

ELLIS FISCHER STATE CANCER HOSPITAL

AND

CANCER RESEARCH CENTER

ORAL PATHOLOGY SEMINAR #50

April 4, 1975

O.P.S. 75-444

CASE #1. (72-1092-A) (Contributed by Mario G. Martinez, DMD, M.S., Associate Professor & Director, Division of Oral Pathology, University of Alabama in Birmingham, Alabama)

This 41 year old black male was referred to the Oral Surgery Clinic at the School of Dentistry in Birmingham, Alabama, with a large, 6 x 2 cm exophytic lesion protruding from the mucosa of the left mandible, gingival tissue associated with tooth #18. The lesion was rubbery, with hemorrhagic and necrotic areas. Radiographic examination revealed no boney involvement and there was no tooth mobility.

CASE #2. (SC-75-404) (Contributed by Albert M. Abrams, D.D.S., M.S., Professor & Chairman, Department of Pathology, University of Southern California School of Dentistry)

This 52 year old male had been aware of swelling in the right tuberosity for about four weeks. The clinician described the swollen tuberosity as purple and fluctuant. Radiographs revealed a vague zone of decreased radiodensity with faint loss of trabecular pattern. Endodontix therapy had been performed on the maxillary second molar and the first molar possessed a large alloy restoration. The third molar was missing. No other abnormalities were seen.

CASE #3. (D2230-AU) (Contributed by Nathaniel H. Rowe, D.D.S., University of Michigan, School of Dentistry, Ann Arbor, Michigan)

The patient, a 15 year old male, noticed a large "lump" on his lower lip for the past three months. The lesion has gradually increased in size but is otherwise asymptomatic.

CASE #4. (D2234-AU) (Contributed by Nathaniel H. Rowe, D.D.S., University of Michigan, School of Dentistry, Ann Arbor, Michigan)

The patient, a 46 year old male engineer, states that there had been a growth in his palate since age 9 and it has never changed. Physicians who looked at it said they didn't know what it was and to forget it.

CASE #5. (S-3281-74) (Contributed by LTC Joseph T. Fay, DC, D.D.S., Dr. Sharbough, Dr. Sayers, and Dr. Johnson, Eisenhower Medical Center, Hospital Dental Clinic, Ft. Gordon, Georgia, Augusta, Georgia)

M.P. is a 49 year old Caucasian female who first noticed a firm growth in her left cheek three years prior to this biopsy. About one year later, she also noticed a left submandibular cervical lymph node, and she strongly felt that "both growths were connected." At this time, she consulted both her local physician and dentist, neither of which was concerned enough to recommend a biopsy. This specimen was obtained on 30 October, 1974 by a recent

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graduate of the Army's two-year rotating general dentistry residency.

CASE #6. (74-2096) (Contributed by Richard K. Wesley, D.D.S., M.S.D.,
Assistant Professor, Department of Pathology,
University of Detroit School of Dentistry)

This specimen from a 72 year old white female who presented with paresthesia of the lower lip and left mandible alveolar ridge and a poorly defined radiolucent lesion of the left mandible. Clinician's impression was malignant neoplasm. A small biopsy was submitted.

CASE #7. (74-778) (Contributed by Charles Dunlap, University of Missouri-
Kansas City, School of Dentistry, Kansas City, Missouri)

This 45 year old male was seen for a lesion present in the palate which was stated to be present for several years with a gradual increase in size. The lesion was said to be palatal mucosa to the left of the midline opposite the first molar tooth. The patient has all of his natural teeth and does not wear a dental appliance. The lesion was described clinically as being mushroom shaped with a wrinkled surface. There was no evidence of destruction of the palatal bone. Medical history was non-contributory. The lesion was excised and submitted.

CASE #8. (75-73) (Contributed by Charles Dunlap, University of Missouri-
Kansas City, School of Dentistry, Kansas City, Missouri)

This 47 year old male was seen for a soft tissue mass arising from the palatal gingiva and palatal mucosa. The patient states the lesion had been growing for about one year and now interferes with speech. It is pedunculated and measures 5 cm. in greatest dimensions. The lesion had conformed to the shape of the teeth and had grown into a space where there was a missing tooth #5. It was of normal color without any evidence of ulceration. X-rays showed generalized long standing periodontitis with no evidence of increased bone loss in the vicinity of the lesion. It was removed and submitted. Clinical impression was peripheral giant cell granuloma.

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DIAGNOSIS SHEET

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- CASE 1. Undifferentiated malignant tumor. Would like to see a methyl green-pyronin to rule out plasmocytoma.
- CASE 2. Plasmocytoma
- CASE 3. So-called mucocele
- CASE 4. Pleomorphic adenoma (mixed tumor)
- CASE 5. Low-grade mucoepidermoid carcinoma
- CASE 6. Osteosarcoma
- CASE 7. Fibrous polyp with focal chondroid metaplasia
- CASE 8. Neurofibroma with nevus-like areas (or nevus with neurofibroma-like areas)

Juan Rosai
Signature

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

COMMENTS:

JR/mfb

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CASE #1. METASTATIC CARCINOMA

(Contributed by Mario G. Martinez, DMD, M.S., University of Alabama in Birmingham, Alabama)

Doctors Dunlap and Barker from Kansas City, Missouri, Dr. Spjut from Houston, Texas, and Dr. Waterhouse from Chicago, all considered the lesion as metastatic. Most of the different consultants preferred to call it, "undifferentiated malignant tumor." Dr. Lauren V. Ackerman from Stony Brook Long Island felt, "not carcinoma although it is malignant."

Past History; revealed that six months prior to admission the patient had a laparotomy for "locked bowels" with the findings of a tumor mass in the small intestines. The local pathologist rendered the diagnosis of carcinoma without lymph node involvement. The patient was then referred to the University of Alabama in Birmingham Medical Center for further evaluation and treatment. The intestinal lesion was interpreted, by one of the pathologists from Alabama, as a histiocytic lymphoma, giant cell type. The slides were returned to the local hospital. The patient was treated on an out-patient basis with radiation and chemotherapy, but one month after the lesion was biopsied, the patient died of diffuse metastases; an autopsy was not performed. At the time of this admission in Alabama, consultations were requested. The opinion of Dr. Abrams, from U.S.C., is as follows: "I believe the jaw tumor is probably metastatic and would favor a diagnosis of adenocarcinoma. I cannot definitely exclude an unusual leiomyosarcoma or a melanoma. I do not believe the jaw lesion represents lymphoma. Pete Schwinn, M.D., Surgical Pathologist at Los Angeles County Hospital, agrees with our comments." The diagnosis of the AFIP was, "poorly differentiated malignant neoplasm," with the following comments; "the material has been widely circulated among the staff. Intramural consultation was sought with both Soft Tissue and Skin and GI Divisions. While passing consideration was given to an alveolar rhabdomyosarcoma, the pattern in the present slides were more consistent with a lesion of epithelial origin. There is evidence of sheeting with cohesiveness of cells. At the suggestion of the Soft Tissue Branch, one of the slides was decolorized and stained for mucin. While there was extracellular mucin, no intracellular mucin could be appreciated in the section. Review by Skin and GI Division of this slide concurred with this interpretation. They also felt that the lesion represented a carcinoma or possibly a lymphoma. All reviewers commented that review of the original bowel biopsy material was germane to the interpretation of the present lesion and agreed that the histology of the current biopsy is not that of the typical adenocarcinoma of the bowel."

CASE #2. MULTIPLE MYELOMA

(Contributed by Albert M. Abrams, D.D.S., M.S., Department of Pathology, University of Southern California School of Dentistry)

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This was the diagnosis by almost unanimity given by the consultants. There were however, a few, who although suspicious of this patient having multiple myeloma or plasmacytoma, had difficulties in excluding an extreme chronic inflammatory reaction and plasma cell hyperplasia in the oral cavity and reserving their diagnosis until more clinical information is obtained.

The follow-up of the patient including laboratory studies and a roentgenograms of the skeleton confirmed the diagnosis of multiple myeloma.

CASE #3. MUCOUS EXTRAVASATION PHENOMENON (MUCOCELE)

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

This was also the most popular diagnosis. Some of the other diagnosis included from Fort Gordon, Georgia, Dr. Sayers, Dr. Sharbough, and Dr. Kolas from the Medical College of Georgia School of Dentistry called it, "a mucocele with reactive proliferative changes and vascular leiomyoma." From the National Institute of Health, Oral Biology Section, Dr. Corio called it, "organizing mucocele," Dr. Tarpley called it, "vascular lesion," and Dr. Crawford called it, "glomangioma." Dr. Das from Chicago called it, "traumatized sclerosing mucocele." Dr. Shafer from Indiana remarked, "we don't see anything here but a plain old mucocele."

CASE #4. PLEOMORPHIC ADENOMA WITH EVIDENCE OF PREVIOUS HEMORRHAGIC EPISODE

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

Dr. Thoma from the University of Houston, Texas, Dental Branch, stated, "Benign mixed tumor with old hemorrhage." Dr. Berthrong from Colorado Springs, Colorado states, "I don't see any reason why a pleomorphic adenoma (mixed tumor of minor salivary gland) that has been present for 37 years might not have a large amount of hemosiderin pigment in it as this one does." Dr. Abrams, from the University of Southern California, and Dr. Ackerman, from Stony Brook Long Island, also called it, "pigmented mixed tumor, and they ought to have a melanin stain." Dr. LeGal from Strasbourg, France, called it, "mixed tumor of accessory salivary gland." Dissenting diagnosis include: pigmented anlage tumor and melanotic mixed tumor, probably malignant.

CASE #5. MUCOEPIDERMOID CARCINOMA

(Contributed by LTC Joseph T. Fay, DC, D.D.S., Dr. Sharbough, Dr. Sayers, and Dr. Johnson, Eisenhower Medical Center, Ft. Gordon, Georgia, Augusta, Georgia)

In most of the slides submitted in the sets, a few contained remnants of

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tumor as, in the case of Dr. Abrams from California and Dr. Thoma from Texas; both agree with the diagnosis. However, in the greatest majority of the consultants' slides, no tumor was observed which was reflected in their diagnosis that included myxoma of muscle, hyperplastic sialadenitis, duct blockage phenomenon with mucous extravasation and the like. The following remarks from Dr. Fay, "we must apologize for the block we sent. It was sent to the AFIP, and when we retrieved the block from them it appeared to have sufficient tumor tissue remaining. Just to prove it was a mucoepidermoid carcinoma, he sent one of the original slides from the excisional biopsy."

CASE #6. OSTEOSARCOMA

(Contributed by Richard K. Wesley, D.D.S., M.S.D., Department of Pathology, University of Detroit School of Dentistry)

Although a few complained about the size of the biopsy material, an almost overwhelming majority called it osteogenic sarcoma. Dr.'s Tarpley, Corio, and Crawford from Bethesda, Maryland called it, "malignant neoplasm, rule out clear cell metastasis."

CASE #7. OSTEOCHONDROMATOUS METAPLASIA

(Contributed by Charles L. Dunlap, D.D.S., and Bruce Barker, D.D.S., University of Missouri-Kansas City, School of Dentistry, Kansas City, Missouri)

Dr. Abrams remarked, "This is a reactive-hyperplastic lesion with ossification." How about mushroomed peripheral giant cell fibroma with metaplastic ossification and focal myxochondromatous mucinosis? Seriously it does not seem to fit any well recognized disease entity. I doubt if it will provide much of a problem for the patient." Dr.'s Corio and Crawford, Bethesda, Maryland, call it, "osseous and cartilagenous choristoma." From Fort Gordon the opinions were divided; "atypical mesodermal hamartoma" was the diagnosis of Dr.'s Sayer, Sharbough, and Johnson; "peripheral ossifying fibroma with cartilagenous metaplasia" was the diagnosis by Dr. Fay, and "chondro osteoma" was submitted by Dr. Kolas. Dr. Rosai from Minnesota called it, "fibrous polyp with focal chondroid metaplasia." Dr. Spjut from Houston called it, "hamartoma." Dr. Thoma from Houston called it, "fibroma with chondroid metaplasia." Dr. Wesley from Detroit, "fibroma exhibiting myxomatous degeneration."

B I B L I O G R A P H Y

Duane E. Cutright, Colonel, DC, U.S.A.; OSSEOUS AND CHONDROMATOUS METAPLASIA CAUSED BY DENTURES: ORAL SURGERY, Vol. 34; 625-633: Oct. 1972.

CASE #8. NEUROFIBROMA

(Contributed by Charles L. Dunlap, D.D.S., and Bruce Barker, D.D.S.,

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University of Missouri Kansas City, School of Dentistry
Kansas City, Missouri)

This was also the diagnosis of Dr. Hori, from Moberly, Missouri, and Dr. Abrams from Southern California. Dr. Rosai from Minnesota called it, "neurofibroma with nevus like areas (or nevus with neurofibroma like areas)." Dr. Berthrong from Colorado Springs, Colorado called it, "neuronevus." Dr. Wesley from Detroit called it, "benign fibrous lesion compatible with nodular pseudosarcomatous fasciitis." Dr. Das from Chicago called it, "neurogenic neoplasm." There were other diagnosis which included mesenchymal chondrosarcoma, myxosarcoma, acinic cell adenocarcinoma, embryonal cell tumor, and fibrous histiocyoma, etc.