ELLIS FISCHEL STATE CANCER HOSPITAL

AND

CANCER RESEARCH CENTER

ORAL PATHOLOGY SEMINAR #49

February 14, 1975

CASE #1. (OP-1073-74) (Contributed by John P. Waterhouse, M.D., Department of Oral Pathology, University of Illinois, Medical Center Campus, Chicago, Illinois)

A 53 year old male black American had had elsewhere one year previously surgical treatment for a lesion diagnosed histopathologically as "mixed tumor" of the parotid. He is now presented with clinically invasive disease of the surgically treated region and these studies are from the new surgical specimen. The earlier studies are not available.

CASE #2. (74-738M) (Contributed by Jose Hori, M.D., Community Memorial Hospital, Laboratory Department, Moberly, Missouri)

This is a 74 year old widow with a lump in the right cheek for an undetermined period of time. Because of this, she was unable to wear her dentures. She has a past history of goiter, urinary frequency, and arthritis. On examination, a 2.5 cm mass was palpated at the level of the first premolar and canine.

CASE #3. (S74-4324) (Contributed by Mario A. Luna, M.D., M.D. Anderson Hospital and Tumor Institute, Department of Pathology, Houston, Texas)

A 22 year old white male admitted to M.D. Anderson Hospital with the history of having had Hodgkin's disease, diagnosed by right submandibular node biopsy at another Institution which resulted in x-ray therapy to the right neck in 1972. The patient was referred to M.D. Anderson Hospital in June 1974 because of a right oropharyngeal mass. Examination revealed a large submucosal right oropharyngeal mass measuring 3 x 5 x 2 cm. A biopsy of the right parapharyngeal mass was performed.

CASE #4. (74-2521) (Contributed by Carlos Perez-Mesa, M.D., Chief Pathologist, Ellis Fischel State Cancer Hospital, Columbia, Missouri)

This is a 78 year old Caucasian male, who first noticed a mass at the angle of the right mandible approximately 13 months ago. It has been painless, however, has persistently increased in size. He denied any weight loss, fever, night sweats and chills. He has been asymptomatic although he is known to have mitral insufficiency and hypertension. Of further concern in the past history is a v-excision of a carcinoma of the lower lip seven years ago. The pertinent findings of the physical examination reveals a 4 x 3 cm. firm, non-tender mass situated in the right submandibular area. It is not attached to the bone and does not involve the seventh cranial nerve. Full ENT evaluation included naso-pharyngoscopy, laryngoscopy and thorough examination of the oral mucosa failed to reveal evidence of any primary. A thyroid scar showed a cold area at both lower poles. The bronchoscopy was normal. On 11-26-74 the patient underwent exploration of the neck mass. A whole section of the lesion is included.

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CASE #5. (74-821) (Contributed by Charles Dunlap, D.D.S., Department of Oral Pathology, University of Missouri, School of Dentistry, Kansas City, Missouri)

This is a 48 year old male which was seen in 1967 and had a tumor removed from the left maxilla. It was stated to involve the jaw including most of the antrum and to the orbit. It was removed and he had gone approximately seven years with no evidence of recurrence. He was seen December 1974 with what appears to be a pedunculated recurrent lesion in the soft tissue overlying the previous operative defect. The lesion has been present for six weeks.

CASE #6. (74-844) (Contributed by Charles Dunlap, D.D.S., Department of Oral Pathology, University of Missouri, School of Dentistry, Kansas City, Missouri)

This 35 year old female was seen for a firm nodular lesion just beneath the mucous membrane of the upper lip. It did not exceed 1 cm. in greatest dimensions. Clinical impression was mucocele.

CASE #7. (74-880) (Contributed by Charles Dunlap, D.D.S., Department of Oral Pathology, University of Missouri, School of Dentistry, Kansas City, Missouri)

This 64 year old female had a 3.5 x 2.5 cm. sessile pink soft tissue lesion which was slowly growing in the roof of her mouth and had been present for at least ten years. The clinical impression was fibroma.

CASE #8. (74-2733) (Contributed by R.M. Ramirez, M.D., Pathologist, Doctors Hospital, Inc., Poplar Bluff, Missouri)

This is a 74 year old Caucasian male who consulted the referring physician for a mass in the left upper neck. A parotidectomy was performed. The patient did not have a history of weight loss, denied pruritus, night sweats and had no other symptomatology. On physical examination there were four small peasized hard masses, 2 in the left supraclavicular region and 2 in the anterior cervical chain. No other adenopathy was noticed. The rest of the physical examination was essentially unremarkable except some facial paralysis, secondary to surgery. An excisional biopsy of the neck node showed benign hyperplasia. Your slide represents the tissue from the parotidectomy.

ATTENTION: (OPS74-1920, CASE #1., A-74-136)

Enclosed you will find a color slide which corresponds to the previous seminar, Case #1, contributed by Doctor Oxenhandler, University of Missouri Medical Center, Columbia, Missouri.

ELLIS FISCHEL STATE CANCER HOSPITAL

ORAL PATHOLOGY SEMINAR

DIAGNOSIS SHEET

O.P.S. 75-100

February 14, 1975

CASE 1.

CASE 2.

CASE 3.

CASE 4.

CASE 5.

CASE 6.

CASE 7.

CASE 8.

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Signature

"OFFICIAL DIAGNOSIS"

ORAL PATHOLOGY SEMINAR #49

February 14, 1975

O.P.S. 75-100

CASE #1. ADENOCARCINOMA OF PAROTID SALIVARY GLAND

(Contributed by John P. Waterhouse, M.D., University of Illinois, Medical Center Campus, Chicago, Illinois)

Most of the consultants agree with the diagnosis of adenocarcinoma; however, many of them agreed that the tumor appeared to be arising in a mixed tumor, for this reason the diagnosis of "malignant mixed tumor of the salivary gland" was the most popular. Dr. Waterhouse, from the University of Illinois, Chicago commented, "I see no evidence of mixed tumor now and I feel that acinic cell carcinoma be excluded by cell type and arrangement." Dr. Berthrong, Colorado Springs, Colorado, felt that this was a recurrent mixed tumor. He further stated that, "I can see no evidence that this is a carcinoma arising in a mixed tumor. I can see no evidence that it is an adenoid cystic carcinoma. It worries me that there are not "mixed" patterns present with a predominent epithelial growth." Dr. Shafer, from Indiana University School of Dentistry, called this adenocarcinoma, possibly arising in a mixed tumor. Dr. LeGal, Strasbourg, France stated that this was an adenocarcinoma (low grade malignancy). His associates, Dr. Philippe and Dr. Weill-Bousson, also agreed with this interpretation. Dr. Martinez, from the University of Alabama, called this a mixed tumor with acinic cell patterns. Dr.'s Dunlap and Barker, from University of Missouri at Kansas City, interpreted this case to be ductal carcinoma vs. trabecular adenocarcinoma.

CASE #2. MUCOEPIDERMOID CARCINOMA OF MINOR SALIVARY GLAND

(Contributed by Jose Hori, M.D., Community Memorial Hospital, Moberly, Missouri)

This was the most popular diagnosis. Dr. Abrams, from University of Southern California, Dr.'s Fay, Sharbough and Kolas from Fort Gordon Georgia, and Dr.'s Archard and Martinez, from University of Alabama, all agreed on the same diagnosis. Dr. Shafer, from Indiana, also called it mucoepidermoid carcinoma, oncocytoid type. He also added, "Probably developing in a papillary mucous cystadenoma." Dr.'s LeGal, Philippe and Weill-Bousson, from Strasbourg, France, also favored low grade mucoepidermoid carcinoma. The differential diagnosis of Dr.'s Dunlap and Barker from Kansas City, was between oncocytoma and mucoepidermoid carcinoma.

CASE #3. PLASMA CELL TUMOR IN MULTIPLE MYELOMA

(Contributed by Mario A. Luna, M.D., M.D. Anderson Hospital & Tumor Institute, Houston, Texas)

Dr. Waterhouse commented, "Malignant lymphoma, lymphocytic type poorly differentiated: rule-out myeloma." Dr.'s Fay and Kolas interpreted it as histiocytic lymphoma. Dr. Philippe, from Strasbourg, offered

the diagnosis of leukemia, myelomonocytic." Plasmocytoma was the most accepted diagnosis. Dr. John Meyer, from the Jewish Hospital, St. Louis, Missouri, commented, "Wonder whether the lymph node diagnosed as Hodgkin's disease may have actually been metastatic plasmocytoma." Dr. Berthrong, from Colorado Springs, shared the same feelings stating, "I wonder if the previous diagnosis might be in error."

FOLLOW-UP:

After the diagnosis of plasma cell tumor was rendered; bone survey revealed lytic lesions in the 6th right rib, and calvarium. In addition, there was a monoclonal spike on serum electrophoresis of 2.8 gr%. The 24-hour urine did not contain any abnormal protein. Bone marrow taken from the hip was normal. The biopsy from 1972 was reviewed and revealed identical histology as the oropharyngeal mass.

COMMENTS BY DR. LUNA:

In a recent review of 869 cases of multiple myeloma seen at the Mayo Clinic from 1960 through 1971, revealed that 98% of the patients were 40 years of age or older. In this report, there were only four patients below 40 years of age. This paper was published in the Mayo Clinic Procedings, Vol. 50, page 29, January 1975. In our own experience, we have seen only two patients below this age. One was a 17 year old boy who was admitted to M.D. Anderson Hospital with "multiple osteolytic lesions in the bones." The second case is the patient now presented. The right submandibular node removed at another Institution in 1972 was requested and reviewed and the lesion was composed of only plasma cells. In 1972, there were no studies of the skull and the chest film was never submitted to our institution. The tissue diagnosis in the present case was "PLASMA CELL TUMOR." Further studies prove that the patient has multiple myeloma.

CASE #4. PAPILLARY CYSTADENOMA LYMPHOMATOSA

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

This case was just self-indulgence. This was to show the technical skills of one of our technicians, Diana Palmer.

CASE #5. ODONTOGENIC MYXOMA

(Contributed by Charles Dunlap, D.D.S., University of Missouri School of Dentistry, Kansas City, Missouri)

This diagnosis was entertained by ten different consultants. Six consultants considered this as a liposarcoma, myxoid type. Dr. Berthrong, from Colorado Springs commented, "While I tried to make this into an odontogenic fibroma I could find no epithelial cords

and suspect that it actually is a myxo-liposarcoma. Dr. Luna, from M.D. Anderson, called it low grade sarcoma, consistent with neurogenic origin; his second choice was, myxoid fibrosarcoma. Dr. Shafer, from Indiana, called this a rhabdomyosarcoma. Dr. Hori, Moberly, Missouri, also agreed on calling this a fibrosarcoma, low grade. Dr. Abrams, from University of Southern California stated, "The differential lies between cellular myxofibroma of the jaw and neurofibroma. I prefer neurofibroma but examination of original surgical specimen would probably help decide the matter." Dr. LeGal, Strasbourg called it, lipomyxosarcoma. Dr. King, from Southern Illinois University, called it mesenchymal chondrosarcoma vs. osteosarcoma. Dr. Rosai, from University of Minnesota Medical School, called it, odontogenic myxoma.

CASE #6. CLEAR CELL CARCINOMA, TYPE UNDETERMINED

(Contributed by Charles Dunlap, D.D.S., University of Missouri School of Dentistry, Kansas City, Missouri)

Dr. Shafer called this a clear cell carcinoma, probably mucoepidermoid, but rule-out metastatic hypernephroma. Dr. Abrams, from U.S.C., made the following comments, "I suppose this would fit what some call "clear cell carcinoma" but, I do not like that terminology because I am not sure such a disease is a legitimate separate salivary gland entity. I would favor acinic cell carcinoma but would not argue against mucoepidermoid carcinoma. Sebaceous carcinoma is remotely possible, but I seriously doubt it." Dr. Rosai, from University of Minnesota, Dr. Hori, from Moberly, Missouri, Dr. Meyer, Jewish Hospital in St. Louis, Dr. LeGal, Strasbourg, France, Dr. Weill-Bousson, also from Strasbourg, France, and Dr. Archard, University of Alabama, called this case an acinic cell carcinoma. Dr.'s Johnson, Fay, Sharbough, and Kolas, commented, "This is a clear cell carcinoma of sebaceous gland origin." Dr. Berthrong, from Colorado Springs, Colorado, and Dr. Pullon, from St. Louis, Missouri, called it a clear cell adenocarcinoma. Dr. Ordie King, Southern Illinois University, called it a mucoepidermoid carcinoma, sebaceous type.

CASE #7. FIBROUS HYPERPLASIA (BENIGN HAMARTOMA)

(Contributed by Charles Dunlap, D.D.S., University of Missouri School of Dentistry, Kansas City, Missouri)

Dr. Berthrong, from Colorado Springs, made the following comment, "This peculiar tumor would appear to me to be a mixture of fat, fibrous tissue and lymph channels. I've never been quite certain what a benign mesenchymoma is but it would seem to suit this perfectly benign lesion." Dr. Rosai, Minnesota, called it lymphangiofibroma, short of a mesenchymoma. The diagnosis of hamartoma was favored by Dr. Tarpley and Dr. Corio, from N.I.H., Oral Biology. Dr. Pullon, from Washington

University, St. Louis, Dr. Luna from M.D. Anderson, Dr. Shafer from Indiana, Dr. Waterhouse, University of Illinois, at Chicago, the Residents from St. Louis University, all called this fibromatosis as well as Dr. Archard. Dr. Robinson, from the University of Alabama, as well as Dr. Weill-Bousson, Strasbourg, France, called it neurofibroma. Dr. LeGal, also from Strasbourg, France, called it lymphangiectatic fibrous polyp.

CASE #8. BENIGN LYMPHOEPITHELIAL LESION

(Contributed by R. M. Ramirez, M.D., Doctors Hospital, Inc., Poplar Bluff, Missouri)

The predominant diagnosis was of a benign lesion. Some of the terms most commonly used were pseudolymphoma, chronic sialadenitis, lymphoreticular lesion of salivary gland, benign lymphoepithelial lesion and the like. The proportions of benign lesions vs. malignant were 3:1. The diagnosis of the "malignant" consultants were varied from malignant lymphoma, malignant lymphoma with plasmocytic differentiation, malignant lymphoma developing in Mikulicz's disease, lymphoma, and multiple myeloma. The follow-up of the patient, to date, has been rather benign and the only sequela left from the disease is facial paralysis, results of the excision of the salivary gland.