

ABSTRACT

and both epitheliomatoid and sarcomatoid (fuscellular) aspects. Immunohistochemical (IHC) staining was essential for neoplasm identification; positivity for S-100 and CKpool (dot-like) was found thus suggesting the diagnosis of oral amelanotic melanoma. Abdominal and neck ecography were performed in order to evaluate possible secondary locations and to achieve a neoplasm staging. No abdominal space-occupying lesion (SOL) came up (M0), while a lymphadenopathy (3,4 cm) at the left mandible angle and several bilateral hypoechoic neck lymph nodes with evident germinal centres were identified. Then, oral lesion was surgically removed by radical bone resection, extended to left upper jaw, premaxilla and nasal floor. The Patient was also sent to oncologist to organize both chemotherapy and radiotherapy treatment. Radical surgical treatment allowed the complete clinical healing of oral lesion and the patient has been rehabilitated with an obturator prosthesis. However Patient is undergoing chemotherapy and radiotherapy.

CONCLUSIONS: The oral amelanotic melanoma has a poor prognosis and an high aggressivity, therefore an early diagnosis and a multidisciplinary approach using medical and surgical treatments are essential for the correct management of the disease. Immunohistochemical stainings have an essential role for the correct diagnosis and, consequently, for a better therapeutical approach.

Lymphoepithelial carcinoma in a HCV patient: a case report

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BACKGROUND: Lymphoepithelial carcinoma (LEC) is a rare subtype of oral squamous cell carcinoma, characterized by a prominent reactive lymphoplasmacytic infiltrate, morphologically indistinguishable from nasopharyngeal carcinoma. This tumor is mainly located in the nasopharynx region, although has been reported in other head and neck regions, such as oral cavity, oropharynx, nasal cavity, and paranasal sinuses. The average annual incidence rate of LEC is less than 1 case per 100,000 persons, but it has an endemic geographic distribution, particularly in Southeast Asia. This condition exhibits close association with Epstein-Barr virus (EBV). Diets deficiencies in vitamin C and consumption of food that contains potentially carcinogenic N-nitrosamines have been implicated as contributing factors. Tobacco also has been implicated as a risk factor; however, the magnitude of its contribution to carcinogenesis is subject to debate. To date, no concomitant HCV infection in patients with LEC has been reported. The first case of metastasized LEC in a man with concurrent EBV and HCV infection is described herein. **METHODS:** On April 2017, a 43-year-old Caucasian man was referred to dentistry clinic of Marche Polytechnic University by his general practitioner for 4.8 tooth extraction. Furthermore, a 2-months history of lateral cervical adenopathy was reported. His medical history was significant for HCV infection in treatment with interferon. A past history of heroin and cocaine abuse was reported, but denied any recent drug use. Regarding pharmacological anamnesis, the patient was in treatment with methadone and lorazepam. Extra-oral

examination showed an enlarged and firm neck mass, with a diameter greater than 4 cm. Diagnostic iter included neck ultrasonography, complete CT scan, and ENT examination.

RESULTS: Ultrasonographic investigation revealed a hypoechoic, not confluent group of lymph nodes with clear signs of periadenitis and colliquation in its innermost part. CT examination showed diffuse and confluent laterocervical adenomegalies which were associated to a hypodense ill-defined nasopharyngeal lesion and a volumetric increase of right side submandibular gland which reached basicranium passing through oval foramen. Given the CT results, an endoscopic investigation was performed. A neoplastic lesion on the right side of the nasopharynx spreading into the homolateral nasal fossa. Biopsy specimen was obtained. Histological examination showed mild differentiated nonkeratinizing squamous cell carcinoma with a prominent reactive lymphoplasmacytic infiltrate. The presence of the EBV within tumor cells was proven with in situ-hybridization.

CONCLUSIONS: The exam findings were consistent with a final diagnosis of locally-advanced LEC of nasopharynx with multiple latero-cervical lymphadenopathies. To date, this is the first case of a LEC of nasopharynx occurring in a patient affected with HCV infection. This is similar to the case reported by Terada et al. In 2013, describing a LEC of esophagus in a patient with concurrent EBV and HCV infection.

MRONJ in patients treated with antiresorptive or antiangiogenic agents: a preliminary study

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BACKGROUND: Medication related osteonecrosis of the jaw (MRONJ) is a potential adverse effect related to the use of several drugs, including antiresorptive and antiangiogenic drugs. This pathology is triggered by a continuity solution of the mucosa, such as a dental extraction, and is characterized by the progressive bone destruction in the maxillofacial region. The presence of all the following characteristics may indicate that the patient is affected by MRONJ: current or previous treatment with antiresorptive or antiangiogenic agents; exposed bone or bone that can be probed through a fistula in the maxillofacial region that persists for more than 8 weeks; no history of head and neck radiotherapy or metastatic disease to the jaws. Regarding the pathogenesis, there are several hypotheses that could explain its unique localization to the jaws, involving inflammation and infection, bone remodeling suppression, and compromised angiogenesis. In this retrospective work we present the recurrence rate of MRONJ in a group of patients in treatment with antiresorptive (zoledronic acid) or antiangiogenic agents (denosumab).

METHODS: We report a case series of 12 consecutive patients affected by MRONJ, allocated in three groups on the basis of previous/current administered therapy: group A (zoledronic acid), group B (denosumab), and group C (zoledronic acid + denosumab). All patients were treated against osteoclast-mediated bone loss due to bone metastases. Age, sex, type of therapy, systemic and local risk factors were recorded. Treatment depended on the stage of MRONJ, consisting in medical and minimally-invasive surgical procedures. Follow-