

CALIFORNIA TUMOR TISSUE REGISTRY

LOS ANGELES COUNTY HOSPITAL

PROTOCOL

FOR

MONTHLY SLIDES

JUNE 1966

TUMORS OF HEAD AND NECK

NAME: I. H.

AGE: 87 SEX: Female RACE: Caucasian

JUNE 1966 - CASE NO. 1

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

ACCESSION NO. 14376

Outside No. S65-4242

TISSUE FROM: Neck mass near angle of right mandible

CLINICAL ABSTRACT:

History: This 87-year-old Caucasian female was admitted to the hospital on August 5, 1965 complaining of a mass in the right side of the neck near the angle of the jaw for 1 year which had enlarged rapidly during the previous 2 to 3 months. She ate well and was in generally good health except for the residuals of a stroke she had 10 years ago, leaving her with left hemiparesis and urinary incontinence.

Pertinent physical findings: BP - 164/100, P - 72, R - 18. She was afebrile. Her face revealed residual asymmetry from strokes with the left side more impaired than the right side. Multiple small scaling lesions of the face were present suggestive of basal cell carcinoma.

Beneath the angle of the right jaw was felt a firm mass measuring 4 x 6 x 2 cm. which was slightly movable, somewhat tender and non-pulsating. No bruits were heard in the neck. The mass did not transilluminate nor was it ballotable.

The physical findings were not otherwise contributory except for left hemiparesis.

Laboratory and x-ray studies were not remarkable.

SURGERY:

On August 5, 1965 the mass was removed intact under general anesthesia.

GROSS PATHOLOGY:

The specimen was an encapsulated soft light tan homogeneous node measuring 4 x 2.1 x 2.5 cm. and weighing 22 gm.

FOLLOW-UP:

The patient expired on January 3, 1966 of arteriosclerotic heart disease and bronchopneumonia of three days duration. No autopsy was done.

NAME: G. H.

JUNE 1966 - CASE NO. 2

AGE: 65 SEX: Male RACE: Caucasian

ACCESSION NO. 14774

CONTRIBUTOR: J. H. Cremin, M. D.
679 S. Westlake Avenue
Los Angeles, California

Outside No. E 139-64

TISSUE FROM: Nasopharynx

CLINICAL ABSTRACT:

History: The patient was admitted for the last time on January 9, 1964. Shortly before December 31, 1963, he developed pain over the left eye accompanied by diplopia, lacrimation and photophobia. He consulted a physician who diagnosed a nasopharyngeal mass. On December 31, 1963 a biopsy was taken. The patient was hospitalized for 3 days following the biopsy because of massive epistaxis which followed the biopsy.

Physical examination: The left nares revealed a nasal mass. This was accompanied by nasal mucosal hyperemia. The blood pressure was 155/80 with a pulse rate of 88 per min. and a regular sinus rhythm. The prostate was slightly enlarged but rubbery. The cranial nerve examination revealed no definite deficit.

Laboratory findings included a hemoglobin of 14.0 gm.% with a white count of 13,700, 80% of which were neutrophils with 2 band cells. The urinalysis revealed a positive glucose oxidase reaction. No reducing substance was found.

SURGERY:

Surgery was performed on the 10th of January, 1964. This revealed a tumor which was located behind the mucous membrane of the nasopharynx, about 1 1/2 inches below the nares, and was at least an inch wide and about 2 1/2 inches long. The mass plugged the left nares completely. It extended into the sphenoid sinus. Massive hemorrhage developed during the procedure and was controlled by packing.

GROSS PATHOLOGY:

The principal mass measured 6 x 3.5 x 3 cm. It was roughly ovoid with a nodular bulge at one pole. It included a 4.5 cm. portion of mucosa said to be pharyngeal, and a polypoid nodular area 1.5 cm. which was said to have bulged into the nasal cavity. It was covered by some fragments of skeletal muscle. In part it had a hemorrhagic surface. The cut surfaces were bulging, glistening, faintly translucent, and yellowish-tan.

A second major portion of the specimen measured 4.5 x 3 x 2.5 cm. It included a portion of the pterygoid bone, soft palate, and maxilla with a portion of maxillary sinus. The mucosa of the maxillary sinus when stretched out measured 3.5 cm. in greatest dimension, and the mucosal surface was smooth here. The soft palate appeared uninvolved by tumor. The surfaces were covered in part by skeletal muscle. There was some ill-defined, firm, yellowish-gray tissue lying in contact with the soft palate and also lying just under but not ulcerating the sinus mucosa.

COURSE:

Following surgery the patient developed hemiplegia and became comatose. He expired on the 13th of January, 1964. No autopsy was obtained.

FOLLOW-UP:

February 25, 1966: Seen for purulent nasal discharge and bronchitis. Chest was clear. Temperature was 101.2 degrees F., rectally. She has not been seen since. No other significant comments in physician records other than history of the lung surgery as an infant.

NAME: E. A.

JUNE 1966 - CASE NO. 3

AGE: 72 SEX: Male RACE: Caucasian

ACCESSION NO. 14069

CONTRIBUTOR: D. R. Dickson, M. D.
Santa Barbara Cottage Hospital
Santa Barbara, California

Outside No. S65-527

TISSUE FROM: Right maxillary pterygoid fossa

CLINICAL ABSTRACT:

History: In November, 1964 this 72-year-old dentist noted slight asymmetry and swelling of his right cheek (zygomatic region) with associated difficulty in widely opening his mouth.

Physical examination revealed swelling of the right cheek which extended over to and beyond the right zygomatic process. There was some limitation of motion of the mandible. Intra-orally, in the right gingivobuccal sulcus there was a hard, nodular mass, to which the buccal mucosa was not fixed. Stensen's duct was intact. There were no other palpable or visible lesions of the head, neck, larynx or hypopharynx.

X-ray showed a density (mass) involving the right maxilla, right zygomatic process and extending posteriorly. Chest x-ray, February 1, 1965, revealed several bilateral soft tissue densities, 3 to 7 mm. in diameter in the periphery of the lung fields, suggestive of metastases.

The laboratory findings revealed the hemogram and urinalysis to be within normal limits.

SURGERY:

On February 6, 1965 through a right Webber-Ferguson incision a large tumor was completely removed from the right maxillary pterygoid fossa. The mass extended posteriorly beneath the right orbital plate and medially above but not infiltrating the maxillary antrum. The right maxillary antrum was removed for better exposure and, in order to facilitate excision of the mass.

GROSS PATHOLOGY:

The specimen, which weighed 104 gm., was a rounded and bosselated, triangular mass, measuring 78 x 68 x 32 mm. in greatest dimensions. The major portion of the surface was enclosed in a transparent capsule, beneath which were numerous blood vessels and to which in several areas were adherent compressed dark red muscle fibers. Over one lateral aspect was a 35 mm. long tear and from here extruded fragments of friable, glistening, tan neoplastic tissue. Sectioned surfaces exhibited a well defined central kidney-shaped mass 62 mm. in greatest dimensions surrounded by a tough laminated, fibrous capsule-like structure up to 2 mm. thick. Peripheral to this capsule were scattered at least five flattened, ovoid nodules varying from 11 to 30 mm. in greatest diameter. Sectioned surfaces of all nodules were bulging, homogeneous, moist, glistening, and tan about the periphery, but the central portion of the larger two nodules were friable, necrotic dry, and yellow-pink. No cyst formation was present. A single 2 mm. diameter focus of calcification was encountered.

FOLLOW-UP:

The patient expired in August or September, 1965. Information not available as to whether autopsy was performed.

NAME: O. L. H.

JUNE 1966 - CASE NO. 4

AGE: 57 SEX: Female RACE: Caucasian

ACCESSION NO. 13267

CONTRIBUTOR: Doris Herman, M. D.
Los Angeles County General Hospital
Los Angeles, California

Outside No. 63-13276

TISSUE FROM: Parotid gland

CLINICAL ABSTRACT:

History: This was a 57-year-old obese Caucasian female who was admitted to the hospital on September 10, 1963 for removal of a left preauricular mass which had been present and gradually enlarged over a period of 18 years. The mass was painless and asymptomatic.

Past history: The patient had been treated for 8 years prior to admission for hypertension and for the past two years for angina pectoris, osteoarthritis with effusions in the knee joints, and occasional bouts of epistaxis. In the more distant past she had numerous pregnancies, two episodes of pneumonia, and a varied assortment of diseases of love with the only apparent sequellae being a rectal stricture secondary to lymphogranuloma venereum for which she underwent successful surgery.

Physical examination revealed an obese Caucasian female in no acute distress. BP - 230/100, P - 78, R - 22, T - 98⁶. Other than marked obesity the pertinent physical findings were confined to a firm nontender freely movable mass in the left preauricular region, about 3 x 3 x 1 cm., which was not translucent or cystic. No palpable nodes or other masses were felt.

Laboratory and x-ray studies were not remarkable.

SURGERY:

On September 11, 1963 a left parotidectomy was performed.

GROSS PATHOLOGY:

The specimen consisted of a very firm fragment of pink tan gray tissue measuring 5 x 3 x 3 cm. On cut section it was yellowish, appeared to be distinctly encapsulated and focally nodular. No cystic structures was identifiable.

FOLLOW-UP:

The hospital course was uneventful.

NAME: L. P.

JUNE 1966 - CASE NO. 5

AGE: 41 SEX: Male RACE: Caucasian

ACCESSION NO. 14440

CONTRIBUTOR: D. R. Dickson, M. D.
Santa Barbara Cottage Hospital
Santa Barbara, California

Outside No. S53-2885

TISSUE FROM: Right parotid gland

CLINICAL ABSTRACT:

History: The tumor was first noted in the right parotid area in 1933. This was excised in 1934 and again in 1935 and was diagnosed as a "fibromyxoma without malignant characteristics." Recurrence was again noted by 1938. A steady slow progression in size had occurred since 1938 so that by admission he had a firm fixed mass, 12 x 10 cm., pushing the right ear lobe upward. On September 3, 1952 at surgery, a sizable tumor was found extending into the submental area to the vertebrae posteriorly, superiorly to beneath the orbit and posterior to the maxillary bone and into the temporomandibular fossa, necessitating sacrifice of the seventh nerve.

The second admission was on October 26, 1953. He had been well aside from the left seventh nerve paralysis, but in the past few months had noted recurrence of hard lumps in the right side of the neck. A hard mass, 3 x 4 cm., was present just anterior to the right mastoid process and several smaller firm nodules were palpable subcutaneously down the anterior border of the sternocleidomastoid muscle. In the right tonsillar fossa was a small white elevated nodule.

SURGERY:

On October 27, 1953 recurrent neoplasm which was infiltrating muscle and the parotid gland was excised, but it was impossible to remove all of the tissue.

GROSS PATHOLOGY:

The specimen which weighed 200 gm. consisted of three large portions of firm pearly gray to pale yellow tissue the largest measuring 8 x 7 x 5.5 cm. The external surfaces were ragged and fibrous. The sectioned surfaces were firm to hard, somewhat fasciculated, and varied from pale pearly gray to light yellow-gray.

COURSE:

The patient was admitted to another hospital in April, 1955 with massive left pleural effusion. After this was drained, x-ray showed nodular densities, presumably metastases in the left lung. He died at home on July 28, 1957 and an autopsy was not performed.

NAME: K. K.

JUNE 1966 - CASE NO. 6

AGE: 56 SEX: Male RACE: Caucasian

ACCESSION NO. 14574

CONTRIBUTOR: Milton L. Bassis, M. D.
2425 Geary Boulevard
San Francisco, California

Outside No. AF64-145

TISSUE FROM: Pharynx

CLINICAL ABSTRACT:

History: This 56-year-old male became aware of a mass in the left neck six weeks prior to admission followed by persistent throat irritation. Examination two weeks ago showed an ulcerating lesion on the left side of the epiglottis and biopsy was done. The patient was admitted on December 6, 1962 for partial laryngectomy, partial left thyroidectomy, and left neck dissection. The pathology specimen revealed an occult papillary carcinoma of the thyroid, also with lymph node metastases.

Post-operative thyroid suppressive therapy was given and discontinued because of development of hypertension and congestive heart failure. A new primary (?) carcinoma appeared in the left tonsillar fossa and lateral pharyngeal wall. This was treated with radiation with little remission of the tumor. Nitrogen mustard therapy injected locally caused an initial surprising remission, but the tumor rapidly recurred and was little effected by subsequent mustard injections. The pharyngeal tumor enlarged to the point of beginning obstruction of the pharyngeal airway, and an elective tracheotomy was done for comfort on January 7, 1964. Nasogastric tube feedings were started and home care was given with the patient becoming progressively weaker. He was admitted for terminal care on June 22, 1964 with a large tumor filling the entire pharynx and bilateral submental and submandibular masses. Respirations were moderately labored with oxygen being given through the tracheotomy. Bleeding episodes occurred from the tracheobronchial tree due to necrotic tumor. At this time the patient was also thought to have a bronchopneumonia, and he expired on June 23, 1964.

Past history revealed the patient smoked 40 cigarettes a day for 30 years and a moderate alcoholic intake.

GROSS PATHOLOGY:

At the left base of the tongue involving the left pharyngo-epiglottic fold was a variegated gray-red to tan necrotic polypoid and bosselated tumor measuring 6 x 10 cm. It completely replaced the left tonsillar area, extended along the left margin of the posterior third of the tongue, and invaded into the muscle of the tongue. The tumor extended caudad to within 2.5 cm. of the left true vocal cord. It extended laterally in the left side of the neck to involve the submental and submaxillary areas, obliterated the thyrohyoid membrane. It then extended into the fibrotic thickened connective tissue underlying the area of the left radical neck dissection and crossed the midline in front of the pretracheal fascia to involve the submental and submaxillary in the right neck. The central portions of the tumor were necrotic with fresh hemorrhage around the periphery.

NAME: E. K.

JUNE 1966 - CASE NO. 7

AGE: 54 SEX: Female RACE: Caucasian

ACCESSION NO. 12585

CONTRIBUTOR: Kenley Falconer, M. D.
St. Mary's Hospital
Reno, Nevada

Outside No. S-2791-62

TISSUE FROM: Right parotid gland

CLINICAL ABSTRACT:

History: The patient was a 54-year-old Caucasian female who was admitted with a chief complaint of sinusitis and swelling of the glands in the right neck. For the past year this patient has had sinusitis with pain in both antra and with obstruction of the nose. This became worse after she had influenza in February, 1962. The glands in the right side of her neck had become progressively more swollen during the summer and fall of 1962. The patient entered the hospital for surgical resection of the glands in the neck.

Physical examination was negative except for a multilobular firm mass measuring about 2 inches in the lower pole of the right parotid region. There was also marked deviation of the nasal septum causing partial obstruction.

SURGERY:

An excision of the parotid tumor was performed on September 18, 1962.

GROSS PATHOLOGY:

A flat unencapsulated mass of tough gray-tan fibrous like tissue, 5.5 x 3.5 x 1.5 cm., was received. The cut surfaces had a mottled gray-tan fibrous appearance. Also received were two small unencapsulated masses of similar tissue and about 8 or 9 mm. in size.

FOLLOW-UP:

The patient was last seen by her physician on June 10, 1964, at which time the opposite parotid gland was enlarged and hard. The patient is an R.N. and requested surgery. In view of the previous biopsy, the physician believed the situation did not warrant surgery, and his diagnosis was Mikulicz's disease. The patient also had problems of dry eyes and mouth and was referred to another doctor. However, the patient apparently never asked for an appointment.

NAME: B. F.

JUNE 1966 - CASE NO. 8

AGE: 8 SEX: Male RACE: Caucasian

ACCESSION NO. 14587

CONTRIBUTOR: D. R. Dickson, M. D.
Santa Barbara Cottage Hospital
Santa Barbara, California

Outside No. S65-4874

TISSUE FROM: Adenoid region of nasopharynx

CLINICAL ABSTRACT:

History: In December, 1964 radiation therapy was given to the adenoid region of the nasopharynx in order to shrink lymphoid tissue which was felt responsible for a hearing loss. The hearing problem subsided entirely and the boy has been asymptomatic. For 2 to 3 weeks prior to admission the parents had noted a foul odor emanating from his nose and mouth.

Physical examination was entirely negative with no evidence of enlarged cervical lymph nodes, other nodes or viscera.

X-ray revealed the chest to be normal. Skull x-ray was normal with particular attention to the nasopharyngeal region.

Laboratory report: Hemogram and urinalysis were within normal limits. The WBC was around 10,000 with a normal differential. ESR was 12 mm./1 hr. Serum electrophoresis was normal.

SURGERY:

An adenoidectomy was performed.

GROSS PATHOLOGY:

The specimen was submitted in two containers. The first container held approximately 20 fragments of firm, pinkish-tan tissue ranging from about 6 mm. to 2 cm. in greatest dimensions and weighing approximately 5 gm. The second container held about 6 fragments of similar appearing tissue weighing approximately 2 gm. and measuring up to 2.5 cm. in greatest dimension.

FOLLOW-UP:

The patient received a total of 5,500 rad to the nasopharyngeal area between October 18 and December 12, 1965, administered by cobalt. As of May 3, 1966 he appeared in good health, no weight loss, no residual or recurrent tumor, and is making straight A's in school.

NAME: B. P.

JUNE 1966 - CASE NO. 9

AGE: 35 SEX: Male RACE: Caucasian

ACCESSION NO. 11989

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

Outside No. 4495-61

TISSUE FROM: Orbit

CLINICAL ABSTRACT:

History: The patient, a truck driver, stumbled and fell while at work on September 2, 1961 and suffered moderate blunt trauma to the area of the right supra-orbital ridge. At the time of his initial admission on September 13, 1961 there had been persistent pain and swelling of the right eye with some anterior displacement of the globe. The orbit was explored with the expectation of finding a retrobulbar hematoma. However, a tumor was encountered which was widely excised on his second admission on October 2, 1961.

SURGERY:

An orbital exenteration was performed removing the right eye, the upper and lower lids, and the orbital contents down to and including the periosteum of the bony orbit. A large, firm tumor was present which displaced the globe anteriorly and downward and involved the bony wall of the lateral aspect of the orbit. Considerable bone was removed from the lateral orbital wall, the ethmoid area and along the course of the optic nerve.

GROSS PATHOLOGY:

The major portion of the specimen was an enucleated eye with attached upper and lower lids and orbital soft tissues. The cornea, anterior chamber and conjunctivae were unremarkable. Posterior to the globe, a large, firm and somewhat moveable mass measuring 1.5 x 1.8 cm. was noted. Section revealed dense, whitish and rather homogeneous mass of tumor tissue attached to but not infiltrating the sclera. The globe itself appeared essentially normal.

Bony fragments were submitted from the frontal bone, lateral wall of the orbit and ethmoid bone.

COURSE:

On October 30, 1961 the patient was seen by the Tumor Board. The operative site was almost completely healed with no evidence of local recurrence. Treatment with 5-fluorouracil and radiation was instituted.

FOLLOW-UP:

The patient expired on August 24, 1962 with metastases to the right femur and sternum. No autopsy was performed.

NAME: N. L.

JUNE 1966 - CASE NO. 10

AGE: 21 SEX: Female RACE: Caucasian

ACCESSION NO. 14380

CONTRIBUTOR: Francis V. Howell, D. D. S.
Albert Abrams, D. D. S.
La Jolla, California

Outside No. D-20-64

TISSUE FROM: Mandible

CLINICAL ABSTRACT:

History: About eighteen months ago the patient had pain in the lower left cuspid and saw her dentist who did not take an x-ray. The tooth was not carious, and the dentist assured her it was "all right". Thirteen months ago, she noted pain in her chin whenever she put pressure on it. Six months ago she noticed a slight swelling in the mandibular lateral incisor area but did nothing because of lack of finances. The swelling had gradually increased in size and spread laterally. One month ago, she finally saw her private dentist who referred her to the Tumor Board for evaluation and therapy.

Radiograms revealed a large radiolucent lesion in the body of the mandible extending from the left second bicuspid area to the right second bicuspid area. The border was somewhat irregular, and there was expansion with an intact cortex on the lingual, buccal and labial. There had been some horizontal resorption of the involved teeth with a slight spiking. There was also noted a somewhat, mottled, ovoid area, measuring 0.6 x 0.4 cm., in the right maxilla between the cuspid and lateral incisor teeth.

On March 5, 1964 incisional biopsies of the mandible and maxilla were performed. Aspiration was negative. The bone over both sites was very thin. The tissue was rubbery and friable with no vascularity. It was white in color. The teeth were slightly mobile, and all of the teeth were vital except the lower left cuspid.

SURGERY:

An excision of the lesion was performed on April 8, 1964. The lesion appeared encapsulated and peeled out fairly easily from its bony cavity. The labial plate over the lesion was paper thin and expanded. It was attached to the periosteum and the mentalis muscle in the labial area and had to be sharply dissected out of here. The cut area was encapsulated and enclosed a shiny, white, hard and rubbery hyaline-like material. The center contained a small, brownish jelly-like material.

GROSS PATHOLOGY:

The specimen consisted of six pieces, the larger piece had been bisected, measuring 0.5 x 3.0 x 3.1 x 3.6 cm. - 3.0 x 3.0 x 2.5 cm. Both segments were roughly ovoid with concavity on one surface. The cut surface was smooth and white, and the outer surface was pinkish-brown to light tan. Two thin slices were made with considerable resistance with some calcification. The third segment was light brown and appeared inflamed, measuring 1.4 x 1.8 x 1.6 cm. On transverse cuts the surface was similar to the main mass. The remaining segments were small, fibrous tags.

FOLLOW-UP:

On May 4, 1964 an excisional biopsy of the maxilla was done which was diagnosed as fibrous dysplasia.

The patient was last seen on May 20, 1966 at which time there was no clinical or x-ray evidence of recurrence.

NAME: M. S.

JUNE 1966 - CASE NO. 11

AGE: 65 SEX: Male RACE: Caucasian

ACCESSION NO. 13733

CONTRIBUTOR: S. T. Nerenberg, M. D.
3700 California Street
San Francisco, California

Outside No. 064-2179

TISSUE FROM: Maxilla

CLINICAL ABSTRACT:

History: The patient was admitted to the hospital on June 22, 1964 with the chief complaint of pain in the left temporal region, external auditory canal and area surrounding the left ear for 2 months. He had tinnitus of left ear for last week, but not continuous.

Past history: Operation on maxilla 3 years ago (local removal) and another, more extensive operation 2 years ago.

Physical examination: Pain in left frontal sinus area, left temporal and left auditory region. Hearing good. Dentures, upper and lower; left maxillary area partially resected. Physical examination otherwise negative.

Laboratory findings: Hemoglobin 11.6 gm. per cent. Hematocrit 35. White blood count 7,900 with 70 segmented neutrophils, 2 bands, 23 lymphocytes, 3 monocytes, 1 eosinophil and 1 basophil. Urinalysis was negative.

SURGERY:

The patient was taken to the operating room on June 23, 1964 for a maxillectomy, left, with skin graft reconstruction.

GROSS PATHOLOGY:

The specimen consisted of a lobulated, reddish-grey tumor mass, measuring 9.5 x 6 x 3 cm., which on gross section had a greyish-white, mucoid appearance. Several cystic structures were seen scattered within the main body of the tumor mass. The cystic structures varied from 1.5 to 3 cm. in diameter.

FOLLOW-UP:

The patient developed a third recurrence in September of 1965 which was not surgically resectible. When he was last seen he was hospitalized on a terminal basis in December of 1965 at the San Francisco General Hospital.

NAME: K. G.

JUNE 1966 - CASE NO. 12

AGE: 3 SEX: Male RACE: Caucasian

ACCESSION NO. 14320

CONTRIBUTOR: J. L. Heard, M. D.
Mercy Hospital
San Diego, California

Outside No. 5538-64

TISSUE FROM: Left frontal region

CLINICAL ABSTRACT:

History: The patient was a 3-year-old Caucasian boy with a small osteolytic tumor just above the left eyebrow. The tumor was asymptomatic. It was biopsied on November 5, 1964. On December 15, 1964 the patient was found to have a locally destructive lesion of the temporal bone causing exophthalmus.

SURGERY:

Excision was performed on December 14, 1964. The lesion was found to extend from the deep fascia of the temporal muscle to the dura from which it was scraped. It extended into the orbit from which it was removed easily. The lesion measured 5 cm. in greatest dimension and weighed approximately 12 gm.

GROSS PATHOLOGY:

The specimen consisted of 8 separate fragment of tissue. The largest tissue was firm pinkish-white measuring 4 x 2.5 x 1 cm. Several pieces of similar tissue had attached bone and muscle fragments. One piece of tissue consisted of the lacrimal gland.

FOLLOW-UP:

The patient has had no recurrence and at present is well and healthy.

STUDY GROUP CASES
FOR
JUNE 1966

TUMORS OF HEAD AND NECK

CASE NO. 1, ACCESSION NO. 14376, J. J. Bocian, M. D., Contributor

LOS ANGELES:

Carotid body tumor, neck, 10.

OAKLAND:

Chemodectoma, 9.

CENTRAL VALLEY:

Chemodectoma, 4.

WEST LOS ANGELES:

Carotid body tumor, 10.

SANTA BARBARA:

Chemodectoma, 6.

FILE DIAGNOSIS: Chemodectoma, neck

030-3981

JUNE 1966

CASE NO. 2, ACCESSION NO. 14774, J. H. Cremin, M. D., Contributor

LOS ANGELES:

Adenocarcinoma arising in minor salivary gland, 10.

OAKLAND:

Adenocarcinoma, low grade, 5; benign adenoma, 4.

CENTRAL VALLEY:

Low grade adenocarcinoma of nasopharyngeal mucosa, 4.

WEST LOS ANGELES:

Papillary adenocarcinoma, 5; papillary adenoma, 5.

SANTA BARBARA:

Well differentiated adenocarcinoma, 6.

FILE DIAGNOSIS: Adenocarcinoma, nasopharynx

318-8091

Papillary phase →

JUNE 1966

CASE NO. 3, ACCESSION NO. 14069, D. R. Dickson, M. D., Contributor

LOS ANGELES:

Fibrosarcoma, 3; malignant hemangiopericytoma, 7.

OAKLAND:

Hemangiopericytoma, 5; fibrosarcoma, 3; angiofibrosarcoma, 1.

CENTRAL VALLEY:

Sarcoma, probably neural origin, 4.

WEST LOS ANGELES:

Malignant hemangiopericytoma, 10.

SANTA BARBARA:

Sarcoma, unclassified, 2; fibrosarcoma vs. hemangiopericytoma, 1;
fibrosarcoma, 1; synovial sarcoma, 1; malignant schwannoma, 1.

FILE DIAGNOSIS: Hemangiopericytoma, maxillary pterygoid
fossa 321-8531

JUNE 1966

CASE NO. 4, ACCESSION NO. 13267, Doris Herman, M. D., Contributor

LOS ANGELES:

Oncocytic adenoma in a mixed tumor, 10.

OAKLAND:

Mixed tumor of salivary gland, 7; oncocytoma, 2.

CENTRAL VALLEY:

Trabecular carcinoma, 2; oncocytoma, 2.

WEST LOS ANGELES:

Oncocytoma, 5; oncocytic variant of a mixed tumor, 5.

SANTA BARBARA:

Oxyphil adenoma, 6.

FILE DIAGNOSIS: Mixed tumor, parotid gland

621-8842

Cross file: Oncocytoma

621-8852

JUNE 1966

CASE NO. 5, ACCESSION NO. 14440, D. R. Dickson, M. D., Contributor

LOS ANGELES:

Malignant schwannoma, parotid gland, 10.

OAKLAND:

Neurofibrosarcoma, 9.

CENTRAL VALLEY:

Neurofibrosarcoma, 2; fibrosarcoma, 1; malignant mixed tumor, 1.

WEST LOS ANGELES:

Low grade recurrent fibrosarcoma, 10.

SANTA BARBARA:

Fibrosarcoma, 6.

FILE DIAGNOSIS: Neurofibrosarcoma, parotid

621-8451 F

JUNE 1966

CASE NO. 6, ACCESSION NO. 14574, Milton L. Bassis, M. D., Contributor

LOS ANGELES:

Carcinosarcoma, pharynx, 10.

OAKLAND:

Squamous cell carcinoma with pseudosarcomatous stroma, 5; adenocarcinoma with pseudocarcinomatous stroma, 2; blastic sarcoma, 1; malignant tumor, unclassified, 1.

CENTRAL VALLEY:

Anaplastic carcinoma, 2; carcinosarcoma, 2.

WEST LOS ANGELES:

Carcinosarcoma, 9; uncertain, 1.

SANTA BARBARA:

Carcinosarcoma, 3; anaplastic carcinoma, 3; malignant mesenchymoma, 1.

FILE DIAGNOSIS: Carcinosarcoma, pharynx

631-8834

JUNE 1966

CASE NO. 7, ACCESSION NO. 12585, Kenley Falconer, M. D., Contributor

LOS ANGELES:

Benign lymphoepithelial lesion, parotid gland, 10.

OAKLAND:

Lymphoepithelial lesion, Mikulicz disease with Sjogrens syndrome, 9.

CENTRAL VALLEY:

Benign lymphoepithelial lesion (Godwin's tumor), 4.

WEST LOS ANGELES:

Benign lymphoepithelial lesion associated with Sjogren's syndrome, 10.

SANTA BARBARA:

Benign lymphoductal tumor, 7.

FILE DIAGNOSIS: Adenolymphoma, parotid
(Benign lymphoepithelial lesion or
Benign lymphoductal tumor.)

621-8842 A

JUNE 1966

CASE NO. 8, ACCESSION NO. 14587, D. R. Dickson, M. D., Contributor

LOS ANGELES:

Reticulum cell sarcoma, 8; embryonal rhabdomyosarcoma, 2.

OAKLAND:

Malignant lymphoma, 6; lymphoepithelioma, 2; undifferentiated malignant tumor, 1.

CENTRAL VALLEY:

Anaplastic carcinoma, 3; reticulum cell lymphosarcoma, 1.

WEST LOS ANGELES:

Malignant lymphoma, 10 (reticulum cell sarcoma, 7; lymphoblastoma, 3).

SANTA BARBARA:

Anaplastic carcinoma, 5; lymphoblastic lymphosarcoma, 2.

FILE DIAGNOSIS: Reticulum cell sarcoma, nasopharynx 318-831

JUNE 1966

CASE NO. 9, ACCESSION NO. 11989, D. A. DeSanto, M. D., Contributor

LOS ANGELES:

Adenoid cystic carcinoma of lacrimal gland, 10.

OAKLAND:

Adenocarcinoma of lacrimal gland, 9.

CENTRAL VALLEY:

Anaplastic adenocarcinoma, 3; adenocystic carcinoma, 1.

WEST LOS ANGELES:

Adenoid cystic carcinoma, 10.

SANTA BARBARA:

Adenoid cystic carcinoma, lacrimal gland, 7.

FILE DIAGNOSIS: Adenoid cystic carcinoma, lacrimal gland X-62-8091

Ref Hum Pathology 13: 219-225 1982

JUNE 1966

CASE NO. 10, ACCESSION NO. 14380, Francis V. Howell, D. D. S.,
and Albert Abrams, D. D. S., Contributors

LOS ANGELES:

Ossifying fibroma, 10.

OAKLAND:

Cementifying fibroma, 9.

CENTRAL VALLEY:

Fibrous dysplasia, 4.

WEST LOS ANGELES:

Fibrous dysplasia, 3; ossifying fibroma, 2; odontogenic fibroma
(fibrocementoma), 5.

SANTA BARBARA:

Fibrous dysplasia, 4; odontogenic fibroma, 3.

FILE DIAGNOSIS: Ossifying fibroma, mandible

219-870 A

JUNE 1966

CASE NO. 11, ACCESSION NO. 13733, S. T. Nerenberg, M. D., Contributor

LOS ANGELES:

Ameloblastoma, 10.

OAKLAND:

Ameloblastoma with acanthomatous features, 9.

CENTRAL VALLEY:

Acanthotic ameloblastoma, 3; squamous cell carcinoma, 1.

WEST LOS ANGELES:

Ameloblastoma, 10.

SANTA BARBARA:

Ameloblastoma with acanthotic features, 7.

FILE DIAGNOSIS: Ameloblastoma, maxilla

218-886 E

JUNE 1966

CASE NO. 12, ACCESSION NO. 14320, J. L. Heard, M. D., Contributor

LOS ANGELES:

Benign giant cell lesion, unclassified, 10.

OAKLAND:

Benign fibrous lesion of bone, 3; reparative granuloma of bone, 5.

CENTRAL VALLEY:

Aneurysmal bone cyst, 2; giant cell tumor, 2.

WEST LOS ANGELES:

Giant cell tumor of bone (Grade III), 6; cell reparative granuloma, 1; sclerosing angioma with giant cell features, 1; fibromatosis with giant cell features, 2.

SANTA BARBARA:

Non-osteogenic fibroma, 4; benign giant cell tumor, 2; fibrous dysplasia, 1.

FILE DIAGNOSIS: Giant cell lesion, temporal bone. 213-874