

## ORAL PATHOLOGY SEMINAR

## CASE HISTORY

April 7, 1978

O.P.S. 78-430

CASE # 1 (77-2921)

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

This is from a 65 year old female who presented with an asymptomatic soft nonfluctuant swelling of the left palate. She had no lymphadenopathy and her peripheral blood studies were normal. All teeth in the area were vital. The clinicians provisional clinical impression was salivary gland tumor (mucoepidermoid carcinoma).

The patient was treated with radiation for a lymphocytic lymphoma of the palate.

CASE # 2 (SC-77-3952)

(Contributed by Dr. Albert M. Abrams, D.D.S., M.S., Professor of Pathology, University of Southern California, School of Dentistry, 925 West 34th St., Los Angeles, California)

The patient is a 42 year old male who presented because of a rapid enlargement of the lower buccal vestibule opposite the first molar tooth. This was extremely firm but apparently did not extend into the bone. Recent endodontic therapy had been completed in the area but no significant findings were noted on radiographic examination.

CASE # 3 (C3456-AW)

(Contributed by Dr. Nathaniel Rowe, D.D.S., M.S.D, Univ. of Michigan, Dental School, Ann Arbor, Michigan 48104)

The patient is a 13 year old male student, with history of large multilocular appearing lesion of left buccal mucosa near corner of mouth. Appears traumatic in origin.

CASE #4 (H-78-72)

(Contributed by Dr. Bruce Barker, and Dr. Charles Dunlap, D.D.S., Dept. of Oral Pathology, Univ. of Mo., Kansas City, School of Dentistry, 650 E. 25th St., Kansas City, Mo.)

This 17 year old boy was seen in 1966 for a 3-4 cm sharply circumscribed unilocular lesion in the body of the mandible centered about the bicuspid region. The lesion was curetted and the tissue diagnosis was a cyst. In 1972 he was seen with a lesion occupying the area of previous surgery. The lesion was multilocular, consisting of three compartments. They were purely radiolucent. The jaw was expanded and the overlying gingiva appeared slightly blue. The lesion was aspirated and 20 cc's of whole blood were taken from the lesion. Over the next several months, repeated aspirations produced 10-20 cc's of blood. X-ray showed the lesion appeared to be filling in. He was lost to follow-up before it completely healed.

In 1978, he was seen in Jefferson City where the lesion was curetted. Your slides were made from the 1978 lesion.

CASE # 5 (78-113)

(Contributed by Dr. Bruce Barker, and Dr. Charles Dunlap, D.D.S., Dept. of Oral Pathology, Univ. of Mo., Kansas City, School of Dentistry, 650 E. 25th St., Kansas City, Mo.)

This is a 35 year old black male who was seen with a 1 cm submucosal nodule in the height of the buccal vestibule in the vicinity of the upper left second bicuspid tooth. It was asymptomatic and the duration was said to have been about one year. The patient stated that the lesion would shrink when he took antibiotics, but then would enlarge when he discontinued the antibiotic therapy. A 1 X 1 X 0.8 cm yellow, tan, nodular was removed.

CASE # 6 (77-670)

(Contributed by Dr. Hori, Davis Memorial Hospital, Elkins, West Virginia)

This is a 63 year old caucasian male. This is recurrent nodule in the vermillion border of the lip. The initial lesion appeared in May 1977, and recurrence occurred eight months later.

CASE # 7 (2366-78)

(Contributed by Dr. Yvon LeGal, Institut D'Anatomie, Pathologique, Faculte De Medecine, 1 Place De L' Hopital, Strasbourg (Bas-Rhin) France )

CASE HISTORY IS ATTACHED!

In order to preserve the international and polyglotal composition, of the seminars and to avoid linguistic pollution, no translation attempt was made.

(Hope your French is well!)

RESUME DE L'HISTOIRE CLINIQUE CONCERNANT MONSIEUR PFISTER CHARLES.

né le 26.07.1944

- fin décembre 1977 : présente une hypoesthésie du menton à gauche

- douleur dentaire siégeant au niveau de la 8e inférieure gauche,

extraite fin décembre, quelques jours après l'hypoesthésie.

Les 6e et 7e inférieures gauches ont été extraites depuis très longtemps.

D'après le dentiste, la 8e inférieure gauche est saine.

- 8 jours après : tuméfaction de la gencive.

- A consulté le même dentiste pour des douleurs importantes.

La radio de le remplacement la 8e est normale.

Ce dentiste l'a envoyé chez le Docteur Franck qui pratique une radiographie plus complète ainsi qu'un prélèvement.

Puis le malade a consulté le Docteur MAITRE d'après les conseils du Docteur FRANCK.

- Il a été opéré le 13.2.78.

Voici le compte-rendu opératoire :

Résection d'une tumeur gingivale à croissance rapide, mandibulaire inférieure gauche :

Premier temps opératoire, par voie buccale, pour extemporané :

Résection en passant au large en muqueuse saine de la tumeur, qui nécessite un gros sacrifice de muqueuse. Section du périoste, Rugination. Toute la tumeur, du moins ce qui est mou dans la tumeur est enlevé et envoyé en extemporané, après dissection du nerf lingual qui est conservé. Extemporané difficile nécessitant le déplacement du Docteur LAEDLEIN, qui affirme qu'il ne s'agit pas d'une tumeur maligne mais peut-être d'un améloblastome ou d'un granulome éosinophile. Il nous conseille d'être le plus conservateur possible. On enlève donc le sous bassement osseux à la curette avec examen histologique de l'os. Il s'agit d'os sucre mouillé surtout au centre de l'os à sa partie médullaire, et dans cette médullaire existent des granulomes grisâtres. Tout est enlevé, et on découvre le nerf dentaire au microscope, lequel est hémorragique, tuméfié, oedématisé et conservé entièrement. On décide d'être conservateur et on pratique en:

RESUME DE L'HISTOIRE CLINIQUE CONCERNANT MONSIEUR PFISTER CHARLES.

né le 26.07.1944

Deuxième temps : Incision de Sébileau sous maxillaire. Conservation du rameau mentonnier du facial. On découvre la branche horizontale et l'angle de la mâchoire. On rugine le masséter et on dénude tout le nerf dentaire jusqu'à la première pré-molaire, jusqu'à l'épine de Spix. Autour de nerf dentaire, effectivement, on retrouve les granulomes suspects, notamment à sa face inférieure, mais on peut conserver le rebord basilaire et une petite baguette osseuse de la corticale externe en haut, toute la corticale interne est conservée, la nerf étant dénudé et conservé. L'os est sain, et on peut gratter jusqu'à la corticale est donc conservée. On plombe au Spongel autour du nerf dentaire et on resuture le périoste. Fermeture en trois plans, y compris le peaucier et la peau. A l'intérieur de la bouche, on peut rapprocher les téguments. Mèche iodoformée de 0.5 cm.

Fotografias del especimen y de las radiografias estan induidas.



UNIVERSITY OF MINNESOTA  
TWIN CITIES

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April 3, 1978

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

Dear Carlos:

Here are my impressions on the cases for the Oral Pathology Seminar 78-430.

Case 1. If I had to sign this case myself, I would probably call it "atypical lymphoid infiltrate (see description)." However, I favor a diagnosis of malignancy, either well differentiated lymphocytic lymphoma, or chronic lymphocytic leukemia. Apparently, the latter is out because of the bone marrow and peripheral blood findings.

Case 2. I would diagnose this case as a malignant lymphoma which in Rappaport's Classification would probably be classified as histiocytic. I believe there is a vague nodularity in the lesion, although, by and large, the pattern is that of a diffuse lymphoma. However, this nodularity is enough for me to suggest that this probably represents a lymphoma of germinal centers.

Case 3. This is a salivary gland tumor all right, but I have some difficulties in deciding the specific type. For lack of a better name I guess I will call it a monomorphic adenoma because of the palisading at the edge of some of the tumor nests giving it a basaloid appearance.

Case 4. I guess that this is a dentigerous or follicular cyst, because in looking through the WHO booklet I noticed that they describe mucin containing cells as part of these cysts. However, this is not really my area and I wish you would not quote me on this.

Case 5. This seems like a pretty typical case of pleomorphic adenoma (benign mixed tumor). The interesting feature is the presence of intraluminal crystals which may well correspond to those described by Nochomovitz and Kahn as being composed of tyrosine. It just happens that Dr. Nochomovitz is now a member of our Department. I showed him the slides and he agreed that the crystals look similar to those that he reported in the Archives of Pathology paper.

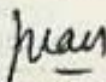
Case 6. This is a pretty classic pyogenic granuloma and I am not quite sure why it is being included in the seminar. I hope that nobody called this angiosarcoma or Kaposi's sarcoma.

April 3, 1978

Case 7. The appearance of this tumor is very peculiar and varies quite a bit from area to area, but I would favor the interpretation that we are looking at different morphologic expressions of osteosarcoma.

I will be visiting St. Louis during the last days of May and I hope I have a chance to see you there.

Best regards,



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

JR/mfb

"OFFICIAL DIAGNOSIS"

ELLIS FISCHER STATE CANCER  
HOSPITAL  
AND  
CANCER RESEARCH CENTER  
ORAL PATHOLOGY SEMINAR  
#60  
O.P.S. 78-430  
APRIL 7, 1978

CASE # 1 (77-2921)

LYMPHOCYTIC LYMPHOMA OF PALATE  
(Contributed by Richard K.  
Wesley, D.D.S., M.S.D., Associate  
Professor, Dept. Pathology,  
University of Detroit, Detroit, MI)

A few considered the lesion as probably benign and various terminology were used including "reactive lymphocytic infiltration, chronic inflammation, possibly Sjogren's type, benign inflammatory reaction, probably post radiation damage, lymphoid lesion of the palate, benign, chronic sialadenitis." Dr. Shafer called it: "diffuse well differentiated lymphocytic lymphoma" (Lymphoproliferative Disease of the Hard Palate), Vol. 39, No. 5, page 754-768, May, 1975. Dr. Waldron from Emory stated: "atypical lymphocytic infiltrate. Our experience, although more limited than the Indiana group and AFIP also indicates most of these lesions turn out to be lymphoma." Dr. Abrams, Southern California Dental School stated: "we would probably call this biopsy an example of the so-called lymphoproliferative disease of the palate. It seems that when follow-up is available most of our cases we have turn out to be malignant lymphoma. Apparently this patient was treated with that possibility in mind." Dr.'s McClatchey and Batsakis from Michigan called it "lymphocytic lymphoma." Dr. Sciubba from Long Island Jewish-Hillside Medical Center called it "lymphoproliferative disease of the palate." Dr. Ackerman from Stony Brook stated: "No diagnosis, rule out lymphoma."

CASE # 2 (SC-77-3952)

MALIGNANT LYMPHOMA  
(Contributed by Dr. Albert Abrams,  
D.D.S., M.S., Professor of Path.,  
Univ. of Southern California,  
School of Dentistry, 925 West  
34th St., Los Angeles, California)

Dr.'s Dunlap and Barker from University of Missouri, Kansas City, called it "poorly differentiated malignant neoplasm, favor histiocytic lymphoma." Dr. Azar from Tampa called it "malignant lymphoma, histiocytic type." Dr. Rosal, University of Minnesota stated: "I will diagnosis this case as a malignant lymphoma which in Rappaport's Classification would probably be classified as histiocytic. I believe there is a vague nodularity in the lesion, although, by and large, the pattern is that of a diffuse lymphoma. However, this nodularity is enough for me to suggest that this probably represents a lymphoma of germinal centers." Dr. Wesley from Detroit called it "lymphoma, histiocytic type." Dr. Tarpley from Bethesda called it: "poorly differentiated malignant

neoplasm, lymphoma, (histiocytic type) versus metastatic tumor for the pharynx (lymphoepithelioma)." Dr. Berthrong from Colorado Springs stated: "this is an undifferentiated malignant neoplasm and I favor an undifferentiated carcinoma through I cannot exclude a malignant lymphoma."

CASE # 3 (C3456-AW)

MONOMORPHIC ADENOMA

(Contributed by Dr. Nat Rowe,  
D.D.S., M.S.D., Univ. of Michigan,  
Dental School, Ann Arbor, Michigan)

Similar diagnosis was made by Dr. LeGal from Strasbourg, Dr. Betsakis and Dr. McClatchey from Michigan, Dr. Hori, West Virginia, Dr. Abrams from Southern California, and Dr. Rosai from Minnesota. Dr.'s Azar from Tampa, Shafer, Indiana, Corio and Tarpley from Bethesda, Sciubba and Ackerman from Long Island called it "mucoepidermoid tumor." Dr. John Meyer from St. Louis stated: "Pleomorphic adenoma of minor salivary gland. The presence of ducts and hyaline stroma in the midst of the squamous proliferation lead me to this diagnosis, but I have never before seen one like it." Dr. Waldron from Emory stated: "This one caused our group all kinds of problems. It is a salivary gland tumor but I find it most difficult to classify. It appears cytologically benign but the multinodularity and apparent infiltration bothers me. I would certainly recommend a wider re-excision. If I was forced to sign this one out on the basis of this one slide I would vote for a cellular mixed tumor with a comment as to its apparent infiltrative pattern." Dr. Abrams stated: "Although this tumor seems to be unencapsulated and multinodular, I would like to call it benign in that metastasis is not expected. It may be related to basal cell adenoma showing marked squamous metaplasia. One might succumb to the temptation and call this a baso-squamous cell adenoma."

CASE # 4 (H-78-72)

BOTRYOID ODONTOGENIC CYST

(Contributed by Dr. Bruce  
Barker, and Dr. Charles Dunlap,  
D.D.S., Dept. of Oral Pathology,  
Univ. of Mo., Kansas City,  
School of Dentistry, 650 E. 25th  
St., Kansas City, Mo.)

Dr. Waldron from Emory stated: "This has the features of the so called botryoid odontogenic cyst. I fell this is a multilocular primordial cyst. We can't make ameloblastoma out of this one. If a fair amount of mucin can be demonstrated, I might want to revise my diagnosis to a variety of central mucoepidermoid tumor with marked cystic features. Dr. Wesley from Detroit, Dr. Fay and associates from Eisenhower Medical Center, Ga, Dr. Sciubba and Ackerman from Long Island called it "cystic mucoepidermoid carcinoma." Dr. Abrams from USC stated: "This is either a hyperplastic follicular cyst with mucous cell prosoplasia or a cystic mucoepidermoid tumor. I prefer the former possibility but I would not become too emotional if someone wanted to consider it as an incipient mucoepidermoid tumor." Dr.'s Betsakis and McClatchey from Michigan stated: "salivary inclusion cyst-doubt odontogenic mucoepidermoid carcinoma." Dr.'s Corio and Tarpley called it "odontogenic (Botryoid) cyst." Dr. Shafer from Indiana stated: "We have seen several cases with this peculiar mixture and have been calling them sialo-odontogenic cyst."



CASE # 5 (78-113)

MIXED TUMOR WITH TYROSINE CRYSTALS  
(Contributed by Dr. Bruce Barker,  
and Dr. Charles Dunlap, D.D.S.,  
Dept. of Oral Pathology, Univ.  
of Mo., Kansas City, School of  
Dentistry, 650 E. 25th St.,  
Kansas City, Mo.)

Mixed tumor or pleomorphic adenoma was the favorite diagnosis by almost everyone. "Pleomorphic adenoma with tyrosine crystals" was the diagnosis of Dr. Sciubba, of Long Island, and Dr.'s Nochomovitz and Rosai from Minnesota. Reference: W.K. Bullock: Mixed Tumor of Parotid Gland with Tyrosine Crystals in the Matrix. American Journal Clinical Pathology, 23:1938-1939, 1953. L.E. Nochomovitz, and L.B. Kahn: Tyrosine Crystals in Pleomorphic Adenomas of the Salivary Gland, Arch Pathol/Vol 97; 141-142, 1974.

CASE # 6 (77-670)

HEMANGIOENDOTHELIOMA  
(Contributed by Dr. Hori, Davis  
Memorial Hospital, Elkins, West  
Virginia)

This was the overwhelming diagnosis, although with some variations. Some preferred to call it pyogenic granuloma. Other diagnosis included "capillary hemangioma, cellular capillary hemangioma, intramuscular hemangioma, glomic tumor." Dr. Hughes from Eisenhower Medical Center called it "benign." Dr. Ackerman from Stony Brook commented: "Hemangioma-this is unusual in this age group."

CASE # 7 (2366-78)

OSTEOSARCOMA  
(Contributed by Dr. Yvon LeGal  
Institut D'Anatomie, Pathologique,  
Faculte De Medecine, 1 Place De  
L' Hopital, Strasbourg (Bas-Rhin)  
France)

Osteosarcoma was the overwhelming diagnosis. Dr. Quigley from Ohio state called it "osteosarcoma." Dr. Rosai from Minnesota commented: "The appearance of this tumor is very peculiar and varies quite a bit from area to area, but I would favor the interpretation that we are looking at different morphologic expressions of osteosarcoma." Dr. Batsakis and McClatchey from Michigan called it "parosteal osteogenic sarcoma." Dr.'s Tarpley and Corio from Bethesda called it "myxochondro sarcoma." A few consultants called it "calcifying odontogenic tumor." Dr. Rowe, from Michigan called it "osteosarcoma."