CASE #1 (S-2835-81)
Contributed by C. Dunlap, D.D.S. and B. Barker, D.D.S., University of Missouri-Kansas City School of Dentistry, Kansas City, Missouri

A 50 year-old male had experienced pain in the upper right jaw for approximately three months. Clinical examination showed nodulo-ulcerative lesion extending over the expanse of several teeth in the upper right gingiva. Clinical impression was carcinoma.

CASE #2 (81-S-2037)
Contributed by C. Dunlap, D.D.S. and B. Barker, D.D.S., University of Missouri-Kansas City School of Dentistry, Kansas City, Missouri

This 8 year-old male had a radiolucent sharply demarcated cystic lesion of the body and ramus of the left mandible. The developing crown of the mandibular second molar was displaced to the inferior border of the jaw. On operation, the lesion was filled with a clear yellow fluid. Nodular, intraluminal growths were observed within the lesion. Clinical impression was dentigerous cyst.

CASE #3 (G. W.)
Contributed by C. Dunlap, D.D.S. and B. Barker, D.D.S., University of Missouri-Kansas City School of Dentistry, Kansas City, Missouri

A middle-aged female had expansion of the edentulous left maxilla. X-rays showed a compartmentalized purely radiolucent lesion filling much of that portion of the jaw.

CASE #4 (S81-4691)
Contributed by Henry A. Azar, M.D., Chief, Laboratory Service, Veterans Administration Hospital, Tampa, Florida

69 year-old male with a recurrent squamous cell carcinoma of the skin. At the present time there is no evidence of tumor. Included is a microphotograph of "rest" that had puzzled the contributor. It may represent a Malassez rest. Your opinion will be welcome.

CASE #5 (E.F. 81-1464)
Contributed by John M. Boyce, M.D., Audrain Medical Center, Mexico, Missouri

60 year-old Caucasian female with a history of mass in the left parotid of several years duration. She noticed that three months prior to surgery the tumor grew rapidly, twice the previous dimension with some tenderness. A parotidectomy was performed.
CASE #6 (E.F. 81-1564)
Contributed by Fred P. Handler, M.D., St. Mary's Health Center, Jefferson City, Missouri

49 year-old Caucasian farmer, who, two years prior to admission, while working in a barn noticed that the hayloft above had a large amount of bird droppings up to his knees. He took about three to four days to clean it. A year later he developed pain around the left lower molar and he went to a local dentist who removed his tooth. Subsequently, all the teeth of his upper mouth were removed. Approximately nine weeks prior to admission he tore the "skin" of his mouth with hard pie crust. A little ulceration developed. Biopsies from the ulcer were obtained. The biopsy material is rather scanty, but is diagnostic.

CASE #7 (81-1747)
Contributed by Carlos Perez-Mesa, M.D., Ellis Fischel State Cancer Hospital, Columbia, Missouri

R.C. is a 70 year-old white male admitted to Ellis Fischel with a 4.0 x 3.0 cm, smooth, firm movable mass of the angle of the left mandible. Excisional biopsy was obtained.

CASE #8 (S-79-15703)
Contributed by W. C. Bucher, M.D., Boyce & Bynum Laboratories, Columbia, Missouri

68 year-old Caucasian female developed a 3.0 x 2.0 cm mass located in the right anterior cervical triangle about 3 cm from the mandibular angle. E.N.T. examination showed areas of thickening of the vocal cords, the Rosenmuller foci and left lateral pharyngeal wall. Biopsies from these areas show similar changes; microscopic slides include tissue either from the Rosenmuller foci or from the left lateral pharyngeal wall.

This case has been previously discussed in Seminar #69. It consisted of a mass in the left neck, 2.5 cm in greatest diameter, which was found to be separated from the submandibular gland. The lesion showed features of Warthin's Tumor and all the consultants agreed with the diagnosis. Unfortunately, when the protocol was prepared at that time the name of the patient was interchanged with Case #7 of that seminar, who had malignant lymphoma. We apologize for the confusion.
February 18, 1982

Dr. Carlos Perez-Mesa  
Department of Pathology  
Ellis Fischel State Cancer Hospital  
Columbia, MO 65201

Dear Carlos:

Here are my diagnostic impressions for the O.P.S.# 82-138:

1) Histoplasmosis.
2) Dentigerous cyst with reactive hyperplasia of lining epithelium (not early ameloblastoma).
3) Odontogenic myxoma
4) Odontogenic nest of same sort. Not recurrent carcinoma. Actually, it looks more like a chorionic villus!
5) Carcinoma in pleomorphic adenoma (malignant mixed tumor)
6) Histoplasmosis (great history!)
7) Warthin's tumor, predominantly solid type, with scanty lymphocytic component.
8) Oncocytic papillary cystadenomatosis, similar to that described in Cancer, 44:2306, 1979.

I never got the slides on O.P.S.#74. Any chance of obtaining a set for my files? I don't want to make this fantastic collection incomplete!

Best regards,

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

JR/dmp
OFFICIAL DIAGNOSES

CASE #1 (S-2835-81) HISTOPLASMOSIS
Contributed by C. Dunlap, D.D.S. and B. Barker, D.D.S., University of Missouri-Kansas City School of Dentistry, Kansas City, Missouri

This was the diagnosis of the majority of the consultants.

LeGal from Strasbourg, France and Azar from Tampa preferred "Leishmaniasia".

Pindborg from Copenhagen suggested "a sort of a fungus infection".

Hori from West Virginia called it "granulomatosis disease".

A few comments at random:

Azar: "Probable mucocutaneous leishmaniasis, due to Leishmania brasilienensis. (Is this patient a U.S. native? If yes, leishmaniasis is unlikely. Other possible diagnoses are histoplasmosis and toxoplasmosis.)"

Berthrong from Colorado Springs: "Acute histoplasmosis. The size of the organism would appear clearly to be correct and I do not believe that it is a very rare case of granuloma inguinale of the oral cavity. Donovan bodies should be considerably smaller than these."

Weidener, also from Colorado Springs commented: "I do not believe the character of this cytoplasmic organisms suggest rhinoscleroma, granuloma inguinale or leishmaniasis."

CASE #2 (81-S-2037) PLEXIFORM UNICYSTIC AMELOBLASTOMA
Contributed by C. Dunlap, D.D.S. and B. Barker, D.D.S., University of Missouri-Kansas City School of Dentistry, Kansas City, Missouri

Most of the consultants offered a diagnosis of "ameloblastoma."

Wesley from Detroit called it "plexiform ameloblastoma arising from a dentigerous cyst" which was also the diagnosis of Happonen from Finland.

"Ameloblastoma" with further qualifications were the diagnosis of Lilly from Iowa, Batsakis and Luna from Houston, Hori from West Virginia.

"Dentigerous cyst with ameloblastoma" was the diagnosis of LeGal.

Shafer from Indiana commented: "Ameloblastoma of the pseudoplexiform type, not to be confused with plexiformis vera type."
Corio and Tarpley from Bethesda commented: "Plexiform unicystic ameloblastoma according to the criteria of Drs. Gardner and Corio after reviewing approximately 50 cases."

Happonen from Finland: "Ameloblastoma arising in a dentigerous cyst (dentigerous cyst with plexiform epithelial proliferation). My opinion is that these lesions should be separated from ordinary ameloblastomas because of their "more benign" behavior."

Pindborg from Copenhagen: "A plexiform ameloblastoma developing from follicular cyst epithelium. Quite rare at such an age!"

Weathers from Emory: "Lumenal ameloblastoma. This, in our experience, is often the histologic features we see in ameloblastoma in children. Sometimes distinction between this and a pseudoadamantine hyperplasia sometimes seen in cyst walls may be very difficult."

There were also, however, several dissenting diagnoses.

Rosai from Minnesota: "Dentigerous cyst with reactive hyperplasia of lining epithelium." (Not early ameloblastoma).

Abrams from USC: "Hyperplastic dentigerous cyst. I do not believe this is a malignant tumor."

Toto from Loyota: "Dentigerous cyst with luminal proliferation of epithelial buds."

Weidner from Colorado Springs commented: "I do not believe that the character of the epithelial processes demonstrate sufficient ameloblastomatous alteration to justify a diagnosis of ameloblastoma, (Cancer 26: 699, 1970). My diagnosis is inflamed dentigerous cyst with reactive proliferating rete processes (ameloblastomatous hyperplasia)."

Glass and Young from Oklahoma: "Inflammatory epithelial hyperplasia. We do not feel this represents ameloblastic change."

The slides were reviewed by Gardner and he agreed with the diagnosis, "Plexiform unicystic ameloblastoma, (Cancer 47: 1358, 1981)."

CASE #3 (G.W.) ODONTOGENIC MYXOMA
Contributed by C. Dunlap, D.D.S. and B. Barker, D.D.S., University of Missouri-Kansas City School of Dentistry, Kansas City, Missouri

This was the overwhelming diagnosis.
CASE #4 (S81-4691) MALASSEZ REST ? ORGAN OF CHIEVITZ ?
Contributed by Henry A. Azar, M.D., Chief, Laboratory Service, Veterans Administration Hospital, Tampa, Florida

There were many opinions concerning the nature of the structure represented and the microphotograph.

Batsakis and Luna: "? (Without site guess-work; neuroepithelial inclusion?; Chievitz organ)."

Rosai from Minnesota commented: "Odontogenic nest of some sort. Not recurrent carcinoma. Actually, it looks more like a chorionic villus!"

"Organ of Chievitz" was the diagnostic impression of White from U.K.

Hori offered, "Appears to be a nerve grafted inside a vascular channel (most likely S.M.M. Case - surgeon made mess.)"

Corio and Tarpley commented: "Entrained epithelium in nerve - The histogenesis is doubtful (either of odontogenic or salivary gland). Ref., papers of Eversole and Scuibba, we do not believe it is representative of 'A Malassez Rest'."

Shafer commented: "We haven't the foggiest."

Toto interpreted it as "odontogenic epithelium showing differentiation (atypia?)."

Lumerman from New York contributed: "Vascular channel containing metastatic carcinoma." While Cornyn offered: "Check for testicular tumor. Also step section for epithelial tumor capping organized thrombus."

CASE #5 (E.F. 81-1464) CARCINOMA EX. PLEOMORPHIC ADENOMA
Contributed by John M. Boyce, M.D., Audrain Medical Center, Mexico, Missouri

Carcinoma ex. pleomorphic adenoma was the overwhelming diagnosis.

LeGal preferred to call it "Comedocarcinoma" of the parotid gland.

CASE #6 (E.F. 81-1564) HISTOPLASMOsis
Contributed by Fred P. Handler, M.D., St. Mary's Health Center, Jefferson City, Missouri

"Histoplasmosis" was the almost unanimous diagnosis.

Abrams from USC commented: "Histoplasmosis. What is this, an epidemic?"

Cornyn from Texas: "Cryptococcus versus Histoplasmosis. (Some suggestion of extracellular "massing". Would like a mucicarmine to rule out crypto)."
Sciubba commented: "Cryptococcosis (up to his knees?)"

CASE #7 (81-1747) ONCOCYTOMA
Contributed by Carlos Perez-Mesa, M.D., Ellis Fischel State Cancer Hospital, Columbia, Missouri

"Oncocytoma" was the overwhelming diagnosis.

Shafer commented: "Oncytoma vs. oncocytic cystadenoma."

Rosai diagnosed: "Warthin's tumor, predominantly solid type, with scanty lymphocytic component."

Lumerman commented: "Papillary cystadenoma. We suppose that some people may choose to call this cystic onc cytoma."

Pindborg preferred: "Oxyphilic adenoma with foci of adenolymphoma."

"Papillary cystadenoma" was the diagnostic impression of Sciubba and Cornyn.

CASE #8 (S-79-15703) DUCTAL ONCOCYTIC HYPERPLASIA
Contributed by W. C. Bucher, M.D., Boyce & Bynum Laboratories, Columbia, Missouri

This was the most popular diagnosis. A few comments at random:

Batsakis and Luna: "Ductal oncocytic hyperplasia. Not Warthin's Tumor.

Rosai commented: "Oncocytic papillary cystadenomatosis. Similar to that described in Cancer: 44, 2306, 1979."

Abrams commented: Oxyphilic papillary cystadenoma, multifocal (sans lymphomatous). This patient must have papillary cystadenomatosis.

Weidner commented: "I favor a diagnosis in this case of oncocytic adenoma to hyperplasia or multiple papillary oncocytic cystadenomas depending upon one's philosophy as to the histogenesis of the lesion (i.e., hyperplasia vs neoplasia). I do not believe there is sufficient lymphoid stroma to justify a diagnosis of Warthin's Tumor. Whether the lesion is malignant or benign is difficult to know, but I lean toward multiple benign lesions."

LeGal commented: "Multiple oncocytopomas, benign. It is not a metastasis of the lesion of the seminar #69."

Berthrong: "... The thought that this represents malignant tumor with metastasis has occured to me but it would be a very strange metastatic location so I have dismissed that possibility. My diagnosis is either multifocal oncocytic hyperplasia, or more likely, multifocal oncocytopomas.
Weathers: "Oncocytosis."

Azar: "Oncocytomas (multiple): These two lesions, plus the one presented earlier in Seminar #69, illustrate the interesting relationship between Warthin's tumor, oncocytomas and oncocytic hyperplasia or metaplasia."

A few dissenting views:

Dunlap and Barker from Kansas City: "A pharyngeal wall lesion—oncocytic papillary cystadenoma. Rosenmuller foci—oncocytic papillary cystadenoma with malignant neoplasm (NOS) in surrounding lymphoid tissue."

White called it "Malignant oncocytic tumor."

Lumerman preferred: "Papillary cystadenocarcinoma."

Glass and Young considered: "The lesion still has some features of Warthin's Tumor, however, we think this probably represents a papillary cystadenocarcinoma of salivary gland origin."

Corio and Tarpley offered the following: "Papillary oncocytic cyst adenoma vs. oncocytosis with areas of mucous prosoplasia - these areas are particularly worrisome in the tissue from the Rosenmuller Foci and a consideration of mucoeipidermoid carcinoma must be ruled out."