PATHOLOGY OF THE GASTROINTESTINAL TRACT, PART I

V. practical training
3rd year General Medicine
Epulis gigantocellularis
Carcinoma of lips and tongue
Carcinoma of tongue
<table>
<thead>
<tr>
<th>Odontogenic cysts</th>
<th>Epithelial origin</th>
</tr>
</thead>
<tbody>
<tr>
<td>radicular</td>
<td>Malassez epithelial islets</td>
</tr>
<tr>
<td>apical</td>
<td>Hertwig sheath</td>
</tr>
<tr>
<td>lateral</td>
<td></td>
</tr>
<tr>
<td>Folicular (containing a tooth)</td>
<td>Internal and external epithelium of a enamel organ</td>
</tr>
<tr>
<td>lateral</td>
<td></td>
</tr>
<tr>
<td>eruptive</td>
<td></td>
</tr>
<tr>
<td>periradicular</td>
<td></td>
</tr>
<tr>
<td>extrafolicular</td>
<td></td>
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<tr>
<td>with rest of a tooth</td>
<td></td>
</tr>
<tr>
<td>folicular (toothless)</td>
<td>Tooth crests and its developing disorders</td>
</tr>
<tr>
<td>primordial</td>
<td></td>
</tr>
<tr>
<td>keratocyst</td>
<td></td>
</tr>
<tr>
<td>parodontal</td>
<td>Malassez epithelial islets</td>
</tr>
<tr>
<td>desmodontal</td>
<td>Hertwig sheath</td>
</tr>
<tr>
<td>gingival</td>
<td></td>
</tr>
<tr>
<td>residual cyst</td>
<td>radicular, folicular or parodontal cyst remained after tooth extraction</td>
</tr>
</tbody>
</table>
Radicular cyst
Ameloblastoma
Ameloblastoma
Pleiomorphic adenoma
Pleiomorphic adenoma
Adenoid cystic carcinoma
Adenoid cystic carcinoma
Cystic adenolymphoma of parotid (Warthin’s tumour)
Gastritis A

1 inflammatory infiltrate
2 pseudopyloric metaplasia
3 intestinal metaplasia
4 adenomatous dysplasia

Total atrophy of a mucosal surface
Gastritis A – in a detail

1. Inflammatory infiltrate
2. Pseudopyloric metaplasia
3. Intestinal metaplasia
Gastritis B - Helicobacter pylori (Warthin-Stary)
Chronic gastritis
Chronic gastritis
Chronic gastritis
Chronic gastritis
Acute peptic ulcer of stomach
Lauren’s classification of a stomach cancer

1) Intestinal type (40% of ca) — usually preserved tubular structures sometimes with papillary or solid areas, large hypechromic nuclei, frequent mitoses.

2) Diffuse type (50% of ca) — usually solid cell mass or with smaller groups of cells with dissociation, smaller nuclei, often picnotic, mitoses difficult to evaluate.

3) Mixed type (10% of ca)

Prognosis:
Diffuse type metastazise more often, time of survival is shorter (about 90% die within 3 years).
Stomach carcinomas

Metastasize via: lymphatics to regional, perigastric, abdominal and paraaortal lymph nodes
    blood vessels to a liver and bone marrow

Frequent-carcinosis of the peritoneum.

Common complications: pyloric stenosis (cachexia, risk of a perforation)
    haemorrhage (melaena)
    perforation (peritonitis, fistulation)
Acute peptic ulcer of a stomach – detail of surface
Chronic peptic ulcer of a stomach
Chronic peptic ulcer of a stomach
Adenocarcinoma of the stomach – exophytic cancer growth
1. Infiltration by medium-differentiated tubular adenocarcinoma – intestinal type
2. Transition to nontumorous glandular epithelium
Muscularis propria infiltrated with adenocarcinoma structures

1. Structures of tubular adenocarcinoma
2. Muscularis propria infiltrated by adenocarcinoma
Carcinoma solidum
Carcinoma solidum
Diffuse /scirrhotic/ carcinoma
Carcinoma of stomach, infiltration of oesophagus
MALT lymphoma of the stomach
MALT lymphoma of the stomach
MALT lymphoma of the stomach – mantle zone
Carcinoma of stomach – peritoneal carcinosis