EFSCH & CRC
ORAL PATHOLOGY SEMINAR
September 28, 1973
DOF73-100

CASE I. (Contributed by J. B. Whitten, D.D.S., Southern Ill. Univ. Dental School, Edwardsville, Ill.) P-42-73 - A 28 year-old female presented with a raised, red soft lesion, 2.5 x 1.5 cm, the left hard palate. The lesion had been present for 4.5 months and it slowly increased in size. The patient reported with manipulation from her tongue the lesion was mildly painful.

CASE 2. (Contributed by Carlos Perez-Mesa, M. D., EFSCH, Columbia, Mo.). 73-816 - EFSCH # 40094 - 95 year-old white male. This represents a lesion of the hard palate which has been of several years duration. It was excised in toto. A substandard photo is included.

CASE 3. (Contributed by John S. Meyer, M.D., The Jewish Hosp. of St. Louis, St. Louis, Mo.). S-73-1685 - 19 year-old male. The tumor was attached to the maxilla or palate and had a vascular appearance. Its duration is not known. The preoperative diagnosis was pyogenic granuloma or peripheral giant cell granuloma. Grossly it was 2.5 x 1.5 x 0.4 cm, yellowish, lobulated, firm to hard with scattered areas of whitish granules and had a whitish, homogeneous surface. A good photograph is included.

CASE 4. (Contributed by Ordie H. King, Jr., D.D.S., Ph.D., West Virginia Univ., School of Dentistry, Morgantown, West Virginia). S73-1061, Oral Pathology Laboratory, West Virginia Univ. The specimen is from the rt. mandibular alveolar ridge of a 48 year-old Caucasian female. It was described as a 2.5 mm, elevated, white lesion adjacent to an extraction site. The clinical diagnosis was possible mucocele.

CASE 5. (Contributed by Ordie H. King, Jr., D.D.S., Ph.D., West Virginia Univ.) SP73-0320 - The specimen is a naso-pharyngeal biopsy from a 44 year-old Caucasian male. No other information was given.

CASE 6. (Contributed by Patrick J. Manning, D.V.M., Sinclair Comparative Medicine Research Farm, Columbia, Mo.) 73-706 - Four years after extraction of the maxillary and mandibular canine teeth an 8 year-old rhesus monkey was noted to have a round, firm swelling of the lt. maxilla most prominent above the first two premolar teeth. The lesion was incised at the mesobuccal fold and a small amount of serosanguineous fluid and "fatty" material removed. During the next 6 months the maxillary swelling remained unchanged and the monkey was killed for unrelated reasons. Roentgenograms of the lesion were taken. Included for your evaluation are a photograph of the roentgenogram and tissue within the maxillary swelling.

CASE 7. (Contributed by Charles L. Dunlap, D.D.S., Univ. of Mo., Kansas City School of Dentistry) - 73-313 - This subject is a 7 year-old male who was seen by a dentist early in the spring of 1973. He had a loose molar tooth in the upper lt. quadrant and the dentist extracted the tooth. On two occasions a brownish-red mass protruded from the extraction socket and it was curetted and discarded. On the third occurrence the patient was referred to UMKC Dental School for evaluation. At the time we saw him he had a dome shaped reddish-brown mass extending from the extraction socket several mm. above the surrounding mucosa. X-rays revealed a lytic lesion of the lt. maxillary tuberosity. A biopsy was taken and the smaller slide you received is the biopsy specimen. The patient later on had extensive surgery and the larger slide you received is of the later surgical specimen.

CASE 8. (Contributed also by Charles L. Dunlap, D.D.S.) 73-423 - This 25 year-old female had an asymptomatic radiolucent lesion of the posterior mandible which radiographically appeared to be a classic dentigerous cyst. It was removed and submitted for microscopic study.

CASE 9. (Contributed by John P. Waterhouse, , M. D., Univ. of Illinois, College of Dentistry, Chicago, Ill.) - 1064-73 - 18 year-old white male with rapidly growing tumor of right maxilla. Extends from tuberosity to sinus walls and lateral nasal wall. Painless growth to midline of palate in 5 months. Biopsy includes overlying mucosa.

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"OFFICIAL" DIAGNOSIS

I. CHRONIC SCLEROSING SIALOADENITIS WITH SUPERIMPOSED ACUTE INFLAMMATION
(Contributed by J.B. Whitten, D.D.S., Southern Ill. Univ. Dental School, Edwardsville, Ill.)
For some observers the changes present in the slides are nondiagnostic including Dr. Wesley, Univ. of Detroit, Rosai, Washington Univ. and Waterhouse from the Univ. of Ill. Acute sialoadenitis was the preferred diagnosis of the residents of the Univ. of St. Louis, Dr. Luna, of M. D. Anderson and Dr. Rowe from the Univ. of Michigan. Dr. LeGal from Strasbourg, France called it "mucous gland with hypersecretion." Dr. Spjut from the Texas Medical Center called it Mucous gland hypertrophy and inflammation. Dr. Berthrong from Colo. Springs called it "adenoma of the mucous glands with escape of some of the mucin and acute inflammation resulting there from." Dr. Tarpley, Jr., and Corio from the National Institute of Dental Research called it "chronic mucositis, minor salivary gland tissue did not appear in sufficient quantity to be hyperplastic or hamartomatous as described by Giansanti and Waldron.

2. VERRUCOUS CARCINOMA
(Contributed by Carlos Perez-Mesa, M.D., EFSCH, Columbia, Mo.)
There was a lonely dissenting opinion of squamous papilloma.

3. PERIPHERAL GIANT CELL REPARATIVE GRANULOMA
(Contributed by John S. Meyer, M.D., Jewish Hosp. of St. Louis, St. Louis, Mo.)
This case was not discussed during the proceedings, however, this was the diagnosis of Dr. Whitten, Southern Ill. Univ., Dr. Waterhouse, Univ. of Ill., and Dr. LeGal from Strasbourg, France. The diagnosis of peripheral odontogenic fibroma with superimposed ossification and calcification was submitted by Dr. Wesley, Univ. of Detroit, Tarpley, Jr., and Corio from the National Institute of Dental Research. Ordie King, Jr., West Virginia, Dr. Boyle from Univ. of Mo.-Columbia, Dr. Shuler, Sedalia, Dr. Rowe, Michigan, and Dr. Fay, Ft. Leonard Wood Army Hospital. Dr. Berthrong, Colo. Springs, and Dr. Luna from M. D. Anderson called it "pyogenic granuloma."Dr. Spjut from Houston and Steven Nuernberger from St. Louis Univ. called it "plasma cell granuloma." Dr. Dunlap from Kansas City, called it "nodular inflammatory fibrous hyperplasia with ossification."

4. MYXOMA
(Contributed by Ordie H. King, Jr., D.D.S., Ph.D., West Virginia Univ. School of Dentistry, Morgantown, West Virginia.)
This was the most popular diagnosis including among others Dr. King from West Virginia, Dr. Halliwell from Univ. of Mo. Veterinary School, Dr. Manning from Sinclair Comparative Medicine Research Farm, Columbia, Mo., Whitten from Southern Ill. Univ., Wesley from Univ. of Detroit, Nuernberger from St. Louis Univ., Luna from M. D. Anderson, Rowe from Univ. of Michigan, Spjut from Houston, Rosai from Washington Univ., LeGal from Strasbourh, France. Dr. Berthrong from Colo. Springs interpreted it as an "acquired fibrous polyp with myxoid change rather than a true myxoma. Dr. Boyle from Columbia offered a similar interpretation. Dr. Corio from NIDR called it "focal muconosis." Dr. Tarpley, Jr. from the same institution commented "even though the area is well demarcated and has the appearance of benignancy, I seriously question whether this is a rhabdosarcoma vs a liposarcoma as no duct or glandular tissue was present in the examined sections." Dr. Dunlap from Kansas City interpreted it as "myxedematous hyperplasia."

5. MALIGNANT LYMPHOMA
(Contributed by Ordie H. King, Jr., D.D.S., Ph.D., West Virginia Univ.)
This was the most accepted diagnosis. Dr. Spjut from Houston and Dr. Rowe from the Univ. of Michigan, Ann Arbor, called it "malignant tumor." For many, it represented a malignant lymphoma, histiocytic type which included Dr. Berthrong, from Colo. Springs, Dr. Luna, Houston, Dr. LeGal,Strasbourg, France, Dr. Rosai, Washington Univ., St. Louis, Dr. Whitten, Southern Ill. Univ., Dr. Robert Horn, Henry Ford Hosp., Detroit. On the Resident Staff of St. Louis Univ. Hospital the opinions were divided between malignant lymphoma, undifferentiated carcinoma and malignant melanoma. Dr. Spjut from Houston called it "malignant tumor,

probably carcinoma, need more slides." Dr. Berthrong commented "reticulum stains sometimes helps but sometimes is of no value: it is no value to me here, not having it, and I can use that as an excuse." The diagnosis of lymphoepithelioma was offered by some including Dr. King, Jr., from West Virginia, Dr. Fay, Fort Leonard Wood Army Hosp. Anaplastic carcinoma was the diagnosis offered by Manning and Boyle from Columbia.

E 6. AMELOBLASTIC ODONTOMA ARISING IN A DENTIGEROUS CYST
(Contributed by Patrick J. Manning, D.V.M., Sinclair Comparative Medicine Research Farm, Columbia, Mo.)

This case has been previously published in The American Journal Veterinary Medicine, October, 1972. This was the most popular diagnosis. Dr. Spjut from Houston called it "ameloblastic cystic tumor." Dr. Rowe from Ann Arbor, Michigan called it "ameloblastoma, Simian variant."

E 7. OSTEOSARCOMA
(Contributed by Charles L. Dunlap, D.D.S., Univ. of Mo., Kansas City School of Dentistry.)
Many diagnosis were submitted as osteosarcoma, chondroblastic type. Dr. Fay from Fort Leonard Wood Army Hosp. commented "although some areas look like mesenchymal chondrosarcoma we will call this lesion osteogenic sarcoma."

E 8. AMELOBLASTOMA ARISING IN A DENTIGEROUS CYST
(Contributed also by Dr. Charles Dunlap)
This was also the diagnosis of Dr. Whitten from Southern Ill. Univ., Boyle from Columbia, Tarpley and Corio from NIDR, King, Jr., From West Virginia, Wesley from Univ. of Detroit and Luna from M. D. Anderson. Dr. Rowe from Ann Arbor, Michigan, Spjut from Houston and Rosai from Washington Univ. called it "odontogenic cyst with ameloblastic proliferation."

E 9. (Contributed by John P. Waterhouse, M. D., Univ. of Ill., College of Dentistry, Chicago, Ill.)
This case will be presented next month since at the time of the proceedings the surgical specimen from the definite operation was not available.