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ELLIS FISCHEL STATE CANCER HOSPITAL
AND
CANCER RESEARCH CENTER
ORAL PATHOLOGY SEMINAR #47
O.P.S. 74-1084
June 21, 1974

CASE #1. (OPS74-1084) (Contributed by Mario A. Luna, M.D., M.D. Anderson Hospital and Tumor Institute, Department of Pathology, Houston, Texas)

This is a 29 year-old, white male admitted to M.D. Anderson Hospital with the compiaint of persistent soreness, itching and burning in the left side of his jaw of two years duration. X-ray of the left mandible by routine projections revealed a destructive lesion involving the ascending ramus of the left mandible. The right mandible was unremarkable. Tomograms from the skull revealed a mass in the region of the left pterygoid pallatine fossa invading the base of the skull in the region of the foramen rotundum with destruction of the pterygoid processes of the sphenoid bone on the left. On June 1968, the tumor was excised along with a partial resection of the left ramus of the mandible. (Representative slides and radiography and gross picture are included for this case)

CASE #2. (D3076-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)

This is a verrucous lesion of the maxillary gingiva in a two year-old child. The size is 2 x 1 cm in diameter. It appeared verrucous or pebbly on its surface. The color was the same as the surrounding tissue (normal). The lesion was excised in totality. It had been present at least 1 month. The surgeon thought he got it all. The clinical impression is lymphangioma.

CASE #3. (OP#74-447) (Contributed by Mario G. Martinez, Jr., D.M.D., M.S., Division of Oral Pathology, University of Alabama in Birmingham, Alabama)

J.D.S., a 10 year-old, Caucasian male with a hard, blister-like lesion of the lower left lip which has been present for about two months. There was no pain, trauma or proceding ulcer. There were two other separate lesions with similar pathologic courses. At the time of the biopsy, the tissue cut hard and was gritty.

CASE #4. (UMKC 74-194) (Contributed by Richard F. Grahm, D.D.S., Columbia, Missouri and Dr. Dunlap of University of Missouri, Kansas City)

This was an 80 year-old, Caucasian male who had a lesion in the maxillary left buccal vestibule in the vicinity of the cuspid-bicuspid area. The patient was edentulous, but had worn a vulcanite denture for 30 years. The lesion was described as white, rough, multi-centric and measured 1.0 x 2.5 cm in total surface area. The clinical impression was hyperkeratosis. The lesions were known to have been removed on one previous occasion about one year ago, and we had the opportunity to examine the material and the microscopic features are approximately the same. The recurrence was similar to the primary. (Clinical photos of this case are included)

CASE #5. (UMKC 74-13) (Contributed by Charles Dunlap, D.D.S., and Bruce Barker, D.D.S., Department of Oral Pathology, University of Missouri, School of Dentistry, Kansas City, Missouri)

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This 58 year-old female was referred to UMKC School of Dentistry for evaluation of a "sore mouth". The patient stated that her mouth had been sore for eight or nine years. Clinical examination revealed redness, but no appreciable enlargement of the marginal gingiva throughout most of her mouth. Additionally, she had several ulcers of the posterior hard and soft palate. Ulcers ranged in size from 1.0 to 1.5 cm. The patient took vitamins A and B and D plus ascorbic acid. She also took Trivall for tension and one quarter grain thyroid extract three times a day for the last two months. She also was taking an "appetite killer" but did not know the name of it. She had been a borderline diabetic for eight years, but was taking no medication for it. She had a hysterectomy performed in 1962. A gingival biopsy was taken. (Dr. Dunlap apologizes for the small biopsy specimen on the representative slides but, that was the best he could get) (Clinical photos are included for this case)

CASE #6. (S74-389) (Contributed by Dr. Earl Kerr and Dr. Paul Boyle, University of Missouri Medical Center, Columbia, Missouri)

This 74 year-old, white male who became aware of a slowly enlarging mass in the right neck first noted 6 months prior to the initial examination. He reported no pain, fever, weight loss or anorexia. On physical examination, the patient was described as having a lymph node 1 cm x 1 cm in diameter located in the right posterior triangle near the mandibular angle. The node was described as firm, nontender and matted. There was no 7th nerve involvement evident on the physical examination. Three weeks post initial examination the node was described 3 cm in diameter, movable, firm and rubbery and located over the right mandibular angle. In addition to the right neck mass the patient had a diagnosis of parapsoriasis, squamous cell carcinoma of the tragus of the left ear, basal cell epithelioma of the left nasolabial fold, inclusion cyst right nose, inclusion cyst over sternum, and thrombocytopenia. Your histopathologic section represents tissue obtained from the specimen of a right superficial parotidectomy.

CASE #7. (S74-2744) (Contributed by Dr. Thomas McMurry and Dr. Earl Kerr, University of Columbia, Medical Center, Columbia, Missouri)

This 21 year-old white female had a right upper molar extracted two year ago. The patient subsequently developed a mass in the right maxillo-alveolar area. A biopsy at that time showed nonspecific inflammatory changes. On recent admission to the VA Hospital, physical examination revealed a slight swelling on the right side of the face over the maxillary area which was slightly tender to palpation and measured 6 x 8 x 1 cm. The mass extended into the right buccal sulcus. The physical examination wasotherwise within normal limits. Laboratory data were within normal limits with the exception of a slightly elevated serum alkaline phosphatase. X-rays showed a lesion in the area of the right maxillary sinus and alveolar ridge with destruction of the lateral and inferior maxillary sinus walls as well as destruction of the right alveolar ridge and erosion of the coronoid process of the right mandible. Also erosion of the angle and body of the right mandible. A biopsy was performed and the histologic diagnosis was stated as fibro-epithelial tissue, granulation tissue, fibrosis and chronic inflammation. The lesion was excised 5 weeks after the previous biopsy. (your slide represents a section from the excised lesion)

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CASE #8. (#74-1465) (Contributed by Harold H. McCartney, M.D.,Department of Surgical Pathology, St. Louis University Hospital, St. Louis, Missouri)

This is a mandibular lesion from a 73 year-old male of unknown duration. The x-rays showed a lytic lesion present in the mandible.

CASE #9. (AM73-1821) (Contributed by Albert M. Abrams, D.D.S., M.S., Professor and Chairman, Department of Pathology, University of Southern California School of Dentistry, Los Angeles, California)

The lesion manifested as a well demarcated radiolucency measuring approximately 2.0 x 1.5 cm inferior to the horizontally impacted mandibular third molar tooth in a 19 year-old female. The mucosa was intact and there was no communication between the lesion and the oral cavity. The surgeon stated that the tooth was in intimate association with the lesion which grossly seemed to be somewhat cystic.

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CASE #1. ALVEOLAR SOFT PART SARCOMA

(Contributed by Mario A. Luna, M.D., M.D. Anderson Hospital and Tumor Institute, Department of Pathology, Houston, Texas)

Two years after the operation, the patient developed several small nodules in the lungs. There was evidence of extensive destruction of the base of the skull. He was placed on chemotherapy with no response and the patient died on February 19, 1972. Post mortem examination revealed a large destructive lesion in the base of the skull with invasion of the brain. There were multiple metastatic nodules in the lung fields.

BIBLIOGRAPHY

1. Lieberman, Philip, et al: Alveolar soft part sarcoma JAMA 198: 1047-1051, 1966.

2. DUTT, A.K., et al: Alveolar soft part sarcoma with invasion of bone. The Journal of Bone and Joints Surgery 51A: 765, 1969.

Alveolar soft part sarcoma was the most popular diagnosis. Dr. Corio and Dr. Tarpley from National Institutes of Health, Bethesda, Maryland, called it a malignant neoplasm. Dr. Shafer, Indiana University, Indiana, called it atypical fibroxanthosarcoma. Dr. Barker from the University of Missouri, Dental School, Kansas City stated, "This is a malignant tumor and cannot rule-out chordoma."

CASE #2. UNDIFFERENTIATED SMALL CELL SARCOMA

(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 differential diagnosis appears to be between embryonal rhabdomyosarcoma and malignant hemangio-endothelioma," consultation was obtained by Dr. Rowe: "All consultants were in agreement with the diagnosis of sarcoma; opinions were divided, but favored embryonal rhabdomyosarcoma over hemangio-endothelioma, malignant." Dr. Barker from the University of Missouri, Kansas City, Dr. Thoma, University of Texas, Houston, Residents of Fermin Desloge Hospital, St. Louis, Dr. Berthrong, Colorado Springs, Colorado, Dr. Abrams, University of Southern California, Los Angeles, and Dr. Spjut from St. Luk's Episcopal Hospital, Texas, also agreed with this diagnosis of embryonal rhabdomyosarcoma. Dr. Wesley, Detroit and Dr. King from Southern Illinois University, called it lymphangiosarcoma.

CASE #3. NON-CASEATING GRANULOMA, SUGGESTIVE OF SARCOIDOSIS

(Contributed by Mario G. Martinez, Jr., D.M.D., M.S., Division of Oral Pathology, University of Alabama in Birmingham, Alabama)

This was the most popular diagnosis. Dr. King, Southern Illinois University, and Dr. Shafer, Indiana University, considered cheilitis granulomatosa. Dr. Corio and Dr. Tarpley, National Institute of Health, Bethesda, Maryland, Dr. LeGal, Strausbourg, France, as well as Dr. Waterhouse

considered a possiblility of a plexiform neurofibroma.

CASE #4. PSEUDOCARCINOMATOUS HYPERPLASIA WITH INTRA-EPITHELIAL VESCICLE FORMATION

(Contributed by Dr. Dunlap, D.D.S., Deaprtment of Oral Pathology, University of Missouri Dental School, Kansas City, and Dr. Richard F. Grahm, D.D.S.,Columbia, Missouri)

There were a diversity of opinions ranging from pemphigus, verrucous leukoplakia with contact stomatitis superimposed, carcinoma in situ, verrucous carcinoma, Darier's disease to adenosquamous carcinoma. Comments by Dr. Abrams, U.S.C., "I cannot seem to fit this one into a slot. After considering various forms of pemphigus, dyplasia, warty dyskeratoma and Darier's disease, I settled on Darier's disease but I am not happy about it." Dr. Thoma from the University of Texas at Houston stated, "I have difficulty in interpreting this lesion, mostly it looks like verrucous leukoplakia with contact stomatitis superimposed."

CASE #5. BENIGN MUCOUS MEMBRANE PEMPHIGOID

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

This was also the diagnosis of Pathology Residents from Fermin Desloge Hospital, St. Louis, Missouri, Dr. Waterhouse, University of Illinois, Dr. King, Southern Illinois University, and Dr. Abrams from U.S.C., Los Angeles. Dr. Martinez and Dr. Archard from Birmingham, Alabama, Dr.'s Fay, Sing and Sharbough, Fort Gordon, Georgia, Dr. Berthrong, Colorado Springs, Colorado, and Dr. Hori from Moberly, Missouri, called it "drug indused gingivitis."

CASE #6. BASAL CELL ADENOMA

(Contributed by Dr. Earl Kerr, Dr. Paul Boyle, both from the University of Missouri Medical Center, Columbia, Missouri)

This was the overwhelming diagnosis.

CASE #7. FIBROMATOSIS

(Contributed by Dr. Thomas McMurry and Dr. Earl Kerr, University of Missouri Medical Center, Columbia, Missouri)

This was the most popular diagnosis submitted by the consultants which in some cases qualify it as "aggresive" and "juvenile". In addition to this diagnosis Dr. Berthrong from Colorado Springs, Colorado, considered fibrosarcoma. Lowgrade leiomyosarcoma was the diagnosis from Dr.'s Archard and Martinez. Dr. Thoma from the University of Texas commented, "I Think this is a fibrosing vascular lesion of some sort. Would like a reticulum stain to rule in or out hemangiopericytoma." The later diagnosis was considered by Dr. Abrams which was also favored by Dr.'s Corio and Tarpley.

CASE #8. (?) !!!

(Contributed by Harold H. McCartney, M.D., Department of Surgical

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Pathology, St. Louis University Hospital, St. Louis, Missouri) All of the consultants considered the lesion to be malignant. 75% considered a tumor arising from the area and a sarcoma. There was a great deal of dicrepancy about the histiogenisis being from muscle, nerves or were unable to determine. The metastatic faction considered it as from the bladder, lung, or liver.

CASE #9. ACINIC CELL ADENOCARCINOMA

(Contributed by Albert M. Abrams, D.D.S., M.S., Professor and Chairman, Department of Pathology, University of Southern California School of Dentistry, Los Angeles, California)

This was also the diagnosis submitted by Dr. Berthrong, Colorado Springs Colorado, Dr. Martinez and Dr. Archard, Birmingham, Alabama, Dr. Dunlap and Dr. Barker, University of Missouri, Kansas City, Dr. Wesley from Detroit, called it central mucoepidermoid carcinoma of the mandible. Dr. Spjut call it mucoepidermoid carcinoma also along with Dr. Hori, Moberly, Missouri. Another diagnosis included, "mucinous metaplasia in wall of dentigerous cyst," and "Pindborg tumor;" "adenocarcinoma" arising from an aberrant salivary gland was also considered.