TUMOR SEMINAR COLLECTION

SET XIX

Arthur Purdy Stout Club, June, 1949

Set XIX

CASE 1 P&S 28838

Arthur Purdy Stout Club
Seminar - 1949

DIAGNOSIS: Hibernoma of axilla

MICROSCOPIC: This tumor is made up of rounded cells of a remarkable degree of uniformity in size. They have a rather small eccentrically placed nuclei and a cytoplasm containing fine acidophilic granules but characterized especially by many small vacuoles which contain a lipoid material as demonstrated by the Scharlach R stain. No mitoses are seen. Each cell is enclosed within a reticulin sheath and groups of cells are collected into lobules separated by fibrous septa. The tumor is sharply circumscribed but it does invade the fragment of striated muscle to which it is attached to a very limited extent. Moreover extending outward for a microscopic distance into the encircling fibrous tissue, are tiny slender cords of tumor cells which have granular acidophilic cytoplasms and no vacuoles which makes them very much smaller than the others. Their nuclei are of the same size as the vacuolated cells. No adult fat cells or signet ring cells are observed.

DISCUSSION: This is a rare but distinct tumor type. I have seen only three examples of it. The first was at the Fondation Curie in Paris when I was reviewing all of their tumor material in 1936. It was a growth which developed in the soft parts of the thigh and it had been labelled "hibernome" by Gricoureff, the pathologist, who no doubt was struck by its microscopic resemblance to brown fat in humans and the hibernating glands in animals. The second case was in the interscapular region of a 45 year old colored male and was sent to the Laboratory by Dr. Osborn Brines, professor of pathology at Wayne Medical School in Detroit during Bill Lehman's period of residency. The third case came also during Bill Lehman's residency from Jack Gaisford in Pittsburgh. It developed in the popliteal space of a 54 year old male and reached a size of 20 x 20 x 6 cm. and was intimately attached to the muscles. There can be little doubt about the resemblance of these tumors to brown fat and hibernating glands. The brownish color of the gross specimen would support this idea also. The acidophilic granular cytoplasm might make one think of granular cell myoblastoma but the regularity with which lipoid droplets are found in almost every cell seems reason enough for supposing that it is a different tumor type. I think we may distinguish it also from simple xanthoma since these cells do not appear to be phagocytes. What is the relationship of this tumor to liposarcoma? If we are correct in supposing that these are specialized lipoblastic cells, I presume that this must be a lipoblastic tumor and hence potentially at least malignant. In some cases of malignant metastasizing liposarcomas I have observed areas largely composed of rounded lipoblasts of the brown fat type. These definitely malignant tumors were not so orderly in their growth nor composed of such uniform cells arranged in such definite lobules. We must wait, I presume, until we obtain more information about clinical course and recurrence after removal before passing final judgment. At present this information is lacking.

REFERENCE: Brines, O.A., and Johnson, M.H. Hibernoma, a Special Fatty Tumor - Report of a Case. Am. J. Path. 25:467-479, 1949.

CASE 2 P&S 29839

Arthur Purdy Stout Club
Seminar - 1949

MULTIPLE KERATOACANTHOMAS (FERGUSON-SMITH)

DIAGNOSIS: Multiple squamous cell epitheliomas of comedones of skin

MICROSCOPIC: The two slides made from different areas of the skin surface show a comparable picture. There are a remarkable number of comedones formed with wide open pores. Sometimes there are several openings for a single elongated cystic space. The cysts are lined with squamous epithelium with epidermoid characteristics and filled with epithelial debris. They lie in the superficial part of the corium. From the outer aspect of the epidermal epithelium lining these comedones, spring squamous cell epitheliomas which invade the corium freely and in section A, also the subcutaneous fat. Differentiation varies from good to medium; in some cases the tumor cells are arranged in slender cords of spindle shaped cells with intercellular bridges but no keratinization.

DISCUSSION: This remarkable case is characterized by the rather sudden development of multiple comedones and associated squamous cell cancers over much of the body surface and concomitant with an itching skin eruption of an unnamed kind. The sudden development of multiple skin epithelial tumors on the body surface is not unknown. In 1939 Poth reported a case in a 45 year old male two and one-half months after severe sunburn of the hands. Tumors grew and after a time underwent spontaneous regression. They were studied by many dermatological pathologists and variously interpreted as keratosis, verruca vulgaris and carcinoma. That case differed from the present one first because the proliferations occurred only in parts exposed to severe sunburn and also because the tumors while epithelial were not certainly malignant and were not associated with comedones. Warvi and Gates in discussing cysts and cystic tumors of the skin have nothing to say about any developments such as this. I have not undertaken any research into the literature of skin epitheliomas; it would require more time than is at my disposal, but it is my impression that this is a most bizarre and unusual case and I am not acquainted with any like it.

REFERENCES:

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CASE 3 P&S 29808

Arthur Purdy Stout Club
Seminar - 1949

DIAGNOSIS: Onkocytoma of parotid salivary gland

MICROSCOPIC: This tumor is composed of lobular collections of large polymorphous, cylindrical and pear-shaped cells usually packed together in tight groups but not infrequently forming gland-like structures, the lumens of which are either empty or occasionally contain a mucoid material stringy and basophilic. The cytoplasm of the cells is voluminous and filled with strongly acidophilic fine granules. Salivary gland tissue is attached to one end of the section and a little striated muscle to the other. There is some fibrosis and cystic dilatation of some of the glandular spaces.

DISCUSSION: This is beyond question a glandular adenomatous tumor characterized by its composition of cells containing strongly acidophilic granules in the cytoplasm. They also demonstrate their ability to secrete mucus. The tumor springs from the parotid salivary gland. The ducts in that gland have cells in their lining of similar appearance to these tumor cells which Hamperl, the German pathologist, has called onkocytes. He described two salivary gland tumors composed of these cells and called them onkocytomas. There seems to be good reason for this and I have accepted the term. I have had an opportunity to see sections of one other tumor similar to this which grew for twenty years in the parotid of a 76 year old male. It has been reported by our friend Lauren Ackerman. These tumors are seemingly benign.

REFERENCES:

Ackerman, L.V., Oncocytoma of the Parotid Gland, Arch. Path. 36:508-511, 1943

Hamperl, H. Über das Vorkommen von Onkocyten in Verschiedenen Organen und ihnen Geschwulsten, Virchow's Arch. of Path. Anat. 298:327, 1936

Meza-Chávez, L., Oxyphilic Granular Cell Adenoma of the Parotid Gland (Oncocytoma) Am. J. Path. 25:523-547, 1949

CASE 4 P&S 29840

Arthur Purdy Stout Club
Seminar - 1949

MIXED MESODERMAL TUMOR

DIAGNOSIS: Teratoma of uterus

MICROSCOPIC: It is quite obvious that in these curettings there are two different varities of malignant tissue. The glandular elements while well differentiated are obviously neoplastic and the anaplastic cells with mitoses and the formation of irregular tubes sometimes with papillary proliferations and of solid cell masses assures the diagnosis of malignancy. But in addition there is a totally different kind of neoplastic tissue featured by the presence of bizarre rounded giant cells with acidophilic fibrillated cytoplasm and occasionally by strap cells with unmistakable cross striations.

DISCUSSION: It is obvious that we are dealing here with one of the rare uterine teratomas or carcinosarcomas of the uterus in an elderly woman. Both epithelial and sarcomatous elements are evidently potentially malignant and such tumors are almost invariably fatal. One must be prepared to encounter a considerable number of uterine tumors with a confusing histological picture. There are first the grape sarcomas (sarcoma botryoides) of infants and occasionally young adults. These tumors are of various histological composition either pure rhabdomyosarcomas, pure myxomas, or they contain mixed mesodermal tissues and can be called mesenchymomas. Clinically these tumors involve especially the cervix and vagina, form semi-translucent nodules and are characterized by stubborn infiltrative growth so that although generally they do not metastasize they are almost always fatal. Similar tumors spring from other parts of the genito-urinary tract in males and females. There are next the massive corpus tumors which are found generally at or past the menopause and grow outward into the lumen where they may form massive necrotic masses. These also have a varying histological composition. Sometimes like this tumor they are teratomas made up of a diversity of tissues both epithelial and mesodermal; these tissues can be all anaplastic or some may be anaplastic and others differentiated. There may also be pure mesodermal tumors of malignant composition but without any epithelial elements. These are mesenchymomas. Another variant is a carcinoma, part of which is glandular and part so anaplastic that its spindle-shaped cells imitate the appearance of a sarcoma. These anaplastic epithelial tumors always metastasize as carcinomas. Finally, it is apparently possible to have a submucous leiomyoma invaded by a carcinoma. It is not always possible to recognize to which category these fungating tumors in elderly women belong but clinically all of them are very malignant and require drastic treatment.

CASE 5 P&S 30008

Arthur Purdy Stout Club
Seminar - 1949

BONE, ILIUM - EWING'S SARCOMA

DIAGNOSIS: Reticulum cell sarcoma (?) of inguinal region

MICROSCOPIC: This section shows one part of a tumor which is apparently enclosed within a fibrous capsule. It is composed of masses of solidly packed rounded cells of moderate size with large nuclei. While these have distinct markings the nucleoli are small and mitoses rare. So far as I can tell from the H & E section there is very little reticulin between the cells. The cell masses are, however, frequently interrupted by lakes of old extravasated red blood cells. The tissue outside of the fibrous capsule contains many engorged and some dilated blood vessels. There are some groups of tumor cells but whether or not these are artefactual in this situation is uncertain.

DISCUSSION: The microscopic appearance of this tumor is strongly suggestive to me of the reticulum cell form of Ewing tumor. I do not understand the extensive hemorrhages but presume that they are nothing more than that because I cannot detect any lining to the spaces which seem simply artefacts due to blood extravasation. There are many interesting questions connected with the case about which one can only speculate. It is possible to have a Ewing tumor in a bone with a minimal degree of bone involvement and a very large mass outside. It seems to me very questionable indeed, however, whether any tumor was ever present in the tibia since it was never detected by biopsy and the x-ray showed no evidence of bone destruction. I would rather believe that the tibia lesion was unrelated to the tumor. I would rather suppose that the tumor (if indeed it is a Ewing tumor) was primary in the pubis and ilium with manifestations first in the inguinal region and later in the pelvis. The relatively long duration is not too uncommon in Ewing tumor. Another possibility is to suppose a primary origin in the soft parts of inguinal region or pelvis - in this case it would have to be called a reticulum cell sarcoma. The bone invasion would then be secondary. This is a much rarer event than for a tumor such as this to start in bone marrow.

CASE 6 P&S 30009

Arthur Purdy Stout Club
Seminar - 1949

DIAGNOSIS: Malignant schwannoma (?) of lateral neck region
Multiple neurofibromatosis

MICROSCOPIC: Section B, representing one of the skin nodules, shows the characteristic picture of a neurofibroma. Section A, from the tumor found inside the carotid sheath is made up of bundles of spindle shaped cells which run in various directions and tend to interlace. The cells are slender and the cytoplasm sparse and granular without intracellular fibrils. The trichrome stain shows wire fibers between most of the cells which are long and usually not wrapped around the individual cells. No nuclear palisading is seen.

DISCUSSION: This is a case of spindle cell tumor developing inside the carotid sheath of a patient with von Recklinghausen's disease. The history does not record any relationship of the tumor with a nerve - presumably it was not in connection with the vagus but it might have been with some small unnoticed sympathetic nerve twig. There is some evidence suggesting that the tumor cells may be Schwannian and not simple fibroblasts. There are no intracellular fibrils and the reticulin fibers between the cells are wiry and prolonged instead of being wrapped around the individual cells. This is not proof of the nature of the tumor but it is suggestive. The position of the growth would be an odd one for a simple fibrosarcoma - moreover one would expect a greater degree of local infiltrative growth from a fibrosarcoma. However, the evidence is not sufficient to do more than suggest the diagnosis of malignant Schwannoma.

REFERENCE: Stout, A.P., Tumors of the Peripheral Nervous System
J. Missouri State Med. Ass.
46:255-259, 1949

CASE 7 P&S 29864

Arthur Purdy Stout Club
Seminar - 1949

DIAGNOSIS: Ganglioglioma of nasal region

MICROSCOPIC: This lesion has a very distinctive morphology. Enclosed by thick fibrous septa are anastomosing masses of glial tissue containing a number of ganglion cells. Differential stains are a great aid to diagnosis and interpretation. Trichrome and Laidlaw stains show that there are no connective tissue fibers in the nervous tissue except for the sheaths of occasional blood vessels and occasionally at the periphery where the nervous tissue inter-digitates with the encompassing fibrous septa. The Bodian stain shows definite and exceedingly delicate neurites which spring from the occasional ganglion cells. The glial cells are astrocytes and the trichrome stain shows the dense tangle of red stained fibroglial fibers. All tissues are completely differentiated.

DISCUSSION: This is an example of the so-called gliomas of the nasal region which are found either here in the region of the glabella or attached high up within the nasal cavity where they may appear like nasal polyps. Rarely they are also found in the orbit. Most of the external nasal growths are small but we have one in the Surgical Pathology Laboratory that formed a huge subcutaneous cyst extending from the root of the nose to the occiput in a new-born infant. The majority of these tumors are isolated but an occasional example retains an attachment to the brain and death from meningitis has followed surgical removal. In the nose Davis favors the hypothesis of Schmidt that these growths result from the formation of an encephalocele during later embryonal development either with or without the cutting off of the stalk. This would account for the fact that a few of the tumors are still attached to the brain when removed. He rejects the hypothesis of Süssenguth that some of them come from the olefactory bulb rather than the brain.

REFERENCES: Davis, E.W., Gliomatous Tumors in the Nasal Region, J. Neuropath. and Exper. Neurol. 1:312-319, 1942

Guthrie, D., and Dott, N., Occurrence of Brain Tissue Within the Nose; so-called Nasal Glioma, J. Laryngol. & Otol. 42:733-745, 1927

Rocher, H.I., and Anglade; Les fibrogliomas de la region nasale, Rev. de chir, Paris, 62:147-178, 1924

Schmidt, M.B., Ueber Seltene spaltbildungen in Bereiche des mittleren Stunfortsatzes, Virchow's Archiv. 162:340-370, 1900

Süssenguth, L., Ueber Nasengliome, Virchow's Archiv., 195:537-544, 1909

CASE 8 P&S 29877

Arthur Purdy Stout Club
Seminar - 1949

DIAGNOSIS: Myxoma of Vas Deferens

MICROSCOPIC: Attached to one side of a few heavily muscled tubes presumably of the vas deferens is a very loose textured tumor with wide open spaces containing a mucoid material between delicate reticulin fibers which form a meshwork. Set in this meshwork are the isolated cells which are of many shapes; spindle, stellate, and polymorphous. Most of the cells are rather small, only occasionally does a larger cell with more than one nucleus appear. A secondary infiltration with inflammatory cells sometimes obscures the picture. Lipoid-type vacuoles are not detected in the cells although sometimes there is a suggestion that the mucoid material is contained within the cytoplasm. The tumor is seemingly enclosed within a capsule. It is furnished with a moderate number of small capillaries which do not seem to form a definite vascular pattern.

DISCUSSION: This myxoid tumor must be either a liposarcoma or a myxoma. I believe it is a myxoma because I cannot detect any evidence of lipogenesis and because there is not found the definite vascular pattern which characterizes ordinary embryonal fat and is so frequently reproduced in the liposarcoma. This tissue looks like an exaggeration of embryonal mesenchyme with an unusually large amount of hyaluronic acid. Myxomas connected with the genito-urinary tract are most commonly found in infants or somewhat older children and belong to the class of tumors called sarcoma botryoides. There are only three such tumors recorded in our files - one formed a polypoid mass projecting into the bladder springing from the region of the prostatic urethra of a two year old child. The second developed in the urethra of a seventeen year old girl with polypoid masses projecting both into the vagina and into the bladder. The third developed in the prostate of an elderly male and obstructed the urethra. This was 2 cm. in diameter, encapsulated and was removed by suprapubic prostatectomy. When I investigated the literature of myxomas I found recorded six other cases involving the spermatic cord or scrotum. These were about equally divided between children and adults. Excluding the heart, the commonest sites for the development of myxomas are: 1) subcutaneous and aponeurotic tissue; 2) bone; 3) genito-urinary system, and 4) the skin. They have been found in many other sites but only in very small numbers. Myxomas are stubborn infiltraters but do not metastasize. I prefer to regard them as locally malignant tumors and classify them with the sarcomas because they can kill by local infiltrative growth.

REFERENCE: Stout, A.P., Myxoma, the Tumor of Primitive Mesenchyme, Ann. Surg. 127:706-719, 1948

P&S 29877 - ADDENDUM: When this report was prepared I did not have at hand the Scharlach R stain and had completely forgotten that it demonstrates the presence of lipoid filled droplets in the tumor cells. I suppose that this forces us to change the diagnosis to liposarcoma although it makes me unhappy to do so because now I shall not feel any confidence in my ability to differentiate between myxoma and liposarcoma from ordinary stains.

AMENDED DIAGNOSIS: Liposarcoma of vas deferens.

CASE 9

A-10073

Arthur Purdy Stout Club
Seminar - 1949

DIAGNOSIS: Fat necrosis of the newborn

MICROSCOPIC: The section shows skin and subcutaneous fat. The corium seems a little thick but is not otherwise remarkable. The subcutaneous fat shows extensive necrosis although its architecture is generally undisturbed. In many areas the fat cells lack nuclei and the fat spaces instead of being empty contain a pink stained granular material and sometimes the outlines of needle shaped crystals. There is very little reaction to this; in places the intercellular spaces contain phagocytes and sometimes a few leucocytes and lymphocytes.

DISCUSSION: It is evident that this is an example of subcutaneous fat necrosis in the newborn for which various names have been coined. These include sclerema neonatorum, adiponecrosis neonatorum, sclerosis neonatorum, lipophagic granuloma, acute sclerema, preagonic induration and sclerema. There are two different clinical processes; the first and probably the commoner develops within a few days after birth with involvement in a patchy fashion of the tissues of various parts of the body but generally commencing above the waist. The process commences in an otherwise healthy infant and after a course lasting a few weeks during which the affected tissues are thickened and lardaceous with discoloration of the skin, the lesions decrease and eventually disappear completely. The other process commences in the lower extremities generally of somewhat older marantic infants, gradually spread to involve the whole subcutaneous fat and the deep body fat as well and is probably a terminal condition. McIntosh, Waugh and Rosa suggest the term preagonic induration for this fatal process while Gray calls it acute sclerema. Gideon Wells says: "This condition seems to depend upon a deficiency in olein in the subcutaneous tissue which causes the adipose tissue to have an abnormally high melting point. The resulting mixture of stearin and palmitin crystallizes at body temperature and the crystals may excite an inflammatory foreign body reaction". Obstetrical trauma and cold have both been suggested as precipitating etiological factors. A lipase capable of hydrolyzing body fat has not been demonstrated in scleremateous tissue, according to McIntosh and his associates. Histologically the appearance of the two conditions is similar so that they cannot be distinguished one from the other

We have one other case recorded in the Laboratory sent by Dr. A. O. Severance. This started a few days after birth in a male colored child with areas involving the buttocks and thigh. At four months the child was in good health but the areas had not disappeared. The biopsy shows very much the same picture as in the present case except that some of the necrotic areas had become calcified and there was more fibrosis around them.

(continued on next page)

This condition is of course quite different from Weber-Christian disease which is an inflammatory febrile disease and does not occur in the newborn.

REFERENCES:

Flory, C.M., Fat Necrosis of the Newborn
Arch. Path. 45:278-288, 1948

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Arch. Derm. & Syph. 27:237, 1933

Gray, A.M.H., Fat Necrosis of the Newborn
Arch. Derm. & Syph. 14:635, 1926

Larkin, V.deP., deSanctis, A.G., and Margulis, A.E.
Relapsing Febrile Nodular Non-Suppurative
Panniculitis (Weber-Christian Disease)
Am. J. Dis. Child. 67:120-125, 1944

McIntosh, J.F., Waugh, T.R., and Rosa, S.G.
Sclerema Neonatorum (Subcutaneous Fat Necrosis)
Am. J. Dis. Child. 55:112, 1938

Ormsby and Montgomery, Diseases of the Skin. Fat
Necrosis of the Newborn. 7th Ed. 1948, pp.627-628

Wells, H.G., Adipose Tissue, A Neglected Subject
J.A.M.A. 114:2177-2183 and 2284-2289, 1940

CASE 10 P&S 29325

Arthur Purdy Stout Club
Seminar - 1949

DIAGNOSIS: Glioma (astrocytoma) of orbit

MICROSCOPIC: Enmeshed with the fibromuscular tissues of the orbit is a growth composed of glial cells and fibrils arranged in anastomosing strands with fibrous tissue containing blood vessels and sometimes striated muscle fibers between. Most of the glial cells are probably fibrous astrocytes. The Bodian stain fails to show any definite neurites so that although some of the cells suggest the appearance of ganglion cells, it seems wiser to suppose the growth is made up entirely of glial tissue.

DISCUSSION: This is the first example I have ever seen of a so-called glioma of the orbit and in a hasty survey of the literature I have not found any cases like it. The lesion is different from gliomas of the optic nerve which have been exhaustively studied by Davis in 1940. These are in the nature of glial proliferations within the optic nerve without extensions into the orbital tissues outside of it. They are very rare and have generally been found in cases of von Recklinghausen's disease. When Reese published his classification of ocular pathology in 1940 he included glioma of the optic nerve but made no mention of this lesion in the orbit. It would seem that it must be due to a congenital malformation similar to that which results in the gliomas of the nose by which a portion of the brain is dislocated into the orbit. The dislocated portion in this case must have been completely separated and have grown as a tumor-like proliferation within the orbital tissues. Because the tumor involved the region of the nasolacrimal fossa, the question arises as to whether or not it could have any relationship with a nasal glioma. From the information at hand, there is no intranasal glioma and in no reported case is any such extension of a nasal glioma reported.

REFERENCES:

Davis, F.A. Primary Tumors of the Optic Nerve
(A Phenomenon of Recklinghausen's Disease)
Arch. Ophthal. 23: 735-821 and 957-1018, 1940

Reese, A.R., Classification of Ocular Pathology
Arch. Ophthal. 24:1077-1099, 1940

Path - Bad -

Set XIX

P&S 28838

CASE 1 - HIBERNOMA OF AXILLA -

Male, age 32. (Source: Dr. Richter)

Patient first noted lump in left axilla about 3 weeks before admission (October 1948). This was about 4 x 5 cm. in diameter, low in the axilla, at the level of the 4th rib. The surface was smooth, the mass was firm and freely movable. No tenderness.

X-rays of the chest showed a soft tissue mass with no apparent osseous involvement.

The mass was removed surgically from beneath the latissimus dorsi muscle, and was thought clinically to be a fibrosarcoma.

On macroscopic examination the mass was encapsulated, measured 8 x 5 x 2 cm. The cut surface bulged and was composed of light brown tissue in which was a fine network of firm grey tissue.

✓1. Hibernoma - benign acidophilic granules in cytoplasm.
✓2 Set on case Each cell wrapped about by
✓3 Review article reticulin fibres.

Am J. Path 24 675 1948

Brown multilobular fat
1905 - 6 cases
Somewhat similar to granular myobl.
18 yr female 10x4x2 + + scapular

Vit. in hib. glands

P&S 29839

CASE 2 - MULTIPLE KERATOACANTHOMAS (FERGUSON-SMITH)

Male, 49 years of age. (Source: Dr. M. Richter)

Occupation: Inspector of shoes.

The patient's illness began about 8 months before admission with the appearance of a "pimple" on the nape of the neck and another one on the left side of the chin.

A biopsy of the skin lesion was interpreted as "epidermoid carcinoma". The patient was treated with X-ray. A similar lesion appeared over the right malar bone and this was also treated with X-ray. A few months later the patient was treated for a condition of the left lower gum which was diagnosed as "X-ray burn". At that time a "prickly heat" type of rash appeared over the shoulders. A little later the patient developed abdominal pain which was diagnosed as probable carcinoma of the liver. Exploration revealed a normal liver but a diseased gall bladder which was removed.

A few months later there began to appear over the trunk posteriorly and then the legs, then arms and abdomen, and finally the entire body, the rash which is now present. This itches severely in localized areas but these areas apparently shift. The lesions never weep, and seem to contain a hard core. In general the lesions are papular. They are minute in size to several cc. in diameter. They are raised, firm, some with crater-like appearance, others containing a white center which might be extruded if pressure is applied. They are not tender. The mucous membranes are not involved. There is also generalized lymphadenopathy, the nodes being small and firm.

comedones.

Path

Thiersfelder
Howard Conley CG

P&S 29808

CASE 3 - ONCOCYTOMA OF SALIVARY GLAND -

Male, 53 years of age. (Source: Dr. M. Richter)

Patient complains of swelling on left side of face near the angle of the jaw. This was first noticed 1½ years ago. He believes that it has grown slightly larger recently. It causes him no distress or pain.

Physical examination showed nothing of interest except for the local tumor mass.

Oncocytoma

Check the H&E ✓

sebaceous glands in oral mucosa
" " " sal. glands
lacrimal
" glands - cervical glands just beyond junction of gland. & cerv. epith.

CASE 4 - MIXED MESODERMAL TUMOR OF UTERUS -

Female, 79 years of age. (Source: Dr. M. Richter)

Four months before admission the patient began to have a vaginal discharge. At first this was brownish, then pink, and was later followed by frank vaginal bleeding which persisted for 8 or 10 days. At the time of admission blood was mixed with a brownish discharge. There had been a loss of 3-5 pounds in weight.

Dilatation and curettage was performed, with insertion of radium.

? [illegible].

1. [illegible]
2. [illegible]

Cross Pharm MX.

P&S 30008

CASE 5 - EWING'S SARCOMA OF PELVIC BONES -

White male, age 17 years. (Source: Dr. R. Horn)

Patient admitted 11-29-42 with history of pain in left knee for one year beginning after being kicked by a mule at that site. X-ray showed periosteal proliferation with fine perpendicular striations around upper outer shaft of tibia. Cortex intact. Biopsy showed only mature fibrous tissue and a little new bone formation. For 9 months patient did well and repeated x-ray examinations were interpreted as showing healing. In January 1945 (25 months after biopsy) patient was re-admitted with a mass in left inguinal region which had been growing for about six months. This was excised. The mass measured approximately 8 cm. in greatest dimension and was soft and bloody.

At this time the early history was clarified. Following the initial trauma (inflicted by a friend, not a mule), the patient was seen at another hospital, refused first an amputation, then a biopsy, and was given an unknown but presumably large amount of therapeutic radiation.

In March 1946 noted pain and swelling of entire leg on weight bearing. Bone survey and chest film negative.

December 1948 - More pain, readmitted. Mass in left side of pelvis, displacing bladder and with some destruction of pubis and ilium. Other bones and chest negative. General condition excellent -- only complaint pain. Sections are of inguinal mass.

SUMMARY

Nov. 1941 - Onset tibial lesion followed by radiotherapy.
Nov. 1942 - Negative biopsy of tibia, University Hospital.
Jan. 1945 - Inguinal mass removed.
Jan. 1949 - Large pelvic mass. No involvement in lungs or other bones.

P&S 30009

CASE 6 - SOFT TISSUE, NECK - MALIGNANT SCHWANNOMA
SKIN, - NEUROFIBROMA -

White female, age 36 years. (Source: Dr. R. Horn)

Mass in left side of neck of 10 years duration. Beginning 2 months before admission, developed rapidly progressing difficulty swallowing with 15-20 lb. weight loss in 2 weeks.

Operated upon 9/24/36 with diagnosis of non-toxic nodular goiter. Mass found to be within carotid sheath. Tumor encapsulated (8 x 5 x 4.5 cm), soft, yellow-tan flecked with red and marked by several small cystic areas (Section A). Multiple skin nodules present many years; several biopsied. One was a basal cell epithelioma. Two others were seen in Section B.

Seeking follow-up data.

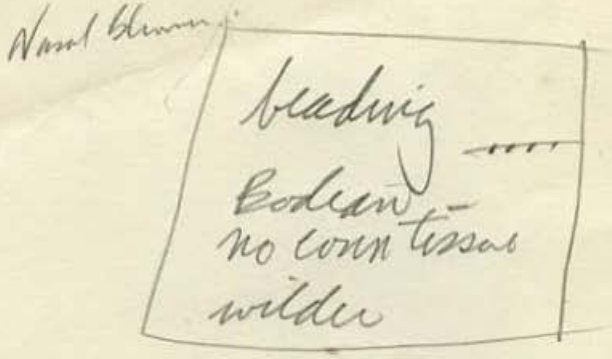
A. Malignant Schwannoma
B. Neurofibroma M-Tumor

CASE 7 - SOFT TISSUE, NOSE - GANGLIOGLIOMA -

White male infant, age 4 months. (Source: Dr. L. Ackerman)

Patient was born with a cystic mass over the glabella, primarily to the left side. This did not increase in size.

Examination revealed an approximately 2 cm. in diameter, oval shape, cystic mass over glabella, more to the left side, not attached to the skin, ? pedicle, no tenderness and no inflammatory reaction.



P&S 29877

CASE 8 - SCROTUM - MYXOID LIPOSARCOMA -

Male, 52 years of age. (Source: Dr. A. O. Severance)

About eight months prior to operation, patient first noticed a mass in the left scrotum. There was no pain. The mass appeared to be getting larger, especially in the last two months.

? Lipoma.

? Myxoma

SP A-10073

CASE 9 - SKIN - FAT NECROSIS OF THE NEWBORN

Baby C. Unit No. 932628 (Babies Hospital, N.Y.)

Clinical Abstract:

Born Nov. 20, 1948, full term normal delivery, no complications.
Nov. 24, 1948 - Temp. 102.4 - Dx as dehydration, responded to fluids. Inadequate fluid intake. More fluids added to diet.
Nov. 25 & 27 - Temp. again rose to 100.2 p.r. No evidence of infection
Nov. 28 - Temp. 100.6 p.r. Small pustules were noted above inner canthus of each eye. Infant isolated and given penicillin locally and systemically. Fever subsided.
Nov. 29 - An extensive, inflamed tender indurated pitted area on the upper back was noted. Well developed, well nourished Spanish-American 9-day old infant, moderately ill, irritable when moved or disturbed. The involved skin of the back extends from the neck to the sacrum and involved the lateral aspects of arms and thighs, hard, dark-red, overlying skin hot, almost phlegmonous.
Impression: Subcutaneous infection of back.
Nov. 30 - No change in lesion after 48 hours of penicillin.
Dec. 2 - No change in lesion except it is darker red in color. There is still lack of systemic reaction. Adequate feeding. No diarrhea. Needle aspiration culture negative.
Dec. 6 - X-ray of long bones: Normal.
No abnormalities seen on trunk.
Dec. 8, 1948 - Tenderness of adductor muscles of thigh noted.

Write up
Multiple fat necrosis -
Subcutaneous fat
necrosis in
the newborn.
at this age

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CASE 10 - ORBIT - GLIOMA (ASTROCYTOMA) -

Male infant, 5½ months of age. (Source: Dr. J.R. Dawson)

Baby was seen at the age of 2 months with round soft mass in area of medial canthus and extending to naso-lacrimal fossae. Complete blockage of naso-lacrimal duct, caniculi, however, are open. Removed - supposedly completely - from naso-lacrimal fossae (bone exposed) at age 4 months. Complete specimen sent to pathologist and slide is section thereof. Two weeks later mass appeared and is growing larger with cyst at inner angle of eye displacing globe laterally and cysts invading upper and lower eyelids. Cyst at inner angle punctured and yellow visced material removed. Patient is now 5½ months old. Should it be removed? Is there likelihood that it will recur?

H.