

- CASE #1. (75-2353) (Contributed by Carlos Perez-Mesa, M.D., Chief Pathologist, Ellis Fischel State Cancer Hospital, Columbia, Missouri)

This 72 year old female presented with a 2.5 cm mass of four months duration located in the oral cavity at the junction of the hard and soft palate.

The mass was well circumscribed and clinically was felt to be cystic. There was no lymphadenopathy and all lab studies were within normal limits. An excisional biopsy was performed.

- CASE #2. (S-1990-75) (Contributed by Joseph T. Fay, DC, Oral Pathology, Eisenhower Medical Center, Hospital Dental Clinic, Fort Gordon, Georgia, Augusta, Georgia)

1 cm freely movable mass located beneath the labial mucosa in the upper lip (left side) of a 51 year old black female.

- CASE #3. (S-2340-75) (Contributed by Joseph T. Fay, DC, Oral Pathology, Eisenhower Medical Center, Hospital Dental Clinic, Fort Gordon, Georgia, Augusta, Georgia)

This 22 year old black male presented with a 2 cm diameter growth lingual to the maxillary left first molar tooth and extended to the midline of the palate. It has been present for two months and aspiration of the lesion was "non-productive." The clinical impression was "granulation tissue." Following enucleation the bone was noted to be eroded.

- CASE #4. (S75-6476) (Contributed by Mike Harrington, M.D., Department of Pathology, University of Missouri Medical Center, Columbia, Missouri)

55 year old white male who two months PTA, noticed a mass in the right side of his neck which became progressively larger. On admission the lab work-ups were within normal limits. On second admission, chest x-ray revealed three discrete densities of the right upper lobe.

Gross description: A 15 cm x 6 cm x 5 cm reddish, gray soft mass appearing to be encapsulated. Labelled as right submandibular gland.

- CASE #5. (K.C. 75-3384) (Contributed by Charles Dunlap, D.D.S., Oral Pathology, University School of Dental Medicine, Kansas City, Missouri)

This is an elderly male with past history of irradiated squamous cancer of the right maxillary alveolus. Recently a recurrence?? in the lingual

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sulcus extending into left hypopharynx and pyriform sinus. Now has a tumor mass in posterior mouth (exact location unknown). Your slide is of the most recent tumor.

CASE #6. (P-177-75) (Contributed by Ordie King, D.D.S., Department of Pathology, School of Dental Medicine, Southern Illinois University, Edwardsville, Illinois)

The patient, a 33 year old black male graduate student, was referred for extensive ulcerations and granulation tissue in the maxillary right, mandibular right, and mandibular left posterior areas. A private practitioner had applied chromic acid to these lesions on multiple occasions, without success. The patient had previously been evaluated by a gastroenterologist in Jackson, Mississippi in 1972 and treated since that time for regional enteritis. He had been hospitalized and treated for a posterior anal ulcer in 1972 (diagnosis: "histiocytoma.") He had an appendectomy performed in Greenwood, Mississippi in the Fall of 1972, repair of an anal fistula in 1973, and a cholecystectomy in May 1974 with readmission for lysis of adhesions in July 1974. The patient stated that he had a spontaneous pneumothorax in 1973 and again in 1974.

The patient's main continual complaint since 1972 was recurring episodes of severe, right upper quadrant, abdominal cramping pains which he described as "abdominal crises". The patient stated that these usually required a visit to the emergency room and injections of morphine to relieve the pain.

C.B.C. on first visit: R.B.C. - 4,590,000/cu. mm.  
Hgb. - 12.6 Gm/100 ml.  
Hct. - 40.1%  
W.B.C. 7,800/cu. mm.

Differential White Cell Count was within normal limits.

A biopsy was taken from the mandibular right buccal gingiva in the first molar area. (Kodachromes included)

CASE #7. (S-569-75) (Contributed by James J. Sciubba, D.M.D., Ph.D., Department of Dentistry, Long Island Jewish-Hillside Medical Center, New Hyde Park, New York)

A 59 year old male was referred to Long Island Jewish Hospital for evaluation for an expansile fungating mass of the left posterior maxilla. A mobile molar tooth was extracted 12 months ago. A slight degree of proptosis was evident as well as a mild degree of suborbital fullness which had obliterated facial contours in the area. The lesion was noted 3 to 4 months ago and has been increasing in size since then. Appropriate radiographs revealed clouding of the ipsilateral maxillary sinus, orbit and frontal sinus. Tonograms of the maxillary sinus demonstrated that the neoplasm had perforated the orbital floor and had extended into the orbit. An incisional biopsy was performed for routine histologic and electron microscopy studies. (roentgenograms included)

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CASE #1. WELL DIFFERENTIATED LYMPHOCYTIC LYMPHOMA

(Contributed by Carlos Perez-Mesa, M.D., Ellis Fischel  
State Cancer Hospital, Columbia, Missouri)

The majority of the observers agreed with this diagnosis although some variation existed concerning the differentiation or the type of the tumor cells. Dr. Berthrong from Colorado Springs called it, "Nodular and a mixture between large and small cleaved cells otherwise known as a poorly differentiated lymphocytic malignant lymphoma, nodular type." Dr. Waterhouse from the University of Illinois stated, "Lymphoma. The pattern of infiltration of muscle suggests malignant lymphoma despite the negative findings in this patient." Dr. Batsakis from the University of Michigan called it, "Lymphocytic lymphoma, moderately differentiated." Dr. Rowe from Michigan also called it, "Suggest histiocytic lymphoma." Dr. Luna from M.D. Anderson stated, "Atypical lymphocytic infiltration, most likely benign, but the muscle infiltration is worrisome."

FOLLOW-UP:

A physical examination of the patient disclosed no other evidence of tumor involvement. Because the lesion was not adequately excised, postoperative radiotherapy was given, and up to the present time no further evidence of the disease has been recognized in the patient.

CASE #2. MONOMORPHIC ADENOMA

(Contributed by Joseph T. Fay, DC, Eisenhower Medical  
Center, Fort Gordon, Georgia)

This was the diagnosis of numerous observers however, the majority preferred the term pleomorphic adenoma. Dr. Batsakis from Michigan, Doctors McCartney and Eichel from Fort Ord, California, Dr. Desai and the Residents from Surgical Pathology of St. Louis University called it basal cell adenoma. Dr. Sciubba and Dr. Ackerman from Stony Brook called it a pleomorphic adenoma.

CASE #3. PLEOMORPHIC ADENOMA

(Contributed by Joseph T. Fay, DC, Eisenhower Medical  
Center, Fort Gordon, Georgia)

There was an almost general unanimity of the diagnosis of pleomorphic adenoma. Dr. LeGal from Strasbourg, France preferred a benign mixed salivary gland tumor.

CASE #4. MALIGNANT MELANOMA METASTATIC TO THE RIGHT PAROTID GLAND

(Contributed by Mike Harrington, M.D., University of  
Missouri Medical Center, Columbia, Missouri)

An extreme diversity of diagnostic opinions were offered which

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included liposarcoma, leiomyosarcoma, malignant hemangiopericytoma, alveolar soft part sarcoma, spindle cell carcinoma, fibrosarcoma, malignant schwannoma, metastatic tumor from the kidney or thyroid vascular leiomyosarcoma, etc., etc., etc.

FOLLOW-UP:

Electron microscopic studies were not contributory, but supportive of the initial diagnosis of anaplastic carcinoma. Approximately two months after the surgery on the parotid, the patient developed numerous pigmented cutaneous lesions in the neck and the chest wall and subsequently symptoms of intestinal obstruction produced by metastatic tumor also occurred. In the microscopic studies of the material obtained from these sites, the melanotic nature of the lesions were clearly demonstrated. In the sections distributed in the Seminar a few slides showed a scanty amount of melanin present in the tumor cells; this melanin pigment was recognized by several observers which included Dr. Pullon from Washington University, Dr. King from Southern Illinois University and Doctors Dunlap and Barker from University of Missouri-Kansas City.

CASE #5.

SPINDLE CELL SQUAMOUS CARCINOMA

(Contributed by Charles Dunlap, D.D.S., University of Missouri School of Dental Medicine, Kansas City, Missouri)

There was a great diversity of opinions. Dr. Hori from Moberly, Missouri stated, "Possible osteosarcoma? pseudosarcoma, spindle cell squamous carcinoma." Dr. Rowe and Dr. Kerr from Michigan suggested, "Osteosarcoma, radiation induced and radiation induced spindle cell sarcoma." The entire Department of Pathology at the Eisenhower Medical Center unanimously called it post radiation osteogenic sarcoma. Dr. Kolas from the Medical College of Georgia School of Dentistry called it also post radiation osteogenic sarcoma. Dr. Luna from M.D. Anderson stated, "Pleomorphic carcinoma with sarcoma-like stroma. However, I find it extremely difficult to exclude a post radiation osteosarcoma." The latter was the diagnosis of Morgan Berthrong from Colorado Springs. Dr. Abrams from University of Southern California at Los Angeles called it osteosarcoma which was also the diagnosis of Dr. Wesley from the University of Detroit. Dr. Batsakis from the University of Michigan called it pleomorphic squamous cell carcinoma (focal pseudosarcomatous squamous cell carcinoma). Dr. Ackerman made the following comment, "Post irradiation osteosarcoma. We need the history of the radiotherapy to this region in terms of amount of radiation and when in time the dosage was administered. Examination of the primary lesion might be helpful." Doctors Tarpley, Corio, and Crawford from the National Naval Dental Center in Bethesda stated, "Radiation induced sarcoma (one vote for a spindle cell carcinoma with osteoid and bone formation)."

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CASE #6. HISTIOCYTOSIS X

(Contributed by Ordie King, D.D.S., Southern Illinois University, Edwardsville, Illinois)

This was the prevalent diagnosis. Dr. Waterhouse from the University of Illinois stated, "Mucosa and granulation tissue from lesions consistent with histiocytosis." This was also the diagnosis of Dr. Wesley from the University of Detroit. Dr. Sciubba and Dr. Ackerman from Stony Brook stated, "Non-specific, possibly related to Crohn's disease."

CASE #7. BASAL CELL AMELOBLASTOMA

(Contributed by James J. Sciubba, D.M.D., Ph.D., Long Island Jewish Hillside Medical Center, New Hyde Park, New York)

The diagnosis of basal cell carcinoma was made by many. The Residents from St. Louis University called it adenocarcinoma of the salivary gland with basal cell pattern. Dr. Batsakis from University of Michigan and Dr. LeGal from Strasbourg, France called it squamous cell carcinoma probably arising in the sinus. This was also the diagnosis of Dr. Zaloudek from the Eisenhower Medical Center in Georgia. Comments by Dr. Sciubba are as follows: "The clinical data concerning ethmoid and orbital floor involvement had us considering this to be a true malignancy. To rule out a pseudoadamantine type of adenocarcinoma, electron microscopy studies were performed which indicated the tumor cells to be of odontogenic origin. At surgery sphenoid and ethmoid sinus curettage produced tissue of the same histologic type. The surgeon feels that residual tumor exists in the above-mentioned sinuses. Certainly this is a most aggressive odontogenic tumor."

To all of the Seminar participants,

For circumstances out of my control, the next Seminar which was going to take place the 26th of March will be temporarily postponed. Certainly you will be notified of the next meeting.

Sincerely,

*CARLOS PEREZ-MESA, M. D.*  
Carlos