ELLIS FISCHEL STATE CANCER HOSPITAL
AND
CANCER RESEARCH CENTER
ORAL PATHOLOGY SEMINAR #48
O.P.S. 74-1920
December 6, 1974

CASE #1. (A-74-136) (Contributed by Ronald W. Oxenhandler, M.D., Department of Pathology, University of Missouri Medical Center, Columbia, Missouri)

A.H., eight month old infant, was the product of a normal gestation. No congenital abnormalities were noted at the time of birth. Three months after birth the pediatrician noted raised, pigmented lesions over the right parietal region. These enlarged and became confluent. Biopsy was interpreted as capillary hemangioma. No abnormalities were noted on fundoscopic examination. The patient developed stridor ncessitating tracheostomy. At this time laryngoscopy revealed approximately 85% occlusion by the "externally protruding"hemangioma. Prednisone therapy was began without appreciable improvement. She has several spontaneous bleeding episodes from this enlarging hemangioma, which now extended from the parital region to the postauricular area. A right submandibular mass was noticed also, however, no bruit was heard. The patient was found dead at 8 months of age with her treach tube out. Her family history is significant in that her older sister died at 3 months of age of diffuse hemangiomatosis with optic, nerval and abdominal visceral involvement.

CASE #2. (SP74-0394) (Contributed by Ordie King, D.D.S., Southern Illinois University, Carbondale, Illinois)

This patient, a 25 year old Caucasian male was first seen at West Virginia University Hospital in 1966 with "some difficulty in breathing." At that time, the patient was referred to this hospital for possible "nose surgery." He was treated in ENT Clinic and given a 6 week follow-up appointment. He did not return for this appointment and was next seen at this institution on January 17, 1974, having been referred for a "left parotid mass." On admission, the patient stated that he had had a "bout" of left parotid swelling while working in flood waters. He had no further symptoms until approximately one month prior to admission when his left cheek began swelling again. The swelling had gotten progressively larger since that date, and the patient had weight loss, a low grade fever, and night sweats prior to admission. Physical examination revealed a left preauricular mass measuring approximately 16 x 16 cm with marked trismus allowing opening of the mouth approximately 2 cm.
Admission laboratory data revealed a white count of 10,200 with a hemoglobin of 13.6. The differential was within normal limits, and the SMA 12-60 was within normal limits except for cholesterol of 134 and LDH of 319. SMA 6-60 was completely within normal limits as was the urinalysis, urine culture and chest x-ray. Sinus films revealed bilateral maxillary sinusitis and evidence of chronic mastoiditis on the left. A sialogram was attempted, unsuccessfully. Tomograms of the left mandible revealed an abnormal left mandibular ramus with and irregular radiolucent area, described as somewhat septated. Tomograms also revealed destruction of the pterygoid plates. The patient has a needle biopsy of the mandibular mass followed by an open biopsy through modified parotectomy incision. (representative microscopic slide)

CASE #3. (74-586) (Contributed by Bruce F. Barker, D.D.S., University of Missouri at Kansas City, Missouri)

This is a biopsy of the left mandible of a 28 year old male. He had swelling and tenderness of the endentulous area posterior to the left bicuspid. He had been dentulous in that area for 5 years. Clinically, the gingiva was purple in color. X-ray (enclosed) revealed a lytic lesion with no cortical expansion. (representative microscpic slide enclosed)

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CASE #4. (Contributed by Bruce Barker, D.D.S, University of Missouri at Kansas City, Dental School)
This is a section of uvula of a 27 year old, Negroid male who presented at General Hospital in some respiratory distress. Examination revealed an enlarged uvula. History showed one previous episode of similar swelling. His sister had also experienced swelling of the uvula and had had a uvulectomy performed. (representative microscopic slide)

CASE #5. (69-911A) (Contributed by Richard K. Wesley, D.D.S., M.S.D., Department of Pathology, School of Dentistry, University of Detroit, Detroit, Michigan)
The specimen is from an eight year old male, and represents soft tissue growth adjacent to a deciduous mandibular right molar. The painless lesion had been slowly increasing in size for the past three weeks. Radiographically, there was an irregular radiolucencey surrounding the tooth and extending from the crest of the alveolar ridge partially into the mandible. The clinician's provisional diagnosis was"fibrous hyperplasia." The tumor was excised subsequently, by en bloc resection of the mandible and there has been no recurrence for the past six years. (representative microscopic slide)

CASE #6. (74-1217) (Contributed by Carlos Perez-Mesa, M.D., Ellis Fischel State Cancer Hospital, Columbia, Missouri)
58 year old Caucasian female, noticed a mass on the left side of the neck below the mandible 3 months before admission. She had no pain or nerve paralysis. The positive physical findings consisted of enlargement of the left submandibular gland without fixation and freely moveable. Laboratory studies were non-contributory. In June of 1974 an excision of the mass was performed. (representative slide)

ELLIS FISCHEL STATE CANCER HOSPITAL

ORAL PATHOLOGY SEMINAR

DIAGNOSIS SHEET

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CASE 1.

CASE 2.

CASE 3.

CASE 4.

CASE 5.

CASE 6.

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Signature

December 4, 1974

Dr. Carlos Perez-Mesa
Department of Pathology
Ellis Fischel State Cancer Hospital
Columbia, Missouri

Dear Carlos:

Thank you for sending the sets of the Oral Pathology Seminars. Below are my impressions on Seminar #48. I hope this letter will get to you in time.

CASE 1.- Typical benign hemangioendothelioma of parotid gland (also called hyperplastic hemangioma or juvenile hemangioma). Since it seems to be associated with hemagiomas elsewhere, one may like to call this condition hemangioendotheliomatosis. It would be interesting to find out whether there were any bone lesions.. Sometimes these tumors are associated with the so-called "disappearing bone disease". I think it is important to emphasize that this is not a malignant vascular tumor, despite the fact that this child died from it.

CASE 2.- This is a sarcoma and probably not a malignant lymphoma. I considered embryonal rhabdomyosarcoma but my first choice is Ewing's sarcoma. I would be very interested in knowing the result of the glycogen stain.

CASE 3.- Typical example of histiocytosis X (differentiated histiocytosis). Since it seems to be a solitary, localized process, I would put it into the eosinophilic granuloma category.

CASE 4.- Marked edema of uvula, associated with vascular proliferation. I suppose it is consistent with hereditary angioneurotic edema.

CASE 5.- This looks to me like a benign but potentially aggressive fibroblastic lesion. If it is primary in the soft tissues of the mouth, I would call it fibromatosis. If it is primary in the bone with soft tissue extension (which seems more likely from the history) I would give it the name of desmoplastic fibroma. I think that desmoplastic fibroma of bone is the osseous counterpart of the soft tissue fibromatosis.

CASE 6.- Beautiful demonstration of malignant mixed tumor, or, using the W.H.O. nomenclature, carcinoma in pleomorphic adenoma.

Best regards,

Dr. Juan Rosai

"OFFICIAL DIAGNOSIS"

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CASE #1. DIFFUSE NEONATAL HEMANGIOMATOSIS

(Contributed by Ronald W. Oxenhandler, M.D., University of Missouri Medical Center, Columbia, Missouri)

All the received diagnosis consisted of variants of hemangioma and the like. Dr. Sharbough from Fort Gordon, Georgia, called it "hemangioma - congenital with pseudoinvasion of the minor salivary gland tissue (analagus to inter-muscular hemangioma.)" Dr. Rosai from the University of Minnesota commented, "Since it seems to be associated with hemangiomas elsewhere, one may like to call this condition hemangio-endotheliomatosis. It would be interesting to find out whether there were any bone lesions. Sometimes these tumors are assoicated with so-called "disappearing bone disease." I think it is important to emphasize that this is not a malignant vascular tumor, despite the fact that this child died from it."

REFERENCES

K. Holden and F. Alexander, PEDIATRICS, 46:411-421, 1970.

J. Scarcella, E. Dykes, and R. Anderson, PLASTIC AND RECONSTRUCTIVE SURGERY, 36:38-49, 1965.

CASE #2. EWING'S TUMOR

(Contributed by Ordie King, D.D.S., Southern Illinois University, Carbondale, Illinois)

Ewing's tumor was the most prominent diagnosis. Embryonal rhabdomyosarcoma was another diagnostic possibility suggested by various consultants. Esthesioneuroblastoma was also considered. The PS stains were positive. Follow-up was as follows: Following biopsy diagnosis, the patient was transferred to the Oncology Service on 1/24/74 and was started on radiation chemotherapy. The patient was started on Cytoxan, 1500 mg., Methotrexate 25 mg., and Vincristine, 1mg., all I. V. The patient received Cytoxan at three weekly intervals and Methotrexate and Vincristine weekly. The patient received 1500 rads in five fractions from Cobalt 60 source with an interval of one week and repetition of the same radiation dose two additional times. On 4/16, the patient began an additional course of Actinomycin D, .5 mg. daily for five days.

The patient was last seen on 6/3/74. At that time, he was administered Phenergan, 50 mg., I.M., Methotrexate, 8 mg. I.V., Vencristine 1 mg., I.V., and Cytoxan, 1500 mg. I.V. There has been little change in the tumor, but no metastatic disease has been found on radiographs.

CASE #3. HISTIOCYTOSIS X

(Contributed by Bruce F. Barker, D.D.S., University of Missouri At Kansas City, Missouri)

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Dr. Waterhouse from the University of Illinois, Chicago, gave a diagnosis of eosinophilic granuloma as well as most of the other consultants. Dr. Thoma, from Houston, Texas commented, "If patient has sickle cell disease, would exclude chronic salmonella, bone abscess by appropriate culture."

CASE #4. ANAPHYLACTOID ANGIOEDEMA

(Contributed by Bruce Barker, D.D.S., University of Missouri, School of Dentistry, Kansas City, Missouri)

Numerous other diagnosis were submitted, including familial telangectasia, elephantitosis of uvula, amyloidosis, cavernous hemangioma and angioneurotic edema. Somebody called it, "Big uvula." Two diagnosis not included in SNOP were, "deep throat injury" and "Linda Lovelace syndrome."

CASE #5. FIBROMATOSIS OF CHILDHOOD

(Contributed by Richard k. Wesley, D.D.S., M.S.D., School of Dentistry, University of Detroit, Michigan)

Other diagnosis included leiomyoma, neurofibroma, fibrosarcoma Grade I, desmoid type. Dr. Rosai from University of Minnesota commented, "Benign, but potentially aggressive fibroblastic lesion. If it is primary in the soft tissue, of the mouth, I would call it fibromatosis. If it is primary in the bone with soft tissue extension, I would give it the name of desmoplastic fibroma. I think that desmoplastic fibroma of the bone is the osseous counterpart of the soft tissue fibromatosis." Dr. Abrams from U.S.C., California, preferred to call it, "vascular leiomyoma." Dr. Fay and Dr. Kilas from Fort Gordon, Georgia, called it neurofibroma. Dr. LeGal, Strasbourg, France, called it fibromatosis or low malignancy fibrosarcoma. Dr. Berthrong, from Colorado Springs, Colorado, interpreted it as a low grade leiomyosarcoma. Dr. Tarpley, Dr. Corio, and Dr. Crawford, from Bethesda, Maryland, interpreted it as juvenile fibromatosis versus low grade fibrosarcoma.

CASE #6. MALIGNANT MIXED PLEOMORPHIC ADENOMA

(Contributed by Carlos Perez-Mesa, M.D., Ellis Fischel State Cancer Hospital, Columbia, Missouri)

This diagnosis was generally accepted by all the consultants.