ROYAL COLUMBIAN HOSP.
NEW WESTMINSTER, B.C.

173 c

Case 1. S-4047-64

This 42 year old white female, with a history of previous abdominal surgery ten years ago, was admitted to this hospital with a chief complaint of chills and fever and an "aching" pain in the right upper abdomen of two to three months' duration. She stated that she has been more tired and "run-down" than normal since the birth of her last child, 19 months ago. She reported a 22lb. loss over the past six months. Her admitting blood pressure was 108/64 with a pulse of 68 and respirations of 16. Physical examination revealed a firm, slightly tender, irregular nodular mass below the liver and occupying the right flank. It was difficult to be certain whether or not it was contiguous with the liver. Chest x-ray revealed numerous small nodularities averaging 3 mm. in diameter throughout both lungs. A section from the lung biopsy is submitted.

GROSS: The specimen consists of a portion of lung measuring 2.0 x 1.5 x 1.5 cm. On cut section there are numerous well-delineated spherical, grayish-yellow bodies which protrude above the cut surface and vary in diameter from 1 to 3 mm.

Submitted by Terence F. Cochran, Prov. Hosp., Portland.

Case 2, No. 949-63.

The tissues submitted are incidental findings in two autopsies of women, one 44 with a long history of nutritional cirrhosis and secondary anemia of 5 gm. Hgb, and the other of a 69 year old, diabetic, with heart disease who died with pulmonary embolus. In each case the left adrenal gland had a nodule 1 to 1.5 cm. in diameter which looked like an adenoma, well circumscribed, one was yellowish white and the other was light tan with slight central hemorrhage.

Submitted by Drs. Vimont & Cordova, St. Joseph's Hospital,
Tacoma, Washington.

Case 3, No. A44-64

This is an 84 year old white man confined to a nursing home with a long history of heart failure. On admission to the hospital he was having marked respiratory difficulty and obvious congestive heart failure. On the right side of the chest a tumor mass of 5 cm. in diameter was seen elevating the skin. X-ray showed densities scattered in the right lung with the appearance of pleural and parenchymal secondary neoplasm. This man expired shortly after admission. At autopsy there were large masses of friable gray tumor in the right parietal and visceral pleura and tumor also in the chest wall involving and partially destroying the 5th rib. Besides this local involvement the right adrenal also had a tumor nodule. The rest of the organs and tissue were free of tumor. B.P. fluctuated from 90/50 to 140/70.

Submitted by Drs. Vimont &Cordova, St. Joseph's Hospital,
Tacoma, Washington.

Case 4, No. S-2525-65

Female 34. Nausea and vomiting, abdominal cramps and distention. G.I. films showed a heavy mucosal pattern in the proximal half of the stomach. Gastroscopically the mucosa showed many superficial erosions and a dusky erythemia. Hgb. 12.7 gm; hematocrit 40, Free gastric acidity after a standard meal rose to 26° in the 4th specimen. Serum proteins (electrophoresis); Total protein 4.67, albumin 3.42, globulin 1.25. After given 150 gm of serum albumin over 4 days the total protein rose to 7.98, albumin 5.94 globulin 2.04. A partial resection was carried out. Grossly the mucosal rugae appeared hypertrophic. There were no ulcers. After fixation the mucosa measured 4.5 mm. in thickness.

Submitted by Dr. Warren Hunter, Portland, Oregon

Case 5, No. 899

This 69 year old white male was hospitalized because of recent symptoms which had been attributed to prostatism; namely, burning on urination, nocturia and difficulty in starting a slow urinary stream. In 1963, diabetes mellitus had been diagnosed, but had been well controlled by diet. Painful joints had been troublesome for many years, and the diagnosis of rheumatoid arthritis had been made. Otherwise the patient had been well. As a youth he had matured early, and had commenced shaving before he was 13 years old. During many years of marriage he and his wife had considered his role as a husband "satisfactory" although there were no children. The patient said that during the past year he had been unable to maintain an erection and there was a decrease in the amount of seminal fluid. He had had a plastic repair for hypospadias in 1925.

The patient was a short, stocky bald man. The testes could not be felt in the scrotum or groins. Some hypospadias persisted. The prostate was hard and small.

Several biopsies of the prostate were variously interpreted. One specimen which was obtained by needle was considered to have evidence of adenocarcinoma, but the pathologist later reviewed the case and decided that there were atypicalities of small glands without enough evidence for a diagnosis of tumor.

Routine urinalysis was not contributory. Blood chemistry determinations were as follows: Blood urea nitrogen - 21 mgm./100ml; Fasting blood sugar 109 mgm./100 ml; glucose tolerance test with a diabetic type curve; Creatinine 1.3 mgm./100 ml; total serum acid phosphatase 1.0 King-Armstrong units, and prostatic serum acid phosphatase 0.6 King-Armstrong units. Additional studies of corticosteroids were done at a different laboratory and were reported as follows: (Untreated patient) Urinary excretion per 24 hrs. pregnanetriol 6.65 mgm; 17-ketosteroids 131 mgm; DHA-17 ketosteroid sulfate 18.4 mgm. No excretion of 17-hydroxycorticosteroids was detected. (After adrenal cortical suppression treatment) 17-ketosteroids 10.7 mgm./24 hrs. Plasma pregnanetriol was reported as 131 micrograms/100 ml. The section is from a biopsy taken at explatory laparotomy.

Submitted by Drs Sarkaria, Chester & Orendurff,
Veterans Administration Hospital, Portland, Ore.

Case 6 No. S-3147-62

Male 76. A 9 year history of lump in the thyroid increasing in size with the development of multiple nodules. Tumor had been treated with thyroid for 9 years. Loss of weight 40-50 lbs. in past 3 years with dysphagia. On physical exam. the tumor was huge occupying all of the space between the mandible and clavicle. It displaced the trachea and carotid artery. There was no evidence of distal metastasis.

The tumor was resected. It was multilobulated, measured 12 x 10 x 10 cm. and weighed 470 gm. The capsule was defective over an area measuring about 3 cm. in diameter where the tumor appeared to have been cut through. Two pedunculated nodules were attached to the main tumor mass one measuring 3.5 cm., the other 2.5 cm. in diameter. No appreciable amount of non-tumorous tissue or connective tissue is attached to the specimen

Submitted by Dr. Elizabeth Holmes, King County Hospital.

Case 7 No. 65-S-1148

A 31 year old male with a 2 week history of tenderness and increasing size of his left testicle to approximately 2 times normal. No history of trauma or V.D. No inguinal lymphadenopathy. No response to penicillin therapy. Diagnosis probable seminoma of testicle. GROSS - an enlarged testicle measuring 4 x 4 x 7 cm with a homogenous soft, edematous cut surface. The tunica appeared intact. The epididymus was edematous and firm.

Submitted by Dr. A. H. Pontifex, Royal Columbian Hospital.

Case 8 No. 64-S-11264

Female aged 44 with a 10 year history of hypertension. Major symptom was headache. Average blood pressure during 10 days of hospitalization with usual treatment 200/120. Lowest pressure recorded 180/100. Additional history of moderate to marked generalized weakness and nocturia. Average Blood K when not on diuretics 3.1 mg. Average am urine pH 7.5, B.U.N. 10 mg%; Hgb 12.4 gm%; urinalysis - random S.G. 1.012, protein negative, sediment nil, growth nil; V.M.A. 6.9 mg/24 hrs; 5HIAA negative.
Rt. ureteric specimen Na 123 mEq/1, K 31 m Eq./1, urea 130 mg%.
Lt. ureteric specimen Na 149 mEq/1, K 37 m Eq./1, urea 185 mg%.

At laparotomy a tumor measuring 2 cm. in diameter was excised from the left adrenal.

Submitted by Dr. C. J. Coady, Royal Columbian Hospital

Case 9 No -S66-922

A 33 year old female, para 1, complained of urinary incontinence and was found to be 6 months pregnant.
An asymptomatic 2 cm. diameter smooth polyp was seen protruding from left posterolateral cervix and was biopsied. This is the whole tissue of the slide.

Past History: A known epileptic since age 10 years, partially controlled by Dilantin 100 mg. t.i.d. Had calcified scar of left temporal pole excised at age 21 yrs. with little relief.

Submitted by Vancouver General Hospital

Drs. H. Fidler and G. Elliot

Case 10 No 66-S-1443

Male 43 yrs. Patient has known he had a lump in his thyroid for past 15 years. It had been symptom free until approximately one month before removal at which time it became "uncomfortable" and "started to grow". GROSS: A tan spherical structure 8 cm. in diameter with a central hemorrhagic, semicystic area measuring 5 cm and a cuff of soft, edematous tissue averaging 1.5 cm. in thickness. The lesion appears well encapsulated.

Submitted by Dr. F. L. Sturrock, Royal Columbian Hospital.

Case 11 Nos. 65-S-3392, 65-AO-305.

Female aged 26. Presented as a case of moderately severe hypothyroidism. Six months later developed left cervical and left axillary adenopathy. Gland biopsied (65-S-3392). Treated with Cobalt irradiation but did not do well. Within 7 months she had obvious extensive pulmonary disease and died shortly thereafter. At autopsy there was massive tumor infiltration of both lungs and the mediastinum (Sections of lung and mediastinal nodes) The thyroid was also diseased; the left lobe appeared to be replaced by firm homogeneous, white tumor (thyroid).

Submitted by Dr. D. G. Murray, Royal Columbian Hospital.

Case 12 134-A-65 & No-3

Summary of past and present illness: in E.L.H., born 1910.

In 1959 - large lesser curve gastric ulcer occurred which responded to medical treatment. small duodenal ulcer which healed after one month medical treatment.

In 1961 - developed persistent epigastric pain, anorexia and weight loss due to partial pyloric obstruction. At surgery a large ulcer was found in the first part of the duodenum. Subtotal gastrectomy performed. No mention of pancreatic examination. One month following surgery epigastric pain recurred.

In 1962 - Patient admitted in January with perforation which was treated conservatively. Upper G.I. Series in February demonstrated stomal ulcerations.
In April further surgery revealed two ulcers in stomal region. The jejunal loop was resected and a new anastomosis formed. The pancreas was not explored.
In May epigastric pain recurred and similar stomal ulcerations were demonstrated radiologically.
Because of recurrent severe epigastric pain a transthoracic vagotomy was done in October.
Severe recurrence of pain and anorexia in December.

In 1963 - In February the abdomen was explored again and several nodules were noted in the region of the tail of the pancreas. The remainder of the stomach, the spleen and the tail of the pancreas were resected with anastomosis of a loop of jejunum to the esophagus. A portion of the pancreatic tumor was sent to a Dr. Wilson in Milwaukee for analysis.

Following the above surgery the patient was transferred to Shaughnessy Hospital for dietary rehabilitation and following 2½ months hospitalization this had progressed to the point where he could be discharged for home care. Fourteen months later the patient was re-admitted to Shaughnessy Hospital because of weakness, weight loss and severe continuing anorexia. The patient had arbitrarily stopped taking multivitamins and Pancreatin 4 months prior to this last admission as he had found that they increased this indigestion. He was in the hospital for 8 months prior to death. During this interval dietary management posed a continuing serious problem. It was noted at the time of admission that his liver was palpable and this increased in size latterly. The precipitant cause of death was a fulminating bronchopneumonia

Submitted by Dr. Ted Brites, Shaughnessy Hospital
Dr. R. English, St. Paul's Hospital

Case 13 No. 321

A 58 year old man was admitted with chief complaint of a superior mediastinal tumor picked up on routine chest x-ray 11 months before, and massive hematemesis. The mass had grown, with chest pain and tenderness, and its hard, fixed extension, immobile upon swallowing, was felt above the sternal notch on the right. Biopsy was performed. The mass was fixed to the trachea.

Submitted by Dr. Jacobson, V.A., Vancouver, Washington.

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PACIFIC NORTHWEST SOCIETY
OF PATHOLOGISTS

SPRING MEETING, April 22 & 23, 1966.

SEMINAR DIAGNOSES

NUMBER	DR. MC MILLAN'S DIAGNOSIS
Case #1 S-4047-64 Submitted by Dr. Corcoran Providence Hospital Portland, Oregon.	Metastatic adenocarcinoma of the adrenal. to lung Dr. Corcoran's Diagnosis: Metastatic pheochromocytoma.
Case #2. 949-63.	Myelolipoma. of adrenal
Case #3. A44-64	Malignant pheochromocytoma. of adrenal
Case #4 S-2525-65	Menetriers Disease
Case #5 899(carbon 21 block)	Adrenogenital syndrome with female pseudohermaphroditism. (ovary)
Case #6 3F3147-62	Papillary adenocarcinoma of the thyroid.
Case #7 65-S-1148	Malignant lymphoma of the testicle, type undetermined. A.F.I.P. diagnosis - nonspecific orchitis.
Case #8 64-S-11264	Benign cortical adenoma of the adrenal (Zona glomerulosa variety).
Case #9 S66922	Malignant mixed tumor of the cervix (sarcoma Botryoeides). BENIGN POLYP, a la TAYLOR A.F.I.P. diagnosis: Benign pregnancy polyp. Dr. Hertig's diagnosis: Malignant mixed tumor. Dr. Elliot's diagnosis: Benign pregnancy polyp.
Case #10 66-S-1443	Benign follicular adenoma of the thyroid.
Case #11 65-S-3392 65-AO-305	Hodgkin's sarcoma involving cervical node, thyroid, lung and mediastinal node.
Case #12 186 A65 and No.3	Malignant islet cell tumor with metastasis (Zollinger-Ellison syndrome).
Case #13 321	Malignant tumor type unspecified. of lung