

EFSCH & CRC
ORAL PATHOLOGY SEMINAR
DOF 73-115

October 26, 1973

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- CASE 1. (Contributed by Richard K. Wesley, D.D.S., M.S.D., Univ. of Detroit, School of Dentistry, Detroit, Mich.) 69-710 - This is a biopsy specimen from a 39 year-old female who presented with multiple vesicular lesions on the palate. Her clinical symptoms included generalized malaise, cervical lymphadenopathy, and an elevated temperature.
- CASE 2. (Contributed by Mario A. Luna, M.D., M.D. Anderson Hosp. & Tumor Institute, Houston, Texas) 70 year-old female admitted to M. D. Anderson Hosp. on June 1966 with the chief complaint of "tumor of the right lower jaw" which had been present for 6 months. External examination of the head and neck revealed a 7 x 6 cm hard, nodular, external swelling of the right mandible. Examination of the neck revealed no abnormalities. Other physical findings and laboratory data were noncontributory. Radiographs of the mandible and a skeletal survey revealed a large osteolytic lesion involving the posterior body and ramus of the rt. mandible, but no other lesions were evident.
- CASE 3. (Contributed by Shelby Rose, M.D., St. Lukes Hospital, Wellington, Kansas) S-73-652 - The slide is from a 1.6 cm granular firm brown lesion from the right cheek of an 8 year old child. This lesion had been present for several months and had been treated with steroids by other physicians.
- CASE 4. (Contributed by William H. Halliwell, D.V.M., Ph.D., University of Mo, Dept of Path, School of Veterinary Medicine) 4899-73 Tissue submitted to the Veterinary Diagnostic Laboratory from a two-year-old terrier type dog. The sample was described as two tumors, the larger from the dorsal surface of the tongue and a smaller dark red tumor from the ventral surface of the tongue.
- CASE 5. (Contributed by John P. Waterhouse, M.D., Univ. of Illinois. Oral Pathology Dept., Chicago, Ill) 73-4437 - The slide is from the surgical specimen from the patient in Case 9 of DOF73-100, which was the biopsy specimen of an 18 year old male with tumor of the right maxilla.
- CASE 6. (Contributed by Charles L. Dunlap, D.D.S., Univ. of Mo.-Kansas City School of Dentistry, Kansas City, Mo.) 73-549 This patient's trouble started back in 1963 when he had a huge radiolucent lesion of the ramus of the mandible. There was an unerupted molar tooth in the lesion, regarded as being dentigerous cyst. It was curetted and the diagnosis was "ameloblastoma." Over the next few years the lesion recurred several times and was repeatedly curetted, and in 1970 a hemimandibulectomy was done. Metal prosthesis was placed. In 1973 he fractured the prosthesis and upon re-entering the lesion to repair the break, an abnormal soft tissue mass was encountered and excised and reported as being recurrent tumor. In Sept. 1973 he developed a fistula opening onto the skin of the face overlying the area of previous surgery. A wedge biopsy was taken, and your slide is made from this most recent procedure.
- CASE 7. (Also contributed by Charles L. Dunlap, D.D.S.) 73-2686 This 26 year-old male was seen at St. Luke's Hosp. for removal of a radiodense lesion of the anterior maxilla. The patient had a retained deciduous cuspid tooth, and the permanent cuspid tooth was seen to be impacted in bone and located at the superior pole of the lesion. The lesion was removed, and your slide was made from that material.

CASE 8. (Contributed by Paul O. Boyle, d.D.S., University of Missouri Medical Center, Columbia.) The patient is a 15 y/o caucasian male with a chief complaint of swelling of the left mandible. On August 3, 1973 he received blunt trauma to this area. Swelling occurred one month later and he denied any enlargement prior to the trauma. Pain was elicited on palpation of the hard mass. The overlying mucosa was normal. Pulp tests of the left mandibular teeth were positive with the exception of the left second premolar which was negative. The size of the lesion is evident in the radiographs and clinical photograph.

- (A) inter-radicular
- (B) inferior to (A).

ELLIS FISCHER ORAL PATHOLOGY CONFERENCE

October 1973

Case Histories

(Contributed by: Ordie H. King, Jr., D.D.S., Ph.D., West Virginia University,
School of Dentistry, Morgantown, West Virginia)

- CASE 9. OS73-1014, Oral Pathology Laboratory, West Virginia University, School of Dentistry. The specimen represents the contents of a radiolucent lesion of the mandible of a 48 year old Caucasian female. The lesion extended from the mesial root of the first molar tooth to the cuspid tooth on the same side. There was resorption of the mesial surface of the mesial root of the first molar tooth, resorption of one-half of the root of the second bicuspid tooth, slightly less resorption of the first bicuspid tooth root, and moderate resorption of the cuspid tooth root. Radiologically, the lesion was a well-demarcated, but irregular in outline, radiolucency which was irregularly oval in shape, unilocular, and exhibited no significant sclerotic border. Duration of the lesion was unknown, and there were no missing teeth in the area.
- CASE 10. S73-1422, Oral Pathology Laboratory, West Virginia University, School of Dentistry. The specimen represents curettings from the sockets of the first and second right deciduous molar teeth of an 8 year old Caucasian boy. Radiologically, there was moderate horizontal bone loss in the mandible, and there was bone loss to the apices of the roots of the deciduous first and second right molar teeth. A large amalgam restoration was present on the second molar tooth, but the first molar tooth revealed no significant abnormalities. All four permanent first molar teeth were missing, and the alveolar crest was slightly perforated by the erupting second molar tooth cusps. The deciduous molar teeth were extracted because of excessive mobility. A clinical diagnosis at the time of extraction was "abscessed teeth with associated granulation tissue." Since this patient was referred to the dental clinic from the University Hospital, further investigation yielded the following history:
At the age of 10 months, this patient was first admitted to the University Hospital with the diagnosis of chronic osteomyelitis of the left tibia. Necrotic tissue was curetted from the left tibia and the diagnosis at that time was, "chronic osteomyelitis, left tibia."
At the age of five years, this patient was again admitted to the University Hospital with enlarged cervical lymph nodes.

These nodes were biopsied, and the pathologic diagnosis at that time was chronic granulomatous inflammation. At the age of 6 years, the child was again admitted to the University Hospital with a right neck mass which was biopsied. This was diagnosed as "inflamed granulation tissue."

At the age of 8 years, in April of this year, the child was again admitted to the University Hospital with "periosteal elevation with cystic changes on the right first metatarsal." The clinical diagnosis was "osteomyelitis, possibly due to *Serratia marcescens*." The pathologic diagnosis on the biopsy of the right first metatarsal was "cortical bone with reparative changes."

- ① Herpes simplex infection.
- ② Metastatic thyroid follicular carcinoma
- ③ Embryonal rhabdomyosarcoma
- ④ ? Anaplastic malignant melanoma
- ⑤ Osteosarcoma
- ⑥ Ameloblastoma
- ⑦ Lindborg's tumor
- ⑧ Fibrous dysplasia
- ⑨ ~~Ameloblastoma~~ Ameloblastoma
- ⑩ granulomatous inflammation
(? chronic granulomatous disease)

ORAL PATHOLOGY SEMINAR

OCTOBER 26, 1973

"OFFICIAL" DIAGNOSIS

- Case 1. "Herpes Simplex" (Contributed by Richard K. Wesley, D.D.S., M.S.D., Department of Pathology, University of Detroit, Detroit, Michigan.)
The case "represents tissue from a ruptured vesicle of a viral lesion most likely herpes simplex....Rarity of seeing a histological section of Herpes....cyromorphological alterations which one would expect to see in a viral infection affecting the epithelium. Lipschuts inclusion bodies....replacing the nucleus" quote from Dr. Wesley. Most of the received opinions agreed with this diagnosis: A few dissenting views were received including pemphigus and molluscum.
- Case 2. "Metastatic Follicular carcinoma of thyroid." (Contributed by Mario Luna, M.D., Department of Pathology, M.D. Anderson Hospital and Tumor Institute, Houston, Texas)
Unanimous diagnosis - A paper reviewing the experience of the Anderson Hospital was published in the Triple O. (Surg., Med., and Path.) 31:380, 1971 by McDaniel, Luna and Stimson.
- Case 3. "Embryonal Rhabdomyosarcoma: (Contributed by Shelby Rose, M.D., St. Luke's Hospital, Department of Pathology, Wellington, Kansas)
No disagreements.
- Case 4. "Malignant Melanoma" (Contributed by William H. Halliwell, D.V.M., University of Missouri, Department of Pathology School of Veterinary Medicine, Columbia, Missouri.)
Drs. G. Thoma, Dental Branch, University of Texas at Houston, Herb Taylor, St. Louis and Pathology Residents from St. Louis University interpreted it as histiocytoma. The diagnosis of Dr. Thomas Tarpley, Jr. from the laboratory of Oral Medicine, N.I.O.R. Washington, D.C. was transmissible reticulum cell tumor of dogs vs. mastocytoma - Dr. Mario Luna from M.D. Anderson offered plasmacytoma vs. atypical mastocytoma - Mastocytoma vs. non-traumatic neuroma was the diagnosis of Dr. Jack Whitten from Southern Illinois University. Dr. John P. Waterhouse from the University of Illinois Medical Center, Chicago considered plasma cell granuloma vs. soft tissue plasmacytoma - Hemangioendothelioma was the diagnostic impression of Dr. Ordie King, Jr., West Virginia University, School of Dentistry - For Dr. Wesley, Detroit was "possible malignant lymphoma" - Malignant melanoma was the diagnosis of Charles Dunlap, Kansas City, Missouri - Quoting Morgan Berthrong, M.D., Colorado Springs, Colorado "The mitotic figures and the moderate pleomorphism of the cells I suspect it is malignant but I am puzzled by the total absence of any junctional activity: it reminds me of the so-called cellular blue nevus of man....that is what I call it, suggesting it may be malignant."
- Case 5. "Chondroblastic Osteosarcoma: (Contributed by John P. Waterhouse, M.D., Oral Pathology Department, University of Illinois, Chicago)

This was the most widely accepted diagnosis including Drs. Whitten, Southern Illinois University, Rowe, University of Michigan, Luna, M.D. Anderson, Herb Taylor and Residents in Pathology, St. Louis University, Hori, Ellis Fischel State Cancer Hospital, J. Faye from Fort Leonard Wood, Spjut from Houston and Halliwell from Columbia, Missouri. Drs. Dunlap from Kansas City, Missouri, Ordie King from Morgantown, West Virginia, Wesley from University of Detroit and Berthrong from Colorado Springs called it chondrosarcoma.

Case 6 "Ameloblastic Carcinoma" (Contributed by Charles Dunlap, D.D.S., and Bruce F. Barker, D.D.S., University of Missouri, School of Dentistry, Kansas City, Missouri.)

Same diagnosis was made by Jack Whitten, Southern Illinois University, Berthrong, Colorado Springs, Tarpley, Jr., Washington, D.C., King, Jr., Morgantown. Commented Dr. Thoma, Houston "If review of the material from 1963 confirms the original diagnosis of ameloblastoma then I would consider this a transformation to malignant ameloblastoma". Dr. Wesley from Detroit wrote "This represents a primary intraosseous epidermoid carcinoma. The history leads me to believe that this is a carcinoma arising from previous ameloblastoma or from epithelium of odontogenic origin: Shear, M.: Primary intra-alveolar epidermoid carcinoma of the jaw" J. of Path. 97: 645, 1969.

Case 7 "Odontoma with Gorlin Cyst" (Contributed by Drs. Charles Dunlap and Bruce F. Barker, Kansas City, Missouri) or Tarpley, Jr., Washington D.C., agree with this diagnosis - Drs. Rowe from Michigan, Spjut from Houston, and Faye from Fort Leonard Wood call it complex odontoma. Gorlin's cyst was the diagnosis of Drs. Whitten from Southern Illinois University, King, Jr., from Morgantown, Berthrong from Colorado Springs, and Waterhouse from Chicago. For Mario Luna from M.D. Anderson the differential diagnosis was between complex odontoma and ameloblastic odontoma. Dr. Thoma from Houston commented "complex odontoma, I do not see enough epithelial proliferation in my slide to make a diagnosis of ameloblastic odontoma, although other sections may show this."

Case 8 "Cementifying Fibroma" (Contributed by Paul O. Boyle, D.D.S., Luna, M.D. Anderson, Joy Faye, Fort Leonard Wood, George Thoma, Houston, Tarpley, Jr., N.I.O.R., Washington, D.C., Wesley, Detroit, and Whitten, Southern Illinois University agreed with this diagnosis. Several dissenting opinions considered the lesion as fibrous dysplasia including Ordie King from Morgantown, Berthrong, Colorado Springs, Spjut from Houston, Herb Taylor and the Pathology Residents from St. Louis University.

Case 9 "Plexiform Ameloblastoma" (Contributed by Ordie King, Jr., D.D.S., Ph. D., West Virginia University School of Dentistry, Morgantown, West Virginia). This was the diagnosis of Drs. Jack Whitten, Southern Illinois University, Luna, M.D. Anderson, Faye, Fort Leonard Wood, Dunlap, Kansas City, Tarpley, Jr., Washington, D.C., Rowe, Michigan, Residents of Pathology, St. Louis University, Herb Taylor, St. Louis - Dr. Thoma

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from Houston made the following comments "I suspect this is a ameloblastoma but in my slide I can only say cyst with prominent hyperplasia of the lining. Would like to examine multiple sections or rebiopsy material" Berthrong, From Colorado Springs made considerations along similar lines.

Case 10 "Chronic Granulomatous disease of Childhood" (Contributed by Ordie H. King, Jr., D.D.S., Ph. D., University of West Virginia, School of Dentistry, Morgantown, West Virginia)
Reference "Immunobiology" Good and Fischer - Sinauer Assn., Inc. Publisher, 1971 - Chapter V.