CALIFORNIA TUMOR TISSUE REGISTRY

LOS ANGELES COUNTY HOSPITAL

****

PROTOCOL

FOR

MONTHLY SLIDES

JANUARY 1965

TUMORS OF HEAD AND NECK

NAME: T. M. JANUARY 1965 - CASE NO. 1

AGE: 49 SEX: Male RACE: Negro ACCESSION NO. 13774

CONTRIBUTOR: C. P. Schwinn, M. D. Outside No. 64-11746
Los Angeles County Hospital
Los Angeles, California

TISSUE FROM: Right parathyroid

CLINICAL ABSTRACT:

The patient is a 49 year old negro male who has been followed since 1962 with a diagnosis of multiple endocrine adenomas.

The patient presented with symptoms of a gastric ulcer and was found to have an islet cell adenoma or adenocarcinoma and was diagnosed as having a Zollinger-Ellison syndrome. The patient was treated with a subtotal gastrectomy which was done elsewhere. Since then, the patient has been found to have a chromophobe adenoma of the pituitary, a possible adrenal adenoma (which however may represent metastases from the pancreatic tumor). The pituitary lesion was treated with radiation therapy. In addition, the patient has had since 1962 a gradually expanding coin lesion in the right lung. Patient had a thoracotomy and was found to have metastatic disease probably originating in the pancreas. The patient was found to have a marginal ulcer in May 1964, which has been treated medically.

The patient developed an enlarging neck mass for which he was subjected to a neck resection on August 4, 1964. The histologic diagnosis was Hurthle cell adenoma of parathyroid and a cervical lymph node removed at that time showed metastatic adenocarcinoma, believed to represent spread from the pancreas.

In summary: This patient presumably has had an islet cell carcinoma which metastasized to adrenal gland, lung and cervical nodes. He has had a chromophobe adenoma of the pituitary treated with radiation and a parathyroid Hurthle cell tumor removed surgically. He is being followed for recurrent ulcer symptoms despite therapy with a Billroth II. The patient failed to keep his endocrine appointment.

GROSS PATHOLOGY:

Grossly, the parathyroid adenoma was 1.5 x 1.0 x 0.5 cm. tissue fragment weighing 3 gm. and was stated to be the right inferior parathyroid. The mass had a brown glistening surface and at one pole there was a cap of yellow tissue which measured 0.3 x 0.4 x 0.2 cm. This was sectioned longitudinally and the cut surface revealed firm brown lobulated tissue.

NAME: H. B. W. JANUARY 1965 - CASE NO. 2

AGE: 80 SEX: Male RACE: Unknown ACCESSION NO. 13479

CONTRIBUTOR: I. M. Reingold, M. D. Outside No. S-3151-63
Veterans Administration Hospital
Long Beach, California

TISSUE FROM: Nasal mass

CLINICAL ABSTRACT:

History: The patient entered the hospital because of leg weakness and loss of weight (25 lbs.) in the past 3 months; known diabetic. A mass, measuring 4 x 3 cm., occluded the right nostril and was attached to the septum. It had been present for six months and was associated with some bleeding. Pulse 80; blood pressure 150/80; weight 115.

Laboratory report: WBC 9,000 with 75 neutrophils, 21 lymphocytes; hematocrit 45; hemoblogin 15. Serum calcium 9.4; phosphates 3.4. Serology non-reactive. Bone marrow negative. Bence Jones negative.

Radiographs of the chest, dorsal spine (hypertrophic changes), lumbar spine, and skull were essentially negative.

SURGERY:

The mass was removed in September 1963.

GROSS PATHOLOGY:

The nasal mass was received in several segments, the largest measuring 3 x 1.5 cm. and totally measuring about 4 x 3 x 2 cm. The segments were polypoid, grayish-brown, glistening and solid, although soft.

FOLLOW-UP:

On July 30, 1964, there was recurrence of the mass in the left middle meatus and right inferior turbinate. Biopsy on August 7 and 26, 1964 showed the tumor to be similar to that in your slide. Radiation therapy to the area resulted in shrinkage of the tumor and clearing of the nasal cavity (4,000 r in 39 days). As of November 23, 1964, there is no evidence of recurrence.

NAME: S. W. JANUARY 1965 - CASE NO. 3

AGE: 45 SEX: Male RACE: Unknown ACCESSION NO. 13099

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

Outside No. 780-63

TISSUE FROM: Frontal sinus

CLINICAL ABSTRACT:

History: On May 1, 1962, the patient had an industrial fall while working on stairs and among numerous bruises he drove the nose piece of his glasses into the bridge of his nose or inner canthus. The injury didn't seem severe but this area would swell and subside until it became worse in August 1962. He had x-rays made which were said to reveal no fracture of the nose or any sinusitis. He was seen by his physician who felt the patient had subacute frontal sinusitis and gave him antibiotics for 4 days, cortisone for several days, and nose spray at frequent intervals. His last treatment was January 1963. Since then there has been progressive swelling of the inner canthi so that he could hardly wear his glasses. Also there has been gradual enlargement, warmth and tenderness of the glabellar region.

Radiographs: Lateral projections revealed an irregular 2.5 x 1. cm. zone of bone destruction on the anterior margin of the frontal bone in the supraorbital region of the frontal sinuses. The nasal bone was destroyed, as well as a major portion of the anterior part of the nasal septum.

SURGERY:

Frontal scalp flap and biopsy of tumor of skull was performed on March 29, 1963. At surgery the glabella region was diffusely swollen about three quarters of an inch above its normal level and the inner canthi were widened. Surgery revealed a thick, granular mass making up the glabellar region and anterior wall of the frontal sinus. The granular tissue was in the frontal bone and in the entire frontal sinus going down into the nose. There was no gross purulent material. There was some serous fluid within the membranes of the frontal sinus and the sinus was filled with a cheesy, cholesterol material. Frozen section was reported as epidermoid carcinoma, grade II, of frontal sinus. Radical surgery was felt to be not indicated.

GROSS PATHOLOGY:

The specimen was submitted in the fresh state and measured 7 cm. in length, 2 cm. in width, and 1 cm. in thickness. It was pale yellow-white in color and appeared to be granular and soft in consistency.

FOLLOW-UP:

On June 25, 1964, the patient expired. Autopsy revealed metastases to brain and liver.

NAME: J. K. JANUARY 1965 - CASE NO. 4

AGE: 29 SEX: Male RACE: Caucasian ACCESSION NO. 12757

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

Outside No. AF 62-245

TISSUE FROM: Posterior pharynx

CLINICAL ABSTRACT:

History: The patient was first seen in the outpatient department on June 1, 1962, complaining of an enlarging lump in the left deltoid region present for 6 months. He also noted that a chronic cough had become worse during the past month. A biopsy of the mass revealed a 1 x 2 cm. subcutaneous nodule which on section proved to be metastatic. A chest radiograph on this date revealed diffuse pulmonary metastasis most marked on the left.

On June 6, 1962, the patient was hospitalized for a diagnostic work-up. At that time, history revealed that the patient considered himself in good health and had been in good health all his life. During the past year he had noted a decreased appetite but no weight loss. He denied difficulty swallowing and throat pain but had noted a brown-tinged sputum for several months. He smoked over one pack of cigarettes per day for many years.

Physical examination: An irregular, black, raised papillary lesion was noted extending on the posterior pharynx from the level of the tongue to the level of the larynx. It did not involve the nasopharynx, the lateral pharyngeal wall or the larynx. There were no palpable cervical nodes. In addition to this, the patient was noted to have chronic bilateral middle ear diseases, rales in the left chest, palpable nodes in the left axilla, and multiple benign appearing pigmented nevi of the skin. A sigmoidoscopic examination to 25 cm. was reported as normal. Biopsy of 5 pigmented skin lesions proved them to be benign. Biopsy of the pharyngeal lesion revealed a primary melanocarcinoma.

Laboratory report: A cytology smear of the sputum on July 6, 1962 revealed malignant cells containing brown pigment in the cytoplasm.

The patient's white count and hematocrit remained fairly stable throughout his illness. However, the platelet count gradually decreased from normal levels to 40,000 per cm. on September 20, 1962. This was thought due to the Thio-Tepa therapy. The patient never exhibited any bleeding problems. Urinalysis on September 15, 1962 revealed the urine to be dark brown in color with a trace of albumin, no glucose, 6 to 8 WBC, 2 to 4 RBC, and 1 to 3 coarse granular casts.

Chest x-rays revealed diffuse metastasis most prominent on the left. A bone survey, skull and cervical spine x-rays were all negative.

COURSE:

The patient was followed as an outpatient until August 6, 1962, during which time he rapidly developed subcutaneous metastatic nodules to all areas of the skin. He began to note malaise, easy fatigability and anorexia. By July 24, 1962, he was no longer able to work. He began to note headaches and severe neck pains which were made worse by sudden movements of the head. He began to experience severe left chest pains and had one episode of an auditory hallucination. While still an outpatient the patient received 75 mg. of Thio-Tepa, I.V. at one to two week intervals. This appeared to relieve his chest pain and decrease the size of the pharyngeal lesion but did not change the subcutaneous nodules which continued to increase in size and number. The patient received a total of 360 mg. of Thio-Tepa in 9 weeks of outpatient therapy.

On August 6, 1962, the patient was unable to care for himself and was admitted to the hospital in acute pain. He deteriorated rapidly. The subcutaneous metassatic nodes were noted to enlarge rapidly. The patient became anorexic, experienced nausea and vomiting in addition to the steady increase in headaches and neck pains. He received 250 mg. of Thio-Tepa in divided I.V. doses over a 3 week period, but this did not appear to alter the patient's symptoms. On September 13, 1962, the patient began to experience episodes of generalized convulsions. He expired on September 21, 1962 and autopsy was performed.

GROSS PATHOLOGY:

Autopsy revealed marked emaciation. Examination of the oral cavity and pharynx revealed a 4 x 5 x 3 cm. black, soft, verrucoid nodule on the left lateral wall of the pharynx at the oropharynx-laryngopharynx level, 1.5 cm. caudad to the base of the tongue. Three cm. caudad to the right pyriform recess in the esophageal-tracheal sulcus was a 0.5 x 0.5 x 1.8 cm. black, soft, smooth lymph node. Two cm. caudad and 1 cm. mesiad was a 0.3 x 0.3 x 0.5 cm. lymph node similarly involved. There were extensive metastases to paratracheal and all of the periaortic nodes. The lungs, liver, spleen, kidneys, gastro-intestinal tract, testes, skin and brain were also massively involved.

NAME: T. A. JANUARY 1965 - CASE NO. 5

AGE: 70 SEX: Male RACE: Caucasian ACCESSION NO. 13711

CONTRIBUTOR: M. Barrows, M. D.
Notre Dame Hospital
San Francisco, California

Outside No. AN 64-16

TISSUE FROM: Larynx

CLINICAL ABSTRACT:

History: This patient was hospitalized for arteriosclerotic heart disease in April 1964 and died from acute coronary thrombosis. The patient had persistent hoarseness over a period of several years correlating with a mass (pseudotumor) in the left false vocal cord.

Examination of the larynx clinically about 5 years before death showed only swelling without definitive diagnosis or therapy. The patient had weakly reactive VDRL tests on three out of four occasions during recent years, but showed no evidence of lues in the heart, aorta, or brain at autopsy. Apical scarring with localized caseation (negative to acid fast cultures) was thought to represent arrested tuberculosis.

GROSS PATHOLOGY:

Examination of the trachea and larynx at autopsy showed some injection of the mucosa. The right vocal cord appeared small and normal while the left one was impinged upon by a firm yellowish-tan mass, measuring 1.5 cm. in diameter. It showed no obvious surface ulceration. The tissue immediately deep to the tumor, including the esophagus and regional lymph nodes, showed no sign of local extension of the mass.

NAME: A. H. JANUARY 1965 - CASE NO. 6

AGE: 81 SEX: Female RACE: Caucasian ACCESSION NO. 12210

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

Outside No. 486-62

TISSUE FROM: Left nostril

CLINICAL ABSTRACT:

History: The patient complained of the left nostril being blocked. This was recurrent since November 1961. He also had recurrent nose bleeds with mucus and post-nasal drip. The last nose bleed occurred on January 19, 1962 when this area was cauterized. Treatment with antihistamines resulted in the nasal passages being less blocked but polypi were still present.

Examination of the left nostril revealed nasal polypi, 2-3 plus, obstructing left nostril.

SURGERY:

Removal of nasal polypi was performed on February 20, 1962.

GROSS PATHOLOGY:

The specimen composed of 6.5 gm. of varying sized translucent and hemorrhagic polypoid structures stated to be nasal polyps. There were a total of six ranging in dimensions from 1 x 0.5 x 0.5 up to a cluster of hemorrhagic polyps that measured 4 x 2 x 1 cm. Cut surface showed a smooth glistening mucoid stroma admixed with extensive interstitial hemorrhage and brownish discolored zones.

FOLLOW-UP:

Patient was hit by a car and expired on March 27, 1963 of accidental death. Autopsy revealed no evidence of disease.

NAME: A. P.

JANUARY 1965 - CASE NO. 7

AGE: 36 SEX: Male RACE: Unknown

ACCESSION NO. 12786

CONTRIBUTOR: Milton L. Bassis, M. D.
Permanente Medical Group
San Francisco, California

Outside No. SF62-9432

TISSUE FROM: Left nose

CLINICAL ABSTRACT:

The patient complained of his nose being plugged up and stated that this frequently happened and usually was associated with dull headaches. There was no history of known allergy. A large red polyp was seen arising from the left nasal turbinate. This was locally excised.

GROSS PATHOLOGY:

The specimen consisted of three nasal polyps, having ovoid configurations and gray congested edematous cut surfaces, the largest measuring 2.2 cm. in its greatest dimensions.

FOLLOW-UP:

The patient was last seen in January 1963, at which time he was asymptomatic and has not been examined since.

NAME: J. L. JANUARY 1965 - CASE NO. 8

AGE: 61 SEX: Male RACE: Caucasian ACCESSION NO. 12470

CONTRIBUTOR: W. T. Sweeney, M. D.
St. Luke Hospital
Aberdeen, South Dakota

Outside No. S-768-62

TISSUE FROM: Right nasopharynx

CLINICAL ABSTRACT:

This 61 year old white male had multiple polypoid lesions in the right nasopharynx which showed x-ray evidence of bony destruction. Duration unknown.

GROSS PATHOLOGY:

The specimen consisted of an 11 cm. collection of varisized polyps measuring 1 to 4 cm. in greatest diameter. They were smooth and gray white. The base showed a similar pattern with some hemorrhage, cartilage and bony spicules. The sectioned surface was cystic, gray to tan yellow, with some foci of hemorrhage evident.

FOLLOW-UP:

To date there is no evidence of recurrence.

NAME: L. R. D. JANUARY 1965 - CASE NO. 9

AGE: 21 SEX: Male RACE: Caucasian ACCESSION NO. 13867

CONTRIBUTOR: P. R. Thompson, M. D. Outside No. 2860-64
St. Luke Hospital
Pasadena, California

TISSUE FROM: Left mandible

CLINICAL ABSTRACT:

History: Patient complained of locked jaw since July. He was in usual state of health until approximately five months ago at which time he developed mumps. Following this he began to note increasing problems with opening of jaw. Patient entered the hospital for definitive treatment.

Physical examination was essentially negative except for inability to open jaw. There was no unusual spasm, tumor, lymphoid or thyroid enlargement.

Laboratory report: Hemoglobin 13.1. WBC 7,650.

Radiograph: The left 3rd mandibular molar tooth was absent along with a portion of the alveolar margin about its roots. Best shown on the PA projection was a large saucerized bone defect on the medial margin of the mandible at the junction of the body and ramus representing the recent operative defect. The oblique projections suggested additional removal of bone almost to the promontory of the angle of the mandible. The upper portion of the left mandibular ramus appeared intact. The anterior portion of the body on the left and the entire right half of the mandible appeared normal. Roentgen conclusion: Post-operative left mandible. Bony detail was partially obscured by soft tissue swelling, but no irregular bone destruction suggestive of malignant invasion shown at this examination.

SURGERY:

Exploration of the mandible and removal of tumor was performed on November 13, 1964.

GROSS PATHOLOGY:

The specimen consisted of 15 grams of membranous to solid tan-white tissue, with an occasional piece of muscular tendinous type tissue. The larger solid pieces measured up to 3.0 cm. and had a tan, smooth outer surface, with a cut surface of a ripe pear. The surface was slightly slimy and in areas appeared to be lobulated. The solid portion was quite firm, while the membranous portion was moderately tough, but friable. In one area the muscle appeared to be involved.

NAME: R. V. JANUARY 1965 - CASE NO. 10

AGE: 38 SEX: Male RACE: Caucasian ACCESSION NO. 13879

CONTRIBUTOR: C. P. Schwinn, M. D. Outside No. 64-16810
Los Angeles County Hospital
Los Angeles, California

TISSUE FROM: Thyroid, right.

CLINICAL ABSTRACT:

History: The patient was admitted to the hospital on October 15, 1964 with a chief complaint of puffy eyes and weakness. The patient was in excellent health until one year prior to admission when he noted the gradual onset of muscular weakness, nervousness, easy fatiguiability, and loss of libido. He also became aware of puffy eyes, dry skin and deepening of his voice. He was seen at LACGH on March 6, 1964 and was followed in clinic. During the next 8 months, the patient lost 25 lbs. Patient denies leg edema and genitourinary tract symptoms.

Physical examination in October 1964 revealed pulse 80, respiration 20, and blood pressure 120/70. The skin was warm and smooth. No lid lag was present. The fundi were not remarkable. A 1 cm. firm node was palpable over the right anterior jugular vein. The neck was supple. The thyroid gland was diffusely enlarged with questionable nodularity of the right lobe. Examination of the heart, lungs, and abdomen were not remarkable.

Laboratory report, 3-6-64: Hemoglobin 12.2; WBC 5700. Blood glucose 110. BUN 19, Cholesterol 474. PBI .9. 4-1-64: The patient was started on thyroid therapy, gr. I. 9-17-64: PBI 4.3. Cholesterol 265.

SURGERY:

On November 4, 1964, the patient had a total right thyroidectomy and subtotal left thyroidectomy.

GROSS PATHOLOGY:

The right thyroid and isthmus, 5 x 3 x 0.7 cm., was encapsulated. The isthmic portion measured 1 cm. The external surface was covered by tan, glistening, semi-transparent capsule. A mass was easily palpatedat one pole wherein a few black silk sutures were identified. Serial sectioning disclosed a well-circumscribed ovoid reddish mass, measuring 1 cm. in diameter. The mass was surrounded by the remainder of the thyroid parenchyma which was for the most part tan gray and faintly lobulated. No other masses were identified.

The left lobe of the thyroid measured 2.5 x 1.0 x 0.4 cm. It was somewhat nodular and encapsulated. The cut surface was tan pink.

FOLLOW-UP:

The patient has been followed in clinic and maintained on thyroid since then. Bone marrow studies are pending.

NAME: R. N. S. JANUARY 1965 - CASE NO. 11

AGE: 35 SEX: Male RACE: Caucasian ACCESSION NO. 13700

CONTRIBUTOR: T. S. Kimball, M. D.
Eureka, California
Outside No. A-2408

TISSUE FROM: Trachea

CLINICAL ABSTRACT:

History: The patient was admitted to the hospital on September 24, 1963, with a history of difficult breathing for about two weeks. Many years ago when a small boy he had a tracheotomy done because of diphtheria. Actually since that time he has had some difficulty with breathing and has always had a hoarse voice. He thought that the hoarseness had been worse since about June 1963. He has had a croupy cough lately.

Physical examination: The lung fields were clear. There was a scarred area below the larynx which was the site of the old tracheotomy. There was an aperture present through which part of the breath passed and made a "croupy" sound. There was some retraction with inspiration. Adequate examination with laryngeal mirror was impossible because of gagging and lack of cooperation of the patient. He coughed up some blood-tinged mucus during the examination.

Laboratory report: Complete blood count and urine were normal. Throat culture normal flora. NPN 63 mgm%. Fasting blood sugar 167 mgm.%.

Chest radiograph was normal.

The patient was advised to have a laryngoscopy but refused and suddenly expired during that same night.

GROSS PATHOLOGY:

At autopsy the upper portion of the trachea externally showed marked deformity with such severe narrowing of the lumen that there was almost complete obstruction. The remaining lumen measured 3 to 4 mm. in diameter. This was thought to be due to marked excessive fibrous tissue and scarring. However, on section, this was found to be due to invasive carcinoma. A large amount of mucopurulent exudate was found in the terminal portion of the trachea and the first portion of the bronchi. The thyroid was not remarkable. There was marked edema of the larynx with a polypoid structure measuring 6 mm. in diameter present on the right vocal cord. This was thought to be related to the patient's progressive hoarseness.

NAME: E. R. JANUARY 1964 - CASE NO. 12

AGE: 18 SEX: Female RACE: Caucasian ACCESSION NO. 12865

CONTRIBUTOR: D. R. Dickson, M. D. Outside No. S63-1405
Santa Barbara Cottage Hospital
Santa Barbara, California

TISSUE FROM: Nasal mass

CLINICAL ABSTRACT:

History: This 18 year old female, Mexican national, was admitted to the hospital on March 24, 1963, complaining of complete nasal obstruction for the past three years. Prior to the last three months, she had always lived in Tijuana.

Physical examination showed widening across the bridge of the nose and complete nasal obstruction by bilateral masses of firm, rubbery, tan-pink, polypoid tissue. No necrosis, foul drainage, or bleeding was evident. The remainder of the physical examination was not remarkable.

Laboratory report: Urinalysis, hemogram, VDRL, bleeding and clotting times were within normal limits.

SURGERY:

On March 25, 1963, a bilateral nasal polypectomy was performed. There was complete obstruction by large polypoid masses with adhesions of the right inferior turbinate to the septum. After removal of the polyps, the left lateral wall architecture appeared abnormal with the turbinates atrophic. Bilateral hypertrophy of the lateral pharyngeal bands was also present.

GROSS PATHOLOGY:

The specimen consisted of 5.5 gm. of gragmented, firm, rubbery, pale tan tissue with an occasional semblance of polypoid configuration. No ulceration, necrosis or hemorrhage was seen.

FOLLOW-UP:

She received a course of aureomycin post-operatively. There has been no further obstruction of the nasal airway, but the floor and lateral aspects of the nasopharynx are granular and occasionally crusted. The lateral pharyngeal bands are thickened and nodular, but this is producing no symptoms. The patient was last seen the first of November 1964 and her general health was good.

STUDY GROUP CASES
FOR
JANUARY 1965

TUMORS OF HEAD AND NECK

CASE NO. 1, ACCESSION NO. 13774, C. P. Schwinn, M. D., Contributor

LOS ANGELES:

Oxyphil adenoma, parathyroid, 5.

OAKLAND:

Parathyroid adenoma, 11.

CENTRAL VALLEY:

Parathyroid adenoma, 11.

SAN DIEGO:

Oxyphil adenoma, parathyroid gland, 9.

UNIVERSITY OF KENTUCKY:

Parathyroid adenoma, 4.

SANTA BARBARA:

Oxyphil parathyroid adenoma, 5.

SAN FRANCISCO:

Oxyphil adenoma, 18.

WEST LOS ANGELES:

Oxyphilic (Hurthle cell) adenoma, 10.

ORANGE:

Benign oxyphilic adenoma of the parathyroid, 6.

FILE DIAGNOSIS: Oxyphil adenoma, parathyroid	820-8091 A
Cross-file: Hurthle cell tumor	820-8065 A

JANUARY 1965

CASE NO. 2, ACCESSION NO. 13479, I. M. Reingold, M. D., Contributor

LOS ANGELES:

Plasmacytoma, nasal cavity, 15.

OAKLAND:

Malignant tumor, 11 (plasma cell myeloma, 5; reticulum cell sarcoma, 3; anaplastic carcinoma, 3).

CENTRAL VALLEY:

Anaplastic (transitional cell) carcinoma, 6; plasmacytoma, 4; melanoma, 1.

SAN DIEGO:

Plasmablastoma of nose, 6; anaplastic carcinoma, 3.

UNIVERSITY OF KENTUCKY:

Plasmacytoma, 4.

SANTA BARBARA:

Extraosseous plasmablastoma, 3; malignant plasmacytoma, 2.

SAN FRANCISCO:

Plasmacytoma, 12; undifferentiated carcinoma, 5; reticulum cell sarcoma, 1.

WEST LOS ANGELES:

Extramedullary plasmacytoma, probably malignant, 10.

ORANGE:

Plasmacytoma of the nose, malignant, 5; undifferentiated carcinoma, 1.

FILE DIAGNOSIS: Plasmacytoma, nasal cavity 310-833 F

JANUARY 1965

CASE NO. 3, ACCESSION NO. 13099, Paul Thompson, M. D., Contributor

LOS ANGELES:

Squamous carcinoma, frontal sinus, 15.

OAKLAND:

Squamous cell carcinoma, 11.

CENTRAL VALLEY:

Epidermoid carcinoma, 11.

SAN DIEGO:

Squamous cell carcinoma, 9.

UNIVERSITY OF KENTUCKY:

Squamous cell carcinoma with venous invasion, 4.

SANTA BARBARA:

Squamous cell carcinoma, 5.

SAN FRANCISCO:

Squamous cell carcinoma, 13.

WEST LOS ANGELES:

Squamous cell carcinoma, 10.

ORANGE:

Epidermoid carcinoma, grade II, 6.

FILE DIAGNOSIS: Squamous carcinoma, frontal sinus 322-814 F

JANUARY 1965

CASE NO. 4, ACCESSION NO. 12757, Milton Bassis, M. D., Contributor

LOS ANGELES:

Melanoma, pharynx, 15.

OAKLAND:

Melanoma, primary ?, 11.

CENTRAL VALLEY:

Melanocarcinoma of mucous membrane of posterior pharynx, 11.

SAN DIEGO:

Malignant melanoma, 9; discussion was heard on whether this was primary or metastatic and feelings were mixed.

UNIVERSITY OF KENTUCKY:

Malignant melanoma, primary at this site, 4.

SANTA BARBARA:

Primary malignant melanoma hypopharynx, 5.

SAN FRANCISCO:

Melanoma, 13.

WEST LOS ANGELES:

Malignant melanoma, 10.

ORANGE:

Primary melanocarcinoma of the pharynx, 6.

FILE DIAGNOSIS: Melanoma, pharynx 318-8173 F

JANUARY 1965

CASE NO. 5, ACCESSION NO. 13711, M. Barrows, M. D., Contributor

LOS ANGELES:

Amyloid tumor, larynx, 15.

OAKLAND:

Amyloidosis, larynx, 11.

CENTRAL VALLEY:

Amyloid tumor (focal amyloidosis), 11.

SAN DIEGO:

Amyloid tumor of the larynx, 9.

UNIVERSITY OF KENTUCKY:

Amyloidosis, 4.

SANTA BARBARA:

Amyloid tumor of larynx, 5.

SAN FRANCISCO:

Amyloid, 18.

WEST LOS ANGELES:

Amyloid tumor, 10.

ORANGE:

Benign laryngeal nodule, hyaline stage, 5; granulomatous lesion, benign, 1.

FILE DIAGNOSIS: Amyloid tumor, larynx 330-922

JANUARY 1965

CASE NO. 6, ACCESSION NO. 12210, Paul Thompson, M. D., Contributor

LOS ANGELES:

Reticulum cell sarcoma, nasal cavity, 15.

OAKLAND:

Lymphoma, 7; anaplastic carcinoma, 3; esthesioneuroblastoma, 1.

CENTRAL VALLEY:

Anaplastic carcinoma, 3; lymphoma, 3; plasmacytoma, 1; malignant hemangiopericytoma, 2; angiosarcoma, 1; melanoma, 1.

SAN DIEGO:

Anaplastic carcinoma of left nostril, 3; reticulum cell sarcoma, 5; hemangiosarcoma, 2; sarcoma, 1.

UNIVERSITY OF KENTUCKY:

Undifferentiated sarcoma, 2; undifferentiated carcinoma, 2.

SANTA BARBARA:

Lymphoepithelioma, 3; retinal anlage tumor, 1; lymphoepithelioma vs. reticulum cell sarcoma, 1.

SAN FRANCISCO:

Undifferentiated carcinoma, 8; undifferentiated malignant tumor, 8.

WEST LOS ANGELES:

Esthesioneuroblastoma, 3; malignant lymphoma (reticulum cell), 5; carcinoma, 2.

ORANGE:

Malignant lymphoma, 5; esthesioneuroblastoma, 1.

FILE DIAGNOSIS: Reticulum cell sarcoma, nasal cavity 310-831 F

CASE NO. 7, ACCESSION NO. 12786, Milton L. Bassis, M. D., Contributor

LOS ANGELES:

Angiofibroma, nasal cavity, 8; myxofibroma, 4; no vote, 3.

OAKLAND:

Angiofibroma, 5; fibroma, 2; myxoma, 2.

CENTRAL VALLEY:

Fibromyxomatous polyp, mesenchymal, 8; olfactory esthesioneuroepithelioma, 3.

SAN DIEGO:

Angiomyxofibroma of left nose, 10; nasal polyp, 1.

UNIVERSITY OF KENTUCKY:

Fibromyxomatous nasal polyp, 3; allergic type nasal polyp, 1.

SANTA BARBARA:

Angiofibroma, 3; cellular fibroma, 1; angioma, unclassified, 1.

SAN FRANCISCO:

Myxomatous nasal polyp, 9; angiofibroma, 6; embryonal rhabdomyosarcoma, 1; benign mesenchymoma, 1.

WEST LOS ANGELES:

Cellular fibrous nasal polyp, 2; cellular angiofibroma, 7; polypoid fibroma, 1.

ORANGE:

Fibrous nasal polyp, 3; angiofibroma, 2; nasal pharyngeal fibroma, benign, 1.

FILE DIAGNOSIS: Angiofibroma, nasal cavity 310-871 B

Cross-file: Myxoma 310-871 B

JANUARY 1965

CASE NO. 8, ACCESSION NO. 12470, W. T. Sweeney, M. D., Contributor

LOS ANGELES:

Epithelial (squamous) papilloma, nasopharynx, 15.

OAKLAND:

Inverted papilloma, 11.

CENTRAL VALLEY:

Squamous papillomatosis, 11.

SAN DIEGO:

Schneiderian papilloma (verrucal papilloma, right nasal pharynx), 10; squamous cell carcinoma, low grade (schneiderian), 1.

UNIVERSITY OF KENTUCKY:

Schneiderian papilloma, 4.

SANTA BARBARA:

Schneiderian papilloma, 5.

SAN FRANCISCO:

Inverted papilloma of nose, 18.

WEST LOS ANGELES:

Inverted papilloma (Schneiderian), 10.

ORANGE:

Benign squamous papilloma, 4; squamous cell carcinoma, grade I, 2.

FILE DIAGNOSIS: Squamous papilloma (Schneiderian) nasopharynx 318-814 A

CASE NO. 9, ACCESSION NO. 13867, P. R. Thompson, M. D., Contributor

LOS ANGELES:

Malignant schwannoma, mandible, 7; fibrosarcoma, 1; spindle cell sarcoma, 7.

OAKLAND:

Sarcoma, 8 (myo and fibro mentioned); odontogenic fibroma, 2.

CENTRAL VALLEY:

Odontogenic fibroma, 2; synovial sarcoma, 1; sarcoma not otherwise classified, 2; fibrosarcoma, 6.

SAN DIEGO:

Squamous sarcoma, 11.

UNIVERSITY OF KENTUCKY:

Fibrosarcoma, 4.

SANTA BARBARA:

Odontogenic fibroma, 4; fibrosarcoma, 1.

SAN FRANCISCO:

Fibrosarcoma, 7; sarcoma, 5; myosarcoma, 3; synovial sarcoma, 2; neurofibrosarcoma, 1.

WEST LOS ANGELES:

Sarcoma, 10 (Neurofibro, 4; spindle cell, 3; odontogenic fibro, 1; endothelial, 1; synovial, 1).

ORANGE:

Fibrosarcoma, 4; embryonal rhabdomyosarcoma, 1; neurofibrosarcoma, 1.

FILE DIAGNOSIS: Fibrosarcoma, mandible 219-870 F

JANUARY 1965

CASE NO. 10, ACCESSION NO. 13879, C. P. Schwinn, M. D., Contributor

LOS ANGELES:

Plasmacytoma, thyroid, 15.

OAKLAND:

Plasmacytoma, 7; small cell carcinoma, 2; Hashimoto's disease, 1.

CENTRAL VALLEY:

Primary anaplastic carcinoma of thyroid, 7; thyroiditis, 4.

SAN DIEGO:

Hurthle cell carcinoma of thyroid gland, 1; plasmacytoma, 5; anaplastic carcinoma, 5.

UNIVERSITY OF KENTUCKY:

Plasma cell thyroiditis (reactive), 2; plasmacytoma of thyroid (tumor), 2.

SANTA BARBARA:

Plasmacytoma with probably amyloid, 4; pleomorphic carcinoma, 1.

SAN FRANCISCO:

Undifferentiated carcinoma, 11; plasmacytoma, 4; medullary carcinoma with amyloid stroma, 1.

WEST LOS ANGELES:

Hurthle cell carcinoma, 1; plasmacytoma, 8; malignant tumor, type ?, 1.

ORANGE:

Plasmacytoma of the thyroid, 3; giant cell carcinoma of the thyroid, 2; undifferentiated carcinoma, 1.

FILE DIAGNOSIS: Plasmacytoma, thyroid 810-833 F

JANUARY 1965

CASE NO. 11, ACCESSION NO. 13700, T. S. Kimball, M. D., Contributor

LOS ANGELES:

Squamous carcinoma, trachea, 15.

OAKLAND:

Squamous cell carcinoma, 11.

CENTRAL VALLEY:

Squamous carcinoma arising at the site of tracheostomy, 11.

SAN DIEGO:

Squamous cell carcinoma of trachea, 11.

UNIVERSITY OF KENTUCKY:

Squamous cell carcinoma, 4.

SANTA BARBARA:

Squamous carcinoma of trachea, 5.

SAN FRANCISCO:

Squamous cell carcinoma, 13.

WEST LOS ANGELES:

Squamous cell carcinoma, 10.

ORANGE:

Squamous cell carcinoma, grade II, 6.

FILE DIAGNOSIS: Squamous carcinoma 340-814 F

CASE NO. 12, ACCESSION NO. 12865, D. R. Dickson, M. D., Contributor

LOS ANGELES:

Rhinoscleroma, nasal cavity, 15.

OAKLAND:

Rhinoscleroma, 11

CENTRAL VALLEY:

Rhinoscleroma, 11.

SAN DIEGO:

Rhinoscleroma of nose, 6; polypoid chronic granular tissue, 5.

UNIVERSITY OF KENTUCKY:

Rhinoscleroma, 4.

SANTA BARBARA:

Rhinoscleroma, 5.

SAN FRANCISCO:

Rhinoscleroma, 18.

WEST LOS ANGELES:

Rhinoscleroma, 10.

ORANGE:

Rhinoscleroma, 5; fibroxanthomatous polyp, 1.

FILE DIAGNOSIS: Rhinoscleroma, nasal cavity 310-130