CALIFORNIA TUMOR TISSUE REGISTRY
LOMA LINDA UNIVERSITY
PROTOCOL
FOR
MONTHLY STUDY SLIDES
MARCH 1993
GENERAL PATHOLOGY
CONTRIBUTOR: Wally E. Carroll, M.D.
Santa Barbara, CA

CASE NO. 1 - MARCH 1993

TISSUE FROM: Left Leg

ACCESSION NO. 27222

CLINICAL ABSTRACT:

History: This 28 year-old Hispanic female had a lump on her leg for about eight months, and then, on October 12, 1992, had removal of the lump from the back side of her left calf in Mexico. A week later she noted erythema and swelling, which had not changed by her admission to Cottage Hospital in December 1992. Although painful, the patient had been able to walk on her left leg. She had some paresthesias.

Physical Examination: Patient in no acute distress. Examination within normal limits, except for the extremities, which revealed a very tense, swollen left calf. It was very hard below the surface. It was not red, and there was a scar on the backside of the calf which appeared to have healed nicely. Neurovascular status was intact with good pulses to both feet. Patient had symmetrical reflexes, intact positions of sensation and good 5/5 muscle strength bilaterally. Radiographs: Left calf X-ray revealed a lytic lesion in the fibula near the knee joint. MRI of the left calf and thigh revealed an enhancing, soft tissue mass involving all three compartments of her left lower extremity, and extending to approximately 12 cm below the knee. MRI of the distal thigh, however, revealed no evidence of involvement. Bone scan revealed abnormal soft tissue uptake in the proximal left calf in the area of the known tumor, and intense activity within the proximal left tibia and fibular head. There was no evidence for other distal skeletal metastases. CT scan of the patient's abdomen, chest and pelvis revealed a small lung nodule less than 5 mm in diameter and a 15 mm left groin lymph node. CT-guided biopsy was done and revealed no tumor in the lymph node. The lung nodule will be followed to rule out metastasis.

SURGERY: (December 11, 1992)

Left above the knee amputation was performed.

GROSS PATHOGRAPHY:

The specimen was a left leg amputated approximately 100 mm above the knee, which measured 370 mm from the heel to popliteal fossa. The foot was 230 mm long. The skin in general was pale tan. On the posterior aspect of the leg, beginning at the popliteal fossa at a point 40 mm from the posterior skin margin of the resection, was a slightly raised, pink, 135 mm long surgical scar which varied from 3 to 9 mm in width. 50 mm from the proximal end of the scar was a shallow 3 mm wide depression covered by a 2 mm scab. 60 mm further was a 3 mm wide shallow ulceration within the scar, and 7 mm further was a fleshy, dome-shaped, round 7 mm purple protrusion up to 3 mm in height. The skin around the scar on palpation had a firm quality up to approximately 30 mm. The fatty subcutaneous tissue beneath the skin scar was indurated to a depth of 15 mm to the surface of the junction of the lateral and medial heads of the gastrocnemius muscle. A narrow 25 mm deep fibrous scar extended through the gastrocnemius muscle consistent with previous biopsy site. The scar through the muscle extended to a large, fleshy, tan, translucent to opaque tumor mass filling and expanding the fascial plane between the gastrocnemius and soleus muscles. It measured up to 40 mm wide and approximately 200 mm in length, and extended proximally to within 35 mm of the attachment of the lateral head of the gastrocnemius muscle. The tumor compressed the overlying gastrocnemius muscle and extended along the deep aspect to the peristeum of the posterior surface of the tibia. The tumor mass was up to 55 mm wide and at its distal most extent there was a 90 mm long and 25 mm wide blood clot filled cavity consistent with previous biopsy site.
CLINICAL ABSTRACT:

History: This 79-year-old Caucasian female was first seen in the Emergency Room on 11/26/92 because of left lower abdominal and left flank pain. A catheter was used to obtain a urinary specimen, which had some blood clots. Her condition was stable, and she was admitted to the Medicine Service. After completion of her radiographs and laboratory work, the patient's hemoglobin dropped from 12 gm/dl to 8.2 gm/dl, despite two units of packed RBC's. The patient was overly anti coagulated and required four units of packed red cells as well as four units of fresh frozen plasma and 8 units of cryoprecipitate to correct not only her anemia but coagulopathy. Even with vigorous transfusion, her hemoglobin continued to drift down and in effect, she was taken to the Operating Room when stabilized as much as possible.

Past Medical History: The patient had been on Coumadin for atrial fibrillation x one episode in June 1992, and cerebrovascular accident eight years ago. In addition, she was on Lopressor, Ativan, Digoxin, and Valium.

Physical Examination: This slender, well-developed, well-nourished elderly female was alert and oriented x 3. She was in moderate distress secondary to abdominal and back pain. Her physical examination was within normal limits, except for the back area, which had diffuse pain to percussion on the left side. Laboratory Findings: The EKG showed normal sinus rhythm. Urinalysis was significant for greater than 50 red blood cells. The CBC showed white blood cell count 12.6, hemoglobin 12.4, hematocrit 35.1, platelets 288. The electrolytes showed sodium 131, potassium 4.0, chloride 97, CO2 26, BUN 11, creatinine 0.7, glucose 156. The PT was 23.6 with an INR of 1.0, PTT 49.8. The acute abdominal series showed increased feces and no air fluid levels, no ileus. Radiographs: IV-pyelogram was normal on the right. The left side showed no renal outline, and no contrast in the collecting system. Ultrasound revealed a large hematogenous mass anterior to the kidney which was interpreted as a large hematoma or a neoplasm. Fluid was present under the left hemidiaphragm. The spleen was difficult to see. The prothrombin time was 24.5 seconds with an INR of 4.3. The CT-scan of the abdomen revealed a large 9.6 x 8.9 cm unhomogeneous mass in the region of the left kidney, which with contrast revealed patchy enhancement. Thus, the overall lesion appeared to measure 15 cm in the cephalocaudad dimension. There was no lymph adenopathy.

SURGERY: (November 28, 1992)

An exploratory laparotomy and left radical nephrectomy were performed. At surgery, it was noted that the tumor had ruptured through its pseudocapsule into the retroperitoneum and had bled.

GROSS PATHOLOGY:

The specimen was a 721 gram, 15 x 13 x 5 cm kidney and a patent 5 cm ureter. An 11 x 10 x 4 cm well-circumscribed, yellow-tan, friable tumor with multiple regions of necrosis and hemorrhage was present at the central portion of the specimen, sparing the upper and lower poles. The mass caused a 3 cm protrusion of the lateral wall and pushed into the pelvis, replacing approximately 70% of the renal parenchyma. The overlying serosa was purple to black-tan. A grossly uninvolved kidney was gray-tan with a 1 cm cortical rim. Accompanying was a 13 x 10 x 1 cm aggregate of yellow-tan lobulated adipose tissue and purple-tan blood clot. No lymph nodes were grossly identified in the adipose tissue.
CONTRIBUTOR: Robert H. Zuch, M.D.
Irvine, CA

CASE NO. 3 - MARCH 1993

TISSUE FROM: Spleen

ACCESSION NO. 26236

CLINICAL ABSTRACT:

History: This 31 year-old Hispanic male presented with a six (6) week history of left upper quadrant pain.


Physical Examination: Revealed marked splenomegaly (palpable ten (10) cm below left costal margin). Laboratory tests were remarkable for platelet count of 80,000. CT-scan of spleen (1/87) showed hyper and hypo-lucent areas with calcification. Total body gallium scan shows lesions similar to splenic lesion in: both shoulders, left hip, meninges, left lower lobe of lung, forehead, left elbow, left distal thigh, and right calf.

SURGERY: (April 14, 1988)

A splenectomy was performed.

GROSS PATHOLOGY:

The specimen was a 986 gram intact spleen which measured 18.0 x 8.0 x 5.0 cm. The capsular surface had a relatively smooth surface, however, there were numerous white to light pink fibrous adhesions present on the surface. The hilar structures appeared unremarkable. Upon serial sectioning, diffuse ill-defined flesh-colored areas were revealed which were roughly wedge-shaped, all appearing to be subcapsular. Intermixed within these areas were flecks of light yellow to almost orange deposits. In addition, there were stellate-shaped areas of fibrosis within the central regions of these areas.
CLINICAL ABSTRACT:

**History:** This 86 year-old Caucasian male was admitted to the Emergency Room on 9/12/92 for feelings of dizziness and nausea when attempting to stand. After evaluation by the Emergency Room physician, the patient was found to be severely anemic with a hemoglobin of 4.4 and hematocrit of 13.3, and with guaiac positive stools with bright red blood. NG tube aspirate was negative. The patient had syncope in the upright position.

**Past History:** Patient had been diagnosed with a "tumor in the right colon" during a 1990 colonscopic procedure in Bakersfield, California. He had recurrent rectal bleeding off and on for approximately two years. The patient had ASHD with cardiac arrhythmia's. The patient did not smoke or abuse alcohol.

**Physical Examination:** Patient was an elderly, Caucasian male who was conscious, alert, and oriented times three. The blood pressure was 138/80 mmHg, pulse 90 per minute and regular, and respiratory rate of 20 per minute. The conjunctivae were pale, and the sclera anicteric. The neck veins were flat. Chest examination showed good air entry bilaterally. No rales or rhonchi were noted. The heart was S1, S2, regular. The abdomen was soft and non-tender, with no organomegaly and no masses felt. The bowel sounds were normoactive. Rectal examination did not reveal any rectal masses. Laboratory: The admitting findings were: WBC 8,200; hemoglobin 4.4; hematocrit 13.3 with 35 segs, 0 bands and 12 lymphocytes; platelet count was 180,000. MCV was 67. Prothrombin time was 13.5, partial thromboplastin time was 31. Chem-7 - sodium 141, potassium 4.2, blood sugar 99, BUN 16, creatinine 1.4. Digoxin level was 1.8. EKG showed normal sinus rhythm with ST segment depression in leads II, III and AVF and V3 through V6. After several packed red blood cell transfusions (6 units), the hemoglobin was 8.4 and the hematocrit 25.7. The last hemoglobin was 8.8 and hematocrit 27.1.

SURGERY: (September 28, 1992)

A colonscopy was performed on 09/18/93, which revealed a large polypoid lesion in the hepatic flexure, which was biopsied. An esophagagogastroduodenoscopy was performed on 9/21/92, which revealed a hiatal hernia associated with gastritis. Although the patient was initially reluctant to undergo surgery, he agreed to undergo a right hemicolecctionomy on 09/28/92.

GROSS PATHOLOGY:

A right hemicolecctionomy specimen weighed 317 grams. The important portion was the ascending colon and cecum. The ascending colon measured 10 cm in length and 5 cm in diameter. The cecum measured 9 cm in length and up to 7 cm in diameter. Near the upper junction of the cecum and ascending colon was a discrete single polypoid mass 4 cm in diameter. The surfaces were dark red-purple with fibrinous exudate. Surfaces made by cutting were solid, light tan-white and easily fragmented. The mass attached to the cecum by a stalk 1.5 x 1.2 cm. It did not appear to involve the muscle layers of the bowel.
CLINICAL ABSTRACT:

History: This 12 year-old white male had been having difficulty breathing through the nose and had nasal congestion for approximately six months. This was considered to be on an emotional basis due to the unexpected death of his father following minor surgery. However, when the symptoms persisted, allergy tests were performed and were negative. Six months later, the patient was again seen, at which time his voice was quite muffled and he had difficulty swallowing. Indirect laryngoscopy showed a large mass filling the hypopharynx which appeared to arise from the epiglottis.

Physical Examination: Examination revealed a well-developed, well-nourished male who was alert, cooperative and intelligent. He was in no acute-distress. Examination of the nose revealed pale, somewhat edematous membranes obstructing the airway. The septum was in the midline. Examination of the mouth revealed a large, pale, whitish-pink mass filling the hypopharynx, visible on indirect laryngoscopy. The patient's voice was rather muffled due to the mass.

SURGERY: (March 13, 1963)

A pharyngotomy and excision was performed. At surgery, it was apparent that the mass was much larger than had been thought on a clinical basis, and appeared to be invasive. The base was rather broad and the tumor had pushed the larynx and epiglottis over to the right and was grown to the superior portion of the epiglottis.

GROSS PATHOLOGY:

The specimen consisted of an irregularly-shaped, somewhat lobulated mass of gray-tan tissue, 5.5 x 4.0 x 3.2 cm. The cut surface was somewhat variegated in appearance, and in some areas somewhat fibrous and fleshy in appearance. Some foci, representing calcium, were encountered.
CLINICAL ABSTRACT:

History: This 4 year-old male presented with vague symptoms of recurrent left ear problems and a slightly unsteady gait. Approximately nine months before definitive diagnosis, the mother found an ill-defined bump on the left side of the roof of the mouth.

Radiographs: Subsequent panorex X-rays and CT-scan revealed a large primary soft tissue mass expanding the left maxillary sinus with some high density regions compatible with calcium. The mass extended inferiorly into the roof of the mouth with anterior erosion through the maxilla. It was, on CT-scan, considered to be probably odontogenic and benign.

SURGERY: (September 6, 1988)

An open biopsy of the left maxillary sinus was performed. Patient was returned to surgery on September 13, 1988, where a left extended Caldwell-Luc maxillectomy was performed. Both procedures were tolerated well without incident.

GROSS PATHOLOGY:

Our material was taken from the second surgery on September 13, 1988. The specimen was submitted in four parts. Part one, labeled left maxillary mass, was received as two fragments of ovoid, tan and red-tan soft tissue which measured 3.0 and 4.5 cm. Sectioning the tissue showed irregular lobulation. The majority of the lesional tissue was gray and slightly gritty. There was distinct irregular lobulation. Between the lobules was some edematous, almost myxoid-looking tissue. Part two, labeled palatal tissue, consisted of edematous connective tissue. No distinct neoplastic tissue was identified. Part three, labeled orbital floor, was a fragment of osseous tissue. Part four, labeled alveoli tissue, consisted of four fragments of edematous gray, soft tissue.
CONTRIBUTOR: Donald L. Alcott, M.D.  
San Jose, CA

TISSUE FROM: Right Lobe of Liver  
ACCESSION NO. 8150

CLINICAL ABSTRACT:

History: This 3-1/2 year old Mexican male was well until one day prior to admission, when he suddenly complained of abdominal pain, malaise and anorexia.

Physical Examination: The child was febrile and the abdomen was greatly protuberant. There was tender hepatomegaly. Laboratory: WBC result was 16,000 with 90% PMNs, and Hemaglobin result was 7.5 grams.

SURGERY: (November 2, 1954)

The patient had an abdominal laparotomy, and expired after a febrile course on 11/04/54.

GROSS PATHOLOGY: (Autopsy)

The peritoneal cavity contained 800-1000 cc of dark red liquid blood and clots. The liver weighed 1400 grams. The right lobe was greatly enlarged and accounted for most of the hepatomegaly. Its surface was occupied by a grossly nodular tumor mass with nodules up to 5 cm in diameter. Over the anterior surface, on the peritoneal area, was a 7 x 3 x 3 cm crater in the liver parenchyma. The hepatic substance was necrotic around the crater. Small whitish-gray tumor nodule implants were seen in the left lobe.
CONTRIBUTOR: Stanley Hino, M.D.
Menifee, CA

TISSUE FROM: Neck

ACCESSION NO. 26445

CLINICAL ABSTRACT:

History: This 76 year-old Caucasian female was referred by her family physician for a mass in her right mandibular region and possible enlargement of the artery. The enlargement of the submaxillary gland, which measured 4-5 cm in diameter, had been progressively increasing in size over the past year.

Past History: The patient was seen by an ENT specialist three years prior, at which time the mass was not enlarged, and was told to just watch it. The patient had known hypertension and took Dyazide for many years. The patient had a hysterectomy.

Physical Examination: The patient was well-nourished and in no acute distress. Physical examination was within normal limits, except for a slight enlargement of the right submaxillary gland, which was just prominent. There was a mass measuring about 4-5 cm just below the mandible, right over the area of the submaxillary gland, consistent with enlargement. There was no palpable supraclavicular or cervical nodes noted, and there was slight tenderness to palpation.

SURGERY: (February 1, 1989)

Excision of the right submaxillary gland was performed. The patient tolerated the procedure well and left the operating room in satisfactory condition.

GROSS PATHOLOGY:

The specimen consisted of three portions of tissue. The first was a well-circumscribed, red-brown, soft, slightly lobulated tissue fragment, 7.0 x 4.5 x 2.2 cm in greatest dimension. The outer surface was smooth. The cut surface showed red-tan tissue with central areas of gray fibrosis. There was no evidence of necrosis or hemorrhage. The second consisted of a similar-appearing, dark red, soft, well-circumscribed tissue fragment measuring 2.5 x 2.0 x 0.8 cm. The cut surface showed similar-appearing red-tan tissue. The third consisted of red-tan tissue, 2.0 cm in aggregate dimension.
CONTRIBUTOR: S.N. Trivedi, M.D.
Paramount, CA

CASE NO. 9 - MARCH 1993

TISSUE FROM: Neck

ACCESSION NO. 25972

CLINICAL ABSTRACT:

History: This 39 year-old female presented with a mass on the back of her neck. No laboratory tests or X-rays were felt to be needed as the immediate plan was to remove the "sebaceous cyst".

Physical Examination: All within normal limits, except for the large cyst on the back of the neck, 5-6 cm in diameter.

SURGERY: (March 20, 1987)

An excision was performed to remove the sebaceous cyst. There were no complications, and the patient was transferred to the Recovery Room in satisfactory condition.

GROSS PATHOLOGY:

The specimen consisted of a large firm portion of multilobulated white tissue, ovoid in shape, measuring 4.8 x 3.2 x 2.6 cm. The outer surface was a variegated white-tan with focal areas of blood stain. Upon sectioning the interior, it was seen to be homogeneous white with small yellow flecks. There were no gross areas of hemorrhage or necrosis.
CLINICAL ABSTRACT:

History: This 76 year-old male was admitted January 4, 1993. He had been admitted to the hospital in 1988 with a right inguinal hernia, at which time a prostate nodule was found which was needle biopsied and diagnosed as benign. The hernia was repaired at that time. Patient was lost to follow-up and re-appeared in his doctor's office in November 1992. The prostate was found to be firm, particularly in the right lobe, but the patient reported no urinary tract difficulties.

Physical Examination: The patient was a pleasant, well-developed, well-nourished gentleman. Blood pressure 140/80. Pulse 80. Temperature 98.0. The findings were essentially normal, except for the rectal examination, which revealed an enlarged and firm prostate. A needle transrectal biopsy with guidance was done, as well as a serum PSA, which was 5.2 ng/ml. The pathological evaluation of the ultrasound revealed invasive carcinoma of the prostate in both right and left lobes. A bone scan revealed no evidence of disease.

SURGERY: (January 4, 1993)

Radical retropubic prostatectomy, bilateral vesiculectomy, and bilateral pelvic lymph node dissection, including external iliac, internal iliac, and obturator nodes were performed.

GROSS PATHOLOGY:

The prostate gland was submitted with attached seminal vesicles and segments of vasa deferentia. The prostate gland weighed 70 grams. It measured 5 cm in length, 6 cm in width, and 4 cm in antero-posterior dimension. The left side was inked in blue, and the right in red. Serial sections of the prostate gland revealed a gray and focally microcystic parenchyma without foci of yellow discoloration.
CONTRIBUTOR: Joseph Carberry, M.D.
Los Angeles, CA

TISSUE FROM: Right Frontal Lobe Tumor

CLINICAL ABSTRACT:

History: This 28 year-old Hispanic female went to see her physician because of a headache of two to three months duration, the severity of which increased for the last two-three weeks.

Radiographs: A CT-scan of the head showed a large enhancing mass of the right frontal area. An angiogram was interpreted as a meningioma of the right parietal area.

SURGERY: (May 23, 1989)

The tumor was attached to the dura, embedding into the right parietal lobe, and was removed without difficulty. The patient made an uneventful recovery and was discharged on 05/27/89.

GROSS PATHOLOGY:

The specimen was received in three parts. Part one was submitted for rapid frozen section, and was a bright red fragment of rubbery tissue which measured 10 x 7 mm. Rapid frozen sections were performed and reported as "Tumor not typical but consistent with meningioma." Part two was a large tumor mass and several smaller fragments of tumor weighing 24 grams in aggregate. The tumor mass measured 4.5 x 4.0 x 2.5 cm. Attached to the main surface was a white, fibrous-appearing membrane which measured 33 x 12 mm at its greatest dimension, and less than 2 mm in thickness. This was attached to the tumor itself. The tumor had a mottled bright pink color, a soft to rubbery consistency, and an edematous, glistening cut surface. Part three was a fragment of tissue which measured 8 x 6 x 4 mm. It had a mottled pink-white color and a fibrous consistency.
CLINICAL ABSTRACT:

History: This 82 year-old male was admitted on January 5, 1993, because of a history of abdominal pain and Guia positive stools.

Radiographs: Barium studies revealed extrinsic compression of small bowel within the pelvis by a 12 cm, centrally cystic mass. This was confirmed by CT-scan. A CT-guided fine needle aspiration was performed.

SURGERY: (December 31, 1992)

An exploratory laparotomy revealed a 12 cm rubbery, white-gray, centrally cystic mass adherent to small bowel. Multiple nodules were present on the dome of the bladder and mesentery. Wedge resections of the nodules were attempted, and resection of a 17 cm segment of small bowel with the mass was performed.

GROSS PATHOLOGY:

A 17 cm segment of bowel was received. Contained in its midportion was a 11.5 cm firmly attached, round mass. When opened, the luminal surface was thinned but the mucosa was intact. The rest of the mucosa was also unremarkable. The tumor was arising from the muscularis propria, and its external surface away from the bowel wall was smooth. Multiple surfaces made by cutting revealed the central cavity, which were bright pink-white, except for a 1.5 cm small, well-demarcated bright yellow-white nodule.
MINUTES
FOR
MONTHLY STUDY SET
MARCH 1993

"GENERAL PATHOLOGY"

Suggested Reading:

Cancer, 1990 (Supplement); 66(5):1007-1089.

Cancer, 1992 (Supplement); 70(1):207-378.

Human Pathol, 1993; 24(3):298-310.
CASE NO. 1 - ACCESSION NO. 27222

LOS ANGELES - Sarcoma, NOS (6).

SAN BERNARDINO (INLAND) - Monomorphic synovial sarcoma (4); Epithelioid sarcoma (2); Liposarcoma, round cell type (1).

LONG BEACH - Sarcoma, NOS (7); Rhabdomyosarcoma (1).

SAN DIEGO - Epithelioid sarcoma (17); Melanoma (1).

SANTA BARBARA - Poorly-differentiated malignant neoplasm, favor liposarcoma (1).

OAKLAND - Rhabdomyosarcoma (6); Liposarcoma (1).

SANTA ROSA - Malignant synovial sarcoma vs. metastatic adenocarcinoma (1); Metastatic, consistent with synovial sarcoma, etc. (1); Malignant synovial sarcoma with a prominent epithelioid component vs. metastatic adenocarcinoma (1).

OHIO - Alveolar soft part sarcoma (1); Epithelioid sarcoma/melanoma, clear cell sarcoma vs. melanoma (1); Rhabdomyosarcoma (2).

JAPAN - Epithelioid sarcoma (1).

SPECIAL STAINS: (CTTR)

Desmin - negative; vimentin - positive; S-100 - negative; actin - negative; cytokeratin - negative; EMA - moderately positive; LN 1,2,3 - moderately positive. (Contributor): Actin, vimentin - positive; desmin, S-100 - negative; trichrome stains cytoplasm red.

FOLLOW-UP:

This is a recurrent malignant tumor originally excised in Mexico. We do not know what the clinical appearance was. Our's, as well as the contributor's, immunoperoxidase stains do not support the diagnosis of epithelioid sarcoma or others listed above.

DIAGNOSIS:

EPITHELIOID SARCOMA. X-FILE: SARCOMA, NOS.

REFERENCES:

LOS ANGELES - Collecting tubule carcinoma (6).

SAN BERNARDINO (INLAND) - Renal cell carcinoma (7).

LONG BEACH - Renal cell carcinoma (collecting duct type) (8).

SAN DIEGO - Xanthogranulomatous pyelonephritis (5); Renal cell carcinoma (13).

SANTA BARBARA - Renal cell adenocarcinoma (1).

OAKLAND - Collecting duct carcinoma (6); Well-differentiated renal cell carcinoma, NOS (1).

SANTA ROSA - Renal cell carcinoma, collecting duct type (1); Consistent with renal cell carcinoma (1); Renal cell carcinoma, possibly collecting duct type (1).

OHIO - Renal cell carcinoma (5).

JAPAN - Renal cell adenocarcinoma (1).

SPECIAL STAINS:

No documentation of special stains.

FOLLOW-UP:

Patient presented with right back pain and distended abdomen approximately three months after surgery. Her physician ordered an ultrasound, the results of which were unavailable.

DIAGNOSIS:

COLLECTING DUCT CARCINOMA.

REFERENCES:


CASE NO. 3 - ACCESSION NO. 26236

MARCH 1993

LOS ANGELES - Diffuse angiomatosis {very rare} (6).

SAN BERNARDINO (INLAND) - Epithelioid hemangioendothelioma (6); Malignant endovascular papillary angioendothelioma (1).

LONG BEACH - Multicentric angiomatosis involving spleen (8).

SAN DIEGO - Angiomatosis (18).

SANTA BARBARA - Hemangioma with associated systemic hemangiomatosis (1).

OAKLAND - Hemangioma (7).

SANTA ROSA - Metastatic carcinoma {adenocarcinoma vs. germ cell tumor} (1); Hemangioma, benign, r/o congenital hemangiomatous syndrome (1); Malignant neoplasm, favor adenocarcinoma vs. germ cell tumor (1).

OHIO - Kaposi’s sarcoma (2); Hemangioma (1); AV malformation (2).

JAPAN - Hemangioma (1).

SPECIAL STAINS:

No documentation of special stains.

FOLLOW-UP:

Unable to obtain follow-up history.

DIAGNOSIS:

DIFFUSE ANGIOMATOSIS, SPLEEN.

REFERENCES:


CASE NO. 4 - ACCESSION NO. 27184

MARCH 1993

LOS ANGELES - Malignant schwannoma, cecal polyp (6).

SAN BERNARDINO (INLAND) - Malignant stromal tumor (7).

LONG BEACH - Metastatic melanoma (5); Leiomyoblastoma (2); Neuroendocrine carcinoma (1).

SAN DIEGO - Malignant G.I. stromal tumor (17); Melanoma (1).

SANTA BARBARA - Cellular leiomyoma vs. low grade leiomyosarcoma (1).

OAKLAND - Gangliocytic paraganglioma (8).

SANTA ROSA - Malignant adenocarcinoma vs. carcinosarcoma (1); Malignant mesenchymal vs. carcinoid (1); Malignant adenocarcinoma vs. malignant mixed tumor {adenocarcinoma and sarcoma} (1).

OHIO - Leiomyosarcoma (3); Spindle cell neoplasm (2).

JAPAN - Carcinoid tumor (1).

SPECIAL STAINS: (CTTR)

S-100 - strongly positive; cytokeratin, NSE, desmin - negative. (Contributor): Trichrome - consistent with smooth muscle origin.

FOLLOW-UP:

Patient's last follow-up visit was 12/09/92, at which time there was no further evidence of bleeding. Patient is scheduled for a six-month post-operative scope later this year.

DIAGNOSIS:

MALIGNANT SCHWANNOMA, ASCENDING COLON.

REFERENCES:

Enzinger FM, Weiss SW: Soft Tissue Tumors (Second Edition): The C.V. Mosley Company, Figure 28.8 and Figure 29.9, pages 788-789. Cursory review of literature revealed no similar tumor at this site (colon).

LOS ANGELES - Malignant synovioma, hypopharynx (6).

SAN BERNARDINO (INLAND) - Juvenile angiofibroma (2); Lymphangioma (2); Synovial sarcoma (2); Hemangiopericytoma (1).

LONG BEACH - Synovial sarcoma (8).

SAN DIEGO - Synovial sarcoma (18).

SANTA BARBARA - Angiofibroma (1).

OAKLAND - Synovial sarcoma (8).

SANTA ROSA - VAS neoplasm vs. salivary gland tumor vs. embryonal neoplasm (1); Malignant tumor, r/o synovial sarcoma (1); Lymphangiomatous vs. minor salivary gland tumor (1).

OHIO - Synovial sarcoma (5).

JAPAN - Synovial sarcoma (1).

SPECIAL STAINS:
No documentation of special stains.

FOLLOW-UP:
The tumor recurred by September 1963, forming a mass with an overall greatest dimension of approximately 1.5 cm. The mass was biopsied. The tumor was subjected to radiation, which caused it to shrink, and only a small red area in the left vallecula remained. The tumor at least appeared to be quite radio-sensitive. The patient subsequently gained 25 lbs, felt well and was eating well. A chest X-ray on September 10, 1963 revealed no evidence of metastatic tumor.

DIAGNOSIS:
MALIGNANT SYNOVIOMA, HYPOPHARYNX.

REFERENCES:


CASE NO. 6 - ACCESSION NO. 26377

Los Angeles - Ameloblastic fibro-odontoma (6).

San Bernardino (Inland) - Ameloblastic fibroma (7).

Long Beach - Ameloblastic fibro-odontoma (8).

San Diego - Ameloblastic fibro-odontoma with focal stromal atypia (17); Ameloblastic fibro-odontoma with focal stromal fibrosarcoma (1).

Santa Barbara - Ameloblastoma (1).

Oakland - Ameloblastoma (8).

Santa Rosa - Odontogenic tumor, possibly malignant (1); Ameloblastic fibroma, r/o sarcoma (1); Odontogenic tumor, favor malignant (1).

Ohio - Ameloblastoma (4); Ameloblastoma fibroma (1).

Japan - Adenomatoid odontogenic tumor (1).

Special Stains:

No documentation of special stains.

Follow-Up:

No documentation of follow-up.

Diagnosis:

AMELOBLASTIC FIBRO-ODONTOMA.

Consultation:

K. Unni, M.D., Mayo Clinic: Ameloblastic fibro-odontoma.

References:


CASE NO. 7 - ACCESSION NO. 8150

MARCH 1993

LOS ANGELES - Liver cell carcinoma (6).

SAN BERNARDINO (INLAND) - Childhood hepatocellular carcinoma (7).

LONG BEACH - Hepatoblastoma {epithelial} (8).

SAN DIEGO - Hepatoblastoma (18).

SANTA BARBARA - Hepatoblastoma (1).

OAKLAND - Hepatoblastoma (8).

SANTA ROSA - Mesenchymal sarcoma (2); Hepatoblastoma, r/o malignant mesenchymal tumor (1).

OHIO - Hepatoblastoma (5).

JAPAN - Hepatoblastoma (1).

SPECIAL STAINS:

No documentation of special stains.

FOLLOW-UP:

Patient expired within two days of surgery.

DIAGNOSIS:

HEPATOCELLULAR CARCINOMA, LIVER.

REFERENCES:


CASE NO. 8 - ACCESSION NO. 26445

MARCH 1993

LOS ANGELES - Rhabdomyoma (6).

SAN BERNARDINO (INLAND) - Rhabdomyoma (7).

LONG BEACH - Rhabdomyoma (8).

SAN DIEGO - Rhabdomyoma (18).

SANTA BARBARA - Rhabdomyoma (1).

OAKLAND - Rhabdomyoma (8).

SANTA ROSA - Mucoepidermal tumor vs. oncocytoma (1); Oxyphillic granular cell adenoma, oncocytoma/granular cell tumor (1); Malignant muco-epidermoid carcinoma vs. oncocytoma (1).

OHIO - Rhabdomyoma (1).

SPECIAL STAINS:

No documentation of special stains.

FOLLOW-UP:

Patient alive and well as of April 1993.

DIAGNOSIS:

Rhabdomyoma, Adult Type.

REFERENCES:

Proliferating pilar tumor (6).

Proliferating trichilemmal cyst (7).

Proliferating trichilemmal tumor {proliferating pilar tumor} (8).

Proliferating trichilemmal cyst (18).

Keratoacanthoma (1).

Proliferating pilar tumor (8).

Malignant neoplasm with epithelial and mesenchymal (1); Probable pilar {trichilemmal} cyst (1); Malignant - malignant teratoma vs carcinosarcoma (1).

Proliferating pilar tumor (5).

Proliferating follicular cystic neoplasm (1).

No documentation of special stains.

No documentation of follow-up.

PROLIFERATING TRICHILEMMAL CYST.

LOS ANGELES - Prostatic adenocarcinoma (6).

SAN BERNARDINO (INLAND) - Moderately differentiated adenocarcinoma, multifocal, Gleason's pattern 3, with focal PIN (7).

LONG BEACH - Moderately differentiated adenocarcinoma of prostate with extensive high grade prostate intraepithelial neoplasia (8).

SAN DIEGO - Well-differentiated prostate cancer (18).

SANTA BARBARA - Adenocarcinoma (1).

OAKLAND - High grade PIN and adenocarcinoma (8).

SANTA ROSA - Adenocarcinoma vs. myoepithelial tumor vs. hemangiopericytoma (1); Adenocarcinoma, Gleason's III/IV, total of VII/X (1); Adenocarcinoma, clear cell (hypernephroid variant), differential diagnosis includes hemangiopericytoma (1).

OHIO - Adenocarcinoma of prostate, Gleason's Grade V (5).

JAPAN - Prostatic adenocarcinoma, Gleason's Grade III/III (1).

SPECIAL STAINS:

No documentation of special stains.

FOLLOW-UP:

No documentation of follow-up.

DIAGNOSIS:

ADENOCARCINOMA, MULTIFOCAL, WITH PROMINENT PIN, GLEASON'S GRADE III/III.

REFERENCES:


CASE NO. 11 - ACCESSION NO. 26199

LOS ANGELES - Angioblastic meningioma (6).

SAN BERNARDINO (INLAND) - Microcystic meningioma (7).

LONG BEACH - Meningioma {microcystic} (8).

SAN DIEGO - Angioblastic meningioma {hemangioblastoma type} (18).

SANTA BARBARA - Meningioma (1).

OAKLAND - Microcystic meningioma (6).

SANTA ROSA - Cellular meningioma vs. hemangiopericytoma (1); Meningioma (2).

OHIO - Angioblastic meningioma (3); Meningioma (2).

JAPAN - Meningioma (1).

SPECIAL STAINS:

No documentation of special stains.

FOLLOW-UP:

No documentation of follow-up.

DIAGNOSIS:

ANGIOBLASTIC MENINGIOMA.

REFERENCES:


LOS ANGELES - Leiomyosarcoma (6).

SAN BERNARDINO (INLAND) - Malignant stromal tumor (7).

LONG BEACH - Leiomyosarcoma (7); Malignant gastrointestinal stromal tumor (1).

SAN DIEGO - Malignant G.I. stromal tumor (7); Leiomyosarcoma (11).

SANTA BARBARA - Leiomyoma (1).

OAKLAND - Gastrointestinal stromal tumor, malignant (5); Gastrointestinal stromal tumor, uncertain malignant potential (1).

SANTA ROSA - Malignant papillary mesothelioma (2); Malignant mesenchymal neoplasm, r/o leiomyosarcoma (1).

OHIO - Leiomyosarcoma (5).

JAPAN - Smooth muscle tumor of undetermined malignant potential {stump} (1).

**SPECIAL STAINS:** (Contributor)

The following battery of immunoperoxidase stains was performed on a FNA sample taken ten days prior to the biopsy specimen: Vimentin - strongly positive within tumor cells; S-100 - negative within tumor cells; Desmin - negative within tumor cells; Muscle specific actin - focally positive within tumor cells.

**FOLLOW-UP:**

At the time of surgery, there were multiple nodules studding the peritoneum. Because of the patient's desire for no further therapy, the patient was sent home without treatment.

**DIAGNOSIS:**

**LEIOMYOSARCOMA. X-FILE: MALIGNANT STROMAL TUMOR.**

**REFERENCES:**


ADDITIONAL INFORMATION:

CASE NO. 7 - ACCESSION NO. 26002          FEBRUARY 1993

Immunoperoxidase stains were redone by the CTIR. The findings were as follows: Keratin - +++ staining of ducts; Colloidal iron - +++ staining of epithelial stroma and ducts.

FINAL DIAGNOSIS:

METAPLASTIC CARCINOMA OF BREAST.