TUMOR TISSUE REGISTRY

LOS ANGELES COUNTY HOSPITAL

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PROTOCOL

For

MONTHLY SLIDES

December, 1960

TUMORS OF THE DIGESTIVE SYSTEM

CASE NO. 1 December, 1960

ACCESSION NO. 10809 OUTSIDE NO. 59-521

NAME: S. J.
AGE: 42 SEX: Male RACE: Cauc.

CONTRIBUTOR: E. F. Ducey, M. D.
Foster Memorial Hospital
Ventura, California

TISSUE FROM: Cecum (surgery)

CLINICAL ABSTRACT:

In January, 1959, the patient noted some bright red blood in the stool, not associated with any clinical symptoms. He was examined in a physician's office, proctoscopic study and barium enema being reported as negative. In February, 1959, he passed more bloody stools, and was again examined in the physician's office without any significant findings on physical examination. A hemogram disclosed a rather severe secondary anemia, which an upper GI series revealed a peptic ulcer. He was hospitalized for a short time and given several transfusions. A second X-ray study of the upper GI tract again demonstrated a pyloric ulcer. The bleeding was presumed to be from this ulcer and the patient returned home under ulcer management. About March 1, 1959, the patient noted a lump on the right lower quadrant which was seen by his physician. In view of the history of much rectal bleeding, exploration was decided upon without further X-ray study.

SURGERY:

On March 11, 1959, a bulky tumor involving the cecum with extension up to the root of the mesocolon was discovered. Resection was performed without much difficulty, including a large wedge of mesocolon and all visible lymph nodes. There was no indication at the time of surgery of extension to the liver or other abdominal organs. He left the hospital eight days later, apparently in good condition.

GROSS PATHOLOGY:

The specimen, a 15 cm. length of terminal ileum plus 48 cm. of colon, was removed en bloc, together with a mesocolic fat wedge measuring 9 cm. in greatest width. The mesial aspect of the cecum was involved in a round, doughnut-shaped tumor 6 cm. in diameter which completely encircled the ileocecal valve, with some stenosis of the latter so that it admitted a little finger rather snuggly; from this point the neoplasm extended around the wall of the cecum to involve about half of its circumference, and it completely replaced the subjacent muscle coats over most of its extent with commencing extension into the mesocolic fat. The mucosa about the ileocecal valve was necrotic and ragged, while the cut surfaces of the tumor were uniformly soft, reddish-grey, highly cellular tissue showing some interstitial bleeding. The appendix was not involved at all in the

neoplasm, and the mucosa of the colon was normal except for two tiny polyps 3 to 4 mm. in diameter found at a distance of 10 cm. and 22 cm. respectively from the large tumor. Numerous soft lymph nodes were found in the mesocolic fat of the ileocecal angle, one of these measuring 3 x 6 cm.

FOLLOW-UP:

A mass recurred in the right lower abdomen, for which "X-ray therapy" was administered during June, for palliation. A chest film revealed pulmonary metastasis. He declined rather rapidly and was readmitted to the hospital on June 13, 1959, in a terminal condition, including evidence of involvement of the central nervous system. He expired on July 12, 1959, of carcinomatosis; autopsy was not obtained.

CASE NO. 2 December, 1960

ACCESSION NO. 10774 OUTSIDE NO. SC59-2702

NAME: P. L.
AGE: 54 SEX: Male RACE: Cauc.

CONTRIBUTOR: William H. Winchell, M. D.
Santa Cruz, California

TISSUE FROM: Meckel's diverticulum (surgery)

CLINICAL ABSTRACT:

History: On December 28, 1959, the patient was admitted to the hospital with a history of gradual onset of cramping pain in the lower abdomen two days previously. Urination caused pain, but there was no burning or frequency. The day before, he had had slight nausea, but no vomiting. Bowel movement was normal. He was anorexic, and his temperature was 100°F. On the night of December 27, 1959, the pain became less severe, but it became constant and localized in the right lower quadrant.

Physical examination: On admission, physical examination revealed a moderately protuberant abdomen with tenderness and marked guarding over McBurney's point. Hb 12.7 grams; PCV 41; WBC 13,600, with 76 segs., 14 bands, 10 lymphocytes. The patient was taken to surgery with the preoperative diagnosis of acute appendicitis.

SURGERY:

At surgery a circumscribed tumor mass was found attached to the small bowel within three feet of the ileocecal valve. The tumor was thought to be arising from a Meckel's diverticulum. The mass was loosely adherent to the posterior bladder wall.

GROSS PATHOLOGY:

The gross surgical specimen consisted of an irregularly lobular, flattened, ovoid, 8.5 x 6.9 x 5.0 cm., soft, rubbery mass. The surface was covered by serosa on which focal areas of fibrinous exudate were present. On the undersurface of the mass was a 3.0 x 1.5 cm. ostium, apparently representing the site of transection from the small bowel. Sections revealed a solid, pink-gray tissue with areas of hemorrhage and a 4.0 x 3.0 x 3.0 cm. abscess containing foul-smelling, mucopurulent material.

FOLLOW-UP:

Follow-up not received.

CASE NO. 3 December, 1960

ACCESSION NO. 10851 OUTSIDE NO. 29032

NAME: C. G.
AGE: 42 SEX: Male RACE: Mexican

CONTRIBUTOR: H. Russell Fisher, M. D.
Santa Fe Hospital
Los Angeles, California

TISSUE FROM: Tongue (surgery)

CLINICAL ABSTRACT:

The tumor was present on the tongue for approximately two months. It had been painful on compression for the entire duration.

SURGERY:

The entire tumor, with a 1 mm. margin, was excised on February 19, 1960.

GROSS PATHOLOGY:

The specimen consisted of a semispheroidal, 21 x 18 x 13 mm. piece of tissue which was more than half covered by a dome-like layer of lingual mucosa. Section exposed a solid ovoid tumor which had a rather sharp margin, which bulged from the surrounding supporting tissue and had a pink, homogeneous, lobulated interior tissue.

FOLLOW-UP:

The patient was seen "a short time ago." His private physician reported that the tumor had not recurred.

CASE NO. 4 December, 1960

ACCESSION NO. 10518 OUTSIDE NO. 902-59

NAME: K. H.
AGE: 38 SEX: Female RACE: Cauc.

CONTRIBUTOR: John J. Gilrane, M. D.
St. Luke Hospital
Pasadena, California

TISSUE FROM: Stomach (surgery)

CLINICAL ABSTRACT:

In 1948, the patient was noted to have diminished gastric acid secretion. In 1949, she had an episode of jaundice, nausea, and vomiting. In 1950, she was operated on for an extra-uterine pregnancy. Upper abdominal pain, nausea, and vomiting developed in 1952. One year later, she had "bilious vomiting." Gastroscopy revealed "gastritis" and it was stated that she had deficiency of gastric acid. On October 14, 1954, she underwent an appendectomy in New York, and "all abdominal viscera (were) examined and found to be normal. A rather elaborate battery of tests were performed at that time and found to be negative."

Since 1954, the patient had experienced episodes of abdominal pain before eating, followed by cramps, nausea, and vomiting after eating. These episodes were accompanied by a weight loss of up to 50 pounds, and a weight gain of 40 pounds following the episodes. These have occurred four or five times in the past five years and were always associated with major changes in home environment. The patient had a strong functional overlay, cathartic habit, and bowel neurosis. She was also strongly surgically prone. There was a history of an insecure childhood.

GI X ray done on January 13, 1959, revealed findings "consistent with diffuse scirrhous carcinoma of the stomach, or so-called 'linitis plastica.'"

Inventory of other systems was negative. Physical findings were stated to be negative.

SURGERY:

At laparotomy on March 26, 1959, the entire stomach was contracted and indurated. The entire stomach, tail of the pancreas, omentum, spleen, regional lymph nodes and adjacent portions of the esophagus and duodenum were removed en bloc.

GROSS PATHOLOGY:

"The external surface of the stomach presented glistening, though slightly thickened serosal aspect, without any evidence of infiltration, but merely a diffuse faint granularity, suggestive of fibrinous exudation.

Within the gastro-hepatic ligament were a number of succulent lymph nodes, approximately five in number, none of which disclosed any evidence of tumor. Similarly, confined primarily to the distal one-half of the stomach within the gastro-pelvic ligament, were a total of approximately six large succulent lymph nodes, none of which grossly disclosed any tumorous involvement. On opening the stomach, it appeared shrunken; the total stomach measured no more than 9 cm. along the lesser curvature by 14 cm. along the greater curvature excluding the 2 cm. segment of attached duodenum. There had been a complete ablation of the normal rugal gastric markings with replacement by a fine, hemorrhagic, rough, granular appearing mucosa, stippled with punctate translucent areas, grossly thought to represent cystically dilated mucosal glands. Interestingly, along the magenstrasse, in the distal one-half of the stomach, there was a patchy, geographic-appearing, purulent-like membrane, yellowish in color, which could be lifted with difficulty from the underlying mucosa, and a moderately indurated muscularis externa."

COURSE:

The patient was hospitalized from July 12 to October 23, 1959, in Germany at The Freie und Hansestadt Hamburg Universitäts-Krankenhaus Eppendorf. Their final diagnoses were as follows:

Pancreatic insufficiency;
Deficiency of intrinsic factor due to total gastrectomy;
Deficiency of vitamin A;
Chronic filamentary keratitis with decreased secretion of the lacrimal glands; and
Chronic purulent maxillary sinusitis.

Their encyclopedic work-up included numerous diagnostic measures and tests. She improved under therapy which consisted of vitamins A and B_{12}, iron, gastric and pancreatic enzymes, and hydrochloric acid. She underwent a maxillary sinus operation in which the chronically inflamed mucosa was removed.

FOLLOW-UP:

She has returned to the U.S. and communication in November, 1960, revealed that the patient has no evidence of GI disease but continues treatment for "glaucoma (and) chest complaints unrelated to past history.

CASE NO. 5 December, 1960

ACCESSION NO. 10717 OUTSIDE NO. 3143-59

NAME: K. W.
AGE: 63 SEX: Female RACE: Cauc.

CONTRIBUTOR: Paul R. Thompson, M. D.
St. Luke Hospital
Pasadena, California

TISSUE FROM: Ileum (surgery)

CLINICAL ABSTRACT:

The patient had sudden onset of severe abdominal pain on October 26, 1959. The pain was so severe, she "doubled over." The family, thinking it to be due to indigestion, gave her Alka-Seltzer. The next day the doctor was called and the patient was hospitalized with a tentative diagnosis of acute peritonitis, probably due to ruptured viscus. Past history was negative for ulcers. X rays of the abdomen showed no free air. Abdominal tap yielded "gastric juice."

SURGERY:

On October 27, 1959, a considerable amount of intestinal content was found in the peritoneal cavity. Exploration of the stomach, duodenum, and colon revealed no evidence of perforation. At approximately four feet from the ileocecal valve was found a large lump which had perforated. The bowel was resected with a wide margin.

GROSS PATHOLOGY:

The 80 cm. length of small bowel had an average diameter of 5 to 6 cm. and an attached cuff of mesentery 4 to 5 cm. wide. The serosal surface was hemorrhagic and covered with fibrinopurulent exudate.

At a distance of 30 cm. from one of the surgical margins there was an annular neoplasm almost completely encircling the bowel and measuring 5 cm. in length and 6 cm. in circumference. The neoplasm appeared to have ulcerated and penetrated through the serosal surface leaving an opening in the crater of the ulcer measuring approximately 5 mm. in diameter.

FOLLOW-UP:

The surgeon reports the patient to have no evidence of disease as of October, 1960.

CASE NO. 6 December, 1960

ACCESSION NO. 11047 OUTSIDE NO. ST-532-60

NAME: B. N.
AGE: 67 SEX: Female RACE: Cauc.

CONTRIBUTOR: John J. Gilrane, M. D.
Santa Teresita Hospital
Duarte, California

TISSUE FROM: Stomach (surgery)

CLINICAL ABSTRACT:

History: The patient entered the hospital for the first time on July 26, 1960. One week prior to hospital entry she noticed upper abdominal distress with indigestion, dull aching pain, bloating, and gaseous eructations. After two or three days she became nauseated and began to vomit intermittently. The night prior to the hospital entry she became acutely ill with persistent vomiting and dull epigastric pain. The patient had no diarrhea, constipation, and denied any previous intestinal disorders except for a transient episode six months prior to entry, which lasted two days and was mild though similar to the present illness. The patient was stated to have had a hysterectomy 35 years ago and pneumonia at some unknown time in the past.

Physical examination: Salient physical findings were those of a somewhat emaciated Caucasian female. There was an ill-defined, tender, palpable mass in the epigastrium. There was no guarding or rigidity. The liver and spleen were not palpable. Laboratory work on hospital entry disclosed a hemoglobin of 14.8 grams, hematocrit 41, leukocytes 13,750 with 79 segmented neutrophils, 1 eosinophil, 17 lymphocytes, 3 monocytes. An upper GI series revealed marked enlargement of the stomach with 80% fluid retention. At the end of two hours no appreciable amount of barium was seen to have left the stomach. Interpretation of "a high-grade pyloric obstruction" was made.

SURGERY:

At surgery on July 29, 1960, the distal one-half of the stomach was found to be constricted, the wall thickened, hard, and firm, particularly around the antrum. No abnormal lymph nodes were noted. The rest of the abdomen was grossly unremarkable. A subtotal gastric resection was done including the proximal 2 cm. of the duodenum.

GROSS PATHOLOGY:

The specimen consisted of a subtotally resected stomach measuring along its greater curvature 23 cm. and along its lesser curvature 10.5 cm. The serosal surface of the stomach on its anterior aspect showed an area approximately 3.0 x 1.5 cm. of fibrous white thickening in the serosa and

surrounding this rather marked congestion. The stomach was fairly indurated in this area adjacent to the lesser curvature. The remainder of the serosal surface including the posterior aspect of the stomach showed foci of surgical hemorrhage but other than this was grossly unremarkable. The stomach was opened up along its greater curvature revealing a rather markedly hypertrophied gastric mucosa with marked elevation of the gastric ruga, some measuring as much as 8 mm. in height. No large ulcerations or erosions were seen. However, there was rather marked congestion of the gastric mucosa. Examination of the mucosa corresponding to the previously described anterior lesser curvature serosal area of fibrosis revealed no obvious ulceration or tumor lesion. However, the bowel wall in this area measured up to 8 mm. in thickness and was quite densely fibrotic. No grossly palpable lymphadenopathy was noted on examining the omentum, mesentery of the lesser curvature or the omentum immediately adjacent to the greater curvature.

Many sections were taken and only a few areas of actual foci of carcinoma connecting with the mucosa were present. These are not shown in the slides presented.

COURSE:

The patient subsequently developed intestinal obstruction involving the sigmoid colon. She underwent surgery in September, 1960, and was found to have "carcinomatosis of the abdominal cavity." She died in October, 1960, and no autopsy was performed.

CASE NO. 7 December, 1960

ACCESSION NO. 10915 OUTSIDE NO. A-422-59

NAME: V. R.
AGE: 70 SEX: Female RACE: Cauc.

CONTRIBUTOR: Suleiman K. Abul-Haj, M. D.
Washington, D. C.

TISSUE FROM: Retroperitoneal mass (autopsy)

CLINICAL ABSTRACT:

The patient was referred to the Brooke Army Hospital for recurrent pyelonephritis eight months prior to demise. Complete urologic work at that time revealed pyuria, and urine cultures grew E. coli. An intravenous pyelogram performed at that time revealed essentially normal kidneys and collecting system. Physical examination was unremarkable. She was treated with antibiotics with good response and was discharged for follow-up in the outpatient clinic.

She was readmitted to the hospital one month prior to demise complaining of nagging lower back pain, and a sensation of heaviness in the pelvis. Physical examination revealed a large pelvic mass located within the right pelvic gutter, which was thought to be arising in the right adnexa.

SURGERY:

On December 2, 1959, an exploratory laparotomy was performed. A large pelvic retroperitoneal mass, which involved the right fallopian tube, cecum, ascending colon and terminal ileum was found. The right ovary could not be identified. It was decided that the mass was inoperable, and only a biopsy was taken, on which exact diagnosis could not be made.

Course: Postoperative laboratory examination revealed the following: Hb 11.4 gm.%; blood smear showed neutrophilic leukocytosis; bone marrow was not done. Total protein fluctuated on repeated determination between 10.8 and 11.4 gm.%, the globulin being 6.8 to 8.5 gm.%. Electrophoresis showed high gamma globulin peak and the various fractions as follows: albumin 21.7%, alpha-1 3.5%, alpha-2 7.6%, beta 7.6%, and gamma 59.6%. Urinalysis revealed Bence-Jones protein on several determinations and urine electrophoresis revealed moderate peak in the B-globulin fraction. Radiologic bone survey was unremarkable. The patient expired on December 14, 1959, of acute peritonitis and hemorrhagic septicemia.

GROSS PATHOLOGY:

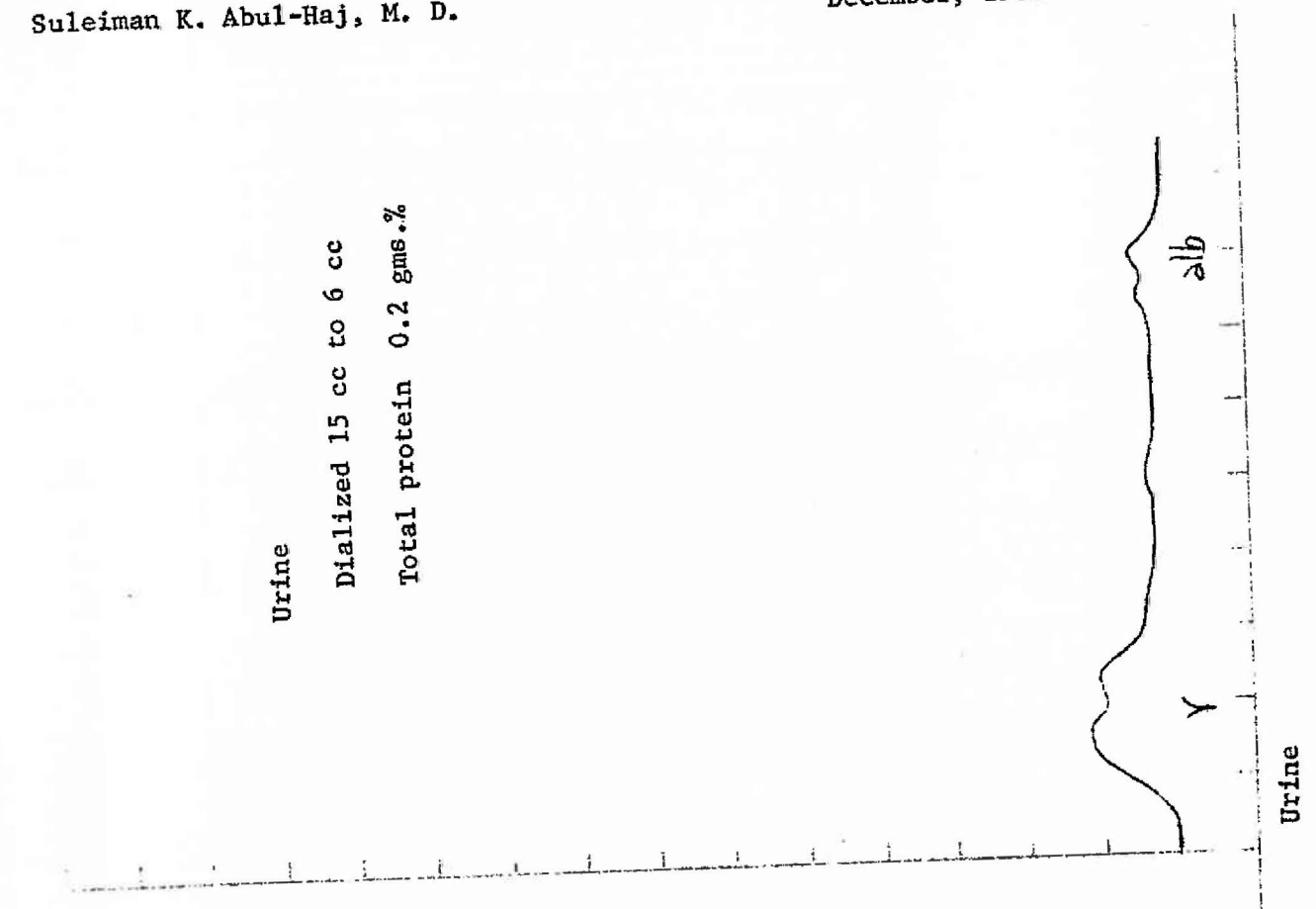
There was a large retroperitoneal, rounded 27.0 cm. mass apparently arising from the right adnexa, with contiguous extension into the cecum, ascending colon, and terminal ileum. The mucosa of the bowel-involved areas was intact over the tumor. There were no metastases to other viscera and the skeleton was not involved.

Suleiman K. Abul-Haj, M. D. December, 1960

Urine

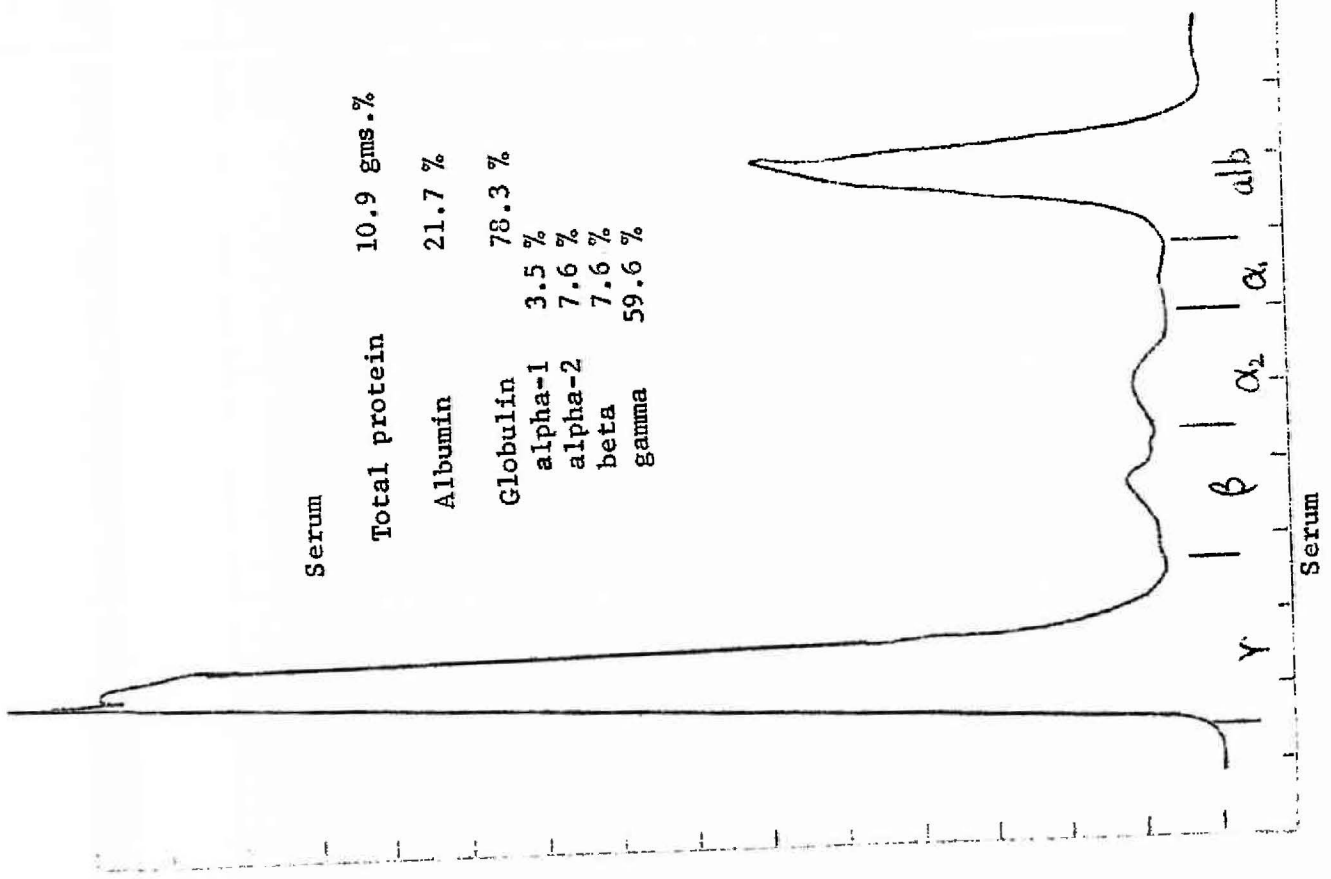
Dialized 15 cc to 6 cc

Total protein 0.2 gms.%



Serum

Total protein	10.9 gms.%
Albumin	21.7 %
Globulin	78.3 %
alpha-1	3.5 %
alpha-2	7.6 %
beta	7.6 %
gamma	59.6 %



CASE NO. 8 December, 1960

ACCESSION NO. 10882 OUTSIDE NO. 60-S-493

NAME: W. N.
AGE: 32 SEX: Male RACE: Cauc.

CONTRIBUTOR: D. Gordon Johnston, M. D.
St. John's Hospital
Oxnard, California

TISSUE FROM: Stomach (surgery)

CLINICAL ABSTRACT:

History: The onset of symptoms of vomiting and epigastric distress occurred in June, 1959. On June 1, 1959, an upper GI series revealed a filling defect in the distal stomach. The patient improved on ulcer management, and two days later an upper GI series was interpreted as showing marked improvement. One month after the first GI series, the films were reported "normal." The patient had no more symptoms of specific nature, but complained that "he just felt that his stomach was not right." In March, 1960, there was vomiting but no pain. An upper GI series revealed a filling defect similar to that seen in June of 1959. There was decided clinical improvement after this, but in two or three weeks a repeat GI series revealed an area suspicious of a polyp of the antrum of the greater curvature near the pylorus.

Laboratory examination: Laboratory work revealed no anemia, slight leukocytosis, no occult blood, negative serological test for syphilis and no free hydrochloric acid, except following stimulation with histamine.

SURGERY:

The patient was operated on March 30, 1960. There was increase in the thickness throughout the distal third of the stomach with an unyielding characteristic of the pylorus and moderate stenosis.

GROSS PATHOLOGY:

The specimen consisted of a partially opened portion of the stomach measuring 5 cm. on the lesser curvature and 11 cm. on the greater curvature. An opening was present on the anterior surface near the greater curvature, measuring 5 cm. in length. The external surface was otherwise not remarkable, save for lobulated adipose tissue tags on the lesser and greater curvatures. The region of the distal resection, particularly along the lesser curvature and posterior surface, was extremely indurated and thickened. This extended 3 to 4 cm. proximately. The mucosal pattern in this area was regular, but definite ulceration could not be recognized. The remaining mucosal pattern was normal except for slight depression of non-indurated mucosa in the mid-portion of the anterior surface of the lesser curvature.

FOLLOW-UP:

The patient felt fine since surgery. He was contacted on November 22, 1960, and stated that he feels well and is asymptomatic.

CASE NO. 9 December, 1960

ACCESSION NO. 10541 OUTSIDE NO. SF59-3889

NAME: G. V. R.
AGE: 47 SEX: Male RACE: Unknown

CONTRIBUTOR: Milton L. Bassis, M. D.
Kaiser Foundation Hospital
San Francisco, California

TISSUE FROM: Ileum (surgery)

CLINICAL ABSTRACT:

The patient had abdominal pain localized just below the umbilicus for one year. X ray showed chronic deformity of the duodenum with no active ulcer crater. Upper small intestine was dilated but had no evidence of obstruction. He was admitted to the hospital for ten days. Three days after his discharge he was readmitted. His symptoms each time were similar--cramping, abdominal pain with paraumbilical localization, vomiting twice several hours after eating supper. There was no change in bowel habits. He had a 20-pound weight loss in the last month. Laboratory work was essentially normal.

SURGERY:

A diagnosis of intermittent small intestinal obstruction was made, and he was operated on June 18, 1959.

GROSS PATHOLOGY:

The specimen was a 92 cm. length of ileum and attached mesentery. There was an annular, ulcerated tumor having slightly raised margins 31 cm. from one end extending along the mucosa for a distance of 5 cm. and infiltrating the entire thickness of the bowel wall and the mesenteric fat for 0.7 cm. The tumor narrowed the lumen and produced dilatation of the proximal segment to almost twice the diameter of the segment distal to the tumor. The cut surface of the tumor was firm, glistening and gray. Many lymph nodes in the mesentery measuring up to 1.4 cm. were isolated with no evidence of metastatic tumor.

FOLLOW-UP:

The patient was last in in March, 1960. At that time he was feeling fine and had no complaints. His appetite was good. Examination of the abdomen was negative. Routine blood count was normal.

CASE NO. 10 December, 1960

ACCESSION NO. 11206 OUTSIDE NO. 4223-11-60

NAME: Unknown
AGE: 50 SEX: Male RACE: Cauc.

CONTRIBUTOR: E. Conforth, M. D.
San Diego, California

TISSUE FROM: Duodenal polyp (surgery)

CLINICAL ABSTRACT:

The patient was well until four weeks prior to admission, when he developed weakness for three weeks and tarry stools that persisted for seven to ten days. Hb was 9.9. Stool was negative for blood. GI series showed a polypoid mass in the duodenum attached to the superior wall of the duodenal bulb.

SURGERY:

In November, 1960, the polypoid mass was resected.

GROSS PATHOLOGY:

The polyp was teardrop shaped, measuring 2.7 cm. in length and 2.2 cm. through the expanded tip. Several pitted areas and one 3-mm. focus of ulceration were noted on the mucosa-covered surface. The lesion was sharply circumscribed and grossly resembled pancreas (although this impression was not confirmed on microscopic examination).

CASE NO. 11 December, 1960

ACCESSION NO. 11196 OUTSIDE NOS. 60-14109
60-14578

NAME: J. S.
AGE: 47 SEX: Male RACE: Cauc.

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

TISSUE FROM: Esophagus (surgery)

CLINICAL ABSTRACT:

History: Five weeks prior to admission the patient developed dysphagia and sharp substernal pain when swallowing solid foods. The pain had increased in severity and had always been associated with swallowing solids. The pain did not radiate, never lasted more than several minutes, and was not associated with dysphagia. He was partially relieved by belching. The patient had been forced to take a soft diet and liquid in the last week and had lost ten pounds since the onset of the symptoms. There had been no vomiting or hematemesis. Besides a few chills and fever associated with the present episode, the patient has been in perfect health up to this time.

Physical examination: On physical examination, the patient appeared healthy. There was no lymphadenopathy, no venous distention in the neck, and no significant findings in the thorax or abdomen. At esophagoscopy, multiple 0.5 to 1.0 cm. in diameter polyps of the esophagus were seen at the 25 to 35 cm. level. Esophagogram on October 19, 1960, showed barium flowing freely through the esophagus demonstrating a 10 to 12 cm. in length fungating mass in the middle third of the esophagus. No apparent obstruction to the barium flow was seen proximal to this area.

SURGERY:

On November 2, 1960, bronchoscopy under anesthesia revealed no tumor in the trachea or bronchi. A thoracic esophagectomy with esophagogastrostomy was done. Several small nodes along the gastric vessels were found. One was found to have malignant cells. There was no gross evidence of extension of the tumor downward on the esophagus or into the stomach. The liver contained no evidence of metastasis. The esophagus had an intraluminal mass which did not extend through the walls and was not fixed to the vena cava, the aorta, the tracheobronchial tree or the surrounding mediastinal structures.

GROSS PATHOLOGY:

The specimen consisted of a segment of esophagus and adjacent portion of stomach measuring 10.8 cm. in length and varying in circumference from 3.5 to 6.5 cm. Arising from the esophageal mucosa near the proximal

surgical margin were four papillary masses and a sessile polypoid mass, dark brown to black, partially necrotic. The underlying mucosa was partially ulcerated. The most proximal mass measured 1.5 cm. in diameter in the base, 2 cm. in greatest elevation and 2 cm. in greatest diameter. This was located very near the resected margin. The next mass was 2 cm. from the margin, measured 3 cm. in the base, had a maximum elevation of 6.5 cm. and was 5 cm. in greatest diameter. Three more masses measured as follows: 1 cm. at the base by 4 cm. in greatest diameter; 1.2 cm. at the base, 2.4 cm. in diameter; the last one was sessile, 3.2 cm. from the margin, 3.2 cm. in diameter and 0.8 cm. in elevation.

FOLLOW-UP:

The patient was discharged on November 14, 1960. At that time "he was tolerating diet well."

CASE NO. 12 December, 1960

ACCESSION NO. 10687 OUTSIDE NO. A57-261

NAME: C. G.
AGE: 67 SEX: Male RACE: Cauc.

CONTRIBUTOR: Donald L. Alcott, M. D.
Santa Clara County Hospital
San Jose, California

TISSUE FROM: Peritoneal mass (autopsy)

CLINICAL ABSTRACT:

History: The patient was operated on for bowel obstruction in October, 1956. A huge, mobile, nodular tumor mass was found involving the omentum and attached to the transverse colon. Regional nodes were involved with tumor. Resection of the transverse colon and tumor were accomplished with an end-to-end anastomosis of the colon.

On August 30, 1957, he was admitted to Santa Clara County Hospital with symptoms of partial bowel obstruction for one month. A 10 cm. mass was palpated in the RLQ, which was non-tender and immobile. Films of the abdomen revealed calcification in the tumor mass, ascites and multiple gas-filled loops of small bowel. On September 3, 1957, an ileotransverse colostomy was performed. Liver metastases were present.

Course: The patient expired four days postoperatively after intractable shock.

AUTOPSY FINDINGS:

"The peritoneal cavity contained approximately 1000 cc. of serosanguineous fluid. . . (Three) large, yellow-tan masses were present in the RUQ, the RLQ, and the left lower abdomen near the midline. . . (and measured) from 8 to 12 cm. in diameter. So far as can be ascertained grossly, the masses involved only the serosal surfaces and the mesentery. . . The three masses in the abdomen were sectioned, and it was noted that the yellow-tan color of the capsule was present in a ring approximately 2 cm. in diameter inside of which the same type of fibrous tissue had a darker, reddish-purple coloration." No distant metastases were identified.

STUDY GROUP CASES

FOR

DECEMBER, 1960

TUMORS OF THE DIGESTIVE SYSTEM

CASE NO. 1, ACCESSION NO. 10809, E. F. Ducey, M. D., Contributor

LOS ANGELES:

Anaplastic carcinoma, 11; malignant carcinoid, 1; paraganglioma, 1; melanoma and reticulum cell sarcoma.

The latter was not considered further after the reticulum stain was shown.

SAN FRANCISCO:

Anaplastic carcinoma, 5; reticulum cell sarcoma, 2; anaplastic malignant tumor, 4 (melanoma 2?).

SAN DIEGO:

Anaplastic tumor.

Metastatic malignant melanoma, lymphoma, metastatic reticulum cell carcinoma, adrenal carcinoma, anaplastic carcinoma, and malignant paraganglioma were considered, but it was agreed that no definitive diagnosis could be made.

CENTRAL VALLEY:

Leiomyosarcoma, 3; anaplastic adenocarcinoma, 2; melanoma, 2; anaplastic carcinoid, 1.

OAKLAND:

Fifteen thought it was a poorly differentiated tumor, two of these favored a diagnosis of reticular cell sarcoma; one favored melanoma.

WEST LOS ANGELES:

Metastatic melanoma, 7; myosarcoma, 2; metastatic carcinoma, 1; don't know, 1.

FILE DIAGNOSIS: Anaplastic carcinoma, cecum. 660-8191G

December, 1960

CASE NO. 2, ACCESSION NO. 10774, William H. Winchell, M. D., Contributor

LOS ANGELES:

The diagnosis of Schwannoma and leiomyosarcoma were considered. It was stated that smooth muscle tumors are more likely to occur in the gastro-intestinal tract than nerve sheath neoplasms. Gastro-intestinal smooth muscle tumors are notoriously odd in their morphology, and do not produce a pattern which has been labeled "symplastic."

Leiomyoma, 10; leiomyosarcoma, 1; and neurilemoma, 2.

SAN FRANCISCO:

Leiomyosarcoma, 8 (myosarcoma 1?); leiomyoma, 3 (neurilemoma?).

SAN DIEGO:

Schwannoma, benign, 2; leiomyoma, 2; neurogenic sarcoma, low-grade malignancy, (1); fibrosarcoma, 1.

CENTRAL VALLEY:

Neurofibrosarcoma, 1. Attention was drawn to Dr. Stout's comment on his original arbeit on neurogenous tumors of the gastro-intestinal tract and his current belief as to the extreme rarity of such tumors. Three votes for benign leiomyoma; four for low-grade leiomyosarcoma.

OAKLAND:

Leiomyosarcoma, low grade - unanimous.

WEST LOS ANGELES:

Leiomyosarcoma - unanimous.
Cross-file - neurosarcoma.

FILE DIAGNOSIS: Leiomyoma in Meckel's diverticulum. 658-866A

Cross-index: Neurilemoma. 658-8452B
Leiomyosarcoma. 658-866F
Neurosarcoma. 658-870F

Reference:

Cowdell, R.H.: Smooth-muscle tumours of the gastro-intestinal tract. Brit. J. Surg. 38: 3-11, 1950.

December, 1960

CASE NO. 3, ACCESSION NO. 10851, H. Russell Fisher, M. D., Contributor

LOS ANGELES:

This was declared a beautiful example of a rhabdomyomatous tumor, and opinion was equally divided (6 to 6) in regard to the malignant or benign characteristics of the lesion.

SAN FRANCISCO:

Rhabdomyoma - unanimous.

SAN DIEGO:

Rhabdomyoma - unanimous.

CENTRAL VALLEY:

Cellular rhabdomyoma, 4; low-grade myosarcoma, 3; myoblastoma, 1.

OAKLAND:

Rhabdomyoma - unanimous.

WEST LOS ANGELES:

Rhabdomyosarcoma - unanimous.

Four of our group thought this might have low-grade malignant potentiality.

FILE DIAGNOSIS: Rhabdomyosarcoma, tongue. 612-867F

References:

Cappell, D.F., Montgomery, G.L.: "On Rhabdomyoma and Myoblastoma." J. Path. and Bact. 44: 517-548, 1937.

Stout, A.P.: Tumors of the Soft Tissues. A.F.I.P. Washington, 1953.

December, 1960

CASE NO. 4, ACCESSION NO. 10518, John J. Gilrane, M. D., Contributor

LOS ANGELES:

The diagnosis considered by the discussant was chronic lymphocytic gastritis and pseudoleukemia of Briquet. It was thought the lesion did not really fit the latter, because apparently the entire gastro-intestinal tract was not involved, rather it was a lesion limited to the stomach. All agreed that the lesion was not a neoplasm.

Chronic granulomatous process involving the stomach - unanimous.

SAN FRANCISCO:

Chronic ulcerating gastritis (lues?) - unanimous.

SAN DIEGO:

Severe, chronic, cicatrizing gastritis, 8; plasmacytoma, 1.

It was felt that the emotional tie-up of this lesion was similar to that of ulcerative colitis.

CENTRAL VALLEY:

Non-neoplastic. Two were willing to commit themselves to the specific diagnosis of lues, and two more used the term granuloma.

OAKLAND:

Benign, inflammatory - unanimous.

WEST LOS ANGELES:

Chronic ulcerative gastritis - unanimous.

A number of our group thought that this lesion might be related to a picture of chronic ulcerative colitis. Other members felt strongly that a luetic process should be excluded. An involuted neoplastic process was considered but discarded.

Note: The Wasserman STS was negative.

FILE DIAGNOSIS: Chronic lymphocytic (granulomatous) gastritis.
640-100.0

References:

Chronic non-specific granulomatous inflammation of the stomach was

described by Konjetzny and Prinz as chronic lymphatic gastritis in Der Chirurg 10:260, 1938, and Bruns Beitrage zur klinischen Chirurgie 183:129, 1951.

Also cf Ewing- Neoplastic Diseases, 1919 ed., p. 363 (gastro-intestinal pseudoleukemia).

Wells, H. G., and Maver, M.B.: Pseudoleukaemia Gastrointestinales. Amer. J. Med. Sc. 128: 837-855, 1904. This article mentions Briquet's original case which was described in Curveilhier's Atlas. Vol. 2, p. 34, 1835-1842.

December, 1960

CASE NO. 5, ACCESSION NO. 10717, Paul R. Thompson, M. D., Contributor

LOS ANGELES:

The differential diagnoses included malignant lymphoma (reticulum cell type, Hodgkin's disease), histiocytic medullary reticulosis, and anaplastic carcinoma. The cells appeared to be blast forms and characteristically had horse shoe nuclei and multinucleated forms.

Lymphoma, 10 (7 thought it was Hodgkin's sarcoma), and anaplastic carcinoma, 2.

SAN FRANCISCO:

Anaplastic carcinoma, 1; reticulum cell sarcoma, 6; myosarcoma, 1; malignant tumor, unclassified, 2; Hodgkin's sarcoma, 1; Hodgkin's granuloma, 2.

SAN DIEGO:

Malignant lymphoma - unanimous, with about an equal division between Hodgkin's reticulum cell sarcoma.

CENTRAL VALLEY:

Hodgkin's sarcoma, 4; Hodgkin's not otherwise specified, 4.

OAKLAND:

Hodgkin's sarcoma - unanimous. Two raised the diagnostic possibility of carcinoma.

WEST LOS ANGELES:

Hodgkin's disease, 2; reticulum cell sarcoma, 6; anaplastic carcinoma, 1; polymorphous lymphoma, histiocytic type, 1; undetermined, 1.

FILE DIAGNOSIS: Anaplastic carcinoma, ileum. 650-8191G

Cross-index: Malignant lymphoma. 650-839F

December, 1960

CASE NO. 6, ACCESSION NO. 11047, John J. Gilrane, M. D., Contributor

LOS ANGELES:

Linitis plastica - unanimous. Some slides showed adenocarcinoma in mucosa and submucosa.

SAN FRANCISCO:

Carcinoma stomach, 13 (linitis plastica)

SAN DIEGO:

Infiltrating carcinoma of stomach - unanimous.

CENTRAL VALLEY:

Linitis plastica - unanimous.

OAKLAND:

Carcinoma, stomach linitis plastica type - unanimous.

WEST LOS ANGELES:

Diffuse undifferentiated adenocarcinoma - unanimous.

FILE DIAGNOSIS: Carcinoma of stomach, diffuse, scirrhous. 640-8076G

Cross-index: Adenocarcinoma, stomach. 640-8091F

December, 1960

CASE NO. 7, ACCESSION NO. 10915, S. K. Abul-Haj, M. D., Contributor

LOS ANGELES:

Extramedullary myeloma, 8; "reticulum cell type of myeloma," 5.

Discussion centered around the terminology for tumors which produced abnormally disproportionate amounts of proteins and were composed of young-looking, undifferentiated cells. Extramedullary stem cell sarcoma was offered as a diagnosis. It was pointed out that hyperglobulinemia may be produced by "reticulum cells" as well as "plasma cells," yet some considered these cells fit more easily into the category of plasma cells.

SAN FRANCISCO:

Plasmacytoma anaplastic, 13.

SAN DIEGO:

Plasma cell myeloma, 3; reticulum cell sarcoma, 4; malignant lymphoma, pleomorphic type, 2.

CENTRAL VALLEY:

Plasmacytoma, 6; reticulum cell sarcoma, 1; Hodgkin's, 1.

OAKLAND:

Myeloma, extraskeletal - unanimous.

WEST LOS ANGELES:

Plasma cell myeloma - unanimous.

FILE DIAGNOSIS: Extramedullary myeloma, retroperitoneum. 065-833F

December, 1960

CASE NO. 8, ACCESSION NO. 10882, D. Gordon Johnston, M. D., Contributor

LOS ANGELES:

Gastric lymphosarcoma, 12; gastric Hodgkin's disease, 1; the possibility of pseudolymphoma was pointed out.

SAN FRANCISCO:

Lymphosarcoma, 13.

SAN DIEGO:

Lymphocytic lymphosarcoma - unanimous.

CENTRAL VALLEY:

Benign lymphoid lesion, 3; lymphosarcoma, 3; small-cell carcinoma, 1; reticulum cell sarcoma, 1.

OAKLAND:

Lymphoma, malignant - unanimous.

WEST LOS ANGELES:

Malignant lymphoma - unanimous.

Some members of our group felt that this showed reticulum cell differentiation in places and in other places it was polymorphous.

FILE DIAGNOSIS: Lymphosarcoma, stomach. 640-830

Cross-index: Pseudolymphoma, stomach. 640-925

December, 1960

CASE NO. 9, ACCESSION NO. 10541, Milton L. Bassis, M. D., Contributor

LOS ANGELES:

Leiomyosarcoma, 4; malignant lymphoma, 4; anaplastic carcinoma, 2.

SAN FRANCISCO:

Leiomyosarcoma, 11; myosarcoma, 2.

SAN DIEGO:

Reticulum cell sarcoma, 5; leiomyosarcoma, 3; malignant lymphoma, 1.

CENTRAL VALLEY:

Leiomyosarcoma, 4; carcinoid, 2; rhabdomyosarcoma, 1; reticulum cell sarcoma, 1.

OAKLAND:

Poorly differentiated malignant tumor, 1; leiomyosarcoma, 7 (plus 1 probably); anaplastic carcinoma, 1.

WEST LOS ANGELES:

Myosarcoma, 6; anaplastic carcinoma, 1; reticulum cell sarcoma, 4.

FILE DIAGNOSIS: Leiomyosarcoma, ileum. 650-866F

Cross-index: Anaplastic carcinoma, ileum. 650-8191G
Malignant lymphoma, ileum. 650-839F

December, 1960

CASE NO. 10, ACCESSION NO. 11206, E. Conforth, M. D., Contributor

LOS ANGELES:

Hamartoma, 5; adenoma of Brunner's gland, 6.

The discussion centered on the differentiation between a neoplastic proliferation of Brunner's gland and a hamartomatous lesion.

SAN FRANCISCO:

Brunner's gland adenoma, 13.

SAN DIEGO:

Brunner's gland adenoma - unanimous.

CENTRAL VALLEY:

Adenoma of Brunner's glands - unanimous.

OAKLAND:

Brunner's gland adenoma - unanimous.

WEST LOS ANGELES:

Adenoma of Brunner's gland - unanimous.

FILE DIAGNOSIS: Brunner's gland adenoma. 650-8091A

Reference:

Stephens, G.L., and Harbrecht, P.J.: "Bleeding Brunner Gland Adenoma of Duodenum Simulating Duodenal Ulcer." Ann. Surg. 148: 845-850, 1958 (Good bibliography).

December, 1960

CASE NO. 11, ACCESSION NO. 11196, W. K. Bullock, M. D., Contributor

LOS ANGELES:

Melanoma of the esophagus - unanimous. (Twenty-one cases of esophageal melanoma have been published in the world literature; this case will be published as the 22nd case).

SAN FRANCISCO:

Malignant melanoma, 13.

SAN DIEGO:

Malignant melanoma, probably primary.

CENTRAL VALLEY:

Melano-carcinoma of the esophagus - unanimous.

OAKLAND:

Malignant melanoma, primary, 14; melanoma, secondary, 1.

WEST LOS ANGELES:

Primary malignant melanoma - unanimous.

FILE DIAGNOSIS: Melanoma, esophagus. 637-8173F

References:

Loring, W.E. and Zeppa, R.: Melanocarcinoma of the esophagus. J. Thor. Surg. 32: 35-45, 1956.

Guibert, H.L., and Oriol, R.: Les Melanomes Primitifs de l'oesophage. Rev. de laryngol. 81:46-91, 1960.

December, 1960

CASE NO. 12, ACCESSION NO. 10687, D. L. Alcott, M. D., Contributor

LOS ANGELES:

Leiomyosarcoma with metaplastic bone, 3; fibrosarcoma producing bone, 7.

SAN FRANCISCO:

Extra osseous osteosarcoma, 10; mesothelial sarcoma, 1; fibrosarcoma, 1; retroperitoneal fibrosis with heteroplastic bone, 1.

CENTRAL VALLEY:

Mesenteric fibrosarcoma, 1; osteosarcoma, 7.

SAN DIEGO:

Extra osseous osteogenic sarcoma, 3; fibrosarcoma with bone formation, 2; malignant mesenchymoma with predominant osteogenic features, 3; ossifying fibromatosis, 1.

OAKLAND:

Extraosseous osteogenic sarcoma, 13; multiple ossifying fibromas, 1; mesothelioma with ossification, 1.

WEST LOS ANGELES:

Extraosseous osteogenic sarcoma, 1; malignant mesenchymoma with osteogenic elements, 9; fibrosarcoma with osseous metaplasia, 1.

FILE DIAGNOSIS: Fibrosarcoma with metaplastic bone formation, peritoneum. 060-870F

Cross-index: Osteosarcoma, extraosseous, peritoneum. 060-876F