CALIFORNIA CANCER COMMISSION

SEMI-ANNUAL SLIDE CONFERENCE

ON

TUMORS vs PSEUDO-TUMORS

MODERATOR:

HUGH G. GRADY, M.D.

Scientific Director

Armed Forces Institute of Pathology,
Washington, D.C.

CHAIRMAN:

Gerson R. Biskind, M.D.
San Francisco, California.

SUNDAY, DECEMBER 4, 1955

9:15 A.M.

COLONIAL ROOM,
AMBASSADOR HOTEL,
Los Angeles, California.

Please send in your diagnoses, using the separate sheets enclosed, on or before November 23rd, 1955, so that they may be tabulated before the meeting.

Please bring your protocol, but do not bring slides or microscopes to the meeting.

CONTRIBUTOR: F. E. Davis, M.D.,
Hollywood Presbyterian Hospital,
Los Angeles, California.

CASE NO. 1

December 4, 1955

ACCESSION NO. 1751
OUTSIDE NO. SP. 50-13629

NAME: A. J.
AGE: 79 SEX: Male RACE: Cauc.

TISSUE FROM: Mass, right popliteal space.

HISTORY: This patient had noted an enlarging mass in the lower right thigh since June 8, 1949. Physical examination was essentially negative, except for blood pressure of 220/112 and a 10 x 15 cm. firm mass in the right popliteal space. The skin overlying the area was reddened and slightly indurated. No regional adenopathy.

SURGERY: The tumor was removed totally on December 14th, 1950.

GROSS PATHOLOGY: The specimen consisted of an encapsulated, firm, slightly bosselated mass which measured 12 x 8 x 6⅓ cm. The surface was covered in part by connective tissue and skeletal muscle fragments. Cut sections revealed a capsule 2 mm. in thickness that grated and contained a considerable amount of calcium. The cut edges were moist, white-yellow, with numerous fibrous strains radiating from the center peripherally. Scattered, slightly depressed, gelatinous areas were visible. Areas of moderately firm, calcareous material were present.

CONTRIBUTOR: Wilfred E. Toreson, M.D.,
University of California Hospital,
San Francisco 22, California.

CASE NO. 2

December 4, 1955.

ACCESSION NO. 8089
OUTSIDE NO. 2143-X

NAME: F. K. S.
AGE: 40 SEX: Male RACE: Cauc.

TISSUE FROM: Popliteal space.

HISTORY: The patient complained of a swelling behind the right knee which had been present for several years. Periodically it increased and decreased in size. It caused some discomfort on flexion of the knee. There was no history of trauma; the knee had never locked.

SURGERY: On July 7th, 1955, a large cystic mass was displayed in the right popliteal space. It was attached by a thin, narrow, fibrous strand to the posterior surface of the joint capsule, and bulged outward from a position between the medial head of the gastrocnemius and the semimembranosus. It was readily freed from its loose attachments and removed totally.

GROSS PATHOLOGY: The specimen consisted of a multiloculated and multilobulated cystic mass. It was crudely spherical, 14 cms. in maximum diameter. (The cysts had been opened previously and 50 ccs. of viscid yellow fluid was submitted separately.) The walls of the cysts varied from ragged torn fibrous membranes of tissue-paper thinness to disc-like plaques and many warty nodules which varied from a few millimeters to 1.8 cms. in thickness and as much as 9 cms. in diameter. A 1 mm. layer of fibrin was loosely adherent to the inner smooth, but wrinkled surface, of the largest cyst. Externally, the plaques appeared greyish-white with faint streaks of orange. Fresh surfaces were fleshy, succulent pinkish-white with linear streaks of bright orange.

CONTRIBUTORS: H. R. Fishback, M.D.,
P. G. Winquist, M.D.,
2001 Dwight Way,
Berkeley, California.

CASE NO. 3.

December 4, 1955.

ACCESSION NO. 8105
OUTSIDE NO. HMH 54-857

NAME: F. W.
AGE: 13 SEX: Male RACE: Cauc.

TISSUE FROM: Mass, popliteal fossa.

HISTORY: This patient gave a history of having injured his left knee slightly while wrestling in September, 1953. Two weeks later it swelled, became painful and was aspirated. It continued to hurt and in March, 1954, an orthopedic surgeon palpated a mass in the popliteal fossa. There was limitation of motion.

SURGERY: On March 25th, 1954, the mass was removed.

SURGICAL FINDINGS: The mass was the size "of half an orange", firmly bound to the popliteal face of the femur, the proximal portion of the posterior face of the knee joint and to the overlying tissues. It appeared to be periosteal in origin, but showed no destruction of underlying bone.

GROSS PATHOLOGY: The specimen consisted of an ellipsoidal portion of firm, pink and gray tissue which measured 6 x 3.5 cm., and had a shaggy surface. It sectioned with cartilaginoid resistance. Within the tissue there was a 2 cm. cyst, filled with clear, watery, dark amber fluid and was lined by a glistening thin membrane. The lining was mottled red, yellow, brown, tan and gray. The cut surfaces of the cyst wall were glassy and pale gray, mottled with tan and showed scattered millimeter-sized bright orange spots.

FOLLOW-UP: Fifteen months after the operation the patient is symptom free.

CONTRIBUTOR: Dorothy Tatter, M.D.,
LACH,
Los Angeles, California.

CASE NO. 4.

December 4, 1955.

ACCESSION NO. 4886
OUTSIDE NO. SP 53-2218

NAME: B. G.
AGE: 30 SEX: Female RACE: Cauc.

TISSUE FROM: Right thigh.

HISTORY: The patient was admitted to LACH on February 28th, 1953, with complaints of a pain in the right hip, knee and leg of 2½ years duration and a swelling of the right leg for two weeks before entry. There was no history of trauma. Examination revealed the right thigh to be 23 cm. in diameter, the left thigh 20.5 cm. in diameter. The right thigh was tender, indurated, also warmer than the left. The patient was anemic and had had amenorrhea since June, 1951.

LABORATORY FINDINGS: Hg 9 grams, other blood findings were normal. Calcium 5.2 m.eq/l, phosphatase 3.9 Bodansky units. X-ray taken on February 27th, 1953, showed a laminated productive periosteal bone formation on the anterior aspect of the femur at the junction of the middle and distal third, consistent with a malignancy.

SURGICAL FINDINGS: At surgery March 5, 1953, the tumor appeared to be arising in the muscle of the thigh. It was firm, translucent, tan and replaced the anterior muscles of the thigh. It was not encapsulated. The exact extent of the tumor could not definitely be ascertained, but as much as possible was removed. Rapid frozen section was diagnosed as a fully malignant sarcoma.

GROSS PATHOLOGY: The specimen consisted of a mass which measured approximately 18 x 9 cm. and on one surface was the imprint of the femur. The tumor was tan-white and the general pattern was that of fascicles of replaced muscle tissue. It was firm, not friable and in some portions on the periosteal surface there were fragments of bone. The tissue when sectioned, had a more translucent bluish-white appearance and what appeared to be atrophic muscle fibers could be made out in the periphery. Occasionally there was an area of necrosis that had a vivid yellow color against the background of the blue-white tumor. Also submitted were numerous fragments of similar tissue.

FOLLOW-UP: X-ray taken on March 29th, 1953, of the right femur revealed irregularity of the cortical bone on the anterior aspect of the lower 1/3 which suggested surgical defect. Chest X-ray taken on March 17, 1953 was negative. No evidence of metastases.

Patient returned to Peru in September, 1953. One month later she suffered a fall on her right leg and was placed in a body cast from head to toe. She expired on January 15, 1954. No information available regarding an autopsy report.

CONTRIBUTOR: W. C. Thomas, M.D.,
Robert Clellan, M.D.,
Children's Hospital,
Los Angeles, California.

CASE NO. 5

December 4, 1955.

ACCESSION NO. 7822
OUTSIDE NO. S-323-54

NAME: D. I.
AGE: 2 SEX: Female RACE: Cauc.

TISSUE FROM: Surgery May 19th, 1954.

HISTORY: This child, born in September, 1953, was first seen at the Children's Hospital on January 28th, 1954. A mass in the right neck had been noted by the parents three weeks prior to admission. A similar but smaller mass, appeared in the right axilla two weeks prior to admission. Both had been asymptomatic.

Physical examination was negative, except for the presence of a 5 cm. cystic globular mass in the subcutaneous tissue of the neck and a similar 2 cm. mass in the axilla on the same side.

SURGICAL FINDINGS: At surgery on February 3rd, 1954, a firm, relatively fixed mass which measured approximately 4 cm. in diameter, was found in the right axilla and a similar mass was found lying in the right supraclavicular fossa. These were well encapsulated masses of lobar appearing fat, which were connected to each other in the subcutaneous fat layer.

GROSS DESCRIPTION: The specimen consisted of several fragments of tissue which were fairly well encapsulated before dissection. The external appearance revealed numerous nodules which were confluent with the main mass. The external surface was smooth and had a yellowish-pink appearance with small dark reddish-brown striations. The consistency of the tissue was soft and malleable. On cut section, numerous lobules were noted which measured from 1 cm. to 1 mm. in diameter. In the larger lobulations, numerous striations were noted to radiate from the central portion of the lobule. The mass had the appearance and consistency of adipose tissue. Several large blood vessels were noted on the surface of the tumor, but the internal surface was not vascular.

FOLLOW-UP: On May 11th, 1954, the child was re-admitted to the hospital with the history that six weeks prior to this second admission, the masses had returned and had gradually increased in size.

On May 19th, 1954, a radical excision of the mass was performed, with the following surgical findings: A soft, fatty-like, yellow-white gray tissue was found to have invaded the skin of the right neck, anterior chest wall, cervical structure and pectoralis major and minor. It extended beneath the clavicle and was adherent almost to every element of the brachial plexus and the major vessels and to the entire under-surface of the scapula, as well as to the chest wall.

continued next page-

Case No. 5 - continued.

GROSS DESCRIPTION: The specimen consisted of a mass of tissue which measured 15 x 6 x 5 cm. At one extremity there was a portion of skeletal muscle which measured approximately 3 to 4 cm. in diameter. The remainder of the tissue was light gray and firm with lobules of light yellow-gray tissue. On section, the lobules were noted to measure between 3 and 5 cm. in diameter and to be composed of a slight gray-yellow tissue which showed a slippery palpation. The tissue appeared homogeneous. The intervening fibrous tissue trabeculae were about 2 to 6 mm. in width.

CONTRIBUTORS: P. G. Winquist, M.D.,
H. R. Fishback, M.D.,
Herrick Memorial Hospital,
Berkeley , California.

CASE NO. 6.

December 4, 1955.

ACCESSION NO. 7749.
OUTSIDE NO. HMH 55-222

NAME: D. H.
AGE: 19 SEX: Female RACE: Negro.

TISSUE FROM: Tumor of left thigh.

HISTORY: The patient entered the hospital with complaints of a mass in the upper lateral aspect of the left thigh of seven years (?) duration, with gradual growth during this time. There was no pain.

SURGERY: February 25, 1955, excision of tumor.

SURGICAL FINDINGS: The tumor was found between the upper end of sartorius and anterior vastus muscles, adherent to rectus femoris, adjacent ilium and anterior to the superior iliac spine.

GROSS PATHOLOGY: The specimen consisted of a round, rubbery, pale gray mass 6 cm. in diameter and a separate fragment of similar tissue with adherent tendon and/or fascia. The larger mass sectioned with slight resistance and showed pale gray, glassy, gelatinous cut surfaces that exuded mucinous fluid.

FOLLOW-UP: A hemi-pelvectomy was performed on March 9th, 1955. Also submitted at that time was a 3 x 1.5 x 1.5 cm. pale, soft mass removed from the right breast.

Slide present is from surgery on February 25, 1955.

CONTRIBUTOR: Robert W. Huntington Jr., M.D.
Kern General Hospital,
Bakersfield, California.

CASE NO. 7.

December 4, 1955

ACCESSION NO. 8095
OUTSIDE NO. S-2423-53

NAME: A. S.
AGE: 5 SEX: Male RACE: Mexican

TISSUE FROM: Tumor over fibula.

HISTORY: This patient was noted to have pre-auricular tubercles of both ears and was hospitalized in May, 1951, for otitis media and diarrhea. He was circumcised in December of that year. In November of 1953, his left leg was noted to be larger than the right. The mother first noted this difference four months previously after the child had been kicked, and that it became increasingly more noticeable. Examination showed an ill-defined hard mass in the calf of the left leg. No tenderness could be elicited, however, the child favored the left leg. X-ray report revealed a soft tissue density in the calf of the left leg, probably fibrosarcoma.

MISCELLANEOUS DATA: The mother had had a pre-auricular tubercle of the left ear.

SURGERY: At exploration on November 20th, 1953, a whitish, oval-shaped mass was found lying over the fibula and interosseous space, which shelled out easily.

GROSS PATHOLOGY: The specimen was described as an oval tumor mass which measured 10 x 5 x 4 cm. and weighed 82 grams. The tissue was firm, nodular and rubbery. The "capsule" was thin and there were remnants of connective tissue adherent to it. On cut section, the tumor bulged from the cut surface and had a glistening surface made up of dense white, interlacing strands interspersed with yellow, lobulated areas suggestive of fat. No areas of necrosis or hemorrhage were noted.

FOLLOW-UP: Follow-up x-ray suggested areas of cortical thickening and irregularity on the proximal third of the fibula. Re-exploration on December 4th, 1953, revealed what was interpreted as tumor mass involving the soleus muscle. This was resected with adjoining portion of portion of the fibula. The wound healed well.

In March, 1955, the child was seen in Tumor Board and seemed entirely well and was walking without the slightest difficulty. Chest X-ray was clear.

CONTRIBUTOR: L. J. Tragerman, M.D.,
Hospital of the Good Samaritan,
Los Angeles, California.

CASE NO. 8.

December 4, 1955.

ACCESSION NO.7968
OUTSIDE NO. B-543-53

NAME: Mrs. H. R. S.
AGE: 59 SEX: Female RACE: Cauc.

TISSUE FROM: Pectoralis muscle.

HISTORY: The patient was admitted to the hospital on February 2, 1953, with the history of sawing wood one week previously, following which she noted soreness over the left anterior chest (pectoral area). Two days later, she had noted a lump just below the clavicle. This mass was tender and non-movable and the pain was increased by tensing the left arm. There were no other masses.

Examination showed an irregular mass, approximately 2 x 2 inches, near the anterior axillary line, just below the clavicle. The mass appeared movable to the examiner, but seemed to become fixed on tensing the pectoral muscle. Several soft axillary nodes were palpated.

SURGERY: A local excision was performed on February 3, 1953. A firm grayish mass about 1½ inches was found in the pectoralis major muscle, near the anterior axillary fold, which was excised taking grossly normal muscle on all sides.

COURSE: The wound healed well and the patient was discharged on February 7th, 1953.

GROSS PATHOLOGY: The specimen consisted of an irregular oval mass of skeletal muscle in which was a poorly circumscribed firm mass which measured 3 cm. in diameter. Normal skeletal muscle appeared to surround the mass. The lesion was firm, light tan-gray in color, with some fleshy areas. Other areas were almost fibrous in texture. The latter areas showed grossly visible muscle fibers mixed with the diseased tissue.

FOLLOW-UP: October 17, 1955. Patient is asymptomatic except for slight stiffness in area of surgery. X-ray taken about four months ago were clear. There were no physical findings, except for mild essential hypertension.

CONTRIBUTOR: John W. Hamlin, M.D.,
Sequoia Hospital,
Redwood City, California.

CASE NO. 9.

December 4, 1955.

ACCESSION NO. 8016
OUTSIDE NO. SS55-1412

NAME: J. B.
AGE: 49 SEX: Male RACE: Cauc.

TISSUE FROM: Stomach.

HISTORY: This patient gave a history of having had a vague, upper abdominal pain for two years. This was followed by indigestion, which was relieved by Amphyogel Donnatol, however, the last recurrence, four weeks before admission, was not relieved by medication. Upper G.I. revealed a gastric mass in the distal third. There was no weight loss, no blood in stool and no vomiting. Patient was essentially negative at time of admission.

LABORATORY FINDINGS: Blood count and urinalysis normal.

SURGERY: May 19th, 1955, resection of gastric mass.

GROSS PATHOLOGY: The specimen consisted of a segment of the stomach which measured 15.0 cm. in length along the lesser curvature and 19.0 cm. in length along the greater curvature. The distal portion included 1.0 cm. of the duodenum. The pylorus was intact. The serosa was smooth, shining and glistening, revealing nothing noteworthy. Portions of omentum were attached, both on the greater and lesser curvatures. The entire gastric omentum covered an area of 20.0 cm. In the mesentery, along the lesser curvature, were several small firm gray lymph nodes ranging up to 5.0 mm. in diameter. The specimen had been opened along the lesser curvature. The rugal pattern was within normal limits and the mucosa was intact throughout the stomach. Lying within the wall on the greater curvature, approximately 4.0 cm. proximal to the pylorus, was an intramural mass which measured 25.0 mm. in diameter. This mass was covered by intact mucosa and muscularis externa lying, as it did within the lamina propria. The mass on section, showed a mottled, soft, reddish-brown cut surface.

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

CASE NO. 10.

December 4, 1955.

ACCESSION NO. 7979
OUTSIDE NO. 578-55

NAME: L. M.
AGE: 54 SEX: Female RACE: Cauc.

TISSUE FROM: Mesentery tumor.

HISTORY: This patient gave a history of cramping abdominal pain of two days duration, with nausea and passing of gas by rectum. Physical examination showed a mass, the size of a small football, in the left lower abdominal quadrant, movable and tender. Pelvic examination showed the mass to be apparently attached to the uterine fundus. The patient was dehydrated because of food intolerance.

LABORATORY FINDINGS: Urinalysis showed only a four plus acetone with a few white blood cells. Blood count and serology normal. Chest X-ray normal. Abdominal X-ray showed a large soft tumor mass in the mid-abdomen.

SURGICAL FINDINGS: At surgery on April 22nd, 1955, several large fatty tumors were found in the mesentery of the mid-ileum, with one larger tan mass in the mesentery. The small bowel was partially obstructed by extrinsic pressure. The tumors and adjacent small bowel were removed and an end to end anastomosis made. In the root of the mesentery, small fatty masses were palpable, that could not be removed without sacrificing a dangerous amount of small bowel.

GROSS PATHOLOGY: The entire specimen weighed 1225 grams and in a somewhat contracted state, the normal appearing small bowel segment was 31 cm. long. The mesentery had large masses of hypertrophic fat overlapping the bowel. About 3 cm. removed from the bowel, the mesentery had an oval mass 15 x 12 x 9.5 cm. in size with a rough, purple-tan serosa and a depressed yellow, necrotic area at the tip. Section showed meaty, fairly uniform, tan tissue with large yellow patches of necrosis and cystic areas of softening up to 2 cm. in size. The tumor had a sharp border and could be shelled out of the surrounding fat. In the mesentery, there was another pedunculated mass 10.5 x 7.5 x 5 cm. in size that was encapsulated and composed of yellow, greasy tissue, typical of a lipoma. There were no enlarged lymph nodes.

COURSE: Post-operative course was uneventful.

CONTRIBUTOR: Capt. H. V. O'Connell, MC, USN.
U. S. Naval Hospital,
Oakland, California.

CASE NO. 11.

December 4, 1955.

ACCESSION NO. 8086
OUTSIDE NO. S54-11

NAME: B. G. H.
AGE: 23 SEX: Male RACE: Cauc.

TISSUE FROM: Psoas muscle.

HISTORY: This patient was apparently in good health until the first part of August, 1953, at which time friends and relatives noted a change in his normal behavior pattern. Whereas, he had previously been an alert, aggressive individual, he now had become docile, somewhat withdrawn and appeared lethargic, slept heavily and easily, was difficult to arouse and did not express much interest in his surroundings. On August 8, 1953, while at work, he apparently fainted. He remained unconscious and was taken to a local dispensary where he responded with intravenous fluids, the nature of which were not known to the patient. He responded satisfactorily and was discharged from the sick list at that time and apparently continued in a satisfactory manner until about the first part of December, 1953, at which time he again fainted. Because of the previously noted change in behavior pattern and his episodes of fainting, he was admitted to the Psychiatric Service with a diagnosis of Schizophrenic Reaction, catatonic type. Patient continued to be drowsy, somnambulant, difficult to arouse, combatative at times and because of the severity of these symptoms, he was then transferred to the U. S. Naval Hospital where he was admitted to the Psychiatric Service.

Upon his arrival to this service on December 19, 1953, physical examination was reported as entirely within normal limits. The most striking abnormal physical findings were noted in the abdomen, where a firm globoid tumor was noted in the right hypochondrium, which measured approximately 10 cm. in diameter. It was slightly movable, but did not move with respiration. Lying behind this tumor and more laterally in the flank area, was a large, very firm, non-tender, immovable tumor whose outlines were not definable, but roughly measured approximately 40 cm. in length.

LABORATORY FINDINGS: Blood count, urinalysis and blood chemistries were obtained at this time, all of which were reported as within normal limits, except for a blood glucose, which was reported as 32 mg%. Ten percent glucose in water was started intravenously and within 1/2 hour, the patient began to demonstrate signs of response and continued as long as glucose was administered. X-rays of the skull, the chest and the abdomen were obtained and were reported as normal, except for areas of calcification in the right flank, corresponding to the mass previously noted there on physical examination.

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Accession No. 8086 - continued.

SURGERY: On January 4, 1954, a large retroperitoneal extra-renal tumor rising from the right ilio-psoas muscle was excised.

GROSS PATHOLOGY: The specimen consisted of a large rubbery, firm mass of tissue which was encapsulated by a paper thin fibrous tissue. Externally, the mass was lobulated and considerable muscle tissue was seen attached directly to the capsule. It measured about 16 cm. in diameter and weighed 1200 grams. Numerous blood vessels were seen coursing through the tumor. On section, it had a tawny to yellowish brown color with areas of a more yellow and gray appearance. In some areas there were definite circumscribed, markedly firm zones, while in other areas there was palpable calcification.

COURSE: The immediate post-operative course was uneventful. He was maintained on the routine post-operative surgical fluids, subsequent blood sugars have remained within normal limits and the patient has remained alert. A 50 gram oral glucose tolerance test was reported as within normal limits showing no abnormal curves. At the present time the patient has been recovering satisfactorily from his operation.

FOLLOW-UP: January 11, 1955. Patient was in good health. X-rays negative.

CONTRIBUTOR: William Waldmann, M.D., Kern General Hospital, Bakersfield, California.

CASE NO. 12.

December 4, 1955.

ACCESSION NO. 8097
OUTSIDE NO. S-1073-54.

NAME: W. W.
AGE: 60 SEX: Male RACE: Negro.

TISSUE FROM: Periprostatic tissue.

HISTORY: This patient was seen in June, 1950, following a "seizure". Physical examination was essentially negative. Following urinary complaints, he had KUB study which showed calcifications in the lower pole of the left kidney. Cystoscopy on July 31, 1950, showed a displacement of the left lateral bladder mucosa by a space-occupying mass. The trigone was elevated and immobile, as well as the left side of the bladder. The left ureteral orifice could not be found. The patient was hospitalized in August, 1950, with hematuria and dysuria. Cystoscopy revealed similar findings. Bladder biopsies showed cystitis cystica.

Patient was re-admitted in April of 1954, with complaints of pain in the back. The examiner described a deep seated mass from the umbilicus to the symphysis on the left side of the linea alba. Prostatic enlargement, Grade II to III, was noted with a 15 cc. residual urine. Barium enema showed a large external filling defect on the upper portion of the rectum and sigmoid in the region of the sacral promontory. Barium enema in 1952, had been unremarkable. Cystogram showed the bladder to be compressed and displaced to the left by a soft tissue mass. Punch biopsies of the prostatic region showed a neoplasm.

SURGERY: At exploratory laparotomy, May 21, the surgeon described a tumor seated in the prostatic fossa, extending beneath the trigone.

GROSS PATHOLOGY: The specimen consisted of two large and numerous small fragments of tissue, together weighing 775 grams. Cut section revealed firm nodules of tumor tissue and yellow and red areas of hemorrhage.

COURSE: The patient was discharged on September 3, 1954. In October, 1954, his liver was noted to be enlarged and nodular. His final admission was in April, 1955, at which time the abdomen was filled with fluid. Chest film showed numerous metastases. Acid phosphatase was 0.97. (Normal up to 3.25). Patient expired on June 5, 1955.

AUTOPSY FINDINGS: Autopsy showed the upper abdomen to be occupied by an enlarged liver filled with tumor nodules. Multiple small nodules were noted in the lung. The bladder was firmly attached to the pelvic wall and tumor mass. The prostate was small and separate from the pelvic tumor mass. A staghorn calculus was present in the left kidney.

Slide present is from surgery May 21, 1954.

CONTRIBUTOR: Raymond Bangle, Jr., M.D.
679 South Westlake Avenue,
Los Angeles, California.

CASE NO. 13.

December 4, 1955

ACCESSION NO. 7964
OUTSIDE NO. B-1024-55

NAME: Mrs. A. J. S.
AGE: 39 SEX: Female RACE: Cauc.

TISSUE FROM: Retroperitoneal tumor.

HISTORY: This patient entered the hospital on January 6, 1955, with a two month history of intermittent low grade fever, chills, malaise, night sweats, nausea, anorexia, headache, sacroiliac and right sciatic pain, as well as lower abdominal pain. There had been a weight loss of approximately 14 pounds. Patient had had an appendectomy previously.

LABORATORY FINDINGS: Hemoglobin 12.8 gms. Rbc 4.3 million, Wbc 12,300 with 65% segmented neutrophiles and 28% lymphocytes. ESR corrected to 40 mm. per hour. Urinalysis negative. Sternal within normal limits; agglutination tests for typhoid paratyphoid A and B and Brucellosis were negative; several blood cultures were negative; A.S.T. 12 Todd units; Tuberculin PPD, coccidioidin and histoplasmin skin tests were all negative. X-rays were interpreted as disclosing a right retroperitoneal mass.

COURSE: The patient was given a course in antibiotics, including penicillin and achromycin, without response.

SURGERY: On February 25, 1955, exploration of the right retroperitoneal area was done.

SURGICAL FINDINGS: A solid tumor 9.5 x 6 x 4 cms., apparently thinly encapsulated, was found beneath the right psoas fascia anterior to the muscle belly proper. It was composed of solid, soft, rubbery, yellowish or pale grayish-yellow, glistening tissue in which there were a few small questionable abscesses. The tumor appeared to be adherent to the right renal vein. The major portion of the mass was removed, leaving behind the small part which was adherent to the renal vein.

Post-operatively, the patient's temperature decreased to normal.

CONTRIBUTOR: Donald Howie, M.D.,
Kern General Hospital,
Bakersfield, California.

CASE NO. 14.

December 4, 1955.

ACCESSION NO. 8096
OUTSIDE NO. S-867-55

NAME: R. C.
AGE: 38 SEX: Male RACE: Mexican

TISSUE FROM: Retroperitoneal tumor.

HISTORY: This patient was admitted on March 28, 1955, with complaint of a mass in his stomach. X-ray studies had previously revealed a duodenal ulcer. About one month prior to admission, he had noted a mass in the left lower quadrant which had been growing rapidly. It was noted to be hard, non-movable and very tender. The bowel movement the morning of admission was the first for four days. X-ray showed barium impaction, sigmoid and descending colons and the possibility of a diverticulitis was suggested. He was discharged on April 5th, feeling "pretty good", but returned on April 10th with a moderately distended abdomen and hypo-active peristalsis.

SURGERY: On April 15th, 1955, exploration revealed a massive retroperitoneal tumor, apparently arising from the area between the aorta and the vena cava, slightly above the bifurcation of the aorta.

FOLLOW-UP: The patient improved following surgery and was discharged on April 25th. He was re-admitted on May 22nd, with abdominal swelling, went rapidly down hill and expired on June 4th.

AUTOPSY FINDINGS: At autopsy, a tumor mass was found to be binding down all parts of the abdominal contents and extended into the pelvis. Many nodules of encephaloid tissue were present over the peritoneal surface and within the diaphragm. A single anthracotic node in the superior mediastinum contained tumor. A section from this node showed numerous bizarre giant cells.

Slide present is from surgery on April 15th, 1955.

CONTRIBUTOR: John D. Bauer, M.D.
Missouri Pacific Hospital,
St. Louis, Missouri.

CASE NO. 15.

December 4, 1955.

ACCESSION NO. 8058
OUTSIDE NO. 22201

NAME: C. F. G.
AGE: 46 SEX: Male RACE: Cauc.

TISSUE FROM: Retroperitoneal tumor.

HISTORY: In 1948, on the basis of radiographic examination and clinical history, the diagnosis of duodenal ulcer was made. Since that time the patient has had duodenal ulcer symptoms intermittently every two or three months. In 1952, the patient had a myocardial infarction. In October, 1954, the epigastric pain became more severe and was associated with vomiting. The patient was admitted to the hospital on October 29th, 1954. Medical work-up led to a diagnosis of chronic duodenal ulcer, posterior penetrating, with almost complete pyloric obstruction.

LABORATORY FINDINGS: Noncontributory, blood sugar normal.

SURGERY: Laporatory was done in November, 1954.

SURGICAL FINDINGS: Exploration disclosed a fair degree of inflammatory reaction around the pylorus and duodenum. An ulcer crater could be felt on the anterior margin of the duodenum. In addition, a tumor mass was found in the mesentery of the small bowel, adjacent to the origin of the superior mesenteric artery. A sub-total gastrectomy was carried out and the lower three-quarters of the stomach, as well as the duodenal ulcer, were removed. The tumor in the mesentery of the small bowel was excised completely.

GROSS PATHOLOGY: The stomach and duodenum showed the usual changes. The mass from the retroperitoneal space consisted of a large encapsulated tumor which measured 6 x 4 x 4 cms. The cut surface was dark-red and interrupted by small yellowish foci. The consistency of the lesion was that of fish-flesh.

CONTRIBUTOR: John J. Gilrane, M.D.
LACH,
Los Angeles, California.

CASE NO. 16.

December 4, 1955.

ACCESSION NO. 8062
OUTSIDE NO. SP54-6234

NAME: S. W.
AGE: 59 SEX: Male RACE: Cauc.

TISSUE FROM: Skin, forearm.

HISTORY: This patient entered the dermatology clinic in May, 1954, because of a scaling papular eruption on both legs and forearms. There were several prominent keratotic papules on both arms. Within the preceding three months one of the forearm papules grew to an eroded keratotic nodule 1.0 cm. in diameter.

Surgery: Excision of the nodule with a skin ellipse was done on May 22, 1954.

GROSS PATHOLOGY: The specimen consisted of an ellipse of skin which measured 4 x 3 cm.,in the central portion of which was a hemispherical mass on the vertex of which was a hard, warty, central portion. The skin margins contained numerous keratotic areas and for the most part, the protruding mass appeared to be made up of the same type of skin that was at the periphery of the tumor. This was partially desquamating until it reached the vertex where it was brownish, roughened and slightly everted. The surgical surface was flat and when sectioned through the central portion, there was a well circumscribed, gray, coarsely granular fleshy, firm tissue that was covered by numerous little punctate white dots. The surface, when scraped, had a grating sound. The lesion appeared to have arisen from within and grown outward, pushing the skin in its progression, leaving the edges of the lesion covered by a tense, slightly altered skin with a central portion ulcerated and slightly everted as though the contents were about to rupture.

FOLLOW-UP: When seen three months postoperatively, the excisional site was well healed and the other lesions were subsiding.

CONTRIBUTOR: Howard A. Ball, M.D.,
233 -A Street,
San Diego, California.

CASE NO. 17.

December 4, 1955.

ACCESSION NO. 7948
OUTSIDE NO. C964-J

NAME: V. B.
AGE: 57 SEX: Male RACE: Cauc.

TISSUE FROM: Right tonsillar fossa.

HISTORY: The patient was first seen on April 15th, 1954, with a history of bloody sputum and soreness in the right tonsil and dysphagia. Onset of symptoms had been two to three months previously. An ulcerative fungating type of growth of the right tonsillar fossa was present which extended inferiorly onto the posterior pharyngeal wall for a distance of approximately 3.5 cm. Total diameter of the mass was 5 x 4 x 3 cm. Radiation therapy was given.

SURGERY: Excision of the growth on June 11th, 1954.

GROSS PATHOLOGY: The specimen consisted of a mass of flattened, soft, grayish tissue with a somewhat nodular, but not frankly ulcerated surface. The cut surface exhibited peculiar segmentation of the surface unlike lymphoid tissue.

COURSE: The patient re-entered the hospital in September, 1954, because of voice change and hemoptysis, which had been present for six weeks, accompanied by pain radiating to the right ear for one month. Tumor filled the entire cephalocaudate portion of the right lateral and posterior wall of the hypopharynx and extended down to the right lateral and posterior wall of the hypopharynx, to the level of the right arytenoid cartilage and the glottis, but did not involve the larynx primarily. It was removed in multiple portions and dissected at the margins with what was considered to be an adequate border of normal tissue, and down to the periosteum. The right posterior one-quarter of the base of the tongue was removed and the anterior and posterior pillars. The entire floor was cauterized.

Re-examination in December, 1954, revealed a recurrent tumor in the right side of the hypopharynx which extended down to the pyriform fossa, but did not involve the larynx. There was a small area which extended forward to the right base of the tongue. Endoscopic removal was attempted, but bleeding was too profuse and it was removed through the lateral hypopharyngeal wall with the deep jugular vein, lymph nodes and internal jugular vein. Tumor was observed to be growing through the hypopharyngeal wall in the region of the thyroid cartilage, ala of the cartilage and also through the region of the hyoid bone.

FOLLOW-UP: Despite X-ray therapy the tumor continued to grow which resulted in respiratory interference. The patient was re-admitted on April 27th,1955, with a bloody diarrhea which had developed several days before. There was a large tumor mass which extended from the hypopharynx up to the lower part of the nasopharynx with about 75% obstruction. A tracheotomy was done but the patient steadily deteriorated and expired May 8th,1955.

CONTRIBUTOR: James D. Barger, M.D.,
Good Samaritan Hospital,
Phoenix, Arizona.

CASE NO. 18.

December 4, 1955

ACCESSION NO. 7869
OUTSIDE NO. S-55-1729

NAME: M. B.
AGE: 32 SEX: Female RACE: Cauc.

TISSUE FROM: Broad ligament.

HISTORY: The patient was admitted to the hospital with complaints of having had vague distress in the right lower abdomen and pelvic area for approximately one year. There had been an onset of acute pain on March 26th, 1955, over the entire suprapubic area, more severe on the right side, and it extended to the right loin area. On March 28th, 1955, the patient noted a tumor mass which increased rapidly in size and by March 29th, 1955, it had extended from right Pouparts ligament to within 2 cm. of right margin of the fundus.

LABORATORY FINDINGS: Blood count and urinalysis were within normal limits. Sed. rate 47 mm/hr. VDRL negative.

SURGERY: Date of surgery not given.

SURGICAL FINDINGS: A gray,soft, partially encapsulated tumor mass was found in the right broad ligament which extended along and replaced the round ligament. This extended into the inguinal canal for approximately half of its length and to within 2 cm. of the uterus. The tumor measured 7 cm. in length. It was 3.5 cm. in diameter in the inguinal canal and 5 cm. in diameter in the broad ligament. It grossly resembled brain tissue.

FOLLOW-UP: The patient has had multiple small skin tumors which have all been lipomas. No bone marrow examination was done. She has had no hepatomeglia or splenomegaly and has had no further symptoms since operation.

CONTRIBUTOR: Albert F. Brown, M.D.
1509 East Wilson Avenue,
Glendale, California.

CASE NO. 19.

December 4, 1955.

ACCESSION NO: 8071
OUTSIDE NO. GSH 54-2757

NAME: Mrs. O.E.C.
AGE: 51 SEX: Female RACE: Cauc.

TISSUE FROM: Fragments of ovarian tissue.

HISTORY: A radical mastectomy was performed in June, 1949, for carcinoma. Subsequent bony metastases responded to radiation and then to testosterone therapy which she had been on for two years. High estrogen levels were in the urine. Patient had had menopause in 1948.

SURGERY: Oophorectomy and adrenalectomy, December 7, 1954.

GROSS PATHOLOGY: The ovaries appeared normal for the patient's age. The specimen itself consisted of numerous congested yellow-white tan fragments, without intact cysts, recognizable cyst wall or gross tumor.

FOLLOW-UP: In January, 1955, a left adrenalectomy and removal of metastases to the rib,was performed. Patient expired early in March, 1955.

AUTOPSY FINDINGS: Salient autopsy findings were secondary tumor in all bones examined,including the skull. Tumor was also found in the stomach and liver, extramedullary hematopoiesis in spleen and liver, secondary tumor in posterior pituitary, adenomyosis of uterus, nodular goiter with hyperplasia.

Slide present is from surgical specimen December 7, 1954.

CONTRIBUTOR: Houghton Gifford, M.D.,
Stanford University,
School of Medicine,
San Francisco, California.

CASE NO. 20

December 4, 1955

ACCESSION NO. 8013
OUTSIDE NO. 4E-381

NAME: B. C.
AGE: 38 SEX: Female RACE: Cauc.

TISSUE FROM: Endometrial ulcer.

HISTORY: The patient first consulted her physician for sore throat, fever and an increased tendency to bruise. During the following weeks the patient had ecchymosis over the body.

Past history and family history were negative, with the exception of the use of "Roux" hair dye for years.

A diagnosis of acute leukemia of undifferentiated cell type was made. The patient died of this disease on November 26th, 1954. This diagnosis was confirmed at autopsy where numerous leukemia infiltrations in various tissues of the body were found.

AUTOPSY FINDINGS: There was an incidental finding of an ulcer on the anterior wall of the endometrial cavity just above the internal os. This ulcer measured 8 x 6 mm. with sharp margins and an hemorrhagic material over its base. This had nothing to do with the leukemia and the slide submitted is from this ulcer.

CONTRIBUTOR: H. Russell Fisher, M.D.,
Huntington Memorial Hospital,
100 Congress Street,
Pasadena, California.

CASE NO. 21.

December 4, 1955.

ACCESSION NO. 8100
OUTSIDE NO. 2542-55

NAME: Mrs. E. M. C.
AGE: 26 SEX: Female RACE: Cauc.

TISSUE FROM: Left fourth rib.

HISTORY: An asymptomatic nodular mass was discovered fixed to the fourth rib at the anterior axillary line one month before surgery, by mobile X-ray unit. There was no history of injury. The X-rays disclosed no other masses including axillary or cervical.

SURGERY: Resection of the fourth left rib on June 24th, 1955.

GROSS PATHOLOGY: The specimen consisted of an 18 cm. long segment of rib, the central part of which was expanded by a fusiform enlargement 15 cm. long and 3.5 cm. in maximum diameter. Both extremities of the rib specimen was free from alteration. The cortex of the expanded portion was thinned. The interior consisted of soft, pink tissue. Only the thin cortical shell contained calcified tissue. At one point on the expanded tumor portion, the cortical surface was roughened at the site of attachment of intercostal muscle; elsewhere it appeared intact.

CONTRIBUTOR: Reuben Straus, M.D.,
St. Joseph Hospital,
Burbank, California.

CASE NO. 22.

December 4, 1955

ACCESSION NO. 8073
OUTSIDE NO. S-869-55

NAME: R. M.
AGE: 12½ SEX: Male RACE: Cauc.

TISSUE FROM: Mandible.

HISTORY: This patient was first seen by his dentist on November 29th, 1954, with a painless swelling in the lower right third molar region.

X-ray examination of the area demonstrated normal development of the first molar tooth; the second had been depressed and its roots almost penetrated the inferior margin of the mandible. Overlying this was an ovoid tumor process of dense, small, ovoid "rudimentary teeth", encased in one mass. There was no surrounding, clearly defined fibrous soft tissue. This mass involved the superior half of the molar region from the anterior aspect of the coronoid process to the distal root of the first molar tooth. The cortex of the mandible was expanded, but intact.

GROSS PATHOLOGY: The specimen received consisted of an irregular, nodular, grayish-red to grayish-white mass which appeared to be calcified. Only a small amount of soft tissue was present at the periphery.

FOLLOW-UP: Subsequent X-rays on February 25, 1955, revealed the lesion to be completely excised.

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

CASE NO. 23.

December 4, 1955

ACCESSION NO. 7977
OUTSIDE NO. SP. 55-5856

NAME: B. P.
AGE: 18 SEX: Female RACE: Negro

TISSUE FROM: Tumor mass, left breast

HISTORY: This patient entered the hospital on April 26, 1955, because of a mass in the left breast of five years duration. Originally, it was about the size of a walnut, but had enlarged and grown in the last two years to its present massive proportion. There had been no mastodymia or nipple discharge. The patient, at time of admission, was three months pregnant.

PHYSICAL EXAMINATION: Examination disclosed that the entire left breast was twice the size of her right breast and contained one enormous hard, movable tumor mass surrounded by a number of small movable satellite masses. The veins of the overlying skin were rather dilated. There appeared to be no fixation to the underlying chest wall, nor was there any supraclavicular adenopathy. There were a number of small 1 cm. axillary nodes bilaterally. The right breast disclosed a few shotty nodules.

SURGERY: On May 7th, 1955, the gigantic tumor mass was excised, which occupied almost the entire left breast surrounded by a number of small satellite similar nodules.

GROSS PATHOLOGY: The specimen was composed of a well encapsulated tumor mass, ovoid in shape which measured 14 cm. in diameter x 9.5 cm. in thickness and weighed 720 grams. It was flesh color, separated by interlacing clefts which extended throughout the entire tumor and appeared to represent ducts. Otherwise, the tumor was rather homogeneous, except for a few areas of yellowish-white discoloration. These separate nodules were received from the same breast and varied in size from approximately 2.5 x 3.5 to 5.5 cm. in diameter. Each piece appeared to be similar to the larger tumor mass and was composed of glistening white, flesh-colored tissue, somewhat in a whorled pattern and grossly resembled a fibro-adenoma.

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

CASE NO. 24

December 4, 1955

ACCESSION NO. 7940
OUTSIDE NO. 2501-55

NAME: J. H. G.
GE: 60 SEX: Male RACE: Cauc.

TISSUE FROM: Thyroid

HISTORY: This patient was first seen on August 31st, 1954, for a lesion on the lower lip, which was removed on December 3,1954, and diagnosed as non-malignant keratotic lesion. An incidental swelling was noted in the right lobe of the thyroid which on follow-up showed a steady growth. On April 26th, 1955, it was removed.

SURGICAL FINDINGS: At surgery, the upper three-fourths of the right lobe was replaced by a hard gray-white mass and was enlarged four times. There were several 1 cm. nodules palpated in the left lobe. The right lobe was removed.

GROSS PATHOLOGY: Completely invested by a connective tissue capsule and weighing 45 grams was a lobe of thyroid which measured 6.2 cm. x 5.5 cm. x 3.8 cm. The external surface was gray-pink, smooth and focally hemorrhagic, and no parathyroids were adherent. The entire lobe was diffusely enlarged, firm, but not hard. The cut surface showed a grayish-yellow pseudolobulated gland with focal areas of well-defined grayish-red colloid with intervening areas of thyroid parenchyma. Focal areas of hemorrhage were present. There was no discernible necrosis, abscess or calcification present.

Also enclosed was a lymph node which measured 1.5 cm. x 1 cm. x 0.4 cm. The node was gray-pink and smooth. The cut surface showed a glistening, gray, focally hemorrhagic lymphoid tissue.

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

CASE NO. 25.

December 4, 1955

ACCESSION NO. 8031
OUTSIDE NO. S54-937

NAME: R. S.
AGE: 25 SEX: Male RACE: Cauc.

TISSUE FROM: Tunica vaginalis, left testicle.

HISTORY: This patient, an inmate of the Santa Clara County Jail Farm, had noted at various times in the past that he seemed to have "4 to 5 balls" in his left scrotum. He further complained of intermittent aching in his left testicle. The number of months or years that these findings were present were not recorded. Prior to admission on May 17th, 1954, he apparently had had an upper respiratory infection with severe cough. He was given penicillin intramuscularly and apparently was in good health as of May 16th, 1954. He was awakened at 4:15 A.M., May 17th, 1954, by a severe pain in his left scrotum and was brought to the hospital shortly thereafter. There was no nausea or vomiting.

Past history noncontributory.

PHYSICAL EXAMINATION: Physical examination was not remarkable, except for the external genitalia. The left scrotum was swollen three times its normal size. There was transillumination and the mass was fluctuant. The head of the epididymis was palpable and very tender. The spermatic cord was not enlarged above the mass, but was tender. The right testicle was normal. There was no penile discharge. The prostate was small, boggy and non-tender. BP 118/70, T. 98.8 P. 72.

LABORATORY FINDINGS: Friedman test was negative. Other laboratory findings noncontributory. X-ray of the chest, KUB and IUP were not remarkable.

On May 18th, 1954, a hydrocele tap was performed and 20 cc. of fluid was removed. The fluid gelled almost immediately in the test tube. Cultures of this material were negative. The acute phase subsided and there was considerable reduction in size, however, a hard firm mass persisted.

SURGERY: A total left orchiectomy was performed on June 3rd, 1954.

GROSS PATHOLOGY: The specimen consisted of a partially formalin-fixed, rubbery, hard mass 6 x 5 x 4 cm. with 12 cm. of attached spermatic cord. The cut surface revealed a sharply circumscribed broad c-shaped band of grayish-white, whorled, firm tissue, varying from 0.5 to 1.5 cm. in thickness and tended to encompass the testis and epididymis. The testis was 3 x 3 x 2.5 cm. and was easily separated from the encircling tumor mass.

CALIFORNIA CANCER COMMISSION
SEMI-ANNUAL SLIDE CONFERENCE

HUGH G. GRADY, M. D., MODERATOR
December 4, 1955

CASE NO.	ACC. NO.	DIAGNOSIS
1.	1751	Synovial sarcoma, popliteal space
2.	8089	Villonodular synovitis, popliteal space
3.	8105	Myositis ossificans
4.	4886	Rhabdomyosarcoma
5.	7822	Lipoblastomatosis (Case No. 6A in Soule Conf, Dec. 66)
6.	7749	Myxosarcoma
7.	8095	Fibromatosis, traumatic
8.	7968	Regenerating striated muscle, post-traumatic
9.	8016	Leiomyoma, stomach
10.	7979	Liposarcoma, mesentery small intestine
11.	8086	Fibrosarcoma, low grade and well differentiated
12.	8097	Leiomyosarcoma, bladder
13.	7964	Fat necrosis with reactive inflammation involving fat
14.	8096	Embryonal rhabdomyosarcoma. Xf: Metastatic epithelial malignant tumor
15.	8058	Carcinoid
16.	8062	Keratoacanthoma, forearm
17.	7948	Verrucal carcinoma, tonsillar fossa
18.	7869	Chronic inflammatory response, broad ligament. Xf: Extramedullary hematopoiesis
19.	8071	Cortical ectopic decidua, ovary
20.	8013	Tumor of uncertain type, breast. Xf: Pseudotumor
21.	8100	Fibrous dysplasia, rib
22.	8073	Ameloblastic odontoma
23.	7977	Fibroadenoma, breast
24.	7940	Lymphocytic goiter (thyroiditis)
25.	8031	Pseudofibromatosis. Nodular periorchitis, scrotum or tunica vaginalis

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