ELLIS FISCHEL STATE CANCER HOSPITAL

AND

CANCER RESEARCH CENTER

ORAL PATHOLOGY SEMINAR # 58

SEPTEMBER 28, 1977

O.P.S 77-1964

CASE # 1 (S77-52)

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

The patient is a 68 year old white male who was referred to a local oral surgeon for the extraction of a carious tooth. The specimen is an excision of a lesion noted on routine oral examination and was accompanied by the following information: "Patient has a very carious maxillary right second molar-Palatally, there is a lesion 5 mm--Cauliflower like. To me this possibly represents a fistulous tract from the infected maxillary left second molar---Specimen sent to rue out tumor of minor salivary gland. Duration unknown."

CASE # 2 (77-5182)

(Contributed by John S. Meyer, M.D., Jewish Hospital of St. Louis, 216 South Kingshighway, P.O. Box 14109, St. Louis, Mo. 63178)

M.C.J., is a 57 year old black woman who had a tumor in the cheek. She had noted swelling in the cheek for several years without pain. Her history included labile hypertension, "Ruptured disc," and cholecystectomy. She was obese and had blood pressure of 130/65 mm Hg. A 7 X 7 cm nontender, round, nonfluctuant mass was palpated in the left cheek. No organomegaly was detected on palpation of the abdomen, but a pelvic examination was not done. At operation under general anesthesia the tumor extended from near the commissure of the mouth halfway across the cheek. It lay closer to the mucosa than the skin, was encapsulated, and was shelled from the cheek by blunt dissection. No unusual bleeding was noted. After excision, the tumor was a fairly round, firm, slightly nodular piece of encapsulated tissue with a shiny smooth coat. It was composed of several nodules with firm, white, shiny cut surfaces. A gross photograph showing the external and cut surfaces is enclosed.

CASE # 3 (77-1760)

(Contributed by Richard K. Wesley, D.D.S., M.S.D., Associate Professor Dep rtment of Pathology, School of Dentistry, 2985 Jefferson Avenue, Detroit, Michigan 48207

The patient is a 25 year old male who presented with a white exophytic lesion on the right lower lip.

The lesion has doubled in size within the past four months. Provisional clinical diagnosis by the oral surgeon was, Epidermoid Carcinoma.

CASE # 4 (77-630)

(Contributed by Dr. Charles Dunlap, D.D.S., School of Dentistry, 650 East 25th St. Kansas City, Missouri.)

A 30 year old female was referred for evaluation of possible Sjogren's syndrome. The patient had a positive LE prep in 1967. For the last six months she has had increasing symptoms of dryness of her eyes. She is experiencing increasing dryness in her mouth for the past four to five months. She states that her "cheeks have enlarged" over the past several months.

A biopsy of the sublingual salivary gland was done.

CASE # 5 (77-846)

(Contributed by Dr. Charles Dunlap, D.D.S., School of Dentistry, 650 East 25th St. Kansas City, Missouri.)

This 14 year old femalehad a large unilocular lesion in the right maxillary. It was asymptomatic. The maxilla was expanded.

CASE # 6 (77-1411)

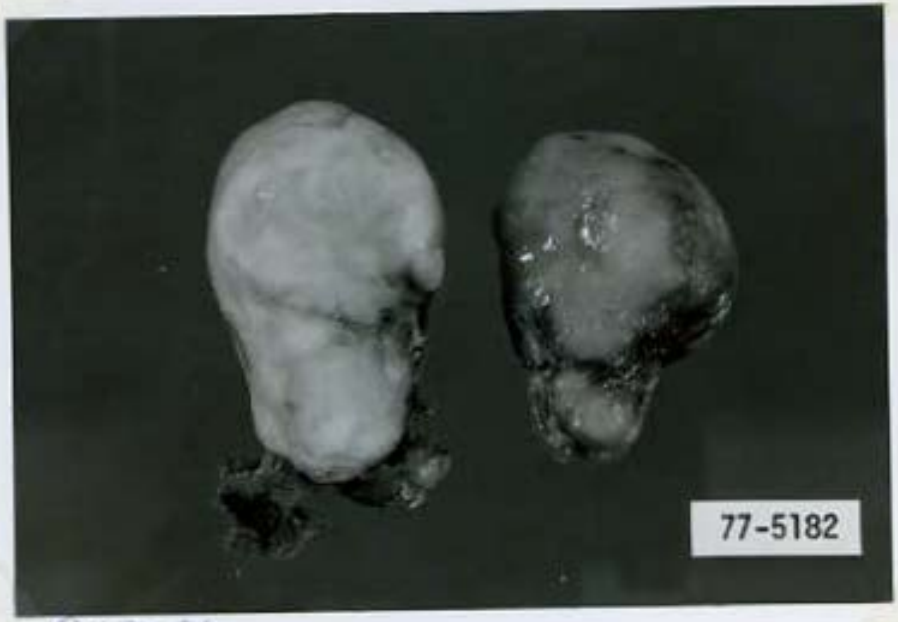
(Contributed by Dr. Fred P. Handler, Physician's Laboratory, Medical Arts Building, Jefferson City, Mo., and Dr. Carlos Perez-Mesa, Ellis Fischel State Cancer Hospital, 115 Business Loop 70 W. Columbia, Mo.)

This is a 69 year old caucasian male, who in 1969 developed a mass in the roof of his mouth on the right side, which was excised. The lesion recurred in 1972. This time extending into the right maxillary sinus. This lesion was also excised. The lesion measured 4 X 3 cm. The material is represented from the initial lesion in 1969.

CASE # 7 (77-1488)

(Contributed by Dr. Carlos Perez-Mesa, Chief Pathologist, Ellis Fischel State Cancer Hospital, 115 Business Loop 70 West, Columbia, Mo).

This is a 80 year old caucasian female, who developed a 1.9 X 1.5 lesion in the hard palate, extending into the soft palate. Roentgenograms of the lesion shows it to appear to be of tumor induration. On the physical examination, it found to consists of a 1.2 cm submandibular lymph node. Included are photographs of the lesion.



CASE 2

UNIVERSITY OF MINNESOTA
TWIN CITIES

Department of Laboratory Medicine and Pathology
Medical School
Box 609 Mayo Memorial Building
420 Delaware Street S.E.
Minneapolis, Minnesota 55455

September 20, 1977

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

Dear Carlos:

Thank you for sending me the slides and protocols of the oral pathology seminar #58. Following below are my diagnostic considerations on the cases:

Case 1: I believe that this is a benign tumor originated from the terminal or intraepithelial portion of minor salivary glands. It seems to me that a tumor having an identical or at least similar appearance to this, has been reported in the past under the name of sialadenoma papilliferum.

Case 2: This seems to be a rather straightforward case of leiomyosarcoma. It has both the atypia and the high mitotic count needed to make such a diagnosis.

Case 3: My diagnosis of the basic condition in this case is that of actinic keratosis. At the edges it has a very lichenoid pattern and in that regard, it fits the description of the so-called lichen planus-like keratosis, which at least in some instances, seems to be a morphologic variant of actinic keratosis. As far as the centrally located area, I would interpret it as hypertrophic area of actinic keratosis rather than squamous cell carcinoma. I suspect it may well be a precursor stage of squamous cell carcinoma, but I do not like to make such a diagnosis in the absence of more cellular atypia and/or infiltrative characteristics.

Case 4: The changes in this small salivary gland biopsy are certainly consistent with the diagnosis of Sjögren's syndrome. I believe I even saw some abortive myoepithelial islands.

Case 5: This looks to me like a typical case of ondontogenic myxoma. I was burned once by diagnosing a hypertrophic dental papilla as a myxoma. I suppose such a possibility does not exist here in view of the radiographic changes.

Case 6: My diagnosis on this case is that of adenoid cystic carcinoma. It looks like a very well differentiated tumor in the sense that it has a cribriform pattern throughout. Perzin, from Columbia University, has a very good paper in press in Cancer regarding this entity, which shows that adenoid cystic carcinoma having this peculiar morphology have a relatively good prognosis.

Case 7: This looks like a classical example of acinic cell carcinoma and the only unusual feature about it seems to be the location. Incidentally, I got the impression that there was something wrong with the history of the case. You might like to check on this.

I hope that everything is going well for you. I will try to fish a case or two from our files to contribute for future seminars.

Best personal regards,

Juan

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

JR/mfb

ORAL PATHOLOGY SEMINAR # 58

"OFFICIAL DIAGNOSIS"

O.P.S. #77-1964

SEPTEMBER 28, 1977

CASE # 1

SIALADENOMA-PAPILLIFERUM

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

This was the predominant diagnosis.

Dr. John Meyer, from the Jewish Hospital, St. Louis, Dr. Morgan Berthrong, Colorado Springs, Colorado, called it oxyphil adenoma. Dr. John Batsakis Ann Arbor, called oncocytic hyperplasia of minor salivary gland. Two other consultants called it necrotizing sialoademtis, and excelosecretory ductal carcinomatosis. Dr. Shafer from Indiana commented-"sialadenoma papilliferum: Actually just a plain old intraductal papilloma."

CASE # 2

LEIOMYOMA

(Contributed by John S. Meyer, M.D., Jewish Hospital of St. Louis, 216 South Kingshighway, P.O. Box 14109, St. Louis, Mo.)

During the discussion, Dr. Meyer presented illustration of several tumor markers which in his interpretation indicates a benign process. The opinions of the consultants were sharply divided. Dr. LeGal from Strasbourg called it leiomyoma. "It is presumed benign, in spite of the cytology, because no mitotic figures if primary. But funny things may happen with leiomyosarcoma." Dr. Rose from Wichita, Kansas, and Dr. Quigley, from Ohio State also called it benign. Dr. Fay from Eisenhower Hospital, Fort Gordon, Ga., called it neurogenic sarcoma, while the rest of the staff called it malignant schwannoma. Dr. Waldron from Georgia, commented: " I always have trouble with these spindle cell tumors. I'd like to see special stains which, really only means "I'm hedging." In spite of the apparent encapsulation, I'm worried about the atypia in areas. If I have to call it on the basis of this one slide, I will vote for a malignant schwannoma although my degree of certanity is not very high." Dr. Shafer from Indiana called it "ancient neurolemmoma," which was also the diagnosis of Dr. Abrams, Southern California. Dr. Sciubba, Stony Brook, called it neurofibroma with atypical cellular features. It was also the diagnosis of Dr. Das of University of Illinois at Chicago. Dr. Azar from University of Southern Florida called it schwannoma. Dr. Berthrong, Colorado Springs, stated: "I think this is a leiomyosarcoma. I am quite certain of its malignancy since mitoses are reasonably prominent. The atypism alone is probably not enough to call malignant. I am never quite sure of the cell of origin of such tumors. The predominant pattern for me is smooth muscle. I cannot exclude a malignant schwannoma or even a fibrous histiocytoma. I would

CASE # 2 (cont.)

be very concerned about the shelling out of this tumor because it obviously does not have a true capsule. Dr. Hori, West Virginia, called it "low grade leiomyosarcoma." Dr. Rosai from Minnesota, said: "This seems to be a rather straightforward case of leiomyosarcoma. It has both the atypia and the high mitotic count needed to make such a diagnosis." Dr. Ordie King, Jr., called it sarcoma. (1) leiomyosarcoma, metastatic (2): Rhabdomyosarcoma." Dr. Barker and Dr. Dunlap, Kansas City, called it leiomyosarcoma. Dr. Lucas, Jr., and some of the staff of Cleveland Clinic called it leiomyosarcoma. Dr. Wesley of Detriot, called it neurosarcoma. Dr. McGavran from Baylor, called it leiomyosarcoma: May be metastatic from uterus. Dr. Abrams commented: " I am having a great deal of difficulty with this one. The lesion is quite cellular and some nuclei are bizarre to say the least. There seems to be only a few mitoses. I sense a neutral origin for this tumor. I will "go out on a limb" and call it an "ancient" neurolemmoma. No doubt I will hear from you that the lesion has metastasized."

The follow-up of this patient will be reported in a future meeting.

CASE # 3

KERATOCANTHOMA

(Contributed by Dr. Richard K. Wesley, D.D.S., M.S.D., Associate Professor Dept. of Pathology, School of Dentistry, 2985 Jefferson Ave., Detroit, Michigan 48207)

There was some distension in the diagnosis of the consultants: Dr. Waldron from Emory stated: "Verrucous hyperkeratosis: There are some features of a K.A., here but is really not classic." Keratocanthoma was the diagnosis, of Dr. Shafer, Indiana, Dr. Sciubba, from Stony Brook, Dr. Fay, and the rest of the staff from Eisenhower Medical Center, Dr. Hori, of West Virginia. "Hyperkeratotic papilloma or verruca vulgaris" was the diagnosis of Dr. Azar, Tampa, Fla., Dr. Das from Chicago, Dr. Barker, Kansas City. Dr. John Meyer from St. Louis, called it "keratosis-May be the edge of K.A." "Actinic keratosis was the diagnosis of Dr. Rosai from Minnesota, and Dr. Lucas and the staff of the Celveland Clinic. Verrucous carcinoma was the diagnosis of Dr. Ordie King of Southern Illinois and Dr. Batsakis of Ann Arbor. Dr. Berthrong stated: "Perhaps I should use a gynecologic diagnosis and say "nicht carcinom alber besser heraus." If the the patient were older it "would be the smallest verrucal carcinoma on record." Dr. Abrams from USC stated: "I do not believe this is a malignancy and the designation keratoacanthoma might be appropriate for it."

CASE # 4

SJORGEN'S SYNDROME

(Contributed by Dr. Charles Dunlap, D.D.S., School of Dentistry, 650 East 25th St., Kansas City, MO.)

The diagnosis was unanimous.

CASE # 5

ODONTOGENIC MYXOMA

(Contributed by Dr. Charles Dunlap, D.D.S., School of Dentistry, 650 East 25th St., Kansas City, Mo.)

This was the overwhelming diagnosis. Some preferred to call it mixofibroma or myxomaneurofibroma.

CASE # 6

ADENOCYSTIC CARCINOMA

(Contributed by Dr. Fred P. Handler, Physician's Lab., Jefferson City, Mo., and Dr. Carlos Perez-Mesa, Ellis Fischel State Cancer Hospital, Columbia, Mo.)

Dr. Rosai commented: "Itlooks like a very well differentiated tumor in the sense that it has a cribriform pattern throughout. Perzin, from Columbia University, has a very good paper in press in Cancer regarding this entry, which shows that adenoid cystic carcinoma having this peculiar morphology have a relatively good prognosis." This was the general accepted diagnosis.

CASE # 7

ACINIC CELL CARCINOMA

(Contributed by Dr. Carlos Perez-Mesa, Ellis Fischel State Cancer Hospital, Columbia, Mo.)

This was the overwhelming diagnosis. Dr. Rosai commented:"The only unusual feature about it seems to be the location." Dr. Abrams commented: " I was a little confused about the history of this case, but the microscopic slide certainly indicated minor salivary origin. With my experience, this is a most unusual occurance."