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ELLIS FISCHEL STATE CANCER HOSPITAL
AND
CANCER RESEARCH CENTER
ORAL PATHOLOGY SEMINAR
D.O.F.-74-5
February 15, 1974

CASE #1 (SM8251) (Contributed by Harold McCartney, M.D., Chief, Surgical Pathology Resident, Firmin-Desloge Hospital, Pathology Department, St. Louis University Medical School.)

A twenty-four year old Caucasian male presented with a swollen, somewhat tender area beneath the right side of the mandible present for one year. Occasionally the patient spat up a small amount of blood. Massage of the submaxillary gland never yielded any material from the submaxillary duct. The mass measured 5 x .5 x 3.5 cm, and on section showed a well circumscribed, 4.5 cm nodule. It was pale, pinkish-tan, surrounded by unremarkable glandular tissue.

CASE #2 (S3262-73) (Contibuted by John Tsai, M.D., Jim Goforth, M.D., Joe Fay, D.D.S., Department of The Army, Fort Leonard Wood Dental Activity, Fort Leonard Wood, Missouri.)

The patient is a W.D.W.N. 18 year old male with no significant past medical history. He was presented with a 1-1.5 cm moderately firm ill-defined right posterior neck mass. The surgeon noted that the lesion was partially embedded in skeletal muscle and he felt most of the growth was removed in the initial surgical procedure.

CASE #3 (OS73-1638) (Contributed by Ordie H. King, Jr., D.D.S., Ph.D., Department of Oral Pathology, West Virginia University Medical Center, Morgantown, West Virginia.)

The patient is a 17 year old Caucasian female who was referred to a local oral surgeon by her family dentist. Radiologically, there was a unilocular, expansile radiolucency which extended from just anterior of the distal root of the mandiblular right second molar tooth to midway up the ascending ramus of the mandible on the same side. Superio-inferiorlly, the lesion extended from the bifurcation of the roots of the second molar tooth to the lower border of the mandible which was expanded and thin. There was a radiolucent lesion involving the apex of the mesial root of the first molar tooth with a tract extending to the larger radiolucency. The lesion was described by the oral surgeon as being 5 x 6 cm in diameter, and the material received was submitted from the "front half of the lesion." The front half of the lesion was described as being filled with soft tissue, and the distal portion of the specimen was described as being an empty cavity without a lining. There was some fluid which was described as being dark red and watery in consistency The patient had experienced some discomfort.

CASE #4 (SP73-5980) (Contributed by Ordie H. King, Jr., D.D.S., Ph.D., Department of Oral Pathology, West Virginia University Medical Center, Morgantown, West Virginia.)

The specimen is a biopsy of a right parotid gland mass in a 66 year old Caucasian female. The patient has a history of several prior surgical procedures for the past six years for excision of this tumor. Previous diagnosis at other hospitals on the prior surgical specimens were oxyphilic adenoma (oncocytoma), and the most recent outside diagnosis was malignant onococytoma. No cervical lymph nodes were noted at the time of the present biopsy.

CASE #5 (SP73-5532) (Contributed by Ordie H. King, Jr., D.D.S., Ph.D., Department of Oral Pathology, West Virginia University Medical Center, Morgantwon, West Virginia.)

The specimen is from a therapeutic curettage of the angle of the right mandible.

The patient is a 26 year old Caucasian female who was first seen at West Virginia University Hospital in September of 1972. At that time, the patient had a right parotectomy and a moderately extensive diagnostic curettage of a radiolucent lesion in the angle of the mandible. (see case No. 4, W.V.U., SP72-4145, Ellis Fischel Oral Pathology Conference, February 1973.) Our diagnosis at that time was chrondroblastoma with the comment that this patient should be followed, clinically, very closely. The patient was lost to follow-up until she returned to the out-patient clinic on November 6, 1973, with complaints of a mass in the right jaw. Radiographs revealed a moderately well defined radiolucent lesion with destruction of the posterior cortex at the angle of the mandible. (Previous diagnosis submitted by participants at the February 1973 Ellis Fischel Conference included rhabdomysarcoma, osteosarcoma, myositis ossificans, plasma cell tumor, and undifferentiated malignant tumor.)

CASE #6 (D1264AT) (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 material comes form a sixty year old female who gives a lengthy history (7-8 months) of Angioedomatous swelling of the upper lip only. It now presents as a firm everted lip. (Slides are missing in some sets from this case and two clinical photos are included.)

CASE #7 (73-756) (Contributed by Charles Dunlap, D.D.S., Department of Oral Pathology, University of Missouri, School of Dentistry, Kansas City, Missouri.)

J.C., a 54 year old male, was seen by a local Kansas City oral surgeon. He complained of a mass in the cheek which started developing following the removal of a tooth six weeks ago. It appeared to the clinician to be a hypertrophic 3.0 x 2.0 cm non-painful lesion with a crater-like area inferior to the bulk of the mass. (We received a rather short history on this case and there is no mention as to whether or not the lesion exteds into bone or has any connection at all with the tooth which was extracted six weeks previously.)

CASE #8 (73-758) (Contributed by Charles Dunlap, D.D.S., Department of Oral Pathology, University of Missouri, School of Dentistry, Kansas City, Missouri.)

This 14 year old boy was seen by local oral surgeon. His parents had stated that some of the teeth were not erupting on time. Clinical examination showed the first and second permanent maxillary molars on the left side to be abnormal radiographically and also unerupted. The first molar had somewhat the appearance of a "ghost" tooth, and a second molar was not easily seen because it ran off the side of the x-ray. The mucosa and bone overlying these unerupted teeth were said to be expanded. The surgeon intended to remove this tissue, hoping that it would provide a pathway through which the teeth would erupt. Representative tissue overlying the crowns of there unerupted teeth was taken and it is from this tissue that your sections were prepared. Additionally, the two teeth were extracted and were submitted, but sections are not yet available because they are being decalcified.

CASE #9 (73-8842) (Contributed by Charles Dunlap, D.D.S., Department of Oral Pathology, University of Missouri, School of Dentistry, Kansas City, Missouri.)

This 52 year old male was seen at the University of Missouri School of Dentistry because of swelling of the region of the left parotid. The swelling was of two weeks duration. The patient compained of numbness of the lower left lip. X-rays of the jaws show a large, oval radiolucent lesion in the left ramus. A needle biopsy was attempted and inadequate tissue was received for diagnosis. The patient became impatient with us and went to a general surgeon who admitted him to the hospital and planned to operate him for a parotid tooth. We had the opportunity to talk

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with the surgeon who at the time was unaware of the underlying jaw lesion. Upon seeing the x-rays of this lesion the general surgeon referred him to the University of Kansas Medical Center where he eventually was biopsied. Your tissue was taken from the jaw lesion shown in the accompanying x-ray.

CASE #10 (5668-B-73) (Contributed by William H. Halliwell, D.V.M., Ph.D., Veterinary Teaching Hospital, Columbia, Missouri.)

Specimen is a portion of the right parotid salivary gland from an 8 year old domestic shorthaired cat.

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CASE #1. MUCOEPIDERMOID CARCINOMA

(Contributed by Harold McCartney, M.D., Chief Pathology Resident, Firmin-Desloge Hospital, St. Louis University Medical School, St. Louis, Missouri)

Mucoepidermoid carcinoma was the most popular diagnosis. Dr. Thoma from Houston, Texas commented, "Low grade mucoepidermoid carcinoma. The capsullary infiltration and slight pleomorphism excluding a benign tumor in my opinion." Dr. Shafer from Indiana stated, "We are in agreement that this case represents a mucoepidermoid carcinoma." Several consultants including Dr. Berthrong from Colorado Springs, Colorado, Dr. Asher and Dr. Tariq Murad from the University of Alabama, Dr. Spjut from Texas Medical Center, Houston and Dr. Waterhouse from Chicago agreed on acinic cell adenocarcinoma, more or less atypical. Other diagnosis included adenocarcinoma and oncocytoma.

CASE #2. FIBROMATOSIS

(Contributed by John Tsai, M.D., Jim Goforth, M.D., Joe Fay, D.D.S., Department of The Army, Fort Leonard Wood Dental Activity, Missouri)

The overwhelming diagnosis was fibromatosis. Similar or related lesions were considered by some, probably refering to the same entity, although using a different nomenclature such as, extra-abdominal desmoid, musculara pineurostic fibromatosis, desmoplastic fibroma, non metatasizing fibrosarcoma and the like.

CASE #3. ODONTOGENIC MIXOFIBROMA WITH AMYLOID DEPOSITS

(Contributed by Ordie King, Jr., D.D.S., Ph.D., Department of Oral Pathology, West Virginia University Medical Center, West Virginia)

Dr. Hori from Moberly, Missouri commented, "Reactive lesion, cholesterol crystal and probable amyloid like deposits." The diagnosis of Dr. Dunlap, Kansas City, was fibromyxomatous connective tissue with cholesterol deposits, suspect cyst (no tumor). Dr. Luna from M.D. Anderson prefered, "solitary unicamerol bone cyst." Dr. Abrams, U.S.C., California diagnosed this case as, "Organizing simple bone cyst (traumatic bone cyst) with cholesterol foreign body reaction. Dr. Le Gal from Strasbourg, France suggested, "Radicular cyst with inflammation and cholesteatoma. Dr. Shafer from Indiana made the following comment, "This is difficult to interpret; it could be some type of odontogenic cyst or possible even a traumatic cyst.

CASE #4. ACINIC CELL TUMOR

(Contributed by Ordie King, Jr., D.D.S., Ph.D., Department of Oral Pathology, West Virginia Medical Center, West Virginia)

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Acinic cell tumor was the overwhelming diagnosis. Dr. Berthrong from Colorado Springs, Colorado stated, "While this tumor has some of the features of the oncocytoma, there are areas where the tumor cells are finely vacuolated in the fashion of the acinic cell adenocarcinoma. I think its clinical behavior is far more characteristic of the acinic cell adenocarcinoma than of the usually described benign course of the oncocytoma. Frankly, the cellular detail in this slide makes it difficult for me to be certain between these two tumors." There was a minority of dissenters which considered mucoepidermoid tumor and trabecular carcinoma.

CASE #5. ATYPICAL BENIGN OSTEOBLASTOMA

(Contributed by Ordie H. King, Jr., D.D.S., Ph.D., Department of Oral Pathology, West Virginia Medical Center, West Virginia)

Dr. King, the contributor, believed that this lesion still represents a benign, although atypical, osteoblastoma. Most of the consultants considered the lesion as an osteosarcoma. Dr. Shafer from Indiana commented, "We still think this is an osteosarcoma, just as we did last time." Other diagnosis included, unclassified malignant tumor: probably reticuloendothelial. Dr. Le Gal, from France, called it "ignotoma."

CASE #6. CHEILITIS GRANULOMATOSA

(Contributed by Nathaniel H. Rowe, D.D.S., M.S.D., Department of Oral Pathology, University of Michigan, School of Dentistry, Ann Arbor, Michigan)

The overwhelming diagnosis was cheilitis granulomatosa. Other diagnosis included, chronic vasculitis, vascular erythema and granulomatous inflammation with tubercle formation. The discussion of this case with pertinent bibliography data is included in appendix #1.

CASE #7. UNDIFFERENTIATED NEOPLASM

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

Other diagnosis included, rhabdomyosarcoma, metastatic carcinoma, malignant lyphoma (histiocytic type), lymphoepithelioma, poorly differentiated liposarcoma, and undifferentiated carcinoma. Dr. Abrams, from U.S.C., Los Angeles, California, called it malignant fibrous histiocytoma.

CASE #8. REGIONAL ODONTODYSPLASIA

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

Regional odontodysplasia was the overwhelming diagnosis: (see accompaning bibliography in appendix #2.)

CASE #9. METASTATIC CARCINOMA FROM THE THYROID

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

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All the other diagnosis were, oncocytic and acinic cell tumor, trabecular adenocarcinoma, and malignant metastatic carcinoma from either the thyroid, prostate, or kidney. Subsequently, a tumor was discovered in the thyroid of this patient: the patterns of the removed tumor showed identical patterns to the one exhibited by this lesion.

CASE #10. ADENOCARCINOMA

(Contributed by William H. Halliwell, D.V.M., Ph.D., Veterinary Teaching Hospital, Columbia, Missouri)

There were several other diagnosis including, mucoepidermoid carcinoma and adenocarcinoma: probable primary, parotid. However, the previlent opinion was "feline" adenocarcinoma.

APPENDIX #1

CHEILITIS GRANULOMATOSA

Cheilits granulomatosa is a macro-cheilia having a sudden onset and progressive course that terminates in chronic enlargement of the lips.

CLINICAL MANIFESTATIONS

Cheilitis granulomatosa apparently may occur in either sex at any age; it begins as a diffuse, soft, nonpitting swelling of the lips, particularly the lower lip. A feeling of fullness or tension may be the first symptom. The enlargement may involve the buccal mucosa near the lip commissures, causing it to press against the teeth when the buccal musculature is at rest. This produces indentations corresponding to the teeth. A prolonged course of gradual enlargement follows, which results in nonreversible macrocheilia. Laymon (1) suggested that when cheilitis granulomatosa is associated with facial paralysis and fissured tongue, the diagnosis of Melkersson-Rosenthal syndrome should be made. He was careful to make clear that he did not believe cheilitis granulomatosa to be an abortive form of the Melkersson-Rosenthal syndrome.

PATHOLOGY

The surface epithelium is uninvolved. Discrete round or oval granulomas consisting of mature lymphocytes and pale staining epithelioid cells are seen within the subepithelial connective tissue and muscularis, generally in a perivascular distribution. Collections of epithelioid cells with an occasional giant cell have been reported and suggest to some observers an etiologic relationship with sarcoid.

TREATMENT

Cosmetic reduction by surgical excision of excess tissue has been utilized in some cases. Recently Eisenbud and associates (2) reported successful treatment by local injections of steroid into preanesthetized affected lip tissue.

(1) Laymon, C.W.: Cheilitis granulomatosa and Melkersson-Rosenthal syndrom, Arch. Derm., 83:112-118, 1961.

(2) Eisenbud, L., Hymorvitz, S.S., Shapiro, R.: Cheilitis Granlomatosa, Oral Surg., 32:384-389, 1971.

APPENDIX #2

REGIONAL ODONTODYSPLASIA

Abrams, A.M., and Groper, J.: Odontodysplasia, Journal of Dentistry for Children. 33: 353-362, 1966.

Gardner, D.G., and Sapp, T.P. Regional Odontodysplasia Oral Surgery 35: 351-365, 1973.

Pinkham, J.R., et al. Odontodysplasia, Oral Surgery 36: 841-850, 1973.

Sapp, J.P., et al. Regional Odontodysplasia, Oral Surgery, 36: 383-392, 1973.