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ELEVENTH ANNUAL TUMOR SEMINAR
SAN ANTONIO SOCIETY OF PATHOLOGISTS
November 6, 1954
BROOKE ARMY HOSPITAL
Fort Sam Houston, Texas

DIAGNOSES BY BRIGADIER GENERAL ELBERT DeCOURSEY, M.C.

Case 1: Aplastic anemia secondary to ionizing radiation.

This amounts to about 500 r body dosage.

Case 2: Radiation reaction.

The original ulcer was one of pseudoepitheliomatous hyperplasia.

DIAGNOSES BY WEBB E. HAYMAKER, M.D.

Case 3: Meningioma. vs. astrocytoma

This is macro- and microcystic. Dr. Globus reported a very similar case of this rare form.

Case 4: Papilloma of choroid plexus with foci of cells resembling an ependymoma.

Case 5: Astrocytoma (piloid type). with Rosenthal fibers

Considered synonymous with so-called spongioblastoma.

Case 6: Teratoid pinealoma.

Case 7: Metastatic carcinoma (probably primary in lung). vs. oligodendroglioma

Dr. Haymaker reluctantly but definitely relinquished the diagnosis of oligodendroglioma here.

DIAGNOSES BY F. K. MOSTOFI, M.D.

Case 8: Interstitial cell tumor.

Case 9: Teratoma of testis.

Case 10: Teratocarcinoma. EMBRYONAL CARCINOMA

Dr. Mostofi has seen these metastasize as embryonal carcinoma, teratoma, teratocarcinoma, and choriocarcinoma.

Case 11: Embryonal myosarcoma.

Appears to arise in epididymis. This would differentiate to both rhabdo- and leio- forms. The rest of the AFIP group favored calling this a mesenchymoma.

11th Annual Tumor Seminar, S.A.S.P.

DR. MOSTOFI'S DIAGNOSES (Cont):

Case 12: Teratocarcinoma and sarcoma.

DIAGNOSES BY LENT C. JOHNSON, M.D.

Case 13: Codman tumor (which he calls an epiphyseal enchondromatous giant cell tumor).

Dr. Johnson considers this lesion a "sheep in wolf's clothing." It is always benign and frequently amputated by error. The diagnoses submitted were chondroblastoma 22; other benign 4; sarcoma 17.

Case 14: Metaphyseal enchondromatous giant cell tumor. ? OSTEOSARCOMA

He says this is a new kind of bone tumor. It is seen in the small bones of the hands and feet and also long bones. It looks like a Codman tumor in the metaphysis. A special example is called by some "chondromyxoid fibroma (Jaffe)." Thirty called this malignant; 13 benign.

Case 15: Malignant giant cell tumor.

This case he feels has the minimum required criteria for diagnosis of malignancy. The "stromal cells" vary in size, shape and staining quality; the giant cells or osteoclasts show the same change; there is production of matrix between "stroma" in the absence of microfractures. He stated giant cell tumors are always metaphyseal and never epiphyseal, except by late overgrowth. Loculation on x-ray means slow growth, but the rate of growth may not be related to the degree of malignancy. He grades them as malignant, benign, and "don't know." He is utterly opposed to the treatment of any bone tumor by x-rays except where it is decided in advance that the irradiated material is going to be excised or removed. A possible exception is giant cell tumor of the vertebral body. He feels so-called osteolytic sarcoma is a super-malignant form of giant cell tumor with loss of giant cells. Forty opinions called this benign and three malignant.

Case 16: Parosteal sarcoma.

This is a "wolf in sheep's clothing." This low-grade, progressive, deep-seated tumor is curable by removal but is generally not removed and ends with metastasis. This is the form called by Geschickter and Copeland "parosteal osteoma" and by Jaffe and Lichtenstein "juxtacortical osteogenic sarcoma." Dr. Johnson says most people call this myositis ossificans or osteochondroma. This lesion is always located at the junction of shaft and metaphysis. In treatment the lesion must be removed right down into the marrow cavity. Often the pulmonary metastases are called benign hamartoma. The submitted diagnoses were sarcoma 2; benign 39 (osteochondroma 18, myositis ossificans 2).

11th Annual Tumor Seminar, S.A.S.P.

DR. JOHNSON'S DIAGNOSES (Cont):

Case 17: Myositis ossificans.

The picture produced in this condition is extremely variable, depending on time of injury and onset; quantity of tissue; and position. In this case it probably began in a tendon. He thinks this condition is related to osteochondromatosis and is the same disease as subperiosteal hematoma (subperiosteal giant cell tumor or aneurysmal bone cyst).

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Set 88

ELEVENTH ANNUAL TUMOR SEMINAR

SAN ANTONIO SOCIETY OF PATHOLOGISTS

November 6, 1954

BROOKE ARMY HOSPITAL

FORT SAM HOUSTON, TEXAS

GUEST CONDUCTORS

BRIGADIER GENERAL ELBERT DeCOURSEY, M.C.

Director
Armed Forces Institute of Pathology
Washington, D.C.

Discussion of Cases 1 and 2

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WEBB E. HAYMAKER, M.D.

Chief of Neuropathology Section
Armed Forces Institute of Pathology

Discussion of Cases 3 through 7

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F. K. MOSTOFI, M.D.

Chief of Genito-Urinary Pathology Section
Armed Forces Institute of Pathology

Discussion of Cases 8 through 12

* * *

LENT C. JOHNSON, M.D.

Chief of Orthopedic Pathology Section
Armed Forces Institute of Pathology

Discussion of Cases 13 through 17

The meeting will be held in the Auditorium of Annex IV at Brooke Army Hospital on November 6, 1954, from 9:00 a.m. to 12:00 noon and from 1:30 to 5:30 p.m.

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The cases will be presented by means of lantern slides. The registrants are advised not to bring microscopes, since there will be no occasion for their use.

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Please fill in your diagnoses on the form on the last page, detach, and mail to the Chief of Laboratory Service, Brooke Army Hospital, Fort Sam Houston, Texas, by November 1 so that diagnoses may be summarized for presentation at the Seminar. These need not be signed.

THE FOLLOWING ASSISTANCE
IS GRATEFULLY ACKNOWLEDGED

This Tumor Seminar is supported in part
by grants from

THE TEXAS DIVISION
OF THE
AMERICAN CANCER SOCIETY

and

THE SOUTH CENTRAL REGIONAL COMMITTEE
OF THE
COLLEGE OF AMERICAN PATHOLOGISTS

* * *

Microscopic slides were prepared by the laboratories of the participants and contributors, with special assistance from Dr. Charles F. Pelphrey, Austin, Texas, and the Fourth Army Area Medical Laboratory, Fort Sam Houston, Texas, Colonel Charles J. Farinacci, Commanding.

CASE 1

Contributed by Brigadier General Elbert DeCoursey, Armed Forces Institute of Pathology, Washington, D.C.

A 31-year-old male was admitted to the hospital complaining of high fever, pain over the 6th rib laterally, and painful gums. He had had malaise for about 4 weeks which he said started with a gastro-intestinal upset with nausea and vomiting. His fever continued; he developed a cough which increased in severity and was productive of purulent sputum. Three months after onset hemoptysis occurred. White blood cell count was 6,500 and red blood cell count 2,200,000. Occasional red blood cells were found in urine. The patient's wife and daughter had died of a similar disease in the second week after onset.

My diagnosis: _____

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General DeCoursey's diagnosis: _____

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Comment: _____

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CASE 2

Contributed by Brigadier General Elbert DeCoursey, Armed Forces Institute of Pathology, Washington, D.C.

Eight months ago a dull ache was noted over the lower lateral right leg. Examination showed a reddish purple nodule 18 mm. in diameter about 4 inches above the ankle. It was incised and yellowish, blood-tinged pus drained from it. After a week it increased to about 2½ cm. in diameter. Four very small reddish nodules appeared at its periphery. After 2 months the nodules had healed. Five months ago the area was excised with a ¼-inch margin. After the pathology report the patient received fourteen x-ray treatments.

My diagnosis: _____

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General DeCoursey's diagnosis: _____

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Comment: _____

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CASE 3

Contributed by L. J. Manhoff, Jr., M.D., Robert B. Green Hospital, San Antonio, Texas.

A 26-year-old white male was admitted with complaints of increased intracranial pressure of 3 weeks' duration. A craniotomy was performed but the patient expired the following day. At autopsy a rounded, fairly well-circumscribed tumor mass was found in the left frontal region. Cut section presented a soft, light tan, homogenous and almost translucent appearance. The tumor was adjacent to the midline and appeared to extend into the right hemisphere and posteriorly into the corpus callosum.

My diagnosis: _____

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Dr. Haymaker's diagnosis: _____

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Comment: _____

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CASE 4

Contributed by J. M. Moore, M.D., Santa Rosa Hospital, San Antonio, Texas.

A 7-year-old child was admitted with a history suggestive of "chronic meningitis." X-ray revealed widening of the skull beyond normal for the patient's age. There was separation of the coronal and saggital sutures. There was no intracranial calcification. A ventriculogram revealed dilatation of the ventricular system above the fourth ventricle. At surgery a large tumor was removed from the fourth ventricle and right cerebellar hemisphere. The patient died shortly after surgery.

My diagnosis: _____

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Dr. Haymaker's diagnosis: _____

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Comment: _____

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CASE 5

Contributed by L. J. Manhoff, Jr., M.D., Robert B. Green Hospital, San Antonio, Texas.

A 22-year-old female had had headaches for one year. Two months prior to admission there was nausea and vomiting. A ventriculogram showed hydrocephalus with obstruction of the aqueduct. At surgery no tumor could be found. The patient died six days later and a well-circumscribed tumor was found in the superior pole in the midline of the cerebellum, compressing the aqueduct.

My diagnosis: _____

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Dr. Haymaker's diagnosis: _____

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Comment: _____

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CASE 6

Contributed by J. M. Moore, M.D., Santa Rosa Hospital, San Antonio, Texas.

An adult female was admitted with the chief complaints of lethargy, nausea, and vomiting. A personality change also was noted. The patient had had diabetes for several years which had been well controlled with insulin except for a daily urinary output of nearly 9 liters. The patient developed a right facial lag and weakness of the extraocular movements. She spiked a temperature of 104° and expired. At autopsy a soft, gelatinous, gray mass measuring 2 x 1 cm. was found compressing the upper portion of the aqueduct.

My diagnosis: _____

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Dr. Haymaker's diagnosis: _____

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Comment: _____

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CASE 7

Contributed by A. O. Severance, M.D., Baptist Memorial Hospital, San Antonio, Texas.

A 52-year-old white male was admitted with the chief complaint of headaches of 4 months' duration. Fundiscopic examination showed papilledema with hemorrhages. There was a right hemiparesis with hyperreflexia; Babinski and Hoffman were positive. At operation an infiltrating tumor mass, gray to red, soft and mucinous, and measuring approximately 3.0 cm. in diameter, was found in the left frontal lobe.

My diagnosis: _____

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Dr. Haymaker's diagnosis: _____

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Comment: _____

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CASE 8

Contributed by Colonel C. J. Lind, Brooke Army Hospital, Fort Sam Houston, Texas.

A 21-year-old white male had a history of gynecomastia for one-and-one-half years. Breasts were sore and tender and the right testis was slightly enlarged. There was a female distribution of hair, but no voice changes or other symptoms. The testis contained a yellowish tan, discrete, unencapsulated mass 2.2 x 1.8 x 1.5 cm. in the middle of the slightly compressed testicular parenchyma. No hemorrhage was noted within the tumor or testis.

My diagnosis: _____

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Dr. Mostofi's diagnosis: _____

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Comment: _____

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CASE 9

Contributed by L. J. Manhoff, Jr., M.D., Robert B. Green Hospital, San Antonio, Texas.

This 9-month-old Latin-American male had an enlarged testis which was first noted by the parents approximately three to four days after birth and which had increased only slightly in size. There were no other symptoms. The gross specimen was a testis and spermatic cord, the testis being replaced by a mass measuring approximately 4 x 3 x 2.5 cm. On section a variety of tissues was noted, including hair, bone, and small cystic spaces filled with keratinized debris.

My diagnosis: _____

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Dr. Mostofi's diagnosis: _____

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Comment: _____

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CASE 10

Contributed by Captain Abe Oyamada, USAF Hospital, Lackland Air Force Base, San Antonio, Texas.

A 26-year-old colored male noticed a painless, hard right testis with no apparent swelling 3-4 months before operation. A testis weighing 50 grams and measuring 5 x 4 x 3.5 cm. with 7 cm. of cord structure attached was removed. On section the entire testis was found to be replaced by an opaque, granular, yellowish white tumor mass containing numerous greenish yellow cystic areas. The largest cyst, 3 x 2 cm., was in the upper pole, had a smooth interior with a few septal ridges, and contained greenish yellow fluid. The only recognizable testicular tissue was a thin, 3-mm. compressed peripheral layer on one aspect. Neoplasm appeared limited to testis with possibly slight extension into adjacent cord.

My diagnosis: _____

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Dr. Mostofi's diagnosis: _____

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Comment: _____

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CASE 11

Contributed by Colonel H. A. Van Auken, Fitzsimons Army Hospital, Denver, Colorado.

This 20-year-old male noted progressive heaviness and swelling of the right testis following a parachute jump on 6 September 1951. Treatment for nonspecific orchitis failed to relieve the symptoms and on 20 October following exploration the testis, containing a fleshy, pale yellowish gray tumor mass, and the spermatic cord were removed. By December 1951 the patient had lost 40 pounds and metastatic masses were noted in the supraclavicular, axillary, and epigastric areas. There was mediastinal involvement by March 1952. The patient died on 23 April 1952.

My diagnosis: _____

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Dr. Mostofi's diagnosis: _____

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Comment: _____

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CASE 12

Contributed by Dr. K. F. Mostofi, Armed Forces Institute of Pathology, Washington, D.C.

A 68-year-old male had a history of testicular tumor of 20 years' duration, which grew to the size of a watermelon and completely incapacitated the patient (making it impossible for him to walk). It weighed 5,000 grams and was necrotic and cystic in its center. Its relation to the testis could not be determined. The opposite testis was normal.

My diagnosis: _____

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Dr. Mostofi's diagnosis: _____

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Comment: _____

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CASE 13

Contributed by J. M. Moore, M.D., Santa Rosa Hospital, San Antonio, Texas.

This 16-year-old boy had a benign giant cell tumor removed from the right fibula in February 1953. In April 1953 x-ray of the right knee revealed an oval area of rarefaction in the intercondylar notch of the distal right femur with slight condensation in the adjacent bone which suggested an unusually large area of osteochondritis dissecans. The patient had pain in the right knee on walking but no significant weakness or loss of weight-bearing ability in the affected knee. Removal of the medial meniscus and biopsy of the synovial membrane was performed. Pathology reports were those of normal meniscus and mild chronic synovitis. Following this operation the patient's knee became quite swollen and tender. He was again admitted to the hospital in July 1953. There was no evidence of recurrence of the giant cell tumor by x-ray. There was no change in the appearance in the lesion of the lower femur. The patient was readmitted in October 1953 because of continued pain in the right knee and moderate weight loss. X-ray of the right knee showed increasing rarefaction of the intercondylar area of the distal articular surface of the right femur. A 1-cm. portion of the intercondylar notch suggested destruction of the articular surface. The patient was finally readmitted in February 1954 because of progressive swelling, pain and loss of motion in the right knee. X-ray of the right knee disclosed marked generalized demineralization of all the bones with a cystic appearance of the distal femoral epiphysis. The extent of involvement was slightly greater than on previous examination in October 1953.

My diagnosis: _____

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Dr. Johnson's diagnosis: _____

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Comment: _____

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CASE 14

Contributed by J. M. Moore, M.D., Santa Rosa Hospital, San Antonio, Texas.

A 21-year-old male had injured his left knee by a fall 3 years ago and had persistent swelling for the past 2 years. Needle biopsy a year prior to admission was reported as "malignant tumor." X-rays following admission showed marked deformity of the distal 8 inches of femur associated with a large soft tissue tumefaction containing numerous irregularly deposited osseous filaments. Twirls of irregular calcification were found in the mass which extended down to the articular plate of the femur and into the joint space anteriorly. The distal femur was involved by an irregular osteolytic process with almost total dissolution of the femoral shaft above the condyles and destruction of the lateral condyle and most of the medial condyle. Numerous large rarefactions were noted in the proximal shaft along the involved area.

My diagnosis: _____

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Dr. Johnson's diagnosis: _____

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Comment: _____

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CASE 15

Contributed by Dr. L. C. Johnson, Armed Forces Institute of Pathology, Washington, D.C.

A 33-year-old white male had some ache in his right shoulder for about two weeks. Two days before admission he fell on his extended right arm and developed pain at the deformity and swelling. He was admitted to the hospital as a probable fracture. X-rays showed extensive destruction of the upper end of the humerus extending almost to the articular surface, involving a portion of the epiphysis and the entire metaphysis.

My diagnosis: _____

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Dr. Johnson's diagnosis: _____

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Comment: _____

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CASE 16

Contributed by Dr. L. C. Johnson, Armed Forces Institute of Pathology, Washington, D.C.

A 32-year-old white male noted a lump on the inner aspect of his left thigh while taking a shower. It was entirely asymptomatic. On x-ray an exceedingly dense, rather sharply demarcated area of sclerotic bone measuring 6.5 x 4 cm. was noted arising from the metaphyseal side of the epiphysis on the medial aspect of the distal femur. There was a suggestion of a slight brush-like effect at the junction of the soft tissue and the tumor. There was no involvement of the underlying bone. The entire mass appeared to be rather sessile and the brush border suggested a thin cartilage cap.

My diagnosis: _____

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Dr. Johnson's diagnosis: _____

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Comment: _____

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CASE 17

Contributed by Dr. L. C. Johnson, Armed Forces Institute of Pathology, Washington, D.C.

About 10 days before delivery an 18-year-old pregnant white female complained of a tender hot nodule above the condyle on the lateral aspect of her left knee. It had been present for about a week. The lesion was felt to be inflammatory and was treated with heat and bed rest. A week later no improvement was noted. She was hospitalized and given local heat and antibiotics. Five days later there was still no fluctuation. The lesion, about 4 x 6 cm., had become somewhat rubbery in character and could be palpated just beneath the skin. X-rays were reported within normal limits.

My diagnosis: _____

_____

Dr. Johnson's diagnosis: _____

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Comment: _____

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BROOKE ARMY HOSPITAL
Fort Sam Houston, Texas

November 6, 1954

DIAGNOSES:

CASE 1: _____

CASE 2: _____

CASE 3: _____

CASE 4: _____

CASE 5: _____

CASE 6: _____

CASE 7: _____

CASE 8: _____

CASE 9: _____

CASE 10: _____

CASE 11: _____

CASE 12: _____

CASE 13: _____

CASE 14: _____

CASE 15: _____

CASE 16: _____

CASE 17: _____

This page may be retained for your own reference.

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DIAGNOSES:

CASE 1: _____

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CASE 3: _____

CASE 4: _____

CASE 5: _____

CASE 6: _____

CASE 7: _____

CASE 8: _____

CASE 9: _____

CASE 10: _____

CASE 11: _____

CASE 12: _____

CASE 13: _____

CASE 14: _____

CASE 15: _____

CASE 16: _____

CASE 17: _____

Please fill in your diagnoses and mail this page to the Chief of Laboratory Service, Brooke Army Hospital, Fort Sam Houston, Texas, by 1 November so that diagnoses may be summarized for presentation at the Seminar. These need not be signed.