1357

PROTOCOL

FOR

MONTHLY SLIDES

October, 1956

TUMOR TISSUE REGISTRY

LOS ANGELES COUNTY HOSPITAL

CASE NO. 1 October, 1956.

ACCESSION NO. 8466 OUTSIDE NO. S-56-240.

NAME: B. A.

AGE: 17 SEX: Female RACE: Cauc.

CONTRIBUTOR: Lawrence L. Frost, M.D.,
Alta Vista Hospital,
Pasadena , California.

TISSUE FROM: Cervical lymph node.

CLINICAL ABSTRACT:

History: Two months prior to admission on February 10th, 1956, this patient had an acute follicular pharyngitis with enlargement of the cervical lymph nodes. She was treated with penicillin and responded well with all nodes disappearing, except for one group in the left anterior cervical chain.

Laboratory findings: February 9th, 1956: Rbc 3.7 m., Wbc 11, 200, Hb 10.5 gms., polys 58%, lymphs 33, monos 6, eos. 3. Red cells showed slight anisocytosis and hypochromasia. The white cells showed slight toxic granulations.

Sed. rate (Westergren) 39 mm. in one hour.

Urine was negative except for 8-10 rbc/HPF. Heterophile antibody test-positive in 1: 56 dilution.

February 13th, 1956: Rbc 3.9 m. Wbc 7,100, Eg. 11-1, polys 54%, lymphs 28, monos 12, eos. 6. Rbc normal.

X-ray showed mitral configuration of the heart. There was no evidence of calcification or other abnormality of the soft tissues of the neck.

Surgery: On February 10th, 1956, the persistent nodes in the left anterior cervical chain were biopsied.

Gross pathology: The specimen consisted of a large irregular mass 5.2 cm. in diameter and 1.2 cm. in thickness. The surface was covered by a thin translucent light-tan capsule which appeared to be intact. Cut sections revealed finely granular, light tan surfaces showing irregular gray-white trabeculation. Also presented was a 1.5 cm. lymph node, cut sections of which were not remarkable.

CASE NO. 2 October, 1956

ACCESSION NO. 8426 OUTSIDE NO. SP 55-16024

NAME: G. T.

AGE: 26 SEX: Female RACE: Cauc.

CONTRIBUTOR: W. K. Bullock, M.D.,
Los Angeles County Hospital,
Los Angeles, California.

TISSUE FROM: Inguinal mass.

CLINICAL ABSTRACT:

History: This patient was admitted to LACH in December, 1955, because of a left inguinal mass which had been slowly enlarging over a one and a half year period. It was described as rubbery and lobulated and measured 12 x 14 cm. On pelvic examination the mass was felt to protrude on to the left lateral pelvic wall for a distance of 10 cm. It was not tender, but she complained of pain radiating anteriorally down her leg to the knee. The patient was a Grav. V, Para IV, Ab. I, and during the pelvic examination it was discovered that she was two to three months pregnant. A hysterectomy and salpingo-oophorectomy were done before X-ray therapy was instituted to the mass.

Laboratory findings: Hgb. 13.5 gms., Rbc 4.7 m. Wbc 7,600 with 55% polys, 20% band cells, 13% lymphs, 8% monos, 3% eos., 1% basophiles.

Surgery: On December 19th, 1955, the left inguinal nodes were resected.

On January 11th, 1956, a hysterectomy and bilateral salpingo-oophorectomy were done. At this surgery, extensive enlargement of the left iliac and preaortic nodes extending up to the root of the mesentery, was noted. The liver and spleen showed no gross abnormalities.

Gross pathology: The first specimen consisted of approximately five large smooth, moderately soft, yellowish-tan lymph nodes, the largest of which measured more than 5 cm. in diameter.

The uterus, tubes and ovaries were unremarkable except for the changes of pregnancy.

Follow-up: The patient's inguinal mass responded to radiation. She subsequently developed left supraclavicular nodes which were also treated. When last seen on August 16th, 1956, she had no adenopathy and her liver and spleen were not palpable. Her left thigh was slightly larger than the right, but there was no palpable disease.

CASE NO. 3 October, 1956.

ACCESSION NO. 8866 OUTSIDE NO. 56-2044

NAME: R. M.

AGE: 21 SEX: Male RACE: Cauc.

CONTRIBUTOR: E. M. Hall, M.D.,
San Antonio Community Hospital,
Upland, California.

TISSUE FROM: Inguinal lymph nodes.

CLINICAL ABSTRACT:

History: This patient was admitted to the San Antonio Hospital with a history of swelling and tenderness in the left groin for approximately six weeks. There had been no fever or weight loss.

Laboratory findings: Chest X-ray, blood count and urinalysis negative.

Surgery: On September 7th, 1956, the right inguinal nodes were removed.

Gross pathology: The specimen consisted of the right inguinal group of lymph nodes, the largest measuring 5 x 3.5 x 2 cm. On section they were gray-white to brown, firm and with a few fibrous trabeculations.

CASE NO. 4 October, 1956.

ACCESSION NO. 8424 OUTSIDE NO. 56-264.

NAME: C. H.

AGE: 71 SEX: Male RACE: Cauc.

CONTRIBUTOR: E. M. Hall, M.D.,
San Antonio Hospital,
Upland, California.

TISSUE FROM: Mass in groin.

CLINICAL ABSTRACT:

History: This patient first noticed enlarged lymph nodes in the right groin and a mass in the abdomen above the right groin, about two years prior to examination. About one year previously he had noticed enlargement of the nodes in the left groin and both axillae. Those in the right groin and abdomen had enlarged.

The patient felt well and had been able to work. His blood count was normal and his spleen was not palpable .

Surgery: On January 24th, 1956, the nodes in the right groin were biopsied.

Gross pathology: The specimen consisted of three mottled lymph nodes, the largest measuring 2.5 x 2.5 cm. The capsule was smooth, the cut surface gray-white and moderately firm.

CASE NO. 5 October, 1956.

ACCESSION NO. 8285 OUTSIDE NO. 5700-55

NAME: C. S.

AGE: 38 SEX: Female RACE: Cauc.

CONTRIBUTOR: Nathan Friedman, M.D.,
Cedars of Lebanon Hospital,
Los Angeles, California.

TISSUE FROM: Axillary mass.

CLINICAL ABSTRACT:

History: This patient had a mass in her axilla which had developed rather rapidly. X-rays of her spine at about the same time revealed one vertebral body involved in a destructive process. Marrow studies and blood count were negative. A diagnosis of metastatic carcinoma was made and the breast on the same side was removed, but no tumor was found after careful study.

Subsequent work-up revealed negative chest X-rays, negative blood cultures, and standard agglutination tests. The patient developed a hard mass in the supraclavicular area, went downhill and died four months after the node was removed. Autopsy was not obtained.

Surgery: The axillary mass was excised circa September 23,1955.

Gross pathology: The specimen was 7 cm. in greatest diameter and consisted of hemorrhagic and edematous fat with a central 5 cm. mass suggesting a lymph node or a group of lymph nodes with considerable necrosis.

CASE NO. 6 OCTOBER, 1956.

ACCESSION NO. 8609 OUTSIDE NO. SA 56-16

NAME: H. M.

AGE: 81 SEX: Male RACE: Cauc.

CONTRIBUTOR: Stewart Lindsay, M.D.,
Sequoia Hospital,
Redwood City, California.

TISSUE FROM: Tumor, anterior mediastinum.

CLINICAL ABSTRACT:

History: There were no clinical symptoms related to the tumor which was an incidental finding at autopsy. The patient had died of a massive left myocardial infarct.

Autopsy findings: When the chest was opened, the mediastinum was seen to lie in the midline. In the midportion of the anterior parietal pericardial layer was an ovoid flattened mass measuring 5 x 5 x 4 cm. It appeared circumscribed and partially encapsulated and on section was composed of large lobules of soft, grayish-pink tissue. The thymus appeared fatty.

CASE NO. 7 October, 1956.

ACCESSION NO. 8802 OUTSIDE NO. 3813-56

NAME: I. M.

AGE: 60 SEX: Female RACE: Cauc.

CONTRIBUTOR: D. A. DeSanto, M.D.,
Mercy Hospital,
San Diego, California.

TISSUE FROM: Mass in anterior neck region.

CLINICAL ABSTRACT:

History: This patient had a history of increasing stridor, dyspnea and hoarseness of a few weeks duration. She had also noticed a few small, firm nodules under the skin of her right breast and abdomen. There had been no weight loss or pain. There was an anterolateral swelling in her neck which measured 8 x 7 cm. She had had a thyroidectomy in 1943 for an unknown reason and had been taking one to two grains of thyroid daily since.

Laboratory findings: Blood pressure was 160/56. I 131 uptake was 1.4%. Hgb. 13.2 gms.

After a needle biopsy of the nodules and neck swelling, surgery was performed.

Surgical findings: On August 5th, 1956, the tumor in the anterolateral portion of the neck was removed.

Gross pathology: The specimen consisted of four pieces of tissue of about equal size and weighing 45 grams in aggregate, the largest measuring 6 x 4 x 2 cm. There was no evidence of definite encapsulation. The tumor was firm and rubbery in consistency and the cut surface was pinkish tan in color. Scattered through the surface of the tumor were hemorrhagic and necrotic areas. No well-defined normal thyroid tissue was seen.

CASE NO. 8 October, 1956.

ACCESSION NO. 8691 OUTSIDE NO. H-1740-56

NAME: I. L.

AGE: 38 SEX: Male RACE: Cauc.

CONTRIBUTOR: W. W. Hall, M.D.,
Mercy Hospital,
Bakersfield, California.

TISSUE FROM: Tonsillar mass.

CLINICAL ABSTRACT:

History: This man had had a tonsillectomy 25 years ago. He reported to his private physician that the tonsil had grown back on the left side. The doctor removed this as an office procedure.

Surgery: Removal of tonsillar mass, circa September, 1956.

Gross pathology: The mass measured 3.5 x 2.5 x 2 cm. Its free surface appeared granular and irregular and was thought to be ulcerated.

CASE NO. 9 October, 1956

ACCESSION NO. 8338 OUTSIDE NO. 2640-55.

NAME: B. F.

AGE: 15 SEX: Male RACE: Cauc.

CONTRIBUTOR: Elmer Smith, M.D.,
Dameron Hospital,
Stockton, California.

TISSUE FROM: Cervical lymph nodes.

CLINICAL ABSTRACT:

History: This patient was hospitalized because of cervical lymphadenopathy of three weeks duration. On physical examination there was a bilateral chain of nodes, the one on the left being solid and continuous, and the one on the right a nodular chain. There was also some inguinal adenopathy, especially on the right.

Surgery: On December 21st, 1955, two lymph nodes were removed.

Gross pathology: The larger of the two nodes removed measured 23 x 13 x 12 mm.

Follow-up: On March 29th, 1956, the patient was well, but still had enlarged nodes.

CASE NO. 10 October, 1956

ACCESSION NO. 7970 OUTSIDE NO. SP-27793

NAME: L.P.

AGE: 62 SEX: Male RACE: Cauc.

CONTRIBUTOR: Richard Skahen, M.D.,
Veterans Administration Hospital,
Oakland, California.

TISSUE FROM: Axillary mass.

CLINICAL ABSTRACT:

History: In July, 1954, this obese white male noted an asymptomatic mass in the right axilla. The mass attained its final size rather quickly and then remained static. The patient did nothing until January, 1955, when he consulted a dermatologist with a complaint of pigmentation of the skin. The dermatologist treated him with vitamins with a diagnosis of possible pellagra. The patient denied any episodes of soreness of the hands, infection of the hand or arm, or any other cause of adenitis. Clinically, the mass was 3 x 3 x 5 inches, did not seem firmly attached to any structure and was nontender and freely movable.

Laboratory findings: A bone survey and G.I. series were negative. The Wbc was 10,850 with 66% polys, 2 % bands, 28% lymphocytes, 2% monocytes and 2% eosinophiles. The Rbc. was 3.8 m., Hb 7.8 gms. The urine was negative, serum protein normal and cholesterol normal.

Surgery: The axillary mass was excised circa, April, 1955.

Gross pathology: The specimen consisted of an irregularly lobulated mass measuring 8 x 6 x 4 cm. On section, two rounded masses were present, divided into irregular segments by coarse trabeculae. The surface was cream-white, finely granular, homogenous and rubbery. Between the two rounded masses there were areas of yellowish discoloration which appeared necrotic.

MINUTES OF

LOS ANGELES SENIOR STUDY GROUP

MONTHLY MEETING

October 17, 1956.

The members present included Drs. Brown, Budd, Bullock, Butt, Edmondson, Fisher, Foord, Friedman, Hall, Kahler, Kimball, Konwaler and Small. Dr. Edmondson presided.

Members absent and excused: Drs. Hummer, Kaplan, Keasbey, Lichtenstein, Madden, Pratt and Tragerman.

CASE NO. 1, ACCESSION NO. 8466, L. L. Frost, M.D., Contributor.

Dr. Budd considers this as a well-burned-out granulomatous process. He would have difficulty making a definite final diagnosis from this material. He suspects that the patient might have Hodgkin's disease, but cannot make that diagnosis at this time; the case should be followed for a long period. As a subsiding granulomatous inflammation, it has many etiologic possibilities. Dr. Small was impressed with its similarity to subsiding streptococcic lymphadenitis. There was discussion concerning the term lymphogranuloma for this type of process.(Friedman).

Votes: Chronic sclerosing lymphadenitis 9, possible Hodgkin's disease 5.

Members of the Central Valley Senior Study Group voted: Hodgkin's 2, sclerosing lymphadenitis 1. Guests: Hodgkin's 1, lymphadenitis 2.

Members of the San Diego Senior Study Group voted: Plasmacytoma 2, chronic lymphadenitis 5. It was suggested by some of the members who had this opinion that a parasitic infestation of some sort might account for the numerous eosinophils.

Hodgkin's disease 1. Although it does not seem too likely from the slide, it was felt that further studies of the heterophil antibody should be done to rule out any possibility of infectious mononucleosis.

FILE DIAGNOSIS: Chronic sclerosing lymphadenitis.
Cross-file: Hodgkin's disease.

CASE NO. 2, ACCESSION NO. 8426, W. K. Bullock, M.D., Contributor.

To Dr. Edmondson, the architectural changes are those of Hodgkin's disease exhibiting reticulum cell proliferation, Reed-Sternberg cells, fibrosis and numerous eosinophiles.

continued-

Case No. 2 - Accession No. 8426 continued.

There was discussion about women exhibiting a better prognosis with Hodgkin's disease than men (Jelliffe, A.M., and Thomson, A.D., Brit. J. Cancer, Vol. 9, pgs. 21-36, March, 1955. The Prognosis of Hodgkin's Disease). Dr. Budd reported in detail on a 13 year old female with Hodgkin's disease requiring adenectomy with partial mastectomy, who has had two children subsequently and is now 23 years old, without exhibiting progression of the disease. Several other reports of long lasting Hodgkin's disease were made, including a case reported by Dr. Foord in which adrenal sandwiches were used for therapy.

The vote was unanimous for Hodgkin's granuloma.

Members of the Central Valley group voted: Hodgkin's 3.(granuloma 2, sarcoma 1). Guests: Hodgkin's 3.

Members of the San Diego group voted unanimously for Hodgkin's disease, (8 votes).

FILE DIAGNOSIS: Hodgkin's disease.

CASE NO. 3, ACCESSION NO. 8866, E. M. Hall, M.D., Contributor.

Dr. Konwaler presented this as a case of Hodgkin's sarcoma exhibiting a marked proliferation of the reticulum cells with loss of nodal architecture, fibrosis, eosinophilia and the development of cells conforming with the Reed-Sternberg type. He felt that the background cells included transitional lymphoblasts. Dr. Foord thought of this as a metastatic epithelial tumor, and in his study looked for melanin, but could not find it. Dr. Friedman joined in this interpretation of a possible epithelial nature. The question of Hodgkin's versus carcinoma could not be unanimously resolved. Dr. Butt expressed the majority opinion that this was an excellent example of reticulum cell proliferation.

The votes: Hodgkin's disease 10, metastatic carcinoma 3.

Members of the Central Valley Group voted: Hodgkin's (sarcoma) 3. Guests: Reticulum cell sarcoma 1.

Members of the San Diego Group voted unanimously for Hodgkin's sarcoma, (8 votes).

FILE DIAGNOSIS: Hodgkin's disease.
Cross-file: Metastatic carcinoma.

CASE NO. 4, ACCESSION NO. 8424, E. M. Hall, M.D., Contributor.

Dr. Friedman observes the follicular cracking-off here, but will not lean on it. The numerous capillaries would favor an inflammatory process, (Warren). No Reed-Sternberg cells are present. The arrangement of lymphoid cells in railroad-car rows around these follicles and the fasnion in which these cells sweep through the capsule into the surrounding fat, favor a neoplastic proliferation, consequently he would term it lymphadenosis, possible leukemic lymph node, but he would prefer to observe rather than actively treat the individual. The numerous secondary follicles are noted. Drs. Kahler and Kimball support the diagnosis of follicular lymphoma (Rappaport et al, Cancer Vol. 9, pgs 792-821, 1956. Morrison and Scott, Arch. Int. Med. Vol. 14 pgs. 2073-2090, 1941). Mitotic figures are not common and are not needed in the diagnosis of malignant lymphoma (Rappaport). The term pseudo leukemia was inconclusively kicked around.

Follow-up report on the patient indicates that he feels fine, the process is static, and the radiologists are not treating it.

The vote was unanimous for follicular lymphoma.

Members of the Central Valley Group voted: Chronic inflammatory lymphadenitis 2, giant follicular lymphoblastoma 1. Guests: Chronic lymphadenitis 2, giant follicular lymphoblastoma.

Members of the San Diego Group voted: Malignant lymphoma, giant follicle type 7, malignant lymphoma, unclassified 1.

FILE DIAGNOSIS: Follicular lymphoma.

CASE NO. 5, ACCESSION NO. 8285, Nathan Friedman, M.D., Contributor.

Dr. Kahler, pinch-hitting for Dr. Keasbey, observed the sinusoidal reticulum cell proliferation as a free floating malignant reticulocytosis. The process reminds Dr. Kahler of an adult pattern of Letterer-Siwe's. The important question is Hodgkin's versus metastatic carcinoma and Dr. Friedman championed the latter view.

The votes: Malignant reticulo-endotheliosis 6, metastatic carcinoma 5, unclassified malignant tumor, possibly melanoma 1.

Members of the Central Valley group voted: Metastatic carcinoma 2, histiocytosis (Hand-Schuller-Christian) 1. Guests: Hand-Schuller-Christian 2, chronic lymphadenitis 1.

Members of the San Diego Group voted: Hodgkin's disease 6, metastatic carcinoma, possibly from bladder or pancreas 1, metastatic melanoma 1.

FILE DIAGNOSIS: Malignant reticulo-endotheliosis.
Cross-file: Metastatic carcinoma.

CASE NO. 6, ACCESSION NO. 8609, Stewart Lindsay, M.D., Contributor.

Dr. Brown presented this case as a thymoma of the spindle cell, epithelial type. Dr. Fisher commented on the interpretability of this as a lymphangiopericytoma and Dr. Friedman discussed Dr. Liebow's concept of these thymic tumors being lymphangiopericytoma, which is now poorly supported. Dr. Edmondson commented on the similarity with fibrous mesothelioma of the pericardium.

The vote was unanimous for thymoma.

Members of the Central Valley Group voted: Thymoma 2, no vote 1. Guests: Thymoma 3.

Members of the San Diego Group voted: Benign thymic tumor 4, lymphangio-endothelioma 3, fibrous mesothelioma 1.

FILE DIAGNOSIS: Thymoma.

CASE NO. 7, ACCESSION NO. 8802, D. A. DeSanto, M.D., Contributor.

Dr. Kimball observed that this is a uniform, single cell type tumor in which the cells are supported by a fine reticulum. His diagnosis is reticulum cell sarcoma. Dr. DeSanto submitted this case as a transition between reticulum cell sarcoma and plasmacytoma. The A.F.I.P. gave a diagnosis of anaplastic small cell carcinoma of the thyroid. There was considerable discussion of the cell type, some thinking that these were lymphoblasts (Budd and Foord) and others, that they were myelocytic in origin (Kahler). With appropriate stain an abundant reticulum fiber matrix is seen.

The vote: Reticulum cell sarcoma 10, lymphoblastic lymphosarcoma 3.

Members of the Central Valley Group voted: Small cell carcinoma of thyroid 2, lymphosarcoma 1. Guests: Lymphosarcoma 3.

Members of the San Diego Group voted: Carcinoma of thyroid, undifferentiated small cell type, 3, Malignant tumor unclassified 1 and reticulum cell sarcoma 4.

FILE DIAGNOSIS: Malignant lymphoma, probable reticulum cell sarcoma.

CASE NO. 8, ACCESSION NO. 8691, W. W. Hall, M.D., Contributor.

Dr. Kimball volunteered that this was a garden variety lymphosarcoma, not necessarily associated with the generalized features of lymphadenosis. The majority accepted the type cell as the lymphoblast.

The vote was unanimous for lymphoblastic lymphosarcoma. continued-

CASE NO. 8 - Accession No. 8691 continued.

Members of the Central Valley Group voted: lymphosarcoma 3. Guests: lymphosarcoma 2, lympho-epithelioma 1.

Members of the San Diego Group voted: Lymphosarcoma, lymphoblastic type 7, embryonic rhabdomyosarcoma 1.

FILE DIAGNOSIS: Lymphoblastic lymphosarcoma.

CASE NO. 9, ACCESSION NO. 8338, Elmer Smith, M.D., Contributor.

This case exemplifies the importance of adjuvant clinical information in the diagnosis of lymphadenopathy. Dr. Foord, taking cognizance of the strongly positive heterophile agglutination test and the febrile course of the patient, made the diagnosis of infectious mononucleosis. Several stated that the microscopic appearance and pattern was typical of this condition, while others confessed their inability to make this diagnosis without clinical information. The long period of post-febrile lymphadenopathy in some of these cases was commented upon.

The vote was unanimous for infectious mononucleosis.

Members of the Central Valley Group voted: Benign hyperplasia 2, no vote 1. Guests: Hyperplastic lymphadenitis 3.

Members of the San Diego Group voted: Hyperplasia 5 and Hodgkin's paragranuloma 3.

Follow-up information received after presentation of this case states that the boy is perfectly well and that the remaining glands have subsided, and that the patient is now back in school.

FILE DIAGNOSIS: Infectious mononucleosis.

CASE NO. 10, ACCESSION NO. 7970, Richard Skahen, M.D., Contributor.

Dr. Fisher discussed this tumor, which extensively replaces a lymph node. The large uniform polyhedral cells, with abundant cytoplasm and a large central nucleus, are growing in continuous sheets. He considers this to be a metastatic carcinoma; there appears to be no clinical clue as to the site of origin of this tumor. Because of the cell type, he suggested the possibility of origin from the adrenal cortex, this concept being vaguely supported by the pigmentation developing in the patient.

continued-

Case no. 10- Accession No. 7970 continued.

The vote was unanimous for metastatic carcinoma of lymph node, possible adrenal origin 6 votes.

Members of the Central Valley Group voted: Metastatic melanoma 2, Gaucher's disease 1. Guests: Gaucher's disease 2, non-lipid histiocytosis 1

Members of the San Diego Group voted: Metastatic carcinoma 7. No one had any definite opinions as to the possible source of this tumor, but the following were suggested: Adrenal or liver 2, melanoma 3, no origin suggested 2. Hibernoma 1 vote.

FILE DIAGNOSIS: Metastatic carcinoma of lymph node.

Meeting adjourned at 9:30 P.M.

H. Russell Fisher, M.D.,
Secretary.