ST. MARY'S
HOSPITAL AND
MEDICAL CENTER

450 STANYAN ST • SAN FRANCISCO CA 94117 • (415) 750-5751
EXT. 6170

DEPARTMENT OF PATHOLOGY

[redacted]EY, JR. M.D.
M.D.
[redacted]N, M.D.
, M.D.

ACCESSION NO. 84 SM 2884

MR# 50 92 93
KENNETT, TERESA M.
BD: 2-4-49 Age: 35

7-18-84 Rm ~~800~~ 808

DOCTOR
J[redacted]e, M.D./J[redacted]n, M.D.

CLINICAL DIAGNOSIS: Abdominal mass.

TISSUE: Mesentery node. Mesentery node. Needle biopsy, liver. Wedge biopsy, liver. Accessory spleen.

GROSS DESCRIPTION: Several specimens, the first presented at the time of surgery as a lymph node from the mesentery, and this was a discrete, ovoid, moderately soft structure, measuring 16 x 14 x 15 mm. It would appear to have an intact thin membranous capsule, and the cut surface was uniform, bulging slightly and was yellow-tan in color, without localizing or distinguishing gross features. Frozen Section performed upon this specimen was read as showing what was consistent with a lymphoma, having a nodular pattern, being of small cell type. Histological evidence of Hodgkin's could not be defined at the time of this examination.

Later, another specimen was an even larger node, submitted from the mesentery. This measured 2.5 x 2 x 2 cm, and otherwise was quite identical in appearance and character to the earlier smaller lymph node. Initially, material from the lymph node was taken in the sterile condition and submitted for various types of culture, if necessary. Imprints were made from multiple areas of the surface of both nodes, some subsequently stained and others retained for possible immunological studies. A portion of each node was fixed in gluteraldehyde for possible subsequent electron microscopic study. Another portion of each node was quick frozen, retained at a minus-sixty degree centigrade. Finally, a portion of each node is fixed in formalin, Zenker's fixative, and in Carnoy's solution.

The formalin-fixed material was blocked as "A", and the Carnoy's-fixed material as "B", and the Zenker-fixed material as "C".

Still another specimen consists of a needle biopsy of the liver, this being a small tubular strand of granular, yellowish-brown tissue, 16 cm in length and a 0.5 mm in uniform diameter, blocked as "D".

Still another specimen is stated to be a wedge from the liver, and this is a triangular segment of reddish-brown tissue, triangular in outline, measuring 12 x 10 mm and tapered in dimension, two surfaces showing intact thin membranous capsules, and the cut surface of the liver parenchyma finely granular, uniform, and reddish-brown in color. This specimen is trisected and blocked in its entirety. This material is blocked as "E".

ST. MARY'S
HOSPITAL AND
MEDICAL CENTER

450 STANYAN ST • SAN FRANCISCO CA 94117 • (415) 750-5751
EXT. 6170

DEPARTMENT OF PATHOLOGY

[redacted]Y, JR. M.D.
M.D.

[redacted]N, M.D.
M.D.

A sixth and final specimen is known to be a small accessory spleen that was also submitted. This consist of a small ovoid dark bluish-black structure measuring 6 mm in greatest dimension, and marginated along one surface by a tuft of lobulated and unremarkable-appearing yellow adipose tissue. On section, the splenic tissue is uniform in appearance and dark bluish-red in color. It is bisected and blocked as "F".

MICROSCOPIC DESCRIPTION: The two enlarged lymph nodes, submitted from the mesentery, demonstrate diffuse involvement by a neoplastic process, having a nodular pattern and characterized by the presence of various-sized, prominent follicle-like structures that comprise the entire parenchyma of the node. These structures that mimick follicles occur throughout the entire node structure, and in turn, there is infiltration of the pericapsular tissue by strands of similar lymphocytes. These altered nodular foci or follicles are composed of moderate-sized cells of prominent central nuclei that occasionally are angulated or indented, have fine even nuclear chromatin and inconspicuous nucleoli and very little discernible cytoplasm. A narrow zone of less altered appearing small lymphocytes often occur about the periphery of these prominent nodular and follicular areas. The interesting aspect of the case is the occurence of irregular bands and deposits of eosinophilic collagenous tissue within some of the larger nodular centers, producing a picture of focal sclerosis and fibrosis.

The accessory splenn, while small, shows scattered altered follicles, also, in which the center of most these follicles consist of cells similar to those seen within the nodular follicles within the lymph nodes. In turn, there are narrow mantles of peripheral small and non-neoplastic-appearing lymphocytes about these altered and neoplastic splenic follicles. The intervening red pulp is hyperemic and the sinusoids engorged and dilated. The parasplenic adipose tissue is without infiltrate.

Both the needle biopsy from the liver, as well as the wedge biopsy of liver parenchyma, fail to show involvement of the liver by the lymphomatous process. The liver displays a normal architecture, in which the lobules are composed of cords of normal hepatic cells, without significant or localized feature or change. The portal areas are not conspicuous and are without fibrosis or cellular infiltrate. In summary, this case demonstrates lymph nodes from the mesentery involved by a non-Hodgkin's type lymphoma that from a cytological standpoint presents features of a small-cell, cleaved type with a nodular or follicular pattern. This working formulation classification correlates with a nodular lymphocytic type of lymphoma of Rappaport's earlier classification. The splenic follicles appear to be involved by a similar process as seen in the resected small accessory spleen. The liver is without demonstrable involvement by the lymphoma.

ST. MARY'S
HOSPITAL AND
MEDICAL CENTER
450 STANYAN ST • SAN FRANCISCO CA 94117 • (415) 750-5751
EXT. 6170
DEPARTMENT OF PATHOLOGY
[redacted], JR. M.D.
[redacted], M.D.
[redacted], M.D.

ACCESSION NO. 84 SM 2884

KENNETT, TERESA M.

DIAGNOSIS:

LYMPHOMA, LYMPH NODE, MESENTERY, FOCAL (FOLLICULAR, PREDOMINANTLY SMALL CLEAVED-CELL TYPE, NODULAR; NODULAR FOLLICULAR LYMPHOMA, SMALL CELL TYPE)
558-834

LYMPHOMA, SPLEEN (ACESSORY SPLEEN), FOLLICULAR PREDOMINANTLY SMALL CLEAVED-CELL TYPE (NODULAR SMALL CELL LYMPHOCYTIC TYPE)
5501-834

NORMAL TISSUE, LIVER, FOCAL (NEEDLE AND WEDGE BIOPIES)
680-Y00

[redacted], Jr. M.D.
Pathologist

7-19-84

ST. MARY'S
HOSPITAL AND
MEDICAL CENTER

450 STANYAN ST • SAN FRANCISCO CA 94117 • (415) 750-5751
EXT. 6170

DEPARTMENT OF PATHOLOGY

[redacted]Y, JR. M.D.
M.D.

[redacted]N, M.D.
, M.D.

ACCESSION NO. 84 B 56

MR# 50 92 93
KENNETT, TERESA M.
BD: 2-4-49 Age: 35

7-18-84 Rm 800

DOCTOR
J[redacted], M.D./J. [redacted], M.D.

CLINICAL HISTORY: A 35-year-old female, who is three months postpartum, and noted to have abdominal lymphadenopathy, without hepatic or splenic enlargement. An abdominal lymph node biopsy was recently performed and interpreted as a malignant lymphoma, low-grade, follicular, predominantly small-cleaved cell type (nodular, poorly-differentiated lymphocytic lymphoma of Rappaport).
Laboratory values include: Hgb 12.8, H'crit 37.7, RBC 3.89, WBC 6.3, MCV 96.8, MCH 32.9, MCHC 34, with 69 segs, 21 lymphs and 10 monos. Platelets 293k.

TISSUE: Bone marrow aspirate and biopsy (3.5 x 0.2 x 0.2 cm), left posterior iliac crest.

PERIPHERAL BLOOD SMEAR: The red blood cells appear normochromic and normocytic, without significant morphologic alterations. Rare atypical cleaved lymphoid cells ("Buttock" cells), are identified on the smear. The white blood cells otherwise appear morphologically unremarkable. Adequate numbers of platelets are present, and appear normal.

ASPIRATE: Examination reveals numerous particles showing active erythro- and myelopoiesis. A normal ratio of maturing myeloid and erythroid elements is present, and adequate numbers of megakaryocytes are identified, showing normal morphologic features. Red cell maturation is normoblastic, and granulocytic maturation appears normal, without predominance of one cell type. In addition to these findings, approximately 30% of the cells present are lymphocytes, many of which have cleaved, or irregular nuclear contours. Several aggregates of these cells are noted. Similar findings are identified in the clot sections examined.

BONE MARROW BIOPSY: Sections reveal an overall cellularity of approximately 40-45%. As noted in the aspirate, maturing myeloid, erythroid, and megakaryocytic elements are present in normal ratios. In addition, there is a diffuse infiltration of the marrow spaces by small lymphoid cells, some of which have cleaved, or angulated nuclear contours. Several small aggregates of these cells are noted, and one convincingly paratrabecular aggregate is identified. The bony trabeculae appear unremarkable. No additional significant histologic abnormalities are detected.

SPECIAL STAINS: Prussian blue stained sections of the aspirate reveal adequate iron stores. No ringed sideroblasts are identified.

ST. MARY'S
HOSPITAL AND
MEDICAL CENTER

450 STANYAN ST • SAN FRANCISCO CA 94117 • (415) 750-5751
EXT. 6170

DEPARTMENT OF PATHOLOGY

[redacted]EY, JR. M.D.
M.D.

[redacted]N, M.D.
M.D.

ACCESSION NO. 84 SM 56

KENNETT, TERESA M.

COMMENT: In view of the clinical history, the above findings indicate marrow involvement by malignant lymphoma, similar to that seen in the previous abdominal lymph-node biopsy.

DIAGNOSIS:

BONE MARROW, LEFT-POSTERIOR ILIAC CREST, ASPIRATE AND NEEDLE BIOPSY - BONE MARROW INVOLVEMENT BY MALIGNANT LYMPHOMA, LOW GRADE, SMALL, CLEAVED-CELL TYPE

[redacted]ta, M.D.
7-26-84

[redacted]e, M.D.
Pathologist

ST. MARY'S HOSPITAL AND MEDICAL CENTER
450 STANYAN • SAN FRANCISCO CA 94117 • 415 668-1000

KENNETT, Teresa
800
Drs. J. C[redacted]/J. S[redacted]
MR# 50 92 93

OPERATIVE REPORT

DATE OF OPERATION: 7/18/84

PREOPERATIVE DIAGNOSIS: Lymphoma, probable non-Hodgkin's.

POSTOPERATIVE DIAGNOSIS: Lymphoma, histology pending, probable non-Hodgkin's.

OPERATION: Exploratory laparotomy with mesenteric small bowel lymph node excisional biopsy x2, wedge and needle biopsy of liver, accessory spleen excisional biopsy, left iliac posterior superior spine marrow aspirate and biopsy.

SURGEONS: Drs. J. C[redacted]/M. P[redacted]/F. P[redacted]

SURGERY TIME: 7:55 a.m. to 9:30 a.m.

ANESTHESIOLOGIST: Dr. [redacted]

FINDINGS: Extensive paracaval to para-aortic left common iliac adenopathy with extension from left common iliac to the diaphragm. Extensive small bowel mesentery, paraduodenal and porta hepatis adenopathy. Normal appearing liver and spleen. A milkly fluid localized to the pelvis on the initial exploration.

INDICATION: This 35 year old female approximately three and one-half months postpartum normal vaginal delivery noted periumbilical and epigastric mass effects approximately three months prior to admission. Initial ultrasound in May was nonspecific with a barium enema performed in May also being within normal limits. The patient was followed by Dr. John Clarke and Dr. Jerome Schofferman and to date the patient denied fever, chills, night sweats, fatigue, weight loss or other constitutional symptoms. Over the past week the patient noted the increase in size in the periumbilical mass and subsequently underwent ultrasound and CT exam on 7/16/84 which illustrated extensive pericaval, periaortic and mesenteric adenopathy. On physical examination, the patient was found to be without symptomatology with negative peripheral node bearing areas by palpation and no evidence of hepatosplenomegaly. An epigastric periumbilical mass was palpated. The patient elected to undergo exploratory laparotomy with excisional node biopsy, liver biopsy and marrow aspirate and biopsy.

PROCEDURE: On 7/18/84 the patient was brought to the OR and after the induction of general anesthesia and intubation the patient was prepped and draped in the usual sterile fashion for a mildine exploratory laparotomy. A midline skin incision was made and extended from the infraxiphoid area down to a point midway between the pubis and umbilicus. The incision was carried through skin, subcutaneous tissue, anterior rectus sheath, posterior rectus sheath and through the peritoneum. The initial exploration of the abdomen revealed a milkly fluid localized to the pelvis. Cultures were taken and the

fluid was aspirated from the pelvis. The initial exploration revealed normal colon mesentery with a normal appearing uterus and postpartum ovaries bilateral. The initial evaluation of the posterior abdominal wall revealed ~~right~~ left common iliac adenopathy with continuous palpable adenopathy extending from the bifurcation to the diaphragm involving para-aortic and pericaval nodes. Evaluation of the small bowel mesentery revealed extensive matted adenopathy extending to the base of the small bowel mesentery with palpable paraduodenal adenopathy and adenopathy in the porta hepatis. There was no splenic hilar adenopathy appreciated but an accessory spleen was noted. The examination of the liver appeared normal and there was no evidence of splenomegaly by direct visualization or palpation.

Attention was then directed to the small bowel mesentery where an excisional biopsy was carried out on two areas of adenopathy. Following hemostasis by Bovie electrocautery, the peritoneal layer was reapproximated with 3-0 Dexon sutures. Attention was then directed to the liver where following the placement of atraumatic hepatic sutures, a wedge biopsy was executed followed by two needle biopsies of the right lobe. A patch of the falciform ligament was then incorporated over the area of wedge biopsy following the achievement of hemostasis with Bovie electrocautery. As noted above, an accessory spleen was visualized and was subsequently excised for histological examination. Following exploration of the abdomen and pelvis the omentum was placed in a normal position and a two layer closure was executed with 0 Vicryl running on the peritoneum, followed by 0 Vicryl interrupted sutures in the anterior rectus sheath. Staple were utilized for skin approximation.

Following the placement of a dressing, the patient was repositioned in the right decubitus position and was subsequently prepped and draped in the usual sterile fashion for marrow biopsy and aspirate. Under the direction of Dr. John Clarke, Dr. Mendes executed the marrow aspirate and biopsy in the standard fashion and in a standard sterile technique. Subsequently, a pressure dressing was placed over the aspirate and biopsy site.

DRAINS: None.

FLUIDS: D5 Ringer's lactate.

POSTOPERATIVE CONDITION: Satisfactory.

ESTIMATED BLOOD LOSS: Approximately 25 cc. Blood replacement: None.

MP/pt
D: 7/18/84
T: 7/19/84

[redacted] M.D.