ELLIS FISCHEL STATE CANCER HOSPITAL

AND

CANCER RESEARCH CENTER

ORAL PATHOLOGY SEMINAR #52

O.P.S.75-1699
October 17, 1975

CASE #1. (P-106-75) (Contributed by Ordie H. King, Jr., D.D.S., and Jack Whitten, D.D.S., Department of Pathology, School of Dental Medicine, Southern Illinois University, Edwardsville, Illinois)

A 57 year old Caucasian female housewife was found to have a "4-5 millimeter in diameter, white lesion in the mandibular left retromolar pad area." The lesion was of unknown duration, and it "appeared round, the size of a pea, and of fibrous tissue." The clinical impression was:

1. Fibroma
2. Papilloma (doubtful)
3. Neuroma
4. ?

CASE #2. (P-116-75) (Contributed by Ordie H. King, Jr., D.D.S., and Jack Whitten, D.D.S., Department of Pathology, School of Dental Medicine, Southern Illinois University, Edwardsville, Illinois)

The patient, a 61 year old Caucasian male attorney, was referred for clinical consultation by his son, a dental student at this institution. The following history was submitted with the biopsy specimen; History of patient's illness: "None; lesion present for 15 years." No pain associated with lesion. Location of lesion: right buccal mucosa, 1/2 centimeter posterior to commissure. Size of lesion: 8 millimeters. Color: white with red center. Duration of lesion: "15 years. Sores at lesion site that come and go for this length of time." There was no lymphadenopathy and no previous treatment in this area. Clinical impression: "white fibrous lesion, firm to palpation onthe buccal mucosa posterior to right commissure." The lesion was submitted as an excisional biopsy.

CASE #3. (555-7-CA) (Contributed by Richard K. Wesley, D.D.S., M.S.D., Assistant Professor, Department of Pathology, School of Dentistry, University of Detroit, Detroit, Michigan)

Your slide represents a portion of the surgical specimen from the submitted case #74-2096 of the April 4, 1975 Oral Pathology Seminar #50. The clinical history was as follows:
This specimen, from a 72 year old Caucasian female who presented with paresthesia of the lower lip and left mandible alveolar ridge, is a poorly defined radiolucent lesion of the left mandible. Clinician's impression was malignant neoplasm. (This is a follow-up because at that time the material was considered insufficient by some observers.)

CASE #4. (75-696) (Contributed by Richard K. Wesley, D.D.S., M.S.D., Assistant Professor, Department of Pathology, School of Dentistry, University of Detroit, Detroit, Michigan)

Your slide represents a mass removed from the floor of the mouth in a 59 year

old male. The lesion has been slowly growing for the past two years and was located inferior to Wharton's duct. Upon removal, it was well encapsulated and shelled out easily. The patient had no lymphadenopathy or other suspicious neck masses. The slide represents a portion of a 6.0 x 4.0 x 4.0 cm solid tumor.

CASE #5. (S-207-75) (Contributed by Joseph T. Fay, LTC, DC, Oral Pathology, Eisenhower Medical Center, Hospital Dental Clinic, Fort Gordon, Georgia, Augusta, Georgia)

The patient, an 18 year old soldier, complained of swelling in the right mandible for a period of three months. He felt that the lesion had grown rapidly in the last month so that he was now biting into the superior soft tissue portion of the mass (slide #2). The radiograph (slide #4) showed a missing mandibular right first bicuspid along with a well-demarkated multilocular radiolucency. At surgery, as the flap was raised, the soft tissue mass pulled away fromthe bone and was attached to the flap. Following curettage several osseous compartments were noted in the base of the lesion. There has been no recurrence during the eight month follow-up period.

CASE #6. (75-3125 & A-75-151) (Contributed by Juan Rosai, M.D., Professor of Laboratory Medicine and Path., Director of Anatomic Path., Univ. of Minnesota, Medical School, Minneapolis, Minnesota)

This is a 54 year old female who had an obvious mass involving the right mandible and was easily palpated in the vicinity of the right jaw. X-rays of the jaw revealed erosion of the right mandible most likely due to metastatic carcinoma. There is swelling in the region of the lower jaw with posterior extension to the inferior margin of the ear and extension across the midline. The swelling is soft in consistency but, the overlying skin is not ulcerated. (see representative x-ray of jaws and mandible)

CASE #7. (I0033/62) (Contributed by Yvon LeGal, M.D., Director & Professor, Faculte De Medecine, Institut D'Anatomie Pathologique, Strasbourg, France)

This is an 82 year old male with a tumor which has been growing for 45 years. Resection of the mandible was done with a pre-op diagnosis of "giant cell tumor."
(See representative x-ray)

CASE #8. (85264) (Contributed by Ronald Oxenhandler, M.D., Department of Pathology, University of Missouri Medical Center, Columbia, Missouri)

This is a 14 year old Caucasian male who developed a lesion in the left parotid gland from which a biopsy was obtained. The material that you are examining is from an additional surgical excision.

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CASE #1. ~~LEIOMYOMA~~ FIBROMA

(Contributed by Ordie H. King, Jr., D.D.S., and Jack Whitten, D.D.S., Southern Illinois University, Edwardsville, Illinois)

The overwhelming majority of the consultants believe that this lesion represents a reactive or neoplastic growth of fibrous tissue. Dr. Sciubba stated, "Localized fibrous hyperplasia containing binucleate and stellate fibroblasts (so called "giant cell fibroma")." Dr. Abrams from U.S.C., Dr. Luna from M.D. Anderson, Dr. Berthrong, Colorado Springs, Dr. Meyer from Jewish Hospital in St. Louis, and Dr. Zaloudek from Fort Gordon, Georgia considered the lesion as a reactive process. Dr. LeGal from Strasbourg, France called it fibroepithelial polyp.

CASE #2. PSORIASIS

(Contributed by Ordie H. King, Jr., D.D.S., and Jack Whitten, DDS, Southern Illinois University, Edwardsville, Illinois)

Many of the observers interpreted this lesion as some sort of pseudoepitheliomatous hyperplasia. Included is a diagnosis of verrucous carcinoma. However, the majority interpreted this lesion as some sort of psoriatic lesion. Dr. Abrams, U.S.C., and Dr. Rowe from Michigan interpreted the lesion as a migratory stomatitis suggesting, "Check skin for psoriasis." Dr. Shafer from Indiana called it, "Chronic inflammation and some shaggy parakeratin representing healing ulcer." Dr.'s Tarpley, Corio, and Crawford from N.I.H. stated, "Chronic non-specific mucositis with PEH and vasculitis. A psoriasiform pattern is present and psoriasis should be ruled out."

CASE #3. OSTEOSARCOMA

(Contributed by Richard K. Wesley, D.D.S., M.S.D., University of Detroit, Detroit, Michigan)

Inspite of new and more abundant tissue from the specimen, various observers were unable to make the diagnosis of osteosarcoma which was recognized by some others. Benign diagnoses were offered by Dr. Sciubba from Long Island, New York, Dr. Berthrong from Colorado Springs, Colorado, Dr.'s Zaloudek, Kolas, and Johnson from Fort Gordon, Georgia, Dr. Meyer from Jewish Hospital in St. Louis, Dr. Hori from Moberly, Missouri, and Dr. Shafer from Indiana. Dr. Rowe from Michigan called it, "Fibromatosis - no cancer." Dr. Luna from M.D. Anderson stated, "It does not look like the previous material." Additional diagnoses of malignancy were offered by Dr. LeGal, fibrosarcoma, Dr. King from S.I.U., carcinoma, and Dr. Azar from Tampa, Florida called it, "Adenocarcinoma, probably arising in minor salivary gland." Dr.'s Tarpley,

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Crawford, and Corio from NIH called it, "Malignant neoplasm, rule out metastasis forming bone."

CASE #4. BENIGN NEOPLASM OF UNDETERMINED HISTOGENESIS

(Contributed by Richard K. Wesley, D.D.S., M.S.D., University of Detroit, Detroit, Michigan)

The contributor had sent this case for consultation and the various opinions are as follows:

Cellular adenoma with oncocytoid features was given by Dr. Hoffman from A.F.I.P. Dr. John Batsakis from University of Michigan called it, "Oncocytoma (?) malignant." Paraganglioma was the diagnosis offered by Dr. Robbins from William Beaumont Hospital, Michigan. Dr. Shafer from Indiana called it, "Chemodectoma or non-chromaffin paraganglioma," at that time. Dr. Shafer saw this case again in the present seminar and his diagnosis is still paraganglioma. Many observers called it oncocytoma including the residents from St. Louis University, Dr. Azar from Tampa, and Dr.'s Tarpley, Corio, and Crawford from NIH. Dr. Rowe from Michigan called it, "Oncocytoma, recommending an EM to rule out malignant soft part sarcoma." Dr. Luna from M.D. Anderson, Dr. Sciubba from Long Island, and Dr.'s Fay, Zaloudek, Turner, and Kolas from Fort Gordon, Georgia called it adenoma. The diagnosis of low-grade trabecular adenocarcinoma was offered by Dr. Abrams, Dr. Berthrong, Dr. Sayers, Dr. Meyer, and Dr. Waterhouse. Dr. Dunlap from Kansas City submitted the diagnosis of oncocytoma, maybe malignant?

FOLLOW-UP:

As to date, six months following removal of the tumor there is no recurrence or metastasis of the residual tumor. The patient is free of other primary tumors.

CASE #5. OSSIFYING FIBROMA

(Contributed by Joseph T. Fay, LTC, DC, Eisenhower Medical Center, Fort Gordon, Georgia)

With a few exceptions, this was the prevalent diagnosis.

CASE #6. ADENOCARCINOMA OF MINOR SALIVARY GLAND

(Contributed by Juan Rosai, M.D., University of Minnesota, Minneapolis, Minnesota)

All of the observers agreed that this represented a malignant neoplasm and the majority felt th-t this most likely was metastatic strongly suggesting the possibility of the primary being in the lung. A few felt that the lesion was primary in the jaw suggesting Ewing's tumor and malignant lymphoma.

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FOLLOW-UP:

Subsequently the patient died and at the time of the autopsy, tumor was found disseminated throughout the body. The metastases were found in the liver, lungs, vertebrae, cranial and spinal dura, nerve roots, and cauda equina.

CASE #7. CALCIFYING EPITHELIAL ONDONTOGENIC TUMOR (PINDBORG TUMOR)

(Contributed by Yvon LeGal, M.D., Institut D'Anatomie Pathologique, Strasbourg, France)

This represented the most popular diagnosis. Most of the observers indicated a few odd features and a minority intertained diagnoses including rhabdomyosarcoma, malignant oncocytoma, and adenoid cystic carcinoma.

CASE #8. UNDIFFERENTIATED CARCINOMA

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

The initial biopsy material was interpreted by A.F.I.P. as a muco-epidermoid carcinoma, poorly differentiated, since they were able to demonstrate the presence of mucous material. However, in additional material observed from the specimen, including tissue obtained from metastasis, the appearance is similar to the one present in the slides of the seminar. Dr. Abrams from U.S.C. commented, "Adenocarcinoma with marked fibrosis which certainly could be of salivary gland origin. Maybe you could call it a "scirrhous adenocarcinoma." Dr. Azar from Tampa offered a diagnosis of mixed tumor. Dr.'s Tarpley, Corio, and Crawford from NIH stated, "Malignant salivary gland tumor, not otherwise specified." The residents from St. Louis University called it malignant mixed tumor. Dr.'s Meyer from St. Louis, Waterhouse, Chicago, Luna from M.D. Anderson, and LeGal from Strasbourg called it undifferentiated carcinoma.

FOLLOW-UP:

The patient is still alive and has metastatic deposits in many sites and is being treated with Radiotherapy.