CASE HISTORIES

CASE 1: 138-88 (1 slide)
Submitted by Dr. Virgilio Cardona Lopez, Hospital Escuela, Republic of Honduras, Central America.

77 year old man with a mass in the right nasal fossa of 7 months duration. The tumor was excised which measured 8 x 7.5 x 4 cm. in greatest dimension.

CASE 2: 5-2477-87 (1 slide)
Submitted by Dr. Neal Granneman, Phelps County Regional Medical Center, Rolla, Missouri.

This 64 year old caucasian woman had a 5-6 year history of a mass in the area of the right parotid. There was recent increase in size. It was not tender and she had no symptoms from it. The tumor was located in the superficial portion of the parotid, 3 x 2.3 x 2.1 cm. On sectioning, it was homogeneous and light-tan. It appeared to be well encapsulated.

CASE 3: 88-156A (3 slides)
Submitted by Dr. Carlos Perez-Mesa, Ellis Fischel Cancer Center, Columbia, Missouri.

G.S. - 69 year old caucasian male developed mass in the superficial lobe of the right parotid of 6 months duration. In 1975, he received R.T. for squamous cell carcinoma in the right buccal mucosa. No lymph nodes are palpable. An excision of the superficial lobe of the right parotid was done.

CASE 4: 88-092 (1 slide and 2 gross photos)
Submitted by Drs. Charles Dunlap and Bruce Barker, University of Missouri-Kansas City School of Dentistry, Kansas City, Missouri.

A 14 year old girl who developed painful stomatitis in December 1987. Onset coincided with placement of orthodontic bands. By early January 1988, she had lost 7 lbs. because of inability to eat and took Tylenol # 3 for pain. Representative lesions are seen in the photographs; biopsy came from right buccal mucosa.
CASE 5: 88-319 (1 slide)

A 37 year old attorney had swelling of the body of the mandible for 1 year; radiograph showed an approximately 3.5 cm. radiolucent lesion.

CASE 6: S88-78 (1 slide)
Submitted by Dr. Frederick Volini, St. Mary's Health Center, Jefferson City, Missouri.

Right neck mass excised from an 84 year old man.

CASE 7: S88-1044 (1 slide and 1 gross photo)
Submitted by Drs. Mark Bookout and Ronald Oxenhandler, Memorial Hospital, Chattanooga, Tennessee.

8/6/87 office visit without tongue lesion for 1 month PTA. It started as a bump and grew. It occasionally hurts. Exam: verrucous lesion of mid-dorsum of tongue with slight red base; it is raised a few mm. from surrounding tongue. There was another small pinpoint lesion raised approximately 2 mm. from the surface of the tongue further posteriorly. 8/12/87 excised. Sent to St. Elsewhere for pathology. 1/27/88 regrew rapidly. Now 8 x 15 mm. with small satellite papillomata.

CASE 8: 88-164 (2 slides)
Submitted by Dr. Carlos Perez-Mesa, Ellis Fischel Cancer Center, Columbia, Missouri.

J.A.B. - 28 year old caucasian female with painless mass 3 x 2 cm. located beneath right ear lobe of many years duration.

CASE 9: 76-345 (1 slide)
Submitted by Dr. Carlos Perez-Mesa, Ellis Fischel Cancer Center, Columbia, Missouri.

R.L.S. - 57 year old female with mass in front of right ear of 2 months duration without other symptoms. It is attached, slightly to deep structures. No lymph nodes are palpable. An excision of the superficial lobe of the parotid was done.
CASE 1: HEMANGIOPERICYTOMA (138-88)
Contributed by Dr. Virgilio Cardona Lopez, Hospital Escuela, Republic of Honduras, Central America.

Hemangiopericytoma was preferred by almost half of the consultants. A few opinions randomly selected:

Kyriakos from Washington University in St. Louis, "Differential is fibrous histiocytoma vs. hemangiopericytoma. If the latter, then the size is worrisome. I do not believe this is a MFH from its morphology, although its clinical course could be aggressive. Neither is it the hemangiopericytoma-like lesion of Compagno. I favor hemangiopericytoma - get a reticulin stain."

Santa Cruz from St. John's Mercy Medical Center, St. Louis, "Fibrohistiocytic tumor, benign - the tumor has a "smell" of hemangiopericytoma."

Tomich from Indiana, "This very interesting case has areas which are suggestive of a malignant fibrous histiocytoma and a hemangiopericytoma. A reticulin stain might be helpful in separating the two. I favor a hemangiopericytoma."

Others who preferred the diagnosis of hemangiopericytoma, Gnepp on sabbatical in Washington at AFIP, "Fibrous histiocytoma - AFIP agrees"; White from Kentucky; LeGal from Strasbourg; Drs. Simon, Videla, Gallard and Oliva from San Juan, Argentina stated, "Hemangiopericytoma (the fibrinoid necrosis do not allow us to orient the lesion, but we believe it is benign, without atypia)"; Abrams from USC preferred hemangiopericytoma over fibrous histiocytoma.

Dissenting opinions selected at random:
Lumerman, Freedman, Kerpel from Flushing, "Fibrous histiocytoma. Even though the lesion is quite cellular there is minimal cytoplasmic atypia and mitotic activity. The lesion should behave in a benign manner."

Waldron and Weathers from Atlanta, Hansen from San Francisco also prefer the diagnosis of fibrohistiocytoma.

Weidner from Brigham and Women's Hospital, Boston, "I believe this is basically a low-grade, soft-tissue tumor. It has thick-walled vessels and foamy histiocytes, features frequently associated with Schwann-cell differentiation (my bias regarding the current case). However, it also shows areas sometimes found in hamangiopericytomas, and I have also considered meningioma. Impax and EM studies might clarify the type of differentiation present.

Hartmann from Memorial Medical Center, Long Beach, "This is a vascular tumor which has both hemangiopericytoma and smooth muscle differentiation. There are focal areas that are extremely cellular and there is some necrosis present. On those two observations I would be concerned that this is not going to be your usual benign lesion."

Azar from the VA Hospital in Tampa, "Benign stromal tumor, perhaps another hemangiopericytoma-like intranasal tumor." This was also the opinion of Oxenhandler from Chattanooga.
CASE 2: MONOMORPHIC ADENOMA (S-2477-87)
Contributed by Dr. Neal Granneman, Phelps County Regional Medical Center, Rolla, Missouri.

This was the most popular of all the diagnoses. A few opinions at random:

Hartmann from Long Beach, California, "This is a very pretty example of what I refer to as a filligree pattern monomorphic adenoma. Others have different names for it, but basically I think the lesions are the same."

Sprague from Nebraska, Cardona Lopez from Honduras, Abrams from USC, Gnepp from Washington, Dunlap and Barker from University of Missouri-Kansas City, among others preferred the diagnosis of monomorphic adenoma.

There was another group, however, who preferred the diagnosis of cellular mixed tumor including Kyriakos from Washington University, Waldron from Emory, Donath from Hamburg, Santa Cruz from St. Louis. Weathers from Atlanta labeled it as "atypical mixed tumor" while White from Kentucky and El-Mofty from Washington University prefer pleomorphic adenoma, rather monomorphic in pattern.

One consultant called it "adenoid cystic carcinoma", another thought it was "well differentiated carcinoma in pleomorphic adenoma"; another "carcinoma ex-mixed tumor" and another consultant preferred "low-grade adenocarcinoma, NOS."

Lumerman, Freedman, Kerpel commented, "Salivary gland adenoma. It looks like the benign counterpart of lobular carcinoma of minor salivary gland origin."

Weidner from Boston made the following commentary: "Like many salivary gland tumors, I believe this tumor is showing adenomyoepitheliomatous differentiation (Dardick & Van Nostrand. Head Neck Surg 1985;7:395-408). Unlike the usual mixed tumor, it does not have cartilaginous metaplasia; and yet, I believe this tumor will likely demonstrate the biological behavior of a mixed tumor (hence making the diagnosis of mixed tumor a reasonable one). However, my bias is to call this tumor a low-grade adenomyoepithelioma, likely to recur locally (if not adequately excised) but unlikely to metastasize distantly."

CASE 3: MALIGNANT LYMPHOMA, NOT FURTHER CLASSIFIED (88-156A)
Contributed by Carlos Perez-Mesa, M.D., Ellis Fischel Cancer Center, Columbia, Missouri.

With the exception of one dissenting vote, the rest of the consultants interpreted it as malignant lymphoma. Some considered diffuse lymphocytic, others mixed, low-grade, high-grade and poorly differentiated. A few commentaries:

Kyriakos from Washington University, "By pattern it should be a lymphoma. I was not impressed with the cell morphology until my local hematology people showed me cells which are not too happy - they think it is a small cell lymphocytic lymphoma - who am I to argue?"

Oxenhandler from Chattanooga, "Malignant lymphoma with plasmacytoid component? nodular (slides too poor to adequately evaluate)."

Santa Cruz from St. John's Mercy, "Probably lymphoma. A good case to ask for thinner cuts and then send it out in consultation."

Simon, Videla, Gallard, Oliva from San Juan, Argentina, "Large noncleaved lymphoma FCC (vs. Merkeloma). Majority for lymphoma of parotid."
Abrams from USC, "Lymphoma with radiation atrophy and fibrosis of the parotid."
Lumerman, Freedman, Kerpel, "Malignant lymphoma. There are also numerous
epithelial islands and duct-like structure within the fibrous connective tissue
between the lobules of adipose tissue. Could these ducts be the residual glandular
tissue remaining after the previous radiation therapy?"
Gnepp from Washington, "Lymphoma - salivary gland atrophy and hyperplasia."

This patient 13 years before the diagnosis of lymphoma of the salivary gland was
made, received radiation therapy for squamous cell carcinoma in the right buccal
mucosa. Reviewing the photographs of the patient during the radiotherapy
treatment, the right parotid gland was included within the field of treatment. I
have interpreted the nonmalignant parotid as fatty atrophy due to irradiation effect
which incidentally I have been unable to find a recent study of chronic irradiation
effect of the parotid gland. In the figure 5f of the Journal of American Dental
Association, Vol 70, 868-883, 1965 depict "lobular adiposis surround some
scattered acini centered on excretory ducts." In Archives of Surgery, Vol. 16:
329-331, 1981, there is an interesting article "Radiation - Induced Parotid Cancer
by Walker, et al, with a recent review of salivary gland malignant tumors probably
induced by radiation therapy. I believe the present case is highly suggestive of
such association.

CASE 4: ALLERGIC CONTACT STOMATITIS (NICKEL ALLERGY) (88-092)
Contributed by Drs. Charles Dunlap and Bruce Barker, University of Missouri-
Kansas City School of Dentistry, Kansas City, Missouri.

Much of the opinions of the consultants related the lesion to an allergic reaction
due to organisms bacterial or fungal, or to various substances including cement or
to nickel. The lesion promptly disappeared after the orthodontic bands were
removed which contained high proportion of nickel.

CASE 5: AMELOBLASTOMA (88-319)
Contributed by Drs. Charles Dunlap and Bruce Barker, University of Missouri-
Kansas City School of Dentistry, Kansas City, Missouri.

This was the unanimous diagnosis of all the consultants. A few opinions at
random:

Tomich from Indiana, "I believe this could be termed a "kerato-ameloblastoma"."
Toto from Loyola and Donath from Hamburg prefer ameloblastoma,
acanthomatous type.
El-Mofty from Washington University commented, "Ameloblastic proliferation
associated with odontogenic keratocyst. R/O nevoid basal cell carcinoma
syndrome."
LeGal from Strasbourg, "Ameloblastoma acanthomatous and why not sebaceous ?"
Makek from Zurich, "Ameloblastoma from a dentigerous cyst."

The contributors also suggest the possibility that it could be arising from a
keratocyst.
CASE 6: MULTINODULAR, MULTIFOCAL, ONCOCYTOMA (S88-78)
Contributed by Dr. Frederick Volini, St. Mary's Health Center, Jefferson City, Missouri.

Weidner from Brigham and Women's Hospital, "Multinodular oncocyntoma. (Human Pathol 1984;15:485-486)."
Oncocytosis was preferred by many including Sprague from Nebraska, Waldron and Weathers from Atlanta, Kyriakos and El-Mofty from Washington University.
White from Kentucky commented, "Multinodular oncocyntoma (oncocytosis), R/O hereditary variant."
Makek from Zurich labeled it as "Nodular oncocyntic hyperplasia."

CASE 7: PAPILLARY EPITHELIAL HYPERPLASIA (S88-1044)
Contributed by Drs. Mark Bookout and Ronald Oxenhandler, Memorial Hospital, Chattanooga, Tennessee.

Only two of the consultants considered the lesion as "papillary squamous cell carcinoma, malignant and verrucous squamous cell carcinoma. The overwhelming majority interpreted the lesion as benign and viral related. Some comments:

Abrams from USC, "I favor condyloma acuminatum over verrucous hyperplasia" which was also the opinion of Sprague from Nebraska, Tomich from Indiana, White from Kentucky, Hammond, Finkelstein, Vincent, Benjamin, Deahl and Watson from Iowa, Hansen from San Francisco, "Papillomatous hyperplasia, suggestive of viral etiology."
Kyriakos from Washington University, "Papillary or "verrucoid" something - tissue is not as dramatic as clinical photo - probably someone has done those in situ things and found polyomavirus - I wait the answer with baited breath."
Donath from Hamburg and Cardona Lopez of Honduras prefer papilloma.

CASE 8: PLEOMORPHIC ADENOMA (88-164)
Contributed by Carlos Perez-Mesa, M.D., Ellis Fischel Cancer Center, Columbia, Missouri.

This was the official diagnosis with exception of one consultant who considered it as an adenocarcinoma, NOS.

CASE 9: BENIGN LYMPHOCYTICAL LESSION (76-345)
Contributed by Carlos Perez-Mesa, M.D., Ellis Fischel Cancer Center, Columbia, Missouri.

All the contributors agreed with the diagnosis.

Santa Cruz from St. John's Mercy Medical Center, "Lymphoepithelial lesion, benign, until "proven" otherwise by the lymphomaniacs and their concoctions!"