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PATHOLOGISTS' CLUB
OF NEW YORK

MEETING

PRESIDENT
BOYCE BENNETT, M.D.
JACK D. WEILER HOSPITAL OF
ALBERT EINSTEIN COLLEGE OF MEDICINE
1825 EASTCHESTER ROAD
BRONX, NEW YORK 10461

VICE - PRESIDENT
MARIUS P. VALSAMIS, M.D.
DEPARTMENT OF PATHOLOGY
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VALHALLA, NEW YORK 10595

SECRETARY TREASURER
FRED B. SMITH, M.D.
DEPARTMENT OF PATHOLOGY
ST. VINCENT'S HOSPITAL
153 WEST 11TH STREET
NEW YORK, NY 10011

DATE: Thursday, May 6, 1993

PLACE: Columbia Faculty House
116th Street between Morningside and Amsterdam Avenues (entrance, in middle of block, will be indicated by signs)
New York, NY

HOST: Dr. Harold P. Gaetz
Department of Pathology, St. Luke's/Roosevelt Hospital
212-523-8625

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RECEPTION AND DINNER: 5:15 - 7:00 PM: Presidents Room

SCIENTIFIC SESSION: 7:00 - 9:00 PM: Presidents Room

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DIRECTIONS: By subway: Take the #1 train (Broadway IRT local) to the 116th Street stop, walk east through the Columbia campus, and cross Amsterdam Avenue.

By bus: Take the M11 bus (9th/10th Columbus/Amsterdam Ave.) to 116th Street and Amsterdam Avenue. (Uptown buses run on 9th and Columbus Avenues between 14th and 110th Streets.)

PARKING: Street parking around St. Luke's Hospital, 113th and 114th Streets, Morningside and Amsterdam Avenues.
Parking lot near corner of 115th Street and Morningside Avenue.

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FORTHCOMING MEETING: JUNE 3, 1993--LONG ISLAND COLLEGE HOSPITAL

ERRATUM:

Do not use the parking lot at 115th Street and Morningside Avnue, which will close before the meeting ends. Club members may park in the garage a 114th Street and Amsterdam Avenue; bring parking stub to the meeting for reimbursement

S- 7849-92 (1)

This 72 year old female recently returned from a California vacation, was admitted to SLRHC for worsening dry cough, malaise of two weeks duration not responsive to erythromycin. An initial left lower lobe infiltrate during the first week of hospitalization became diffuse and bilateral. Temperature was 103° F, WBC 20,000 with 90% granulocytes, and 6% eosinophils. Respiratory failure developed. An open lung biopsy submitted.

Guest: Dr. Fred Smith Host: Dr. S. Ryan

S- 3869 - 92 (2)

A gradually enlarging cervical adenopathy in a 27 year old previously healthly female for 1 month, PTA

Guest: Dr. James Strauchen Hostess: Dr. E. Ames

S- 6338-92 (3)

Lung wedge biopsy with central 1.5. cm mass from a 25 year old asymptomatic female discovered on work up for knee arthroscopy. History includes childhood rheumatic fever. A bronchial brush/wash was negative.

Guest: Dr. Ming Han Hostess: Dr. Avitabile

S- 1453-93 (4)

A 410 gm. grossly normal placenta membranes and cord were examined because of fetal distress, for which a primary low flap Cesarian Section was done at 36 week resulting in delivery of a live 4lb. 2 oz. boy with an apgar of 8/9.

Guest: Dr. Carlos Navarro Host: Dr. Gaetz

S- 92- 1766 (5)

Recurrent chronic infected draining sinus on back and right buttock in a 54 year old female.

Guest: Dr. Abou-Azama Host: Dr. Gaetz

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MINUTES OF MEETING

ST. LUKE'S-ROOSEVELT HOSPITAL
THURSDAY, MAY 6, 1993

Members were treated to the gracious ambience of the Columbia University Faculty House for the reception, dinner, and scientific session of this meeting, hosted by Dr. Harold Gaetz and the members of the Pathology Departments of St. Luke's and Roosevelt Hospitals. During a brief business meeting, those present honored the memory of Dr. William Ober, a founding member of the Club, by observing a moment of silence. Dr. Bruce Wainer's application for membership in the Club was then approved by a unanimous vote of the members present.

Case 1. Invited discussant: Dr. Fred Smith, St. Vincent's Hospital
Host discussant: Dr. Stephen Ryan

ACUTE EOSINOPHILIC PNEUMONIA DUE TO COCCIDIOIDOMYCOSIS

This case involved a 72 year old woman who had developed progressive dyspnea, accompanied by pulmonary infiltrates and eosinophilia, shortly after returning from a trip to California. The disease progressed to respiratory failure within two weeks, and the specimen for review was an open biopsy of the lung. Dr. Smith illustrated the histologic features in the biopsy, which included edema and predominantly eosinophilic inflammatory infiltrates involving interstitial compartments and blood vessels of the lung. He discussed the differential diagnostic possibilities for acute eosinophilic pneumonitis and for pulmonary vasculopathies. He was unable to implicate a specific agent, but suspected L-tryptophan exposure, on the basis of the relative lack of airspace involvement.

Dr. Ryan demonstrated serial radiographic studies of the patient, which dramatically illustrated the rapid progression of the infiltrates at the beginning of the illness, and equally rapid disappearance with steroid treatment. Although vascular and interstitial inflammation dominated the histologic picture, rare intra-alveolar exudates were present which contained coccidioides organisms, which the patient had presumably inhaled during her recent trip. Although pathologists are familiar with eosinophilic pneumonia as a cause of chronic lung disease, they should also be aware that fulminant eosinophilic reactions may cause acute respiratory failure, as illustrated by this case and others in the recent clinical literature. The case also demonstrates the possibility of a florid eosinophilic response to an agent more commonly associated with chronic granulomatous reactions.

References: Allen JN, et al: Acute eosinophilic pneumonia as a reversible cause of noninfectious respiratory failure. New Engl J Med 321:569 (1989)
_____: Acute eosinophilic pneumonia [edit]. Lancet 947(1990)
Badesch DB, et al: Acute eosinophilic pneumonia: a hypersensitivity phenomenon? Am Rev Respir Dis 139:249 (1989)

Larsen RA, et al: Acute respiratory failure caused by primary pulmonary coccidioidomycosis. Am Rev Resp Dis 131:797(1985)
Lombard CM, et al: Pulmonary eosinophilia in coccidioidal infection. Chest 91:734(1987)
Banner A, Borochovitz D: Acute respiratory failure caused by vasculitis after L-tryptophan ingestion. Am Rev Resp Dis 143:661(1991)

Case 2. Invited discussant: Dr. James Strauchen, Mt. Sinai Medical Center
Host discussant: Dr. Elizabeth Ames

KIKUCHI'S LYMPHADENITIS

An enlarged cervical lymph node from an otherwise healthy 27 year old woman demonstrated paracortical expansion and irregular areas of necrosis, with prominence of karyorrhectic debris, immunoblasts, and histiocytes, and paucity of neutrophiles. Both discussants considered the appearance to be diagnostic of Kikuchi's Disease. Dr. Strauchen reviewed the pertinent differential diagnostic considerations, which include Lupus lymphadenitis (patient usually systemically ill, necrosis more coagulative, more plasma cells, hematoxylin bodies may be present), cat scratch disease, and Kawasaki's Disease (small vessel thrombi present.) Dr. Ames noted that the patient has done well subsequently without specific treatment.

References:
Turner, Martin J, Dorfman RF: Necrotizing lymphadenitis. Study of 30 cases. Am J Surg Pathol 7:115(1983)
Unger PD, Rappaport KM, Strauchen JA: Necrotizing lymphadenitis (Kikuchi's Disease): report of 4 cases of an unusual pseudo-lymphomatous lesion and immunologic marker studies. Arch Pathol Lab Med 111:1031(1987)

Case 3. Invited discussant: Dr. Min Han, Albert Einstein College of Medicine
Host discussant: Dr. Ann Avitable

SOLITARY NECROTIZING GRANULOMA OF LUNG (? DIROFILARIASIS)

A 1.5 cm lung nodule was detected incidentally in a 25 year old woman being worked up prior to knee arthroscopy, and it was subsequently removed by wedge excision. Dr. Han showed the histologic features present in the specimen, a granuloma with central geographic necrosis, giant cell reaction, palisaded histiocytes, granulation tissue and fibrosis at the periphery, and irregular calcified structures throughout the lesion. He reviewed the rather lengthy differential diagnosis of solitary lung granulomas, and said that he felt, in the absence of a specific agent demonstrable on H&E or organism stains, the features were most consistent with dirofilariasis (heartworm). Dr. Avitable concurred, noting that her studies had also failed to demonstrate the organism. This is often the case in dirofilariasis, since the pulmonary lesion is formed when the dead worm embolizes from the right heart after a brief, abortive infection, (dog, not man, is the definitive host for this parasite) and disintegrating or calcified fragments of the worm are all that remain. She demonstrated residua of a large vessel in the center of the lesion, further supporting the suspected diagnosis.

References:
Ulbright TM, Katzenstein AA: Solitary necrotizing granulomas of the lung. Differentiating features and etiology. Am J Surg Pathol 4:13(1980)
Neafie RC, Piggott J: Human pulmonary dirofilariasis. Arch Pathol Lab 92:342(1971)

Case 4. Invited discussant: Dr. Carlos Navarro, Harlem Hospital
Host discussant: Dr. Harold Gaetz

GRANULOMATOUS PLACENTAL VILLITIS DUE TO M. TUBERCULOSIS

Primary material for this case was a histologic section from a 410 gram placenta belonging to a male infant who was small for gestational age (4 lb 2 oz; 36 weeks), delivered by C-section because of fetal distress. Dr. Navarro illustrated the features of granulomatous villitis with congealed villi which were present here, and contrasted this pattern of inflammation with examples of chorioamnionitis. The differential diagnosis of villitis includes a large number of infectious agents (tuberculosis, listeriosis, fungi, tularemia, brucellosis, trypanosomiasis, CMV, toxoplasmosis, varicella, variola), although in many cases an etiologic agent cannot be identified (villitis of unknown etiology.)

Dr. Gaetz stated that an auramine-rhodamine fluorescent stain had demonstrated rare acid-fast organisms in placental sections, and subsequent examination of gastric washings from the infant were positive for acid-fast bacilli. Appropriate therapy was begun for the mother and infant, and both have done well.

References: Sander CH, Stevens NG: Hemorrhagic endovasculitis of the placenta... Pathol Annu 19(pt 1):37(1984)
Nemir RL, O'Hare D: Congenital tuberculosis. Am J Dis Child 139:284(1985)

Case 5. Invited discussant: Dr. Abdel-Moneim Abou-Azama, Brooklyn Hospital Center
Host discussant: Dr. Harold Gaetz

HISTIOCYTOSIS X PRESENTING AS DRAINING SOFT TISSUE SINUS

Dr. Abou-Azama pointed out the variety of histologic changes present in a section of tissue obtained from a recurrent chronic infected draining sinus of the buttock and back of a 54 year old woman. In addition to evidence of old hemorrhage, granulation tissue reaction and xanthomatous areas with cholesterol clefts, the center of the lesion contained sheets of histiocytes whose nuclear configuration suggested they were Langerhans cells. He considered the possibilities of an infectious etiology (A. hinshawii, chronic staph infection) or reaction to silica, but favored Histiocytosis X, provided the histiocytic population could be definitively identified as Langerhans cells. Confirmation was provided by Dr. Gaetz, who showed electron micrographs of typical Birbeck granules in the cytoplasm of these cells.

References: Hammar S: Langerhans Cells. Pathol Annu 23(pt 2):293(1988)
Williams JW, Dorfman RC: Lymphadenopathy as the initial manifestation of Histiocytosis X. Am J Surg Pathol 3:405(1979)

Respectfully submitted,

Fred B. Smith, M.D.
Secretary-Treasurer

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