

SEM 561

CALIFORNIA TUMOR TISSUE REGISTRY
LOS ANGELES COUNTY - UNIVERSITY OF SOUTHERN CALIFORNIA
PROTOCOL
FOR
MONTHLY STUDY SLIDES
MAY 1984
BONE TUMORS I

CONTRIBUTOR: Donald R. Rankin, M. D.
Fontana, California

MAY 1984 - CASE NO. 1

TISSUE FROM: Foot

ACCESSION NO. 24873

CLINICAL ABSTRACT:

History: This 70 year old woman had a slowly growing soft tissue mass on the plantar aspect of the foot beneath the 4th and 5th metatarsal heads, causing tenderness and difficulty in walking.

Radiographs: A soft tissue mass between the right 4th and 5th metacarpophalangeal joints with irregular calcifications was seen. No bony destruction was present.

SURGERY: (March 21, 1983)

The lesion popped-up and shelled out easily from the subcutaneous tissue near the 4th metatarsal head. A connection to synovial tissue was noted, but no finger-like tumor extensions.

GROSS PATHOLOGY:

An ovoid 3.6 x 3 x 2.2 cm. solid, cartilaginous tumor was white-tan to slightly pink in color. The margins were moderately distinct.

FOLLOW-UP:

The patient has done well with no recurrence as of 4/84.

CONTRIBUTOR: Jules A. Kernan, M. D.
Los Angeles, California

MAY 1984 - CASE NO. 2

TISSUE FROM: 8th thoracic vertebral body

ACCESSION NO. 25062

CLINICAL ABSTRACT:

History: A 73 year old man presented with an intermittent pain in the right costovertebral angle of 3 months' duration. This pain radiated to the right flank.

Physical examination: The back was painful to palpation.

Radiographs: The chest x-ray showed a 4 x 5 cm. mass in the posterior mid-portion of the right lung, not present a year earlier. CT scan showed a 5-6 cm. tumor destroying the posterior aspect of the 8th rib and body of the T8 vertebra including the pedicle and lamina on the right, with spinal canal encroachment. X-ray of the spine showed lytic destruction of the right aspect of the T8 vertebral body and proximal 8th rib. A myelogram revealed a block at T8.

SURGERY: (September 27, 1983)

The mass was adjacent to the T8 vertebral body, with projection in the vertebral body and spinal canal. Resection was performed with internal spinal fixation, bone graft, and muscle flap reconstruction.

GROSS PATHOLOGY:

The en bloc dissection was composed of 3 rib segments, skeletal muscle, pleura, and tumor mass. The 10 x 9 x 6 cm. mass was a multilobular, gelatinous, yellow gray soft tissue with focal hemorrhage. White fibrous septae divided the tissue into lobules. The tumor destroyed the 8th rib and protruded under the parietal pleura. Focal hard areas were in the overlying pleura.

FOLLOW-UP:

As of April 12, 1984 patient is alive and well without evidence of recurrence.

CONTRIBUTOR: Jules A. Kernan, M. D.
Los Angeles, California

MAY 1984 - CASE NO. 3

TISSUE FROM: Femoral neck

ACCESSION NO. 24771

CLINICAL ABSTRACT:

History: A 32 year old woman was found to have a lytic lesion of the right femoral neck. No history of trauma or other medical complaints was elicited. A biopsy was performed 6/2/82.

SURGERY: (December 27, 1982)

Resection of the lesion was performed.

GROSS PATHOLOGY:

Multiple fragments up to 2.5 cm. were obtained. Some areas were yellow and white with focal calcific spicules. Firm bony areas and soft yellow-white foci were seen.

FOLLOW-UP:

The patient was last seen a few months ago, at which time she was well though the defect had not healed completely. There was no evidence of recurrence.

CONTRIBUTOR: Paul Roth, M. D.
Los Angeles, California

MAY 1984 - CASE NO. 4

TISSUE FROM: Tibia

ACCESSION NO. 24995

CLINICAL ABSTRACT:

History: A 28 year old man presented in April 1983 with pain and increased swelling of the right leg. He was initially seen in February 1981 when a basketball injury of the right knee prompted an x-ray. A 9 cm. mass of the proximal tibia extended from the epiphysis into the diaphysis. The tumor margins were well defined with some sclerosis of the margin and moderate calcification or ossification within the mass. A pathologic fracture through the inferior aspect of the mass was present. Biopsy revealed bony spicules with chronic inflammation, hemosiderin laden macrophages, but no tumor. The patient was lost to followup for the next two years.

Radiographs: Most of the proximal 11-12 cm. of tibia were involved by a lytic, sclerotic lesion. It extended into the tibial shaft and adjacent soft tissues. Chest x-ray was negative.

SURGERY: (April 1983)

A soft tissue mass with fibrous consistency was found to extend out of the tibia. The cortex of the proximal tibia was destroyed. Friable tumor extended into the medullary cavity. A biopsy was performed.

GROSS PATHOLOGY:

A 20 cc. aggregate of tissue with cartilaginous and firm areas was received. Multiple tiny calcific foci were present.

FOLLOW-UP:

Methotrexate was given without response. Above the knee amputation was performed 6/28/83. A huge cavity involving the proximal 15 cm. of the tibia showed cortical erosion. Bands of white firm tumor protruded from the sides of the defect into the middle of the cavity. There was extension through the cartilaginous plate of the medial condyle. Adjuvant chemotherapy was given for 6 months (cis-platinum, adriamycin, cytoxan, bleomycin, and actinomycin-D). At present the patient is well and no evidence of malignancy is found.

CONTRIBUTOR: Henry Tesluk, M. D.
Sacramento, California

MAY 1984 - CASE NO. 5

TISSUE FROM: Fibula

ACCESSION NO. 24056

CLINICAL ABSTRACT:

History: A 14 year old boy presented with a one week's history of right proximal fibula swelling, first noted after being kicked in the leg. Three to four months earlier he had noted a dull, aching leg pain aggravated by exercise. He had lost 10 lbs in the past month.

A biopsy was performed 8/9/80. A gray-white, soft, nonencapsulated, gelatinous mass was found, expanding against the overlying muscle. The fibula was focally destroyed. A 5 x 10 cm. cystic mass filled with serosanguineous fluid was discovered in the mass.

SURGERY: (October 3, 1980)

Fibulectomy and local tumor excision was performed.

GROSS PATHOLOGY:

An 11 x 8 x 7 cm. tumor replaced the entire proximal fibula, with irregular splaying of the distal bone. The tumor contained numerous blood-filled cystic spaces, up to 3 cm. in diameter. Necrosis and hemorrhage were prominent. Surgical margins were not involved by tumor.

FOLLOW-UP:

Local chemotherapy was given adjunctively as of 1/3/84(3 years and 2 months post-surgery) he had no evidence of recurrence. There was a slight residual foot drop and 3/5 plantar flexion.

CONTRIBUTOR: Robert E. Wybel, M. D.
Bakersfield, California

MAY 1984 - CASE NO. 6

TISSUE FROM: Tibia

ACCESSION NO. 24584

CLINICAL ABSTRACT:

History: A 51 year old man presented with knee discomfort.

Radiographs revealed a lesion of the proximal tibia.

SURGERY: (March 9, 1982)

Biopsy of the left tibia was followed by curettage of the medullary cavity and bone grafting.

GROSS PATHOLOGY:

More than 50 grams of ragged irregular fragments with a pale white, glistening, cartilaginous appearance were received. Focal calcification was prominent.

FOLLOW-UP:

Above the knee amputation of the left leg was performed. A 6 x 4 x 4 cm. curetted neoplasm of the tibia had expanded laterally, distally, and anteriorly through the cortex into the soft tissues. The gray-white tumor had extended proximally to within 1.5 cm. of the epiphyseal plate.

He was last seen 7/19/83 at which time he was able to work and had no evidence of disease.

CONTRIBUTOR: Robert Rosser, M. D.
Van Nuys, California

MAY 1984 - CASE NO. 7

TISSUE FROM: Left foot

ACCESSION NO. 24642

CLINICAL ABSTRACT:

History: A 32 year old male was well until three months prior to admission when he sprained his ankle. He stated that the swelling never subsided, despite continued physical therapy.

Physical examination: There was tenderness over the antero-lateral ankle ligaments with prominent fusiform swelling. The mass did not transilluminate, and aspiration attempts yielded no fluid.

Radiographs: An x-ray showed soft tissue swelling with spiculated calcification.

SURGERY: (August 5, 1982)

A large, somewhat encapsulated tumor was found beneath the superficial fascia of the sinus tarsi, extending proximally toward the ankle joint and distally toward the cuneiforms. Short extensor foot muscle appeared invaded. Once the tumor was removed, an extension deep into the sinus tarsi was noted, but not removed.

GROSS PATHOLOGY:

The specimen consisted of gray-white, gelatinous, soft tissue which measured 5 x 4 x 4 cm. Cut surfaces were gritty and "stringy".

FOLLOW-UP:

The patient was referred to UCLA, where leg saving re-excision of the local area was performed. He currently has no evidence of recurrence, and is doing well.

CONTRIBUTOR: Herbert Harder, M. D.
Glendale, California

MAY 1984 - CASE NO. 8

TISSUE FROM: Thoracic vertebrae

ACCESSION NO. 23328

CLINICAL ABSTRACT:

History: A 76 year old woman complained of numbness of the legs and inability to walk for several days. She had a 25 year history of Paget's disease of bone.

Physical examination: No adenopathy or organomegaly

Laboratory findings: Alkaline phosphatase 350

Radiographs: A sclerotic lesion of the C4 vertebral body was seen. Myelogram demonstrated complete block to cephalad flow at the T7 level.

SURGERY: (January 17, 1979)

Thoracic laminectomy was performed. A large fibrous mass was found at the site of decompression at level T6-9.

GROSS PATHOLOGY :

The specimen was received in two pieces of firm, pink to red gritty tissue measuring up to 2.3 cm. in diameter.

FOLLOW-UP:

She was given steroids and 5000 rads to T5-10 over the next 3 months. She died nearly one year after surgery. No autopsy was performed.

CONTRIBUTOR: George Hummer, M. D.
Santa Monica, California

MAY 1984 - CASE NO. 9

TISSUE FROM: Femur

ACCESSION NO. 24393

CLINICAL ABSTRACT:

History: A 29 year old woman first noted right knee pain in February 1981. Two months later the pain was present in the upper anterior thigh. She described a burning feeling and slight enlargement of the upper thigh during the last few weeks. No trauma history was elicited.

Physical examination: No abnormalities were noted.

Radiographs: A largely radiolucent lesion involving the femoral neck, trochanter, and subtrochanteric region was seen initially. Some areas of increased density were noted, especially near the greater trochanter. The cortex appeared intact.

SURGERY:

A biopsy of the femoral trochanter was performed 8/13/81 followed by resection of the tumor 9/4/81.

GROSS PATHOLOGY:

Eighteen grams of morcellated, granular, red-tan tissue with spicules of bony tissue were obtained.

FOLLOW-UP:

She received intra-arterial local perfusion of the tumor site with several drugs, including adriamycin, in November 1981. En-bloc dissection at UCLA followed, with additional chemotherapy afterwards. She has no evidence of recurrence as of 4/12/84.

CONTRIBUTOR: J. J. Bocian, M. D.
Fresno, California

MAY 1984 - CASE NO. 10

TISSUE FROM: Left lateral femoral epicondyle

ACCESSION NO. 22815

CLINICAL ABSTRACT:

History: A 74 year old male complained of pain in the left knee.

Radiographs: X-ray of the left knee revealed a pathologic fracture through the left lateral condyle of the distal femur. A 6 x 5 cm. lytic lesion was identified in the left lateral aspect of the femoral metaphysis just superior to the condyle. The borders of the lesion were sharp and sclerotic.

SURGERY: (February 14, 1978)

The bone cyst was curetted.

GROSS PATHOLOGY:

Multiple pieces of soft, light tan to brown tissue which measured 6.0 cm. in aggregate were received.

FOLLOW-UP:

The patient was readmitted in November, 1982 in severe heart failure. There was no evidence of recurrent or metastatic tumor at that time.

CONTRIBUTOR: Roger Terry, M. D.
Los Angeles, California

MAY 1984 - CASE NO. 11

TISSUE FROM: Humerus

ACCESSION NO. 25199

CLINICAL ABSTRACT:

History: A 17 year old boy was admitted December 5, 1979 with swelling of his right distal humerus of one year duration. Six weeks prior to admission he twisted his arm while swinging a baseball bat and experienced pain and swelling around the mass. X-rays revealed a pathological fracture, and he was referred to LAC-USC Medical Center in a long-arm cast. A needle biopsy was performed on admission.

Physical examination: The right upper extremity had a nontender, hard mass on the distal humerus, most prominent anteromedially.

Radiographs revealed pathological fracture of the distal humerus with some healing.

SURGERY: (December 18, 1979)

A white, glistening tumor attached to the humerus was found. Curettage and bone grafting were performed.

GROSS PATHOLOGY:

An 11.5 x 8 x 3 cm., 165 gram ovoid mass had a fleshy, hemorrhagic appearance with multiple scattered, blood-filled cysts. The largest cyst was 5 x 3 x 1 cm. One surface was smooth and glistening, the other having multiple attached bony spicules.

FOLLOW-UP:

The humerus healed completely over the next 1½ years and the patient regained full use of the extremity. He was well at his last clinic visit in 1982.

CONTRIBUTOR: Robert E. Riechmann, M. D.
Kenneth A. Frankel, M. D.
Covina, California

MAY 1984 - CASE NO. 12

TISSUE FROM: Ulna

ACCESSION NO. 23765

CLINICAL ABSTRACT:

History: A 25 year old woman presented with swelling of the distal right ulna of short duration.

SURGERY: (January 30, 1980)

The distal ulna was resected.

GROSS PATHOLOGY:

A 4.5 x 2.5 x 2 cm. piece of ulna had a bulging external surface with paper thin, intact cortex. The expanded medullary portion is replaced by firm, white tissue within which there is focal yellow-brown discoloration. The tumor extended to within 1 cm. of the proximal resection margin.

FOLLOW-UP:

The patient was last seen 9/12/83 and was alive and well.

STUDY GROUP CASES
FOR
MAY 1984

CASE NO. 1 - ACCESSION NO. 24873

LOS ANGELES: Chondroma - 10

SAN FRANCISCO: Soft tissue chondroma - 12

MARTINEZ: Synovial chondromatosis - 8

OAKLAND: Extraskeletal chondroma - 9

LONG BEACH: Paraarticular chondroma - 8; synovial chondromatosis - 2

BAKERSFIELD: Synovial chondromatosis - 7

SACRAMENTO: Extraskeletal chondroma - 1

SAN BERNARDINO (INLAND): Tenosynovial chondromatosis - 14

WEST SAN FERNANDO VALLEY: Low-grade chondrosarcoma - 2

SEATTLE: Benign cartilaginous soft tissue tumor - 4

FILE DIAGNOSIS:

Cartilage tumor, foot

REFERENCES:

Chung, E. B. and Enzinger, F. M.: Chondroma of Soft Parts. Cancer
41:1414-1424, 1978.

Dahlin, D. C. and Salvador, A. H.: Cartilaginous Tumors of the Soft
Tissues of the Hand And Feet. Mayo Clin. Proc. 49:721-726, 1974.

CASE NO. 2 - ACCESSION NO. 25062

MAY 1984

LOS ANGELES: Chordoma - 5; myxoid chondrosarcoma - 5

SAN FRANCISCO: Fibrosarcoma, NOS - 1; nerve sheath tumor, myxoid variant - 6;
chondromyxoid fibroma - 3; myxoid chondrosarcoma - 2

MARTINEZ: Mesenchymal chondrosarcoma - 5; malignant mesenchymoma - 3;
chondromyxoid fibroma - 1

OAKLAND: Myxoid chondrosarcoma - 10; chordoma - 1

LONG BEACH: Myxoid chondrosarcoma - 6; chordoma - 3; myxoid malignant
fibrous histiocytoma - 1

BAKERSFIELD: Neurilemmoma - 2; chondromyxoid fibroma - 5

SACRAMENTO: Extraskkeletal myxoid chondrosarcoma (chordoid) - 1

SAN BERNARDINO (INLAND): Myxoid chondrosarcoma - 5; schwannoma - 5;
chondromyxoid fibroma - 4

WEST SAN FERNANDO VALLEY: Myxoid liposarcoma - 1; malignant myxoma - 1

SEATTLE: Chordoma - 2; benign nerve sheath tumor 2

FILE DIAGNOSIS:

Chordoma, 8th thoracic vertebral body

CASE NO. 3 - ACCESSION NO. 24771

MAY 1984

LOS ANGELES: Fibrous dysplasia - 10

SAN FRANCISCO: Fibrous dysplasia - 14

MARTINEZ: Fibrous dysplasia - 9

OAKLAND: Fibrous dysplasia - 11

LONG BEACH: Fibrous dysplasia - 10

BAKERSFIELD: Fibrous dysplasia - 7

SACRAMENTO: Fibrous dysplasia - 1

SAN BERNARDINO (INLAND): Fibrous dysplasia - 14

WEST SAN FERNANDO VALLEY: Non-ossifying fibroma (fibrous cortical defect) - 2

SEATTLE: Fibrous dysplasia - 4

FILE DIAGNOSIS:

Fibrous dysplasia, femoral neck

CASE NO. 4 - ACCESSION NO. 24995

MAY 1984

LOS ANGELES: Osteosarcoma - 10

SAN FRANCISCO: Osteosarcoma, well differentiated - 12

MARTINEZ: Osteosarcoma - 9

OAKLAND: Chondroblastic osteosarcoma - 11

LONG BEACH: Osteogenic sarcoma - 10

BAKERSFIELD: Osteogenic sarcoma - 6; malignant fibrous histiocytoma - 1

SACRAMENTO: Low grade osteosarcoma, predominantly fibrous type - 1

SAN BERNARDINO (INLAND): Osteosarcoma - 14

WEST SAN FERNANDO VALLEY: Fibrosarcoma - 1; sarcoma (NOS) - 1

SEATTLE: Osteosarcoma - 4

FILE DIAGNOSIS:

Osteosarcoma, tibia

CASE NO. 5 - ACCESSION NO. 24056

MAY 1984

LOS ANGELES: Osteosarcoma - 6; chondrosarcoma - 4

SAN FRANCISCO: Telangiectatic osteosarcoma - 2; chondroblastoma - 1;
chondroblastic sarcoma - 9

MARTINEZ: Chondrosarcoma - 9

OAKLAND: Chondrosarcoma - 11

LONG BEACH: Osteogenic sarcoma - 9; chondrosarcoma - 1

BAKERSFIELD: Chondrosarcoma - 7

SACRAMENTO: Osteosarcoma, chondroblastic type - 1

SAN BERNARDINO (INLAND): Chondrosarcoma - 11; chondroblastic
osteosarcoma - 2; cystic chondroblastoma - 1

WEST SAN FERNANDO VALLEY: Chondrosarcoma, grade III - 2

SEATTLE: High grade sarcoma, probably osteosarcoma - 4

FILE DIAGNOSIS:

Clear cell chondrosarcoma, fibula

CONSULTATION:

C. P. Schwinn, M. D. (U.S.C.): Telangiectatic osteosarcoma.

REFERENCES:

Charpentier, Y. L., et al: Clear Cell Chondrosarcoma. Cancer
44:622-629, 1979.

CASE NO. 6 - ACCESSION NO. 24584

MAY 1984

LOS ANGELES: Low grade chondrosarcoma - 10

SAN FRANCISCO: Chondrosarcoma - 11; chondrosarcoma arising in enchondroma - 3

MARTINEZ: Well differentiated chondrosarcoma - 9

OAKLAND: Chondrosarcoma - 11

LONG BEACH: Chondrosarcoma - 10

BAKERSFIELD: Low grade chondrosarcoma - 7

SACRAMENTO: Chondrosarcoma - 1

SAN BERNARDINO (INLAND): Low grade chondrosarcoma - 14

WEST SAN FERNANDO VALLEY: Chondrosarcoma - 2

SEATTLE: Low grade chondrosarcoma - 5

FILE DIAGNOSIS:

Low grade chondrosarcoma, tibia

CONSULTATION:

D. C. Dahlin, M. D. (Mayo Clinic): Chondrosarcoma (grade II).

CASE NO. 7 - ACCESSION NO. 24642

MAY 1984

LOS ANGELES: Mesenchymal chondrosarcoma - 10

SAN FRANCISCO: Synovial sarcoma - 3; sarcoma, NOS - 7; mesenchymal chondrosarcoma - 4

MARTINEZ: Synovial sarcoma - 4; localized modular synovitis - 2; malignant fibrous histiocytoma - 2

OAKLAND: Mesenchymal chondrosarcoma - 9; malignant schwannoma - 1

LONG BEACH: Mesenchymal chondrosarcoma - 9; synovio-sarcoma - 1

BAKERSFIELD: Mesenchymal chondrosarcoma - 7

SACRAMENTO: Dedifferentiated chondrosarcoma - 1

SAN BERNARDINO (INLAND): Monophasic synovial sarcoma - 10; high grade (mesenchymal) chondrosarcoma - 4

WEST SAN FERNANDO VALLEY: Mesenchymal chondrosarcoma - 2

SEATTLE: Sarcoma, possibly clear cell type - 4

FILE DIAGNOSIS:

Mesenchymal chondrosarcoma, foot

REFERENCES:

Salvador, A. H, et al.: Mesenchymal Chondrosarcoma - Observations on Thirty New Cases. Cancer 28:605-615, 1971.

CASE NO. 8 - ACCESSION NO. 23328

MAY 1984

LOS ANGELES: Osteosarcoma arising in Paget's disease - 9; chondrosarcoma arising in Paget's disease - 1

SAN FRANCISCO: Osteosarcoma, osteosclerotic type - 12

MARTINEZ: Osteosarcoma arising in Paget's disease - 9

OAKLAND: Osteosarcoma arising in Paget's disease - 10

LONG BEACH: Osteogenic sarcoma - 10

BAKERSFIELD: Sarcoma arising in Paget's disease - 7

SACRAMENTO: Osteosarcoma in pre-existing Paget's disease - 1

SAN BERNARDINO (INLAND): Osteosarcoma arising in Paget's disease - 14

WEST SAN FERNANDO VALLEY: Osteogenic sarcoma arising in osteitis deformans - 2

SEATTLE: Osteosarcoma in Paget's disease - 5

FILE DIAGNOSIS:

Chondrosarcoma developing in Paget's disease, thoracic vertebrae

REFERENCES:

McKenna, R. J., Schwinn, C. P., et al: Osteogenic Sarcoma Arising in Paget's Disease. Cancer 17:42-66, 1964.

LOS ANGELES: Osteosarcoma - 10

SAN FRANCISCO: Osteosarcoma, osteoblastic type - 8; osteoblastoma, aggressive - 6.

MARTINEZ: Osteosarcoma - 6; osteoblastoma - 3

OAKLAND: Osteosarcoma - 9; aggressive osteoblastoma - 1

LONG BEACH: Aggressive osteoblastoma - 10

BAKERSFIELD: Osteosarcoma - 6; osteoblastoma - 1

SACRAMENTO: Osteosarcoma - 1

SAN BERNARDINO (INLAND): Osteosarcoma - 9; osteoblastoma - 3; adamantinoma - 2

WEST SAN FERNANDO VALLEY: Adamantinoma of bone - 2

SEATTLE: Osteosarcoma, osteoblastic type - 2

FILE DIAGNOSIS:

Osteoblastoma, femur

CONSULTATION:

C. P. Schwinn, M. D. (U.S.C.): Initially examined this case in 1981 at which time he thought this was an osteoblastoma. He reviewed the conference slides in May, 1984 and now feels this may be an osteosarcoma.

REFERENCES:

Schajowicz, F.: Malignant Osteoblastoma. J. Bone and Joint Surg. 58B:202-211, 1976.

CASE NO. 10 - ACCESSION NO. 22815

MAY 1984

LOS ANGELES: Non-ossifying fibroma (fibrous cortical defect) - 10

SAN FRANCISCO: Fibrous histiocytoma of bone - 6; giant cell tumor, fibrous variant - 4; non-ossifying fibroma - 2

MARTINEZ: Fibrous histiocytoma (xanthofibroma) - 6; aneurysmal bone cyst - 2; malignant fibrous histiocytoma - 1

OAKLAND: Fibrous histiocytoma - 10

LONG BEACH: Benign fibrous histiocytic lesion, rule out brown tumor - 10

BAKERSFIELD: Giant cell tumor - 1; xanthofibroma - 6

SACRAMENTO: Malignant fibrous histiocytoma - 1

SAN BERNARDINO (INLAND): Fibroxanthoma - 12; giant cell tumor - 2

WEST SAN FERNANDO VALLEY: Giant cell tumor - 2

SEATTLE: Non-ossifying fibroma with fracture injury - 4; benign giant cell tumor - 1

FILE DIAGNOSIS:

Non-ossifying fibroma, femoral epicondyle

CASE NO. 11 - ACCESSION NO. 25199

MAY 1984

LOS ANGELES: Aneurysmal bone cyst - 10

SAN FRANCISCO: Aneurysmal bone cyst - 12

OAKLAND: Aneurysmal bone cyst - 7; giant cell tumor - 3

LONG BEACH: Aneurysmal bone cyst - 10

BAKERSFIELD: Aneurysmal bone cyst - 7

SACRAMENTO: Giant cell tumor in aneurysmal bone cyst - 1

SAN BERNARDINO (INLAND): Aneurysmal bone cyst - 14

WEST SAN FERNANDO VALLEY: Aneurysmal bone cyst - 2

SEATTLE: Aneurysmal bone cyst - 3; benign giant cell tumor - 1

FILE DIAGNOSIS:

Aneurysmal bone cyst, humerus

CASE NO. 12 - ACCESSION NO. 23765

MAY 1984

LOS ANGELES: Giant cell tumor - 10

SAN FRANCISCO: Giant cell tumor - 12

OAKLAND: Giant cell tumor vs "Brown Tumor" of hyperparathyroidism - 10

LONG BEACH: Giant cell tumor - 10

BAKERSFIELD: Fibrous cortical defect - 4; giant cell tumor - 3

SACRAMENTO: Giant cell tumor - 1

SAN BERNARDINO (INLAND): Giant cell tumor - 14

WEST SAN FERNANDO VALLEY: Giant cell tumor - 2

SEATTLE: Giant cell tumor - 5

FILE DIAGNOSIS:

Giant cell tumor, ulna