THE PENROSE CANCER CONFERENCE

THE BROADMOOR HOTEL
COLORADO SPRINGS, CO
HISTORY OF THE PENROSE CANCER CONFERENCE

In the early 1940's, pathologist Lauren Ackerman and oncologist/radiotherapist Juan del Regato created their classic book, CANCER: Diagnosis and Treatment, at the Ellis Fischel Cancer Hospital in Columbia, Missouri. During this time, Arthur Purdy Stout, the acknowledged founder of surgical pathology as a specialty, visited the Ellis Fischel Cancer Hospital to study diagnostic problem cases with Dr. Ackerman. Dr. del Regato added discussions of the clinical, radiologic and radiotherapeutic data. These informal conferences were highly appreciated by those in attendance.

When Dr. del Regato became the Director and Radiotherapist at Penrose Cancer Hospital, a part of the Glockner-Penrose Hospital, he decided to follow the format used in Missouri to develop a more formal conference primarily for pathologists of the Rocky Mountain area. Under the co-sponsorship of the Colorado Society of Clinical Pathology, the first Penrose Cancer Seminar was held in the Little Theater of the Broadmoor Hotel on September 10, 1949.

Prior to the conference, slide sets of 16 cases were sent to 120 pathologists for their opinions. The cases - a potpourri of breast, skin, salivary gland, etc. - were discussed jointly by Arthur Purdy Stout and Lauren Ackerman. These two physicians disagreed in only three of the 16 cases submitted; however, diagnoses submitted by the 120 Rocky Mountain pathologists were more varied. This fulfilled one of Dr. del Regato's purposes: to show how often good pathologists would justly differ in the diagnoses of difficult cases on the basis of morphology alone! Proceedings of the conference were published in Cancer Seminars, Vol. I, No. I, September 1950.

The conferences continued on an annual basis at the Broadmoor Hotel. As attendance grew, they moved from the theater to the ballroom and finally to the International Center.

The second seminar on September 9, 1950 concentrated on bone tumors and Dr. Phillip Hodes, Professor of Radiology at the University of Pennsylvania, was added as a speaker. From that point on, pathologists and radiologists served as joint speakers. A clinician, usually a surgeon, was added at the sixth conference in 1954. In addition, after the first seminar, which contained a potpourri of cases, each subsequent seminar focused on one organ or one major disease topic.
Dr. Ackerman served as pathologist for the second, third and fourth seminars; Dr. Hodes was the radiologist for the second and third events. After that, the pathologists, radiologists and clinicians who served as guest speakers included leaders in their fields from across the country.

Dr. del Regato led 24 seminars until his departure in 1972. The Pathology Department continued for an additional five years, ending the conferences in 1977.

The Penrose Cancer Seminars were unique. They united the nation's best pathologists and radiologists in a forum to discuss cases, slides and photos of perplexing problems in diagnosis. Opinions of the guest speakers, other world experts, and many of the attendees were published annually, often illustrated by unusual art centered around the crab. The contributions and failures of both tissue morphology and imaging techniques were important lessons for all, as was the importance of utilizing all modalities to arrive at the correct diagnosis.

To celebrate the opening of the new Penrose Cancer Center, and as part of our commitment to cancer care and physician education, the Penrose Cancer Conference is re-established.
ACKNOWLEDGEMENTS

The members of the Penrose Cancer Conference are grateful to the following persons who have submitted cases for review and consideration.

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Breast Case #1
CASE #1 (Breast)
Contributed by Samuel M. Rubinson, M.D., Cosimo G. Sciutto, M.D.
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The Penrose-St. Francis Healthcare System
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HISTORY:
A 59-year-old white male presented for surgical evaluation of bilateral palpable breast masses. He first noticed these several years ago and they had been slowly enlarging. He had no other symptoms related to these masses and he was not on any medications. Family history was negative for breast disease. Past medical history was negative except for having a lipoma removed from his neck. He was known to have other lipomas on his back and right shoulder area.

Physical examination was unremarkable except for the lipomas and breast masses. Examination of the right breast revealed a 3 cm upper inner soft, mobile mass without skin changes or palpable axillary adenopathy. On the left side, the patient had a 1 cm nodule in the upper outer quadrant, again without skin changes or palpable adenopathy.

These masses were confirmed on mammography and subsequent ultrasound revealed that these were solid masses. Ultrasound-guided needle biopsies were done.

GROSS PATHOLOGY:
Five needle core biopsies of the right mass and four fibrous core biopsies of the left breast mass are submitted.

SUBMITTED MATERIAL:
1. Mammogram composite of right and left breast lesions.
2. H & E slide of either the right or left core needle biopsies. Histologically the lesions were identical.

DIAGNOSIS:

Dr. Eklund's Diagnosis: ___________________________

Dr. Rosen's Diagnosis: ___________________________
Case #1

Figure 1 - Lateral oblique view of both the right and left breasts. There is a metallic BB over the palpable mass in the right breast.
Breast Case #2
HISTORY:

This 54-year-old Caucasian woman presented in November of 1992 with a firm lump in the inner, upper quadrant of the right breast. It was tender and was first noted in July of that year. Patient sought medical evaluation because it has been enlarging. Her last prior mammograms were in 1987 and they were reported to be normal.

GROSS PATHOLOGY:

The right breast biopsy consisted of 8.5 x 7.5 x 3.0 cm portion of soft, yellow adipose tissue with a well circumscribed 1.8 x 1.5 x 1.2 cm pink-white nodule. Cut surface of the nodule was trabeculated with a tan to red-brown center.

SUBMITTED MATERIAL:

1. Mammogram of right breast.
2. H & E slide of the circumscribed mass.

DIAGNOSIS:

Dr. Eklund's Diagnosis:________________________

Dr. Rosen's Diagnosis:________________________
Figure 1 - Lateral oblique view of a new palpable mass. There is a metallic BB over this palpable mass. The second smaller mass has been stable on prior films.
Breast Case #3
HISTORY:

A 90-year-old woman without previous medical problems was found to have a mass on a routine mammogram. She underwent a localized needle biopsy of the right breast.

GROSS PATHOLOGY:

A 6 cm diameter localized needle biopsy was received containing a 2 cm, well circumscribed, rock-hard, white mass.

SUBMITTED MATERIAL:

1. Mammogram of right breast.
2. H & E slide of the firm mass.

DIAGNOSIS:

Dr. Eklund's Diagnosis:

Dr. Rosen's Diagnosis:
Case #3

Figure 1 - Lateral oblique view of the right breast showing a single dense mass with central dystrophic calcification.
Breast Case #4
HISTORY:

This post-menopausal 63-year-old female presents with a history of being followed with mammography for several years until an abnormality was found in the left breast in 1993. She has previously had three breast biopsies for benign disease, one on the right and two on the left. She is taking Premarin and Ogen. Family history is negative for breast cancer. The breast examination showed no masses, tenderness, skin changes, nipple changes or axillary lymphadenopathy. Stereotactic biopsy of the left breast was done.

GROSS PATHOLOGY:

Six variable-sized fragments of tissue 1 to 2 mm in diameter, up to 1.7 cm in length are obtained from the abnormal area at 11 o'clock.

SUBMITTED MATERIAL:

1. Mammogram of left breast.
2. Mammogram at the time of stereotactic needle biopsy.
3. H & E slide or transparency slides of the biopsy.

DIAGNOSIS:

Dr. Eklund’s Diagnosis:

Dr. Rosen’s Diagnosis:
Case #4

Figure 1 - Craniocaudal view of the left breast. The area of interest deep within the central slightly medial aspect showing architectural distortion.

Figure 2 - Post-fire film from the stereobiopsy through the area of interest.
Breast Case #5
HISTORY:

The patient is a 68-year-old, white female who had a routine screening mammogram which showed bilateral abnormality. Magnification views of the left breast demonstrated calcifications with a benign appearance. There was concern about an area of architectural distortion on the right breast and a biopsy was recommended. She had no history of previous disease or breast surgery. She stated that she had a mass in the right breast for many years and had been told that it was a lipoma. She had a negative family history for carcinoma of the breast. She has four children and did nurse them. Her last menstrual period was in 1976. She had been on Premarin for a short period of time but is not currently on any hormonal therapy. She had hypertension and was on Dyazide and Tenormin.

On physical examination, there is no axillary nor supraclavicular adenopathy. There was a soft mass at the extreme medial aspect of the right breast which was 1 cm in diameter. There were no other dominant breast masses. Patient subsequently underwent a right breast biopsy with needle localization.

GROSS PATHOLOGY:

A 4.8 x 4.0 x 1.5 cm, needle localized biopsy is received. It contained a 0.8 x 0.4 x 0.2 cm stellate, firm-white lesion. Frozen section was deferred because of the size of the lesion.

SUBMITTED MATERIAL:

1. Mammogram of the right breast.
2. Magnification of the abnormal area.
3. H & E section of the mass.
4. Transparencies of an area near the described mass.

DIAGNOSIS:

Dr. Eklund's Diagnosis:_________________________

Dr. Rosen's Diagnosis:_________________________
Figure 1 - Craniocaudal view of the right breast.

Figure 2 - Magnification view over the area of concern.

Case #5
Breast Case #6
Breast Case #6
CASE #6 (Breast)

Contributed by C. Darrell Lane, M.D.
The Reading Hospital and Medical Center
Reading, Pennsylvania

HISTORY:

This 57-year-old gravida 4, para 4 white female was referred because of an enlarged left axillary mass suspected to be probable lymphoma. There were no constitutional symptoms or other noteworthy physical findings. Hematologic and urinalysis laboratory data were within normal limits. Medications included estrogen, calcium and vitamin B-12. Past medical history included vaginal hysterectomy (ovaries remain), cholecystectomy, appendectomy and T&A. The patient is a non-smoker, does not abuse alcohol and has two maternal aunts with breast cancer. At time of hospitalization for definitive surgery the pendulous breasts were symmetrical with no masses.

GROSS PATHOLOGY:

The largest left axillary lymph node was 3.8 x 3.0 x 2.6 cm. It was fleshy, pink-tan and uniform.

SUBMITTED MATERIAL:

1. Mammogram including the left axilla.
2. Left breast mammogram.
3. H&E slide of the lymph node.

DIAGNOSIS:

Dr. Eklund's Diagnosis:

Dr. Rosen’s Diagnosis:
Case #6

Figure 1 - Metallic BB over the palpable mass in the left axilla.

Figure 2 - Lateral oblique film of the left breast.
Breast Case #7
HISTORY:

This 51-year-old, post-menopausal female had normal mammograms in 1988 and 1990. In 1992 a non-palpable, 1.5 cm diameter mass was noted mammographically in the lateral region of the right breast. Evaluation of the axilla was unremarkable. She has a history of hypertension and is on Tenormin. The patient's mother, grandmother and two aunts have all had breast cancer. A needle localized right breast biopsy was done in August of 1992.

GROSS PATHOLOGY:

The 3.1 x 2.0 x 1.0 cm right breast biopsy contained a central, firm, white-gray to pink, rounded margin, 1.0 cm nodule.

SUBMITTED MATERIAL:

1. Mammogram of the right breast.
2. H & E slide or transparencies of the lesion.

DIAGNOSIS:

Dr. Eklund's Diagnosis: ________________________________

Dr. Rosen's Diagnosis: ________________________________
Figure 1 - Lateral oblique view of the right breast. The mass shown was not palpable.
Breast Case #8
HISTORY:

The patient is a 60-year-old white female who, on October of 1992, noticed a mass in the upper, outer quadrant of her right breast. Mammogram at that time showed a 2 cm solid, dominant mass in the upper portion of her right breast and a biopsy was recommended. She had no other breast symptoms. She had a negative family history for carcinoma of the breast. Spontaneous menopause occurred at age 44 and she was on no hormonal medication. She had four children. She had undergone a hysterectomy in 1977, a resection of thymoma in 1962, and a trigeminal nerve resection for tic douloureux in 1981. She also had hypertension and was on Tenormin and Elavil.

On examination, there was a 2 x 4 cm mass in the superior aspect of the right breast which was smooth and mobile. There was no axillary nor supraclavicular adenopathy.

This mass was resected and proved to be a lipoma. In follow up, there was a recurrent mass medial to the patient’s scar and a subsequent mammogram showed that the initial lesion was still present and had increased somewhat in size. The patient underwent a repeat biopsy of the right breast in April 1993.

GROSS PATHOLOGY:

The 3.7 x 3.5 x 3.5 cm right breast biopsy contained a 2.0 cm, well demarcated cystic cavity with a necrotic, red-brown mass surrounded by bloody fluid. The mass was soft and friable.

SUBMITTED MATERIAL:

1. Mammogram of the right breast.
2. Ultrasound of the right breast.
3. H & E stained slide.

DIAGNOSIS:

Dr. Eklund's Diagnosis: ________________________________

Dr. Rosen's Diagnosis: ________________________________
Case #8

Figure 1 - Craniocaudal view showing a large palpable mass in the medial aspect of the right breast.

Figure 2 - Ultrasound of mass.
Breast Case #9
CASE #9 (Breast)

Contributed by P. Terrence O'Rourke, M.D.
The Penrose-St. Francis Healthcare System
Colorado Springs, Colorado

HISTORY:

Patient is a 69-year-old, white female who had a routine mammogram which showed diffuse changes throughout the left breast and a biopsy was recommended. She had no breast complaints and had no previous breast disease or breast surgery. She had a daughter who had developed breast cancer at age 40. Patient had five children and nursed one of them. She is on no hormonal therapy. She did have rheumatoid arthritis and also Waldenstrom's macroglobulinemia. She was on Prednisone 2 mg daily and Methotrexate 7.5 mg once a week. She had a chest x-ray six months previously which was normal. Biochemical survey was normal and she had a mild anemia on her complete blood count.

She underwent a biopsy of two areas in the left breast: in the upper, outer quadrant and also lower, inner quadrant. Both areas had been localized with needle localization mammographically. Specimen radiographs confirmed the microcalcification in both lesions.

GROSS PATHOLOGY:

Two needle localized left breast biopsies were received. The superior breast biopsy consisted of two pieces of tissue 4.6 x 4.3 x 0.9 cm and 1.1 x 1.0 x 1.0 cm. The inferior breast biopsy was 4.5 x 3.5 x 2.0 cm. Distinct masses were not observed. Punctate necrotic foci were found throughout both biopsies.

SUBMITTED MATERIAL:

1. Composite of the right and left breast mammograms.
2. H & E section of the left breast biopsy. Morphologically, both the superior and inferior biopsies were similar.

DIAGNOSIS:

Dr. Eklund's Diagnosis:

Dr. Rosen's Diagnosis:
Figure 1 - Lateral oblique views of both breasts.
Ovary Case #10
HISTORY:

The patient is a 28-year-old gravida 1 para 0 woman with a last menstrual period six weeks before presenting to the emergency room with intermittent left lower quadrant abdominal pain. Urine pregnancy test is positive. Past medical history is remarkable for cervical squamous cell carcinoma in situ with microinvasion one year earlier. Workup includes transabdominal ultrasound and diagnostic laparoscopy. Exploratory laparotomy is performed.

GROSS PATHOLOGY:

8 x 6 x 5.5 cm tan left ovary with a smooth, glistening external surface and multiple internal loculations filled with clear yellow to thick, oily yellow to hemorrhagic fluid.

SUBMITTED MATERIAL:

1. H & E stained slide of left ovary.
2. Transabdominal image from pelvic ultrasound made in transverse plane (Figure 1);
3. Transabdominal images from pelvic ultrasound longitudinal plane (Figures 2 and 3).

DIAGNOSIS:

Dr. Gosink's Diagnosis:

Dr. Scully's Diagnosis:
Figure 1 - Transabdominal image of the pelvis made in transverse plane.

Figure 2 - Transabdominal image from pelvic ultrasound on the longitudinal plane.

Case #10

Figure 3 - Transabdominal image from pelvic ultrasound on the longitudinal plane.
Ovary Case #11
HISTORY:

The patient is a 68-year-old gravida 2 para 2 woman with her last menstrual period at age 50. She presents with post menopausal bleeding. Physical exam demonstrates an enlarged uterus, approximately 12 weeks in size, fixed to the right side wall. Workup includes a pap smear, endometrial biopsy and CT scan. Exploratory laparotomy is performed.

GROSS PATHOLOGY:

6 x 4 x 3 cm red-tan right ovary with a smooth external surface. Cut surface shows firm tan-white to focally yellow tissue with a central 1.5 cm cystic area with hemorrhage. The distal right fallopian tube is adherent to the ovary with obliteration of the fimbriated end. The left fallopian tube and ovary are unremarkable. The enlarged 15 x 5.5 x 3.5 cm uterus has a smooth pink-tan serosal surface. The left lateral endometrium contains a firm, tan-white, exophytic polypoid mass up to 2 cm in dimension with apparent myometrial invasion to a depth of 0.5 cm.

SUBMITTED MATERIAL:

1. H & E stained slide of right ovary.
2. H & E slide of uterus with endometrium.
3. Pelvic ultrasound, transabdominal (Figure 1).
4. CT image of the pelvis (Figure 2).
5. CT image of the pelvis 1 cm lower than the image in Figure 2 (Figure 3).

DIAGNOSIS:

Dr. Gosink's Diagnosis:

Dr. Scully's Diagnosis:
Case #11

Figure 1 - Pelvic ultrasound, transabdominal.

Figure 2 - CT image of the pelvis.

Figure 3 - CT image of the pelvis 1 cm lower than the image in figure 2.
Ovary Case #12
CASE #12 (Ovary)

Contributed by James Maxwell, M.D., James Lavanway, M.D., Paul Anderson, M.D., Tobias Kircher, M.D., James Borgstede, M.D.
Penrose-St. Francis Healthcare System
Colorado Springs, Colorado

HISTORY:

The patient is a 68-year-old woman with a two month history of progressively increasing lower abdominal pain, bloating, nausea, heartburn, hemorrhoidal bleeding and vaginal bleeding. Physical exam demonstrates a visible and palpable large pelvic mass. Antigen studies show CA-125 79 U/ml (normal <35), CEA 400 ng/ml (normal <4) and CA19-9 500 U/ml (normal <37). Workup includes abdominal CT scan. Exploratory laparotomy is performed.

GROSS PATHOLOGY:

10.5 x 10 x 8 cm tan, 410 gram left ovary with solid and multiple cystic areas measuring up to 5 cm in maximum dimension. The 18 x 11 x 10.5 cm, 1,300 gram right ovary has similar solid and multiple cystic areas. In both ovaries these cystic areas are filled with friable yellow to hemorrhagic material.

SUBMITTED MATERIAL:

1. H & E stained slide of left ovary.
2. CT image of the pelvis after administration of oral contrast (Figure 1).
3. CT image of the pelvis 2 cm lower than in Figure 1 (Figure 2).

DIAGNOSIS:

Dr. Gosink's Diagnosis: ____________________________

Dr. Scully's Diagnosis: ____________________________
Case #12

Figure 1 - CT image of the pelvis after administration of oral contrast.

Figure 2 - CT image of the pelvis 2 cm lower than figure 1.
CASE #13 (Ovary)

Contributed by Barbara Gosink, M.D.
University of California at San Diego
San Diego, California

HISTORY:

The patient is an asymptomatic 68-year-old post-menopausal woman who volunteered for a transvaginal ultrasonographic screening project for three years. The patient has had two normal screening examinations in the last two years. The patient now returns for her final screening examination in this study.

GROSS PATHOLOGY:

3.3 x 1.8 x 1.6 cm lobulated yellow-orange left ovary. Cut section shows a single glistening light-yellow, circumscribed 1.3 cm in diameter unencapsulated mass.

SUBMITTED MATERIAL:

1. H & E stained slide of left ovary.
2. Transabdominal ultrasound performed along the long axis of the left adnexa October 1990 (Figure 1).
3. Transvaginal ultrasound performed along the sagittal axis of the left adnexa January 1991 (Figure 2).
4. Transvaginal ultrasound performed along the sagittal axis of the left adnexa April 1992 (Figure 3).
5. Transvaginal ultrasound performed along the coronal axis of the left adnexa April 1992 (Figure 4).

DIAGNOSIS:

Dr. Gosink's Diagnosis: ____________________________

Dr. Scully's Diagnosis: ____________________________
Case #13

Figure 1 - Transabdominal ultrasound performed along the axis of the left adnexa, October 1990.

Figure 2 - Transvaginal ultrasound performed along the sagittal axis of the left adnexa, January 1991.
Figure 3 - Transvaginal ultrasound performed along the sagittal axis of the left adnexa, April 1992.

Figure 4 - Transvaginal ultrasound performed along the coronal axis of the left adnexa, April 1992.
Ovary Case #14
HISTORY:

The patient is a 49-year-old woman with a two month history of increasing abdominal girth, superficial abdominal tenderness aggravated by pressure on the abdomen, and post-prandial diarrhea. Lab work includes normal CBC, Biochemical Survey and CEA, but elevated CA-125 19,000 U/ml (normal <35). Workup includes CT scan. Exploratory laparotomy is performed.

GROSS PATHOLOGY:

4 x 3 x 2.2 cm tan right ovary with a multinodular external surface with nodules ranging from 1 to 15 mm in diameter. The 5.5 cm long left fallopian tube is distorted by an up to 4 cm multinodular mass which effaces the fimbriated end. The 277 gram 10.5 x 9.5 x 5.5 cm uterus has a granular to nodular serosal surface with numerous 1 to 3 mm in diameter surface nodules. The up to 56 cm omentum is involved by 5 to 50 mm white nodules which occupy 95% of the omental volume. The right fallopian tube appears normal. The left ovary is surgically absent.

SUBMITTED MATERIAL:

1. H & E stained slide of right ovary.
2. H & E stained slide of left fallopian tube.
3. Image from CT scan of the pelvis after administration of oral and intravenous contrast (Figure 1).
4. Image from CT scan of the pelvis 5 cm lower than in Figure 1 (Figure 2).

DIAGNOSIS:

Dr. Gosink's Diagnosis:

Dr. Scully's Diagnosis:
Case #14

Figure 1 - Image from CT scan of the pelvis after administration of oral and intravenous contrast.

Figure 2 - Image from CT scan of the pelvis 5 cm lower than figure 1.
Ovary Case #15
PENROSE CANCER CONFERENCE

CASE #15 (Ovary)
Contributed by James E. Wheeler, M.D.
Department of Pathology, University of Pennsylvania Medical Center
Philadelphia, Pennsylvania

HISTORY:

The patient is a 47-year-old white female gravida 3 para 2 who is found to have a pelvic mass on routine examination. The patient had undergone an elective hysterectomy with bilateral salpingectomy for leiomyomata eleven years earlier. CA-125 is 17 U/ml (normal <35). Workup includes Barium enema, IVP, abdominal ultrasound and CT scan. Exploratory laparotomy is performed.

GROSS PATHOLOGY:

7 x 5 x 5 cm smooth surfaced right ovary with external fibrous constrictions. Sectioning shows biloculation with pale yellow, turbid, mucinous fluid. The larger space is studded with pale yellow excrescences.

SUBMITTED MATERIAL:

1. H & E stained slide of right ovary.
2. CT scan of pelvis (Figure 1).
3. Transvaginal ultrasound of right ovary (Figure 2).

DIAGNOSIS:

Dr. Gosink's Diagnosis:_____________________________

Dr. Scully's Diagnosis:_____________________________
Case #15

Figure 1 - CT scan of pelvis.

Figure 2 - Transvaginal ultrasound of right ovary.
Ovary Case #16
CASE #16 (Ovary)

Contributed by A. Thomas Stavros, M.D.
Swedish Hospital
Denver, Colorado

HISTORY:

The patient is a 16-year-old woman with pelvic pain. The patient has an asymptomatic identical twin. Workup includes ultrasound and Doppler analysis of blood flow. Exploratory laparotomy is performed.

GROSS PATHOLOGY:

15 x 10 x 10 cm, 350 gram right ovary with a smooth, nodular, waxy tan-to-blue external surface. The cut surface shows a yellow mass with punctate 3 to 4 mm areas of red coloration, areas of edema and small 2 to 3 mm cysts.

SUBMITTED MATERIAL:

1. H & E stained slide of right ovary.
2. Transverse, transabdominal image of the right adnexa (Figure 1).
3. Doppler analysis of blood flow in the right ovarian mass (Figure 2).

DIAGNOSIS:

Dr. Gosink's Diagnosis: ____________

Dr. Scully's Diagnosis: ____________
Case #16

Figure 1 - Transverse, transabdominal image of the right adnexa.

Figure 2 - Doppler analysis of blood flow in the right ovarian mass.
CASE 1. MYOFIBROBLASTOMA.
CASE 2. SARCOMA (MYOFIBROSARCOMA VS LIPOSARCOMA)
CASE 3. AMYLOID TUMOR
CASE 4. TUBULAR CARCINOMA
CASE 5. TUBULAR CARCINOMA/TUBULO-LOBULAR CARCINOMA
CASE 6. BREAST CARCINOMA PRESENTING AS AXILLARY LYMPH NODE METASTASIS - PRIMARY TUMOR CLINICALLY OCCULT
CASE 7. ADENOID CYSTIC CARCINOMA ("HIGH GRADE" OR BASALOID VARIANT)
CASE 8. CYSTIC PAPILLARY CARCINOMA
CASE 9. ANGIOTROPIC MALIGNANT LYMPHOMA MASQUERADING AS COMEDOCARCINOMA.

CASE 10 - Sertoli-Leydig cell tumor, mixed heterologous and retiform type
CASE 11 - Endometrioid adenocarcinoma with squamous differentiation of endometrium and ovary, probably separate primary tumors
CASE 12 - Bilateral mucinous adenocarcinoma, intestinal type, most consistent with metastatic carcinoma of the colon
CASE 13 - Cellular fibroma
CASE 14 - Serous papillary adenocarcinoma, probably primary in peritoneum
CASE 15 - Serous cystic tumor of borderline malignancy with microinvasion of stroma
CASE 16 - Dysgerminoma