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CALIFORNIA TUMOR TISSUE REGISTRY

LOS ANGELES COUNTY - UNIVERSITY OF SOUTHERN CALIFORNIA MEDICAL CENTER

PROTOCOL

for

MONTHLY STUDY SLIDES

JUNE 1970

UTERINE TUMORS

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Present illness: In the last two menstrual periods, the patient had excessive menstrual flows accompanied by severe cramping. Each period lasted for nine days.

Past history: The patient had three full-term pregnancies and one miscarriage. Previously, her menstrual pattern had been normal.

Physical examination revealed a mass, which was probably larger than an orange, involving the right side of the uterus. It was freely movable and fixed to the uterus. The adnexa were normal. The remainder of the examination was unremarkable.

Laboratory report: Routine laboratory results were unremarkable except the hemoglobin which was below normal limit.

Surgery:

On 10-24-62, at the time of surgery, the surgeon noticed the sigmoid colon adhered to the left side of the fundus of the uterus with one band of rather dense adhesions. The uterus itself was about the size of a large orange and intra-ligamentous fibroid about the size of a golf ball was present in the right adnexal region. The right ovary was filled with follicular cysts and intimately attached to right side of the fundus in the cul-de-sac. Total hysterectomy and right oophorectomy were performed.

Gross Pathology:

The uterus measured 11.5 x 8.5 x 5.5 cm. Numerous adhesions were present over the serosal surface. Within the wall was at least one circumscribed tumor 4.5 cm. in diameter which had a bulging gray-tan surface. The endometrial cavity was distended by and filled with a large polyp 7.5 x 2.5 x 2.5 cm. The distal 3.5 cm. of the polyp was markedly hemorrhagic and necrotic. It extended down into and distended the endocervical canal almost to the external os. Adherent to the uterus was what appeared to be the right ovary measuring 4.5 x 2.5 x 2.5 cm. Numerous small follicular cysts were present within its substance.

Follow-up:

In November 1969 she had an ovarian tumor 6 x 5 x 4 cm. removed from the left remaining ovary. Microscopically, the tumor resembled closely the uterine tumor removed seven years previously. A vaginal examination in March 1970 revealed thickening of the paravaginal tissues, but no definite tumor was detected. At the present time, she is asymptomatic and is feeling fine.
NAME: J. H. C.  
AGE: 42  SEX: F  RACE: -  
JUNE 1970 - CASE NO. 2  
CONTRIBUTOR: H. A. Fanselau, M.D.  
Glendale Sanitarium and Hospital  
Glendale, Calif. 91209  
ACCESSION NO. 14060  
OUTSIDE NO. 64-4924  

TISSUE FROM: Posterior utero-cervico-vaginal junction  

CLINICAL ABSTRACT:  

Present illness: For the past three months, the patient had continuous intermenstrual spotting along with fatigue and a 20-pound weight loss. She had progressive transverse lower abdominal pain and pelvic pain with radiation to the sacral back accompanied by menorrhagia for several months.  

Past history: She always had difficulty with her menstrual periods—with cramps, excessive flow, secondary anemia, and dyspareunia. She was gravida IV, para IV.  

Physical examination revealed a pale female with bilateral colloid goiter. Tender mass across lower abdomen was noted. The cervix was smooth, having few nabothian cysts. The size of the retroverted uterus was indeterminate because of tenderness but appeared enlarged. Adherent tubo-ovarian masses and cul-de-sac masses which filled the cul-de-sac and encroached on the posterior fornix without invasion of the vaginal mucosa were noted. No intrinsic rectal mass was detected.  

Laboratory report: The hemoglobin was 10.7 gm.; the hematocrit was 33%. The white cell count, 7400 with normal differential. The urinalysis was essentially normal. BUN, 11 mg. per 100 ml.  

SURGERY:  

On 12-29-64, D and C, hysterectomy, and bilateral salpingo-oophorectomy were performed. Because of extensive mass posteriorly (between uterus and rectum) with involvement of the rectum, it was not possible to accurately identify utero-sacral or cardinal ligaments. This mass involved and bound together the rectum to the posterior aspect of the uterus from the lower aspect of the cervix and the adjacent vagina to the area of the endocervix and lower part of the fundus. Frozen sections of this area showed apparent endometriosis, but there was a question of probable malignancy in one section from the lower cervix-vagina where it was bound to rectum. No apparent involvement of the vaginal or cervical mucosa was found, but rather the lesion was behind in the retrovaginal and retrocervical areas. Because of the tenacious and firm mass, not circumscribed, in the retrocervical area, the surgeon left portion of this attached to the rectum.  

GROSS PATHOLOGY:  

The specimen consisted of a uterus measuring 12.5 x 7.5 x 5.8 cm. The cervix and the endometrium appeared unremarkable. The myometrium presented occasional small, distinct and white nodules measuring up to 0.8 cm. in diameter. Attached to the cervix posteriorly was a vaginal cuff measuring up to 2.5 cm. in width. In the posterior and left posterolateral portion, the vaginal mucosa was slightly nodular. Attached to this was an irregular and rather firm 2 x 2 x 1.3 cm. portion of tan-white tissue which was said to be the site of cul-de-sac behind the cervix. Serial sections of the vaginal cuff showed necrotic tissue extending into the adjacent aspect of the cervix posteriorly. A similar piece of firm and irregular tissue was attached to the posterior aspect of the endocervical portion of the uterus measuring 1.2 cm. in maximum diameter. Both the fallopian tubes and the ovaries appeared unremarkable.
COURSE:

On 1-8-65, the patient was reoperated. The patient had a firm tumor involving the cul-de-sac, posterior vaginal wall, the urinary bladder, the bilateral parametrial structures, the left iliac nodes, and the left obturator nodes, as well as the rectum. Excisions of the involved tissues were performed.

FOLLOW-UP:

The patient was not irradiated after original surgery. On 6-4-69, at the time of pelvic laparotomy with lysis of adhesions, there was no evidence of residual or recurrent malignancy. She was given Provera for five years starting from the time of diagnosis of the tumor. This hormone was stopped a couple of months ago. She was last seen in early May 1970, showing no recurrence of the disease.
NAME:  D. E. P.  
AGE:  47  SEX:  F  RACE:  Caucasian
CONTRIBUTOR:  Paul Ortega, M.D.
               Mt. Zion Hospital
               San Francisco, Calif. 94119

TISSUE FROM:  Tumor of uterus

CLINICAL HISTORY:

Present illness: For several years, the patient had an incisional hernia in the lower abdomen which was gradually increasing in size.

Past history: The patient first had a D and C for menorrhagia in 1959. She also had a series of surgical procedures in the past.

Physical examination was unremarkable except for the incisional hernia aforementioned.

Laboratory report: The routine laboratory findings were noncontributory.

SURGERY:

Upon exposure of the hernia, the uterus was adherent to the scarred region of the interior abdominal wall. A subtotal hysterectomy was performed in order to make the repair easier to accomplish.

GROSS PATHOLOGY:

The specimen consisted of a uterus weighing 80 grams and measuring 7 x 8 x 4.5 cm. Located within the fundus was an encapsulated and firm nodule measuring 3.5 cm. in dimension.

FOLLOW-UP:

As up to now, the patient is living and well, showing no evidence of tumor.
History: The patient complained of a heavy sensation in the pelvis accompanied by occasionally vague pain.

Physical examination revealed a large pelvic mass, thought to be of uterine origin, extending up to the umbilicus.

Laboratory report: The hemogram and the urinalysis were within normal limits. Exfoliative cytology of cervix uteri was negative for malignancy.

Radiograph: Barium enema study revealed a large pelvic mass which did not involve the colon intrinsically.

Surgery:

On 7-14-67, at surgical exploration, a large 10 x 20 cm. pedunculated mass coming off the left cornu of the uterus, and a similar palpable mass approximately 10 x 10 cm. located in the right broad ligament. The tubes and ovaries were normal. Total hysterectomy and bilateral salpingo-oophorectomy were performed.

Gross Pathology:

The specimen consisted of a large, roughly bilobed mass representing uterus, bilateral adnexa, and included tumors. The total specimen weighed 1050 grams. The uterus measured approximately 10 x 7 x 6 cm. Bulging from the fundus was a large ovoid neoplasm measuring 12 cm. in diameter. Bulging from the right adnexal area was a second oval neoplasm about 9 cm. in diameter. On section, the larger neoplasm was composed of whorled gray-pink tissue suggesting leiomyoma. The smaller neoplasm showed a soft, degenerative, and fleshy consistency. The endometrium was mostly very thin but in one focus there was a small and degenerative polyp. The ovaries and the tubes were unremarkable.

Follow-up:

When the patient was seen in December 1968 and December 1969, she did not show any sign of disease.
NAME: J. N.  JUNE 1970 - CASE NO. 5
AGE: 27  SEX: F  RACE: Negro
CONTRIBUTOR: E. M. Butt, M.D.
St. Luke Hospital
Pasadena, Calif. 91107
ACCESSION NO. 15818
OUTSIDE NO. 1085-67

TISSUE FROM: Tumor of uterus

CLINICAL ABSTRACT:

History: This 27-year-old primigravida, whose last menstrual period was 12-3-66, was admitted to the hospital on 5-2-67 with prolapse of umbilical cord of one-day duration. Since 4-5-67 she had ruptured membranes. Past medical history was unremarkable.

Physical examination revealed prolapsed umbilical cord. Fetal heart sounds were not elicited.

Laboratory report: The hemogram and the urinalysis were within normal limits.

SURGERY:

On 5-2-67 abdominal hysterotomy with evacuation of products of conception and multiple myomectomy were performed.

GROSS PATHOLOGY:

The specimen consisted of four oval nodules ranging from 3 to 13 cm. in greatest dimensions and having total weight of 850 grams. The first three fibroids were similar. On section, they were composed of interlacing bands of white fibromuscular tissue. The largest fibroid had a cystic and necrotic center which was gray-red and varied from gelatinous to thick gray-red fluid. The female fetus with crown to rump measurement of 17.5 cm., and the placenta appeared unremarkable.

FOLLOW-UP:

The patient's gynecologist has been receiving periodic letters from the patient who has been with a missionary group in Tanzania, Africa. He received a letter dated 11-11-68 informing him that she had an uneventful caesarean section delivery. Another letter from her dated 11-10-69 informed him that she had a repeated caesarean section and was delivered of a male infant who expired after delivery. According to her correspondence, she is asymptomatic, having no recurrence of her tumor.
NAME: G. W.  JUNE 1970 - CASE NO. 6
AGE: 71  SEX: F  RACE: Caucasian  ACCESSION NO. 15932
CONTRIBUTOR: Thomas E. Wynn, M.D.  OUTSIDE NO. 867-396
Presbyterian Hospital  San Francisco, Calif.  94115

TISSUE FROM: Uterus

CLINICAL ABSTRACT:

Present illness: The patient had been considered in good health until 30 hours prior to admission when she suddenly developed a moderately severe and constant abdominal pain accompanied by nausea and vomiting.

Past history: The left ovary had been removed 26 years earlier for unknown cause.

Physical examination: A large ballotable abdominal mass was found filling the lower abdomen. The remainder of the examination was unremarkable.

Laboratory report: Routine preoperative laboratory studies, IVP, and large bowel x-ray studies added no additional significant findings.

SURGERY:

Exploratory laparotomy on 1-20-67 revealed an irregular tumor filling the lower abdomen. It was difficult to remove because of its large size but was not significantly adherent to the pelvic wall. The ovary, tubes, and uterus could not be grossly recognized and appeared totally replaced by the tumor.

GROSS PATHOLOGY:

The specimen consisted of an irregular, multi-lobulated solid tumor weighing 3000 grams and measuring 25 cm. in maximum diameter. Serially sectioning the mass, no recognizable normal structures were found except centrally where there was a cavity, 7 cm. in diameter, which had a smooth wall and was surrounded by tissue resembling uterine muscle. For the most part, the tumor had a glistening white cut surface with scattered areas of necrosis and hemorrhage.

FOLLOW-UP:

In April 1968, when the patient had a cholecystectomy for chronic cholecystitis and cholelithiasis, no residual tumor was detected. During past year, repeated pelvic examinations were consistently negative for pathology. She is living and well at the present time.
NAME: J. C.  
AGE: 66  SEX: F  RACE: Caucasian  
CONTRIBUTOR: Louisa Keasbey, M.D.  
French Hospital  
Los Angeles, Calif. 90012  

TISSUE FROM: Tumor of uterus  

CLINICAL ABSTRACT:  

Present illness: The patient had intermittent vaginal bleeding with cramps over the hypogastrum for six months prior to admission.

Past history: She had uneventful menopause 21 years previously. She was gravida IV, para IV.

Physical examination revealed obese and elderly woman who had soft and nontender abdomen. No mass was felt.

Laboratory report: The hemogram was within normal limits.

SURGERY:  

On 6-17-67, hysterectomy, bilateral salpingo-oophorectomy, and appendectomy were performed.

GROSS PATHOLOGY:  

The uterus measured 13 x 9 x 8.5 cm. The serosa was smooth. The myometrium measured 0.9 cm. in thickness and rather uniform throughout. The entire endometrial cavity, which measured 6.7 cm. in greatest diameter and 9 cm. in length, contained a soft lobulated tumor which appeared to originate from the left inferior portion of the endometrial cavity and filling the entire cavity. The tumor filling the uterus was very sharply circumscribed and sharply demarcated from the surrounding myometrium. The tumor was solid and cohesive upon section, lacking the friability characteristic of carcinoma. It was gray-yellow to yellow-tan in color. Grossly, the tubes, the ovaries, and the appendix were unremarkable.

FOLLOW-UP:  

Patient was seen six weeks postoperatively and had made an uneventful recovery. She left this community shortly afterward. Attempt has been made to contact her family, but no further follow-up information is available.
CLINICAL ABSTRACT:

History: About one and a half years ago, the patient was found to have fibroids of the uterus at the time of her last pregnancy which was otherwise normal. Since her last pregnancy, she had menorrhagia and gradual enlargement of the uterus.

Physical examination was unremarkable except for the enlargement of the uterus.

Laboratory report: The routine laboratory work-up was normal.

Radiograph: Chest x-ray showed no abnormalities.

SURGERY:

On 2-4-69 a vaginal hysterectomy was performed.

GROSS PATHOLOGY:

The specimen consisted of a previously opened uterus measuring 14.5 x 10.5 x 8 cm. and weighing 365 grams. On section, the myometrium showed an ill-defined yellow-tan and slightly rubbery tumor measuring up to 3.5 cm. in diameter. In addition, there were some scattered sharply demarcated white nodules measuring up to 2.5 cm. in diameter. The endometrial cavity was lined by velvety mucosa measuring 0.3 cm. in thickness.

FOLLOW-UP:

The patient is doing well and showing no evidence of tumor.
AGE: 48  SEX: F  RACE: Caucasian
CONTRIBUTOR: Frank R. Dutra, M.D.  ACCESSION NO. 17782
Eden Hospital Laboratories
Castro Valley, Calif. 94546
OUTSIDE NO. 37718

TISSUE FROM: Tumor of uterus

CLINICAL ABSTRACT:

History: The patient was admitted to the hospital on 2-6-68 with chief complaint of lower abdominal pressure accompanied by stress incontinence. The pressure was particularly noticed when she was standing.

Physical examination revealed a third-degree cystourethroccele. Masses were not palpated.

Laboratory report: Routine laboratory results were within normal limits.

SURGERY:

A hysterectomy was performed.

GROSS PATHOLOGY:

The uterus weighed 210 grams and measured 11 x 8.5 x 5.5 cm. The shape was distorted by a myometrial tumor. In addition, two irregular nodular masses were attached to the lateral surface of the uterine cervix. On section, the myometrial tumor, which was measured 2.8 cm. in maximum diameter, presented bulging, whorled, and white cut surfaces. In regions where there was no tumor, the myometrium was up to 2.3 cm. in thickness. The endometrium was hemorrhagic and granular, having a thickness of 1 mm.

FOLLOW-UP:

On 6-4-68, she had a negative vaginal Pap at another hospital. On 5-12-67 she had bilateral salpingo-oophorectomy and appendectomy at other hospital. Follicular cysts of the left ovary were noted. When she was last seen on 3-23-70, she was doing fine.
CLINICAL ABSTRACT:

Present illness: The patient was admitted to the hospital primarily because of a severe anemia caused by menorrhagia of one-year duration.

Past history: She had three normal pregnancies. She had used Ovulen in addition to Enovid-E.

Physical examination revealed an enlarged uterus. Proctoscopic examination was perfectly normal. The remainder of the examination was unremarkable.

Laboratory report: The hemoglobin was 9.3 grams per 100 ml. Chemistry panel was perfectly normal. The urinalysis was negative.

SURGERY:

On 7-2-68 a hysterectomy was performed.

GROSS PATHOLOGY:

The specimen consisted of an entire uterus measuring 110 x 60 x 55 mm. and weighing 235 grams. It had an attached pedunculated rubbery mass which was attached by an 11 mm. diameter stalk. The mass itself weighed 35 grams and was covered by a hemorrhagic and slightly thickened serosa. On section, the mass contained multiple hemorrhagic rubbery nodules varying from 15 to 40 mm. in diameter. The endometrial cavity measured 55 mm. in length and it was markedly distorted by a 38 mm. diameter nodule projecting into the cavity. The endometrium was hemorrhagic tan-pink and measured up to 3 mm. in thickness except for the region overlying the projection where it was thinned to less than 1 mm. in thickness. On cut section, the large nodule presented a whorled gray-white appearance in which there was a single 8 mm. diameter hemorrhagic nodule. The myometrium contained two additional whorled gray-white nodules measuring 11 mm. and 13 mm. in diameter respectively. The myometrium measured up to 25 mm. in thickness.

FOLLOW-UP:

When the patient was last examined in June 1969, there was no evidence of disease.
NAME: M. H.  
AGE: 74  SEX: F  RACE: Caucasian 
CONTRIBUTOR: R. L. Lesonsky, M.D.  
A. A. Channing, M.D.  
Canoga Park Hospital  
Canoga Park, Calif.91304 
Tissue FROM: Endometrium of uterus 
CLINICAL ABSTRACT: 

Present illness: For many months, the patient complained of vaginal spotting accompanied by mild discomfort. Concomitantly, she had a tumor protruding from the cervix. 

Past history: In 1966, she had endocervical and endometrial polyps removed. Subsequently, she had a right radical mastectomy for breast carcinoma. She was on continuous estrogen therapy from 1943 to 1965. 

Physical examination: There was no recurrent breast carcinoma or adenopathy. A large polyp, which appeared red and hemorrhagic, distended the cervical canal. 

Laboratory report: The routine laboratory results were unremarkable. 

SURGERY: 

On 2-26-69, a total hysterectomy and bilateral salpingo-oophorectomy were performed. There were dense pelvic adhesions and the left ovary could not be found. 

GROSS PATHOLOGY: 

The specimen consisted of a total uterus with attached fallopian tubes and one definitely identifiable ovary. The uterus measured 14 x 10 x 8 cm. There was a gaping aperture in the midportion of the endocervix and through this protruded a tan-brown polypoid mass. The endometrial cavity was filled with a gray-tan polypoid mass measuring 11.5 x 5 x 3 cm. This mass was continuous with the polypoid mass protruding through the endocervical canal. The adjacent endometrium appeared to be yellow-gray and cystic with areas of necrosis. It was measured up to 3 cm. in thickness. The underlying myometrium was measured up to 2.5 cm. in thickness and was grossly unremarkable. The fallopian tubes and the ovary were unremarkable. 

FOLLOW-UP: 

Patient has been seen regularly every three months by her attending physician. She is well, has no complications, and no recurrence of tumor. 

1Q
NAME: G. A. T.  
JUNE 1970 - CASE NO. 12
AGE: 37 SEX: F  RACE: -  
ACCESSION NO. 18154
CONTRIBUTOR: Frank J. Glassy, M.D.  
Sutter General Hospital  
Sacramento, Calif. 95816  
OUTSIDE NO. M-69-2443

TISSUE FROM: Tumor of uterus

CLINICAL ABSTRACT:

Present illness: Six days previously, the patient had a tumor of left broad ligament weighing 1074 grams removed surgically. At the time of the surgery, the surgeon noticed a gravid uterus of 4-5 months. There were some intravenous, elongated, worm-like masses in the wall of the uterus. In the face of pregnancy, the surgeon was hesitant to do a hysterectomy at that time.

Past history: The patient developed a right femoral thrombosis in January 1969. After the embolectomy, she did relatively well until few weeks prior to the admission when she developed pelvic discomfort.

Physical examination performed before the first surgery revealed an irregular mass in the left pelvis. The uterus was pushed to the right by the mass.

Laboratory report: Routine laboratory work-up was normal.

Radiograph: Chest x-ray was within normal limit.

SURGERY:

On 5-26-69, a total hysterectomy and right salpingo-oophorectomy were performed.

GROSS PATHOLOGY:

The specimen consisted of a pregnant uterus weighing 2250 grams and measuring 26 x 19 x 12 cm. The left adnexal structures had previously been removed. With a scissors, the dilated veins were traced from the right broad ligament into the wall of the uterus. It was found that there were ramifying branching large vascular channels filled with worm-like masses of neoplasm. These could be traced over all of the surface of the uterus and were found to connect with the right broad ligament. The uterus was sectioned in its long axis. In the superior portion of the uterus, the wall was markedly thickened and there were irregular masses of neoplasm lying within the vascular spaces. Within the endometrial cavity, there was a well formed male fetus with a crown-rump measurement of 15.4 cm. The endometrial mucosa had a slight cobblestone appearance. The right ovary and the right fallopian tube appeared unremarkable.

COURSE:

The postoperative course was uneventful. Microscopically, the tumor of the left broad ligament was similar to the neoplasms of the uterus.

FOLLOW-UP:

She has no pelvic discomfort or masses, and no symptoms of any type, either related or unrelated to her previous problem.
CASE NO. 1. ACCESSION NO. 12660. A.P. Sohn, M.D.-J.W. Callister, M.D., Contributors

LOS ANGELES:
   Benign stromal myosis--1
   Stromal sarcoma--8
   Atypical adenomyosis--1

SAN FRANCISCO:
   Endolymphatic stromal myosis--14

CENTRAL VALLEY:
   Stromatosis--12
      Malignant--1; benign--6; no distinction--5
   Comment: "It was suggested that the left ovarian tumor removed in 1969 may have been, not a metastasis from the uterine tumor removed in 1962, but a new focal transformation of the presumably extensive endometriosis."

OAKLAND:
   Mixed mesodermal malignant tumor--10
   Carcinoma--2
   Endometrioid adenocarcinoma--1
   Adenomyosis--1

WEST LOS ANGELES:
   Stromal myosis--6
   Granulosa-theca cell tumor--3

SANTA BARBARA:
   Stromal sarcoma, low-grade--1
   Stromatosis--1

SOUTH BAY:
   Endolymphatic stromal myosis--4
   Endometrial stromal sarcoma--2
   Benign dysontogenic tumor--1

INLAND (SAN BERNARDINO):
   Carcinosarcoma--1
   Endolymphatic stromal myosis--5
   Hemangiopericytoma--4

FILE DIAGNOSIS: Endolymphatic stromal myosis, uterus 1820-8931
   xf: Stromal sarcoma, uterus 1830-8933

References:

Minutes not received: San Diego, Orange County
CASE NO. 2. ACCESSION NO. 14060. H. A. Fanselau, M.D., Contributor

LOS ANGELES:

Low-grade adenocarcinoma arising in adenomyosis--11

SAN FRANCISCO:

Endometrioid carcinoma--14

CENTRAL VALLEY:

Benign endometriosis--4
Endometriosis with low-grade malignant transformation--5
Adenocarcinoma of Mullerian ducts--2
Low-grade adenocarcinoma--1

OAKLAND:

Adenocarcinoma arising in mesonephric rest--8
Adenocarcinoma arising in adenomyosis--6

WEST LOS ANGELES:

Adenocarcinoma--9
Endometrial adenomyosis origin--7
Endocervical gland origin--0
Endocervical adenomyosis origin--2

SANTA BARBARA:

Endometrioid adenocarcinoma, vaginal wall--1
Adenomyosis--1

SOUTH BAY:

Adenocarcinoma, endometrial type--5
Atypical adenomyosis--2

INLAND (SAN BERNARDINO):

Adenocarcinoma arising in endometriosis--12

FILE DIAGNOSIS: Low-grade adenocarcinoma arising in adenomyosis, uterus

References:


CASE NO. 3. ACCESSION NO. 15085. Paul Ortega, M.D., Contributor

LOS ANGELES:

Adenomatoid tumor (mesothelioma)--10

SAN FRANCISCO:

Adenomatoid tumor--14
(Denign mesothelioma and lymphangioma to be considered)

CENTRAL VALLEY:

Adenomatoid tumor--6
Vascular leiomyoma--6

OAKLAND:

Adenomatoid tumor--10
Lymphangioma--5
Leiomyoma--1

WEST LOS ANGELES:

Adenomatoid tumor--9

SANTA BARBARA:

Adenomatoid tumor--1
Angiomyoma--1

SOUTH DAY:

Adenomatoid tumor--5
Leiomyoma of unusual type--2

INLAND (SAN BERNARDINO):

Adenomatoid tumor, uterus--12

FILE DIAGNOSIS: Adenomatoid tumor, uterus 1829-9050

References:


CASE NO. 4. ACCESSION NO. 15768. Francis S. Buck, M.D., Contributor

LOS ANGELES:
Lipoleiomyoma--10

SAN FRANCISCO:
Leiomyolipoma--13
Leiomyoma--1

CENTRAL VALLEY:
Myolipoma--12

OAKLAND:
Angiomyolipoma--15

WEST LOS ANGELES:
Lipomyoma--9

SANTA BARBARA:
Leiomyoma with lipomatous degeneration--1
Angiolipomyomatous hamartoma--1

SOUTH BAY:
Lipoleiomyoma (angiomyolipoma)--7

INLAND (SAN BERNARDINO):
Lipo-leiomyoma, uterus--12

FILE DIAGNOSIS: Lipoleiomyoma, uterus

1829-8890
1829-8890

References:
CASE NO. 5. ACCESSION NO. 15813. E. M. Dutt, M.D., Contributor

JUNE 1970

LOS ANGELES:

Degenerated leiomyoma, uterus--10

SAN FRANCISCO:

Leiomyoma, degenerating--10
Leiomyosarcoma--4

CENTRAL VALLEY:

Degenerating leiomyoma with pregnancy changes--12

OAKLAND:

Leiomyoma--15

WEST LOS ANGELES:

Leiomyoma with infarction--9

SANTA BARBARA:

Leiomyoma, ischemic and infarcted--2

SOUTH DAY:

Leiomyoma with necrosis--7

INLAND (SAN BERNARDINO):

Degenerating leiomyoma--12

FILE DIAGNOSIS: Degenerating leiomyoma of pregnancy, uterus

References:


JUNE 1970

CASE NO. 6. ACCESSION NO. 15932. Thomas E. Wynn, M.D., Contributor

LOS ANGELES:

Stromal sarcoma--4
Endolymphatic stromal myosis--5

Intravascular leiomyomatosis--1
Hemangiopericytoma--2

SAN FRANCISCO:

Hemangiopericytoma--10
Endolymphatic stromal myosis--4

CENTRAL VALLEY:

Stromatosis--5
Stromal sarcoma--3

Hemangiopericytoma--3
Leiomyoma--2

OAKLAND:

Endolymphatic stromal myosis--10
Hemangiopericytoma--4
Endometrial stromal sarcoma--1

WEST LOS ANGELES:

Malignant stromatosis--3
Stromal myosis--2

Hemangiopericytoma--1
Infiltrating vascular leiomyoma--3

SANTA BARBARA:

Leiomyosarcoma--1
Endometrial stromal sarcoma--1

SOUTH BAY:

Endolymphatic stromal myosis--7

INLAND (SAN BERNARDINO):

Endolymphatic stromal myosis--6
Hemangiopericytoma--4

FILE DIAGNOSIS: Endolymphatic stromal myosis, uterus 1820-8931

References:


CASE NO. 7. ACCESSION NO. 16000. Louisa Keasbey, M.D., Contributor

LOS ANGELES:

Rhabdomyosarcoma--11

SAN FRANCISCO:

Rhabdomyosarcoma--10
Mixed Mullerian tumor--4

CENTRAL VALLEY:

Rhabdomyosarcoma--12

OAKLAND:

Mixed Mullerian sarcoma--8
Rhabdomyosarcoma--7
(Striations present in cells of some participants)

WEST LOS ANGELES:

Mixed mesodermal tumor (necrotic)--9

SANTA BARBARA:

Myosarcoma--2

SOUTH BAY:

Rhabdomyosarcoma--7

INLAND (SAN BERNARDINO):

Mixed mesodermal tumor--12

FILE DIAGNOSIS: Rhabdomyosarcoma, uterus 1829-8903

References:


CASE NO. 8. ACCESSION NO. 17941. V. Thery Ness, M.D. & R.C. Boylan, M.D., Contributors

LOS ANGELES:

Atypical cellular leiomyoma--6
Low-grade leiomyosarcoma--5

SAN FRANCISCO:

Cellular leiomyoma--14

CENTRAL VALLEY:

Stromal sarcoma--2
Leiomyosarcoma--4
Leiomyoma--5
Don't know--1

OAKLAND:

Leiomyoma, cellular--3
Leiomyosarcoma--7

WEST LOS ANGELES:

Leiomyosarcoma--8
Cellular leiomyoma with atypia--1

SANTA BARBARA:

Leiomyoma, cellular--2

SOUTH DAY:

Cellular leiomyoma--5
Leiomyosarcoma--1
Hemangiopericytoma--1

INLAND (SAN BERNARDINO):

Cellular leiomyoma--9
Leiomyosarcoma--3

FILE DIAGNOSIS: Low-grade leiomyosarcoma, uterus 1829-8893
xf: Cellular leiomyoma, uterus 1829-8890

References:


CASE NO. 9. ACCESSION NO. 17782. Frank R. Dutra, M.D., Contributor

LOS ANGELES:

Degenerating leiomyoma--11

SAN FRANCISCO:

Leiomyoma--14

CENTRAL VALLEY:

Leiomyoma--12

OAKLAND:

Leiomyoma, cellular--12
Leiomyosarcoma--2

Comment: "Section sent out was from a 6 cm. tumor of the cervix, not of myometrium."

WEST LOS ANGELES:

Leiomyoma with hyalinization--9

SANTA BARBARA:

Leiomyoma--2

SOUTH BAY:

Leiomyoma--7

INLAND: (SAN BERNARDINO):

Leiomyoma--12

FILE DIAGNOSIS: Leiomyoma, uterus 1829-8890

References:


CASE NO. 10. ACCESSION NO. 17918. W. E. Carroll, M.D., Contributor

LOS ANGELES:
Leiomyosarcoma--10
Atypical degenerating leiomyoma--1

SAN FRANCISCO:
Leiomyosarcoma--10
Atypical leiomyoma--4

CENTRAL VALLEY:
Leiomyosarcoma--11
Atypical leiomyoma--1

OAKLAND:
Leiomyosarcoma--13
Leiomyoma--1

WEST LOS ANGELES:
Leiomyosarcoma (multifocal)--9

SANTA BARBARA:
Leiomyosarcoma--1

SOUTH BAY:
Leiomyosarcoma--5
Sarcoma of undetermined type--2

INLAND (SAN BERNARDINO):
Mixed mesodermal tumor--3
Low-grade leiomyosarcoma--5
Bizarre leiomyoma--4

FILE DIAGNOSIS: Leiomyosarcoma, uterus

References:
CASE NO. 11. ACCESSION NO. 18034. R.L. Lesonsky, M.D.-A.A. Channing, M.D.,
Contributors

LOS ANGELES:
Benign cystic hyperplastic endometrium--11

SAN FRANCISCO:
Cystic endometrial hyperplasia--14

CENTRAL VALLEY:
Giant benign polyp--12

OAKLAND:
Giant polypoid endometrial hyperplasia--14
Comment: Reference: Ross, Livia and Bensussen, Chas. J. Am.J.Ob. & Gyn.,

WEST LOS ANGELES:
Adenomatous polyp--9

SANTA BARBARA:
Endometrial polyp--2

SOUTH BAY:
Polypoid cystic hyperplasia--7

INLAND (SAN BERNARDINO):
Hyperplastic polyp, endometrium--12

FILE DIAGNOSIS: Polypoid cystic endometrial hyperplasia, uterus 1829-7306
1829-7380

References:
1. Campbell, P.E. and Barter, R.A. Significance of atypical endometrial
malignant endometrial changes with clomiphene. Amer. J. Obstet. Gynec.,
CASE NO. 12. ACCESSION NO. 18154. Frank J. Glassy, M.D., Contributor

LOS ANGELES:
Intravenous leiomyomatosis--11

SAN FRANCISCO:
Intravenous leiomyomatosis--14

CENTRAL VALLEY:
Intravascular leiomyomatosis--12

WEST LOS ANGELES:
Endolymphatic leiomyomatosis--9

OAKLAND:
Intravenous leiomyomatosis--12

SANTA BARBARA:
Venous leiomyoma--2

SOUTH BAY:
Intravenous leiomyomatosis--7

INLAND (SAN BERNARDINO):
Intravenous leiomyomatosis--12

FILE DIAGNOSIS: Intravenous leiomyomatosis, uterus 1829-8891

References: