

ELLIS FISCHER STATE CANCER HOSPITAL
ORAL PATHOLOGY NO. 82-400
O.P.S. #76
JUNE 4, 1982

CASE HISTORIES

CASE 1 (5-792-81)

Contributed by Col. Joseph T. Fay, Chief, Oral and Maxillofacial Pathology, Department of the Army, William Beaumont Army Medical Center, El Paso, TX

This 62 year old female noticed a slowly enlarging parotid mass for six months.

CASE 2 (5-7075-1-81)

Contributed by Col. Joseph T. Fay, Chief, Oral and Maxillofacial Pathology, Department of the Army, William Beaumont Army Medical Center, El Paso, TX

The patient is a 26 year old female who noted a slowly growing parotid mass over a two year period.

CASE 3 (6684-81)

Contributed by Virgilio Cardona Lopez, M.D., Honduras, Central America

37 year old Caucasian male from Tegucigalpa, Honduras, who developed a cystic lesion in the floor of the mouth, painful, of two weeks duration. It was excised.

CASE 4 (82-134)

Contributed by T. Coyle, D.D.S., Consultant, O. Guerra, D.D.S., Director of Maxillofacial, and T. H. McElroy, Associate, Department of Maxillofacial, Ellis Fischel State Cancer Hospital, Columbia, MO

32 year old Black female who had pain and tenderness over the left mandible and alveolar ridge. This area was biopsied two years ago and presented in Oral Pathology Seminar #65, September 12, 1979.

CASE 5 (S82-159)

Contributed by William R. Sprague, DDS, University of Nebraska, College of Dentistry, Lincoln, NE

This 46 year old white male presented with a large encapsulated lesion located in the left pterygomandibular area. The patient stated that the mass had grown steadily for three years. The lesion was biopsied.

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CASE 6 (82-1280)

Contributed by James C. Quigley, M.D., Boyce and Bynum Laboratories, Columbia, MO

2 x 2.5 cm submucosal cystic mass in buccal mucosa of a 44 year old male diabetic. The lesion had been painless and slowly enlarging over a one-year period. The patient had been periodically draining it with an insulin syringe and needle.



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May 13, 1982

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

Dear Carlos:

These are my diagnostic impressions on the cases of the Oral Pathology Seminar No. 82-400, to be held on June 4, 1982.

Case 1 - My differential diagnosis here is between monomorphic adenoma and adenoid cystic carcinoma of the so-called "tubular" type. I favor the diagnosis of monomorphic adenoma because of the very well circumscribed nature of the proliferation, the presence of foci of squamous metaplasia, and the nature of the cylinders formed by the tumor cells.

Case 2 - Very nice example of acinic cell carcinoma, in which very typical acinic cells with prominent zymogen granules are seen admixed with ductal cells of the intercalated type.

Case 3 - Benign cystic lesion lined by granulation tissue and containing "rice bodies", which probably represent foci of inspissated fibrin with concentric laminations. Perhaps this represents a giant "extravasation" mucocele. It is closely related to a minor salivary gland.

Case 4 - I still think that this is probably a benign fibrous lesion in the family of fibrous dysplasia, although the hematoxylin staining is so pale that it is hard for me to appreciate the nuclear features or search for cement lines. I am mentioning the latter because I remember that in 1979 some observers favored the possibility of Paget's disease.

Case 5 - I would classify this tumor as a variant of adenoid cystic carcinoma.

Case 6 - This is a low grade adenocarcinoma of minor salivary gland origin, with a prominent cystic component. It probably arises from the terminal ducts. I would not regard it as a type of mucoepidermoid or acinic cell carcinoma, but would rather designate it simply as low grade adenocarcinoma.

I am very saddened, irritated and depressed about the Malvinas situation. It looks like the conflict is reaching its climax, and probably by the time that you receive this letter there will have been a resolution, which I hope will not have costed the lives of too many young men.

I will be leaving for Europe on June 11. We will be spending a month in Spain and Portugal touring and watching some of the games of the Soccer Cup. I will be arriving in Italy for my sabbatical around July 15, and I am planning to stay there for about one year. My home address during that time will be Via del Saletto 4-1, 50142 Florence, ITALY. The telephone number is 78-3965 (country code 39, city code 55). I hope that you will be able to visit us during that year. I promise that if you do that, you will have the most expert Florence guide you will ever get.

Best personal regards,

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

JR/dmp

ELLIS FISCHER STATE CANCER CENTER
ORAL PATHOLOGY SEMINAR NO. 76
O.P.S. # 82-400
June 4, 1982

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OFFICIAL DIAGNOSES¹¹

CASE # 1 (S792-81) MONOMORPHIC ADENOMA WITH ADENOIDCYSTIC CHANGES & SQUAMOUS METAPLASIA
Contributed by Col. Joseph T. Fay, Chief, Oral & Maxillofacial Pathology, Dept. of
Army, William Beaumont Army Medical Center, El Paso, TX
PRESENT ADDRESS: 10th Medical Laboratory, Landstuhl Army Medical Center, APO, New
York 09180, Germany

Saltstein from the University of California, San Diego, commented, "I feel this is
a monomorphic adenoma of the basal cell type. There is focal keratinization with
well defined intercellular bridges. Some of the pattern raises the possibility of an
adenoidcystic carcinoma, but I do not think this is the prominent pattern nor do I
know of squamous metaplasia in such tumors. Also, the lesion appears very well
encapsulated.

Rosal from the University of Minnesota, temporarily in Florence, Italy added,
"I favor the diagnosis of monomorphic adenoma because of the very well circumscribed
nature of the proliferation, the presence of foci of squamous metaplasia and the nature
of the cylinders formed by the tumor cells."

Waidner from Colorado Springs made the following commentary: "In my section this lesion
appears to be well circumscribed and composed of numerous small nests of basaloid
cells fitting together in a jigsaw puzz-like manner... With these features in mind, I prefer
to call this lesion a monomorphic adenoma (so-called membranous adenoma subtype which
is very similar in appearance to the dermal eccrine cylindroma).

LeGal from Strasbourg, France called it "Basal cell adenoma."

John Meyer from the Jewish Hospital in St. Louis called it "monomorphic adenoma of
parotid, (with squamous metaplasia).

Henry Azar from University of South Florida in Tampa commented: "Monomorphic adenoma,
tubular type. The possibility of adenoidcystic carcinoma was also considered in this
limited biopsy."

Cornyn from the University of Texas in San Antonio commented: "Monomorphic adenoma
suggestive of infantile hamartoma. Some may prefer trabecular or canalicular descriptors."

Young and Glass from the University of Oklahoma offered: "Dermal analog tumor or
basaloid tumor."

Batsakis and Luna from M.D. Anderson offered the diagnosis of monomorphic adenoma.
There were also dissenting opinions.

Happonen from Turku, Finland called it: "Adenocystic carcinoma," which was also the
diagnosis of Hori from Elkins, West Virginia.

Abrams from USC commented: "The nuclear atypia and invasion into fibroadipose tissue
caused me to prefer a diagnosis of adenoid cystic carcinoma rather than monomorphic
adenoma."

Lumerman from Flushing, N. Y. commented: "Epithelial salivary gland tumor. The
microscopic appearance is suggestive of an adenocarcinoma but the absence of sur-
rounding normal tissue in the specimen makes it difficult to determine if this tumor
is truly infiltrating."

Weathers from Emory made the following commentary: "I find this to be a difficult slide
since it is very well circumscribed, however, the pattern is very disturbing. I would
therefore call this an adenocarcinoma. I suspect that some may designate this as
adenoid cystic. However, I do not feel that this lesion quite fits my criteria for this."

Hansen and staff from the University of California in San Francisco commented:

"We are inclined to designate this as an adenocarcinoma, NOS, but a majority of our
group favor adenoid cystic carcinoma."

This was also the diagnostic impression of White from the University of Kentucky.

Shafer from the University of Indiana offered the following: "Adenocarcinoma with
features of adenoid cystic, of malignant dermal anlage tumor and of Donath-Seifert tumor."

Pindborg from Copenhagen called it: "Atypical adenoid cystic carcinoma."

Dunlap and Barker from the University of Missouri in Kansas City commented: "A classic something.....cytologically benign..... Adenoma, possibly dermal analogue type. 404

The contributor, Dr. Fay, made the following commentary: "This case was also seen by the AFIP and ENT (Dr. Hyams), who also agreed with the diagnosis of monomorphic adenoma." In addition, he indicated that the EM studies done in his laboratory did not show reduplication of basement membrane which is found in adenoid cystic carcinoma.

CASE #2 (S-7075-1-81) ACINIC CELL CARCINOMA

Contributed by Col. Joseph T. Fay, Chief, Oral & Maxillofacial Pathology, Dept. of the Army, William Beaumont Army Medical Center, El Paso, TX

PRESENT ADDRESS: 10th Medical Laboratory, Landstuhl Army Medical Center, APO, New York 09180, Germany

This was the overwhelming diagnostic impression of the consultants.

A few commentaries at random:

Weathers from Emory commented: "Acinic cell carcinoma. It will be most interesting to see how many consider this an adenoma since I suspect the argument still rages."

Shafer from Indiana commented: "Acinic cell carcinoma (seldom see the real serous type)."

Pindborg from Copenhagen: "Basophilic variant of acinic cell tumor."

Cornyn from the University of Texas commented: "Classical acinar cell adenocarcinoma plus sialolithiasis, extremely rare in parotid in my experience. (It may be that someone will want to defend "acinar cell adenoma" in this instance. I would strongly disagree.)"

CASE # 3 (6684-81) MUCOCELE (MUCOUS ESCAPE RETENTION) WITH EARLY SIALOLITHS

Contributed by Virgilio Cardona Lopez, M.D., Honduras, Central America

Some of the observers were intrigued by the intracystic structures and commented:

Happonen from Finland: "Parasitic infection, (?)."

Saltzstein from San Diego commented: "Of especial puzzlement to me are the laminated, eosinophilic bodies within this cystic mass; I must suspect some sort of parasite. However, don't ask me what the parasite is. Otherwise the lesion is inflammatory in my opinion."

Meyer from St. Louis called it: "Mucocele with pseudophakogesis."

Corio and Tarpley from Bethesda: "Mucous escape phenomena (mucocele) mucous retention phenomena (Ranula) take your choice demonstrates organization, epithelial proliferation of the feeder duct."

Berthrong from Colorado Springs offered the following comment: "I guess this is a mucocele. The lining of chronic granulation tissue somewhat granulomatous is compatible but the ovoid fibrous bodies within the lumen are mystifying. I can't make them out as any kind of parasite since they have no internal structure, so I suspect they represent organizing exudate in the mucocele."

White from Kentucky commented: "Mucous retention phenomenon (mucocele) with multiple hyalinized plugs, probably representing early formation of multiple sialoliths. We have a remarkable similar case but the hyalinized areas were undergoing calcification in a lamellar pattern. Second consideration is microthrombi."

CASE # 4 (82-134) FLORID OSSEOUS DYSPLASIA

Contributed by T. Coyle, D.D.S., Consultant, O. Guerra, D.D.S., Director of Maxillofacial, and T. H. McElroy, Associate, Dept. of Maxillofacial, Ellis Fischel State Cancer Hospital, Columbia, Mo.

This case was discussed during the proceedings by Drs. Dunlap and Barker from the University of Missouri, Kansas City. Very convincingly they diagnosed it as florid osseous dysplasia. There was a great deal of variation in the diagnostic impression among the consultants, especially those who had the opportunity of seeing the material in 1979.

A few commentaries at random:

Lumerman from Flushing, N. Y. "Although the radiographic evidence of involvement of both mandibular quadrants suggests a condition such as florid osseous dysplasia, the microscopic characteristics of the specimen submitted we feel warrants a diagnosis of benign osteoblastoma.

Corio and Tarpley from Bethesda; "Histologic features strongly suggest osteoid osteoma---however, from radiographs one could consider florid osseous-cemental dysplasia."

Hansen from San Francisco: "We prefer to designate this 'Black woman's disease' as florid osseous dysplasia."

White from Kentucky: "Florid osseous dysplasia. Would like to see alkaline phosphatase levels, though."

The following commentary was made from Abrams from USC: "There were two reasons why I was equivocal about Case #4 in the September 1979 set. First, the absence of radiographs when dealing with fibro-osseous jaw lesions often makes definitive diagnosis impossible if not hazardous. Second, the presence of extensive osteoclastic activity is most unusual in florid osseous dysplasia and such a finding together with the marked osteoblastic reaction, vascular stroma, variable bone morphology and prominent reversal lines were suggestive of Paget's disease. It was the prominent osteoclastic activity which gave me concern about Paget's disease. All of the other histomorphologic features displayed on that slide are considered typical of active florid osseous dysplasia. The reason I called Case #4 in the May 1982 set florid osseous dysplasia was because the radiographic features were classical FOD and that together with the microscopic slide for the September set confirmed the diagnosis. The microslide in the May 1982 set was essentially worthless and I can make no comment on it."

CASE #5 (S82-159) METASTATIC ADENOCARCINOMA

Contributed by William R. Sprague, D.D.S., University of Nebraska, College of Dentistry, Lincoln, NE.

Additional follow-up submitted by Dr. Sprague: "This patient is presently being worked up at the Phoenix VA Medical Center. Discussion with the surgeon indicates that no primary has been identified elsewhere. They are inclined now to consider the tumor as originating as a primary in the pterygo-mandibular area."

Oxenhandler from the Ellis Fischel State Cancer Center, Columbia, Mo. offered: "adenocarcinoma, NOS, rule out adenoid cystic carcinoma."

Rosal from Minnesota: "I would classify this tumor as a variant of adenoid cystic carcinoma."

Hansen from San Francisco commented: "We think that this is best designated as an adenocarcinoma, NOS, but it is suggestive of adenoid cystic carcinoma. We, of course, wish to rule out metastatic disease."

Shafer from Indiana offered: "Adenocarcinoma, probably adenoid cystic, probably primary but rule out metastasis."

Azar from Tampa called it: "Adenoid cystic carcinoma."

Young and Glass from the University of Oklahoma suggested: "Salivary gland tumor - that is all we can tell from the material received."

Dunlap and Barker from Kansas City considered it as "adenocarcinoma, primary in salivary gland probably, cannot rule out metastatic tumor."

Most of the diagnoses with a few exceptions were variants of the same general theme of primary versus metastatic.

CASE # 6 (82-1280) ACINIC CELL CARCINOMA

Contributed by James C. Quigley, M.D., Boyce & Bynum Laboratories, Columbia, Mo.

Corio and Tarpley of Bethesda called it: "Acinic cell adenocarcinoma---large areas have definite histologic features of oncocytoma."

Weathers from Emory offered: "I would call this a low grade adenocarcinoma, perhaps of acinar cell origin."

Berthrong from Colorado Springs made the following commentary: "This is an adenocarcinoma presumably of the minor salivary gland tissue and buccal mucosa. Some

areas show a pattern suggestive of a somewhat cystic mucoepidermoid carcinoma, but I nowhere can find unequivocal squamous differentiation. Occasional cells lining the cyst is definitely a Goblet cell. On the other hand, some other areas with their microcystic pattern as well as prominently vacuolated cell suggests an acinic cell carcinoma, and I believe I favor a poorly differentiated acinic cell carcinoma. " Shafer from Indiana called it: "Adenocarcinoma, mucoepidermoid vs. acinic cell." Batsakis and Luna from M.D. Anderson offered: "favor acinic cell carcinoma." Sprague from Nebraska called it: "Adenocarcinoma of a peculiar variety." Happonen from Copenhagen; Lumerman from Flushing, N. Y.; Hansen from San Francisco; White from Kentucky; Young and Glass from Oklahoma prefer to call it: "mucoepidermoid carcinoma." Cornyn from Texas offered the following: "Most interesting. There are features of mucoepidermoid carcinoma (adenocarcinoma side) and acinar cell adenocarcinoma (undifferentiated). Clinical features and cystic areas only remotely suggest Batsakis' "cutaneous analogue." I believe this is a variant often called acinar cell - which displays serous and mucous acinar characteristics plus intercalated duct cell participation."

A few of the consultants offered the diagnosis of pleomorphic adenoma.