ELLIS FISCHEL STATE CANCER HOSPITAL & CANCER RESEARCH CENTER
ORAL PATHOLOGY SEMINAR # 65 O.P.S. 79-1770

September 12, 1979

CASE HISTORIES

CASE # 1 (S79-67) Contributed by O.H. King, Jr., D.D.S., Ph.D., Southern Illinois Pathology Laboratory, Alton, Illinois:

The patient is a 58 year old caucasian male. In 1976, the patient had extraction of 2 mandibular incisor teeth and curettage of the periapical area for a radiolucent lesion. In 1978, the patient had a repeat curettage of the same area for a recurrence. At that time, he refused any further surgery. The present specimen is a saggital section through the middle of a block resection performed in office, recently.

CASE # 2 (79-162-B) Contributed by O.H. King, Jr., D.D.S., Ph.D., Southern Illinois Pathology Laboratory, Alton, Illinois:

The patient is a 17 year old caucasian female with a history of recurrent bouts of swelling of the left floor of the mouth. Spontaneous rupture of the mucosa would occur and the swelling would subside. The clinical impression at the time of surgery was ranula with surgical removal of a normal appearing sublingual gland to prevent recurrent swelling.

CASE # 3 (79-185-B) Contributed by O.H. King, Jr., D.D.S., Ph.D., Southern Illinois Pathology Laboratory, Alton, Illinois:

The patient is a 62 year old caucasian male with a history of bullous lesions of the oral cavity of two weeks duration. The specimen was described as a 1.5 x 0.5 cm bulla of the left lateral border of the tongue, and the patient was described as having large bullous lesions of the left buccal mucosa and tongue and evidence of ruptured bullous lesions of the right buccal mucosa. The lesion submitted for examination was described as being "24 hours old". The clinical impression was pemphigus.

CASE # 4 (S79-15633) Contributed by Thomas E. Coyle, D.D.S., Oral Surgeon, Consultant, Ellis Fischel State Cancer Hospital and L.D. Henry, M.D., Boone County Hospital, Columbia, Missouri:

W.McQ. (48425). This 29 year old black female six months prior to admission noticed a lesion on the left side of her mouth near the left gum-line which was tender and did not bleed. Roentgenograms show bony defects in the mandible, both left and right. A biopsy was done. Included are selected films.

CASE HISTORIES con't

ASE # 5 (OST-1480) Contributed by Carlos Perez-Mesa, M.D., Chief Pathologist, Ellis Fischel State Cancer Hospital, Columbia, Missouri:

F.W. 93 year old caucasian female developed a nodule in the right parotid gland of undertermined duration. The lesion was excised with a portion of the normal salivary gland tissue.

ASE # 6 (67-35-79A) Contributed by Edward Adelstein, M.D., Chief Pathologist, Veterans Administration Hospital, Columbia, Missouri:

Salivary gland tumor from a dog of undertermined breed and of undetermined duration.

ASE # 7 (S79-162-5) Contributed by Noel Lewis, M.D., Pathologist, Missouri State Chest Hospital, Mount Vernon, Missouri:

RVE (79-48163) A 47 year old caucasian male had been admitted elsewhere because of pulmonary tuberculosis. During the hospitalization, they discovered a lesion from the hard and soft palate extending out from underneath his dentures, measuring 3 x 2 cm, generally flat with a granular surface. An excision was done.

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September 7, 1979

Dr. Carlos Perez-Mesa
Department of Pathology
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Dear Carlos:

These are my impressions on the cases of Oral Pathology Seminar #65 that you kindly sent me:

1. I guess there are enough large dilated vessels in the marrow spaces to suggest a diagnosis of cavernous hemangioma, with secondary fibrosis and bone remodeling.

2. Chronic sialoadenitis, with focal "extravasation mucocele" formation.

3. I pass on this one.

4. Benign fibro-osseous lesion. It looks better for fibrous dysplasia than for ossifying fibroma.

5. Acinic cell carcinoma.

6. Poorly differentiated carcinoma. There is a suggestion of sebaceous differentiation. If this is confirmed by fat stain, this tumor could be called a sebaceous carcinoma.

7. Well-differentiated squamous cell carcinoma (not verrucous carcinoma).

Best regards,

Juan

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

JR:Jed

"OFFICIAL DIAGNOSIS"

ELLIS FISCHEL STATE CANCER HOSPITAL
AND CANCER RESEARCH CENTER
ORAL PATHOLOGY SEMINAR #65
O.P.S. 79-1770
December 12, 1979

CASE # 1 (S79-67)

This case was discussed by Dr. Dunlap

ODONTOGENIC MYXOMA
(Contributed by O.H. King, Jr., D.D.S., Ph.D., Southern Illinois Pathology Laboratory, Alton, Illinois)

Dr. Toto from Loyola University calls it, "Myxofibroma, lymphocytic, reactive, premalignant". Dr. Abrams from USC commented, "Although there is not much tissue present, I would have to call this a myxoma. It seems to be infiltrating bone". Drs. Glass and Rohrer fromOklahoma made the following comment: "While there are some features in the slide that suggest a possible myxomatous lesion of the bone, both Mike and I are impressed with this being a reparative/reactive process. It most closely resembles an organizing clot within the trabecular spaces rather than a myxoma. Without further histologic evidence, I would be reluctant to call it more than this". Dr. Shafer calls it, "Odontogenic myxoma". This was also the diagnosis of Drs. Fay, Matsumoto, Burns, and Yetter from Fort Bliss, TX. Other observers interpreted the lesion as some variety of Hemangioma including Dr. Spjut from Houston, Dr. Hori from West Virgina, Dr. Batsakis from Portland, ME, Dr. Rosai from Minneapolis, and Dr. LeGal from Strasbourg, France. Dr. Weathers from Atlanta, GA commented, "We had a little difficulty with interpretation of this particular slide. Most of the specimen appeared to be essentially normal, however, there is a relative increase in the vascularity of the marrow spaces. One small corner shows some myxoid tissue which I think probably is not part of the lesion. Because of the apparent increase in vascularity, I wonder if this is not representative of a vascular anomaly or hemangioma of the mandible". Drs. Corio and Tarpley from NIH commented, "Myxomatous degeneration of a central benign nerve sheath tumor? dx made because of presence of mast cells". Dr. Pindborg from Copenhagen, Denmark interpreted it as "Intraosseous hemangioma".

CASE # 2 (79-162-B)

This case was discussed by Dr. Barker

CHRONIC SIALADENITIS
(Contributed by O.H. King, Jr., D.D.S., Ph.D., Southern Illinois Pathology Laboratory, Alton, Illinois)

All of the observers, with a few exceptions, consider the gland within normal limits acknowledging the presence of chronic inflammation, focal. A few selected commentaries: "Obstructive sialadenitis", Dr. Toto from Loyola. "I am wondering if this patient has evidence of Sjoren's Syndrome", Dr. Abrams from USC. "C.S., with focal "extravasation mucous" formation", Dr. Rosai from Minneapolis. "There is one small focus of mucous retention phenomenon however, the periductal cuffing by lymphocytes and rather discreet foci make one wonder if this does not represent salivary gland changes seen in autoimmune disease. This maybe a chance finding since it does not fit in well with the history", Dr. Weathers from Emory. "Chronic inflammation, dominantly periductal. Any relation to Medications?", Dr. Spjut from Houston. "C.S., post-obstructive", Dr. Azar from Tampa. "Hyperplasia, focal sialadenosis, and small mucous extravasation in sublingual gland", Dr. Batsakis. "Salivary gland showing periductal lymphocytic infiltrate. Suggestive of collagen sialadenosis", Dr. Shafer from Indiana. "Sialadenitis", Dr. Pindborg from Copenhagen.

"OFFICIAL DIAGNOSIS"

CASE # 3 (79-185-B)

This case was discussed by Dr. Barker

VESICULAR-BULLOUS STOMATITIS; RULE OUT BMMP OR BULLOUS PEMPHIGOID
(Contributed by O.H. King, Jr., D.D.S., Ph.D., Southern Illinois Pathology Laboratory, Alton, Illinois)

"Benign mucous pemphigoid" was the diagnosis of Dr. Wesley from Detroit, Dr. Spjut from Houston, Dr. Shafer from Indiana, Dr. LeGal from Strasbourg, and Dr. Pindborg from Copenhagen. "Erythema multiforme" was the diagnosis of Dr. Abrams from USC, Dr. Azar from Tampa, and Dr. Fay from Fort Bliss, TX. Dr. Batsakis from Portland, ME calls it, "Steven-Johnson disease". Dr. Rosai from Minneapolis stated, "I pass on this one".

CASE # 4 (S79-15633)

This case was discussed by Dr. Dunlap

ATYPICAL FIBROUS DYSPLASIA
(Contributed by Thomas E. Coyle, D.D.S., Oral Surgeon, Consultant, EFSCH and L.D. Henry, M.D., Boone County Hospital, Columbia, Missouri)

"Benign fibro-osseous lesion, compatible with ossifying fibroma" was the diagnosis of Dr. Wesley from Detroit. "Ossifying fibroma" was the diagnosis of Dr. Weathers from Emory, Dr. Spjut from Houston, Dr. Azar from Tampa, Dr. Batsakis from Maine, and Dr. Pindborg from Copenhagen. Dr. Rosai from Minneapolis stated, "Benign fibro-osseous lesion. It looks better for fibrous dysplasia than for ossifying fibroma". Dr. Toto from Loyola calls it, "Paget's disease". Dr. Abrams from USC commented, "I am quite suspicious of Paget's disease and would certainly suggest appropriate additional radiographs and blood chemistry studies. Although the patient is a fairly young black female, the bony pattern does not seem to be that which I usually associate with floride osseous dysplasia". Dr. Shafer from Indiana commented, "Certainly looks like Paget's disease but the patient is pretty young". Drs. Corio and Tarpley from Bethesda commented, "Benign fibro/ossous lesion - Focal foreign body reaction. Rule out early manisfestation of Paget's disease". Dr. Weathers from Emory commented, "A very active cementifying and ossifying fibroma". "Ossifying fibroma" was considered the diagnosis by Dr. LeGal from Strasbourg, France. Drs. Glass and Rohrer from Oaklahoma included in the differential diagnosis, "Aneurysmal cyst, ossifying/cementifying fibroma, or atypical fibrous dysplasia". Drs. Matsumoto, Burns, Yetter, and Fay from Fort Bliss, TX sent the following diagnosis: "Benign fibrosseous lesion consistent with: Florid osseous dysplasia".

CASE # 5 (OST-1480)

ACINIC CELL CARCINOMA
(Contributed by Carlos Perez-Mesa, M.D., Chief Pathologist, Ellis Fischel State Cancer Hospital, Columbia, Missouri)

The overwhelming diagnosis was "Acinic Cell Carcinoma".

CASE # 6 (67-35-79A)

ADENOCARCINOMA WITH SEBACEOUS DIFFERENTIATION
(Contributed by Edward Adelstein, M.D., Chief Pathologist, Veterans Administration Hospital, Columbia, Missouri)

"OFFICIAL DIAGNOSIS"

CASE # 6 Continued

Dr. Abrams from USC commented, "There are features present which suggest sebaceous carcinoma. If not that I would call it poorly differentiated adenocarcinoma". Dr. Rosai from Minneapolis commented, "Poorly differentiated carcinoma. There is a suggestion of sebaceous differentiation. If this is confirmed by fat stain, this tumor could be called a sebaceous carcinoma". Dr. Hori from West Virgina included, "Sebaceous carcinoma" in his differential diagnosis. Dr. Azar from Tampa calls it, "Poorly differentiated carcinoma, sebaceous type". Dr. Shafer from Indiana calls it, "Adenocarcinoma with some sebaceous differentiation". Drs. Glass and Rohrer from Oaklahoma consider it, "High grade mucoepidermoid carcinoma". Dr. Handler from Jefferson City calls it, "Low grade wquamous cell carcinoma".

CASE # 7 (S79-162 5)

WELL DIFFERENTIATED KERTINIZING EPIDERMOID CARCINOMA - NOT VERRUCOUS TYPE
(Contributed by Noel Lewis, M.D., Pathologist, Missouri State Chest Hospital, Mount Vernon, Missouri)

This was the diagnosis of Dr. Abrams from USC, Dr. Wesley from Detroit, Dr. Rosai from Minneapolis, Dr. Weathers from Emory, Dr. Azar from Tampa, Dr. Shafer from Indiana, Drs. Corio and Tarpley from Bethesda, Dr. Rohrer from Oaklahoma, and Dr. Pindborg from Copenhagen. Other observers consider the lesion as "Verrucous carcinoma", including Dr. Glass from Oaklahoma, Dr. Hori from West Virginia, Dr. Spjut from Houston, Dr. Batsakis from Portland, ME, and Drs. Matsumoto, Burns, Yetter, and Fay. Dr. LeGal from Strasbourg calls it, "Pseudo epitheliomatous hyperplasia".