

CASE HISTORIES

CASE #1 (DS-958) Contributed by James Sciubba, D.M.D., Ph.D., Island Jewish Hillside Medical Center, New Hyde Park, NY and Lauren Ackerman, M.D., State University of N.Y. at Stony Brook, Stony Brook, NY:

A 71 year old male with a mass located in the left pharyngeal wall.

CASE #2 (80-13) Contributed by M.R. Beck, M.D., Columbia Regional Hospital, Columbia, MO:

(S.N.) A 66 year old Caucasian male who in Nov. 1979 while visiting the dentist for adjusting a dental plate, a lesion was discovered in the left side at the junction of the hard and soft palate, measuring 2 x 1 cm and covered by normal appearing mucosa. The laboratory studies were noncontributory.

CASE #3 (79-1319) Contributed by Charles Dunlap, D.D.S. and Bruce Barker, D.D.S. University of Missouri-Kansas City, Kansas City, MO:

This 32 year old male has a palatal ulcer of one year duration. It was 3 x 3 cm and was raised, indurated and appeared to have multifocal areas of ulceration rather than a single large ulcer. The patient has suffered chronic recurrent spistaxis. The medical history is not contributory. Clinical impression was Wegener's granulomatosis, rule out tumor.

CASE #4 (79-1340) Contributed by Charles Dunlap, D.D.S. and Bruce Barker, D.D.S. University of Missouri-Kansas City, Kansas City, MO:

A 29 year old female has slight swelling of the bone in the anterior maxilla, centered about an edentulous lateral incisor area. X-ray showed a compartmentalized lucency within the bone. A superficial biopsy was reported as "epithelial rests". A deeper biopsy was performed and the diagnosis established. The patient has a larger surgical resection performed and your slide is from this last surgical procedure.

CASE #5 (S79-6592) Contributed by John Mahoney, M.D., University of Missouri-Columbia - Medical Center, Columbia, MO:

48 year old white male who noted a left mandibular angle nontender jaw mass, four weeks prior to admission. Past medical history noncontributory. Physical examination revealed a 2 x 1 cm ulcerated mass left tonsil and an enlarged right tonsil. A large supple nontender mass was palpated in the left cervical region.

CASE #6 (79-A-2574 & 79-1939) Contributed by Ronald W. Oxenhandler, M.D., Ellis Fischel State Cancer Hospital, Columbia, MO:

65 year old Caucasian male with a 6 month history of a slowly enlarging mass below and in front of his right ear. Examination under anesthesia revealed a neoplasm at the base of the right tongue, at the glossopharyngeal fold extending up toward the right tonsillar pillar a short distance and extended towards the midline where it became very hard and felt deeply infiltrating. Slides are from the original tongue biopsy, postmortem tongue, and lung.



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February 19, 1980

Dr. Carlos Perez Mesa  
Department of Pathology  
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Dear Carlos:

Here are my diagnostic impressions on the cases of the Oral Pathology Seminar #67, to be discussed on February 29, 1980.

- 1) Clear cell carcinoma, probably the hypernephroid variant of acinic cell carcinoma arising from minor salivary glands. Naturally, one should rule out the possibility of metastatic renal cell carcinoma (especially in view of the fact that Dr. Ackerman is involved with the case).
- 2) Lymphoid hyperplasia.
- 3) Granulomatous inflammation, with septate fungi present. I don't know whether the fungi are the cause of the ulceration or whether they are superimposed on a preexisting lesion.
- 4) Ameloblastoma.
- 5) Histiocytic nodular lymphoma.
- 6) Mixed carcinoma, with components of oat cell cancer, adenocarcinoma, etc. It is hard for me to figure out from the information given whether this is a lung tumor metastasizing to the oral cavity or the converse.

Best regards,

*Juan*

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

JR:Jed

ELLIS FISCHER STATE CANCER HOSPITAL  
AND CANCER RESEARCH CENTER  
ORAL PATHOLOGY SEMINAR #67  
O.P.S. 80-750  
May 9, 1980

CASE #1 (DS-958)

OXYPHILIC ADENOMA FROM THE "SO CALLED" DEEP  
LOBE OF PAROTID GLAND  
(Contributed by James Sciubba, D.M.D., Ph.D.,  
Long Island Jewish Hillside Medical Center, New  
Hyde Park, NY and Lauren Ackerman, M.D., State  
University of N.Y. at Stony Brook, NY)

The diagnosis of "Clear cell carcinoma", was made by Drs. Rowe from MI, Sprague from NB, Rosai from MH, Cornyn from San Antonio, TX, Spjut from Houston, Azar from Tampa, Rohrer from OK, and Tarpley and Corio from Bethesda. This was also the diagnosis of Dr. Shafer although he included in the differential diagnosis, "Acinic cell carcinoma", which was also the diagnosis of Drs. Hori from WV, Lilly from IA, and Costa from N.I.H. The diagnosis of "Mucoepidermoid carcinoma, intermediate grade", was made by Drs. Bataskis from ME, Abrams from U.S.C., King from S.I.U., Wesley from Detroit, Pindhorff from Denmark, and White from U.K. Drs. Dunlap and Barker from Kansas City call it, "Mucoepidermoid carcinoma, clear cell variant". Dr. Rosai commented, "Clear cell carcinoma, probably the hypernephroid variant of acinic cell carcinoma arising from minor salivary glands. Naturally, one should rule out the possibility of metastatic renal cell carcinoma (especially in view of the fact that Dr. Ackerman is involved with the case)".

Additional information:

Electron microscopy of representative material was done by Dr. Sciubba who interpreted it as "Consistent with oxyphilic adenoma by the presence of numerous abnormal mitochondria occupying much of the cytoplasm of the cells". "..... when one considers the fact that the tissue was formalin fixed in a routine fashion, I think the results are acceptable enough", added Dr. Sciubba.

CASE #2 (80-13)

REACTIVE LYMPHOID HYPERPLASIA  
(Contributed by M.R. Beck, M.D., Columbia Regional  
Hospital, Columbia, MO)

Among the consultants there was an even difference of diagnoses between benign and malignant. The former diagnosis was expressed as "Reactive lymphoid hyperplasia, atypical lymphoproliferative disease of the palate, reactive lymphoid hyperplasia, and nodular lymphoid hyperplasia; among those who considered the lesion was malignant the diagnosis most frequently used were "Nodular lymphocytic lymphoma, malignant lymphoma mixed cellularity lymphoma, lymphocytic type, and malignant lymphocytic proliferative disease of the hard palate. Few offered a diagnosis which included "Sjogren with malignant lymphoma and nodular lymphoma vs. atypical lymphoid hyperplasia. A few commentaries from the various consultants are as follows: Dr. Meyer from Jewish Hospital in St. Louis, "Reactive lymphoid hyperplasia. The follicular nature with germinal centers that contain histiocytes and transformed lymphocytes support a benign diagnosis. I doubt Sjogren's syndrome because in that condition the infiltrate is diffuse". Dr. Bataskis from ME, "Atypical lymphoproliferative disease". Dr. Weathers from Emory, "I see no evidence of frank malignancy in this slide, however, the pattern of the infiltrate is worrisome. I feel that this fits best into the Tomich-Shafer concept of atypical lymphoproliferative disease of the palate". Dr. Abrams from U.S.C., "I would have to call this an atypical lymphoproliferative lesion. I cannot classify it as malignant, however, the morphology of the germinal centers is quite unusual. It even suggests a thymus morphology. Maybe this is diagnostic for some unusual lymphoid lesion of which I am not familiar". Dr. Sprague from NB calls it, "I would call this a nodular lymphocytic lymphoma". Dr. Rosai from ME

calls it, "Lymphoid hyperplasia". Dr Fay and the staff from the Pathology Department from the Medical and Dental Department of Fort Bliss, TX call it, "Benign lymphoproliferative disease consistent with giant lymphoid hyperplasia". Dr. LeGal from Strasbourg calls it, "Benign lymphocytic infiltration of the salivary gland". Dr. Greer from CO calls it, "Malignant lymphoma, nodular, mixed cellularity". Dr. Spjut from Houston calls it, "Lymphoid hyperplasia (lymphoid pseudotumor)". Dr. Pindborg from Denmark calls it, "Nodular histiocytic lymphoma". Dr. Shafer from IN calls it, "Nodular lymphocytic lymphoma". Dr. Lilly from IA stated, "We were mixed in our opinion as to it's cellular class lymphocytic, mixed or histiocytic". Dr. Toto from Loyola calls it, "Mixed lymphocytic, histiocytic lymphoma, nodular type".

## FOLLOW-UP:

Two months after the lesion was excised, the patient remained healthy and the physical examination failed to reveal any evidence of any abnormalities.

## CASE #3 (79-1319)

## MYCOTIC GRANULOMA - ASPERGILLOSIS

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

With the exception of one consultant who called it, "Necrotizing granulomatous disease compatible with Wegener's granulomatosis", the rest of the opinions agree on the diagnosis of a "Fungus infection identifying the mycosis as blastomycosis, candidiasis, phycomycosis, and aspergillosis". Dr. Rohrer from Oklahoma City commented, "This is a beautiful case and certainly surprising to see the reaction caused by the candida organisms". Dr. Lilly from CO stated, "Chronic granulomatous mycotic disease. Most probably aspergillosis. In our experience, when aspergillosis is a pathogen, some underlying disease process affecting host resistance is usually present". Dr. White from KY made the following comment: "Granulomatous disease, etiology being either aspergillus or candida. It appears that the sinus is included and I think it probably started there".

## CASE #4 (79-1340)

## AMELOBLASTOMA

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

This was the universal diagnosis. Drs. Tarpley and Corio from N.J.H. call it, "Ameloblastoma with acanthomatous and basaloid features". Dr. Pindborg from Denmark calls it, "Basal cell ameloblastoma". Dr. Greer from CO commented, "Ameloblastoma". Dr. Cornyn from San Antonio, TX commented, "Ameloblastoma. Foci of squamous cells and basal cells are conspicuous and there is some tendency for arrangement of the basal cell component in aggregates, suggestive of the embryonal enamel knot and enamel cord. We have not seen this variation before, but do not expect it to be of any diagnostic, prognostic or therapeutic consequence". Dr. Sprague from NB commented, "Acanthomatous ameloblastoma". Dr. LeGal from France calls it, "Ameloblastoma, I would add "desmoplastic". Dr. Shafer from IN commented, "An interesting example of ameloblastoma with schirrhous stroma".

## CASE #5 (S79-6592)

## NODULAR HISTIOCYTIC LYMPHOMA

(Contributed by John Mahoney, M.D., University of Missouri-Columbia Medical Center, Columbia, MO)

With exceptions of a few dissenting views who consider the lesion as Benign including diagnosis as non-specific lymphohistiocytic response, atypical lymphohistiocytic reaction; suggestive of infectious disease rule out toxoplasmosis. There were also a few opinions which consider the lesion as an epithelial origin including poorly differentiated carcinoma of nasopharyngeal type, an aplastic malignant tumor of tonsil, nonkeratinizing squamous cell carcinoma, poorly differentiated squamous cell carcinoma

and acinic cell tumor. The majority, however, call it malignant with various types of Hodgkins disease, nevertheless, the overwhelming opinion was that the lesion was a histiocytic lymphoma of the nodular type, including Drs. Toto from Loyola, Rosal from MS, and Bataskis from ME. Drs. Matsumoto and Ready from Fort Bliss, TX call it, "Extranodal nodular PDL (small cell cleaved)". Dr. LeGal from France commented, "This is a secondary lymphoma of a salivary gland. It is difficult to classify. I shall call it "Lennert's lymphoma" with protinaceous interstitial deposit". Dr. Shafer from IN stated, "We think that this fits the criteria from Lennert's lymphoma but cannot totally rule out the possibility of a reactive lesion". Dr. Spjut from Houston commented, "Malignant lymphoma. Is amyloid present?"

## FOLLOW-UP:

Electron microscopy studies done with the biopsy material confirmed that the lesion represented a nodular histiocytic lymphoma. Subsequently, the patient developed manifestation of an impending intestinal obstruction for which laparotomy was done; lymphomatous infiltration of the abdominal lymph node and involvement of the small intestine was found. The patient was classified as a Stage IV-B. At the present time he is alive being treated with radiotherapy and chemotherapy.

CASE #6 (79-A2574 &amp; 79-1939)

CARCINOMA OF THE TONGUE WITH POST IRRADIATION PERSISTENCE AND TWO PRIMARIES, SMALL CELL AND ALVEOLAR CARCINOMA

(Contributed by Ronald W. Oxenhandler, M.D., Ellis Fischel State Cancer Hospital, Columbia, MO)

The majority of the expert consultants consider that the lesion in the tongue represents a primary epidermoid carcinoma and that in the autopsy tissue sample there is radiation effect in the tongue with persistent carcinoma and a second primary in the lung showing features of both poorly differentiated alveolar and small cell carcinoma. There was a minority which interpreted the sequence of events as primary carcinoma of the tongue with post-irradiation persistence and metastasis to the lung. Dr. Bataskis from ME commented, "Despite the epidermoid appearance, large mass and surface dysplasia in tongue, I favor metastasis from a lung primary (adeno, undifferentiated and likely epidermoid) to tongue. Alternatively, the patient has two primary neoplasms; lung and one posterior to base of tongue with secondary invasion of tongue". Dr. Shafer from IN stated, "This appears to be primary carcinoma of the tongue that is metastatic to the lung and, in addition, the patient also has a second tumor in the lung, a primary adenocarcinoma. This may be an example of tumor to tumor metastasis". Dr. Toto from Loyola commented, "Primary bronchogenic carcinoma with intraoral metastasis or extension". Dr. Weathers from Emory stated, "This is a very fascinating slide and I believe that it demonstrates a primary squamous carcinoma of the tongue with metastasis to the lung. In the lung is also an obvious adenocarcinoma". Dr. Abrams from U.S.C. commented, "I would say that the tongue lesion represents a poorly differentiated squamous carcinoma. The presence of dysplasia of the tongue shown on the autopsy slide would seem to support that diagnosis. In addition I see lung malignancy which has both an adenocarcinoma morphology and a small cell type growth pattern. I doubt if the tongue lesion represents metastasis from the lung". Dr. White from KS stated, "Two tumors - 1st adenocarcinoma, 2nd oat cell carcinoma both primaries". A similar opinion is expressed by Dr. Sprague from NB. Dr. Rosal from MS stated, "Mixed carcinoma with components of oat cell cancer, adenocarcinoma, etc. It is hard from me the figure out from the information given whether this is a lung tumor metastasizing to the oral cavity or the converse". Dr. Greer from CO believed that, "The patient had a squamous cell carcinoma of the tongue and an adenocarcinoma of the lung". Dr. Spjut from Houston stated that, "Squamous cell carcinoma of the tongue. Adenocarcinoma and small cell carcinoma of the lung". This is the same opinion of Dr. Azar. Dr. Costa from N.I.H. consider this as, "Bronchogenic carcinoma, mixed cell type (small cell and anaplastic) with metastases to the tongue".

At autopsy in addition to the 2nd primary lung cancers there were also multiple metastases in the lungs from the carcinoma of the tongue. An incidental finding was a mucinous cystadenoma of the gallbladder.