CALIFORNIA TUMOR TISSUE REGISTRY

LOS ANGELES COUNTY HOSPITAL

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PROTOCOL

FOR

MONTHLY SLIDES

MAY 1966

TUMORS OF HEAD AND NECK

NAME: J. H. MAY 1966 - CASE NO. 1

AGE: 66 SEX: Female RACE: Caucasian ACCESSION NO. 14397

CONTRIBUTOR: D. R. Dickson, M. D. Outside No. S-61-1539
Santa Barbara Cottage Hospital
Santa Barbara, California

TISSUE FROM: Thyroid

CLINICAL ABSTRACT:

History: The patient was a 66-year-old Caucasian female who had a goiter present for most of her life and 40 years previously the isthmus of the thyroid had been removed. Calcification in the goiter had been demonstrated by x-ray for many years. Recently the left lobe of the thyroid gland had become enlarged and somewhat tender. Her general physical condition was good and there were no signs, symptoms, or laboratory evidence of hyperthyroidism.

The past history revealed a left radical mastectomy for carcinoma 15 years ago.

Physical examination revealed an old thyroidectomy scar and a mass measuring 3 cm. in diameter was palpable in the base of the left thyroid gland. The remainder of the physical examination was negative.

SURGERY:

On March 28, 1961 an estimated 90% thyroidectomy was performed, removing all of the left lobe and the major portion of the right lobe. Calcified nodules were present in both lobes, and the left inferior parathyroid gland was the only parathyroid identified.

GROSS PATHOLOGY:

The right lobe of the thyroid gland weighed 39 gm. and contained numerous partially calcified colloid nodules, measuring up to 35 mm. in diameter. The left lobe weighed 38 gm. and measured 68 x 40 x 30 mm. The major portion of the left lobe was replaced by a hard, lobulated, ovoid mass, measuring 40 x 28 x 25 mm. The sectioned surfaces of the mass were composed of firm, rubbery, lobulated, tan-white tissue with peripheral discrete scalloped lobules, 4 to 10 mm. in diameter. In the central portion of the mass was a well defined nodule 20 mm. in diameter with a thin shell-like calcification delineating its periphery and containing slender central trabeculations of calcification. Between the calcified trabeculations were lobulations of tissue similar to that about the periphery of the mass. The nodule was not distinctly encapsulated, but no invasion of the thyroid lobe capsule was evident.

COURSE:

Postoperatively blood calcium on March 31, 1961 was 9.6 mg.%. The postoperative course was uneventful and the patient was discharged on the fourth postoperative day. Twenty-four hours after discharge she developed a sudden episode of laryngeal and carpo-pedal spasm with numbness of the face, arms, and hands. This responded to intravenous calcium gluconate. Twenty-four hours after the onset of tetany the serum calcium level was 7.8 mg., phosphorus 2.4 mg., and urine calcium was 0. The patient was put on calcium gluconate and Calciferol, and she had no further clinical evidence of hypocalcemia. Within one month she was able to discontinue all medications.

FOLLOW-UP:

The patient is being seen at monthly intervals for her rheumatoid arthritis which has developed in the past 4 years. She is receiving steroids in high dosage and has developed cushinoid changes. There is no evidence of recurrence of tumor in the neck. Serum calcium on September 14, 1965 was 9.5 mg.%.

NAME: S. P. MAY 1966 - CASE NO. 2

AGE: 63 SEX: Male RACE: Caucasian ACCESSION NO. 14620

CONTRIBUTOR: Clifford N. Tschetter, M. D. Outside No. 65S-1630
St. Rose Hospital
Hayward, California

TISSUE FROM: Left preauricular region

CLINICAL ABSTRACT:

History: The patient was a 63-year-old Caucasian male who was admitted to the hospital for excision of a mass near the angle of the mandible on the left side. This mass had been present for about six months, and according to both the patient and the patient's physician this mass had fluctuated in size, at times almost disappearing. At the time of this admission the mass measured approximately 2.0 x 3.0 cm.

The past history revealed he was a mild diabetic who had been taking Orinase for two years.

Physical examination was negative except for the mass in the left neck. The parotid glands were not palpably enlarged.

Laboratory report: Hemoglobin was 13.9 gm., white blood count was 10,550 with 26% lymphocytes and 74% neutrophiles. Urinalysis was normal.

SURGERY:

On November 8, 1965 the mass was excised. The mass was near, but apparently not attached to, the inferior lobe of the parotid gland. The surgeon felt that there were also enlarged deeper nodes, and a portion of one of these was attached to the main mass.

GROSS PATHOLOGY:

The specimen consisted of a smooth ovoid node, measuring 2.0 x 2.0 x 1.5 cm., which had been previously transected. The node was firm, appeared well encapsulated and had a pinkish-tan cut surface. Attached to this node was a small mass of similar appearing tissue.

FOLLOW-UP:

The patient was seen in February 1966 for the "flu". There was no evidence of recurrence at that time.

NAME: R. M. MAY 1966 - CASE NO. 3

AGE: 60 SEX: Female RACE: Caucasian ACCESSION NO. 14086

CONTRIBUTOR: E. R. Jennings, M. D. Outside No. S 345-65
Memorial Hospital of Long Beach
Long Beach, California

TISSUE FROM: Hard palate (superior aspect)

CLINICAL ABSTRACT:

History: The patient was a 60-year-old Caucasian female who three years prior to her first admission to the hospital had a plastic procedure by an orthodontist on the hard palate. In February 1960 she noticed tenderness on chewing and was referred to a surgeon. X-rays taken on February 11, 1960 revealed an ovoid osteolytic lesion of the palate and antrum sinuses located on the left anteriorly near the alveolar ridge. It was found that the tumor originated in the left antrum extending to the medial wall of the antrum, and into the maxilla posteriorly as far as the pterygoid fossa. The tumor was removed surgically and was considered to represent a primary tumor of the maxillary sinus.

She showed no recurrence until May 1964 at which time she demonstrated extensive recurrence. She was given Cobalt therapy and was re-admitted to the hospital on January 19, 1965 for further surgery.

GROSS PATHOLOGY:

The specimen consisted of a slightly mottled tan and yellow mass measuring 2.6 x 2.5 x 3.5 cm. in maximum dimension, located superior to the hard palate. The specimen, within which this tumor was contained was a portion of maxilla, and the tumor extended beyond the margins of excision. There was gross extension into the right maxillary antrum, and the left maxillary antrum had been previously removed. The tumor was also infiltrating the gingiva and bone of the maxilla. Further surgical excision was carried out; however, only the bulk of the tumor was received at this time. It was uniform and in moderately firm consistency.

FOLLOW-UP:

She was last seen by her physician on August 2, 1965 and at that time there was no evidence of activity.

NAME: D. D. S. MAY 1966 - CASE NO. 4

AGE: 34 SEX: Female RACE: Caucasian ACCESSION NO. 14396

CONTRIBUTOR: D. R. Dickson, M. D. Outside No. S-65-1419
Santa Barbara Cottage Hospital
Santa Barbara, California

TISSUE FROM: Left submandibular region

CLINICAL ABSTRACT:

History: The patient was a 34-year-old Caucasian female who contacted her physician in March 1965 because of a left submandibular mass which was first noted by the patient in 1960. The mass would increase in size with upper respiratory infections and then regress, but in the 6 months prior to admission there had been progressive enlargement.

Past history revealed the patient had a wide excision of a malignant melanoma of the left shoulder in 1955.

Physical examination revealed a large submandibular mass with no palpable cervical or peripheral lymphadenopathy. Examination of the oral pharynx showed a large mass protruding in its place and displacing the left tonsillar pillar and uvula.

Laboratory report: Hemogram and urinalysis were normal.

SURGERY:

The mass was excised on March 25, 1965. Dissection was accomplished with ease and there was no dense attachment to the adjacent structures.

GROSS PATHOLOGY:

The ovoid tumor weighed 75 gm. and measured 90 x 55 x 45 mm. It was enveloped in a thin, transparent areolar capsule with attached bits of membranous tissue. At one pole a fibrovascular pedicle was attached which measured 35 mm. long and 12 x 5 mm. in width. The cut surfaces about the peripheral margins were homogeneous, glistening, slightly bulging, and light tan. Centrally the tissue was finely cystic and gelatinous, varying from yellow to firm red-tan.

FOLLOW-UP:

The patient was seen by her physician on December 1, 1965 with no evidence of recurrence.

NAME: J. K.

MAY 1966 - CASE NO. 5

AGE: 14 SEX: Female RACE: Caucasian

ACCESSION NO. 14441

CONTRIBUTOR: Carter M. Alexander, M. D.
Inter-Community Hospital
Covina, California

Outside No. 3570-65

TISSUE FROM: Parotid gland

CLINICAL ABSTRACT:

History: The patient was a 14-year-old Caucasian female who was seen because of left preauricular swelling present for 7 months prior to admission. There was no marked increase in the size of the mass until May 1965 when the enlargement was associated with pain and tenderness. The mass further increased in size during the past month prior to admission.

Past history revealed the patient to have had a tonsillectomy performed on May 27, 1965. An afebrile episode 7 years previously was thought to be acute rheumatic fever but was concluded to be tonsillitis.

Physical examination revealed a tender mass in the left preauricular area with some enlarged glands just below the angle of the left jaw. Lymph nodes were palpable in both axillae. The remainder of the examination was negative.

SURGERY:

Removal of the left parotid salivary gland tumor was performed on September 7, 1965.

GROSS PATHOLOGY:

The specimen consisted of a nodular piece of ovoid tissue measuring 3 x 2.3 x 2.3 cm. There was an apparent intact thin capsule surrounding the tumor. Sections showed homogeneous and moderately firm tissue or material filling the entire specimen. The margins seemed slightly scalloped and there was faint trabeculation within the lesion. No normal salivary gland tissue was identified. Another piece of tissue measuring 3 x 1.8 x 1.2 cm. was stated to be from the superficial parotid gland and not in continuity with the tumor. This was composed of soft lobulated pale tan tissue, grossly salivary gland tissue. Hanging by threads to one edge were two soft purple nodules up to 3 mm. in diameter that were sectioned.

FOLLOW-UP:

The patient was seen by her private physician on October 22, 1965 and in January of 1966. At the time of both examinations, the patient was clinically well and without clinical evidence of tumor recurrence.

NAME: F. R. MAY 1966 - CASE NO. 6

AGE: 43 SEX: Female RACE: Mexican ACCESSION NO. 14632

CONTRIBUTOR: D. A. DeSanto, M. D. Outside No. 5213-65
Mercy Hospital
San Diego, California

TISSUE FROM: Thyroid gland

CLINICAL ABSTRACT:

History: The patient was a 43-year-old Mexican female who had been aware of a slowly enlarging, painless mass in the left side of her neck for 16 years prior to her admission on November 2, 1965.

Past history revealed that the patient had enjoyed general good health all of her life. She had suffered intermittent pain in the wrists, hands and knees for 10 years prior to admission which she was told was due to rheumatoid arthritis but had not been treated. She had an appendectomy and a tonsillectomy performed many years ago.

Physical examination revealed a firm, non-tender, 6 x 5 x 4 cm. mass to the right of the trachea which moved with swallowing. The right lobe of the thyroid was palpable and not noticeably enlarged. The remainder of the physical examination was negative except for cystorectocele and a mild deformity of the proximal interphalangeal joints.

Laboratory report: Protein bound iodine was 7.0 mct %. Triiodothyronine binding power of the plasma was 23% (normal 25-35%). I-131 uptake was 16% at 6 hours, 32% at 24 hours and the 24 hour conversion ratio was 17%; thyroid scan showed no uptake of iodine 131 over the mass in the left lobe. Hemoglobin was 13.4 gm.% and hematocrit 40%. The electrocardiogram was normal.

SURGERY:

On November 3, 1965 the left lobe, isthmus and a small piece of the contiguous right lobe was excised surgically under general anesthesia with the loss of 150 ml. of blood.

GROSS PATHOLOGY:

The specimen consisted of a tan-red, uniformly lobate, moderately firm, resilient tissue measuring 55 gm. It was covered by filmy, gray, translucent areolar tissue. The bulk of the specimen was an ovoid mass, 6.5 x 4.0 x 4.0 cm., with a trapezoidal extension 2.5 x 2.5 x 1.0 cm.

On section the ovoid mass was largely occupied by a firm, varigated, tan-yellow and brown-red ovoid mass 4.8 x 2.0 x 2.0 cm. in diameter which markedly compressed the surrounding uniformly lobate tan-red tissue of the rest of the specimen. The mass was quite distinct from the compressed tissue but no distinct capsule was noted. The tan-yellow areas were continuous at the periphery of the mass and bulged slightly from its cut surface. The brown red areas were less firm, ovoid, slightly depressed on section and tend to coalesce with adjacent similar areas.

COURSE:

The patient did well after surgery and was discharged home.

FOLLOW-UP:

The follow-up requested but not available at this time.

NAME: D. M. C.

MAY 1966 - CASE NO. 7

AGE: Newborn SEX: Female RACE: Caucasian

ACCESSION NO. 14226

CONTRIBUTOR: S. M. Rabson, M. D.
Mission Hospital
Huntington Park, California

Outside No. 65-12471

TISSUE FROM: Gingiva

CLINICAL ABSTRACT:

History: The patient was a newborn female infant. At birth, the physician saw a mass presenting through the lips. It took origin just to right of the midline from the gum line of the lower jaw. The mass was resected and the area was closed with several sutures.

GROSS PATHOLOGY:

The specimen was received in 2 pieces. The larger piece measuring 4 x 2 x 3 cm. was kidney-shaped and firm. It was basically gray but much of the surface, except for the broad posterior surface where was the small area of resection, was reddened and apparently partly necrotic. There was a small protrusion of the mass where the area of resection was located. On section, the tissues were firm, densely and finely fibrillar, and fleshy pink. The other piece measuring 1.5 x 2.5 x 0.6 cm. was apparently torn away from the reddened necrotic portion of the surface of the first piece.

FOLLOW-UP:

The follow-up requested but not available at this time.

NAME: E. M. B.

MAY 1966 - CASE NO. 8

AGE: 69 SEX: Male RACE: Caucasian

ACCESSION NO. 14400

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

Outside No. 2180-65

TISSUE FROM: Right parotid gland

CLINICAL ABSTRACT:

History: The patient was a 69-year-old Caucasian male who was admitted on September 31, 1965 because he had noted recently a nodule in the lower pole of the right parotid gland. This nodule was enlarging of late and patient entered the hospital on August 31, 1965 for surgical removal.

GROSS PATHOLOGY:

The specimen consisted of a well encapsulated lesion with a small portion of tan lobulated parotid tissue. The encapsulated lesion was approximately 2.5 x 2 x 1.5 cm. It had a purplish-bluish appearance. On sectioning a milky, slightly sticky secretion over-flowed from the cut surface which when scraped away showed what appeared to be the remains of a lymph node and small punctate white areas with the central portion having a papillary appearance and occasional large dilated areas that had a silver lining.

FOLLOW-UP:

The patient is asymptomatic.

NAME: C. J. MAY 1966 - CASE NO. 9

AGE: 73 SEX: Female RACE: Caucasian ACCESSION NO. 13878

CONTRIBUTOR: Harold N. Harrison, M. D. Outside No. A-2751
The Humboldt Medical Laboratories
Eureka, California

TISSUE FROM: Cervical spine extending into nasopharynx

CLINICAL ABSTRACT:

History: The patient was a 73-year-old Caucasian female who for the past year has had pain in her neck with numbness and tingling sensations in both arms. These symptoms have been progressing. She has been a known diabetic for years and took 40 units of insulin. She denied any other serious illnesses or operations other than some studies on the renal tract 4 years before. She denied recent weight loss. On the day of admission the patient suffered a fall and was brought to the Emergency Room. She was unable to move her legs and arms.

Physical examination revealed the patient to be hypotensive. The blood pressure was 80/0, whereas previously she had been hypertensive. She was found to have a complete quadriplegia from the C-4 level down, both sensory and motor. She had absent sensation to pin stick in the lower extremities and left arm.

X-ray of the cervical spine (2 lateral views) revealed an osteolytic destruction of C-3 and C-4. There was no subluxation of the spinal canal.

Attempts to pass a gastric tube was unsuccessful because of the anterior projection of a mass into the posterior pharynx.

COURSE:

The patient was treated with a mild cervical traction to produce comfort, but the patient expired on November 2, 1964.

GROSS PATHOLOGY:

Examination of the cervical vertebrae revealed a linear, soft, hemorrhagic, lobular mass, measuring 6 x 3 x 1 cm., arising from the anterior surface of the body of the 4th cervical vertebra. Digital examination revealed softening of the cancellous bony tissue of the body of the 4th cervical vertebra with erosion of the disc into the 3rd and 5th bodies. There was moderate scoliosis of the thoracic vertebrae. In addition to the cervical tumor the patient was found to have acute hypertensive cardiovascular disease with severe coronary atherosclerosis and myocardial fibrosis. There was evidence for an acute myocardial infarction found contributory to the patient's death.

NAME: A. B. MAY 1966 - CASE NO. 10

AGE: 17 SEX: Male RACE: Caucasian ACCESSION NO. 14469

CONTRIBUTOR: Leo Kaplan, M. D. Outside No. T-2742-65
Cedars-Sinai Medical Center
Los Angeles, California

TISSUE FROM: Right thyroid

CLINICAL ABSTRACT:

History: The patient was a 17-year-old Caucasian male who had a swelling in the right side of the neck since 1959. He had noted that the swelling appeared after being hit by a baseball on that side of the neck.

On physical examination a soft, large mass was felt in the right thyroid lobe.

Laboratory report: Radioactive iodine uptake was 18% with decreased uptake over the mass. The remaining laboratory finding and numerous neck and chest x-rays were non-contributory.

SURGERY:

On August 30, 1965 surgery was performed and a 9.0 x 3.0 x 3.0 cm. mass with overlying dilated vascular channels was found involving the area of the right thyroid and extending to the esophagus. The lesion was very adherent to surrounding tissue. It did not extend to the bifurcation of the carotid artery.

GROSS PATHOLOGY:

The specimen measured 9.0 x 3.0 x 3.0 cm. and appeared encapsulated and covered with dilated veins. On section the tumor was rubbery, whitish tan and occupied the entire "right thyroid lobe". Also received was the left thyroid lobe which was encapsulated, meaty red, and on section showed no involvement by tumor.

COURSE:

Postoperatively the patient developed pleuritis.

FOLLOW-UP:

The patient has returned to college as a full-time student and is currently entirely well without signs or symptoms of recurrence or metastases.

NAME: G. S. MAY 1966 - CASE NO. 11

AGE: 66 SEX: Male RACE: Caucasian ACCESSION NO. 14421

CONTRIBUTOR: Thais R. Thrasher, M. D. Outside No. 65-S-2662C
Loma Linda University Hospital
Loma Linda, California

TISSUE FROM: Neck (tumor attached to vagus nerve)

CLINICAL ABSTRACT:

History: The patient was a 66-year-old Caucasian male who was first seen in November 1964 because of hypertension and blackout episodes which began 5 years previously. Extensive tests and medical examination including carotid angiograms showed partial occlusion of both internal carotid arteries. A left carotid endarterectomy was performed on November 13, 1964, and a right carotid endarterectomy was performed on January 11, 1965. Patient had an uneventful postoperative course. On February 14, 1965 he was seen by a urologist because of difficulty voiding. The prostate was moderately enlarged and tender. A transurethral prostatectomy was performed on February 17, 1965 and adenocarcinoma was found microscopically. A lesion of the tongue was removed in the interim between March and July of 1965. This was stated to be squamous cell carcinoma and a wedge of the right side of the tongue was removed. On July 27, 1965 multiple palpable nodules were found in the right neck.

SURGERY:

On August 10, 1965 a right radical neck dissection was performed, and resection and re-anastamosis of the right internal carotid artery was necessary to remove the tumor. At that time, a 2 cm. rubbery fluctuant grey-black tumor mass was found inherent within the vagus nerve at its entrance at the base of the skull. It was removed with great care to preserve any remaining fibers of the nerve. Postoperatively no symptoms relative to loss of vagus nerve function on that side were noted. Numerous nodes within the radical neck tissue showed metastatic squamous carcinoma, and the segment of carotid artery also showed tumor invasion.

GROSS PATHOLOGY:

The tumor from the vagus nerve was 2 x 1.2 x 1.2 cm. It was an oval mass of soft purple grey tissue. It was attached to the sheath of the vagus nerve at its exit from the cranium. Cut surfaces showed a thin semi-translucent grey wall surrounding uniform homogeneous red-black tissue.

NAME: C. L. MAY 1966 - CASE NO. 12

AGE: 32 SEX: Female RACE: Caucasian ACCESSION NO. 14474

CONTRIBUTOR: Seth L. Haber, M. D. Outside No. 65-3311
Kaiser Foundation Hospital
Santa Clara, California

TISSUE FROM: Parathyroid

CLINICAL ABSTRACT:

History: The patient was a 32-year-old Caucasian female who had a ureteral lithotomy performed in 1965. A recurrent renal stone was noted on the right. The patient had no other symptoms.

Past History revealed that a renal stone was removed in 1956 via a Johnson Basket. In 1962 a spherical, capsulated mass measuring approximately 3 x 2½ x 2 cm. was removed from the anterior margin of the upper 1/3 of the left sternomastoid muscle. It was superficial and was not attached to any muscular or neuro-vascular structures. After consultation with the AFIP, it was signed out as a malignant spindle cell tumor of the neck or possibly metastatic undifferentiated carcinoma. There has been no evidence of recurrence of this lesion.

Laboratory report: Serum calcium ranged from 11.5 to 12.6 mg.%. A 24 hour urinary phosphorus determination was 65 mg.% and the creatinine was 194 mg.%. Postoperatively, the serum calcium ranged from 9 to 10 mg.%.

SURGERY:

At the time of surgery in 1965 an enlarged parathyroid gland was found on the right. This was surgically removed. The other 3 parathyroids were identified and judged "normal".

GROSS PATHOLOGY:

The yellow-brown nodule of tan tissue measured up to 3 cm. in diameter and was shaped like a fat tadpole. Numerous cysts filled with clear gelatinous material were present on the otherwise homogeneous cut surfaces.

FOLLOW-UP:

There is no evidence of recurrence of tumor in the neck.

On October 16, 1965 the laboratory report revealed the serum calcium to be 8.7 mg.%, phosphorus 2 to 5 mg.%, and choostek's sign negative.

On December 17, 1965 the patient still had right renal calculus but was asymptomatic.

On April 1, 1966 the patient was treated with Gastrisin for continued dysuria (cuture grew out Staphylococcus, coagulase negative).

STUDY GROUP CASES

FOR
MAY 1966

HEAD AND NECK TUMORS

CASE NO. 1, ACCESSION NO. 14397, D. R. Dickson, M. D., Contributor

LOS ANGELES:

Parathyroid adenoma, 12.

OAKLAND:

Parathyroid adenoma, benign, 17.

CENTRAL VALLEY:

Parathyroid adenoma, 10.

SAN DIEGO:

Parathyroid adenoma, 6; parathyroid carcinoma, 5.

WEST LOS ANGELES:

Parathyroid adenoma, 7; parathyroid carcinoma, 2.

SANTA BARBARA:

Parathyroid adenoma, 3.

FILE DIAGNOSIS: Parathyroid adenoma 820-8091 A

San Francisco minutes not received.

MAY 1966

CASE NO. 2, ACCESSION NO. 14620, Clifford N. Tschetter, M. D., Contributor

LOS ANGELES:

Lymphoepithelial lesion, 12.

OAKLAND:

Benign lymphoepithelial tumor (Godwin), 17.

CENTRAL VALLEY:

Benign lymphoepithelial lesion (Godwin), 10.

SAN DIEGO:

Benign lymphoepithelial lesion, 9; metastatic carcinoma, 1; sebaceous lymphoadenoma, 1.

WEST LOS ANGELES:

Ectopic, proliferating, parotid gland ducts in lymph node, 7; benign lymphoepithelial lesion, 2.

SANTA BARBARA:

Benign lymphoductal lesion, 2; low grade adenocarcinoma, 1.

FILE DIAGNOSIS: Benign lymphoepithelial lesion, parotid 621-8842

MAY 1966

CASE NO. 3, ACCESSION NO. 14086, E. R. Jennings, M. D., Contributor

LOS ANGELES:

Adenoid cystic carcinoma, 12.

OAKLAND:

Adenoid cystic carcinoma, 17.

CENTRAL VALLEY:

Adenocystic carcinoma (minor salivary gland, cylindromatoid), 10.

SAN DIEGO:

Adenoid cystic carcinoma, 11.

WEST LOS ANGELES:

Adenoid cystic carcinoma, 9.

SANTA BARBARA:

Adenocarcinoma, cylindromatous type, 3.

FILE DIAGNOSIS: Adenoid cystic carcinoma, minor salivary gland
620-8091

FOLLOW-UP:

Additional follow-up information received revealed a recurrence of the original tumor. On May 2, 1966 tissue was removed from the nasal septum.

MAY 1966

CASE NO. 4, ACCESSION NO. 14396, D. R. Dickson, M. D., Contributor

LOS ANGELES:

Benign encapsulated neurilemmoma (schwannoma), 12.

OAKLAND:

Neurilemmoma, 14; neurofibroma, 3.

CENTRAL VALLEY:

Neurilemmoma, 10.

SAN DIEGO:

Neurilemmoma, 11.

WEST LOS ANGELES:

Neurilemmoma, 9.

SANTA BARBARA:

Schwannoma, 3.

FILE DIAGNOSIS: Neurilemmoma, left submandibular region 182-8452

MAY 1966

CASE NO. 5, ACCESSION NO. 14441, Carter M. Alexander, M. D., Contributor

LOS ANGELES:

Mixed tumor, salivary gland, 12.

OAKLAND:

Mixed tumor of salivary gland, 16; adenocarcinoma, Grade I, mixed tumor type, 1.

CENTRAL VALLEY:

Mixed tumor of the parotid, 10.

SAN DIEGO:

Pleomorphic adenoma, 11.

WEST LOS ANGELES:

Mixed tumor, 9.

SANTA BARBARA:

Benign mixed tumor, 3.

FILE DIAGNOSIS: Mixed tumor of parotid gland 621-8852

MAY 1966

CASE NO. 6, ACCESSION NO. 14632, D. A. DeSanto, M. D., Contributor

LOS ANGELES:

Atypical thyroid adenoma, benign, 11; atypical thyroid tumor, probably malignant, 1.

OAKLAND:

Adenoma of thyroid, 17.

CENTRAL VALLEY:

Parathyroid adenoma, 6; thyroid carcinoma (poorly differentiated follicular), 4.

SAN DIEGO:

Benign adenoma (Hazard), 11.

WEST LOS ANGELES:

Trabecular carcinoma, 5; thyroid adenoma, 4.

SANTA BARBARA:

Follicular carcinoma with spindling, 3.

FILE DIAGNOSIS: Thyroid adenoma 810-8091 A

Hyalinizing trabecular adenoma

MAY 1966

CASE NO. 7, ACCESSION NO. 14226, S. M. Rabson, M. D., Contributor

LOS ANGELES:

Granular cell myoblastoma, congenital, 12.

OAKLAND:

Granular cell myoblastoma, or congenital epulis of newborn, 17.

CENTRAL VALLEY:

Granular cell myoblastoma, 10.

SAN DIEGO:

Granular cell myoblastoma, 11.

WEST LOS ANGELES:

Granular cell myoblastoma, 9.

SANTA BARBARA:

Rhabdomyoma, 2; granular cell myoblastoma, 1.

FILE DIAGNOSIS: Granular cell myoblastoma, gingiva 614-868 A

MAY 1966

CASE NO. 8, ACCESSION NO. 14400, Paul Thompson, M. D., Contributor

LOS ANGELES:

Warthin's tumor (papillary cystadenoma lymphomatosum), 12.

OAKLAND:

Papillary cystadenoma lymphomatosum, 17.

CENTRAL VALLEY:

Papillary cystadenoma lymphomatosum, 10.

Dr. Moe stated that though the term Warthin's tumor was common in the American literature, the lesion had been described by earlier observers and that the eponym lacked historical appropriateness.

SAN DIEGO:

Warthin's tumor, 11.

WEST LOS ANGELES:

Warthin's tumor, 9.

SANTA BARBARA:

Warthin's tumor, 3.

FILE DIAGNOSIS: Warthin's tumor, parotid gland 621-8842

MAY 1966

CASE NO. 9, ACCESSION NO. 13878, Harold N. Harrison, M. D., Contributor

LOS ANGELES:

Chordoma, 12.

OAKLAND:

Chordoma, 12; vertebral hemangioma, 2; lymphangiosarcoma, 1.

CENTRAL VALLEY:

Chordoma, 10.

SAN DIEGO:

Chordoma, 11.

WEST LOS ANGELES:

Chordoma, 9.

SANTA BARBARA:

Chordoma, 3.

FILE DIAGNOSIS: Chordoma, cervical spine 221-8886

MAY 1966

CASE NO. 10, ACCESSION NO. 14469, Leo Kaplan, M. D., Contributor

LOS ANGELES:

Chemodectoma, 12.

OAKLAND:

Carotid body tumor, 15; glomangioma, 1; paraganglioma, 1.

CENTRAL VALLEY:

Chemodectoma, 7; thyroid carcinoma, 3.

SAN DIEGO:

Chemodectoma, 11.

WEST LOS ANGELES:

Hemangiopericytoma, 4; paranganglioma (carotid body tumor), 5.

SANTA BARBARA:

Carcinoma of thyroid, embryonal trabecular pattern, 3.

FILE DIAGNOSIS: Chemodectoma, thyroid gland 810-8981

Follicular Carcinoma thyroid

MAY 1966

CASE NO. 11, ACCESSION NO. 14421, Thais R. Thrasher, M. D., Contributor

LOS ANGELES:

Melanotic neurofibroma (neurilemoma), 12.

OAKLAND:

Melanocytoma, 17.

CENTRAL VALLEY:

Malignant melanoma, 10.

Although the neurogenous concept of melanomas is again on the upswing, primary melanomas of nerve trunks must be exceedingly rare, and it was not felt that the site of origin of this particular melanoma was clearly established. The possibility that the "squamous cell carcinoma" of the tongue may have been a melanoma was considered. Since the tumor was conspicuous just where the vagus emerged from the skull, the possibility of primary melanoma of the meninges was considered. This entity was thought to be more thoroughly established than that of nerve trunk melanoma. Although nothing in the record specifically suggested origin in the eye, this possibility was not thought to be completely eliminated.

SAN DIEGO:

Malignant melanoma, 11.

WEST LOS ANGELES:

Pigmented neurofibroma (blue nevus), 3; melanoblastic meningioma, 1; melanoma, 5.

SANTA BARBARA:

"Blue nevus" of vagus nerve, benign, 3.

FILE DIAGNOSIS: Pigmented neurofibroma, neck 182-8451

MAY 1966

CASE NO. 12, ACCESSION NO. 14474, Seth L. Haber, M. D., Contributor

LOS ANGELES:

Parathyroid adenoma, 12.

OAKLAND:

Parathyroid adenoma, 9; parathyroid hyperplasia, 8.

CENTRAL VALLEY:

Parathyroid adenoma, 10.

SAN DIEGO:

Parathyroid adenoma, 11.

WEST LOS ANGELES:

Parathyroid adenoma, 9.

SANTA BARBARA:

Parathyroid adenoma, 3.

FILE DIAGNOSIS: Parathyroid adenoma 820-8091 A

FOLLOW-UP MAY 1966 - CASE NO. 10

ACCESSION NO. 14469

This case has been reviewed by Dr. Philip M. LeCompte of The Faulkner Hospital, Boston, Massachusetts. His interpretation is as follows:

"Slide No. 14469 is most fascinating since it shows how a primary thyroid tumor can mimic a chemodectoma. I have no hesitation in agreeing with you that this is a primary thyroid tumor, and would call it a carcinoma, in view of occasional mitotic figures and its nudging of the capsule and even suggestive beginning blood vessel invasion. Other features against a chemodectoma would be the vacuolation of many of the cells and an arrangement of cells around empty spaces (not blood vessels) in some places. The main thing against chemodectoma is, of course, the location. I am not aware that any one has described a convincing chemodectoma of the thyroid."

An amyloid stain was done by the Registry and reported as negative.