CALIFORNIA TUMOR TISSUE REGISTRY
SEVENTIETH SEMI-ANNUAL SLIDE SEMINAR
ON
ANATOMICAL ASPECTS OF HISTOCHEMICAL AND IMMUNOLOGY OF
NEOPLASTIC DISEASES

MODERATORS:
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SUNDAY, DECEMBER 7, 1980
9:00 A.M. - 4:30 P.M.

REGISTRATION: 7:30 A.M.

SHERATON PALACE HOTEL
SAN FRANCISCO, CALIFORNIA

Please bring your protocol, but do not bring slides or microscopes to the meeting.
CONTRIBUTOR: Frank B. Johnson, M. D.  
WASHINGTON, D. C.  
DECEMBER 1980 - CASE NO. 1J

TISSUE FROM: Colon

ACCESSION NO. 23985

A 55 year old woman was admitted to the hospital complaining of rectal bleeding and hemorrhoids. No other history was available. Several rectal biopsies and a hemorrhoidectomy were performed. These were followed by removal of the distal 20 cm. of colon and rectum.

CONTRIBUTOR: Frank B. Johnson, M. D.  
WASHINGTON, D. C.  
DECEMBER 1980 - CASE NO. 2J

TISSUE FROM: Lung

ACCESSION NO. 24003

A 56 year old man was admitted to the hospital complaining of shoulder pain. He had been followed for 13 years, having been employed as an insulation worker with asbestos and fiberglass. A reticular infiltrate in both lower lobes were found. He was advised to change to a different occupation, but failed to do so. He usually wore a mask when working in close contact with insulating materials. He had been a light smoker as a teenager. He was first admitted to the hospital with mild epigastric discomfort. An upper G.I. series revealed a filling defect at the cardia, but no intrinsic lesion was seen on gastroscopy. He received symptomatic treatment, but continued to experience epigastric discomfort. Right shoulder pain, fatigue, weakness of the right hand and a 7 lb. weight loss developed. The interstitial fibrosis progressed. Several months before the final admission a suspect left renal filling defect was visualized on IVP. There was progressive pain and atrophy of the right trapezius muscle. A cervical myelogram was negative. Several epigastric pain developed without vomiting, nausea, diarrhea or constipation. The pain was worst at night while lying down and bending the body to one side. The previous dry cough became productive of mucopurulent sputum. Progressive abdominal swelling developed. The respiratory symptoms were mild and there was no melena or hematemesis. The chest lesions were stable and most of the laborotory findings were not remarkable. There was moderate elevation of serum alkaline phosphatase and the albumin was depressed to 2.2 gm. %. The patient deteriorated under chemotherapy and supportive measures and expired quietly following a hypotensive episode.
A 68 year old man gave a 20 year history of hypertension and of peptic ulcer symptoms. The latter were relieved by eating and taking antacids. He had not had gastrointestinal bleeding. He had received various medicines for his hypertension including Diuril, Inderal, and Apresoline. On hospitalization, 3 years previously, the patient's 24 hour vanil mandelic acid excretion was elevated to 17.1 mg. His last admission was related to a two-day history of fever (as high as 102°F) chills, malaise epigastric pain and an increase in his usual productive cough. He had smoked a pack to a pack and a half of cigarettes for about 40 years. On admission his blood pressure was 170/90, and temperature 99.8°F.

His chest x-ray revealed some reticular increased density and a scattered infiltrative pattern through both lower lobes. His white blood cell count was elevated to 16,000 with 85% segs. Soon after admission the patient suffered a cardiopulmonary arrest and failed to respond to resuscitation.

A 67 year old woman had nodular masses excised from the region of the left lobe of her thyroid. One year previously, she had received an injection into her vocal cord.
A 64 year old man was admitted for evaluation of fever. Two years previously he was found to have a benign gastric ulcer. His complaints were fever, chills, shortness of breath, abdominal distention and a productive cough. His past medical history revealed severe chronic obstructive pulmonary disease associated with cigarette smoking, alcoholic liver disease, intravenous drug abuse and diet controlled adult-onset diabetes. Physical examination revealed an ill-appearing male in moderate respiratory distress. Breath sounds were distant and there were crackles and rhonchi at both bases. The abdomen was grossly distended and bowel sounds were hypoactive. The skin of the extremities was atrophic. Significant laboratory findings included a platelet count of 310,000, elevated SGOT and LDH, red and white blood cells in the urine and an ectopic atrial pacemaker, as well as a possible remote myocardial infarct. The chest x-rays showed chronic fibrotic changes and blunting of the costophrenic angles.

On the second hospital day the chest x-ray showed interstitial and alveolar infiltrates involving mainly the upper lobes. Sputum smears showed mixed flora and no acid-fast bacilli. Gram negative rods grew out on sputum culture. Multiple blood and urine cultures were negative. Abdominal films were consistent with adynamic ileus. Erythromycin and Gentamycin were prescribed, but the Erythromycin was discontinued because of vomiting. The patient remained febrile and became progressively more disoriented and combative. A few red blood cells were seen in lumbar puncture fluid.

The patient died on the 13th hospital day.

A 67 year old man was admitted to the hospital complaining of severe weakness, shortness of breath and swelling of his ankles. He had been diagnosed as having had liver trouble about 30 years previously in the mid 1940's. He was stated to have had an intra-arterial diagnostic injection. On physical examination his liver and spleen were found to be enlarged.
A 44 year old man had been treated for 4 years with a diagnosis of sarcoidosis of the lungs and skin. He was admitted to the hospital after a 4-5 day complaint of loss of appetite, occasional loose stools and marked dyspnea. On admission he appeared well developed, but poorly nourished and in marked respiratory distress. Bilateral rales were heard and respiration was rapid. Numerous scaly hyperpigmented areas were present over the neck, upper arms and lower extremities. A left indirect inguinal hernia was noted.

He was placed on bed rest in an oxygen tent. He was given antibiotics, Digoxin, Tedral and an expectorant cough syrup. He remained dyspnic, gradually went downhill and expired on the 4th hospital day.

A 60 year old woman was admitted to the hospital with progressively worsening shortness of breath for three days. She had been diagnosed as having post-streptococcal glomerulonephritis four years previously. She was also suspected of having mitral stenosis and congestive heart failure. Over a period of years she had been on dialysis. Initially peritoneal, then hemodialysis.

During the final hospitalization she had spikes of fever and was suspected of having septic endocarditis. No organisms were cultured from blood. On admission her serum calcium was 11.7. Just before death it was 9.7. She died during her sixth week of hospitalization.
CONTRIBUTOR: Frank B. Johnson, M. D. DECEMBER 1980 - CASE NO. 9J
Washington, D. C.

TISSUE FROM: Lung ACCESSION NO. 24035

A 60 year old man received unstated chemotherapy for carcinoma of the mouth and/or tongue. At autopsy there was extensive pulmonary pathology.

CONTRIBUTOR: Frank B. Johnson, M. D. DECEMBER 1980 - CASE NO. 10J
Washington, D. C.

TISSUE FROM: Lung ACCESSION NO. 23988

A painter of unstated age was seen three months before the present hospital admission with pneumonitis and unilateral pleural effusion. The pneumonitis cleared on antibiotics but the effusion persisted, reaccumulating after taps. In the hospital a decortication of the left lung was performed.

CONTRIBUTOR: Frank B. Johnson, M. D. DECEMBER 1980 - CASE NO. 11J
Washington, D. C.

TISSUE FROM: Mediastinum ACCESSION NO. 24023

A 17 year old male student developed right pleuritic pain, a productive cough, anorexia and dyspnea with wheezing and 8 lb. weight loss two weeks before admission to the hospital. Five days prior to admission he developed fever and chills. He had a history of febrile episodes since the age of 6, but no history of asthma. He claimed to be an occasional user of heroin.

Physical examination disclose a temperature of 102°F, cervical, supraclavicular and post-auricular lymphadenopathy, and inspiratory and expiratory wheezing with rales and rhonchi. The white cell count was 33,000 with 52% eosinophiles. Chest x-ray showed hilar and right paratracheal lymphadenopathy. A mediastinal biopsy was performed.
A 46 year old woman admitted with intestinal obstruction. She is said to have had a carcinoma of the thyroid in the remote past. Nine years before the present admission, she had a nephrectomy for a clear-cell carcinoma of kidney. The patient was operated on for her obstruction and a 70 cm. loop of proximal jejunum was removed.

A 53 year old woman was admitted to the hospital complaining of severe shortness of breath, a productive cough, weakness and a weight loss of about 20 pounds. She had had the weakness and a poor appetite for about a year, but had not sought medical attention. She had been a heavy cigarette smoker since childhood and also was a chronic alcoholic and had episodes of mild jaundice.

Physical examination revealed a cachectic female with labored respiration and a temperature of 101°F. The chest x-rays showed a mass in the mediastinum and consolidation of the right lower lobe of the lungs. Her hematocrit was 24 and white cell count 18,000. In spite of antibiotics the patient continued to be febrile and died on the second hospital day.

A 32 year old man fell down the stairs, complained of abdominal pain and went into shock. He was rushed to the hospital where a splenectomy was performed. The resected spleen weighed about 550 grams. Additional clinical information is not available.
A 47 year old man noticed a small mass in the left side of his neck. It slowly enlarge, giving pain and tenderness during the four months up to admission to the hospital. About 28 years previously he suffered an injury to his chin in a motor vehicle accident. About 17 years before admission he was successfully treated for active tuberculosis of the apex of the right lung.

The positive clinical findings noted in the hospital include small irregularity of the right lobe of the thyroid on scanning, an enlarged lymph node in the left side of the neck and bilateral small renal calculi on intervenous pyelography.

A 51 year old man noticed a lump in the right lobe of the thyroid three to four months prior to admission. It had not increased in size subsequently, but was slightly tender for the final three to four weeks.

Laboratory findings were non-contributory.

At operation both lobes of the thyroid were found to be enlarged. About 98% of the thyroid was removed.

The thyroid weighed 15 gms. On the right side there was a soft 2.5 cm. nodule with a tan granular cut surface.
CONTRIBUTOR: Frank B. Johnson, M. D.
Washington, D. C.

DECEMBER 1980 - CASE NO. 16J

TISSUE FROM: Knee
ACCESSION NO. 24038

A 40 year old newspaper printer was admitted to the hospital because of recurrent knee trouble. The right knee was painful and stiff, and showed signs of internal derangement. At times small effusion were present. No abnormalities in clinical laboratory tests, E.K.G. or chest x-rays were detected. An arthroscopy, arthrotomy, and synovial biopsy were performed.

CONTRIBUTOR: Frank B. Johnson, M. D.
Washington, D. C.

DECEMBER 1980 - CASE NO. 17J

TISSUE FROM: Liver
ACCESSION NO. 24011

A 50 year old man was treated for several years for a bleeding duodenal ulcer. His treatment included antacid medication and repeated blood transfusions. On one occasion he developed acute hepatitis and continued to have elevated SGOT activity. During the month of final hospitalization he developed chronic gastrointestinal hemorrhages for which he was transfused.

He died following massive gastrointestinal hemorrhage.
CONTRIBUTOR: C. P. Schwinn, M. D. 
Los Angeles, California

TISSUE FROM: Right knee, ankle, and arm
ACCESSION NO. 24032

CLINICAL ABSTRACT:

History: This 48 year old white female had an 11 year history of tophaceous gout, for which she was receiving colchicine, benamid, and phenylbutazone. There had been multiple hospital admissions for removal of tophi. She was admitted again for removal of gouty tophi.

SURGERY: (April 1, 1966)

Multiple gouty tophi were excised from the right heel, knee, and elbow.

GROSS PATHOLOGY:

The specimen consisted of four pieces of pinkish-white tissue, the largest measuring 8 x 7 x 4 cm., and weighing 92 grams in aggregate. Areas of fat were seen to be interspersed with a white, chalky material.

FOLLOW-UP:

Over the next few years, multiple hospital admissions followed for multiple medical problems due to hyperuricemia complications. She finally expired of chronic renal failure on December 18, 1971.

CONTRIBUTOR: Frank B. Johnson, M. D.
Washington, D. C.

TISSUE FROM: Lung
ACCESSION NO. 24030

A 40 year old man was admitted to the hospital with a diagnosis of bronchogenic neoplasm of the left lung. About a week before admission he had an episode of gross hemoptysis. The hemoptysis occurred twice again. X-rays showed left hilar enlargement. A left upper lobectomy was performed.
CONTRIBUTOR: Frank B. Johnson, M. D.  DECEMBER 1980 - CASE NO. 20J
Washington, D. C.

TISSUE FROM: Hernia  ACCESSION NO. 24007

A 67 year old man gave a two year history of left inguinal hernia for which no surgery was performed. His chief complaint on admission was excruciating pain in the left groin. He stated that his hernia had been easily reducible until the day of admission. He ate breakfast and had a bowel movement. He had no nausea, vomiting, nor melana. He had a past history of hypertension, shortness of breath and mild, very rare chest pain. He had also had two episodes of pneumonia 2 and 24 years previously.

Physical examination revealed a soft nontender abdomen and a left inguinal hernia which was reduced over a 23 minute period without causing pain. Laboratory data was within normal limits. Surgery was performed for the hernia. The cord structures were incarcerated through the external ring by a mass. An orchiectomy was required. The patient tolerated the procedure well.

CONTRIBUTOR: Frank B. Johnson, M. D.  DECEMBER 1980 - CASE NO. 21J
Washington, D. C.

TISSUE FROM: Lung  ACCESSION NO. 24008

A 60 year old retired brick yard worker was admitted complaining to shortness of breath and enlarge lymph nodes in the left side of his neck. During his employment, he had been exposed to considerable dust and did not wear a mask. He had been forced to retire because of respiratory difficulty five years before admission. Physical examination showed rales over both lung fields and enlarged, non-tender, firm lymph nodes in the left side of his neck. Chest x-rays revealed scattered five nodular densities. The laboratory findings were not remarkable.

The lungula of the left lung and the left cervical nodes were biopsied.
A 70 year old man presented with a verrucous nodule on his penis, as well as induration of the organ and a periurethral mass. He denied penile injection or trauma.

A woman complained of lumps in her breast. No other history could be obtained.