

ELLIS FISCHER STATE CANCER HOSPITAL

AND

CANCER RESEARCH CENTER

ORAL PATHOLOGY SEMINAR #55

O.P.S. 76-2330

December 10, 1976

CASE #1. (SC76-2566) (Contributed by Albert M. Abrams, D.D.S., M.S., Professor of Pathology, University of Southern California School of Dentistry, Los Angeles, California)

The patient is a 79 year-old woman with a moderately firm mass in the left buccal mucosa. There was gradual increase in size during the past seven months. At the time of biopsy the lesion appeared to be largely cystic with abundant mucinous material.

CASE #2. (68-179) (Contributed by Carlos Perez-Mesa, M.D., Pathologist, Ellis Fischel State Cancer Hospital, Columbia, Mo.)

This is a 63 year-old Caucasian male who developed a mass in the left gingiva. Roentgenograms of the area showed an osteolytic defect in the base of the lesion.

(roentgenograms are included along with a clinical photograph)

CASE #3. (72-1135) (Contributed by Carlos Perez-Mesa, M.D., Pathologist, Ellis Fischel State Cancer Hospital, Columbia, Mo.)

This is a 91 year-old Caucasian female who developed breathing difficulties from her left nostril and a mass in the left neck. This manifestation occurred approximately 3 weeks before admission. The clinical impression was carcinoma of the maxillary antrum or nasal cavity with metastasis to the neck. The positive findings on physical examination consisted of the presence of a mass as observed on indirect laryngoscopy. It was protruding from the posterior aspect of the nasal cavity extending down to the left pharyngeal wall behind the posterior tonsillar pillar to approximately the top of the mandible. Located in the posterior aspect of the left angle of the mandible, is a 15 x 5 cm hard mass extending from the left mastoid down to the sternocleidomastoid to just above the supraclavicular fossa. There was also a lymph node measuring 1 cm in dimension anterior to the larger mass. The laboratory studies were noncontributory. Roentgenograms of the maxillary antrum shows a total opacification without continuity of the bony margins of the inferior lateral margin of the left maxillary antrum. The medial wall inferiorly also appears to be destroyed. There is a soft tissue mass in the left nare apparently invading the nasal septum causing a displacement of the midline structures of the nose to the right. The right maxillary sinus is also opacified, but no definite bone destruction was observed at this level.

A biopsy of the retromandibular mass was done.

(roentgenograms are included)

CASE #4. (UMKC76-446) (Contributed by Chaires Dunlap, D.D.S., University of Missouri at Kansas City School of Dentistry, Kansas City)

This is a 57 year-old female with a large tumor of the palate of 5 years duration. Slow growth, no symptoms.

(clinical photo included)

CASE #5. (UMKC76-608) (Contributed by Chaires Dunlap, D.D.S., University of Missouri at Kansas City School of Dentistry, Kansas City)

This is a 55 year-old Caucasian male with a painful swelling of the mandible for 48 hours. Your slide is from a biopsy of this lesion.

(X-ray included)

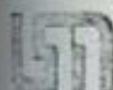
CASE #6. (S76-158) (Contributed by Ordie H. King, Jr., D.D.S., Ph.D., Professor, Pathology and Laboratory Director, School of Dental Medicine, Southern Illinois University, Edwardsville, Illinois)

The patient, a 61 year-old Caucasian female nurse's aid, is a clinic patient and the lesion submitted was asymptomatic and was detected on routine dental radiographs (radiographs submitted). The lesion was stated to be "the size of a quarter" located in the mandibular right third molar region. Clinical impression was "residual cyst from previous extraction." Past medical history revealed only a unilateral oophorectomy performed approximately 20 years ago for "endometriosis". Admission blood chemistries, CBC, sed rate, and serology were within normal limits.



Merry Christmas





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TWIN CITIES

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December 6, 1976

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

Dear Carlos:

These are my diagnoses for the 55th Oral Pathology Seminar:

1. Low grade mucoepidermoid carcinoma. The mucinous elements predominate, but I found a few squamoid foci in the tumor.
2. Sarcoma, probably liposarcoma. I am almost tempted to regard this tumor as the malignant variant of odontogenic myxoma.
3. Malignant tumor, unclassified. I considered the possibilities of esthesioneuroblastoma, undifferentiated carcinoma and sarcoma. I do not think it is a lymphoma.
4. Pleomorphic adenoma (benign mixed tumor). I did not see evidence of malignancy in my section.
5. Radicular cyst with degenerative granular changes in the epithelial cells. The obvious differential diagnosis is that of granular cell ameloblastoma, but I cannot make this diagnosis with the present material.
6. I think this tumor is primary, of odontogenic origin and probably benign, but I cannot give it a specific name. Maybe it is related to the "squamous odontogenic tumor" described by Pullon et al. in Oral Pathology, 40:616, 1975.

Merry Christmas! Un abrazo,

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

"OFFICIAL DIAGNOSIS"

ORAL PATHOLOGY SEMINAR #55 26

December 10, 1976

O.P.S.76-2330

CASE #1. MUCIN PRODUCING PAPILLARY CYSTIC ADENOCARCINOMA
(apparently originating from minor salivary gland)

(Contributed by Albert M. Abrams, D.D.S., M.S., Southern California School of Dentistry, Los Angeles, California)

This was also the diagnosis of Dr. Herb Taylor from St. Louis, Dr. Batsakis from Michigan, Doctors Corio, Crawford and Tarpley from Bethesda, Dr. Shafer from Indiana, and Dr. LaGal from France, Doctors Whitten and King from S.I.U., Dr. Hori from Moberly, Missouri, and Dr. Barker and Dr. Dunlap from Kansas City, Missouri. Doctors Ackerman and Sciubba from Stony Brook, Dr. Clowry from Milwaukee and Dr. Rosai from Minnesota called this a "low grade mucoepidermoid tumor." Dr. Wesley from Detroit and Dr. Cyle from Columbia, Missouri called it, "metastatic adenocarcinoma." Dr. Berthrong from Colorado Springs stated, "I do not believe that this is a carcinoma in spite of the atypical cells and the glands lying in the scar tissue. I think it is all reaction to the rupture of this cyst and suspect that rather than a simple mucocoele, it may have been a cystadenoma of the mucous glands."

CASE #2. METASTATIC RABDOMYOSARCOMA

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

This patient had rhabdomyosarcoma of the left thigh for which he eventually underwent a hemipelvectomy. This was done the year prior to the appearance of a lesion of the left gingiva. It was unfortunate that not all of the material was most representative of this lesion. This generated a variety of diagnosis ranging from "slide showing atrophic muscle, proliferative myositis, degenerating neurofibroma, histologically benign neural neoplasm, clinically and radiographically malignant." The patient died 8 months after metastatic tumor appeared in the gingiva. There was widespread tumor dissemination.

CASE #3. UNCLASSIFIED MALIGNANT TUMOR

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

A great variety of diagnoses were offered. Dr. Rosai from Minnesota called it "malignant tumor, unclassified." Other possibilities considered were esthesioneuroblastoma, undifferentiated carcinoma, and sarcoma. Dr.'s Corio, Crawford and Tarpley from Bethesda, Dr. Hori from Moberly, Dr. Sciubba from Stony Brook, Dr. Barker from Kansas City, and Dr. King and Dr. Whitten from S.I.U. considered the possibility of a malignant lymphoma. Dr. Batsakis commented "I would disagree with those who will probably call this an esthesioneuroblastoma. Wrong location, very old patient. Small cell malignant neoplasm, favor metastatic melanoma." Dr. Ackerman from Stony Brook favored metastatic melanoma. Herb Taylor from St. Louis, Dr. Abrams from U.S.C., and

Dr. Shafer from Indiana called this esthesioneuroblastoma. A plasma cell tumor was suggested by Dr. Clowry from Milwaukee and Dr. Coyle from Missouri.

The patient was treated with radiotherapy and she died shortly afterwards by unrelated causes.

CASE #4. PLEOMORPHIC ADENOMA WITH MELANIN PIGMENTATION (MYOEPIITHELIOMA)

(Contributed by Charles Dunlap, D.D.S., Univ. of Missouri at Kansas City, Missouri)

All of the experts called this a pleomorphic adenoma or mixed tumor. This was the initial diagnosis made by Dr. Barker and Dr. Dunlap, the contributors. However, after reading the article by Dr. Sciubba which was in Oral Pathology, Oral Medicine and Oral Surgery; Vol. 42, Sept. 1976, titled Myoepithelioma; page 328, they changed their diagnosis to myoepithelioma. Dr. Sciubba called it a pleomorphic adenoma (mixed tumor). Dr. Abrams from Southern California called it "mixed tumor with melanin pigmentation."

CASE #5. GRANULAR CELL AMELOBLASTOMA

(Contributed by Charles Dunlap, D.D.S., Univ. of Missouri at Kansas City, Missouri)

This was the diagnosis of Doctors King, Hori, Barker, Batsakis, Tarpley, Corio, and Crawford. Dr. Berthrong from Colorado Springs called it "a dentigerous cyst with residual islands of odontogenic epithelium rather than a cystic ameloblastoma or rather than ameloblastoma arising in a dentigerous cyst. The granular cells do not help me for, while ameloblastomas commonly have such granular cells, I suspect they could form in the follicular epithelium which makes the dentigerous cyst." Dr. Ackerman from Stony Brook and Dr. Taylor from St. Louis called it an odontogenic cyst. Dr. Shafer said, "This is an ameloblastomatous transformation with granular cells in an odontogenic cyst, possibly an odontogenic keratocyst." Dr. Whitten from Southern Illinois University commented "keratocyst with (primordial) ameloblastic transformation." Dr. Abrams called it ameloblastoma apparently arising from follicular cyst.

CASE #6. CLEAR CELL CALCIFYING ODONTOGENIC TUMOR VIEWED RELATIVE TO THE PINDBORG TUMOR

(Contributed by Ordie H. King, D.D.S., Ph.D., Southern Illinois University School of Dentistry, Edwardsville, Ill.)

Dr. Tarpley from Bethesda called this an "oddball odontogenic neoplasm with areas of ameloblastic proliferation consistent with ameloblastoma." Dr. Batsakis called it an ameloblastoma with sebaceous elements. Dr. Shafer from Indiana said; "I've never seen anything like this. It appears to be some type of cystic odontogenic hamartoma although there were a couple of islands that worried me because they seem to be opening up and maybe on the way to a beginning ameloblastoma." Dr. LeGal called it an odontogenic cyst. In the Triple O Journal, December, 1976 there is a paper by Greer, Jr., et al entitled Clear Cell Calcifying Odontogenic Tumor Viewed Relative To The Pindborg Tumor. Dr. King believes this diagnosis is the correct one. He called this case initially as Odontogenic Hamartoma (Serresoma).