PROTOCOL

FOR

MONTHLY SLIDES

November, 1957

TUMOR TISSUE REGISTRY

LOS ANGELES COUNTY HOSPITAL
Case No. 1

Accession No. 9330

Name: C. P.
Age: 9 months
Sex: Female
Race: Caucasian

Contributor: W. W. Hall, M.D.,
Mercy Hospital,
Bakersfield, California.

Tissue From: Lung.

Clinical Abstract:

History: This child was brought to surgery because of the finding of a chronically emphysematous left lower lobe which progressively enlarged and eventually caused almost complete atelectasis of the left upper lobe. The mediastinum was shifted sharply to the right. Weight gain had not been satisfactory and the child appeared to be failing.

Surgery: In March, 1957, the entire left lower lobe was removed.

Surgical findings: At surgery, there was a firm fibrous type of infiltration along the right main bronchus, surrounding the pulmonary vein and continuing into the pericardium.

Gross pathology: On sectioning the lung, the right main bronchus appeared to be encroached upon by the fibrosing process and to become quite narrow a short distance from the cut end of the bronchus.

Follow-up: Postoperatively, the child did very well. The left upper lobe expanded and filled most of the pleural space.
CASE NO. 2

ACCESSION NO. 8693

NAME: J. B.
AGE: 9 SEX: Male RACE: Cau.
CONTRIBUTOR: Robert Cleland, M.D.,
Children's Hospital,
Los Angeles, California.

Tissue FROM: Brain.

CLINICAL ABSTRACT:

History: This child entered the hospital in April, 1956, with a history of anorexia and lethargy of three to four months duration. He had an occipito-frontal headache for three to four weeks.

On physical examination bilateral papilledema, suboccipital tenderness and nuchal rigidity were noted. There were no cerebellar signs, no pathological toe signs and the sensory examination was negative. The child was irritable, but alert and fully oriented. Laboratory studies were negative.

On April 19th, 1956, a ventriculogram showed dilated symmetrical ventricles. The posterior 4th ventricle did not visualize.

Surgery: On April 26th, 1956, a posterior fossa exploration was done.

Surgical findings: A whitish, firm, discrete mass 2 x 2 x 2 cm. was seen on the floor of the posterior 4th ventricle, dumbelling through the foramen. It was subtotally removed.

The patient expired postoperatively on the same day.

Autopsy findings: The brain showed cerebral edema grossly and cerebral and cerebellar herniation. There was a 2 x 2 x 2 cm. portion of the inferior part of the tumor seen surgically, still present below the foramen magnum. There was a 2 x 1 x 1 cm. fibrous white, discrete mass which shelled easily from the left cerebellar hemisphere. There were also discrete masses in the left parieto-occipital lobe and in the pons. Three discrete beads of tumor were noted in the cervical arachnoid.
CASE NO. 3

ACCESSION NO. 8946

NAME: G. C. C.
AGE: 67 SEX: Female RACE: Cauc.

CONTRIBUTOR: Ruth McCammon, M.D.,
Los Angeles County Hospital,
Los Angeles, California.

TISSUE FROM: Brain.

CLINICAL ABSTRACT:

History: This patient had been under the care of a private physician for a number of years for scleroma and in July, 1956, was admitted to LACH because of lateral displacement of her left eyeball. Her nasal secretion had shown specificity to streptomycin and her outside doctor felt that it had controlled the scleroma for some time.

While in the hospital, a spinal tap revealed a protein of 152 mgm. %. Skull series showed erosion over the left sphenoid ridge. Her E.E.G. was normal and her angiogram inconclusive.

Surgery: On August 15, 1956, a left craniotomy was done. Tissue suggestive of tumor was seen in the middle table of the temporal bone and in the dura of the Sylvius fissure. A dural flap was turned and a large intradural extracortical mass was seen attached to the lateral and mid 2/3 of the sphenoid ridge extending into the middle fossa floor and possibly the tentorium. Some of the tumor was removed en bloc and an equal amount removed by electric knife.

Gross pathology: The specimen consisted of an encapsulated lobulated mass measuring 6 x 5.5 x 2.5 cm. The cut surface was firm, yellowish-white with a suggestion of lobulation. Also submitted were numerous grayish-pink fragments of similar consistency measuring in aggregate 5 x 5 x 1.5 cm.
CASE NO. 4

ACCESSION NO. 9006

NAME: A. M.
AGE: 21 SEX: Female RACE: Cauc.

CONTRIBUTOR: Seymour B. Silverman, M.D.,
Memorial Hospital,
Phoenix, Arizona.

TISSUE FROM: Brain

CLINICAL ABSTRACT:

History: This patient entered the hospital because of vertigo, weakness and loss of weight of nine months duration. The clinical diagnosis at one time was "multiple sclerosis."

Autopsy findings: The brain weighed 1200 grams. There were no abnormalities in the cerebral hemispheres, but on the ventral aspect of the medulla there was an irregularly shaped, rubbery, firm tumor which compressed the ventral portions of the cerebellar hemispheres. The mass arose in the medulla proper and was not an "angle tumor". The tumor and brain stem together measured 4 cm. in greatest diameter. When the cerebellum was removed, the tumor was seen to arise in the postero-inferior half of the floor of the fourth ventricle. Sections showed almost complete replacement of and expansion of the substance of the medulla. The only grossly recognizable nerve fiber bundles were in the ventral area. The cut surfaces of the tumor showed fascicles of gray-white, rubbery, firm tissue.
CASE NO. 5

ACCESSION NO. 8667

NAME: L.H.
AGE: 48 SEX: Female RACE: Caus.

CONTRIBUTOR: Meyer Zeiler, M.D.,
Midway Hospital,
Los Angeles, California.

TISSUE FROM: Retroperitoneal mass.

CLINICAL ABSTRACT:

History: This patient had had a subtotal hysterectomy seventeen years prior to hospitalization. She had no current complaints, but a large mass had been palpated in the pelvis.

Surgery: In May, 1956, a lower pelvic laparotomy was performed. A very hard mass was found retroperitoneally in the hollow of the sacrum. It was located posterior to the rectum.

Gross pathology: The specimen consisted of a retroperitoneal mass and both ovaries.

The retroperitoneal mass was irregular and measured 11 x 8 x 5 cm. It was covered in part by smooth glistening capsule; part of its surface was granular and frayed. On section the surface showed two types of composition. At the center there was an irregular, ill-defined, hard area composed of criss-cross yellowish colored fibers. At the periphery it was loose and areolar.

The ovaries were received separately. They measured 4.5 x 2 and 4 x 2 cm., had moderately convoluted and light yellow capsular surfaces. The sectioned surfaces showed many corpora albacantia and no follicles.

Follow-up: October 16, 1957: Patient has been followed since time of surgery, approximately a year and a half ago. Her pelvis is entirely normal. The only complaints she has are hot flushes, undoubtedly brought on by the bilateral oophorectomy at time of surgery. Her general condition is fine.
CASE NO. 6

ACCESSION NO. 8987

NAME: L. M.
AGE: 7 years SEX: Female RACE: Cal.

CONTRIBUTOR: H. R. Irwin, M.D.,
E. Conforth, M.D.,
Donald Sharp Memorial Community Hospital,
San Diego, California.

TISSUE FROM: Retroperitoneal mass.

CLINICAL ABSTRACT:

History: In March, 1955, this child fell from a bicycle and was struck in the left abdomen by the handle bar. She complained of dysuria and abdominal pain. Cellular elements (type not stated) were found in the urine at that time.

Prior to the injury the child had also complained of dysuria and enuresis. She had had urgency for several years and in August, 1956, complained of incontinence on sneezing. In September, 1956, she developed a fever with her dysuria and on physical examination was noted to have tenderness to percussion over the left costovertebral angle.

Surgery: On September 22, 1956, at surgery, a tumor the size of an orange was found just below the left kidney and it was necessary to remove the kidney to reach the tumor. The latter was very adherent to the upper psoas and quadrate lumbarum muscles and appeared to invade the posterior abdominal wall. It was believed to also extend into the crus of the diaphragm. No metastatic nodules were found in the peritoneal cavity.

Gross pathology: The specimen consisted of an ovoid, moderately firm mass 9 x 7 x 6.5 cm., weighing 270 grams. It was covered by fibrofatty tissue and sharply circumscribed. The tissue itself was fibrillar, moist, pinkish-gray and partially demarcated into two lobules, one of which was twice as large as the other. The kidney showed mild hydronephrosis and a depression on the undersurface of the upper pole where the tumor had compressed it.

Follow-up: October 21, 1957: This patient has visited her doctor in the last month. She has gained weight, has no symptoms or signs at this time, and no evidence of recurrence of the retroperitoneal tumor.
CASE NO. 7

ACCESSION NO. 9119

OUTSIDE NO. F-12004.

NOVEMBER, 1957

NAME: H. F.
AGE: 69 SEX: Male RACE: Cauc.

CONTRIBUTOR: Louisa Keasbey, M.D.,
French Hospital,
Los Angeles, California.

TISSUE FROM: Thigh.

CLINICAL ABSTRACT:

History: One year prior to hospitalization this patient noted a small
mass on the inner aspect of the right thigh. It was removed at that time and
subsequently it re-appeared and increased in size producing marked pain on
walking. It was somewhat inflamed and his ankles were swollen.

On physical examination in January, 1957, a large hard irregular mass
measuring 10 x 15 cm., was noted in the right anterior mid-thigh.

Surgery: On January 15, 1957, the mass was excised along with the adduc-
tor muscle group and the right femoral artery and vein.

Gross pathology: The specimen measured 27 x 17 x 19 cm. and was
attached to a skin ellipse measuring 19:5 x 15 cm. Externally the mass con-
sisted largely of muscle. On cut surface it was lobulated and measured 13 x
8 x 8 cm. The surfaces were yellowish, fibrous and nodular; occasional nodules
having undergone cystic mucinous degeneration. Satellite masses extended from
the main tumor mass, one of these was a finger-like projection measuring 1.5
cm. in diameter and 6 cm. in length. Grossly this latter resembled an en-
larged nerve, the fibers of which had been separated and disrupted by tumor.
In the center of the tumor was a major artery measuring 7 mm. in diameter.

A fatty mass removed from the femoral triangle accompanied the specimen.
It measured 2 x 2.5 x 1 cm. and was free of nodes.

Follow-up: The patient expired on March 25th, 1957.

Autopsy findings: No evidence of residual or metastatic sarcoma was
found. The patient had in addition, rheumatic heart disease with stenosis of
the mitral and aortic valves and was markedly emaciated.
History: This patient was admitted to the Osteopathic Unit of the Los Angeles County Hospital on November 25th, 1956, in coma. He had fallen from a ladder three days earlier and had hit his head on a lawn mower. This was followed by headache, nausea, vertigo and projectile vomiting. He became comatose the morning of entry.

On physical examination his blood pressure was 80/52, temperature 102.6. He had a stiff neck and responded to painful stimuli only. A spinal tap yielded 7 cc. of xanthochronic fluid, pressure was 125 mm. H$_2$O. There were 261 Rbc's and 333 Wbc's in the fluid. Protein was 84.5 mgm/l, sugar was 4.5 mgm/l, Cl 90 mgm/l. Gram positive diplococci were seen on smear, but there was no growth on culture media.

The patient was treated for pneumococcal meningitis but did not respond and expired on November 27th, 1956.

Autopsy findings: At autopsy, lobar pneumonia and a tumor arising from the sella turcica were found. The brain was sent to Dr. C. B. Courville for further study. Examination of the brain revealed a minimal atrophy of the frontal convolutions and softening of the left gyrus rectus consistent with a mild contusion.

The essential lesion was a tumor arising from an enlarged sella turcica and extending up above the sella in a rounded mound of tissue which flattened the optic chiasm but had not resulted in demyelination of the optic nerves. The tumor had also grown through the floor of the sella into the sphenoid sinus where it appeared as a rounded mass, roughly the size of an olive. The actual measurements above the sella were 1.8 x 2.3 cm, and below the sella 2.7 x 2.9 cm. The tumor was cut along the anteroposterior midline and showed grossly, granular tissue with a mild degree of necrosis suggested by faint yellow flecks. What may have been remnants of pituitary were found in the lower and posterior portions of the mass. The vertical measurement of the mass was 3 cm. and the anteroposterior measurement 2.7 cm. In the lower most portion there was a dark streak of tissue representing either a focus of hemorrhage or some other structural change in the tumor.
CASE NO. 9

ACCESSION NO. 7963

NAME: L. L. G.
AGE: 10, SEX: Female RACE: Cauc.

CONTRIBUTOR: Dorothy Tatter, M.D.,
Los Angeles County Hospital,
Los Angeles, California.

TISSUE FROM: Residual tumor.

CLINICAL ABSTRACT:

History: This child was seen for the first time at Rancho Los Amigos polio division in April, 1955, because of an atrophy of the muscles of the right calf. Shortly thereafter a popliteal tumor was noted. A biopsy of this specimen showed sarcoma and the leg was amputated at the mid thigh. Analysis of this specimen plus subsequent exploration of the sacral plexus revealed malignant schwannoma.

In November, 1956, a recurrent tumor of the stump was removed. Later that month she was re-admitted to the hospital with intestinal obstruction due to band adhesions. At surgery, numerous large retroperitoneal nodules in the right lateral pelvis and an atonic bladder were noted.

Following this, the patient's condition deteriorated gradually and she was admitted to the Los Angeles County Hospital for the last time on March 1st, 1957 and expired on March 18th, 1957.

Autopsy findings: The main mass of the tumor measured 18 x 10 x 7 cm. and had a lobulated appearance. The inferior portion of the tumor was covered with a necrotic exudate corresponding to a portion which protruded externally over the posterior portion of the greater trochanter.

The cut surface was rubbery, firm, white and whorled with areas of hemorrhage and small areas of fat. Near the spinal cord the nerves were expanded with tumor tissue. One large nerve, probably the sciatic, extended from the main mass and was greatly expanded with tumor even as it entered the cord.

The spinal cord at the anatomic level of T12 presented a bulging tumor 4 x 2 x 2 cm., located beneath the dura and on cut section appearing to encircle the cord. On palpation the distal cord and cauda equina appeared to contain subdural tumor.

The major portion of the mass lay within the pelvis to the right of the rectum and internal genitalia. The tumor spread retroperitoneally overlying the sacral hollow. There were nodes along the iliac vessels, all of which did not appear grossly involved by tumor. However, section of one nodule did reveal a gelatinous, grayish-white mass.

NOTE: Surgical material on the above case was presented as Case No. 3 in the September 28th, 1955 monthly Conference.
History: This patient had been born with Von Recklinghausen's disease. At an unknown time she had developed a callous on the sole of her foot which had not bothered her until just prior to hospitalization when she developed a localized abscess, which she had had biopsied.

Physical findings included a 1.5 cm. freely movable, firm and slightly tender nodule over the left scapula. The left leg was involved in a process of neurofibromatosis with fairly large areas of pigmentation over the lower leg. There was soft swelling in the tissue beneath these pigmented areas. Over the ball of the foot on the left side, there was an almost cartilaginous area of calloused skin. The rest of the body showed a few other scattered areas of pigmentation.

The Tumor Board recommended that the portion of the leg involved by lymphadenitis be resected.


January 18, 1957. Excision of nerve tumors and redundant tissues of foot and ankle. At surgery, it was found that the entire left lower thigh, leg and foot were involved in a marked redundancy of skin and subcutaneous tissues. There was a nerve tumor of the medial plantar flexus, the size of a potato on the sole of the foot. This was continued with a tumefaction of the tibial nerve which was traced to the midcalf.

October 9th, 1957. Further excision of tumors of the left leg with skin graft.

Gross pathology: January 18th, 1957 surgery - The specimen consisted of multiple, irregular skin and subcutaneous masses to which elongated nerve tumors were attached. The specimen included large masses of corrugated, thick skin with subcutaneous tissue plus an encapsulated pear-shaped edematous tumor and three disarticulated toes. The pear-shaped mass weighed 78.5 grams and measured 10.5 x 5 x 3.5 cm. On cut surface this tumor had a variegated appearance with areas of firm, yellow tissue alternating with almost cystic areas with gelatinous contents.

Two segments of nerve trunk and tumor measuring an average of 11.5 cm. in length and 1.5 cm. in diameter, were present. They were cylindrical, branching and appeared well encapsulated as if growing within the sheath of the nerve itself.

The remaining and principle portion of the specimen consisted of skin and a bulky neural tumor weighing 360 grams. The skin here varied up to 2 cm.
CASE NO. 10 - Accession No. 9161 - continued.

in thickness. The tumor attached to the skin had multiple root-like branches which appeared to correspond to the branchings of the principle plantar nerve. The branches measured up to 11 cm. in length and 5 cm. in diameter.

Gross pathology: October 9, 1957 surgery: This specimen consisted of segments of epidermis and subcutaneous tissues along with a sinuous mass of branching cord-like tumor weighing about four pounds. These cords varied in length up to 46 cm., and in thickness up to 3.5 cm. On cut surfaces they were composed of glistening encephaloid tissue which in places formed large nerve fiber trunks within the main cords.

The epidermis in some of the segments presented a diffuse cafe au lait discoloration without any distinct cafe au lait spots. The subcutaneous fat in some of the segments appeared to be irregularly thickened with grayish-white fibrous tissue forming trabeculae.
CASE NO. 11

ACCESSION NO. 9448

NAME: M.G.
AGE: 8 SEX: Female RACE: Cauo

CONTRIBUTOR: Seymour B. Silverman, M.D.,
Memorial Hospital,
Phoenix, Arizona.

TISSUE FROM: Brain.

CLINICAL ABSTRACT:

History: This child had complained of intermittent vomiting since October, 1955, (eighteen months prior to death). She had had diplopia and frequent headaches for several months.

On physical examination she had marked bilateral papilledema of 4 to five diopters and hypo-active tendon reflexes. The X-rays of her skull were normal. A neurosurgical consultant reported a "picture of marked increase of intracranial pressure and signs suggesting a midline mass, possibly a medulloblastoma". The child expired without craniotomy.

Autopsy findings: The positive findings were confined to the brain. There was a large midline tumor mass arising from the floor of the fourth ventricle and expanding dorsally and upward. There was marked compression of the cerebellar hemispheres and the tumor presented posteriorly between the cerebellum and upper cervical cord. The third ventricle was occluded and the lateral ventricles showed marked hydrocephalus.
CASE NO. 12

ACCESSION NO. 9485

NAME: A. R.

CONTRIBUTOR: Seymour B. Silverman, M.D.,
Memorial Hospital,
Phoenix, Arizona.

TISSUE FROM: Mass in neck.

CLINICAL ABSTRACT:

History: This patient had had a mass on the left side of his neck for approximately six years.

Surgery: The mass was excised on November 13, 1956. The inferior pole was attached to the deep tracheo-esophageal sulcus area and lay between the common carotid artery and the vagus nerve and jugular vein.

Gross pathology: The specimen was an ovoid mass measuring $7 \times 5 \times 4$ cm., covered by a thin fibrous like capsule. The cut surfaces were light yellow-gray and fish-flesh in appearance, with foci of myxomatous and edematous degeneration.

Follow-up: October 15, 1957: Complete recovery, with no evidence of recurrence or complications.
REPORT ON THE
STUDY GROUP CASES
FOR
NOVEMBER, 1957.

CASE NO. 1, ACCESION NO. 9330, W. W. Hall, M.D., Contributor.

LOS ANGELES:
Assigned discussor's diagnosis: Inflammatory process in lung.

General discussion and alternate diagnoses:

(1) Pulmonary or bronchial hamartoma with prominent neural component.
(2) Bronchopulmonary sequestration. This is usually left-sided and represents an extra, nonfunctional pulmonary lobe which tends to increase in size. It was likened to the macroscopic often associated with von Recklinghausen's disease. The neural overgrowth may be basic in this abnormality. The vote was unanimous for bronchopulmonary sequestration.

OAKLAND:
Voting was even between ganglioneuromatosis, ganglioneuroma and hamartoma of neurogenic tissue.

SAN DIEGO:
All agreed that this must represent some type of developmental anomaly or hamartomatous lesion.

CENTRAL VALLEY:
In discussing this case, it was noted that the slide in the set of one of the members contained practically nothing but atelectatic and emphysematous lung and it was suspected that many of the slides may not have been as satisfactory as those originally studied by the contributor. Most of the members had made a diagnosis of neural hamartoma from their own sets. However, it was the consensus that the contributor's diagnosis of ganglioneuroblastoma was probably correct. The vote - hamartoma, compatible with ganglioneuroblastoma.

FILE DIAGNOSIS: Bronchopulmonary sequestration.
Cross index: Hamartoma.

CASE NO. 2, ACCESION NO. 8693, Robert Cleland, M.D., Contributor.

LOS ANGELES:
Assigned discussor's diagnosis: Medulloblastoma.

General discussion and alternate diagnoses: Ependymoblastoma. The vote was unanimous for medulloblastoma.

continued--
Case No. 2, Accession No. 8693 — continued.

OAKLAND:
Medulloblastoma 7, ependymoma 3.

SAN DIEGO:
Atypical medulloblastoma 6, ependymoblastoma 3.

CENTRAL VALLEY:
The discussion of this case produced agreement that the classification of these midline subtentorial cellular tumors in children is in a somewhat unsatisfactory state. Thus a tumor submitted by one of the group for Dr. Kernohan's State Conference, was originally classified by Dr. Kernohan as an ependymoblastoma. Dr. Kernohan then rejected both the contributor's diagnosis of medulloblastoma and the alternate possibility of intracranial sarcoma. However, on re-review of the same case several years later Dr. Kernohan felt that the diagnosis of medulloblastoma was the most reasonable one. (Ref. 1, case 3). The Case No. 2 in the current set drew four votes for medulloblastoma and three for ependymoblastoma. Those who favored the latter diagnosis emphasized the amount of apparently extracellular fibrillary material and the suggestion of papillary pattern in some areas. Those who favored the former emphasized the shape of cells and nuclei and the meningeal gliomatosis. It was felt that this difference in preferred words did not involve any particular difference in recognition of the lesion. The question of the relative radioisensitivity of medulloblastomas and ependymoblastomas was raised. It was felt that both were decidedly radiosensitive.

FILE DIAGNOSIS: Medulloblastoma.
Cross file: Ependymoblastoma.

CASE NO. 3. ACCESSION NO. 8946, Ruth McGannon, M.D., Contributor.

LOS ANGELES:
Assigned discussor's diagnosis: Scleroma.

General discussion and alternate diagnoses: The histology is typical of the third stage of scleroma, showing relatively few remaining Mikulicz's cells. Warthin-Starry stain shows the vonFrisch bacilli (Friedlander's). The lesion is rare in the cranial cavity though it is said to have occurred in South American cases where the disease appears to be of a more actively invasive type. The vote was unanimous for scleroma, intracranial extension.

OAKLAND:
Inflammatory lesion consistent with scleroma 4, fibrous meningioma 3, lipoid histiocytosis 1, no opinion 1.

SAN DIEGO:
Granuloma, secondary to rhinoscleroma, 7 votes, lipoid granuloma 1 vote, no diagnosis 1 vote. (Dr. Contreras of Tijuana stated that rhinoscleroma was relatively common in Mexico and that this lesion resembled cases that he has seen in histology although not in location).
Case No. 3, Accession No. 8946 - continued.

CENTRAL VALLEY:

After several members had offered tentative diagnoses of odd meningioma in this case, Dr. Blanchard gave his reasons for considering this lesion an intracranial scleroma. He stated that a superficial search of the literature had failed to reveal reported instances of appearance of intracranial scleroma after apparent control of nasal (rhino) scleroma. However, he felt that the foam cells in this lesion were readily interpreted as Mikulicz cells, that some of the crystalloid hyaline masses resembled Russell bodies and that the dense hyaline fibrosis and the aggregates of plasma cells likewise accorded well with published descriptions of rhinoscleroma. He cited an excellent discussion in Herbst's Textbook of Pathology. Another member gave an additional reference: Baltros, Hamilton, Floyd, Mufti & Imon, Annals of Otolaryngology 63, 1021-1055, 1954. Five of the group accepted Dr. Blanchard's diagnosis. There remained one vote each for meningioma and chordoma.

FILE DIAGNOSIS: Scleroma, intracranial extension.

CASE NO. 4, ACCESSION NO. 9006, Seymour B. Silverman, M.D., Contributor.

LOS ANGELES:

Assigned discussor's diagnosis: Ependymoma.

General discussion and alternate diagnoses: (1) Polar spongioblastoma, (2) astrocytoma, grade III. Diagnostic differences are based largely on variance in terminology though the spindle cell, bundled character of this tumor seems to set it apart. The vote: Polar spongioblastoma 8, astrocytoma, grade III, 1 vote.

OAKLAND:

Malignant schwannoma 1, glioblastoma multiforme (astrocytoma grade III). 9 votes.

SAN DIEGO:

Astrocytoma, Grade IV, or glioblastoma multiforme 7 votes, spongioblastoma polare 2 votes.

CENTRAL VALLEY:

The member who sent in his vote had termed this case a malignant schwannoma. All the members present at the meeting considered that tumor was essentially astrocytic. The principal problem was that of the classification of the large cells somewhat resembling nerve cells. Cells of not too dissimilar appearance are accepted as a matter of course in highly anaplastic astrocytomas (glioblastoma multiforme), but some of the group felt that the fasciulated architecture and the over-all cytology of this tumor were not those of very high grade astrocytoma. Three members therefore favored the term neurocytoma. They concurred with the general remarks about this possibility in the fascicle by Kernohan and Sayre and used the term in a descriptive and not necessarily a histogenetic sense. The other three preferred the simple term astrocytoma. The grading would be placed somewhere between II and III.

FILE DIAGNOSIS: Polar spongioblastoma.

Cross-index: Astrocytoma, Grade III.
CASE NO., 5. ACCESSION NO. 8667, Meyer Zeiler, M.D., Contributor.

LOS ANGELES:
Assigned discussor's diagnosis: Hamartoma.

General discussion and alternate diagnoses: (1) Sclerosed angiofibroma. (2) Sclerosed tumor of unrecognizable origin. (3) Fibrous mesothelioma. The vote was unanimous for sclerosed fibroid tumor.

OAKLAND:
Retroperitoneal sclerosing hemangioma 2, benign retroperitoneal mesothelioma 1, sclerosing granuloma 1, meningioma 5.

SAN DIEGO:
Four members felt that this lesion resembled parts of Case No. 12 in this set and favored a diagnosis of hyalinized neurilemmoma. Other diagnoses were leiomyoma of vascular origin 2 votes, degenerated leiomyoma 2 votes and hemangioma pericytoma 1 vote.

CENTRAL VALLEY:
In the initial discussion on this case, the majority favored some sort of mesenchymal tumor. The group's secretary engaged in some propaganda for the nerve sheath concept, reiterating that hemocytes could produce collagen and other structures usually considered mesodermal and showing a case of his own which Dr. Stout had classified as "a rather typical neurilemmoma". Initially he made very little headway. However, some of the later cases in the current set were more persuasive and before the evening was over, most changed their votes to neurilemmoma for No. 5. The final vote - neurilemmoma 5, hemangioma 1, neuroblastoma (submitted) 1. All those actually present at the meeting felt that the lesion was benign.

FILE DIAGNOSIS: Sclerosed fibroid tumor.
Cross-index: Hyalinized neurilemmoma.

CASE NO. 6. ACCESSION NO. 8987, H. R. Irwin, M.D., and E. Conforth, M.D. Contributors.

LOS ANGELES:
Assigned discussor's diagnosis: Ganglioneuroma. The vote was unanimous for this diagnosis.

OAKLAND:
Benign ganglioneuroma.

SAN DIEGO:
Ganglioneuroma 9 votes.

CENTRAL VALLEY:
There was unanimity (7 votes) for ganglioneuroma on this case. Dr. Dee raised the question as to the nature of the other elements in a so-called ganglioneuroma.

FILE DIAGNOSIS: Ganglioneuroma.
CASE NO. 7, ACCESSION NO. 9119, Louisa Keasbey, M.D., Contributor.

LOS ANGELES:
Assigned discussor's diagnosis: Leiomyosarcoma.

General discussion and alternate diagnoses: Neurogenic sarcoma. Tri-chrome stain shows apparent fibrils of smooth muscle type in some of the cells. The vote was unanimous for leiomyosarcoma of the thigh.

OAKLAND:
Malignant schwannoma.

SAN DIEGO:
Malignant schwannoma, 9 votes.

CENTRAL VALLEY:
No. 7 drew five votes for schwannoma and 2 for neurofibrosarcoma. It was felt that this difference of opinion was essentially dialectical and the group had nothing to add on the schwann cell vs. fibroblast dialectics.

FILE DIAGNOSIS: Malignant schwannoma.
Cross-index: Leiomyosarcoma.

CASE NO. 8, ACCESSION NO. 9360, G. B. Courville, M.D., Contributor.

LOS ANGELES:
Assigned discussor's diagnosis: Ependymoma.

General discussion and alternate diagnoses: (1) Chromophobe adenoma of pituitary, papillary type. (2) Chromophobe carcinoma of pituitary. The vote: Chromophobe adenoma, 7, tumor of glioma group, 2 votes.

OAKLAND:
Chromophobe adenoma of pituitary.

SAN DIEGO:
Ependymoma, 7 votes, chromophobe adenoma of pituitary, 2 votes.

CENTRAL VALLEY:
This was considered to represent a sellar tumor eroding into the sinus. Attention was invited to a recent report by one of the group of a similar experience with a tumor of rather similar appearance (Ref. 1, Case 4). This case was called an ependymoma by four of the group. The other three voted for anaplastic pituitary adenoma, pointing out that the apparent papillary structure could be duplicated in certain portions of the reference case, while other areas showed solid tumor. It was suggested that this particular differential diagnostic problem was an old one and that here again the difference of opinion was largely dialectical.

FILE DIAGNOSIS: Chromophobe adenoma.
Cross-index: Ependymoma.
CASE NO, 9. ACCESSION NO, 7963, Dorothy Tatner, M.D., Contributor.

LOS ANGELES:
Assigned discussor's diagnosis: Neurogenic sarcoma.

General discussion and alternate diagnoses: There is a high incidence of this type of sarcoma in von Recklinghausen's disease. The unusual massiveness of the growth in this case was noted. The vote: Neurogenic sarcoma on the basis of von Recklinghausen's disease - unanimous.

OAKLAND:
Malignant schwannoma 9, malignant tumor unclassified 8.

SAN DIEGO:
Ganglioneuroblastoma 9 votes.

CENTRAL VALLEY:
The submitted vote for this case was for sarcoma (?)rhabdo). All six members present at the meeting agreed that this was a tumor showing both nerve trunk elements and ganglion cells and that it could be called either malignant schwannoma with ganglion cells or ganglioneurosarcoma, depending on one's position in the Penfield-Stout controversy. The adherents of the schwannian view found it relatively simple to conceive of a line of schwann cells reverting to something that would produce something resembling ganglion cells. On the other hand, a tumor composed of ganglion cells and fibroblasts would be a very mixed tumor indeed. The question was raised as to whether the tumor might possibly have arisen within the spinal canal and whether the paralysis for which the patient was originally admitted to the Rancho, could be due to pressure rather than polio. However, it seemed perhaps more likely that the contributor had established the diagnosis of old poliomyelitis at autopsy and that the tumor within the canal was late extension.

FILE DIAGNOSIS: Neurogenic sarcoma on the basis of von Recklinghausen's disease.

CASE NO. 10. ACCESSION NO. 9161, E. M. Butt, M.D., Contributor.

LOS ANGELES:
Assigned discussor's diagnosis: Neurofibromatosis, von Recklinghausen's disease. The vote was unanimous for this diagnosis.

OAKLAND:
Benign neurofibromatosis.

SAN DIEGO:
Neurofibroma, 9 votes.

CENTRAL VALLEY:
There was unanimous vote for malignant von Recklinghausen's tumor on this case. Dr. Miller drew attention to the very variegated pattern with
some structures actually resembling normal nerves in appearance. The secretary commented that although generally a warm advocate of the schwann cell vs. the perineural fibroblast in the genesis of peripheral nerve tumors, he is totally confused on the relation of neuroectodermal and mesenchymatous elements in von Recklinghausen's disease.

FILE DIAGNOSIS: Neurofibromatosis, von Recklinghausen's disease.

CASE NO. 11, ACCESSION NO. 9448, Seymour B. Silverman, M.D., Contributor.

LOS ANGELES:
Assigned discussor's diagnosis: Ependymoma, Grade I (epithelial type). The vote was unanimous for this diagnosis.

OAKLAND:
Ependymoma, unanimous.

SAN DIEGO:
Ependymoma, 9 votes.

CENTRAL VALLEY:
The vote was unanimous for epithelial ependymoma. The resemblance to thyroid tissue was noted.

FILE DIAGNOSIS: Ependymoma, Grade I (epithelial type).

CASE NO. 12, ACCESSION NO. 9485, Seymour B. Silverman, M.D., Contributor.

LOS ANGELES:
Assigned discussor's diagnosis: Neurilemmoma of neck. The vote was unanimous for this diagnosis.

SAN DIEGO:
Neurilemmoma, 9 votes.

OAKLAND:
Neurilemmoma, unanimous.

CENTRAL VALLEY:
Neurilemmoma, 7 votes.

FILE DIAGNOSIS: Neurilemmoma of neck.