

ELLIS FISCHER STATE CANCER HOSPITAL
and
CANCER RESEARCH CENTER
ORAL PATHOLOGY SEMINAR
D.O.F. 74-46
April 19, 1974

CASE #1. (73-1858 A) (Contributed by Richard K. Wesley, D.D.S., M.S.D., Assistant Professor, Department of Pathology, University of Detroit, School of Dentistry, Detroit, Michigan)

This is a representative specimen of a mandibular lesion from an eleven year old boy who complained of a slowly growing mass of the mandibular symphysis. Radiographic evaluation revealed a large multilocular expansile radiolucency which extended from the region of the right cuspid to the left first bicuspid area. There was inferior displacement of the mandibular left cuspid. At the time of surgery the mass was said to "shell out" of the mandibular bone. (occlusal radiograph enclosed)

CASE #2. (D-43711) (Contributed by William G. Shafer, D.D.S., Distinguished Professor and Chairman, Department of Oral Pathology, Indiana University School of Dentistry, Indianapolis, Indiana)

A 68 year old white male complained of swelling in the left mandible. Clinical examination revealed a soft tissue enlargement of the gingiva in the mandible in the left second bicuspid-first molar area. The provisional clinical diagnosis was "pyogenic granuloma."

CASE #3. (D2050-AT) (Contributed by Nathaniel H. Rowe, D.D.S., M.S.D., Department of Oral Pathology, University of Michigan, School of Dentistry, Ann Arbor, Michigan)

An 11 year old female with Ewings sarcoma of the spine - skull, probable mandibular involvement. Now with hyper mobile mandibular, right cuspid and bicuspid. Extraction of dentition and tissue was excised from this area.

CASE #4. (74-472) (Contributed by Joseph T. Fay, LTC, DC, D.D.S., Chief, Oral Pathology and Medicine, Department of The Army, Fort Leonard Wood Dental Activity, Fort Leonard Wood, Missouri)

This 18 year old white male was seen on 1 August 1973 at the hospital on referral from the Reception Station. A multilocular radiolucency was noted on the panorex used for screening these individuals. (slide one) Colonel Anderson completed a diagnostic curettage the same day (slide two), and the patient returned to basic training. A three month follow-up showed an increase in the lesion (slide three). Due to a change of assignment he was lost to follow-up until late April 1974. On 1 March 1974, Colonels Anderson and Cali completed a conservative block resection.

CASE #5. (SP74-1046) (Contributed by Ordie H. King, Jr., Ph.D., D.D.S., Professor of Oral Pathology, West Virginia University School of Dentistry, Morgantown, West Virginia)

The specimen is a biopsy from the naso-pharynx of a Caucasian female, age unstated. The lesion was said to be a large mass pushing the soft palate anteriorly.

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CASE #6. (2762-A-74) (Contributed by William H. Halliwell, D.V.M., Ph.D., University of Missouri - Columbia, School of Veterinary Pathology, Columbia, Missouri)

A 5 year old, female, Abyssinian house cat was presented to the University of Missouri, Veterinary Teaching Hospital. The history included a bilateral enlargement of the submandibular salivary glands and associated lymph nodes. One of these masses was excised and submitted for histologic examination.

CASE #7. (SJR) (Contributed by Clement Schmitt, D.D.S., St. Joseph, Missouri, Bruce F. Barker, D.D.S. and Charles L. Dunlap, D.D.S., Department of Oral Pathology, University of Missouri, School of Dentistry, Kansas City, Missouri)

This 16 year old female presented with expansion of the right mandibular body. The nontender hard 4 x 5 cm. mass was sharply demarcated radiographically. History failed to reveal any evidence of trauma or inflammatory process in this area. Needle aspiration was negative for blood or fluid. At surgery the mass shelled out in toto. The bicuspid and 1st and 2nd molar were also removed.

CASE #8. (74-95B) (Contributed by Bruce F. Barker, D.D.S., and Charles L. Dunlap, D.D.S., Department of Oral Pathology, University of Missouri, School of Dentistry, Kansas City, Missouri)

Tissue is from a 51 year old man who had had swelling in the left anterior maxilla for approximately one month. Several teeth were extracted and antibiotics prescribed. Poor healing ensued. Tissue was recurretted from the extraction area.

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CASE #1. CENTRAL ODONTOGENIC FIBROMA

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

Dr. Wesley the contributor, made the following comment, "Although there is a lack of odontogenic epithelium, the tumor is composed of a mass of mature collagen fibers with fibroblasts placed somewhat at equal distance in the stroma . . . This is a rare lesion, it occurs in children and young adults and has a predilection for the mandible, usually presenting as a multilocular asymptomatic expansile lesion. Treatment is conservative excision and it exhibits no tendency to recur." This was the most prevalent diagnosis. Dr. LeGal from Strasbourg, France also called it ossifying fibroma. Other diagnosis included non-ossifying fibroma, desmoplastic fibroma, and leiomyoma. Dr. Abrams from U.S.C., Los Angeles called it ossifying fibroma and made the following comment, "This appears to be a neoplasm which I would call a ossifying fibroma, mature type, The presence of bone could be argued but, calcification of collagen is present." Dr. Tarpley and Dr. Crawford from N.I.D.R., Bethesda in Maryland stated, "benign fibro-osseous lesion consistent with cementifying fibromas, however it is unusual to find this multilocular appearance and mature collagen."

CASE #2. AMELANOTIC MELANOMA

(Contributed by William G. Shafer, D.D.S., Department of Oral Pathology, Indiana University School of Dentistry, Indianapolis, Indiana)

This case was presented to the meeting of the Central Indiana Pathologist Association and "they were pretty well split between poorly differentiated histiocytic lymphoma and melanotic melanoma;" the first was the favored diagnosis of the Mayo Clinic. This was also the dilemma amongst five consultants. Dr. Berthrong from Colorado Springs, Wesley from Detroit and King from West Virginia, saw junctional nests of cells. The presence of this structure convinced Dr. Shafer and his group of this diagnosis. Other diagnosis included plasma cell myeloma, angiosarcoma and metastatic sarcoma.

CASE #3. EWING'S TUMOR

(Contributed by Nathaniel H. Rowe, D.D.S., M.S.D., Department of Oral Pathology, University of Michigan, School of Dentistry, Ann Arbor, Michigan)

This was the predominant diagnosis. Dr. Dunlap commented, "Malignant neoplasm - favor Ewing's by history but, would like to see a glycogen stain." Dr. Shafer from Indiana stated, "This is certainly compatible with Ewing's sarcoma but, I could not call it that from this slide alone." This was also the opinion of Dr. Mario Luna from M.D. Anderson Hosp., Texas.

CASE #4. AMELOBLASTOMA

(Contributed by Joseph T. Fay, LTC, DC, D.D.S., Chief, Oral Pathology and Medicine, Department of The Army, Fort Leonard Wood, Missouri)

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Dr. Shafer's diagnosis was ameloblastoma with "gorlinoid" features. These comments from Dr. Abrams from Los Angeles summarizes the opinion of others, "The microscopic slide only shows odontogenic cyst (primordial) with preameloblastomatous changes. It has the features described by Vickers as possessing ameloblastoma potential or of actually being a cystic ameloblastoma. I would not like to make the diagnosis of ameloblastoma without evidence of solid infiltrating tumor. In this case, such tumor could be nearby and/or in previous biopsy material."

CASE #5. MALIGNANT LYMPHOMA

(Contributed by Ordie H. King, Jr., Ph.D., D.D.S., West Virginia University School of Dentistry, Morgantown, West Virginia)

This was the most popular diagnosis however, many considered this to be a non-differentiated carcinoma as another likely possibility. Drs. Martinez, Dowling and Archard from the University of Alabama, call it undifferentiated carcinoma probably primary in the nasopharynx.

CASE #6. CRYPTOOCOCCOSIS

(Contributed by William H. Halliwell, D.V.M., Ph.D., University of Missouri - Columbia, School of Veterinary Pathology, Columbia, Missouri)

This was the most popular diagnosis. During the presentation, Dr. Halliwell showed microphotographs of the microorganism with the classical features of this fungi, cryptococcus neoformans.

CASE #7. CEMENTIFYING OR OSSIFYING FIBROMA

(Contributed by Clement Schmitt, D.D.S., St. Joseph, Missouri, Bruce F. Barker, D.D.S. and Charles L. Dunlap, D.D.S., University of Missouri, School of Dentistry, Kansas City, Missouri)

This was the prevalent diagnosis among the consultants. Dr. Shafer from Indiana called it "central, cemento-ossifying fibroma, classical". Dr. Martinez, Archard and Dowling agreed with this diagnosis.

CASE #8. METASTATIC MALIGNANT NEOPLASM

(Contributed by Bruce F. Barker, D.D.S., and Charles L. Dunlap, D.D.S., Department of Oral Pathology, University of Missouri, School of Dentistry, Kansas City, Missouri)

An autopsy report showed a primary carcinoma of the adrenal with widespread metastases to structures including the maxilla. Somebody whose name will remain anonymous said, "This is a wild-ass malignancy, probably metastatic from the lung, pancreas or melanoma."