

Subject ID: LM0007
Pathology Report Date: 1/17/00
Pathology Report Summary

GROSS DESCRIPTION:

Pelvic Mass: Received fresh is a 1.2 x 0.3 x 0.1 cm aggregate of firm tan core biopsies entirely submitted as frozen section #1 and subsequently submitted for permanent section designated #1.

Biopsy fat versus lymph node adjacent to obturator nodes: Received fresh is a 2.4 x 2.2 x 0.4 cm fatty mass, which is bisected. One half is submitted as frozen section #2 and subsequently submitted for permanent section designated #2.

Iliac node: Received fresh is a 1.3 x 1.0 x 0.5 cm firm tan lymph node which is bisected with one half submitted as frozen section #3 and subsequently submitted for permanent section designated #3.

Pelvic tumor: Received is a 15.0 x 15.0 x 11.5 cm yellow-red nodular tumor mass surrounded by soft tissue. Adhered by adhesions to one edge of the specimen but not grossly involved with tumor is a stapled 2.5 x 2.0 x 1.5 cm fragment of small bowel, a section of which is submitted designated #4. On bivalved the mass, the cut surface is firm, gray-white and nodular. Located along one edge of the mass is a 5.0 x 1.5 cm segment of vein, which is not grossly involved with tumor. Located 1.0 cm from this vessel, traversing through the tumor and being extrinsically compressed is an additional section of blood vessel having a diameter of 1.0 cm. A section of the peripheral vessel is submitted designated #5 and a section of the vessel within the main part of the tumor mass is submitted designated #6. The periphery of the specimen has been photographed prior to sectioning. The peripheral soft tissue margins are inked in black and on sectioning, the tumor appears to be surrounded by soft tissue and a thin capsule. Tumor grossly extends in areas to within less than 1 mm of the inked margin. Representative marginal sections are submitted designated #7- #10. Sections from the central portion of the mass are submitted designated #11-#13. On sectioning through the peripheral soft tissue there is a 2.3 x 1.5 x 1.0 cm in apparent lymph node which is trisected and submitted in toto designated #14 and #15. Also noted within the surrounding tissue is a 9.0 x 3.0 mm tubular structure having a central lumen. Representative cross sections are submitted designated #16. Adjacent to this structure is a spherical calcified, white 4 mm nodule.

MICROSCOPIC DESCRIPTION:

Sections of tumors show the tumor to be composed of interlacing bundles of spindle-shaped cells admixed with areas having markedly pleomorphic polygonal cells. Nuclei in general are ovoid with coarse chromatin with some nuclei demonstrating markedly pleomorphic forms. Broad areas of tumor necrosis are present. Numerous mitotic figures are identified including atypical mitotic forms with some areas showing up to 4-5 mitotic figures per high power field. No lymphatic or venous vascular invasion is seen. There is encasement of a thick walled muscular artery with peripheral displacement of a large caliber vein. The margins are represented by thin fibrous membrane less than 1 mm in thickness, however, the margins are clear. A trichrome stain is performed. Using immunoperoxidase technique, sections of tumor are stained for smooth muscle actin and S-100. The controls are appropriate. Tumor cells stain positively for actin and are negative and are negative for S-100. A section of submitted tubular structure shows a hypertrophied vessel with organizing thrombus.

Subject ID: LM0007
Pathology Report Date: July, 2001
Pathology Report Summary (CT SCAN)

TECHNIQUE: Spiral CT scan is obtained of the chest at 10 mm increments with contrast.

FINDINGS:

Correlation is made with a prior scan of 02/21/00. There is a new pleural base pulmonary nodule measuring up to 1 cm in size in the left lower lobe posterolaterally near the left base. There is a second smaller pulmonary nodule measuring approximately 6 mm in maximum dimension in the anterior segment of the left upper lobe as seen on image #105 which is also new compared to the prior scan. No other pulmonary nodules are identified. No acute appearing pulmonary infiltrates are present. There is no pleural effusion or pneumothorax. There are two or three small peritracheal lymph nodes all of which measures less than 1 cm in size and which are unchanged significantly compared to the prior scan. A central line is present in the superior vena cava. No other hilar or mediastinal mass or significant lymph adenopathy is identified. Images obtained through the upper abdomen demonstrate the adrenal glands to be normal in size

IMPRESSION:

- 1 Two new pulmonary nodules in the left lung. These are new compared to the prior scan of 02/21 /01) and therefore likely represent pulmonary metastases in the patient with a history of leiomyosarcoma,
- 2 No evidence of hilar or mediastinal mass or significant lymph adenopathy or other significant change compared the prior chest CT of 02/21/01.

Subject ID: LM0007

Pathology Report Date: July, 2001

Pathology Report Summary (CT SCAN continued)

TECHNIQUE:

A spiral CT scan was initially obtained of the abdomen at 10 mm increments with oral contrast. This is followed by spiral CT of the abdomen and pelvis with both oral and IV contrast at 10 mm increments. Additional delayed images were obtained through the kidneys and urinary bladder.

FINDINGS:

Correlation is made with the prior scan of 2/21/01 as well as a preoperative exam of 12/10/99. The liver, spleen, pancreas, and adrenal glands all remain normal in appearance. There is again demonstrated to be a single stone within the dependent portion of the gallbladder measuring approximately 8 mm in size. There is no evidence of gallbladder wall thickening. The abdominal aorta is of normal caliber. There is no significant periaortic adenopathy. The unenhanced scan shows no evidence of renal calculi. There is excretion of contrast by both kidneys. There is no evidence of a renal mass or hydronephrosis. The previously described post operative changes in the left hemipelvis remain stable compared to the post operative exam of 2/21/01. There is a small umbilical hernia which contains a loop of small bowel. This is also unchanged significantly compared with prior exams. The uterus is reportedly surgically absent. No pelvic mass or significant lymphadenopathy is identified compared to the prior scan.

Subject ID: LM0007

Pathology Report Date: November, 2001

Pathology Report Summary (CT SCAN)

CAT SCAN THORAX WITH CONTRAST, CT ABDOMEN WITHOUT AND WITH CONTRAST, AND CT PELVIS WITH CONTRAST:

CT CHEST: Spiral CT was obtained through the thorax from the base of the neck into the upper abdomen during the intravenous administration of contrast and reformatted as 10 mm axial images. Today's study is compared with prior study of September, 2001. No gross mediastinal masses or significant adenopathy is evident. A few tiny lymph nodes are again present in the mediastinum, but unchanged without gross enlargement. The trachea is relatively small but unchanged in appearance. This is probably developmental. The trachea, main bronchi and major vascular construction of the mediastinum are otherwise unremarkable in appearance. A small nodule in the anterior segment of the left upper lobe and a second small nodule density in the subpleural location posterolaterally of the left lower lobe are unchanged in appearance since 9 /01 but increased since 2/01 or new. These are noncalcified with each measuring approximately 8-10 mm in diameter. No new pulmonary nodules are evident. The adrenal glands are unremarkable in appearance.

CONCLUSION:

1. Stable two left pulmonary nodules measuring up to 1 cm in size~ These are unchanged compared with prior CT of September, 2001. These are significantly increased in size compared with study of February, 2001. These are nonspecific and may represent metastatic nodules or inflammatory nodules.

CAT SCAN ABDOMEN WITHOUT AND WITH CONTRAST AND PELVIS WITH CONTRAST:

Following oral ingestion of contrast, a spiral CT was obtained through the abdomen prior to and then the abdomen and pelvis during the intravenous administration of contrast and reformatted as 10 mm axial images. Delayed images were also obtained through the kidneys. These studies are compared with prior study of September, 2001.

FINDINGS:

There is again diffuse decreased attenuation of the liver consistent with fatty infiltration. The gall bladder is now surgically absent consistent with cholecystectomy since September 4, 2001. There is no biliary or pancreatic ductal extension. The pancreas, adrenal glands, and kidneys are unremarkable in appearance with bilateral renal enhancement and excretion of contrast. The abdominal and pelvic bowel and fat are unremarkable in appearance. There is surgical absence of the uterus. Adnexal regions and urinary bladder are unremarkable in appearance. No gross abdominal or pelvic mass, adenopathy, or abnormal fluid collection are evident.

CONCLUSION:

1. Interval cholecystectomy since September, 2001 study.
2. Persistent diffuse fatty infiltration of the liver without focal lesions evident.
3. Previous hysterectomy
4. No gross abdominal or pelvic tumor evident.

Subject ID: LM0007
Pathology Report Date: 02/07/02
Pathology Report Summary

GROSS AND MICROSCOPIC IMPRESSION:

1. LUNG, LEFT LOWER, WEDGE: LUNG PARENCHYMA WITH -
 - A. Metastatic sarcoma most consistent with leiomyosarcoma.
 - B. Tumor measures 1.0 x 1.0 x 0.9 cm
 - C. Surgical margin free of tumor
 - D. Pleural margin unable to fully evaluate, see comment

COMMENT: As stated in the gross, the mass popped out during resection and was received only partially attached to the lung, therefore the pleural margin cannot be fully evaluated within this area.

2. LUNG, UPPER LOBE, WEDGE: LUNG PARENCHYMA WITH -
 - A. Metastatic high-grade sarcoma most consistent with leiomyosarcoma
 - B. Tumor measures 1.1 x 1.0 x 1.0 cm
 - C. Pleural margin free of tumor.
 - D. Surgical margin free of tumor.

ADDENDUM 02/08/02

Actin/myosin, cytokeratin (AE1), cytokeratin (AE3), and S-100 immunohistochemical stains are performed. The controls stain appropriately. The tumor is strongly positive for actin/myosin and negative for the other markers. This helps confirm the smooth muscle origin of the tumor and the diagnosis of high-grade leiomyosarcoma.

FROZEN SECTION DIAGNOSIS:

MALIGNANT SPINDLE CELL LESION CONSISTENT WITH LEIOMYOSARCOMA.

GROSS DESCRIPTION:

Specimen (1)

The frozen section remnant is submitted in one cassette. The specimen consists of a segment of lung measuring 6.0 x 5.5 x 1.5 cm. It weighs 17.5 grams. On the surface only slightly attached to the surface is a nodule measuring 1.0 x 1.0 x 0.9 cm. Reported by the surgeon, it was subcapsular and actually popped out during resection. No additional masses are identified on the specimen. A section from the margin is submitted in one cassette. A section from the remaining mass not frozen is submitted in a second cassette. (A) Benign lung, (B) the mass.

Specimen (2) consists of a segment of lung weighing 16.8 grams and measuring 7.0 x 3.0 x 1.5 cm. Sectioning through reveals a mass measuring 1.1 x 1.0 x 1.0 cm. A portion is not frozen in (A). A section of the mass in (A and B). A section of lung with margin in (C).