Oral Histopathology

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Series 26 (9 cases)

Case	Features
Osteochondroma	• A condylar resection characterized by proliferation of a cartilage cap which blends into underlying bone, usually present as a growth (resembling an osteoma on radiograph) attached to the condylar head or neck • The cartilage can be seen blending with bone and capped by a collagenous/fibrous cap; marrow elements are also noted • These cases may also represent active growth centers and necessitate condylar resection and reconstruction
Peripheral giant cell granuloma, ulcerated	• Gingival nodule with multinucleated giant cells
Granular cell tumor	• Submucosal lesion from the dorsal tongue • Surface epithelium not identified but there is a clear infiltrative proliferation of pink to violet staining granular cells (compare condensed and uncondensed images); normal skeletal muscle stains more eosinophilic (pink) and a peripheral nerve fiber is also highlighted (the tumor does not surround or invade, it was merely present in the specimen and highlights contrast between nerve, muscle and the granular cells) • Infiltration does not alter prognosis (complete excision is often not feasible but does not tend to portend recurrence or invasion)
Capillary hemangioma	• Submitted as a mucocele (minor salivary glands noted in specimen), this lesion consisted of small endothelial lined vessels (capillaries) beneath the epithelium
Pyogenic granuloma, ulcerated	• Ulcer, fibrin and acute and chronically inflamed granulation tissue
Sclerosing sialoadenitis	• Same case as the pyogenic granuloma, consisting of minor salivary gland lobules with fibrosis/sclerosis and inflammation
Lobular capillary hemangioma	• Same case as the pyogenic granuloma/sclerosing sialoadenitis, consisting of lobules or groups of small capillaries • Entire case highlights, as for the case of *capillary hemangioma* the possibility that mucoceles and hemangiomas may present with similar clinical features (blue to red, nodular, vary in size/shape, blanching characteristics)
Acinic cell carcinoma, low grade papillary microcystic variant	• Clinically presented as a mucocele; at low power appeared to be a mucocele or salivary duct cyst; at high power there is proliferative change to the cyst lining • At first glance resembles mucoepidermoid carcinoma with pale mucus-like cells and some epitheloid cells; all the cells are very pale staining and there is nuclear pleomorphism and nuclear 'inclusions' which are not characteristics of mucoepidermoid carcinoma –condensed and uncondensed images suggest a granular nature to the cells and a more basophilic/purple color to the cytoplasm • This is a carcinoma known as *acinic cell carcinoma* thought to be derived from the serous acini (or possibly ducts); several tumors mimic this: mucoepidermoid carcinoma, acinic call carcinoma and *mammary analog secretory carcinoma* (thought to be similar to a form of breast cancer) are the most commonly reported and all are (fortunately) considered low grade tumors in most instances
Median rhomboid glossitis	• Debatable *candida* related red lesion, dorsum of the tongue • Histology: acute and chronic inflammation, similar to psoriasiform mucositis (geographic tongue) and may or may not have candida in the superficial epithelium (stains such as PAS and GMS may help)