Both cases stained positively for amyloid and case 2 was also positive on EM and was found on chemical analysis to be lambda 2-5 subtype. Both cases were cerebral amyloid presenting as a mass lesion and the diagnosis was amyloidoma.


Case 3

The material in this case stained negatively for amyloid and had a granular appearance on EM. It was strongly PAS positive, but diastase resistant, oil red O positive and alcian blue negative. Several discussands reported similar cases but there was no consensus as to pathogenesis or of the nature of the proteinaceous material except that it was not amyloid. The presenter's diagnosis was pseudoamylloid. The reference cited describes a lesion which is grossly and microscopically similar to the present case. The authors did not prove either histologically or radiologically that this was a colloid cyst.


Case 4

The diagnosis was Pseudo-Tangier Disease. No previous cases have been reported.


Case 5

st commentators thought that the muscle changes were those of Werdig-Hoffman Disease. Many did not find evidence of neuronal loss in the spinal cord sections. The presenter showed definite cell loss in the cranial nerve nuclei. These were associated somatic abnormalities and the diagnosis was Pena-Shokeir Syndrome.


Case 6

The slide showed largely subpial and subependymal inflammation with intranuclear inclusions and a few PML-like white matter lesions. The presenter’s diagnosis was atypical papova virus infection, probably SV-40.


Case 7

The diagnosis was sarcoidosis. The disease was also present in the mediastinal lymph nodes and on the skin of the left foot.


Case 8

Marker studies showed both T & polyclonal B lymphocytes. No organisms were demonstrated by staining or EM. The diagnosis was **idiopathic hypertropic pachymeningitis**.


Case 9

The presenter’s diagnosis was mixed neurilemmoma and astrocytoma. Several commentators, however, thought the astrocytic component was reactive rather than neoplastic.


Case 10

The diagnosis was primative neuroectodermal tumor with ependymal differentiation. The ependymal area was reticulum positive. This tumor apparently has a favorable prognosis.


Case 11

The diagnosis was Lhermitte-Duclos Disease.


Case 12

On H & E this tumor looks like an oligodendroglioma. The Bodian stain showed rosettes and the tumor stained positively for synaptophysin and neuron specific enolase. It showed neuronal characteristics on EM. The diagnosis was intraventricular central neurocytoma. The prognosis is favorable.

