

SLIDE SEMINAR.PACIFIC NORTHWEST SOCIETY OF PATHOLOGISTS.MAY - 1960CASE NO: I.Slide No. H-587-59Submitted by: Lt.Col.T.E.Field, RAMC, & Major K.R.Dirks,MC,  
USA, Queen Alexandra Military Hospital, Millbank, London,  
Eng.

This 33 year old white female developed a lump in her right buttock at the age of six years (1933), following trauma. This lump began to grow rapidly in 1953 and was locally excised in May 1955. It recurred and was excised in March 1958, and again in October, 1959. A draining sinus appeared after the latter operation, and a wide local excision including the sinus tract and surrounding indurated tissue was accomplished in November, 1959.

Gross Pathological Examination:

The gross specimen consisted of an ellipse of skin and subcutaneous tissue measuring 10 x 3.5 x 1.5 cm., traversed by a longitudinal scar, and occupied by a central 1.5 x 1.0 x 1.0 cm. sinus tract. The tract was bordered by firm, gray, fibrous tissue. Near the superior extremity of the specimen was an oval, dark purple, spongy, 1.0 x 0.8 x 0.8 cm. nodule, which was sharply demarcated from the surrounding subcutaneous tissue.

CASE NO. II.Slide No: S-60-2364Submitted by Dr. John H. Sturdy, Associate Director of Laboratories,  
St. Paul's Hospital, Vancouver B.C.

History - 32 year old female, gravida VII, para II. History of severe Rh sensitization. Appendectomy 1944, salpingectomy 1956. For past several years intermittent pain in R.L.Q., worst at time of menses, but becoming constant in past 6 months. Pain described as dull, but became sharp on moving from sitting to standing position. No bowel or bladder symptoms. Pelvic examination unremarkable except for nodularity of sacro-uterine ligaments and increased pain on palpation of right adnexal region.

Total hysterectomy performed without difficulty, but on right superior-lateral edge of urinary bladder was a hard nodular mass 4 x 3 x 2 cm. which appeared to infiltrate the wall.

Gross Pathological Examination:

The specimen consists of a segment of urinary bladder. On the external surface there was an irregular, finely lobulated, firm, yellowish-white mass 4 x 3 x 2 cms., poorly encapsulated, and on section presenting a white fibrous-appearing cut surface. Grossly it appeared to infiltrate the bladder musculature to the submucosal surface.

CASE NO: III.Slide No. S-60-4060.Submitted by Dr. John H. Sturdy, Associate Director of Laboratories,  
St. Paul's Hospital, Vancouver B.C.

A 52 year old female first noted onset of lump in leg just below right knee joint two years ago. At first enlargement only slight, but increased in size a great deal and

CASE NO: III. (Cont'd)

became tender on kneeling. No loss of movement. History of carcinoma of the cervix 10 years ago treated by radium, hysterectomy, followed by deep x-ray therapy. No history of osteomyelitis. On admission general physical examination said to be negative. The swelling was described as being situated in the upper portion of the tibial area. The skin overlying the swelling moved freely over the periosteum.

X-ray report: "There is a multicameral cystic lesion in the proximal third of the right tibia extending to within 0.5 cm. of the joint surface. The cortex is thin but intact. It has benign characteristics. Distal to it is an area of sclerosis extending downward for 7 cms.

The tibia was opened and in the words of the surgeon "there exuded a large amount of almost straw coloured, non-odorous, opaque fluid which on drying had a marked crystalline appearance. This filled the whole cavity, which was about 6 cms. in length and which had involved the whole circumference of the marrow, expanded the general contours of the bone and rendered the cortex very thin. The fluid was removed and with it a small amount of soft tissue which presented as a lining of the cystic mass". The tissue is from the lining of cyst cavity. Cultures of the fluid were sterile.

CASE NO: IV.

Slide No.914. M-898-59.

Submitted by Dr. Sheldon A. Jacobson, Director, Bone Tumor Registry,  
University of Oregon Medical School, Portland, Oregon.

History - This 26 year old white male had a short history compatible with a disc syndrome with remissions and exacerbations. His symptoms became suddenly much more acute than usual, and an x-ray was taken which revealed a destructive radiolucent lesion measuring 7.5 cm. x 7.7 cm. in the left wing of the sacrum, extending from the sacro-iliac articulation medially and across the mid-line. It was demarcated by dense bone and a pathological fracture extended from the lower margin of the left sacro-iliac upwards and medially towards the center of the lumboc sacral articulation. Laboratory work was within normal limits.

At surgery, a cyst-like structure containing xanthochromatic-like fluid and old blood was found. The lining was smooth and glistening and there was soft tissue between the lining and the bone. The area was curetted. The tissue sections consisted of soft tissue fragments varying from dull gray to dark red in color.

CASE NO. V.

Slide No.W2850-59.

Submitted by: Dr. Jesse Marymont, Washoe Medical Center, Reno, Nevada.

This 11 year old white female complained first of chest pain and tiredness in July of 1959. This pain was of some three months duration at the time of admission. She had been seen previously on May 12th, 1959, at which time an enlarged liver was discovered and it was considered to be due to a propable hepatitis. On physical examination in July, the liver was palpable 2 cm. below the costal margin. The remainder of the history and physical examination was not remarkable.

The patient underwent surgery, and a large obviously non-resectable malignant neoplasm was found that appeared to arise in the region of the right adrenal gland, and following surgery the child ran a low-grade fever, but did well and was discharged. The patient was again seen in December of 1959. At that time she had undergone considerable weight loss and had a right upper quadrant and right flank pain which was controlled by narcotics. Chest x-ray revealed massive, bilateral, pulmonary metastasis and the patient

had a large amount of vomiting and abdominal pain.

In the hospital she pursued a gradual downhill course, and expired on February 13th, 1960.

CASE NO. VI.

Slide No: S59-1511.

Submitted by: Dr. Burton S. Eggertsen, Medical Director, Chief, Pathology Service, U.S. Public Health Service Hospital, Seattle, Washington.

The history in this case is that of a 15 year old female who for three weeks noted pain in her right arm after exercise and for two weeks noted a mass under the midportion of the right clavicle. The mass did not change in size during this two-week period, was not tender to palpation, and there was no history of trauma. The physical examination was entirely non-contributory. X-rays of the area revealed some sclerosis of the under portion of the clavicle, but no erosion or other osseous disease. At surgery a 9 x 7 x 5 cm. mass was found lying under the pectoralis muscles and adjacent to but not attached to the rib cage. The axillary vein and long thoracic, thoracolumbar and medial pectoral nerves were involved in the tumor mass. The tumor was irregular in outline, but separated fairly easily from surrounding tissues by blunt dissection. On examination the tumor was found to be of firm consistency and the cut surface was pale yellow in color. On sectioning it was seen to be made up of numerous nodular foci measuring up to 2 cm. in diameter.

CASE NO: VII.

Slide No: 59-S-7018.

Submitted by: Dr. C.J. Coady, Director of Laboratories, Royal Columbian Hospital, New Westminster, B.C.

This 36 year old male first complained of a lump in the axilla in September of 1959. A fragmentary biopsy taken of the superficial portion of the lump, that was described to be 1 cm. in diameter, disclosed what was obviously an anaplastic malignant process with some melanin pigmentation. No primary malignant melanoma of skin could be demonstrated in the drainage area, although there were two or three small pigmented lesions, which when biopsied were all benign. The mass in the axilla was excised and presented a lobulated, cellular tumor measuring approximately 1½ cm. in diameter, poorly circumscribed. This lesion recurred within a matter of four or five weeks, and a second resection was carried out, with a radical dissection of the axilla. Under the original scar there was a mass of yellowish tissue of soft consistency measuring approximately 3 cm. in diameter. The sections are from this tumor.

CASE NO. VIII.

Slide No. A60-228 Mrs. A.B.

Submitted by: Dr. Bill Leach, Vancouver General Hospital, Vancouver B.C.

In 1946 at the age of 17, this woman had a subcutaneous tumor removed from the left forearm, which was considered to be a possible metastatic lesion from the kidney. She was treated with post-operative irradiation. She felt perfectly well until February, 1959, when a nodule appeared in the left deltoid area, this was excised and was considered to be a malignant tumor, possibly a malignant carotid body tumor. Secondary lesions were noted in her lungs at this time, and shortly thereafter she developed the signs and symptoms of cerebral metastases. In May of 1959 she gave birth to a normal 6 lb. 2 oz baby girl. There were no placental abnormalities. She continued slowly downhill thereafter, her chest x-rays revealed multiple lung lesions which were constantly present and increasing in numbers in subsequent x-rays. She finally died on

March 6th, 1960. At autopsy there were widespread multiple necrotic tumor nodules throughout the body. The section is from one of the better preserved nodules in the brain.

CASE NO. IX.

Peripheral blood smear S.2308-58.

Submitted by: Dr. Ross McNeely, Jubilee Hospital, Victoria, B.C.

This 51 year old white male, while serving in Italy and Sicily during the war, had malaria, infectious hepatitis (jaundiced 3 mos.) and a three day bout of diarrhea, undiagnosed. He was well until he had an insurance examination in August 1956, at which time his WBC was 24,000 with 65% adult eosinophils. There was a small mass in the LUQ and it was thought to be spleen. Investigation showed no parasites and ova in the stools on numerous occasions, no parasites in the blood smears, negative Brucella and Widal Agglutination tests, negative Echinococcus skin test, and no further physical abnormalities. No fever at any time. Bone marrow was done and showed 25% adult eosinophils. Absolute eosinophil count was between 9,000 and 11,500 per cu.mm.

Oct. 1957 - Complained of weakness, heaviness LUQ. Definite splenomegally. Hbg. 11.3, RBC 3.6, WBC 54,000 with 84% adult eos. Platelets 255,600. Transfused, discharged.

Dec. 1957. Further consultation and treatment, by X-ray.

Apr. 1958. Splenectomy, questionable fungi seen in section, culture neg. Improved on Mycostatin. WBC 25,000 49% eos.

June 1958. Dyspnea and cough. Liver 2 cm. above umbilicus, ascites. Autopsied - mural thrombi in both ventricles and right auricle, aortic valve. A few large lymph nodes. Pulmonary congestion and hydrothorax.

CASE NO. X.

Slide No: 16786A.

Submitted by: Dr. Philip S. Vassar, Assoc. Surgical Pathologist, Vancouver General Hospital, Vancouver B.C.

This 16 year old boy presented with a nasal discharge and obstruction. He was found to have a lobulated, fleshy and vascular tumor mass apparently rapidly growing and arising from the nasopharynx in the region of the ethmoid sinus. At surgery, the tumor mass was bulky and completely filled the maxillary antrum. Block resection of the tumor was undertaken.

CASE NO. XI.

Slide No: OS-59-24 and S-59-201.

Submitted by: Louise Wiegenstein, M.D., University of Washington, Seattle, Wash.

History - 41 year old single nullipara with intermenstrual bleeding for five months prior to passing a vaginal mass, 15.0 x 8.0 x 7.0 cm., during a regular menstrual period. (OS-59-24). Three weeks later a total hysterectomy and bilateral salpingo-oophorectomy was done, (S-59-201).

CASE NO. XII.

Slide No. 59-S-45.

Submitted by: Dr. C.J. Coady, Director of Laboratories, Royal Columbian Hospital, New Westminster, B.C.

CASE NO. XII (Cont'd)

This 24 year old, young unmarried woman, noted some tenderness in her breast for a two-month period. On examination, both breasts are somewhat nodular to palpation, and the area biopsied was the area in which the pain was felt, but clinically this area was not necessarily any more nodular than multiple other areas in both breasts. This case is presented as a problem in management rather than diagnosis.

CASE NO. XIII.

Slide No: S-317-60.

Submitted by: Dr. Warren C. Hunter, University of Oregon Medical School.

The patient, 26 years of age, first noticed a mass in the breast 2 months before seeing her physician and after she had stopped nursing her baby. Initially, the doctor aspirated about 25 cc. of bloody fluid which cytologically showed nothing in the way of cells other than those normal to blood, plus blood pigment.

The overall dimensions of the fat and fibrous covered specimen were 9 x 8 x 4.5 cm. and the weight was 150 gm. On sectioning, a discrete, white lobulated, generally shiny mass was found to make up most of the specimen. Parts of this were soft and slippery, other portions were distinctly firm to palpation. Along the margin at one point was a now largely collapsed cyst 3.5 cm. in diameter, having brownish margins. Presumably this was the sight of the aspiration of fluid.

CASE NO. XIII.

Slide No: G-59-211.

Submitted by: Dr. Clayton R. Haberman, Everett, Washington.

This patient is a 53 year old white female, para 0, gravida 1, presenting with post-menopausal bleeding. The last normal menstrual period was some two years ago. Past history was unremarkable, the uterus was not enlarged and there were no parametrial masses. The tissue is from a curettage of the endocervical canal, and endometrial cavity. It consisted of multiple firm nodules of light tan tissue, varying from five to eight mm. in diameter, with an irregular contour.

CASE NO: XV.

Slide No: S-3873-59.

Submitted by: Dr. Warren C. Hunter, University of Oregon Medical School.

Present since birth, in a baby one year of age when brought to the doctor, was a mass located opposite the thyroid cartilage laterally and in a location which the surgeon felt was compatible with a branchial cleft remnant. There is no mention of an increase in size over the one year period.

Grossly the mass was very discrete, 3.5 x 3 x 2.5 cm. outwardly multilobulated, but on sectioning proving to be a series of cysts containing thin and brown fluid, except for one in which fresh hemorrhage had occurred. In all instances the cysts had smooth linings. In a core of solid tissue were several black streaks, looking not unlike fine threads.

Note: there is probably some variation in the structures present in as many sections as it was necessary to cut to supply all members with slides. It is possible that not all sections will contain a portion of thyroid gland.

CASE NO: XVI.

Slide No: S-60-4065.

Submitted by: Dr. H.H. Pitts, Director of Laboratories, St. Paul's Hospital, Vancouver, B.C.

The patient is a white female, 52 years of age, who stated that she visited her physician 7½ months ago for a general check-up and was told that she had a small cyst on her left ovary. She had been complaining of headaches, tiredness, hot flushes at that time and also for a short time prior to this had had a pulling sensation in her left lower quadrant when she bent over. About 1½ months ago she began to notice that her clothing was becoming tighter and she was able to feel a mass in her abdomen herself. Loss of 3 pounds in the past 3 weeks noted, but otherwise nothing remarkable.

Past history: Patient has had a great many operations beginning with tonsillectomy and appendectomy in childhood, left simple mastectomy in 1930 apparently for mammary dysplasia, cyst removed from one ovary in 1931 (side not known by the patient), thyroidectomy in 1935, right mastectomy in 1950 apparently also for mammary dysplasia, hysterectomy and hemorrhoidectomy in 1951. On examination of the abdomen a large, firm slightly moveable intra-abdominal mass about 1 inch below the umbilicus, non-tender, was found almost in the mid-line. Remaining examination non-contributory.

Gross examination on the tumour mass: A large ovoid mass of tissue, semi-solid and semi-cystic, weighing 382 grams and measuring 11 x 8 cms. The general color of the tumor appears to be pale yellow, although areas of haemorrhagic extravasation and necrosis appear to have occurred in some sites. It is generally soft, somewhat myxomatous in some areas, very friable and appears to be finely papillary in one or two areas. Approximately one third of the lesion is occupied by a cyst previously evacuated of content, the lining aspect appearing slightly papillary.

CASE NO: XVII.

Slide No. S-60-2075. Submitted by: Dr. Raymond F. Hain, University of Washington.

Submitted by: Dr. H.H. Pitts, Director of Laboratories, St. Paul's Hospital, Vancouver.

The patient is a 26 year old white woman who was six months pregnant and apparently in good health. About 2 days prior she noticed a lump in the tail of the right breast. It was painless, freely moveable and no other enlarged glands could be palpated.

Gross description: Specimen consists of a portion of a mass removed from what is said to be the tail of the right breast. It measures 5 x 4 x 3 cm. The cut surface shows a rather peculiar pattern in that numerous cystic spaces, into which what appear to be papillary projections extend, are apparent. In the more solid portions consistency is very firm, the color white with here and there small micro-cystic areas.

CASE NO: XVIII.

Slide No: Hu 5766.

This patient was a 4.8/12 year old Mexican boy. The mother noted the onset of an enlarged head and rapidly progressive blindness at about eight months of age. A doctor was first consulted at age 18 months, at which time a skull film showed hydrocephalus with marked erosion of the clinoid processes, but without any intracranial calcification. The fundi showed bilateral optic atrophy, and the patient was noted to be blind and pathetic. Severe convulsions were a problem as well. The child was not seen again until his terminal admission, at which time he was having convulsions; was hyperthermic and unresponsive. He died soon after admission.

CASE NO: XVIII. (Cont'd).

Autopsy revealed a head circumference of 64.5 cm. There was a series of coccidioidal granulomas along the left upper lobe bronchus. The brain showed severe internal hydrocephalus, and a huge tumor was noted at the base of the brain which seemed to arise from the area of the infundilulum. The optic nerves could not be identified.

The section is from the large tumor mass.

CASE NO: XIX.

Slide No: Hu 3679.

Submitted by: Dr. Raymond F. Hain, University of Washington.

An eleven (11) month old white female, one of identical twins delivered by Caesarean section, was admitted to Children's Orthopaedic Hospital on August 22nd, 1956, with a history of lethargy, anorexia, and failure to gain weight. Since the age of four months she had been noted to be abnormal by her mother and the attending physician; nystagmus, both horizontal and rotary, had been a constant finding, and she was hyper-irritable on being stimulated. Physical examination revealed a hydrocephalic infant who was unable to raise her head from the bed, or to sit up. The left arm was spastic, and there was a left Babinski reflex.

Lumbar puncture revealed an opening pressure of 220 mm. of water, with a CSF protein of 320 mgm.%. On August 27th, 1956, a right subdural tap was performed, and pale yellow subdural fluid, with 2 gm.% protein, was withdrawn. Subsequent daily sight subdural taps yielded 10 to 14 cc. of similar fluid.

On September 3rd, 1956, right frontal and parietal burr holes were made, and a subdural membrane, too thin to be excised, was encountered and drained; following which she improved and was discharged.

She was readmitted two weeks later because of vomiting and anorexia. The head measured 44.5 cm. in diameter, there was a stiff neck, and bilateral Babinski signs were elicited. Bilateral subdural taps were performed, but no fluid was encountered. A ventriculogram performed on November 2nd, 1956, revealed a 3rd ventricle tumor mass. She expired on November 19th, 1956.

At autopsy two large bulbous tumor masses replaced the optic nerves. The tumor followed the optic tract posteriorly to the lateral geniculate bodies and completely filled the 3rd ventricle. The section submitted is from the large tumor mass replacing one of the optic nerves.

CASE NO: XX.

Slide No: S-60-77-C3

Submitted by Dr. Raymond F. Hain, University of Washington.

A 5½ year old white girl who was otherwise well and developing normally, gave a history of progressive decrease in vision in the right eye for one year and increasing medial deviation and proptosis of the eye for six months.

Examination revealed obvious proptosis and internal strabismus of the right eye. Vision was decreased to 20/200 and fundoscopic examination revealed papilloedema. X-ray studies showed enlargement of the right supra-orbital fissure, suggestive of a retrobulbar mass.

The section submitted is a portion of the tumor mass removed at the time of surgical exploration of the orbit.

Page No. 8.

Enclosed please find additional slides:

Slide No: 8929 Pneumatosis intestinalis, submitted by Dr. Bland Giddings, of Idaho Falls Hospital. This was an incidental finding at operation of pyloric stenosis,  
and:

an unnumbered slide from a case of a turban tumor (Cylindromata Multiple), submitted by Dr. Ross McNeely of the Royal Jubilee Hospital in Victoria B.C.

These sections are submitted for your information and collection only.

"C.J.Coady, M.D., C.M.,"  
Program Committee Chairman,  
Pacific Northwest Society of Pathologists.

SLIDE SEMINAR RESULTS

PACIFIC NORTHWEST SOCIETY OF PATHOLOGISTS

May 21, 1960

Vancouver General Hospital  
Moderated by Dr. L.C. Simard

CASE # & CONTRIBUTOR	CONTRIBUTOR;S DIAGNOSIS	DR. SIMARD'S DIAGNOSIS	FOLLOW-UP INFORMATION PRESENTED AT MEETING
#1-Slide: H-587-59 Lt.Col. T.E. Field, RAMC Major K.R. Dirks, MC, USA	Hemangiopericytoma	Epithelial tumor of skin adnexa (cylindroma)	Subsequent metastases
#2-Slide: S-60-2364 Dr. John H. Sturdy	Adenomatoid tumor	#1-Foreign body granuloma #2-Mesothelioma	Pat mucicarmine and PAS stains all negative
#3-Slide: S-60-4060 Dr. John H. Sturdy	Epidermoid cyst of bone	Epidermoid cyst of bone	
#4-Slide: M-898-59 Dr. Sheldon A. Jacobson	Bone cyst	Bone cyst	
#5-Slide: W-2850-59 Dr. Jesse Marymont	Adrenal-cortical carcinoma	Adrenal cortical carcinoma	
#6-Slide: S-59-1511 Dr. Burton S. Eggertsen	Peripheral neuro-epithelial tumor	#1-?Malignant mesothelioma #2-Anaplastic carcinoma	ALVEOLAR RABBITO MYO-SARCOMA
Other diagnoses mentioned: Synovial sarcoma, Rhabdomyosarcoma, Malignant paraganglioma.			
#7-Slide: 59-S-7018 Dr. Campbell J. Coady	Malignant tumor, type undetermined	?Malignant tumor, possible embryoma	Good response to X-ray therapy followed by recurrence; pt. back to work

Other diagnoses mentioned: AFIP: malignant synovioma.

CASE # & CONTRIBUTOR	CONTRIBUTOR'S DIAGNOSIS	DR. SIMARD'S DIAGNOSIS	FOLLOW-UP INFORMATION PRESENTED AT MEETING
#8-Slide: A-60-228 Dr. Bill Leach	Malignant non-chromaffin paraganglioma	Malignant endocrine tumor (paraganglioma melanoma, or carotid body tumor.)	Autopsy revealed large tumor in one kidney
Other diagnoses mentioned: Carcinoma of kidney & alveolar soft-part sarcoma.			
#9-Slide: S-2308-58 Dr. Ross McNeely	#1-Eosinophilic leukemia	#1-Megaloblastic anemia secondary to parasitism #2-Post-acute hemolytic picture secondary to lymphoma #3-Myelophthisic picture secondary to sarcoma #4-Eosinophilic leukemia	
Other diagnosis mentioned: Loeffler's fibroplastic endocarditis with eosinophilia.			
#10-Slide: 16786A Dr. Philip S. Vassar	Juvenile naso-pharyngeal angio fibroma	Same	
#11-Slide: OS059-24. S-59-201 Dr. Louise Wiegenstein	Malignant mixed tumor of uterus	Malignant mixed tumor of uterus of embryonal origin ("malignant baby")	Operative specimen reveals metastatic tumor to right ovary with bilateral blood filled ovarian cysts, large intramural leiomyoma of uterus.
#12-Slide: 59-S-45 Dr. Campbell J. Coady	Benign mammary dysplasia; advise to follow closely	Benign mammary dysplasia; no operation recommended.	INTERMEDIATE HYPERPLASIA CRIBIFORM
#13-Slide: S-317-60 Dr. Warren C. Hunter	Cystosarcoma phyllodes (benign)	Same	No clinical recurrence

SLIDE SEMINAR RESULTS page 3

CASE # & CONTRIBUTOR	CONTRIBUTOR'S DIAGNOSIS	DR. SIMARD'S DIAGNOSIS	FOLLOW-UP INFORMATION PRESENTED AT MEETING
#14-Slide: G-59-211 Dr. Clayton Haberman	Malignant mullerian tumor probably sarcoma	Adenomyosis	<i>CARE NO SURVIVAL</i>
#15-Slide: S-3873-59	Teratoma of thyroid	Same	No clinical recurrence
#16-Slide: S-60-4065 Dr. H.H. Pitts	Adenocarcinoma (mesonephroid carcinoma?)	Adenocarcinoma with mucus secretion	
#17-Slide: S-60-2075 Dr. H.H. Pitts	#1- Atypical carcinoma of breast #2- Malignant melanoma	Anaplastic carcinoma (?primary breast)	Primary melanoma apparent on buttock; patient subsequently delivered baby, and now relatively well, although with multiple melanotic metastases.
#18-Slide: Hu-5766 Dr. Raymond F. Hain	Optic nerve glioma, (astrocytoma) intracranial, spongioblastoma polare type.	#1- Laminary meningioma of Ortega #2- Astrocytoma #3- Infundibuloma	
#19- Slide: Hu-3679 Dr. Raymond F. Hain	Optic nerve glioma, intracranial, neuroepithelioma or ependymoma type, (originally regarded as astrocytic from material studied, but concur with Drs. Simard & Dolman that the section in the seminar set is not that of astrocytoma)	Ependymal glioma	

Dr. Hain: "Dr. Dolman's observation that obstructive hydrocephalus rather than visual disturbances was the initial symptom deserves consideration. Clinically however, this was thought to be due to the subdural hematomas. Visual disturbances were never noted, not even terminally, and the clinicians were very chagrined when they saw the autopsy findings."

SLIDE SEMINAR RESULTS page 4

CASE # & CONTRIBUTOR	CONTRIBUTOR'S DIAGNOSIS	DR. SIMARD'S DIAGNOSIS	FOLLOW-UP INFORMATION PRESENTED AT MEETING
#20-Slide: S-60-77-C3 Dr. Raymond F. Hain	<p style="text-align: center;">ORBIT</p> Glioma, optic nerve, intra- orbital, astrocytoma type.	Astrocytoma	
#21-Slide: H_V_5529 Dr. Raymond F. Hain	Calcified sub-ependymal astrocytoma		

One additional slide (unlabeled) is an example of a turban tumor.

- 22 - Pneumatosis cystoides intestinalis -
- 23 - Cylindroma of scalp -