DIAGNOSIS • TREATMENT
EDUCATION & RESEARCH

American Academy of Oral and Maxillofacial Pathology

PRESIDENT'S MESSAGE

Carl M. Allen

A *What* Kind of Pathologist?

Does anyone else think that we, in oral and maxillofacial pathology, have a problem? It happened to me again just the other day. The renal doc called the heme/onc doc to look at a tongue lesion; the heme/onc doc was clueless and called the derm people; the derm people suggested that oral pathology be called. The response from the renal doc when I returned her page: "I've never heard of an oral pathologist!". Unfortunately, this seems to be the norm, rather than the exception. How much oral disease is out there, in various stages of misdiagnosis and mismanagement is difficult to say, but there are entire states that don't have an oral pathologist. At least one study has already shown that patients who are ultimately referred to us for clinical evaluation have already seen at least two other doctors. Should we assume that these patients are in the minority, and that the overwhelming majority of people with oral problems are being diagnosed and treated effectively? Currently we have 263 Fellows in the Academy, which works out to about one oral pathologist for every one million-plus people in the US. Is it reasonable to assume that oral disease is being effectively managed with this ratio?

Size Matters

Given our small numbers, it's no wonder that we have a visibility problem! And many of the problems with which we are faced every day probably stem directly from the fact that we appear on nobody's radar screen. Why is our specialty status being challenged? Why have we, as an Academy, not been contacted regarding issues such as oral cancer, sanguinaria-related leukoplakia or the risks of smokeless tobacco? My feeling is that we are such a small group that we are often simply overlooked. Even in those situations where we could contribute significantly, we tend to defer because any legal action might wipe us out financially. We must correct this situation. Relying on our good works and "word of mouth" hasn't done the trick. Some would say this is a job for professional marketing. But really, before we embark on a marketing campaign, we have to figure out what it is that we're trying to accomplish.

Who Are We, Anyhow?

Maybe before we do that, we should agree on what defines our specialty. The last time I checked, our educational standards set out at least two broad areas: histopathologic diagnosis and clinical diagnosis. We've been in discussions with Fellows who seem to emphasize one (usually histopathologic diagnosis) over the other. Is this reasonable? Do any other specialties have this problem? Let's compare our situation to that of Plastic Surgery. Some plastic surgeons operate only cosmetic cases, others operate only congenital anomalies, others specialize in burn management, and still others concentrate on hand injuries. They all train as plastic surgeons initially, however. In a major medical center, a plastic surgeon with a limited practice (caring for burn patients, for example) may be quite busy. In a smaller hospital, the plastic surgeon will probably have to do a bit of everything in order to make a living.

Would it make much sense if the subset of plastic surgeons who only did cosmetic surgery suggested that the manner in which they've limited their practice was the only correct way to define plastic surgery? By way of analogy, some in our ranks believe that oral pathologists practicing outside a dental school should

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IN MEMORIAM

Dr. Steve Kolas (died January, 2003)

Dr. Steve Kolas was born in Korcha, Albania, grew up in Cleveland, Ohio and attended West Tech High School. As a predental student at The Ohio State University, Steve lettered in wrestling in 1944. He attended Dental School at Ohio State and after graduation he joined the faculty as a popular teaching assistant and instructor while pursuing a graduate degree in pathology under Dr. Hamilton B. G. Robinson. He earned his M.Sc. degree in pathology in 1954 and became a regular faculty member at the rank of Assistant Professor. In 1958, Steve became Chairman of Oral Pathology at the rank of Associate Professor on the departure of his mentor, Ham Robinson who became Dean of the University of Missouri Dental School at Kansas City. Steve remained Chairman and in 1967 he was promoted to the rank of Professor. He will be remembered by his colleagues and students at Ohio State for his teaching in dental radiology and oral pathology and for his pleasing personality. In 1968, Steve left Ohio State to join his classmate and teaching associate Dr. Judson C. Hickey who had been appointed Dean of the Medical College of Georgia School of Dentistry in Augusta. Dr. Kolas founded the Oral Pathology department there and remained in that position until his retirement.

Dr. Kolas was appointed Associate Dean (For Student Affairs) in 1977 at the Medical College of Georgia; School of Dentistry and also chairman of Faculty Promotions Committee, from 1972-79. He was a consultant for the Veterans Administration Hospital and Fort Gordon Hospital in Augusta, Georgia. Dr. Kolas was representative of MCG School of Dentistry to Council of Faculties of American Association of Dental Schools from 1972-75. He was also a member of the Education Committee of American Cancer Society (South-East Division).

Submitted by Drs. Gus Cavalaris and Baldev Singh

Professor Emeritus Robert A. Goepp (1930-2003)

Robert A. Goepp, age 72, died March 30, 2003 because of a respiratory illness. Dr. Goepp was a dentist and oral & maxillofacial pathologist who devoted his career to teaching and research. He was a professor at the University of Chicago, where he rose to Professor Emeritus status.

Dr. Goepp was born on November 3, 1930 in Chicago, Illinois. Dr. Goepp received his BS degree in 1953 and DDS degree in 1957 from Loyola University. He was married to his classmate Dr. Iraida Pineeiro in 1960. Dr. Goepp received his PhD from the University of Chicago in Pathology in 1967. He was a Diplomate of the ABOMP and ABOMR. He was Director of the Zoller Dental Clinic at the University of Chicago from 1979 to 1987.

Dr. Goepp had diverse research experiences including development of a birth control device, but his notable research was the effect of radiation on the oral mucosa. He was a contributor and reviewer of scientific articles for ADA Journal. He was one of the Founders of the Academy of Oral and Maxillofacial Radiology.

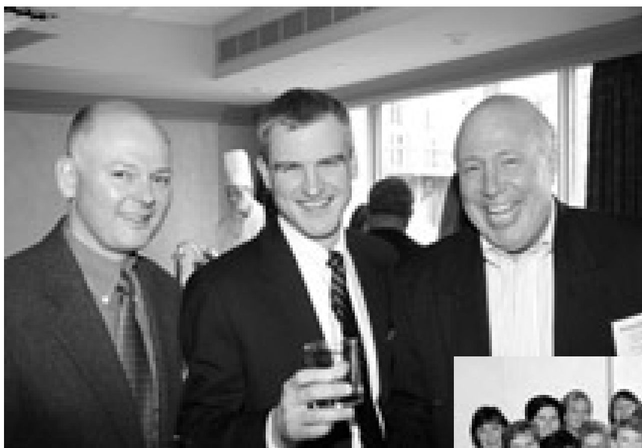
But his greatest contribution to the dental and scientific community is many postdoctoral fellows and graduate students whom he trained and inspired that have gone on to lead many top clinics and universities around the world.

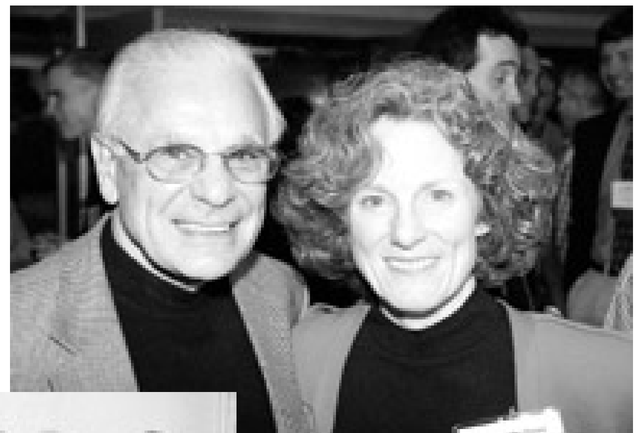
Bob had a strong and resilient personality with a delicate and humane manner. He loved art and played piano well. He was a devoted husband to his wife, Iraida, a loving and responsible father to his children, Robert C., (Heidi) and Myra, and to his two grandchildren, Alex and Charles Schurman. He was an inspiring teacher and scholar to his students and a creative scientist to his peers.

He will be missed.

Reza Mostofi

Annual Meeting and Conti
May 17 - 21, 2003





nuing Education Program
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Congratulations to the
"2003 Gorlin
Award Winner"

Paul C. Edwards, DDS

Long Island
Jewish Medical Center

fit only into a general pathology department. While that might work in a really large tertiary care center, most hospitals don't see that many oral/head and neck cases. One suggested solution: MD degrees for oral pathologists. But is this reasonable? To my knowledge, the few oral pathologists who have gone this route have ended up predominantly practicing general pathology, as these positions are typically more lucrative and are much more widely available.

Does this mean oral pathologists are forever excluded from working in hospitals? Not necessarily. We currently have colleagues working in hospitals, with minimal dental school affiliation, and these people are making a very decent living by using both their histopathologic and clinical diagnostic skills. All without MD degrees. When I question my physician friends about the necessity of an MD degree, their typical response is: why? They point out that, as oral pathologists, we have a unique set of diagnostic skills - no other specialty of medicine or dentistry can claim to understand the full scope of oral diseases as we do. Not only can we contribute in the area of head and neck histopathology, but we can contribute clinically by seeing patients referred from otolaryngology, dermatology, rheumatology, hematology/oncology, and general internal medicine.

Where Do We Go From Here?

The Academy has to make some critical decisions in the near future. The issues described above have been debated in several committees as well as in Executive Council. Our membership is graying, and it is difficult to attract quality people for our residency training programs, given the present scenario. We may be able to hang on for the short term (10-20 years), but I would regard the long-term prognosis as "guarded". Informing the health care community about who we are and what we can contribute to health care is, in my view, necessary to insure our survival. This is marketing, folks. It seems we often view the "M" word negatively, perhaps because it smacks of unprofessionalism, perhaps because it could cost a lot of money, perhaps because each of us, in our own little spheres of influence, are as busy as we want to be. However, with only one oral pathologist per million people in the U.S., would anyone disagree that there is the potential for more job opportunities? A focused marketing campaign can be directed towards the dual goals of 1) increasing awareness of our services within the health care system in general, and 2) highlighting the value-added nature of our profession to both medical and dental providers, as well as health care directors. The Executive Council needs your input regarding this situation - as you can imagine, there is no unanimity of opinion regarding this issue. A survey will soon be sent to the Fellowship, and essentially the thrust of this survey will be to assess your thoughts regarding the direction of the Academy and the future of our specialty.

2003 Fellows

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Emeritus Fellow
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Life Member
James Drummond, DDS, PhD

Banff, Canada Clinical Pathology Conference Diagnosis

Case 1 – Cutaneous choristoma

Case 2 – Odontogenic myxoma

Case 3 – Craniopharyngioma

Case 4 – Turner syndrome with giant cell lesion

Case 5 – Granular cell odontogenic tumor