Case 1

There was general agreement on a diagnosis of leptomeningeal glial heterotopia with striated muscle also called leptomeningeal rhabdomyosis. Anoxic changes are also prominent in this slide.

Case 2

There was general agreement on a diagnosis of familial erythrophagocytic lymphohistiocytosis. Most of the discussion centered on the presence of large cells with faintly PAS positive cytoplasm which stained positively for glial fibrillary acidic protein. The question raised was whether these were phagocytes which had ingested this protein or, indeed, astrocytes. The former view was generally favored.

Case 3

There was general agreement that the diagnosis was granulomatous angitis. The patient also showed lesions in the eye and the fifth cranial nerve. The occasional relationship of granulomatous angitis to herpes zoster was emphasized.

Case 4

The presenter demonstrated epithelial cells in association with the keritin pearls found in the lesion. He emphasized that the keritin was like that seen in craniopharyngioma and not like that seen in squamous cell tumors. The lesions were viewed as drop metasteses.

Case 5

One commentator reported seeing intracellular bridges in the tumor and the author demonstrated desmosomes by electron microscopy. The final diagnosis was squamous cell carcinoma, primary in brain. It was suggested that these tumors may arise from epidermoid cysts.

Case 6

The final diagnosis was cerebral sporotrichosis. Sporotrichum schenckii was isolated from the CSF culture. In tissue sections, this organism is more easily stained with silver methanamine than PAS.

Case 7

There was general agreement that the tumor cells were neuronal in nature. The diagnosis of the presenter was ganglioglioma with neuroblastomatous elements. The question of the relationship of the tumor to tuberous sclerosis was discussed. Most commentators did not support such a relationship.

Case 8

There was general agreement that this represented a case of Jakob-Creutzfeldt disease with long term survival and secondary demyelation.

Case 9

The presenter offered the additional information that the pituitary gland was enlarged. The final diagnosis was hemorrhage into a silent pituitary adenoma with rupture into the third ventricle.

Case 10

Several commentators felt that this represented a late onset rod body myopathy which is unlike the congenital form of nemaline myopathy. Another commentator challenged the diagnosis of rod myopathy because of the inflammatory changes. The presentator made a diagnosis of rod body myopathy, but characterized it as being of a third clinical type, that associated with other diseases, in this case, arthritis and myositis.