TUMOR TISSUE REGISTRY

LOS ANGELES COUNTY HOSPITAL

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PROTOCOL

For

MONTHLY SLIDES

June, 1960

Tumors of the Lung
CASE NO. 1

ACCESSION NO. 10107

NAME: A. H.
AGE: 34 SEX: Male RACE: Cauc.
Occupation: Unknown

CONTRIBUTOR: H. A. Fanselau, M.D.
Los Angeles, California.

TISSUE FROM: Trachea

CLINICAL ABSTRACT:

An autopsy was performed by the Coroner's office because of history of heavy barbiturate ingestion. No other history was available.

AUTOPSY FINDINGS:

Positive autopsy findings were an old healed tracheostomy scar. In addition there was an extensive white papillary tumor growth in the trachea extending from the level of the larynx to within 2 cm. of the carina. The trachea was widely patent. The tumor extended up to 0.5 cm. above the mucosal surface. Smaller papillary projections were present on the right vocal cord. The bronchi were negative. The right lung weighed 980 grams and the left 1000 grams. Both showed severe edema and congestion. Several petechial hemorrhages were present at the epicardium on the left ventricle. There were no other positive findings.
CASE NO. 2

ACCESSION NO. 10214

NAME: R.D.P.
AGE: 64 SEX: Male RACE: Cauc.
Occupation: Real Estate Broker

CONTRIBUTOR: Livia Ross, M.D.
Oakland, California.

TISSUE FROM: Pleura

CLINICAL ABSTRACT:

History: This patient entered the hospital in September, 1958, with upper GI complaints. A routine chest examination taken on August 25, 1958 showed a density in the right lung base located anteriorly, measuring 2 cm. in diameter, and having a definite outline. It was not calcified. The remainder of the lung fields were normal.

SURGERY:

On September 30, 1958, a thoracotomy was performed. At surgery a pedunculated tumor was found on the inferior surface of the right mid lobe, situated between the right mid and right lower lobe.

GROSS PATHOLOGY:

The oval tumor nodule weighed 9 grams and measured 2.7 x 2 x 1.6 cm. One surface was thin and glistening and covered by a minimal amount of lung tissue. Cut sections revealed smooth gray-white glistening tissue.

FOLLOW-UP:

The patient has been seen regularly by the attending physician, and on January 23, 1960 he was reported doing well. The weight was 170 pounds and the chest x-ray was negative.
CASE NO. 3
ACCESSION NO. 10838

NAME: K.A.D.
AGE: 16  SEX: Female  RACE:  Cauc.
Occupation: Student

CONTRIBUTOR: Robert F. Hufner, M.D.
Los Angeles, California

TISSUE FROM: Right lung

CLINICAL ABSTRACT:

This thin but well developed patient was admitted to the hospital on February 9, 1960, and was asymptomatic. A right lung density was found on routine x-ray chest examination. There were no abnormalities. The hemoglobin was 13.2 grams; WBC 11,500 with 63% polys, 27 lymphocytes and 10 monocytes. Urinalysis was negative.

SURGERY: On February 11, 1960 a right thoracotomy was performed. A large mass was found to involve much of the right upper lobe. A rapid frozen section was not conclusive and it was elected to remove the middle lobe as well as the upper lobe since no fissure was present between the two.

GROSS PATHOLOGY:

The specimen weighed 187 grams. The pleura was smooth and glistering except for the slightly roughened area at the hilus. There was a palpable and visible tumor which appeared encapsulated. On sectioning it bulged and was lobulated, maximal dimension was 6.4 cm. The neoplastic tissue was fleshy gray-yellow and had a few pale yellow streaks. The bronchi and blood vessels appeared displaced by the tumor but had no relation to it. The middle lobe was uninvolved.

FOLLOW-UP:

Post operatively the patient did well and was discharged on February 28, 1960. As of April 28, 1960 she was completely asymptomatic.
CASE NO. 4

ACCESSION NO. 9681

NAME: P.A.
AGE: 36  SEX: Male  RACE: Cauc.
Occupation: Butcher

CONTRIBUTOR: Robert F. Hufner, M.D.
Los Angeles, California.

TISSUE FROM: Pleura

CLINICAL ABSTRACT:

Entry was made to the hospital on November 6, 1957, because of dull aching pain in the chest present for one month or more. There was no hemoptysis, coughing or wheezing. For one week he had shortness of breath and dyspnea. After this time an x-ray was made which revealed a tumor in the chest. At the same time the chest x-ray was taken, fluid was removed from the pleural cavity.

Physical examination revealed a well developed, well nourished male in slight distress. Breath sounds over the lower left chest were distant and there was tenderness in the left lower rib cage.

A thoracentesis was performed on November 7, 1957 and 1300 cc. of bloody fluid were removed from the left pleural cavity. Bronchoscopy on the following day was reported as negative. Chest x-ray showed a small area in the left mid lung field that was obscured by presence of fluid. The outline of the homogeneous increased density in the left lung was irregular with the appearance of loculated fluid. The right lung was clear.

SURGERY:

On November 11, 1957, a left thoracotomy was performed. A massive tumor was found to involve the visceral and parietal pleura and appeared to arise at the apex of the lung. Only a portion of the parietal pleura including the tumor was removed. No lung resection was performed.

GROSS PATHOLOGY:

The specimen was received in multiple large to small pieces, the largest of which measured 10 cm. The pleural surfaces were for the most part smooth although they showed dull hemorrhagic areas. The consistency varied from rubbery to moderately firm but not hard. Areas of decreased consistency, of almost jelly-like nature, were found in the hemorrhagic areas. The bulk of the tissue, however, was firm, almost fish-flesh, pale gray-yellow.
FOLLOW-UP:

Following surgery, the patient was treated with x-irradiation (3800 r) to the left chest. On February 8, 1958 he entered the Los Angeles County Hospital because of left chest pain and fatigue. X-ray of the chest revealed a left pleural effusion and multiple nodular masses in the periphery of the left lung. The hemoglobin was 14.6 grams and WBC 8,700. A course of combined ACTH and nitrogen mustard therapy was recommended by the tumor board. He was discharged from the hospital on February 25, 1958 and was advised to return for therapy.

He expired at home on March 7, 1958. Autopsy was not performed.
This patient was in good health until a sudden onset of central chest pain one hour after eating on the evening of December 20, 1959. Dyspnea first occurred at this time and increased in severity. He vomited 4 to 5 hours later. Familial and past history revealed no evidence of cancer, diabetes or tuberculosis. The mother was 74 years old, living and well; the father was 83 years old, living and well. On admission the lips and fingers were cyanotic. Respiration was 30-40 and shallow, pulse was 100, temperature was 98.8 and the blood pressure was 120/70. There were no heart murmurs but there was some cardiac enlargement and a trace of edema. Inspiratory rales were present. X-rays revealed moderate enlargement of the heart and diffuse soft clouding in both lower lung fields. The EKG was interpreted as non-specific T-wave changes consistent with hypoxia secondary to tachycardia. The hemoglobin ranged from 14.7 to 15.2 grams; RBC 5,000,000, WBC 15,750 with 55% segs., 32 bands, 10 lymphocytes and 3 monocytes. BUN 12 mg.%. Sputum culture was positive for beta strep. The patient was digitalized, sedated and given antibiotics and continuous oxygen with intermittent productive pressure. Inspiratory distress continued so that he was unable to take liquids or talk. Respiration varied from 40-60 per min. and frequently he was lethargic. His temperature averaged 100. Without oxygen he became cyanotic. On December 25, 1959 he was placed in an oxygen tent. Physical examination revealed a snapping P-2. Terminally he went into shock, became more lethargic and had labored respirations. He expired seven days after the onset of the illness.

AUTOPSY FINDINGS:

The autopsy revealed marked cardiac hypertrophy. The heart weighed 550 grams and showed dilatation and hypertrophy of the right ventricle. The coronary vessels showed moderate atherosclerosis but were adequately patent. The right lung weighed 850 grams and the left, 1000 grams. The pleural surfaces were smooth and darkly congested. The cut sections showed a solid to spongy gray pulmonary parenchyma relatively uniform in all lobes. In the lower lobes there were small areas from which cloudy fluid exuded. The tracheobronchial tree contained some cloudy fluid and was hyperemic. The pulmonary vessels were unremarkable. Abdominal viscera showed moderate congestion.
This man was seen at the Orange County General Hospital in 1949 because of hemoptysis and severe coughing. X-ray taken at that time showed diffuse mottling of both lung fields with calcification and bilateral emphysema. A diagnosis of silicosis was made. His condition improved and he was discharged to the out-patient clinic. Since then he was followed periodically.

In January, 1959, he was readmitted to the hospital with pulmonary edema and bronchopneumonia. X-rays again revealed extensive fibrosis and calcification in the lung field. The patient expired on February 2, 1959.

A subpleural circumscribed firm nodule was noted in the upper portion of the left lower lobe. The nodule measured 3 x 3 x 4 cm. and was apparently not related to a bronchus. No other tumors were noted in the lungs or other organs in the body.
CASE NO. 7

ACCESSION NO. 10124

NAME: H.C.
AGE: 65 SEX: Male RACE: Caucasian
Occupation: Unknown

CONTRIBUTOR: Hau Chan, M.D.
San Francisco, Calif.

TISSUE FROM: Left lung

CLINICAL ABSTRACT:

This 65 year old white male had no complaints but entered the St. Luke's Hospital on July 6, 1958, because a routine chest examination in June, 1958, revealed a lesion in the left lung. The only symptoms that he recalled included dryness and tickling of the throat with a slightly productive cough for the past six months.

SURGERY:

On July 7, 1958, the left lung was removed.

GROSS PATHOLOGY:

The left lung weighed 350 grams and measured 15 x 15 cm. In the upper portion of the upper lobe, a firm nodular mass measuring 8 cm. in greatest diameter was present. The pleural surfaces on the lateral aspect and partly opposing the interlobar fissure were deeply puckered over an area 3.5 cm. in diameter. The main mass of the tumor appeared to lie in the anterior segment of the upper lobe of the lung expanding that segment, pushing aside the apical posterior segment of the upper lobe. Upon dissection of the lung the nodular area noted exteriorly was found to be made up of firm gray tissue encircling all of the segmental bronchi of the left upper lobe except the inferior segmental bronchus, producing narrowing of the lumens of the bronchi with marked rigidity of their walls. The tumor extended out to the pleural surfaces of the lung in anterior segment. The nodular tumor mass had the greatest diameter of 8 cm. in the cut surface. The gray firm tissue was fairly sharply demarcated from adjacent red subcrepitant lung tissue and was marked by a poorly defined border of black coloration. No encapsulation of the tumor was noted. No areas of necrosis were encountered. The firm solid tumor tissue appeared to extend across and beneath the interlobar fissure from the upper lobe of the lung and all of its involved segments into opposing portions of the superior and anterior medial basal segments of the lower lobe. Multiple firm black lymph nodes measuring up to 2.0 cm. in their greatest diameters were attached to
the hilar aspects of the lung.

**COURSE:**

The patient's post-operative course was uneventful except for the development of auricular fibrillation which was controlled with Cedilanid and quinidine. The patient was discharged on July 14, 1958. When last seen by the attending physician on July 6, 1959 there had been an increase in weight and the right lung was clear. There was no visible or palpable evidence of tumor recurrence. The physician received a Christmas card from the patient December 9, 1959 at which time the patient was feeling well.
This patient was first seen at the Santa Clara County Hospital on June 28, 1954. During the preceding three weeks there had been increasing dyspnea both at rest and with exertion, but apparently there was no orthopnea. He had had a chronic productive cough for many years, which had increased and was productive of 3-4 teaspoons of white sputum per day during the preceding three weeks. His appetite had been poor during the last five years. He had noted no recent change. A weight loss of 10 lbs. had occurred during the preceding year and was accompanied by increasing fatigability. The chest film taken seven years previously was reported as negative.

Physical examination revealed an emaciated white male breathing rapidly and appearing critically ill. The blood pressure was 170/106; pulse 120. The lungs were resonant throughout and tactile fremitus was decreased over the apex posteriorly. Pulses on the right arm were absent. PMI was on the fifth interspace 1 cm. lateral to the mid-clavicular line. Chest x-rays revealed diffuse fibrosis on both lung fields, more marked on the right lower quadrant, with several small densities in both apices.

Course: There was progressive difficulty with respirations. The patient was treated with analgesia and sedation. On July 17, 1954, both femoral pulses were weak and distally they were absent. The feet were cold and moist and showed marked pallor. A right supraclavicular lymph node biopsy showed anaplastic carcinoma. Bronchoscopy revealed narrowing of the right lower lobe bronchus by a white irregular nodular growth.

External irradiation was started on July 23, 1954, through the anterior and posterior portals directed to the right thorax. Clinical course was one of increasing dyspnea and chest pain associated with cyanosis. On August 1, 1954, he developed a left facial paralysis. Coarse rales were heard throughout both lung fields. He expired on August 3, 1954.

AUTOPSY FINDINGS:

The heart weighed 250 grams and showed mild coronary arteriosclerosis and hypertrophy of the right ventricle. There was severe sclerosis of the abdominal aorta and a thrombus was located at the bifurcation of the aorta that extended 4 cm. down into each common iliac artery. The trachea and major bronchi contained thick mucoid material (bronchial involvement by tumor was not described). The right lung weighed 850 grams.
and the left 725 grams. The pleura showed anthracosis. The right upper lobe was atelectatic and had emphysematous blebs at the apex as did the right middle lobe. The middle lobe in addition contained white nodules throughout varying from 0.1 cm. to 0.3 cm. in diameter. The right lower lobe was gelatinous in the upper portion and solid in the lower; it was reddish-brown in color and had white nodules throughout. The left upper lobe showed emphysema in the upper portion while the lower portion was solid and deep red. At the apex of the right upper lobe were a few blebs and throughout the parenchyma were small tumor nodules. The left lower lobe was similar to the right lower lobe. The parabronchial lymph nodes were replaced by abundant white tumor-like tissue. The viscera showed minimal congestion but there was no metastatic tumor.
CASE NO. 9

ACCESSION NO. 10039

NAME: J.S.
AGE: 59 SEX: Male RACE: Cauc.
Occupation: Furniture designer

CONTRIBUTOR: Leo Kaplan, M.D.
Los Angeles, California.

TISSUE FROM: Left lung

CLINICAL ABSTRACT:

This man began to experience severe hacking cough and shortness of breath increasing in severity over the past three months. X-rays of the chest showed a left hydropneumothorax and a left lower lobe shadow. Examination of the chest revealed diminished breath sounds at the left base. The heart was normal with the regular rhythm. The hemoglobin was 12.4 grams; 39% hematocrit and WBC 14,500 with a normal differential. Bronchoscopy revealed a tumor in the left lower lobe bronchus.

SURGERY:

On September 6, 1958, a left pneumonectomy was performed.

GROSS PATHOLOGY:

The specimen weighed 825 grams. At the beginning of the lower lobe bronchus, there protruded a hemorrhagic, grayish, soft neoplastic mass obstructing the lumen. This mass continued in a ramifying fashion into the segmental branches of the bronchus as a luminal mass for distances up to 3 cm. It infiltrated at the juncture of the primary divisions into the lung substance up to 4 cm. The line of demarcation on the lung side was indistinct. Everywhere the luminal and infiltrative neoplasm showed areas of yellowish necrosis but the intact neoplasm was smooth, glistening, uniform and gray. Distal to these obstructions, there was a profound chronic scarifying cylindrical and saccular bronchiectasis and a non-specific pneumonitis. The overlying pleura of the left lower lobe was densely scarified. The neoplasm had metastasized to almost all of the regional hilar lymph nodes and several paratracheal lymph nodes that were submitted separately.

FOLLOW-UP:

Not available.
This 61 year old male had been hospitalized since 1946, because of paranoid schizophrenia. In November, 1952, he began to complain of left sided chest pain and in July, 1953 developed dyspnea and cyanosis. X-rays revealed massive atelectasis of the left lung, and bronchoscopy showed narrowing of the lumen of the left main stem bronchus. A thoracotomy demonstrated extensive pulmonary carcinoma with invasion of the pericardium. He expired 10 hours postoperatively.

Laboratory findings: Blood studies were not significant. X-ray of the chest showed a massive atelectasis of the entire left lung with a shift of the heart to the left and deviation of the trachea to the left. Bronchoscopy showed marked narrowing of the left main bronchus 1 cm. below the carina, with reddened mucosa and marked secretions. EKG showed elevation of the S.T. segments compatible with pericarditis. Later EKG showed right bundle branch block.

**AUTOPSY FINDINGS:**

There was a granularity of the left main stem bronchus mucosa which was apparently an extension from the left lower lobe bronchus. There was massive atelectasis distal to a 15 cm. diameter central (hilar) tumor mass of yellow-gray, firm tissue with irregular mottling of hemorrhage and necrosis. The tumor extended through the anterior wall of the esophagus to protrude into the lumen below the tracheal bifurcation.

The pulmonary artery was separated from the aortic arch by a 10 cm. mass in the mediastinum which invaded the aortic adventitia, the pericardium and left atrium. The auricular appendage was replaced by tumor and the infiltration went as far as the endocardial surface of the left atrium, just superior to the mitral valve. A solitary 4 cm. metastasis was found in the liver. A solitary mucosal metastasis was found in the jejunum, and a metastasis 4.5 cm. in diameter was found in the left cerebellar hemisphere.
The patient entered the hospital on May 6, 1954, in a critical condition. She had complained of shortness of breath for one week and had been treated by her family physician for congestive heart failure without relief. Her blood pressure was 120/60, pulse 130 and irregular, temperature 104. A-P diameter of the chest was increased and there were a few basal rales. The heart was moderately enlarged with an irregular rate. Extremities showed slight pitting edema. The clinical impression was arteriosclerotic heart disease with auricular fibrillation. The EKG showed auricular fibrillation and abnormal findings were compatible with acute myocardial infarction. She was given digitalis and priscoline but without any improvement in her symptoms. She expired 18 hours after admission.

Autopsy revealed a severely emaciated aged female. The pericardium was hardened and thickened up to 1.5 cm. and was entirely replaced by tumor tissue which infiltrated the myocardium and adventitia of the aorta. The coronary arteries could not be traced and it was difficult to evaluate chamber dilatation. Each pleural cavity contained approximately 200 cc. of clear fluid. Both visceral pleura were studded by white tumor nodules which infiltrated the lung parenchyma; these varied from 0.5 cm. to 4 cm. in diameter. The lungs and heart were not weighed as it was impossible to dissect them free from the thoracic cavity. The tracheobronchial tree appeared thickened throughout the right and left primary and secondary bronchi and in some areas there were elevated white nodules. A possible primary tumor measuring 4 cm. in diameter and elevating the segmented bronchus was located in the medial portion of the left lower lobe. Tracheobronchial lymph nodes were hardened and on cut section revealed firm tumor tissue. A small metastatic tumor was found in the head of the pancreas and the lumbar vertebrae showed evidence of tumor metastasis. The liver was studded with tumor.
CASE NO. 12

ACCESSION NO. 10894

NAME: G.P.
AGE: 75  SEX: Male  RACE:  Cauc.
Occupation: Bookkeeper

CONTRIBUTOR: Doris Herman, M.D.
Los Angeles, California

TISSUE FROM: Left lung

CLINICAL ABSTRACT:

On December 26, 1953 this patient entered the hospital because of
a productive cough of nine months duration associated with weight loss.
An x-ray in June, 1953 showed a lesion on the left apex that was thought
to be inactive tuberculosis. On December 21, 1953, the sputum was reported
as positive for acid fast bacilli by a private physician in Long Beach and
repeated x-rays revealed a progressive lesion on the left apex.

Physical examination revealed an emaciated white male with a
blood pressure of 130/50, pulse 110, respiration 22 and a temperature of
100°F. There were coarse rales at the left apex. Neurological examination
revealed Parkinson's tremor of the hands. The hemoglobin was 12 grams;
WBC was 9,600 with 60% polys, and the urinalysis was negative. An acid
fast stain of sputum performed on the ward was reported as "positive".
Chest x-ray revealed a confluent infiltration involving the left upper
lung area and a large hilar mass suggesting neoplastic formation. The
clinical impression was pulmonary tuberculosis and possible bronchogenic
carcinoma. The patient was transferred to the medical chest ward. He
continued to have an afibrile course and expired on December 29, 1953.

AUTOPSY FINDINGS:

The left pleural cavity contained 300 cc. of blood-tinged fluid
and the right pleura showed a fibrinous pleuritis. The left lung weighed
700 grams. Located in the left primary bronchus 1 cm. beyond the carina
was a firm white tumor mass which almost completely obstructed the major
bronchus and extended peripherally to involve the upper segmental bronchus
to the left upper lobe. There was atelectasis of the left upper and lower
lobes. The tumor mass was discrete and measured 5 cm. in diameter. Tracheo-
bronchial lymph nodes were largely replaced by tumor and measured 6 x 5 cm.
On the lateral aspect of the left upper lobe the pleura was thickened for
a distance of 3 cm. and for a depth of 2 cm. Within this fibrotic area was
a metastatic tumor nodule. The right lung weighed 650 grams and showed
fibrosis, edema and congestion and patchy areas of bronchopneumonia. Metas-
tases were found in the cervical and retroperitoneal lymph nodes and both
adrenals. There was dilatation of the right ventricle and moderate coronary
arteriosclerosis. The liver and spleen showed chronic passive congestion.
There was no indication of tuberculosis.
STUDY GROUP CASES

FOR

JUNE, 1960

Tumors of the Lung

CASE NO. 1 ACCESSION NO. 10107, H. A. Fanselau, M.D., Contributor

LOS ANGELES:

Extensive papillomatosis of the trachea and larynx - unanimous. Some of the papillary process are covered with a transitional type of epithelium and others are of the squamoid type.


SAN FRANCISCO:

Papillomatosis of the trachea - 8.

OAKLAND:

Squamous papillomatosis - unanimous. Note: One slide had a lymph node containing glands lined by respiratory epithelium.

CENTRAL VALLEY:

Papillomatosis - unanimous. Three added the qualifying phrase "of low grade malignancy", while 7 considered it benign. The metaplasia of glands was noted with interest. Those who classed the lesion as malignant did so on the basis of the cellular structure of some of the papillary areas, and of the gross character of the process.

WEST LOS ANGELES:

Squamous cell papilloma of the trachea - unanimous.

FILE DIAGNOSIS: Papillomatosis of larynx and trachea, benign.

San Diego - minutes not received.
June, 1960

CASE NO. 2, ACCESSION NO. 10214, Livia Ross, M.D. Contributor.

LOS ANGELES:

Fibrous mesothelioma, pleura, benign - unanimous.

SAN FRANCISCO:

Solitary fibrous mesothelioma - 8.

OAKLAND:

Pleural fibroma, 11; fibrosarcoma, 1; hemangiopericytoma, 2.

CENTRAL VALLEY:

Provoked the expected dispute in terminology.
Localized fibrous mesothelioma, 5; fibroma, 4; low-grade fibrosarcoma, 1.

WEST LOS ANGELES:

Fibrous mesothelioma of the pleura - unanimous.

FILE DIAGNOSIS: Fibrous mesothelioma, pleura, benign. 370-8772A

Cross-index: "Pseudotumor", pleura. 370-926
Post-inflammatory lesion of pleura. 370-100.0
June, 1960

CASE NO. 3, ACCESSION NO. 10838, Robert F. Hufner, M.D., Contributor

LOS ANGELES:
Leiomyosarcoma, lung - 4; fibrosarcoma, 1; pseudotumor, 1.

SAN FRANCISCO:
Fibroma, 3; leiomyoma, 3; neurilemmoma, 2.

OAKLAND:
Leiomyosarcoma, 8; leiomyoma, 6.

CENTRAL VALLEY:
Provoked the expected dispute in terminology. Mesothelioma, 1; fibrosarcoma, 3; benign neurogenous tumor (neurilemmoma), 6.

WEST LOS ANGELES:
Neurofibroma, 4; fibroma, 1; fibrous mesothelioma, 1.

FILE DIAGNOSIS: Leiomyosarcoma, lung. 360-866F
Pseudotumor, lung. 360-926
June, 1960

CASE NO. 4, ACCESSION NO. 9681, Robert Hufner, M.D., Contributor.

LOS ANGELES:

Fibrous mesothelioma, pleura, malignant - unanimous.

SAN FRANCISCO:

Fibrosarcoma, 8.

OAKLAND:

Fibrosarcoma, 9; leiomyosarcoma, 5.

CENTRAL VALLEY:

Provoked the expected dispute in terminology. Malignant fibrous mesothelioma, 4; leiomyosarcoma, 2; malignant Schwannoma, 2; malignant mesenchymoma, 1; fibrosarcoma, 1.

WEST LOS ANGELES:

Fibrosarcoma of pleural origin, 1; fibrous mesothelioma (aggressive), 2; myosarcoma, 3.

FILE DIAGNOSIS: Fibrous mesothelioma, pleura, malignant (fibrosarcoma). 370-870F
June, 1960

CASE NO. 5, ACCESSION NO. 10876, T. C. Nelson, M.D., Contributor.

LOS ANGELES:

Chronic pulmonary fibrosis with acute inflammation and atypical hyperplasia of the alveolar cells - unanimous. The possibility of respiratory irritation due to exposure to organic isocyanates used in the manufacture of fiberglass was discussed.


SAN FRANCISCO:

Chronic interstitial pneumonia with asbestos bodies and diffuse alveolar metaplasia, 8.

OAKLAND:

Pulmonary fibrosis with atypical bronchiolar and alveolar metaplasia - unanimous.

CENTRAL VALLEY:

Non-neoplastic, 7. One member reported seeing refractile material with polarized light, and suggested a possible occupational origin, and two suggested the term Hamman-Rich syndrome. Of the three who considered the lesion neoplastic, one voted for leiomyosarcoma and two for alveolar cell sarcoma. These two stressed the bizarre pyknotic appearance of the giant cells, but the rest of the group considered this insufficient basis for calling the thing a tumor.

WEST LOS ANGELES:

Chronic pneumonitis with squamous metaplasia, 3; chronic pneumonitis with bronchiolar (alveolar) carcinoma, 3.

FILE DIAGNOSIS: Chronic pulmonary fibrosis. 368-9xx

Cross-index: Fiberglass disease, lung. 360-350
CASE NO. 6, ACCESSION NO. 10370, J. G. Hamrick, M.D., Contributor.

LOS ANGELES:

Carcinosarcoma, lung = unanimous.


SAN FRANCISCO:

Malignant hamartoma (teratoma) = 8.

OAKLAND:

Teratocarcinoma, 8; carcinosarcoma, 5; squamous cell carcinoma, 1.

CENTRAL VALLEY:

No. 6 was considered particularly interesting and puzzling. There were four votes for malignant teratoma, two each for liposarcoma and anaplastic tumor unspecified, and one each for chondrosarcoma and leiomyosarcoma.

WEST LOS ANGELES:

Pleomorphic carcinoma of the lung, 3; carcinosarcoma, 3.

FILE DIAGNOSIS: Carcinosarcoma, lung. 360-8831F
June, 1960

CASE NO. 7, ACCESSION NO. 10124, Haw Chan, M.D., Contributor

LOS ANGELES:

Lymphosarcoma, lung, lymphocytic type - unanimous.


SAN FRANCISCO:

Lymphosarcoma, 5; organized pneumonia, 3.

OAKLAND:

Lymphosarcoma, 9; chronic pneumonitis, 4; Boeck's sarcoid, 1.

CENTRAL VALLEY:

Dr. Peck opened the discussion on No. 7. He felt that while this might be called a lymphosarcoma by many pathologists, it was actually non-neoplastic. There was some discussion of alleged localized curable lymphosarcomas of the lung (Cf the recent ASCP seminar) and of the possibility of low-grade lymphoma which might eventually evolve into chronic lymphocytic leukemia. The vote: non-neoplastic reactive process, 7; lymphosarcoma, 3. The secretary expressed surprise that no one had taken refuge in the term Hodgkin's paragranuloma.

WEST LOS ANGELES:

Lymphocytic lymphosarcoma of the lung - unanimous.

FILE DIAGNOSIS: Lymphosarcoma, lung, lymphocytic type. 360-830F
Los Angeles:
Adenocarcinoma, lung - unanimous.

San Francisco:
Mucinous adenocarcinoma of the lung, 8.

Oakland:
Bronchogenic adenocarcinoma (mucinous), 12; alveolar cell carcinoma, 2.

Central Valley:
Mucinous adenocarcinoma, perhaps primary in the lung - 10.

West Los Angeles:
Mucinous adenocarcinoma of the lung - unanimous.

File Diagnosis: Adenocarcinoma, lung. 360-8091F
June, 1960

CASE NO. 9, ACCESSION NO. 10039, Leo Kaplan, M.D., Contributor.

LOS ANGELES:

Polymorphous carcinoma of the lung. Alcian blue and PAS positive after diastase digestion.

SAN FRANCISCO:

Large cell type undifferentiated carcinoma of the lung, 8.

OAKLAND:

Anaplastic epidermoid carcinoma - unanimous. Note: Suggested origin in bronchiectatic cavity.

CENTRAL VALLEY:

Anaplastic carcinoma, 8; rhabdomyosarcoma, 2.

WEST LOS ANGELES:

Pleomorphic (adenocarcinoma of the lung - unanimous.

FILE DIAGNOSIS: Polymorphous carcinoma, lung. 360-814F
360-8091F

Cross-index: Adenocarcinoma, lung. 360-8091F
CASE NO. 10, ACCESSION NO. 5743, Leo Kaplan, M.D., Contributor.

LOS ANGELES:
Leiomyosarcoma of bronchus - unanimous.

SAN FRANCISCO:
Rhabdomyosarcoma - 8.

OAKLAND:
Myosarcoma, 10; sarcoma with silicosis, 4.

CENTRAL VALLEY:
It was emphasized that some of the members' slides were unsatisfactory, showing only nondescript hyaline tissue, rather than the striking pattern of the slide projected. On this basis four members withheld their votes. The remaining six voted for myosarcoma. No one reported seeing any cross striations though the pattern was more suggestive of Rhabdo than Lei. There was some discussion of the actual point of origin of this tumor (bronchus, esophagus, or heart), and it was suggested that the pattern recalled the possibility of a malignant analogue of the so-called rhabdomyoma of the heart.

WEST LOS ANGELES:
Rhabdomyosarcoma of the lung, 4; fibrosarcoma, 1; pleomorphic carcinoma, 1.

FILE DIAGNOSIS: Leiomyosarcoma, bronchus. 350-866F
June, 1960

CASE NO. 11, ACCESSION NO. 10893, Dorothy Tatter, M.D., Contributor.

LOS ANGELES:

Discussants diagnosis - epidermoid carcinoma. PAS after diastase digestion and Alcian blue were positive for intracellular acid mucopolysaccharide. Tumor metastasized as a papillary adenocarcinoma. Idea of mixed "epidermoid and adenocarcinoma vs. adenocarcinoma discussed.

References: Personal communication from Dr. Leiv Kreyberg of Oslo, Dr. Lauren Ackerman, Dr. Arthur Purdy Stout and Dr. Averill Liebow.

SAN FRANCISCO:

Carcinoma, primary site undetermined (? breast), 8.

OAKLAND:

Bronchogenic squamous cell carcinoma, 12; metastatic adenocarcinoma, breast, 1 and pancreas, 1.

CENTRAL VALLEY:

Squamous cell carcinoma of the lung, though one of the ten preferred the subclassification, mucoepidermoid.

WEST LOS ANGELES:

Adenocarcinoma of the lung, 5; oncocytic carcinoma of the lung, 1.

FILE DIAGNOSIS: Mixed epidermoid and adenocarcinoma, lung.
360-814 F
360-8091F
June, 1960

CASE NO. 12, ACCESSION NO. 10894, Doris Herman, M.D., Contributor.

LOS ANGELES:

Epidermoid carcinoma, 3; adenocarcinoma, lung (giant cell type), 4. Discussant mentioned the possibility of metastases from melanoma, carcinoma of thyroid and myosarcoma. The thyroid was negative for tumor. Alcian blue and PAS after diastase digestion were positive for intracellular acid mucopolysaccharide.


SAN FRANCISCO:

Large cell undifferentiated carcinoma of lung (rule out melanoma), 8.

OAKLAND:

Anaplastic squamous cell carcinoma - unanimous.

CENTRAL VALLEY:


WEST LOS ANGELES:

Adenocarcinoma of the lung - unanimous.

FILE DIAGNOSIS: Adenocarcinoma, lung (giant cell type). 360-8091F