ARTHUR PURDY STOUT CLUB

* SEMINAR *

May 17, 1952

San Antonio, Texas

HISTORY: This 10 week old white male child came to surgery because of the progressive growth of a mass protruding in a fungating manner from the skin of the right gluteal region. The patient was born with numerous pigmented nevi over the bathing trunk area and a mass on the right buttock. The mass grew progressively until at the time when it was excised it measured 9.5 x 6.5 cm. and was elevated 2 cm. No ulceration or hemorrhagic discoloration of the mass.

CASE 2.  P&S 37668 Contributed by Dr. A. O. Severance Baptist Memorial Hospital San Antonio, Texas

HISTORY: Male 22. About 5 to 7 years before, a purplish brown spot appeared on the great toe. Gradually this spread to the other toes on the same foot and on up the leg so that at present it is half way up the leg. The lesions appear as multiple foci; they are purplish-brown and slightly elevated, and the foot is warmer than the other one. It is so painful it prevents him from working. It was biopsied several times and finally amputated. Gross examination showed brownish soft "tumor" tissue extending along the tendons about the calcaneus. It does not involve bone but does seem to involve muscle.


HISTORY: Male, 14 yrs. old, with a mass just below the angle of the left scapula noted six weeks previously; rapid growth, tender. X-ray shows areas of calcification in mass but no evidence of bone involvement. The tumor was widely excised. It lay one to two inches below the tip of the left scapula within the bellies of the erector spinae group of muscles and measured 7 x 1 x 3 cm. The patient is without evidence of recurrence one year later, although for several months a soft swelling has been noted about the scar. This has been persistent but has not changed.
CASE 4

P&S 38538
Contributed by Dr. Robt. C. Horn Jr.,

HISTORY:
Three year old girl. History of frequent falling, always to right, between the ages of 18 and 24 months, while learning to walk. Approximately one month before admission, and one week after a fall on right elbow, small soft non-tender lump noted there. Grew rather rapidly while being treated conservatively as infection. Incised 2-3 weeks after onset. One week later, right axillary mass noted, grew rapidly. Biopsy one month before admission.

On admission, local tumor not described. X-ray raised question of erosion of lower end of humerus. Axillary mass size of orange. Marked anemia. Fore-quarter amputation performed. Well nine months later. Dead eleven months after operation with extensive pulmonary metastasis.

CASE 5

P&S 38570
Contributed by Brig.Gen. Elbert DeCoursey
Armed Forces Institute of Pathology
Washington, D.C.

HISTORY: adult. Present 7 months; excised and encapsulated. This patient gives a history of the mass in the thigh increasing rather rapidly in size over a period of 7 months. He gives a definite history of reduction in size of the leg almost to normal about 3 months ago. The mass extended almost from the knee to the upper part of the thigh on the antero-lateral surface. It was firm and clinically appeared to be beneath the muscles. At operation the mass was found to be beneath the muscles and was encapsulated. It had no relationship to the bone. X-ray of the chest and remainder of the physical exam. were negative. Tumor was symptomless.

GROSS:
A roughly spherical mass of tissue which is 14 cm. in diam. It appears to be completely surrounded by a thick capsule. Considerable voluntary muscle is attached to the outer surface. On section, the mass is made up of fairly soft friable tissue which is generally white. In some places the tissue is very soft and semitranslucent. There are numerous areas of old and recent hemorrhage.
CASE 6

P&S 36929

Contributed by Dr. Saul Kay,
Medical College of Virginia,
Richmond, Virginia

HISTORY: This 8½ year old white female had been complaining of an enlargement of the abdomen for the past 4 or 5 years. At laparotomy, a large cystic nodular tumor was removed with the left ovary. The right ovary was called normal. The specimen was received in the laboratory as a collapsed cystic mass about 25 cm. in diameter. Projecting from the cyst surface were multiple firm nodules and in addition degenerated friable tissue which seemed obviously neoplastic, was attached to the wall. No papillary growths were seen and the internal surface of the cyst was essentially smooth.

CASE 7

P&S 37633

Contributed by Dr. Maurice N. Richter,
N.Y. University Hosp., New York

HISTORY: Male, age 59. Patient noticed a mass in scrotum above the left testis about six weeks ago, which has grown rapidly. There is no pain or tenderness.

At operation, the testis appeared normal but a mass was found above it. Within the mass was a hard nodule about the size of the testis itself. The tissue around the mass resembled a hernial sac, but dissection showed no sac to be present.

The specimens removed consisted of:

1. A testis which appeared normal
2. A firm mass of rubbery consistency, about 5.0x3.5x4.0 cm. in diam. The outer surface is smooth. The cut surface is homogeneous, grey.
3. A cord-like structure 12 cm. in length, in the middle of which are two nodules, each about 1 cm. in diameter, similar to the main mass.

Microscopically, the large mass and the two smaller ones are similar. The specimen submitted is from the large one.
CASE 8
S.P. A-23591
Contributed by Dr. John Pickren
Columbia-Presbyterian Medical Center, N.Y.

HISTORY: White male, age 34. There was a completely negative gastro-intestinal tract history until two weeks before hospitalization. At that time he noted black stools. He tired easily and had difficulty in climbing stairs. He noted a tightening feeling in the chest after walking 4 blocks or climbing a few steps of stairs. The tarry stools continued and he reported to the hospital.

On admission, the patient appeared to be a well developed and well nourished male, in no acute distress. Examination was essentially negative except for slight epigastric tenderness. Stool was tarry black at time of admission. X-rays of chest and spine were normal.

At an exploratory celiotomy a 5 x 5 cm. friable cauliflower-like fungating tumor involved the posterior wall of the duodenum at the junction of the 2nd and 3rd portions. This mass was continuous with a retroperitoneal tumor in the hilum of the right kidney posterior to the head of the pancreas. The liver did not contain metastases. A biopsy was made.

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CASE 9
P & S 37322
Contributed by Dr. Philip T. Flynn
Brackenridge Hospital, Austin, Texas

HISTORY: White female, age 44, who was seen in Sept. 1941 with obstruction of the colon. A mass was felt in the rectosigmoid and at the time of operation a diagnosis of endometriosis was made and the patient was subjected to a small amount of radiation through a cone. However, the stricture persisted and in Jan. 1944 the patient was treated by dilatation. In Oct. 1948 polyps were removed from the rectum which were called "inflammatory polyps". In Jan. 1949 more polyps were removed. In Sept. 1949 at the last operation (polypectomy) a constrictive ring was noted at 7 cm.

For the next 8 months the patient was treated by a neuro-path with high colonic irrigations which served to do nothing more than cleanse the polyps and bleed the patient down to two grams of hemoglobin.

In Oct. 1950 two polyps similar to the present slides were removed measuring 5 x 4 x 4 cm. and 2 x 2 x 1 cm.
In Oct. 1951 the patient returned with 4 polyps measuring 4.5, 4, 2.5, and 3.7 cm. respectively.

The rectum and sigmoid were removed surgically and an end-to-end anastomosis performed which included the regional lymph nodes. The histology of the polyps have all been the same.
HISTORY: This 52 year old man had attacks of loss of consciousness preceded by dizziness, for 2 years, which would be aborted by coffee or coca cola. The fasting blood sugar was 25 mg. %. After ingestion of 161 grams of carbohydrate, the blood sugar rose to the highest point of 130 mg. %, at 3 hours, after which there was a sharp fall to 15 mg. % at 6 hours. At this point the patient lost consciousness and began to twitch.

On exploration of the abdomen there was a large pedunculated tumor in the region of the pancreas. It weighed 500 grams and measured 9.5 x 3.5 cm.

HISTORY: A 36 year old female had something removed from the parotid area 6 years ago. Its nature is unknown. The present growth appeared 6 months ago and occupied the parotid area and extended to the cheek. At operation the surgeon thought he removed a parotid tumor and a lymph node in the cheek adjacent but not connected with it. The larger mass measured 6 x 4 cm. No normal parotid tissue was recognized grossly. It was composed of nodules varying in size from 3 mm. to 1 cm. which had the appearance of lymph nodes. The piece of tissue from the cheek had a similar appearance.

HISTORY: Male 43. Well all his life until 2 years ago when a 1.5 cm. mass developed just above the sternum. BMR normal, and no evidence of thyrotoxicosis. Rather quickly it enlarged to a diameter of 10 cm. and on examination protruded mainly on the right side pushing the trachea to the left. His only complaint was a dragging sensation on swallowing. At surgery a mass 15 x 8 x 6 cm. lay partly behind the sternum and was excised. It was said to be soft and gelatinous in consistency some places and rubbery in other areas. It was whitish with interspersed pink areas and much fat. It was lobulated and seemed encapsulated.
CASE 13

P&S 37985
Contributed by Dr. A. O. Severance
Baptist Memorial Hosp., San Antonio, Texas

HISTORY: 23-year-old Latin-American female. First noticed a lump in the left breast about April 15-1950. One month after noticing the appearance of the lump the surgeon locally enucleated it from the breast. The enucleated lump was rubbery, grey, yellow mass of tissue measuring 2.5 x 1.2 x 1 cm. Four hemorrhages were seen in the cut surface. Grossly, it looked like a typical adenofibroma. In November 1951 the patient noticed a recurrent nodule in the scar. In the last few months the tumor has been growing rapidly and the patient feels that it is three times as large as it was when she first noticed the recurrence. A biopsy into the recurrent mass was made in Feb. 1952, and the biopsy consists of four small fragments of greyish white tissue.

CASE 14

P&S 37920
Contributed by Col. Charles Farinacci
Fitzsimons General Hosp., Denver, Colo.

HISTORY: Male 23. This patient suffered from fever and migratory joint pains from May 1949 to October 1951. He lost 26 pounds and was said to have a heart murmur. No pulmonary pathology was noted until March 1951 when a thin walled cavity was described by x-ray in the left upper lobe. No fluid level. Repeated tests failed to demonstrate acid-fast bacilli or fungi. PPD skin tests were twice negative in Arizona and 1 plus at Fitzsimons Hospital. Histoplasmin and Coccidioidin agglutination and skin tests were negative repeatedly. He had lost no weight recently, never had hemoptysis but did have fatigue and shortness of breath with onset in January 1951 and slight cough beginning February or March 1951.

On October 29, 1951, the left upper lobe was removed. Positive gross findings were a 3 cm. thin walled cavity lateral to the transection of the main bronchus. It contained a thin greyish-brown pus and had a soft friable lining. There were also several 2 to 4 mm. sub-pleural nodules on the lateral surface. Their cut surface was firm grey and rubbery. No bronchial involvement was noted. Smears and cultures taken from the material in the cavity were negative for bacteria and fungi.
I happen to have seen this baby when I was at the Fitzsimons Hospital in Denver with Charlie Farinacci. It differs from the usual variety of bathing trunk naevus because while the common type is a slowly developing lesion composed of the usual admixture of down dropping epidermal melanoblasts and intermingled Schwann cells springing up from the skin nerves to intertwine with them, it does not display the alarmingly rapid proliferation of nodules with superficial ulceration shown in this baby. Further, this case, although the area involved is the midsection of the body covered by bathing trunks, it is not one continuous papillary mole but actually a large café-au-lait area with pigmented foci scattered all over it and one actively growing fungating area from which our section comes. This suggests von Recklinghausen's disease and that is confirmed by the microscopic picture. We find an extraordinarily jumbled admixture of proliferated Schwann cells, occasional Wagner Meissner tactile corpuscles, granulation tissue and cords of naevus cells, some pigmented. There are no plexiform neuromas; the nerve twigs are of normal size although the Schwann cells are prominent.

It is quite possible that all of the patients with bathing trunk naevi suffer from von Recklinghausen's disease as well. An excellent illustration of one in an adult male was published by Quigley. This man also had multiple isolated pigmented nodules on his trunk, extremities and neck, isolated café-au-lait spots and gynecomastia.

Is this a malignant process in the present baby? I cannot say so from the histological features and time alone will tell whether or not it will behave as such and how it will do it.

**DIAGNOSIS:**

Bathing trunk naevus

Multiple neurofibromatosis

No change 1953

Ref:


J.A.M.A. 82: 2029, 1921

Arthur Purdy Stout, M.D.

Case #1, P&S 37485 - This patient was followed for one year in Pediatric Clinic with no change in appearance of the lesions. (Col. C. Farinacci, 5-1-53)
It seems to me that the decision here must lie between Kaposi's disease on the one hand and that form of proliferative angiomatosis which is seen in cases of congenital arterio-venous fistula and which can lead to enlargement and overgrowth of an extremity, ulceration and sometimes gangrene. In this case there is no statement about the condition of the large vessels in the thigh so I assume if fistulae existed their presence was not suspected. I must say that the diffuse capillary proliferation throughout the section reminds me of such cases of angiomatosis. I have studied the case also from the point of view that it may be Kaposi's disease. I must say I have been very reluctant to make the diagnosis of Kaposi's disease unless I could find somewhere the characteristic intermingling of fibrous or fibrosarcomatous tissue with capillaries. Further, it is usually found that the capillary vessels show a very free interanastomosis. In this case I can find an intermingling of capillaries with fibroblastic tissue only in the bed of the ulcerated area and here it may be scar tissue instead of tumor tissue. Consequently I feel unable to make an unqualified diagnosis of Kaposi's disease in spite of what the dermatologists say. I have known even a dermatologist to make a mistake. I recognize the possibility of Kaposi's disease but for me the diagnosis remains in doubt.

**DIAGNOSIS:**

Kaposi's disease? or Hemangiomatosis? of leg and foot.

Arthur Purdy Stout, M.D.

DIAGNOSIS: Kaposi's disease? or Hemangiomatosis? of leg and foot.

Arthur Purdy Stout, M.D.

Case #2, P&S 37668 - On 1-13-53 there was no evidence of recurrence in the amputated stump and no evidence of appearance of the disease in other extremities. He is well, without evidence of disease. (Dr. A.O. Severance, 5-4-53)

Case #2 (John Blanchard)
A.P. Stout Club Seminar of 1952

The patient was seen in the doctors office August 31, 1952, and showed no evidence of recurrence in the amputated extremity and no evidence of development of the disease in the other extremity or elsewhere on the body. Patient is in excellent condition.
I must say the seminar slide which I examined first which seems to have formed a great deal of osteoid or hyalinized collagen imitating osteoid confused and led me astray, for I did not at once observe the gland-like slits lined with cells resembling epithelium with the basophilic hyaluric acid secretion nestling in the fibrosarcoma like stroma. The Laidlaw stain confirms the suggestion of the H & E section, that there are reticulin fibers in the fibrosarcoma areas but none in the gland-like spaces. This makes the diagnosis of synovial sarcoma certain. To find one on the back beneath the scapula is very uncommon but it has been established by Eisenberg and Horn that synovial sarcomas are not always confined to the extremities.

DIAGNOSIS: Synovial sarcoma of infrascapular region.

Ref:

Arthur Purdy Stout, M.D.
This is another example of a malignant tumor of childhood and infancy which is unlike tumors in adults. It has a very definite framework of collagen which encloses masses of rounded and polygonal cells. Usually the cells about the periphery are well preserved but toward the center many have degenerated giving an effect of endothelial proliferation inside of vessels. I do not believe, however, that these are vessels because although in some collections there are no reticulin fibers shown among the tumor cells, in many the Laidlaw stain shows fine reticulin fibers. I do not think this occurs with neoplastic endothelial cells, consequently I would reject them as such. Since they show no evidence of secretional activity or tendency to form intracytoplasmic fibers with the mucicarmine and trichrome stains I have only one suggestion left, namely that they are reticuloblasts and that this is a reticulum cell sarcoma of soft tissues. This tumor type can form cell masses like these but generally they are not so small or enclosed by such a thick collagen meshwork; consequently I make the diagnosis only with a question mark.

DIAGNOSIS: Reticulum cell sarcoma (?) of arm.
A first glance at this would lead one to surmise that we are dealing with a growth of tumor cells which have assumed a "perithelial" aspect because poor nutrition at a distance from the vessel has led to necrosis and that the only well preserved cells are near the vessel lumens. But that is not the case with this tumor; the tissue between the vessels and their thick surrounding sheaths of tumor cells is well preserved and fibrous. Therefore we must suppose the vessels and tumor cells form units. The Laidlaw and trichrome stains show that every tumor cell in the vessel walls is surrounded by an exceedingly fine delicate meshwork of reticulin fibers. In shape the cells vary from round to short plump spindles, occasionally with stellate forms intervening. We could not get a very satisfactory trichrome stain but it appears that there are no intracellular fibers or acidophile granules.

I have to believe this is a hemangiopericytoma of an unusual type. I have occasionally seen a similar pattern reproduced but certainly it is an unusual one.

**DIAGNOSIS:**
Hemangiopericytoma of thigh.

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Case #5, P&S 38570 - On 12-8-52 the patient was without any symptoms referable to her neoplasm of the thigh.
(Dr. Elbert DeCoursey, 4-23-53)

Death occurred on 26 August 1953 at Rock Hill, South Carolina.

This tumor in most areas has the general appearance of a theca cell tumor of the ovary. There is the usual interlacing of spindle shaped cells, many of which contain droplets of lipid, which are accompanied by reticulin fibers. Suddenly the picture changes; the orderly arrangement is lost and cells are jumbled together in a helter-skelter fashion. Moreover, they are irregularly rounded, large and sometimes of giant size, with anaplastic nuclei and large nucleoli showing more frequent mitoses and the cytoplasm voluminous. The reticulin fibers in this area have almost all disappeared. This zone then passes on into one of complete necrosis.

Unquestionably this is the histological picture of a malignant tumor and since it has developed in a thecoma we are fortunate in being able to label it a malignant thecoma. I say fortunate, for if I was compelled to give this the name of one of the sarcomas I could not classify.

This is the first example of a malignant thecoma I have ever seen. They must be very rare, for I could find only three old references and most writers ignore the possibility of malignancy in connection with them. Saul Kay, to whom this tumor belongs, with his usual industry has found a recent reference.

**DIAGNOSIS:** Malignant theca cell tumor.

**Ref:**
- Loeffler, E., and Prissel, A.
- Huber, H.
  Zentralbl. f. Gynak. 61: 1h-1937.
- Geist, S.H., and Gaines, J.A.
This case is indeed worthy of inclusion in the agenda of this organization so far as I am concerned for it contains cells which are entirely unfamiliar to me. The major portion of the mass is fibrous; with trichrome and Laidlaw stains one finds reticulin fibers wrapped about every single cell, and in addition collagen fibers rather at haphazard through the tumor. The cells themselves do not look like ordinary fibroblasts; some are cat- or short spindle-shaped, some are rounded and some irregularly stellate. The lesion is quite vascular. If these were all the findings I might at this point hazard an opinion as to the nature of this lesion. Unfortunately scattered at rather wide intervals there are to be found peculiar giant cells with one or more nuclei and a cytoplasm filled with coarse granules which are strongly acidophile and in trichrome are brilliantly red, probably from fuchsin. These cells vary in shape and seemingly are fragile since the granules sometimes appear to have been spilled into the adjacent tissues. Moreover, on high power study it seems to me that many of the other tumor cells have granular cytoplasm although the granules are small and not especially red.

I cannot explain the giant cells unless they be regarded as phagocytes that have taken up coarse red blood cell fragments which does not seem very probable. In any event, I believe they should be disregarded as probably unimportant. This leaves us with a peculiar fibrous growth which does not have the ordinary appearance of the fibromatoses. It reminds me of the fibrous mesotheliomas of the peritoneum, and if I knew more about the relationship of this mass to the tunica vaginalis or the peritoneum I would suspect this of being a solitary benign fibrous mesothelioma. The only other suggestion I can think of is to suppose it might be a peculiar fibromatosis unlike any of the others which I am familiar. With many misgivings, therefore, I suggest the following diagnosis for this case.

**DIAGNOSIS:** Solitary benign fibrous mesothelioma of the tunica vaginalis testis?

Arthur Purdy Stout, M.D.

*Unread another spec. late*

*Shunned same process*

OK 4/30/53

Case #7, P&S 37633 - This patient had another specimen removed from the same region as the original one. It showed only connective tissue with slight chronic inflammatory reaction. None of the peculiar cells seen in the original surgical specimen were present. There has been no further recurrence, and the patient has remained well. (Dr. Maurice Richter, 4-30-53)
The diagnosis in this case of metastatic chorionepithelioma is quite easy because we have a great deal of syncytiotrophoblast as well as the rounded chorionic epithelium. Several times I have had difficulty in recognizing chorionic cancer cells as such when the trophoblasts are few and far between. In this case we have in addition to the chorionepithelioma various glandular and stromal elements indicating that the tumor of origin was a malignant teratome.

Willis reports necropsy records as showing that blood borne metastases from uterine chorionepithelioma in 25 cases showed the following distribution: lungs 23, spleen 15, intestine 15, brain 14, kidney 14, liver 13, pancreas 3, thyroid 2, stomach 2, heart 1, adrenals 1, and bone 1. He seems to think that most of the testicular chorionepitheliomas are just particularly hemorrhagic malignant teratomas. This present case certainly cannot be so interpreted in my opinion.

**DIAGNOSIS:** Malignant teratoma (chorionepithelioma) of duodenum following embryonal cell carcinoma of testis.

**Ref:**
pp. 575-577 and 991.

**Note:** The tumor of origin in this case is the testis. So far as our sections show the tumor there is entirely made up of embryonal glandular tissue without evidence of any chorionepithelioma. It seems probable it must have been present and not found.

Arthur Purdy Stout, M.D.
This case is remarkable for several reasons. The most obvious one is the formation of the large polypoid growths in the sigmoid and rectum of which one section is representative. They are devoid of all epithelial structures and appear to be composed solely of granulomatous tissue with large blood sinuses. Its narrow stalk springs from the mucosa and submucosa. I can see nothing about it suggesting malignancy. The sigmoid mucosa is thin but not otherwise remarkable. The muscular coat is markedly thickened, probably secondary to the disturbance in bowel activity due to the presence of the polyps.

The mesocolic nodes seemingly have been converted into granulomatous replicas of the polyps in the sigmoid. Again there is no evidence of malignant change.

To complete the extraordinary picture, there are to be found in the interstices of the muscularis of the sigmoid and in its submucous scattered gland-like structures filled with a blue tinted mucoid substance and lined with cells varying from cuboidal to flattened. These structures have nothing about them suggesting endometrial stroma nor do the cellular components as a rule suggest the appearance of endometrium. I believe they must be mesothelial cells and that they must represent a malformation or tumor-like growth to which I would like to apply the name benign solitary tubular mesothelioma. It is a curiosity and in its present state of no clinical importance.

I have seen occasional large granulomatous polyps in cases of regional enteritis but there is no suggestion of that in this bowel. It reminds me a little of Andy McBride's case of esophageal polyps for the occurrence of which no one has a good explanation. But these polyps were covered with mucosa except where eroded and these are not. I am afraid this whole case is beyond my powers to interpret.

**DIAGNOSIS:**
- Multiple granulomatous polyposis of colon and rectum
- Granulomatosis of mesocolic lymph nodes
- Solitary benign tubular mesothelioma of sigmoid colon

**Ref:**

Case #9, P&S 37322 - No follow-up.
The chief features which make this case remarkable are the fact that it was pedunculated and the extreme degree of degeneration, fibrosis, and especially calcification. I have seen nothing approaching degenerative changes carried to this degree. However, calcification of these tumors is far from uncommon. In a study of nine of our islet adenomas, Laidlaw found calcification in three. The few remaining recognizable groups of cells are sufficiently characteristic to leave no doubt about the diagnosis. One is often impressed in dealing with the various hormonally active tumors how small a number of active cells are necessary to produce profound effects.

**DIAGNOSIS:** Islet cell adenoma of pancreas, pedunculated with extreme calcification.

Ref:


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Arthur Purdy Stout, M.D.

Case #10, P&S 38329 - This tumor in the surgical specimen showed tumor thrombi in veins without lymph node metastases. This tumor recurred 8 years later in liver, causing death of the patient.

(Dr. Lauren V. Ackerman, 5-2-53)
The difficult problem here is to decide first whether we are dealing with a lymphosarcoma of the parotid or one of the peculiar cases of chronic lymphoid parotitis and second to interpret the significance of the appearance of the islands of odd looking tissue scattered all through the section.

It will be best to discuss these islands first. I find them very hard to comprehend. Using both the H & E and Laidlaw stains, it appears that they are proliferations of acinar cells with obliteration of the lumen and considerable fibrosis in the center of where the Laidlaw stain shows prominent collagen and reticulin fibers. Enclosing each island is a well defined reticulin sheath. Some of these structures look so much like germinal centers that I was almost willing to accept them as such until I found acinar tubes entering them. I presume therefore we must call them foci of hyperplastic parotid acini and ductules without any neoplastic significance.

Turning next to the lymphoid tissue, is it truly neoplastic? I suppose one has to consider this lymphoid infiltration as lymphosarcoma because there is so much of it and it does not form lymphoid follicles - but the cells seem so much like normal lymphocytes that I have hesitated. In any event, most of the lesions called lymphosarcoma of the salivary glands have been curable lesions not associated with other foci except sometimes other salivary or lacrimal glands.

**DIAGNOSIS:**

Lymphocytic cell lymphosarcoma of parotid salivary gland.

Arthur Purdy Stout, M. D.

Case #11, P&S 37224 - Nine months following the surgical excision there was no evidence of recurrence.

(Dr. Saul Kay, 5-6-53)
When I first looked at sections of this mass I felt that here surely was something out of this world. Those curving strands producing an effect like an intracanalicular fibroma and the voluminous fibro-fatty stroma seemed to make a new and unheard of combination. But when I studied the individual cells in higher magnification I realized they bore the characteristics of the chief cells of the parathyroid gland, and when I encountered groups of oxyphile cells the diagnosis seemed no longer in doubt.

This tumor seems of interest to me for several reasons. It is a solitary parathyroid tumor and therefore fulfills that criterion of adenoma. It has developed doubtless from one of the lower group of glands and has come to occupy a substernal position. It is not functional and is very large. I consulted Black and Ackerman’s paper and they refer to a tumor weighing 120 grams. Unfortunately I do not know the weight of this present tumor, nor do the above authors say anything about size, therefore I do not know how the present tumor compares with other reported ones. I suppose it has been natural for authors to feel an interest only in the hormonally active tumors and to brush off the inactive ones with only a word or two. The largest tumor recorded in Norris’ compilation is 10 x 7 x 3 cm. and in a rather hasty survey I have not found records of any larger than that. From the point of view of those of us who must look through microscopes and make diagnoses from what we see, the fantastic pattern of this growth certainly is one to be treasured. What can have influenced the concomitant growth of so much stroma and in such a fashion as to produce a picture in places like that of an intracanalicular adenofibroma of the breast? Why should there be such a thing as a non-functional adenoma or hyperplasia of the parathyroid or indeed of the other glands of internal secretion? Perhaps some of you will find an answer to these enigmas.

DIAGNOSIS: Adenoma of Parathyroid gland (non-functional),

Ref:
Black, B.K.: Tumors of the parathyroid, a review of 23 cases.


Arthur Purdy Stout, M. D.

OK 2/16/53

Case #12, P&S 37145 - This patient was last seen on 2-16-53. At that time he had no local recurrence of the tumor.
(Dr. H. M. Meyer, 5-5-53)

Case 12 of 1952 A.F.S. Club Seminar - P&S 37145

Patient fine, - no recurrence - as of June 2, 1955.
Dr. Stout,
At first glance this appears to be a simple adenofibroma. On closer inspection it is found that in about one-half of the tumor the stroma appears to be composed of large plump spindle and tricorn cells in greater numbers than in the less active portion. While these cells and the accompanying connective tissue fibers do not form interlaced bands as in a fibrosarcoma, they show an unusual number of mitoses. Aside from these observations I can see nothing unusual about this tumor. The glandular and ductal elements are lined by cells which, although prominent and sometimes in double or triple rows, do not seem to me to show any evidence of malignancy.

This tumor recurred following removal and grew rapidly. Is it malignant?

The recent paper on the subject of cystosarcoma phyllodes by Treves and Sunderland reports 77 cases which the authors subdivide into three groups: benign 41, borderline 18, malignant 18. This is a very different aspect of the disease from that which we have gained from the cases recorded in the Laboratory of Surgical Pathology of Columbia University. There are 58 cases and at present we only know of two which have metastasized. This is 3.4%. When Sunderland and Treves cases are analyzed it is found that 9 have metastasized, or 11.7%. Eight others recurred but it was possible to control these cases by local surgical procedures. I presume that the difference between the two series may be explained because the Memorial is a cancer hospital, while the Columbia University cases come from general hospitals not specializing in cancer. While the cases which have metastasized have a cellular sarcomatous stroma, it is not sufficiently different from many of the non-metastasizing ones to permit one to make definite predictions concerning probability of metastasis.

**DIAGNOSIS:** Cystosarcoma phyllodes of female mammary gland (recurrent).

**Ref:**


*Cancer,* 4: 1286-1332, 1951.

Arthur Purdy Stout, M.D.

\[8/4/1953\]

Case #13, P&S 37985 - This patient is well without evidence of further disease. She was last seen in April 1953.

(()Dr. A.O. Severance, 5-4-53)
Because the lesions represented in these sections are not frequently seen by many of us, it seemed worthwhile to include this example. The necrotic membrane which lines the cavities in this lung and is subtended by histiocytes and occasional multinucleate giant cells might tempt some to suggest tuberculosis. Actually, of course, it is not that, for a careful search through the necrotic material will disclose occasional rounded bodies with doubled cell membranes and vaguely defined globular content which are obviously coccidioides. They are easily picked up as purple bodies against a green background with the periodic acid Schiff stain. This also colors mucin.

DIAGNOSIS: Coccidiomycosis of lung.

Arthur Purdy Stout, M. D.

Case #14, P&$ 37920 - This patient recovered uneventfully and returned to full duty. No further follow-up. (Col. C. Farinacci, 5-1-53)