carcinomas, mucoepidermoid carcinoma, clear cell odontogenic carcinoma, and others. We present two cases of jaw tumors and focus on the diagnostic challenge of each.

Case Reports: The first case is a 65 year-old man without diagnosis of a systemic disease, with a gingival red tumor and a radiolucent image with irregular borders in the incisor area. Histopathology showed proliferation of clear cells with round hyperchromatic nuclei, some with atypia. These cells formed solid nests separated by thin connective tissue septa with marked vascular proliferation. The clear cells presented diastase−periodic acid−Schiff, anti-Vimentin, anti-CD-10 and anti-PAX-8, anti-human Ki-67 positivity (30% of the cells) and it was negative for S-100 and CK-7. The diagnosis was clear cell carcinoma suggestive of clear cell metastatic carcinoma (MRCC). The second case is a 36 year-old woman with an asymptomatic radiolucent lesion in the periapical area of maxillary premolars. Histopathology showed a cellular proliferation formed by nests of clear oval and polygonal cells, with mild atypia separated by fibrous connective tissue septa. The immunohistochemical staining showed positivity for cytokeratin AE1/AE3 and negative for both S-100 and-smooth muscle actin. Mucicarmin and Congo-red stains were negative. This case was diagnosed as suggestive of clear cell odontogenic carcinoma (CCOC); it was indicated to rule out metastasis. The imaging evaluation confirmed a renal neoplasm in the first case and rule out the presence of lesions in the rest of the body in the second case.

Conclusions: CCOC and MRCC are histologically similar and immunohistochemistry studies play an important role in diagnosing clear cell tumors. So it is vital for the pathologist to know histomorphology and histo and immuno-histochemistry staining should be considered.

CD30-POSITIVE T-CELL LYMPHOPROLIFERATIVE DISORDER (TLPD), REPORT OF TWO CASES OF THE TONGUE AND THE POSED DIAGNOSTIC CHALLENGES.

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Objective: The presentation of CD30+ lymphoproliferative disorder can pose a diagnostic challenge, as CD30 expression has been observed in various reactive, inflammatory and neoplastic diseases. In this study we described two case reports with the immunohistochemical (IHC) profile of TLPD and ruled out TLPD mimics such as anaplastic large cell lymphoma.

Findings: Case 1: A 90-year-old female presented with a 6-month history of 3 × 5 mm ulceration of the left ventro-lateral tongue. Case 2: A 52-year-old female presented with a 15 × 20 mm deep submucosal mass of the left dorsum tongue. Histopathologic examination in both cases revealed infiltrate of atypical lymphocytes with some showing mitotic figures, mixed with eosinophils that penetrated deep into the muscle layers. The IHC profile revealed positivity for CD3 and CD2. CD30 was also positive in almost 75% of the atypical infiltrating cells. CD1a, EMA, ALK-1 and GRANZB were negative. Case 2 showed scattered positivity for CD20, and more of plasma cells with non-restricted positivity for Kappa and Lambda. In concert with hematopathology, both cases were reviewed and a diagnosis of TLPD was favored due to the increased strong diffuse positivity for CD30, negative expression of ALK-1 and CD1a, and the lack of trauma history.

Conclusion: As TLPD is managed clinically similar to Traumatic ulcerative granuloma with stromal eosinophilia (TUGSE) and follows an indolent course, it is important to recognize these entities to avoid possible overtreatment from a misdiagnosis of anaplastic large cell lymphoma.

WHERE DO AMELOBLASTIC FIBROMA AND AMELOBLASTIC FIBRO-ODONTOMA FIT IN THE CLASSIFICATION OF ODONTOGENIC TUMOURS?

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The 4th edition of the World Health Organization's Classification of Head and Neck Tumours was published in January 2017. In this edition ameloblastic fibroma, ameloblastic fibrodentinoma and ameloblastic fibro-odontoma have been grouped under odontomas as developing odontomas rather than inclusion as mixed odontogenic neoplasms. BRAFV600E mutations and low frequency of fractional allelic loss of tumour suppressor gene loci have been reported in ameloblastic fibroma and ameloblastic fibro-odontoma, indicative of a neoplastic process, however the prevailing view is that once dental hard tissues are produced, these lesions are more likely maturing into odontomas rather than true neoplasms, a view which has some support in the literature. Not withstanding some of these lesions reach significant size prior to diagnosis and management with bone expansion suggesting a neoplastic process. In addition lesions may recur and malignant transformation has been reported. The purpose of this paper is to present a case of ameloblastic fibro-odontoma, a case of ameloblastic fibroma and discuss the merits of the current classification of these lesions.

EXPRESSION OF CYTOKINES (IL22, IL23, IL17) AND STAT 3 WITHIN METASTATIC LYMPH NODES OF ORAL SQUAMOUS CELL CARCINOMA.

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The concept of pre-metastatic niche (PMN) is the process of a tumour preparing the microenvironment at a future metastatic site to facilitate the survival of disseminated tumour cells. The ability to produce a pro-inflammatory response is paramount to prevent the establishment of a PMN. We postulate that establishment of PMN is modulated by specific cytokines and the transcription factor STAT3.

Objectives: The aim of this study was to compare the expression of cytokines interleukin (IL) 22, IL23, IL17 and STAT3 in oral squamous cell carcinoma (OSCC) in lymph nodes with or without metastatic OSCC.

Formalin-fixed paraffin-embedded tissue blocks were obtained from the Oral Cancer Research Coordinating Centre, University