appearing lesion in the area of the deformed, heaped-up skin surface. This involved the soft tissue to a depth of 2.0 cm, coming to within 2.5 cm of the deep surgical margin. No definite tumor was seen within the deep surgical margin, however, tumor involved the muscle just above the deep surgical margin.
ACCESSION 26160: CASE 23

CLINICAL ABSTRACT: This 86-year-old Asian male presented with a mass in the left buttock. The mass was hard, and measured 7 cm in diameter. A wide excisional biopsy was performed.

GROSS PATHOLOGY: The specimen consisted of a roughly elliptical segment of skin and underlying tissue which measured 11 x 5.5 x 3 cm. Multiple nodules projected through the surface of the skin, ranging in size from 0.2 to 3.0 cm in diameter, with evidence of induration at the superior and inferior resection margins near the medial resection end. Sectioning showed the nodules to correspond with firm, grayish-white to pinkish tissue having a semi-translucent appearance in some areas with occasional hemorrhagic nodules, each measuring about 0.4 cm in diameter.

ACCESSION 26293 CASE 24

CLINICAL ABSTRACT: This 65-year-old retired longshorman presented with night sweats of 1.5 months' duration. A chest x-ray revealed an anterior mediastinal mass. The patient had no symptoms of myasthenia Gravis or hyperthyroidism. The patient underwent left anterior thoracotomy with excision of a mediastinal tumor. He subsequently underwent radiation therapy.

GROSS PATHOLOGY: The specimen was a 9.0 x 5.5 x 5.0 cm piece of fatty tissue with adherent pericardium. On sectioning, there was a central tumor which measured 6.0 x 5.5 x 4.5 cm. It was firm, lobulated, and tan-white with focal areas of hemorrhage. There was focal necrosis. The tumor was apparently unencapsulated and pushed into the surrounding mediastinal fat. The tumor appeared to infiltrate to, but not through the pericardium.

FOLLOW-UP: The patient was well as of his last visit, 6-1/2 years post-operatively.

ACCESSION 26419 CASE 25

CLINICAL ABSTRACT: The patient was a 77-year-old male admitted to the hospital with anemia and a working diagnosis of "gastrointestinal bleeding secondary to ulcer disease. Because of a continual dropping of the hematocrit level, the patient was immediately taken for surgery. On opening the abdomen, the surgeon discovered a large amount of intraperitoneal blood present, and present in the retroperitoneum, in the area of the pancreas, was a large (20 cm) soft tumor mass. The surgeon felt that the tumor could not be removed safely, so a biopsy was performed and the patient was closed.

SPECIAL STUDIES: Cytokeratin = negative; vimentin = positive; S-100 = negative; CEA = negative; muscle specific actin = negative; collagen type IV = negative; EMA = negative.

OUTSIDE CONSULTATION: Hector Battifora, M.D.; City of Hope Medical Center: Epithelioid Leiomyoblastoma (Gastrointestinal Stromal Tumor).
CLINICAL ABSTRACT: This 42-year-old female with a nodule on the right side of the thyroid, present for seven years. Thyroid scan confirmed the nodule, which measured 3.5 cm.

GROSS DESCRIPTION: The right lobe of thyroid measured 7 x 5 cm. Upon sectioning, the lower pole was completely replaced by tumor except for a small section.

CLINICAL ABSTRACT: This 64-year-old Caucasian male presented with prolonged episodes of ischemic chest pain. Angiography demonstrated a very complex proximal left anterior descending coronary artery lesion that involved the diagonal branch. Coronary bypass grafting was performed. The post-operative period was extremely difficult for the patient, and he subsequently developed increased fatiguability and dyspnea. During workup, a mass in the right mid lung field was found. Exploratory thoracotomy and excision of the tumor was performed.

GROSS PATHOLOGY: This 240 gram specimen consisted of an encapsulated, moderately firm, lobulated mass which measured 95 x 55 x 60 mm. The covering capsule was smooth and gray, except where roughened by hemorrhagic adhesions consisting of adipose tissue and tags of fibrosarcomatous tissue. There was a distinct lobular appearance on the exterior surface. When sectioned, the parenchyma presented a bulging, rather homogeneous soft pale pink to white surface with punctate areas of hemorrhage. Centrally located was a discrete white calcified nodule measuring 5 mm.

CLINICAL ABSTRACT: This 49-year-old Caucasian female presented with a firm node in the left neck area of approximately one months' duration. Thyroid scan revealed a nonfunctioning lower pole at the site of a palpable thyroid nodule with normal uptake. CT scan demonstrated the enlarged left lobe of the thyroid and showed the two palpable lymph nodes as well. No other abnormalities were identified. Patient has smoked 1-1/2 packs per day for 35 years.

GROSS PATHOLOGY: The specimen consisted of the left lobe of thyroid. It was firm in consistency and measured 3.0 x 5.0 x 5.0 cm in overall dimensions. Cut sectioning revealed a variegated pink-grayish parenchyma.

CLINICAL ABSTRACT: This 56-year-old male injured his left knee while on a weekend outing. During workup for this injury, he was found to have a mass within the lower exterior aspect of the thigh muscles. An excisional biopsy was performed.

GROSS PATHOLOGY: The specimen consisted of a portion of tan to grayish-pink, somewhat gelatinous tissue which measured 4.0 x 3.5 x 2.5 cm. A second specimen measured 12 x 8 x 5 cm, and consisted of a portion of tissue including muscle. The cut surface revealed a mass measuring 10 x 5.5 x 4.5 cm. It was somewhat gelatinous in appearance and extended close to one of the margins grossly.

SPECIAL STUDIES: Vimentin = positive; S-100 - focally positive; HMB-45, actin, keratin, LCA, desmin, myoglobin, neurofilament, and CD34 = negative.
CLINICAL ABSTRACT: This 41-year-old female presented for her annual physical and routine mammogram. She was asymptomatic except for mild fibrocystic disease of the breasts. Mammography revealed suspicious microcalcifications in the right breast, and an excisional biopsy was performed.

GROSS PATHOLOGY: This breast tissue specimen measured 7.0 x 4.0 x 4.0 cm, and was received with a metallic wire in place. The tip of the wire marked grossly calcific tissue. Multiple sections revealed homogenous tissue with a few small cysts.

FOLLOW-UP: Repeat mammogram revealed more calcifications. Patient was scheduled for a re-excision. She was subsequently lost to follow-up.

CLINICAL ABSTRACT: This 60-year-old male presented with a left medial/posterior leg mass noticed one week ago. There is minimal tenderness, though the mass has been increasing in size. Patient denied fever or chills. Physical exam confirmed a 5 cm soft tissue mass without erythema or tenderness. An excisional biopsy was performed.

GROSS PATHOLOGY: The specimen consisted of an ellipse of white-tan skin which measured 7 x 3 cm. There was underlying yellow subcutaneous tissue, as well as a relatively well-demarcated tumor which measured 5 x 4 x 3 cm in maximum dimension. The neoplasm was relatively well-demarcated but not encapsulated. Sectioning revealed relatively homogenous yellow and soft with only rare areas showing hemorrhage.

SPECIAL STUDIES: Keratin, desmin, actin, S-100 = negative; Vimentin = positive.

CLINICAL ABSTRACT: This 67-year-old, Gravida 7, Para 5, Ab 2, female presented with a 1-year history of gradually increasing abdominal girth and vague abdominal pain. An ultrasound showed a large irregular mass in the pelvis, extending to the peri-umbilical area. The mass was poorly marginated with both cystic and solid components. Gallstones and a small amount of ascites were also noted. The liver, kidneys and uterus were normal, and ovaries were not identified. CT scan revealed an enlarged uterus with calcified fibroids, normal liver and spleen, and the presence of a large amount of ascites. GI workup, mammogram and cervical cytology were within normal limits. Endometrial biopsy showed inactive endometrium. Patient had been post-menopausal for 16 years. Two abdominal paracenteses were non-diagnostic. Laparotomy with appendectomy, bilateral salpingo-oophorectomy and multiple biopsies were performed.

GROSS PATHOLOGY: The appendix measured 5.0 x 6.0 x 0.3 cm. While an appendix was visible at the resection margin, most of the remaining specimen consisted of friable material with cystic degeneration and abundant mucinous material on the external surface.
CLINICAL ABSTRACT: The patient is a 74-year-old male who presented with melena. The patient had also been experiencing weakness, and his usual cough and sinus problems. Past medical history was significant for recent hospitalization for gastrointestinal bleeding. Physical exam produced minimal epigastric tenderness with no palpable masses. A distal gastrectomy was performed.

GROSS PATHOLOGY: The specimen consisted of a portion of the gastric antrum. One end of the surgical margin is 11.5 cm in circumference, and the other 9.8 cm in circumference. A nodule which measured 3 x 2.2 x 3.8 cm was present in the submucosa, 2.5 cm from one surgical margin and 1.3 cm from the opposite surgical margin. Cut sectioning through the lesion revealed that it did not infiltrate the serosa. The serosa was pink. The cut surface of the lesion showed pale tan, somewhat soft surfaces. The remaining gastric mucosa was pale tan with the usual mucosal folds. The gastric mucosa overlying the lesion was focally ulcerated (0.2 cm), with hemorrhage in the underlying connective tissue and tumor.

SPECIAL STUDIES:
S-100 negative. Desmin negative. H. Pylori positive.

CLINICAL ABSTRACT: The specimen consisted of a large, hemorrhagic appendix which measured approximately 7 cm in length x 1.5 to 2.0 cm in diameter. The serosa was hemorrhagic and showed a 3.0 x 2.0 cm area of hemorrhagic discoloration and possible perforation. On multiple cross sectioning, a mucinous growth was noted, extending from the lumen into the serosal surface. Additional sectioning of the appendix showed hemorrhage in the serosa, a collapsed lumen, and an intact wall.

CLINICAL ABSTRACT: This 36-year-old white female presented with lower abdominal pains on the left side. Ultrasound revealed a mass in the left ovary. A left salpino-oophorectomy was performed.

GROSS PATHOLOGY: The specimen weighed 567 grams and measured 12.0 x 15.0 x 6.0 cm.

CLINICAL ABSTRACT: This 73-year-old male presented with substernal pain, stridor and severe tracheal stenosis. During surgery, it was found that the tumor encased the trachea and thyroid and extended to the anterior mediastinum. A total thyroidectomy was performed.

GROSS PATHOLOGY: The specimen mass measured 7.0 x 3.0 x 2.5 cm and cut surfaces were firm and gray-tan.

CD-5 Positive
CLINICAL ABSTRACT: This 48-year-old male presented with a mass on the mediastinum.

GROSS PATHOLOGY: The specimen consisted of a 131 gram, 14.0 x 9.0 x 3.0 cm red-tan irregular mass. Scattered throughout the parenchyma were multiple friable well circumscribed nodules ranging from 1.0 to 3.5 cm in greatest diameter. Some of the nodules were focally hemorrhagic and necrotic. The remaining tissue was yellow-tan with rare tan fibrous streaks. The external surface was red-tan and lobulated.

CLINICAL ABSTRACT: This 49-year-old female presented with excessive menstrual period for a one year period and had abdominal pain for four days. Her menses would last 7-8 days with clots but no pain. Ultrasound showed what appeared to be an ovarian tumor. A chest x-ray showed right pleural effusion. Hemoglobin, 11.2, WBC 13.6 on admission and dropped to 6.6 later RBC 3.63. Hb s ab was positive. At surgery there was a discrete mass which was found to be adherent to the small intestine.

GROSS PATHOLOGY: The specimen was 7.0 cm in diameter.

SPECIAL STUDIES:
Congo Red 
Negative

CLINICAL ABSTRACT: This 48-year-old male presented with abdominal pain and localized left lower quadrant tenderness. Extensive workup was performed, and the patient was found to have a liver mass and diffuse small bowel thickening with multiple lymph nodes in the diaphragm area on CT scan. A CT of the chest showed a 3.5 x 4.5 aortopulmonary mass. A CT of the head showed a 3.5 x 4.5 cm left occipital mass. An excision of the intra-abdominal tumor, small bowel resection, and CVP placement were performed.

GROSS PATHOLOGY: The mass measured 23.0 x 13.0 x 9.0 cm and weighed 1450 grams and included three apparent segments of small bowel that ranged from 7.0 to 23.0 cm in length. The cut surface of the tumor was soft, gray and fleshy in appearance.

Tumor encasing small bowel
HMB-45 > positive
S-100