ELLIS FISCHEL STATE CANCER HOSPITAL

AND

CANCER RESEARCH CENTER

276

ORAL PATHOLOGY SEMINAR # 57

June 24, 1977

O.P.S. 77-1257

CASE # 1 (S-482-77)

(Contributed by Lawrence J. Clowry, Director, Surgical Pathology, Milwaukee County General Hospital, 8700 West Wisconsin Avenue, Milwaukee, Wisconsin)

This is a 60 year old male, with radiolucent lesion in association with an impacted lower cuspid. Gross examination shows the lesion was firm, solid, tan-brown in color, with a glistening surface. (Microscopic slides, X-rays are enclosed.)

CASE # 2 (SC-77-656)

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

This is a 47 year old male, with a poorly defined, large, destructive radiolucency extending from the region of the mandibular left second molar to the mandibular right first bicuspid area. The radiolucency appeared to extend from the alveolar crest to the inferior border with erosion of the inferior border of the mandible. Lateral jaw radiographs revealed extensive expansion and possible loss of labial and buccal cortical plates. The patient first noted tenderness of the mandibular left cuspid and lateral incisor region, and symptoms gradually spread across the midline to include the right mandible. There was prominent buccal and labial expansion noted on oral examination.

CASE # 3 (S77-13)

(Contributed by Ordie H. King, D.D.S., PhD., Southern Illinois Pathology Laboratory, Alton Illinois)

This is a 50 year old white male with a lesion of unknown duration. The specimen is an incisional biopsy from the left posterior hard palate. The following is taken from the request form: "Lump on left posterior hard palate-No bleeding at biopsy. Specimen sent to rule out salivary gland or other tumors. Patient complains of headaches. Size 1 cm., normal color."

CASE # 4 (S76-2095)

(Contributed by Dr. Paul Boyle, D.D.S., and Dr. Ron Oxenhandler, M.D., University of Missouri Medical Center, Columbia, Missouri)

APRIL 1969- 26 year old Caucasian male noted a small lump on the lateral aspect of the lower right jaw.
DECEMBER 1971- Golf ball size tumor removed from the right mandible at an outside hospital, and was interpreted as fibrous dysplasia.
EARLY 1972- Jaw enlargement recurred.
JANUARY 1976-The patient presented to UMMC with right mandibular enlargement as shown on radiograph. The lesion was never painful and the overlying mucosa was normal in appearance. The rest of the physical examination and laboratory studies were noncontributory. (Microscopic slides and X-rays are enclosed.)

CASE # 5 (76-8182)

(Contributed by Dr. Oxenhandler, M.D., University of Missouri Medical Center, Columbia, Missouri)

This is a 24 year old male caucasian with a lesion in the parotid gland.

CASE # 6 (76-947)

(Contributed by Dr. Charles Dunlap, D.D.S., Department of Oral Pathology, University of Missouri, Kansas City, 650 E. 25th St., Kansas City, Mo.)

A 27 year old male has a 1.0 cm movable deep-seated mass of the lip. Four years earlier, he had an injury to the same area.

CASE # 7 (77-237)

(Contributed by Dr. Charles Dunlap, D.D.S., Department of Oral Pathology, University of Missouri, Kansas City, 650 E. 25th St., Kansas City, Mo.)

This 51 year old white female had leukoplakia of palatal mucosa in 1969. Biopsy showed hyperkeratosis. In March of 1977, she presented with a white, thick and friable lesion covering most of the palate and edentulous alveolar mucosa. X-ray showed destruction of bone in the right maxilla.

"OFFICIAL DIAGNOSIS"

ORAL PATHOLOGY SEMINAR # 57

276

June 24, 1977

O.P.S. 77-1257

CASE # 1

PINDBORG TUMOR

(Contributed by Lawrence J. Clowry, Director, Surgical Pathology, Milwaukee County General Hospital, 8700 West Wisconsin Avenue, Milwaukee, Wisconsin)

This was the diagnosis of Dr. Abrams from USC. Dr. Waldron, from Emory commented "We have seen several like this, ie. without calcification and with relatively scant epithelial cell population. It always bothers me to make a diagnosis of calcifying epithelial odontongenic tumor without any calcifications but I cannot call it anything else." The entire Oral Pathology staff of the Eisenhower Medical Center called it early Pindborg tumor.

CASE # 2

FIBROSARCOMA

(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 one of the most popular diagnosis. Dr. Sciubba and Dr. Ackerman from SUNY at Stony Brook called it fibrosarcoma, possibly arising in an area of pre-exsisting fibrous dysplasia. Dr. Waldron from Emory called it well differentiated fibroblastic osteosarcoma. Neurofibrosarcoma was the diagnostic impression of Dr. Dunlap, from Kansas City, Dr. Wesley, from Detroit, Dr.'s Tarpley, Corio, and Crawford, from Bethesda, Maryland, Dr. Ordie King, SIU. A minority considered this a fibrous dysplasia, fibromatosis, and neurofibroma. Dr. Zaloudek feels a lowgrade osteogenic sarcoma.

CASE # 3

NECROTIZING SIALOMETAPLASIA

(Contributed by Dr. Ordie H. King, D.D.S., Ph D., Southern Illinois Pathology Laboratory, Alton Ill.)

This was the overwhelming diagnosis. A few observers interpreted the lesion as either inflammatory lesion or sebaceous gland adenoma. Another diagnostic impression was as follows: Non-neoplastic: obstructed minor salivary gland with destruction and squamous metaplasia of acinar cells.

CASE # 4 — CEMENTO-OSSIFYING FIBROMA

(Contributed by Dr. Paul Boyle, D.D.S., and Dr. Ron Oxenhandler, M.D., University of Missouri, Medical Center, Columbia, MO)

This was the overwhelming diagnosis. During the discussion, comments were made concerning the final diagnosis, with some form of fibro-dysplasia.

CASE # 5 — TUBERCULOSIS

(Contributed by Dr. Ron Oxenhandler, M.D., University of Missouri Medical Center, Columbia, Mo.)

Dr. LeGal from Strasbourg, called it chronic inflammation consistent with the diagnosis of sarcoidosis. Non-caseating granuloma was the diagnosis of Dr. Sciubba and Dr. Ackerman. Dr. Batsakis from Michigan called it sarcoidosis. Dr. Waldron from Emory commented "consistent with the diagnosis of sarcoidosis, if TB and other specific infections can be ruled out."

Subsequently, cultures obtained from the lymph nodes resulted in the growth acid fast organisms.

CASE # 6 — GRANULAR CELL TUMOR

(Contributed by Dr. Charles Dunlap, D.D.S., Department of Oral Pathology, University of Mo., Kansas City, 650 E. 25th St., Kansas City, Mo.)

This was the unanimous diagnosis.

CASE # 7 — VERRUCOUS CARCINOMA

(Contributed by Charles Dunlap, D.D.S., Department of Oral Pathology, University of Mo., Kansas City, 650 E. 25th St., Kansas City, MO.)

Only one of the numerous consultants interpreted the lesion as low grade squamous cell carcinoma.

The guest speaker for the entire program, participating in all of the diagnosis, was Dr. Al Abrams from Southern California.