CALIFORNIA CANCER COMMISSION

SEMIANNUAL SLIDE CONFERENCE

ON

TUMORS OF SALIVARY GLANDS AND SKIN ADNEXA

MODERATOR:

LOUISA E. KEASBEY, M.D.

SATURDAY, May 23, 1953

9:30 A.M.

LOS ANGELES COUNTY MEDICAL
ASSOCIATION AUDITORIUM,
1925 Wilshire Boulevard,
Los Angeles, California
Telephone: DUnkirk 7-7175

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

Please send in your diagnoses, using the separate sheets enclosed, on or before May 15, 1953, so that they may be tabulated before the meeting.

11

SUGGESTED CLASSIFICATIONS

SKIN ADNEXAL TUMORS - SWEAT GLAND TYPE

(Proliferative sweat gland cysts - not included)

Papillary Hidradenomas

1. Congenital papillary hidradenoma.
   (Syringoadenomatosus papilliferrus. Syringocystadenoma papilliferum).
2. Hidradenoma papilliferum - vulva.
   (Apocrine. Histological picture same as intraductal papilloma of the breast.)

Adenoid, Hidradenomas

1. Syringoma
2. Aggressive adenoid hidradenoma
   (This name has been coined for the adenoid sweat gland tumors described by Stout -Cancer 4:521,1951, showing aggressive growth and/or metastases.

Primitive Hidradenomas (Solid Hidradenoma)

1. Turban tumor
2. "Sheath cell" or "replacement cell" hidradenoma.
   (Adenomyoepithelioma)
3. Cystic reticular angioid hidradenoma.
4. Hidradenoma - mixed tumor type
   Organoid
   Mucochondroid

Hair-sheath Hidradenoma.

Clear-cell papillary carcinoma. (Amer.J.Path. 25:93,1949)

SALIVARY GLAND TUMORS

Adenoma - Oncocytic or oxyphil cell
Papillary cystadenoma lymphomatosum (Warthin's tumor)
Intraductal papilloma

Lymphoductal tumors

Mixed tumors

1. Typical 2. "Endothelioid" (Reticular)
3. Pseudoalveolar primitive small cell (papillary small clear cell)

Basal cell

1. Solid 2. Tubular 3. Adenocystic

Mucoepidermoid

Benign and malignant

Carcinomas

1. Papillary intraductal
2. Adenoepidermoid
3. Mucous cell
4. Serous cell ("acinic cell"-Foote
5. Squamous cell

Angioma

(Other sarcomas not characteristically salivary in origin.)

SYRINGOCYSTADENOMA
PAPILLIFERUM -

CONTRIBUTOR: Dennis Shillam, M.D. CASE NO. 1a
Pomona, Calif.

ACCESSION NO. 532
OUTSIDE NO. S-921-50

TISSUE: From lesion - left shoulder.

HISTORY: A 7 year old white female with history of a warty birth-mark on left shoulder. Only symptom has been itching.

OPERATION: Surgical excision of entire lesion April 14, 1950.

SURGICAL FINDINGS: Specimen consisted of an elliptical piece of skin measuring 7.5 x 1.5 x 0.5 cm. In the center was a soft elevated wrinkled area 4 cm. long, 10 mm. broad and 3 mm. in height extending grossly to the margins of the specimen.

MISCELLANEOUS: Family history negative.

Attempt at removal April 12, 1948, by application of bi-chloracetic acid - many of lesions were removed and soft scar was left.

Congenital papillary hidradenoma

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HYDRADENOMA
PAPILLIFERUM

CONTRIBUTOR: E. G. Jones, M.D. CASE NO. 1b
Los Angeles, Calif.

ACCESSION NO. 5063
Surg. Path. No. 52-13127

TISSUE: From left vulva.

HISTORY: The patient, a 30 year old white female was admitted to the hospital December 26, 1952, because of painful swelling in the right vulval region. Examination revealed what appeared to be a large Bartholin's abscess on the right side and a small cystic structure on the left. The abscess on the right opened spontaneously and a biopsy was taken of the cystic structure on the left. On January 30, 1953 the entire area was excised.

Basal cell ca
[illegible]

BASAL CELL CARCINOMA -

CONTRIBUTOR: F. M. Rohow, M.D.
Long Beach, Calif.

CASE NO. 2a

ACCESSION NO. 4811
OUTSIDE NO. 1464-52

TISSUE: From tumor mass -scalp.

HISTORY: A 43 year old white female with a history of having had a small cyst, diagnosed as a sebaceous cyst, removed from the scalp in 1940. Recurred 5 years ago, and has been growing slowly since. No other tumors were present.

OPERATION: Tumor mass removed from scalp August 21, 1952.

SURGICAL FINDINGS: Specimen consisted of an elliptical mass measuring 5 x 2.5 cm. and was covered on one surface by epithelium showing a large number of hairs and a smooth elevated mass about the center of the specimen, measuring 2 x 1.5 cm. On section, the mass cut with very little resistance and the cut surface was glistening in appearance and well circumscribed.

Follow-up one year : No subsequent tumors.

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CYLINDROMA

CONTRIBUTOR: Fremont Davis, M.D.
Los Angeles, Calif.

CASE NO. 2b

ACCESSION NO. 3066
Surg. Path. No. 51-11402

TISSUE: From excision of tumor mass- scalp.

HISTORY: A 79 year old white female was admitted to the hospital, September 25, 1951, because of a 6 cm. pedunculated tumor over the vertex of the scalp. It had begun 20 to 25 years ago as a small pedunculated growth. It had gradually increased in size. For the previous year it had drained "mucus and blood" and had become foul smelling. At the time of entry it was hemorrhagic and somewhat necrotic in the center. A biopsy was done and later (November, 1951) it was excised.

CYLINDROMA

CONTRIBUTOR: Tumor Registry CASE NO. 3a

ACCESSION NO. 819
Surg. Path. No. 50-2010

TISSUE: Mass on back.

HISTORY: A 50 year old obese Mexican male was admitted to the hospital in January, 1950, with a fractured tibia and cerebral concussion, having been struck by an automobile while inebriated. While in the hospital for this condition, a mass 3 x 3 x 4 cm. was excised from the right side of back near the midline. The area overlying the tumor was blue-black in color and there was an elevated necrotic area over the entire mass. Clinical impression was hemangioma or melanoma.

SURGICAL FINDINGS: An ulcerated skin flap overlying an encapsulated cystic tumor 3.5 x 5.5 x 2.5 cm. The tumor consisted of a cystic area filled with blood surrounded by a fibrous wall 1 x 2 mm. thick. From one portion of this fibrous capsule reddish brown, slightly firm, hemorrhagic tissue projected into the cyst.

No recurrence in three years.

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? SWEAT GLAND CARCINOMA

CONTRIBUTOR: L. J. Tragerman, M.D.
Los Angeles, Calif. CASE NO. 3b

ACCESSION NO. 5111
OUTSIDE NO. B-2738-49

TISSUE: From tumor on thigh.

HISTORY: A 75 year old female admitted to the hospital with a history of a lump on the thigh for ten years. The mass was the size of a quarter nine years ago, enlarging gradually with rapid growth for the previous year. The mass was located in the anteromedial portion of the Scarpa's triangle.

FIBROEPITHELIOMA

CONTRIBUTOR: Paul Michael, M.D. CASE NO. 4
Oakland, California.

ACCESSION NO. 4730.
OUTSIDE NO. S53-343

TISSUE: From tumor, left side of jaw.

NAME: A.C.

AGE: 34 SEX: Male RACE: White

HISTORY: In 1945 a ceiling panel fell and the corner struck patient on the left side of the jaw, pressing the skin in. He had no medical attention at that time. About three months later, a lump began to form at the site of this injury, which gradually and progressively increased in size until it became the size of a small English walnut. He occasionally "kicked" the skin with his razor. There was a subcutaneous mass, approximately 3 cm. in diameter, 1½ inches lateral to the left angle of the jaw. It was freely movable beneath the skin, except at its central point where there was an irregular 3 mm. scar in the skin to which the tumor was attached; it was not adherent to the underlying tissue. There was no thyroid enlargement and no lymph node enlargement.

OPERATION: Tumor was removed January 17, 1953.

SURGICAL FINDINGS: It measured 2.8 x 2.5 cm. in size, was discrete, encapsulated, and solid, with a satellite similar nodule attached to it, which was also discrete and encapsulated and measured 1.5 x 1.0 cm.

? ATYPICAL GLOMUS TUMOR

CONTRIBUTOR: Meyer Zeiler, M.D.
Los Angeles, Calif.

CASE NO. 5a

ACCESSION NO. 4843
OUTSIDE NO. M4783

TISSUE: From mass on ulnar aspect of ring finger.

HISTORY: 51 year old female patient had an exquisitely painful ring finger on the ulnar aspect of the distal portion for about 25 years. About 20 years previously, some sort of surgical procedure had been done without noticeable relief.

OPERATION: At surgery, the mass was readily enucleated. Post-operatively, the patient has had no pain and has been able to sleep the full night through.

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CHONDROID SYRINGOMA

CONTRIBUTOR: Meyer Zeiler, M.D.
Los Angeles, Calif.

CASE NO. 5b

ACCESSION NO. 4925
OUTSIDE NO. M4094

TISSUE: From scalp tumor.

HISTORY: The patient, a 38 year old white male, had a tumor located near the vertex of skull, just in or beneath the scalp, which had been present for 10 years.

OPERATION: Lesion removed August 14, 1951.

SURGICAL FINDINGS: Specimen measured 3 x 1 cm. On deepest cut surface revealed a lobulated, encapsulated, glistening gray nodule 22 x 10 mm. The cut surface has the appearance of cartilage.

No recurrence as of April 17, 1953.

? BASAL CELL CARCINOMA

CONTRIBUTOR: H. S. Aijian, M.D. CASE NO. 6a
Pasadena, California.

TUMOR REGISTRY NO. 49-3287X
OUTSIDE NO. 0-184

TISSUE: Mass over right side of sacrum.

HISTORY: Patient admitted with complaint of mass over right side of sacrum which started about ten years before. For the previous two years it had increased in size and ruptured several times, draining three to four weeks each time.

OPERATION: A well encapsulated, freely movable cystic mass 2 inches in diameter and rising 1 inch above the surface of the skin was removed. It was shelled out and contained bloody, serous material. One of the lobules was perforated and dirty coffee ground looking watery fluid was released.

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SWEAT GLAND CARCINOMA

CONTRIBUTOR: E. M. Butt, M.D. CASE NO. 6b
Los Angeles, California.

ACCESSION NO. 4669
OUTSIDE NO. 26-53

TISSUE: Tumor mass, base of thumb.

HISTORY: Mass from radial aspect of base of thumb which had been present for a number of years. The mass had started to grow two months before, became ulcerated and drained sanguinous fluid about a month or so later.

? CONJUNCTIVAL CARCINOMA

CONTRIBUTOR: Lewis Guiss, M.D.
Ian Macdonald, M.D.
Los Angeles, Calif.

CASE NO. 7a.

ACCESSION NO. 1456
Surg. Path. No. 50-11033

TISSUE: From region of inner canthus (September 30,1950).

HISTORY: A 58 year old white male was admitted to the Lahey Clinic in October, 1948 with a history of a lesion on the ala of the nose of four years duration. This was excised and ten days later a re-excision of the operative area was performed.

He was first seen here in 1949, having in the meantime been treated by irradiation (dosage not known). A second operation was done in October, 1949 for extensive subcutaneous infiltration around the margin of the previous operative excision. He was next seen with recurrent disease on March 20, 1950, with a history of having returned to the Lahey Clinic for re-excision of the lesion. A radical excision with exenteration of the maxilla was performed at this time.

Patient was admitted to LACH on September 30, 1950. Further extensive surgery including exenteration of the orbit was done at this time. Patient pursued a slow and painful downhill course and died August 8, 1952 with probable brain metastasis. No autopsy.

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ECCRINE ACROSPIROMA

CONTRIBUTOR: H. Russell Fisher, M.D.
Los Angeles, Calif.

CASE NO. 7b

ACCESSION NO. 4926
OUTSIDE NO. MW 1447-49

TISSUE: From nodule over right clavicular area.

HISTORY: The patient was a 36 year old white female. A small nodule in the skin over the right clavicular area was discovered by routine physical examination in November, 1948. The lesion was symptomless and its duration unknown.

OPERATION: The lesion was removed by surgical excision April, 1949.

SURGICAL FINDINGS: Specimen consisted of an elliptical piece of skin 11 x 5 x 4 mm., in the center of which there was a nodular elevation 3 mm. in diameter and 1 mm. high. On section, a small spheroidal tumor appeared to be located in the superficial layer of the specimen.

SWEAT GLAND CARCINOMA

CONTRIBUTOR: S. L. Perzik, M.D.
Los Angeles, Calif.

CASE NO. 8

ACCESSION NO. 3474
Surg. Path. Nos. 52-1124, 52-2622.

TISSUE: From scalp tumor,(February,1952) and preauricular node, March, 1952.

HISTORY: A 29 year old negress (para 7, gravida 8) was admitted in January, 1952 with a complaint of a lump in the right temporoparietal region which had first been noticed when she was in grammar school. It had been removed in 1947 after which it recurred and was again removed in 1950. The scalp tumor appeared again and was a 4 cm. mass at the time of entry. A preauricular mass also had developed in the month before entry.

OPERATION: The scalp tumor was widely excised in February, 1952, and the preauricular mass the following month.

SURGICAL FINDINGS: Enlarged, hard, posterior cervical lymph nodes were noted and 3,000 roentgens were given to this region with temporary regression of the nodes and subjective improvement.

COURSE: Patient was seen December 17, 1952 by the Tumor Board, with recurrent nodes palpable in the back of the neck. At this time she was three months pregnant and had a fusiform 5 x 7 cm. mid-cervical, movable mass. Hysterectomy and radical neck dissection were advised and done.

SWEAT GLAND CARCINOMA

CONTRIBUTOR: Weldon K. Bullock, M.D. Los Angeles, Calif.

CASE NO. 9

ACCESSION NO. 1797
Surg. Path. No.50-14226

TISSUE: Tumor of upper left leg area.

HISTORY: This 57 year old Mexican woman was admitted to the hospital in December, 1950 for treatment of a discolored area overlying the anteromedial aspect of the tibia, which had been present for over twenty years. The patient claimed that she sustained an injury to this region about 29 years ago, from which time a bluish-brown discoloration had been present. For the previous two years, more rapid growth had occurred so that a cone-shaped tumor protruded from the surface of the discolored area. The last four to six weeks tumor growth, apparent to the patient, had involved the skin over the area of discoloration.

PHYSICAL EXAMINATION: Showed a freely movable, deeply seated 8 x 10 cm. mass surmounted by a nipple-like tumor, dusty, brown-red in color and protruding for a height of 1.5 cm. above the skin. This was widely excised, the defect being covered by a skin graft.

SURGICAL FINDINGS: Section of the excised tumor showed multiple, firm, encapsulated, protuberant nodules, forming a conglomerated mass 4 cm. in diameter, under the nipple-like protrusion.

April, 1953, patient was readmitted with obvious inguinal metastases. At surgery, clinically, a tumor involvement extending into the intra-abdominal lymph nodes were found, so that the impression of the operating surgeon was that of hopelessly advanced metastatic disease.

MUCINOUS CARCINOMA (? of SALIVARY GLAND ORIGIN)

CONTRIBUTOR: Paul Kotin, M.D., Los Angeles, Calif.

CASE NO. 10a

ACCESSION NO. 4874
Surg. Path. No. 45-5890

TISSUE: Mass in right axilla (August, 1945)

HISTORY: This 29 year old negro male was operated on in November, 1941, for a skin tumor on the medial aspect of the arm, midway between the axilla and elbow. The patient stated this had started as a single nodule four or five years before. Multiple nodules had developed to form a large nodular mass which became ulcerated. It was removed and the operative wound healed slowly. In January, 1945, the patient was again operated on for an ulcerated, irregular nodular mass 5 cm. in diameter situated in the right axilla. The mass was not fixed and was thought to be a conglomeration of lymph nodes. Microscopic examination showed complete and partial replacement of axillary lymph nodes. In August, 1945, radical dissection of the axilla was performed.

November, 1945, patient was again operated on for a large axillary mass, but this proved to be an abscess. After healing, there was little loss of function and there has been no recurrence to date, March, 1953.

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CONTRIBUTOR: Meyer Zeiler, M.D. Los Angeles, Calif.

CASE NO. 10b ?

ACCESSION NO. 5081
OUTSIDE NO. M-6764

TISSUE: From tumor on left arm.

HISTORY: Tumor on medial aspect of lower third of left arm. Physical examination and laboratory findings were negative.

OPERATION: Excision of tumor December 10, 1952.

SURGICAL FINDINGS: Tumor apparently not encapsulated and attached to neuro-vascular bundle, according to surgeon. Specimen was 4.5 x 2.5 cm. with a fibrous capsule. Cut surface revealed a glistening , fleshy pink tissue, semi-cystic in character with broad irregular septae.

Postoperative radiation was given.

Patient last seen April 15, 1953 with no evidence of recurrence.

Clear cell sweat carcinoma

CONTRIBUTOR: Leo Kaplan, M.D. CASE NO. 11
Los Angeles, Calif.

ACCESSION NO. 4858
OUTSIDE NO. A-233-52

TISSUE: (Autopsy). From subdural tumor mass.

HISTORY: In January, 1946, this 52 year old white male was operated on for a mass 12 mm. in maximum diameter, situated behind the auricle of the left ear and overlying the base of the mastoid bone. This tumor which was enlarging rapidly, was accompanied or preceded by a tender nodule extending into the left external auditory meatus. These two masses were excised in continuity. The mass behind the ear recurred and was treated with radium needles with temporary regression. A second excision was necessary in December, 1946. In March, 1947, a left radical neck dissection was performed with evacuation of the mastoid and removal of the remaining portion of the ear for recurrent and metastatic disease.

Further X-ray treatments were required in November, 1950, and in July, 1951, further radical surgical intervention was attempted. By December, 1951, X-ray revealed a lytic defect of the petrous ridge and temporal bone. The patient lapsed into coma and expired a little over six years after onset of disease.

AUTOPSY: Autopsy revealed the left temporal lobe bound in its fossa by adherence between the cortex and dura. A mass of tumor protruded through the floor of the middle fossa, producing a pressure defect on the under surface of the left temporal lobe measuring 3 x 3.5 x 2 cm. in depth. The contiguous cortex was yellow, soft and grossly degenerated. There was a marked deflection of the ventricular system to the right with herniation of the cingulate gyrus beneath the free margin of the falx cerebrum.

? sweat gland CA

CONTRIBUTOR: Robert J. Huntington, Jr. M.D. CASE NO. 12
Bakersfield, California.

ACCESSION NO: 4715
OUTSIDE NO. PM 153-51

NAME: G.G.R.

AGE: 66 SEX: Female RACE: White

TISSUE:

HISTORY: Patient was seen April 14, 1948 with a 4 x 6 cm. ulcerated lesion on the base of the nose on the right side, which he stated had been present for twenty years. Biopsy was done and since the patient refused surgery, the lesion was treated by X-ray. The lesion never disappeared, but became larger and progressively involved the region of the right orbit. X-rays showed destruction of the superior and nasal portion of the frontal bones and orbit. On admission March 2, 1951, there was a large cauliflower-like mass 6 x 5 cm. over the right eye with a fluctuant swelling at the inner canthus.

Chest X-ray showed areas of increasing density in the right lung. Patient continued to run a downhill course until his death May, 1951.

CYLINDROMA (SALIVARY GLAND)

CONTRIBUTOR: Walter W. Herrmann, M.D. CASE NO. 13
Berkeley, California.

ACCESSION NO. 4410
OUTSIDE NO. S52-2710

TISSUE: From lesion of upper lip.

NAME: J. F.

AGE: 65 SEX: Male RACE: White

HISTORY: Patient admitted to the hospital September 28, 1952, because of a lump in the left half of the upper lip that had been present for five years. This had never ulcerated and had increased very slowly in size.

PHYSICAL EXAMINATION: A walnut-sized, discrete, non-ulcerated, freely movable lump in the left half of the upper lip.

OPERATION: The lesion was removed through an elliptical incision by following "cleavage" planes.

SURGICAL FINDINGS: The surgical specimen was a globular mass 3 x 2.5 x 2 cms. A portion of the surface was covered by an opaque, smooth epithelium without ulceration. The cut surface showed a grayish-white granular tissue beneath the epithelium having a small central "necrotic" focus. The border of the mass was well defined.

OXYPHIL ADENOMA

CONTRIBUTOR: D. A. DeSanto, M.D. CASE NO. 14a
San Diego, California.

ACCESSION NO. 4306
OUTSIDE NO. 4494-52

TISSUE: From parotid tumor.

HISTORY: 83 year old male with complaint of swelling of the right parotid salivary gland of six months duration. Clinically, the tumor appeared to replace the parotid gland and extend over the margin of the mandible into the maxillary area. Grossly, the tumor consisted of two large nodules of pink glistening tissue measuring 8 x 5 x 4 cm., and 5 x 6 x 3 cm. These were well demarcated from the tissue of the parotid gland.

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WARTHIN'S TUMOR

CONTRIBUTOR: Paul E. Rokers, M.D. CASE NO. 14b
Santa Monica, California.

ACCESSION NO. 4922
OUTSIDE NO. 219-52

TISSUE: From parotid mass

HISTORY: 65 year old Italian male came under study in November, 1950, because of a painless swelling in the right parotid for one year. Examination revealed generalized lymphadenopathy without splenomegaly or hepatomegaly. The right parotid mass was about 6 cm. in diameter and could easily be palpated from within the mouth.

LABORATORY DATA: Rbc. 4,900,000. Wbc. 27,900, Hgb. 15 gms. Peripheral blood and sternal marrow study showed a picture consistent with chronic lymphocytic leukemia.

OPERATION: Biopsy of axillary lymph nodes showed the architecture to be replaced by a large accumulation of lymphocytes. Excision of the parotid mass showed a picture as seen in the accompanying slide.

The patient was given X-ray therapy with conspicuous regression of the mass. There has been no recurrence.

BENIGN LYMPHOEPITHELIAL LESION

CONTRIBUTOR: G. K. Ridge, M.D. CASE NO. 15a
Ventura, Calif.

ACCESSION NO. 4427
OUTSIDE NO. 527-1791

TISSUE: Nodule described below.

HISTORY: A 63 year old white female with history of having had an asymptomatic small nodule inferior and slightly anterior to the angle of the right mandible present for previous two to three years. Noted questionable enlargement with some vague tenderness in previous six to eight weeks. General health good.

OPERATION: October 27, 1952.

SURGICAL FINDINGS: Excision revealed a well encapsulated rather hard nodule approximately 1.8 cm. in diameter, not fixed to surrounding structure and with no anatomical connection to the parotid. Clinically and surgically, nodule was considered to be lymph node.

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ADENOCARCINOMA

CONTRIBUTOR: John D. Bauer, M.D. CASE NO. 15b
St. Louis, Missouri.

ACCESSION NO. 4766
OUTSIDE NO. 54310.

TISSUE: From tumor in left parotid.

HISTORY: Patient, a 63 year old white female, was admitted to hospital, August, 1952, complaining of a tumor in the left parotid area. In 1937, a tumor of left parotid was excised. Diagnosis: Adenoma.

Upon readmission, clinical examination revealed a mass which was not adherent to skin or underlying structure.

Submitted material is from the tumor removed in August, 1952.

SURGICAL FINDINGS: Specimen consisted of a mass of reddish-brown tissue which weighed 72 grams. The tumor was lobulated and encapsulated. On section the tissue was firm, smooth and had a lobulated pattern.

Patient was readmitted for recurrence of parotid tumor January, 1953.

NODULAR LYMPHOMA

CONTRIBUTOR: V. L. Andrews, M.D. CASE NO. 16a
Los Angeles, Calif.

ACCESSION NO. 4812
OUTSIDE NO. 7-F-51-18b

TISSUE: This 50 year old white woman was admitted to the hospital in May, 1951, with a recurrent firm non-tender 2½ cm. nodule near the angle of the left jaw. She gave the history of removal of two previous tumors of this region. The first in New York City in 1947, with a diagnosis of chronic parotitis and lymphadenitis. She gave a history of swelling of the submaxillary gland, as well as the parotid gland of the left side. Blood findings- negative for leukemia.

SURGICAL FINDINGS: At surgery a 3 cm. encapsulated mass situated in the tail of the parotid was found.

In December, 1952, X-ray showed widening of the mediastinum interpreted as probable lymphoma. Generalized lymphadenopathy of increasing extent developed rapidly. Blood count remained within normal limits. Patient was treated with radiation and nitrogen mustard.

Patient was admitted to LACH February, 1953, where she ran a rapid downhill course and expired March 16, 1953. Autopsy was performed.

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MIKULICZ

CONTRIBUTOR: Melvin Black, M.D. CASE NO. 16b
San Francisco, Calif.

ACCESSION NO. 4846
OUTSIDE NO. S52-1873

TISSUE: From tumor in superior lobe of parotid.

HISTORY: This 61 year old woman complained of a lump in the left preauricular area of one or two years duration, accompanied by dryness of her mouth. Years before she had had episodes of pain in the left jaw following the eating of sour foods. She had occasionally noted a lump which had come and gone.

PHYSICAL EXAMINATION: Showed a firm movable non-tender smooth mass in the left preauricular region 3 cm. in diameter. X-ray showed no calcification in the parotid gland, but upon surgical exploration of Stensen's duct, an obstruction was said to have been removed by probing and suction. One year later, the patient was re-admitted, the mass then measuring 4 x 5 cm. Upon excision it was found to lie within the anterior aspect of the superior lobe of the parotid. It was encapsulated and measured 4 cm. in diameter.

MIXED TUMOR

CONTRIBUTOR: O. B. Pratt, M.D. CASE NO. 17a
Los Angeles, Calif.

ACCESSION NO. 5044
OUTSIDE NO. 50-1302

TISSUE: From right parotid.

HISTORY: 30 year old negro female admitted to hospital April 18, 1950, with a history of a small tumor anterior to right ear since 1943. This tumor was removed in 1943 and diagnosed as malignant. Tumor recurred five years later and gradually increased in size. Patient complained of pain in ear and up right side of head.

OPERATION: Excision of tumor April 19, 1950.

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- CARCINOMA "ECCRINE CYLINDROMA" TYPE

CONTRIBUTOR: O. B. Pratt, M.D. CASE NO. 17b
Los Angeles, Calif.

ACCESSION NO. 5045
OUTSIDE NO. 48-3368

TISSUE: From parotid tumor.

HISTORY: 63 year old white female admitted October 12, 1948 with complaint of lump under right ear of one year, which had been enlarging gradually. Sharp pains were noted in area almost every day.

OPERATION: October 12, 1948. Total removal of parotid gland with sacrifice of portion of the facial nerve and with primary anastomose of the descendens hypoglossal nerve to the facial nerve. Tumor had invaded pharyngeal muscle; this was cut out with scissors. Diagnosis at that time - adenocarcinoma of salivary gland, low grade.

COURSE: Tumor recurred and patient was again admitted March 5, 1950, with history of growth increase for past three months. Tumor was removed March 5, 1950.

MIXED TUMOR

CONTRIBUTOR: V. L. Andrews, M.D.
Los Angeles, Calif.

CASE NO. 18a

ACCESSION NO. 4796
OUTSIDE NO. 28-A-53-8

TISSUE: From parotid tumor.

HISTORY: This 37 year old male was seen January 23, 1953 with chief complaint of "lump in left side of face." For the past 8 to 9 months the patient had noticed a lump just in front of the left ear. This had gradually enlarged, particularly so the preceding 4 weeks. Slight tenderness and left temporal headaches for the past few days.

PHYSICAL EXAMINATION: Examination of the region of the left temporomandibular joint showed a soft tissue swelling over the joint itself. No evidence of bone involvement.

OPERATION: An encapsulated firm tissue mass measuring 2 cm. in diameter was removed from the posterior third of the left parotid gland.

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MIXED TUMOR

CONTRIBUTOR: Howard A. Ball, M.D.
San Diego, Calif.

CASE NO. 18b

ACCESSION NO. 2918
OUTSIDE NO. 9325

TISSUE: From parotid tumor

HISTORY: A 34 year old white male first noted swelling in region of right parotid in October, 1947. Biopsy, October, 1948, benign parotid tumor. Complete excision advised, but not done. Tumor continued to enlarge.

OPERATION: Tumor excised May 2, 1950.

SURGICAL FINDINGS: A tumor with shaggy, surface 3.7 cm. in diameter. Weight 15 gms. One surface nodule and white mucinous cut surface.

ADENOID CYSTIC CARCINOMA

CONTRIBUTOR: W. W. Hall, M.D.
Bakersfield, Calif.

CASE NO. 19a

ACCESSION NO. 4184
OUTSIDE NO. M-762-52

TISSUE: Retro-orbital tumor, right eye (lacrimal gland).

HISTORY: The patient was a 27 year old white female with a history of swelling of the right eye for one month. At surgery, March 28, 1952, the tumor was found to be adherent to the eyeball and orbital wall. It was removed through a supra-orbital incision.

SURGICAL FINDINGS: Specimen consisted of 5 pieces of spongy, fibrocellular tissue which weighed approximately 2 grams and which, when grouped into a spherical mass, measured $1\frac{1}{2}$ cm. in diameter. On section, it had grayish to cream-white areas interspersed with zones apparently gelatinous in character.

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MIXED TUMOR

CONTRIBUTOR: Tumor Registry
Los Angeles, Calif.

CASE NO. 19b

ACCESSION NO. 5115
Surg. Path. No. 48-5663

TISSUE: From parotid tumor.

HISTORY: The patient was a 55 year old colored female who entered the hospital July 12, 1948, complaining of a slowly growing tumor of the left parotid area for three years. There had not been much discomfort, except for occasional periods of aching.

OPERATION: Excision was done November 16, 1948.

Patient was seen in Tumor Clinic December 8, 1952. No evidence of recurrence.

CLEAR CELL CARCINOMA

CONTRIBUTOR: Ellen P. Feder, M.D. CASE NO. 20a
Palo Verdes Estates, Calif.

ACCESSION NO. 4813
OUTSIDE NO. B516-49A

TISSUE: From tumor - left main bronchus.

HISTORY: A 19 year old white female with a history of having had a diagnosis of pulmonary tuberculosis in February, 1949. (One sputum examination was reported positive for A.F.B.) She was hospitalized in March, 1949. Chest X-ray showed total atelectasis of the left lung.

Bronchoscopy March 30, 1949: Organized fibrinous clots in left main bronchus.

OPERATION: Thoracotomy April 20, 1949: Soft, semi-lobulated, yellowish-white pedunculated 4 cm. x 2.5 cm. x 2 cm. tumor removed from left main bronchus just above its bifurcation by bronchotomy.

Further cultures were negative for acid fast bacilli.

COURSE: Following removal of the tumor, the lung gradually expanded. When contacted in the summer of 1952, the patient was well.

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MALIGNANT MIXED TUMOR

CONTRIBUTOR: Dorothy Tatter, M.D. CASE NO. 20b
Los Angeles, Calif.

ACCESSION NO. 2676
Surg.Path. No. 51-8472.

TISSUE: From Parotid tumor.

HISTORY: The patient, an 86 year old colored male was admitted August 13, 1951, because of a swelling in the parotid area. This had been first noted 10 years before as a mass at the right angle of the jaw. In the past year it had begun to grow and had doubled in size. There was no pain, numbness, weakness of facial muscles or auditory disturbances.

PHYSICAL EXAMINATION: Examination revealed at the angle of the jaw and extending anteriorly over the mandible, a firm movable mass 3 x 2.5 x 1.5 cm. which seemed to be attached to the deeper structures, but not to skin.

OPERATION: Tumor removed August 16, 1951. A mass of tissue 6.5 x 5 x 5.5 cm. was removed.

CARCINOSARCOMA

CONTRIBUTOR: Carroll S. Small, M.D. CASE NO. 21a
Loma Linda, Calif.

ACCESSION NO. 4875
OUTSIDE NO. 48-1638.

TISSUE: From parotid tumor.

HISTORY: A 46 year white male was first seen August 8, 1948, complaining of a small lump in his right parotid of 15 years duration, but which had accelerated in growth the past 6 weeks.

PHYSICAL EXAMINATION: Firm 2 x 2 cm. spheroid tumor in the lower pole of the right parotid just behind and below the lower angle of the jaw. It was movable and could actually be brought forward anterior to the mandible. No local nodes could be felt.

OPERATION: This tumor was excised on August 8, 1948, removing what was considered an adequate amount of surrounding parotid tissue. On August 20, 1948, a radical neck dissection on the right was done. Sections taken through other parts of specimen showed no evidence of tumor invasion. No nodes were involved with tumor.

COURSE: Postoperative X-ray of 2000 r. as measured in air was given. Patient last seen October, 1949. No evidence of recurrence was noted.

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"INTERCALAR" ACINIC CELL CARCINOMA -

CONTRIBUTOR: Hugh Edmondson, M.D. CASE NO. 21b
Los Angeles, Calif.

ACCESSION NO. 2876
Surg. Path. No. 51-9812

TISSUE: From parotid gland.

HISTORY: A 30 year old, white male was admitted September 18, 1951, with a history of asymptomatic, right preauricular tumor of six months duration. A

OPERATION: Subtotal parotidectomy was done September 21, 1951, and a multilocular cystic tumor filled with greenish-brown fluid was removed.

SURGICAL FINDINGS: Cut surface revealed locules lined with round, rough papillations measuring 0.5 cm. in height.

No follow-up obtainable.

ACINIC CELL CARCINOMA

CONTRIBUTOR: James E. Kahler, M.D. CASE NO. 22a
Los Angeles, California.

ACCESSION NO. 4215
OUTSIDE NO. 38398

TISSUE: From nodule behind angle of jaw.

HISTORY: A 70 year old white male with complaints of swelling at right angle of mandible for five months. No pain. The mass has slightly reduced in size after penicillin therapy.

LABORATORY FINDINGS: Blood and urine within normal limits.

SURGICAL FINDINGS: Tender nodule 1 cm. in diameter behind angle of jaw. At surgery the mass was thought to be a lymph node completely separate from the parotid. The mass was ruptured in removal and a small quantity of creamy pus reportedly escaped.

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ACINIC CELL CARCINOMA

CONTRIBUTOR: Irving Schuldberg, M.D., CASE NO. 22b
Los Angeles, California.

ACCESSION NO. 3967
Surg. Path. No. 52-6680

TISSUE: From parotid tumor.

HISTORY: This 67 year old white male was admitted to the hospital for treatment of a painful sore of the lower lip of about six months duration. At the time of admission it was noted that he had a mass 5 cm. in diameter situated in the angle of the left mandible which he said had been present for two or three years.

At surgery, the lesion of the lip was found to be non-malignant and the tumor removed from the anterior lobe of the parotid gland, measuring 4 x 5 x 3 cm., was apparently solid and partly cystic and showed the presence of papillary ingrowths one cm. in height, projecting into the cyst. The tumor appeared well encapsulated. Three lymph nodes resected at the time of parotidectomy showed no metastasis. (Patient free from recurrence 8 months following surgery.)

?? EWING

CONTRIBUTOR: Wilbur C. Thomas, M.D. CASE NO. 23
Los Angeles, Calif.

ACCESSION NO. 4721
OUTSIDE NO. A-161-52

NAME: C. P.
AGE: 7 SEX: Female RACE: White

HISTORY: Patient was admitted to Children's Hospital on October 18, 1950 complaining of a mass behind the left ear. The patient was struck by a rock behind the left ear about one year ago. Several months later the mother noted a lump which pushed the ear forward and became progressively more prominent. There were no associated symptoms.

PHYSICAL EXAMINATION: There was a 5 x 6 stony hard mass which was non-movable and located above, behind and slightly anterior to the left ear. It was non-tender and non-adherent to the skin. No paralysis was present.

LABORATORY FINDINGS: Hemoglobin - 12.2 gms. WBC, 5750. Urine was negative. X-ray of chest and long bones negative for metastasis. Tangential projections of the skull demonstrated bony spicules projecting into the mass from the periosteum.

OPERATION: On November 9, 1950 a biopsy was taken. The specimen consisted of a number of fragments of translucent white cartilaginous looking tissue of various sizes and shapes, the largest fragment measuring 6 x 8 x 10 mm. On November 29, a tumor mass measuring 6 x 8 cm. was removed. At the time of operation , this mass extended into the left lateral sinus on the mastoid and temporal fossa. The tissue appeared similar to that removed in the biopsy. The patient received x-ray therapy to the skull for a total of 4,650 R. On October 3, 1951 a lump was noted in the operative area and left facial paralysis was noted. X-ray of the skull showed destruction of the left zygomatic arch and of the left mastoid and petrous portion of the temporal bone. The growth continued to increase in size slowly when last seen on May 29, 1952. On October 14, 1952, the referring physician announced death of the patient at home . An autopsy was performed.

The largest piece of tissue on the slide is from the parotid mass; the smaller pieces are liver and brain metastases.

MALIGNANT MIXED TUMOR

CONTRIBUTOR: Alvin G. Foord, M.D. CASE NO. 24
Pasadena, California.

ACCESSION NO. 4756
OUTSIDE NO. Surgical #364-51.
Autopsy #223-52.

TISSUE: From tumor of right parotid.
Autopsy: lung metastases.

NAME: E. C. P.

AGE: 61 SEX: Male RACE: White

HISTORY: Patient was first operated on in 1914 for a tumor of the parotid and was resected again in 1942 and 1945 (at which time he also had x-ray therapy). This was done elsewhere and we do not have the complete record or the tissue slides.

In February of 1951. a recurrence was found in the right parotid region, and at this time a radical resection of tissue including all of the remaining parotid gland, a piece of buccinator muscle, skin and fascia were taken.

In April of 1952 there was a metastasis in the first lumbar vertebra with collapse of bone. He was given 3,000 r radiation at this time.

His final hospital entry was on September 19, 1952 at which time he complained of marked weakness and pain in his back. There was marked loss of weight, but no evidence of recurrent tumor in the parotid region or in the neck. A massive right pleural effusion was present. The liver was four fingers' breadth below the costal margin. Patient expired September 23, 1952.

AUTOPSY
FINDINGS: Autopsy showed multiple varying sized metastases in the lungs, pleurae, mediastinal lymph nodes, liver and vertebrae. No tumor was found in the neck. The right pleural cavity contained 3,000 cc. of fluid.

CARCINOMA WITH CARTILAGINOUS METAPLASIA OF THE STROMA

CONTRIBUTOR: Dr. O'Donnell, Lancaster, Pa. CASE NO. 25

ACCESSION NO. 5042
OUTSIDE NO. 15639-18333.

TISSUE: From breast tumor.

HISTORY: A 34 year old white female was admitted to the hospital complaining of a mass in the breast which she said had first been noticed two years before, at which time it had been biopsied with a diagnosis of fibrocystic disease. During the last few months the mass had been growing rapidly. There had been no loss of weight or other symptoms. The patient upon admission was five months pregnant.

OPERATION: At operation, a well circumscribed tumor 3.5 x 2 x 2 cm. was removed. (Tissue on left side of slide.)

The patient refused further surgery until after the termination of her pregnancy at full term. Radical mastectomy 7 months after excisional biopsy. (Tissue on right side of slide.)