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KAPOSI SARCOMA DIAGNOSED AFTER LESIONS INITIALLY FOUND IN ORAL CAVITY

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Background: Kaposi sarcoma is a multifocal, vascular angioproliferative tumor of low-grade malignant potential with cutaneous and extracutaneous involvement. The purpose of our study was to present a case of a first and sole lesion of Kaposi sarcoma in the left palatine tonsil.

Methods: A 60-year-old male was referred to the emergency department withpersistent symptoms ofdysphagia and dyscataposia since the last month. The initial diagnosis in another hospital was peritonsillar abscess and thus antibiotics were given but without response. In our hospital, clinically a dark-red necrotic lesion was observed in the left palatine tonsil but without lymphadenopathy. Specimen was taken for biopsy.

Results: The histopathologic examination revealed a vascular type Kaposi sarcoma. The overall clinical examination and the laboratory exams did not demonstrate pathological findings. The patient was also tested negative for HIV. Additionally, gastroscopy and colonoscopy procedures along with chest and abdominal computed tomography (CT) were all clear. However, enlarged cervical lymph nodes and oedema in the left lingual tonsil were depicted in CT. No other skin ulceration was detected. Surgical removal of the lesion with laser and periodic follow-up was recommended.

Conclusions: The initial lesion in patients with Kaposi sarcoma may be found in the mucosa or lymphatic tissue of oral cavity without any other location in skin, organs or other anatomic sites.

A CASE OF METAPLASTIC/INFRACTED WARTHIN TUMOR

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Background: Warthin tumors are common benign salivary gland neoplasms. Rarely Warthin tumors show areas of extensive squamous metaplasia and degenerative features to the point of obscuring the true histopathology of the neoplasm. Such Warthin tumors are called metaplastic or infracted. The histological distinction can be challenging because of their differential diagnosis with mucoepidermoid carcinoma.

Methods: A 71 years old man presented with swelling of his left side of the neck. Ultrasound examination revealed a heterogeneous mass in the superficial lobe of the left parotid gland. Doppler examination showed vascolarization of the mass. No remarkable findings revealed after the examination of the right parotid gland. Parotidectomy was performed. On gross examination, the gland was reddish and almost fulfilled with a crumbly content.

Microscopically, the mass showed extensive central necrosis which was surrounded by epithelium consisted of non-keratinized squamous, and atrophic cells, comprising also a few mucinous epithelial cells. Mild to moderate cellular polymorphism was observed as well as mild mitotic activity. Focally microcystic formation was identified where the epithelium appeared papillary. Based on the morphological findings and the absence of cellular atypia and invasive growth, a metaplastic/infarcted Warthin tumor diagnosis was set.

Results and Conclusion: It is important to underline that metaplastic Warthin tumor may mimic histopathologically mucoepidermoid carcinoma. Careful clinical and pathological evaluation is needed to clarify the distinction between the two lesions.

A CASE OF POORLY DIFFERENTIATED THYROID CARCINOMA WITH ELEMENTS OF PAPILLARY THYROID CARCINOMA

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Background: We report a case of a poorly differentiated thyroid carcinoma with elements of papillary thyroid carcinoma, because of its rarity and the diagnostic challenges it poses on histological level.

Methods – Results: A 57-year-old woman presented with a sense of weight at the neck. In the ultrasound, the major part of the left lobe of the thyroid appeared to be occupied by a lobulated tumor with evident internal septa and both central and peripheral vascularization with a diameter of 3.7cm.

On gross examination, the tumor was sharply demarcated from the surrounding parenchyma, it was reddish and had fibro-elastic

and partially friable consistency. On histologic examination, the tumor consisted of cells with hyperchromatic, vacuolated and convoluted nuclei, sometimes with pronounced nucleoli, and an eosinophilic or clear cytoplasm, arranged in solid nodules, nests, and files. Large cells, multinucleated cells and areas of necrosis were present. Mitotic activity was marked, counting at least 3 mitoses per 10 high-power fields (HPF) and was more pronounced (even 25 mitoses per 10 HPF) in areas with large cells. Within the tumor, there was a follicular patterned papillary thyroid carcinoma of 0.6cm of diameter. The whole lesion seemed almost completely surrounded by a fibrous capsule.

On immunohistochemical examination the tumor cells showed expression of TTF-1. HBME-1 was expressed in the papillary carcinoma, while no expression of Chromogranin or Calcitonin was observed. The mitotic index (Ki67) was expressed in 20% of the cells.

Conclusion: The histopathological differential diagnosis of poorly differentiated thyroid carcinoma includes medullary carcinoma, follicular carcinoma and the solid variant of papillary carcinoma. Correct diagnosis is crucial due to the neoplasm's aggressiveness.

MIXED CELLULARITY HODGKIN'S LYMPHOMA WITH INTERFOLLICULAR GROWTH PATTERN. A CASE REPORT

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Background: We report a case of Hodgkin's lymphoma with interfollicular growth pattern in a patient with HIV infection.

Methods - Results: We report the case of a 41-year-old man with HIV infection who presented with cervical and supraclavicular lymphadenopathy. Ultrasound examination identified enlarged jugular (upper, middle and lower), posterior cervical and supraclavicular lymph nodes on the left side, measuring up to 2,5cm. Cervical left lymphadenectomy was performed for histological examination.

On histologic examination, the lymph nodes showed preservance of the follicular architecture with varying size germinal centers. Among the follicles, several scattered or aggregated, atypical, cells were observed, with enlarged nuclei, sometimes with eosinophilic nucleoli. Many of the atypical cells exhibited lobulated or multinucleated nuclei. The cytoplasm of these cells was either eosinophilic or clear. Several eosinophilic leukocytes were also present. On immunohistochemical examination, the atypical cell population showed PAX5, CD15, CD30, MUM1 and Cyclin D1 positivity and EMA focal and weak positivity. CLA, CD20, CD3, Bcl-2, Bcl-6, CD68, ALK-1 and k and λ light chains stain were negative. Molecular study demonstrated many positive, atypical, cells for EBER pb.

Conclusion: Hodgkin's lymphoma is a cause of lymph node swelling among HIV positive patients. The interfollicular growth pattern of our case is rarely observed and needs differential diagnosis with lymphadenopathy-lymphadenitis in the setting of HIV-infection.

MULTILOCULAR PAPILLARY THYROID CARCINOMA WITH A LOCUS OF ENCAPSULATED COLUMNAR CELL VARIANT

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Columnar cell variant (CCV) of papillary thyroid carcinoma is a rare tumor that is characterized by a papillary stratified epithelium with absence of nuclear features of papillary thyroid carcinoma and frequent CDX-2 positivity, a gastrointestinal nuclear factor. It is considered an aggressive variant , and the outcome depends on the encapsulation. We report a case of a 59-years-old woman, who underwent total thyroidectomy, because of a nodule of the right lobe characterized as malignant by FNA (Bethesda VI). We received a thyroid gland measuring 4.5x 2.6 x1.8 cm for the right lobe, 4x2,5x1,7cm for the left lobe and 1,5x2x1,1 for the isthmus. Pathologic examination revealed 3 loci of papillary thyroid carcinoma measuring 1, 1 and 1,8cm in the right lobe , left lobe and isthmus respectively. The loci of the right lobe was conventional papillary thyroid carcinoma. In the isthmus it was a follicular variant of papillary thyroid carcinoma. The loci of the left lobe was encapsulated and had morphologic features of CCV. CDX-2 immunohistochemistry was positive. A lymph nodes in the isthmus was negative. Pathological stage was p(3)T1bNx. No lymph node resection was performed. No recurrence ha been reported 6 months afterwards.

SECOND RECURRENCE OF TALL CELL VARIANT OF PAPILLARY THYROID CARCINOMA

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We report a case of an 72 -years -old man, who presented with a mass in his trachea. The man had a history of thyroidectomy in our hospital 4 years ago and the diagnosis was papillary thyroid carcinoma. He had a first recurrence two and a half years later. This was the second recurrence and our diagnose was that of tall cell variant of papillary thyroid carcinoma with evidence of progress towards poorly differentiated carcinoma. Our case confirms that this variant has a poorer outcome than conventional papillary thyroid carcinoma, and an accurate pathological diagnosis is essential.

PLEOMORPHIC ADENOMA (MIXED TUMOR) OF THE NASAL SEPTUM. A CASE REPORT

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Pleomorphic adenomas of the nasal cavity are rare and maybe misdiagnosed clinically. In addition the pathologic diagnosis can be challenging because they have greater myoepithelial cellularity. We present a case of a 41-years-old woman with a soft tissue massof the nasal septum diagnosed clinically as an inverted papilloma. The mass was 27x19x0.7 mm , with low vascularite and pushing the bone. Pathologically the tumor was cellular, with moderate myxoid stroma and immunohistochemistry (EMA, CEA, Calponin, p63) reviled luminal and myoepithelial cells. The proliferative rate (MIB-1) was low. In conclusion pleomorphic adenomas are rare but should be considered in the differential diagnosis of nasal masses.

AMELOBLASTOMA OF THE MAXILLARY SINUS: DIAGNOSIS AND MANAGEMENT

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Background: Ameloblastoma is a benign odontogenic tumor which is mostly reported in the jaw bone. The purpose of our study was to present a rare case of an ameloblastoma in the maxillary sinus.

Methods: A 69-year-old male was referred to our department withpersistent symptoms ofsinusitis. One year earlier, a mass had been removed from his right nasal cavity in another hospital which was sent for biopsy but the patient was not interested for the results. Computed Tomography scan revealed a massive lesion in the right maxillary sinus and in the right nasal cavity.Under local anaesthesia nasal endoscopy was performed which confirmed the existence of a mass and specimen was sent for biopsy.

Results: Thehistopathologicaldiagnosiswasinverted papilloma and thus hemignathectomy was executed in order to remove the tumor from the right maxillary sinus. The patient was examined periodically. 18 monthspostoperatively recurrence of the mass was observed. A new operation was performed and the tumor was completely resectedwith a combined endoscopic and open procedure. However the new biopsy of the resected lesion demonstrated that the tumor was ameloblastoma. After the last surgery the patient is following tactical examinations for possible new recurrences.

Conclusions: Differential diagnosis for maxillary sinus masses includes odontogenic masses. Ameloblastomasduetotheirlocationandtheirhistopathological characteristics, require close follow-up for potential recurrence, even after complete excision.