# PACIFIC NORTHWEST SOCIETY OF PATHOLOGISTS

## SLIDE SEMINAR - May 18, 1963

## DIAGNOSES OF SLIDES

| Slide No. | Diagnosis |
|---|---|
| 1. OP844 | Naevus sebaceous - Jadassohn sebaceous adenoma of face |
| 2. A57-545 | Krabbe's cerebral sclerosis NO SLIDE |
| 3. 2682 | (Multiple angiomatosis) Histiocytosis X of bone - |
| 4. 62 S8169 | (Nodular fasciitis) Liposarcoma, low grade, myxoid, of hand - |
| 5. S 62-4054 | Hashimoto's |
| 6. 63-S-2726 | Ectopic salivary gland in maxillary sinus, vs. adenoma - |
| 7. A63-20 | Alcoholic cirrhosis |
| 8. A62-26 | Giant cell hepatitis |
| 9. A63-25 | Giant cell hepatitis |
| 10. RJH 5780 | Glycogen storage of liver |
| 11. A62-187 | Hepatitis |
| 12. A63-41 | Hepatitis |
| 13. A63-151 | Post-hepatic cirrhosis, thyroiditis |
| 14. 62-A-0276 | Commotio hepatis of Donohue |
| 15. A62-208 | Unknown granuloma and burnt out cirrhosis |

PACIFIC NORTHWEST SOCIETY OF PATHOLOGISTS

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Return to: W.H. Chase, M.D.
Department of Pathology
Faculty of Medicine
University of British Columbia
Vancouver 8, B.C., Canada.

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Moderator: W. Stanley Hartroft, B.Sc., M.D., Ph.D.,LL.D.

Case 7 - Slide A63-20

Submitted by Dr. John E. Hill
Sacred Heart Hospital, Spokane.

This 36-year old, obese, colored female was admitted to Sacred Heart Hospital semi-comatose. Her history was not obtainable, from the patient, but her neighbors stated that she had been somewhat of an alcoholic and that in the previous 4-6 weeks before admission, had become practically a recluse within her home, drinking continuously.

Clinical diagnosis on admission was hepatic coma and the various chemistries confirmed this impression. She expired 24 hours after admission.

At autopsy, the liver was tremendously enlarged, weighing 4,720 gm. It was yellowish-green in color and seemed to have an increase in general consistency. The surface was smooth. The gallbladder appeared somewhat edematous but normal otherwise.

Microscopic sections of all the organs were relatively normal with the exception of some early pneumonic changes in the lungs and the liver. Section of the liver is submitted.

Case 12 - Slide A62-187.

Submitted by John I. Antonius, M.D.
The Mason Clinic, Seattle.

An 84-year old female had a history of ankle edema and fatigue of 2½ years duration. She had been receiving analgesics for back pain. Four days prior to admission she was treated with sulfa tablets for diagnosis of kidney infection. She was dyspneic. There were rales in both lung bases. She had a grade III systolic murmur over the precordium with radiation to the carotid area. Blood pressure was 95/50 and pulse 76 per minute. There was 3+ pretibial edema and the liver was 1 cm. below the costal margin. The urine showed 3-4 red cells and 1-4 pus cells per high power field but no other abnormality. Hemoglobin was 8.6 grams; white blood count was 10,078 with 79% segmented cells. Polys appeared toxic. Serum electrolytes were normal. The electrocardiogram showed auricular fibrillation with QRS and ST-T changes consistent with left ventricular hypertrophy and possible anterolateral infarction.

At autopsy there was a fine fibrinous pericarditis and mild hypertrophy and dilatation of all chambers of the heart. The left atrium was considerably dilated and had many small mural thrombi up to .6 cm. in diameter. Lesser numbers were present in the right atrium. Coronary arteries showed no significant sclerosis although there were small pin-point whitish scars in the myocardium. There were some infarcts in the lungs. The liver weighed 1,000 grams. It was irregularly nodular with yellowish-red nodules varying from 3-10 mm. in diameter. These were separated by very thin and delicate fibrous septae. There were numerous enlarged soft retroperitoneal lymph nodes. The spleen was 250 grams. Other viscera showed no significant change.

Case 8 - Slide A62-26

Submitted by Dr. D.K. Merkeley
Lewiston, Idaho.

This newborn girl died on the second day. At birth ecchymoses were noted on the skin over most of the body. There were no other significant clinical findings.

Laboratory findings

Hgb. 11.7 gms. Platelets between 34,000 and 58,000. Coombs negative. Group O, Rh D,c,e.

A sibling born one year prior to this baby had scattered petechiae and ecchymoses over most of the skin surface at birth, the platelet count was 18,000. The total bilirubin was up to 22 mgm %. This child received one exchange transfusion. A check at two months of age, revealed a normal platelet count.

The mother of these children reportedly had a splenectomy for idiopathic thrombocytopenic purpura two years prior to the birth of the last child.

Case 9 - Slide A63-25

Submitted by John I. Antonius, M.D.
The Mason Clinic, Seattle.

This is a 6 pound, 10 ounce female infant born of a 33-year old white female who is gravid 1, and parous 1. Gestation period was 38 weeks. The mother was Rh positive. Gestational history was uneventful. Presentation was cephalic and the child had respiratory difficulty with shallow respirations from birth. Apgar ratings were as follows: Heart 2, respiratory effort 1, reflex stimulation 1, muscle tone 0, color 0. A few hours after birth there was considerable bruising of the left arm, leg and face. There was increasing lethargy with some laryngeal stridor but no definite central nervous system signs. The child stopped breathing 32 hours after birth.

At autopsy there were petechial hemorrhages and some ecchymosis in the skin. The small bowel had some petechial hemorrhages and the lungs were slightly heavy and hemorrhagic. The liver was pale, being yellowish-red in color but having normal surface markings and topography, It was slightly increased in firmness. Other viscera showed no significant change.

Case 10 - RJH 5780
- S.D. age 3 years. wt. 24 lbs. male.

Submitted by Dr. R.G.D. McNeely
Jubilee Hospital, Victoria, B.C.

First admitted in Sept. 1961 with a large abdominal mass thought to be liver. Laparotomy done and this biopsy taken. The liver contained a large yellow-brown mass occupying most of the right lobe and extending into the left lobe. It was not considered removable by the surgeon, who thought it was a tumor and not a storage disorder. We called it a well differentiated hepatoma. The child was not investigated chemically at this time and was discharged on a low fat, high protein diet.

Continued next page

Case 5 - Continued

He was readmitted in Jan. 1963 (age 3) at the above weight, having learned to walk with difficulty. The liver was well below the umbilicus and filled the entire RLQ, bulging into the LLQ. The surface and edge were smooth and hard and the organ was not tender. His general growth was retarded, his toe nails showed practically no growth. The spleen is now enlarged 4 fingers below the left costal margin. Chest and skull X-rays are normal. T.A. was done since there was obstruction to the breathing. There was some hemorrhage post-operatively.

| Lab. findings: Glucose tolerance: | Blood | Urine | Time |
|---|---|---|---|
| | 72 mgms/100 ml | no spec. | fasting |
| | 82 | 0 | ½ hr. |
| | 104 | 0 | 1 hr. |
| | 98 | 0 | 2 hr. |
| | 80 | 0 | 2½ |
| | 62 | 0 | 3 hr. |
| Gluc. tolerance with ACTH: | 70 | 0 | |
| | 220 | no spec. | |
| | 216 | 0 | |
| | 170 | 0 | |
| urinary and serum ketones | 134 | 0 | |
| were negative. | 100 | 0 | |

Liver function tests:

| | |
|---|---|
| direct bilirubin | 0.1 mgs./100 ml. |
| total bilirubin | 0.8 " |
| total protein | 8 grams " |
| albumin | 4 grams " |
| globulin | 4 grams " |
| thymol turbidity | 4 units |
| thymol flocculation | plus 2 |
| cholesterol | 235 mgms./100 m. |
| Chol. esters | 62% |

Enzymes:

S.G.O.T. 56 units
S.G.P.T. 31 units
Glucose-6-phosphate normal
Erythrocyte glycogen 125 microgms. /gms. hbg.
Amino acid chromatogram-urine
taurine ++ methionine +
ethanolamine +
Analine, tyrosine, glutamine, glycine all normal

(Above tests done on latest admission).

Submitted by Warren C. Hunter, M.D.
Portland Sanitarium and Hospital, Oregon.

Case 6 - Slide OP 844, 1963.

Male, 13 years of age; growth from scalp superior to one ear. Increased from small pea-sized nodule to 6.5 by 1.75 cm. in 9 months time; bleeds when hair is combed.

The piece of skin from a hairy area measures 6.5 by 2 by 0.4 cm. Starting 6 mm. from one end and centrally located is a brown and rough-surfaced, slightly raised area while from here onward toward the other end the seemingly hairless skin centrally is slightly yellow in contrast to the white skin peripherally. On sectioning the subcutaneous connective tissue is faintly yellowish underneath the discolored skin.

Submitted by Dr. C.L. Dolman
Vancouver General Hospital.

Case 2 - Slide A57-545

This baby girl came from a healthy family and had a normal elder sister. There was some difficulty feeding since birth but she seemed to develop normally and was able to hold up her head at 3 months. Then, rapid deterioration set in. She became spastic and died of pneumonia at the age of 6 months. Two years later, a younger male infant of the same parents had an identical illness with the same pathological findings. Grossly the brain was atrophic, hard like wood except for the cerebral and cerebellar cortices. Tiny areas of cystic degeneration were aligned along the outer borders of the thalami and larger cysts partly replaced the pyramids in the medulla.

Submitted by Dr. R. English
St. Paul's Hospital, Vancouver.

Case 12 - Slide A63-41

This 3 year old boy lived with his parents in almost complete isolation in a remote lighthouse. His illness began with fever and severe abdominal pain, and a few days later he became jaundiced. On admission to hospital there was generalized icterus, the liver was enlarged 4 cms. below the costal margin and was tender. The spleen was not palpable. Urinalysis showed 15 - 20 WBC per HPF and a few granular casts. Hgb. 10.5 gms %. Prothrombin time ranged between 27 and 10% of normal. Serum bilirubin: total 35 - 78 mgms %, direct 18.5 - 35.5 mgms %. SGOT over 200 units. BUN varied from 90 - 140 mgms %. Total protein 4.0 gms %. Albumin 2.7, globulin 1.3. Seven days after admission a discrete macular rash developed over the arms, legs and face. Two weeks after admission he had a severe nose bleed. He was very lethargic. Ascites developed, with peripheral edema and pulmonary rales. He gradually became semicomatose and died five weeks after admission, or about six weeks after the onset of his illness.

Submitted by Clermont S. Powell, M.D.
Seattle, Wash.

Case 15 - Slide A62-208

This 17 year old Caucasian male was apparently in good health until August 26, 1962 when he noted general malaise, tiredness, moderate nausea, lower back pain and had dark stools for about three days. On examination a firm, tender, palpable liver was noted. X-ray studies showed ascites and esophageal varices. Hemoglobin was 8.5 gm %. Stools were guaiac positive. Four weeks later the patient was noted to have splenomegaly. He developed signs and symptoms of progressive hepatic failure and died three months after initial examination.

There was no history of previous hepatitis, exposure to toxins or hepatitis, recent transfusions or familial hepatobiliary disease. A history suggestive of nutritional deficiency in childhood was present.

Case 3 - 2682

Submitted by Dr. P. Vassar
Department of Pathology, UBC.

This 4 year old boy was first seen at the age of 6 months because of slow development and multiple skeletal defects. He was found to have many osteolytic bone lesions on X-ray. During the following years the liver became enlarged and nodular, and a retroperitoneal mass developed. All laboratory work was reported as normal; there were no blood abnormalities. His most recent admission was due to a pathological fracture and the tissue submitted is a biopsy from this site.

Case 4 - #62-S-8169

Submitted by Dr. C. Coady
Royal Columbian Hospital.

This 40-year old male first developed a "tumour" in the palm of his hand in 1954. This lesion was resected and considered to be a benign fibrous tumour.

The lesion recurred in 1958 and was re-resected. It recurred in 1959 and extended through to the back of the hand for the first time. A "picking" type of procedure removed all of the grossly visible tumour and left a functioning hand.

In 1962 the lesion recurred for the fourth time. The enclosed sections demonstrated fairly well the nature of the disease at the time of the fourth recurrence.

Case 5 - S-62-4054.

Submitted by Dr. T.R. Harmon
Lions Gate Hospital, Vancouver.

Mrs. E.R. age 46 first noted a lump in the lower neck anteriorly in the middle of September, 1962. This was not associated with any symptoms of pressure or changes in her general health. The right and left lobes of the thyroid gland could be palpated on each side of a central lump which appeared to be continuous with the lobes. The mass moved with swallowing, and was not tender or fixed. She was considered to have a nodular, non-toxic goitre and surgery was performed on October the 15th, 1962. A sub-total resection of both lobes including the isthmus was performed. The gross specimen weighed 8 grams. There was a large clear 1 cm. cyst present in the isthmus and many small cysts present throughout both lobes.

Case 6 - #63-S-2726.

Submitted by Dr. C. Coady
Royal Columbian Hospital.

This 46-year old female suffered from increasing nasal obstruction over the course of some two years. The obstruction started on the right side, but during the two or three months prior to operation became bilateral. There was an associated progressive loss of hearing in the right ear.

On physical examination, there was a large tumour arising from the right maxillary sinus, obstructing the right nares and deviating the septum to almost completely occlude the left nares as well. The tumour measured up to 4 cm. in diameter.

Case 13 - A-63-151

Submitted by W.H. Chase, M.D
Dept. of Pathology, UBC.

This was a 78-year old lady with longstanding history of gastro-intestinal bleeding in the past 10 years which necessitated several admissions to the Vancouver General Hospital for blood transfusions. A surgical procedure was considered to reduce the portal pressure, but because of diabetes, obesity and the patient's age, it was decided that she should carry on with conservative management with blood replacement as necessary. An interesting point in the past history of this elderly lady is a prolonged history of jaundice about 30 to 35 years prior to her death. The last admission was on February 19th, 1963, at which time she was admitted with the main complaint of upper and lower gastro-intestinal bleeding. She expired on February 23rd, 1963, following a massive gastro-intestinal hemorrhage.

Gross autopsy findings were as follows: There was about 300 cc's of straw colored fluid in the peritoneal cavity. The esophagus contained large, dilated vessels with a perforation about 2 mms. in length, about 5 cms. from the cardia of the stomach. The liver weighed 1110 gms., and was finely nodular, yellow and pale in color. On cut section, strands of fibrous tissue could be seen which surrounded the parenchyma of the liver. The rest of the organs appeared normal.

Slides of liver and thyroid are submitted.

Case 14 - #62-AO-276

Submitted by Dr. C. Coady
Royal Columbian Hospital.

This 4 month old female infant was a passenger in an automobile involved in a car accident. The child was violently propelled through the windshield and taken to hospital immediately. She died within half an hour of admission (45 minutes from the time of the accident), due to severe head injuries.