

Oral Histopathology

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Series 21 (12 cases)

Case	Features
Salivary duct cyst	<ul style="list-style-type: none"> Cyst, lined by single to double layer epithelium with oncocytic metaplasia (floor of mouth/tongue)
Nasopalatine duct cyst (NPDC)	<ul style="list-style-type: none"> Cyst, midline anterior maxilla, lined by cuboidal to columnar/respiratory type epithelium; teeth respond, non-lingering, to thermal testing A <i>lateral periodontal cyst</i> in this location may present almost identically; aids to diagnosis would include the radiographic presentation (lateral root versus enlarged round to heart shaped radiolucency in midline) and presence of neurovascular elements (which would favor NPDC)
Gingival cyst	<ul style="list-style-type: none"> Cyst lined by simple to squamous epithelium beneath unremarkable surface epithelium on gingiva A radiograph should be made: osseous change suggests <i>lateral periodontal cyst</i> or 'cupping' effect on bone
Peripheral giant cell granuloma	<ul style="list-style-type: none"> Gingival nodule with multinucleated giant cells and hemorrhagic/granulation tissue background
Peripheral ossifying fibroma	<ul style="list-style-type: none"> Gingival nodule with viable bone in well-formed trabeculae
Peripheral ossifying fibroma	<ul style="list-style-type: none"> Gingival nodule with dystrophic calcifications
Peripheral ghost cell odontogenic tumor	<ul style="list-style-type: none"> Gingival nodule with dentin-like to amorphous 'ghost-like' eosinophilic material, lined by odontogenic type epithelium (tall to columnar cells with palisading resembling ameloblasts) and stellate reticulum (resembles developing tooth; refer to series describing tooth development) Peripheral odontogenic tumors may occur, though less frequently than other reactive gingival nodules; these include peripheral ameloblastoma, peripheral OKC, peripheral ghost cell odontogenic tumor (as in this case), peripheral adenomatoid odontogenic tumor, etc.
Central giant cell granuloma	<ul style="list-style-type: none"> Lytic lesion of mandible with multinucleated giant cells Evaluation for parathyroid and renal disease should be considered Multiple lesions should also raise evaluation for cherubism
Sialoliths, ductal ectasia, sclerosing sialoadenitis	<ul style="list-style-type: none"> Dilated salivary duct (<i>ductal ectasia</i>) with mucin, calcified material (sialoliths) and inflammation and sclerosis in surrounding salivary gland lobules (<i>sclerosing sialoadenitis</i>); the sialoadenitis is likely due to the obstruction
Verrucous carcinoma	<ul style="list-style-type: none"> Papillary hyperorthokeratosis (nuclei absent) with formation of keratin <i>chevrons</i> (V-shaped) structures and some keratin plugging Somewhat fragmented but overall presentation is an exophytic lesion Possible sequella to smokeless tobacco or proliferative verrucous leukoplakia
Verruca vulgaris	<ul style="list-style-type: none"> Benign papillary lesion, a.k.a. "wart" on skin; has similar 'chevrons' as seen in verrucous leukoplakia and verrucous carcinoma but marked orthokeratin, prominent granular layer and 'cupping' effect creating a well-defined lesion
Verruca vulgaris with pilosebaceous units	<ul style="list-style-type: none"> Same case as previous; shows hair and sebaceous units (helps orient this as a skin specimen)