ELLIS FISCHEL STATE CANCER
HOSPITAL
AND
CANCER RESEARCH CENTER
ORAL PATHOLOGY SEMINAR # 61
O.P.S. 78-999
May 25, 1978

CASE # 1 (225D)

(Contributed by Dr. William Halliwell, D.V.M., Ph.D., Lovelace Foundation for Research, Box 5890, Albuquerque, New Mexico)

This is a 6 1/2 year old beagle dog, which was presented with a 10 X 8 X 4 cm mass in the right ventral cervical region. At gross examination, the mass invaded approximately fifty percent of the right parotid salivary gland and surrounding musculature. On cross section, the tumor consisted of white, firm tissue, with a whirled pattern and small cystic spaces containing a red tingid clear fluid.

CASE # 2 (78-2907)

(Contributed by Dr. John Meyer, Dept. of Pathology, Jewish Hospital, 216 S. Kingshighway, St. Louis, Mo.)

JT is a 75 year old black man who had a lump in the left parotid region for six years. Three years ago the lesion drained spontaneously through the skin, and drainage continued for about two years. The mass had enlarged gradually recently. The site of prior drainage could no longer be located. Surgical exploration demonstrated a tumor in the superficial part of the deep lobe of the parotid gland, and a portion of the deep lobe containing the mass together with the superficial lobe was resected. The specimen weighed 25 grams. An ill-defined 8 mm cyst surrounded by denser white tissue was present in the otherwise soft, tan parotid gland.

CASE # 3 (76-345)

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

This is a 57 year old caucasian female from Milan, Mo. Because of a swelling of the right parotid gland of about a few months duration, she was presented to our institution. No other symptoms are referred by patient. The rest of the physical examination was essentially negative. An excision of the parotid gland was done.

CASE # 4 (S78-1081)

(Contributed by Dr. Curtis H. Bourgeois, M.D., Pathologist, and Dr. William Bucher, M.D., Pathologist, Columbia Regional Hospital, Columbia, Mo.)

This is a 72 year old female who developed a nodule beneath the left ear, which according to her had been present for several years. Recently however, it has enlarged. Physical examination findings consisted of a 2.5 cm mass inferior to the left ear in the general region of the angle of the mandible. No lymph adenopathy was evident any place and liver and spleen were not palpable. The laboratory studies were non-contributory. A left superficial parotidectomy was performed with preservation of the 7th nerve. The specimen consists of a segment of parotid gland, which measures 5 X 3.5 X 2.5. On sectioning, toward the center of the gland there was a circumscribed, 3 X 2.5 cm mass of homogenous consistency.

CASE # 5 (78-341)

(Contributed by Dr. Bruce Barker, D.D.S., and Dr. Charles Dunlap, D.D.S., University of Mo., Kansas City, 650 E. 25th St., Kansas City, Mo.)

This 65 year old female had a 1 cm nodule which was asymptomatic and was noted by her dentist six months ago. It was hemispherical and white and located on the mucosa of the left retromandibular trigone.

CASE # 6 (78-370)

(Contributed by Dr. Bruce Barker, D.D.S., and Dr. Charles Dunlap, D.D.S., University of Mo., Kansas City, 650 E. 25th St., Kansas City, Mo.)

This is a 34 year old female who had a lesion of the maxillary alveolar mucosa in the area of the bicuspid and molar teeth. It had grown slowly over a four year period. The clinician stated that it looked like an exostosis until it was removed and found to consist entirely of soft tissue.

UNIVERSITY OF MINNESOTA
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May 23, 1978

Dr. Carlos Perez - Mesa
Department of Pathology
Ellis Fischel State Cancer Hospital
Bus Loop 70 West
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Dear Carlos:

Here are my comments on the cases of Oral Pathology Seminar #61. I hope you get them on time.

CASE 1: Epidermoid carcinoma, probably primary in the salivary gland. I would do a mucin stain to rule out a high grade mucoepidermoid tumor and would take additional sections to rule out a malignant mixed tumor.

CASE 2: (Very) low-grade mucoepidermoid tumor.

CASE 3: Benign lymphoepithelial lesion. I don't like the fact that it is unilateral and so well circumscribed, but microscopically it is the only diagnosis I can make.

CASE 4: Nodular lymphoma, poorly differentiated lymphocytic type. It makes a nice contrast with the previous case.

CASE 5: The technical preparation is poor and the cytologic evaluation is very difficult. On the basis of the low power pattern, I favor a lymphoid hyperplasia.

CASE 6: Benign compound nevus.

I have not yet rescheduled my trip to St. Louis. It is all up to Fred Kraus and perhaps you should contact with him in this regard. Thanks for your invitation. It would be nice to spend a day in Columbia.

Best Regards,

Juan Rosai, M.D.
Professor, Laboratory Medicine and Pathology
Director of Anatomic Pathology

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CASE # 1 (225D)

(Contributed by Dr. William Halliwell, D.V.M., Ph.D., Lovelace Foundation for Research, Box 5890, Albuquerque, New Mexico)

MUCOEPIDERMOID CARCINOMA

This was the diagnosis entertained by Dr.'s King and Whitten from Southern Illinois School of Dental Medicine, Carbondale Illinois, Dr. Azar from The College of Medicine, Tampa, Fla.; Dr. Waldron from Emory, Georgia stated: "my experience with canine tumors is quite limited, it looks like a high grade mucoepidermoid carcinoma." Dr.'s Dunlap from the University of Missouri School of Dentistry, Kansas City, Mo., Batsakis and McClatchey, from Michigan, Sciubba from the School of Dental Medicine and Ackerman from the Medical School of Suny at Stony Brook, and LeGal from Faculte De Medecine, Strasbourg, France called it "thymic malignancy." Dr. King from Carbondale also included "thymoma" in his differential diagnosis. Dr. Rosai from Minnesota wrote "epidermoid carcinoma, probably primary in the salivary gland. I would do a mucin stain to rule out a high grade mucoepidermoid tumor and would take additional sections to rule out a malignant mixed tumor." Dr. Abrams from USC stated "this seems to be a strange squamous tumor which I would be forced to call squamous carcinoma. There is a marked mass cell component but I suppose in a dog this is not unusual." Dr. Shafer, from Indiana, offered: "we felt that this was a poorly differentiated squamous cell carcinoma, probably of parotid origin and probably having a bad prognosis as the tumor counterpart." Epidermoid carcinoma was the most popular diagnosis.

CASE # 2 (78-2907)

(Contributed by Dr. John Meyer, Dept. of Pathology, Jewish Hospital, 216 S. Kingshighway, St. Louis, Missouri)

MUCOEPIDERMOID TUMOR

Mucoepidermoid tumor was also the diagnosis of Dr.'s Hori from Elkins, W. Virginia, Berthrong from Colorado Springs, Colorado, and Abrams from U.S.C. The diagnosis of "Low grade mucoepidermoid carcinoma was made by Dr. Wesley from University of Detroit, Dr. Rosai from Minnesota, Dr.'s Batsakis and McClatchey from Michigan and Tarpley from Bethesda. Dr. Ackerman interpreted it as "benign salivary gland tumor with features of both pleomorphic adenoma and papillary cystadenoma." "Papillary cystadenoma" was also the diagnosis of Dr.'s King and Whitten from Illinois, Dunlap and Barker from Kansas City, Mo., LeGal from Strasbourgh and Hooker from N.I.H., Bethesda. Dr. Shafer from Indiana, Dr.'s Waldron from Emory, Sciubba-Stony Brook, and Corio-N.I.H.,

(cont.)

CASE # 2

Bethesda called it with minor variations, "papillary mucin producing cystadenocarcinoma."

CASE # 3 (76-345)

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

BENIGN LYMPHOEPITHELIAL LESION

This was the overwhelming diagnosis with minor variants.

CASE # 4 (S78-1081)

(Contributed by Dr. Curtis H. Bourgeois, M.D., Pathologist, and Dr. William Bucher, M.D., Pathologist, Columbia Regional Hospital, Columbia, Mo.)

MALIGNANT LYMPHOMA

Everyone agreed with the diagnosis of "malignant lymphoma" with one exception of someone who interpreted it as "benign lymphocytic hyperplasia." However, the lymphoma has been calssified variously as poorly differentiated lymphocytic type, lymphocytic diffuse, nodular lymphocytic and as a poorly differentiated, nodular lymphoma, lymphocytic type which was the favorite diagnosis.

CASE # 5 (78-341)

(Contributed by Dr. Bruce Barker, D.D.S., and Dr. Charles Dunlap, D.D.S., University of Mo., Kansas City, 650 E. 25th St., Kansas City, Mo.)

LYMPHOCYTIC LYMPHOMA

Technical difficulties with the microscopic preparation generated frustrations and a diversity of opinions including "lymphoid hyperplasia" (a favorite), "benign lesion," "giant follicular lymphoma," "embryonic neural crest rest," "lymphocytic hyperplasia , rule out chronic lymphocytic leukemia," "lymphoma nodular type" and "lymphocytic lymphoma."

CASE # 6 (78-370)

(Contributed by Dr. Bruce Barker, D.D.S., and Dr. Charles Dunlap, D.D.S., University of Mo., Kansas City, 650 E. 25th St. Kansas City, Mo.)

INTRADERMAL (NEURAL) NEVUS

This was the overwhelming diagnosis. Dr. Ackerman commented," May recur if incompletely removed." Dr. Berthrong from Colorado Springs stated "pigmented nevus with so-called neuronevus change at the base." Dr. Shafer from Indiana, called it "intramucosal nevus. We would like to have made this into a lipo-neuro-nevus but couldn't quite do it." Dr. Tarpley wrote "intramucosal nevus. (Cellular composition in areas resemble cells in case # 5.)"