PATHOLOGY SLIDE CLUB

\# 77
11 Winslow Drive

August 22, 1980

PRESENT: Drs. S. Naidoo; L. Lu; R. Banerjee; B. Johnston; D. Owen; R. Stark; N.M. Pettigrew, and H. Benediktsson.

REGRETS: Drs. F.W. Orr and W.S. Hwang.

Present in Spirit: Drs. T. Cooney and J. Rosai.

1	J. Rosai	Case 19	19 year old female with carcinoma in situ and adrenal mass. DIAGNOSIS: Six cord stomach tumour. COMMENTS: Adrenal should read adnexal. Diagnosis was missed by most, since the lesion was thought to be adrenal.
2	D. Owen	80-7827	Female aged 58. Gangrene of small bowel with resection. 4 weeks later died of CHF. DIAGNOSIS: Polyarteritis nodosa.
3		80-22215	Female 43, rectal bleeding. DIAGNOSIS: Inflammatory polyp. Fibrous ("eosinophilic granuloma").
4	L. Lu	80-131	80 year old male, died of bilateral adrenal hemorrhage. DIAGNOSIS: Nodular lymphoid hyperplasia of the spleen. COMMENTS: Many made a diagnosis of malignant lymphoma. Patient also had a bronchogenic carcinoma.
5		78-321	A young native Indian who died of a shotgun wound to the head. DIAGNOSIS: lymphangioma with focal endothelial hyperplasia.
6	T. Cooney	79-7427	13 year old male with 2 week history of cough and abnormal chest x-ray. Vague history of asthmatic attacks and a right upper lobe mass. diagnosis; Allergic bronchopulmonary aspergillosis.

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		COMMENTS: Culture grew large numbers of Aspergillus. Post op IgE was 13,000 (N. greater than 100).
7	R. Banerjee	77-2124	Female 15. Axillary lymph node tumour. Similar tumour in related breast. DIAGNOSIS: Anaplastic neoplasm, EM was reported as suggestive of malignant histiocytosis. COMMENTS: Many members favoured alveolar rhabdomyosarcoma. Some suggested mammary carcinoma. None felt that the histology suggested malignant histiocytosis.
8	R. Banerjee	79-5222	Female 71. Previous carcinoma of transverse colon resected some years previous. Now tumour of ascending colong. DIAGNOSIS: Anaplastic tumour, suggestiv of metastatic carcinoma. ? ovary (J. Long). COMMENTS: Other suggestions included malignant melanoma, renal cell carcinoma and inflammatory MFH.
9	R. Stark	80-112	Male 59. Long time user of ethanol. Foun unresponsive in his apartment. Died 21 hours after admission. DIAGNOSIS: Meningitis due to listeria monocytogenes. COMMENTS: Gram positive bacilli should be present.
10	B. Johnston	80-3479	Female 66. Ovarian tumour, 450 gms. DIAGNOSIS: "Mucinous cystadenoma, borderline malignancy, with "sarcoma-like" mural nodules". COMMENTS: Ref. Cancer 46: 1332-1344, 19 (Prat and Scully).
11	H. Benediktsson	80-12071	Male 41. Mass right iliac fossa. DIAGNOSIS: Pleomorphic sarcoma with features suggestive of muscle origin. COMMENTS: EM forthcoming.
12	N.M. Pettigrew	12438-2	Female 62. "retroperitoneal mass". DIAGNOSIS: Pheochromocytoma.

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13	S. Naidoo	80-12403	Female 57. Mass near jaw. DIAGNOSIS: Nodular fasciitis. COMMENTS: Other diagnoses offered by members: sarcoma, not otherwise specified fibrosarcoma; malignant Schwannoma.
14	S. Naidoo	12517-5	Male 81 Enlarged testis. DIAGNOSIS: Leydig cell tumour ? malignant. COMMENTS: EM following.
15	F.W. Orr	10667 -40	Sections from primary tumour of last months case. DIAGNOSIS: Adenoid cystic carcinoma.
16	W.S. Hwang	S80-408 -9	5 month old boy with right upper quadrant mass. DIAGNOSIS: Hepatoblastoma.

NEXT MEETING will be held on September 26th, 1980 at Dr. R. Banerjee's house.
The October meeting will be at Dr. Lu's house, on October 17th, 1980.

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August 27, 1980

Dear Jean:

The club met on Aug. 22. The slides and the minutes are available for your use. At the meeting, we considered to invite two new pathologists from the HSC, one is accepted, other pending. Then by 1980 we need 20 slides for each meeting. I would consider that this is our maximal number of our club, otherwise it would be difficult to manage. This meeting has included several difficult cases and we would appreciate your comments.

1/ 77-2124. The history provided is as female, 15 yrs old, axillary lymphnode containing tumor similar to that present in related breast (present as breast tumor) I has called this tumor as juvenile carcinoma, but felt to be differentiated for this type of the tumor. Original EM - metaplastic anaplastic carcinoma. The EM from the autopsy is suggestive of malignant histiocytosis. When I looked this slide again and felt that the pattern of nodal involvement and cytology of the tumor are consistent with malignant histiocytosis. Would you agree with me?

2/ 79-5222. Female, aged 71 yrs. previous carcinoma of transverse colon resected some years ago. Now presented with tumor of ascending colon. I favor the metastatic carcinoma, site ? lung, ? pancreas, ? kidney and others. Inflammatory Variant of MFH would be very uncommon as a primary tumor of the colon, other than invaded into the colon from the retroperitoneal space.

3, 12438-80. It is a pheochromocytoma, but it destroyed the adrenal cortex and invaded into surrounding soft tissue. Can it be recurrent in the future?

4/ 12071-80 This slide shows a feature of sarcoma compatible with myogenic origin, but the gist is atypical, compatible with well differentiated liposarcoma than a malignant mesenchyma. Do you agree?

Thank you for your comments.

Sincerely yours

Lawrence LU

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September 9, 1980

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CANADA

Dear Larry:

Thank you for your letter of August 29th, which contained the slides and proceedings of the August meeting. These are my comments on the cases in which you wanted to have my opinion:

77-2124 - I definitely think that this is alveolar rhabdomyosarcoma metastatic in a lymph node. I assume that the breast is the primary site. I have seen several cases of primary alveolar rhabdomyosarcomas of the breast that were originally misdiagnosed as undifferentiated carcinomas. I don't care what the electron microscopy shows. This is not malignant histiocytosis. There is nothing specific about the electron microscopy of malignant histiocytosis that I know of. I don't think this is carcinoma either. As you pointed out, this patient is "juvenile" all right, almost a child, but this is not at all the pattern of juvenile carcinoma.

79-5222 - I think that this tumor is an undifferentiated carcinoma. It has the pattern of the so-called inflammatory variant of malignant fibrous histiocytoma, but I am pretty sure that it is not that. Epithelial tumors that most commonly have this pattern are anaplastic carcinoma from the pancreas and lung, and because of that I would suggest those two sites as the most likely possibilities for the primary. However, I have seen tumors with this appearance also originating in the gallbladder and small bowel, and I cannot rule out the possibility of this being a primary tumor in the colon. In any event, it is carcinoma and not sarcoma. Another site to consider is that of the adrenal cortex. This tumor exhibits very prominent phagocytosis of neutrophiles by the giant tumor cells, which is a feature that I have seen in tumors of the adrenal cortex and lung in particular.

12438-80 - This is a pretty typical pheochromocytoma, but the question that you ask is a very difficult one. As you know, it is very difficult, if not impossible in most instances, to tell apart benign from malignant tumors on microscopic grounds. The fact that the lesion invaded the surrounding soft tissues is probably significant, and is quite possible that it will recur. However, I do not think that I would call this lesion malignant simply on the basis of that information.

12071-80 - This is a pleomorphic soft tissue sarcoma with bizarre multinucleated giant cells. I doubt very much whether it represents a rhabdomyosarcoma, and I will not be convinced of that unless somebody shows me cross striations or myoglobin positivity. I have grown very skeptical of the histogenetic classifications of soft tissue sarcomas. I guess if I have to give a name to this tumor, I would call it malignant fibrous histiocytoma, but I don't really believe in that entity myself. I don't like the suggestion of malignant mesenchymoma. The definition of that tumor includes the presence of two or more morphologically recognizable and distinct patterns, which I do not see here. It seems to me that in this tumor there is a definite blending of patterns.

Thank you very much for sending me this collection of great cases. I am looking forward to the next.

Best personal regards,

Juan Rosai, M.D.
Professor, Laboratory
Medicine and Pathology
Director of Anatomic Pathology