TABLE II

London Hosp. P.M. No.	History (months)	Age at Death	Sex	Asbestos Bodies	Histology of Tumour: Epithelial	Fibromatous	Mixed	Involvement of Two of: Peritoneum, Pleura, Pericardium	Metastases: Lymph Node	Bone	Viscera	Soft Tissues	Peri-bronchial Spread	Liver	Focal Necrosis	Pleomorphism (Focal)
Group C																
18. 334/38	2	63	M				+									
19. 467/41	6	45	M	+ + + (F)	+										+	
20. 109/45	3	35	F	+ + + (F)			+									*
21. 241/44	12	42	F	0	+		+	+	+						+	
22. 73/48	12	37	F		+		+	+	+						+	
23. 181/51	6	58	F	0	+		+	+	+						+	
24. 49/55	3	61	F	+ + + + (F)	+		+	+	+						+	*
25. 116/55	12	65	F		+		+	+	+						+	
26. 56/58	12	50	M	+ + + + (F)	+		+	+	+						+	*
27. 327/60	8	70	F	+	+		+	+	+						+	
28. 152/61	12	49	M	+ + + + (F)	+		+	+	+	+					+	
29. 291/61	3	53	M	+ + + + (F)	+		+	+	+						+	
30. 295/62	1	47	M				+	+	+							
Group D																
31. 19/43	—	59	M	0	+			+							+	+
32. 140/56	—	58	F	+	+		—								+	
33. 170/53	—	55	F		+											—
34. 304/54	4	52	F						+						+	+

* Cases included in a previous report (Keal, 1960); Present series Case 20 (Keal's Case 9); Present series Case 24 (Keal's Case 3); Present Series Case 26 (Keal's Case 24). F = Fibrosis of lung.

Keal's cases had had a necropsy examination, and I have classified three of these as peritoneal mesotheliomata.

Of the 37 peritoneal tumours rejected as mesotheliomata, 11 had lung tissue available, and in none of these were asbestos bodies seen.

DISCUSSION

The tumours here recorded are in accord with those in the literature (Godwin, 1957; Winslow and Taylor, 1960). There were no cases regarded as arising in the pericardium, although this was commonly involved by tumour which also involved the pleura or peritoneum.

Histologically, the mixed type, with epithelial and fibromatous elements, was most easily distinguished (Campbell, 1950), although occasionally the fibroblasts of young granulation tissue gave rise to difficulty in recognition and might easily be confused with the fibromatous element of a tumour. If the pattern of indistinct fasciculation, the relative paucity of blood vessels, and the cytology of the plump cells with prominent nucleoli were noted, then the difficulty was usually resolved. Foci of inflammatory cells were occasionally prominent within the tumours, usually lymphocytes and plasma cells, but diffuse inflammatory infiltrate was not seen.

When the fibromatous element abutted upon epithelial areas, the similarity of the cells was obvious (Fig. 12). Epithelial type tumours resembled adenocarcinomata, but the loose arrangement of the tubules, the regularity of the cells, the absence of epithelial mucin (P.A.S. stain), the infrequency of mitoses, and the cytology of the cells all suggested the possibility of mesothelioma. I think it is possible to be reasonably certain of mesothelioma when only a small piece of tissue is available (biopsy). The most difficult differential diagnosis is inflammatory pleural thickening, and when small pieces of tissue are all that is available, then the differential diagnosis may be impossible.

Collagenous, acellular areas may be found in each. In the cellular areas, the cells in inflammatory thickening are usually less plump than those in a tumour, but unless invasion of muscle or vessels is seen, this can still be a difficult distinction. The epithelial type of reaction in inflammatory lesions is usually restricted closely to the mesothelial surface, but tubules with papillae and folds are occasionally found.

Foci of inflammatory cells are prominent in benign (inflammatory) pleural thickening, but are usually restricted to the deeper layers of the pleura. Inflammatory cells in mesothelioma are only a feature when fibrin is present on the surface, but in this circumstance the distinction between the two is extremely fine.

This differentiation reaches its most difficult point in cases of asbestosis, where fibrous pleural