Oral Histopathology

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Series 32 (13 cases)

Case	Features
Hairy tongue	• Clinically hairy tongue does not usually mandate biopsy, but when 'shave' is accomplished and submitted, this is the result: heavily keratinized filiform papillae with filamentous to amorphous violet-staining bacterial debris
Epidermoid cyst	• Cyst lined by squamous epithelium, with keratin being expelled into the cyst lumen • The term *epithelial inclusion cyst* is also an acceptable diagnosis
Salivary duct cyst	• The cyst between minor salivary gland lobules is lined by a double layer of oncocytic cells
Nasopalatine duct cyst, inflamed	• This is a particularly proliferative cyst with an oncocytic to respiratory-type lining and goblet cells, from the area #8-9 where a large radiolucency was noted; the cyst is inflamed (there is notable "blue dot" disease in the background)
Pemphigoid	• Subepithelial separation
TUGSE	• Heavily keratinized and acanthotic (thickened) epithelial layer (suggestive of frictional irritation) and underlying granulation tissue and eosinophils infiltrating the skeletal muscle • *Traumatic ulcerative granuloma with stromal eosinophilia (TUGSE)* often of the tongue
Amalgam tattoo	• A common way to diagnose this is descriptively: *oral mucosa with underlying exogenous pigmented material, consistent with amalgam/metallic tattoo* • A radiograph may be helpful and may show particulate radiopaque material • Clinical evaluation and the presence of a pigmented macule or patch (blue to gray to black, sometimes brown and mimicking melanotic macule) is often what drives the biopsy
BRONJ	• Necrotic bone and bacterial debris in an individual exposed to an oral bisphosphonate • Diagnosis may be *non-viable bone (osteonecrosis/sequestrum) and associated bacterial debris*; mention of granulation tissue and inflammation may be appropriate if discovered – cases should also carry a diagnosis comment regarding the exposure to bisphosphonate and some pathologists, in the absence of history of patient exposure, may add a comment such as "osteonecrosis has been associated with exposure to bisphosphonates/antimetabolites"
c/w fibrous dysplasia	• A fibro-osseous lesion consisting of irregular bone trabeculae without significant osteoblastic rimming and a loose somewhat vascular stroma; there are some larger more irregular spindle cells which may raise suspicion for more aggressive lesions such as osteoblastoma or osteosarcoma; a radiograph is mandatory (this case showed 'ground glass' appearance)
c/w fibrous dysplasia	• Compare to prior case; specimen shows irregular anastomosing bone trabeculae with and without osteoblastic rimming in a fibrous background with retraction of stroma away from trabeculae (reported as a histologic characteristic of fibrous dysplasia in some series)
Inflammatory buccal cyst	• This is a simple case of *epithelial-lined granulation tissue* or an *inflamed cyst*; radiograph and clinical information is important, these are usually radiolucencies associated with furcation of mandibular molars in young patients (8-14 years) and usually periodontal inflammatory processes; patients may be treated with debridement and investigation for cervical enamel projections, enamel pearls or debris that may have contributed
c/w renal cell carcinoma	• This was a poorly differentiated carcinoma with something of a nested architecture; nests are separated by fine vascular networks; clinical history (a known renal cancer) and immunohistochemistry (the specimen stained for specific kidney markers) aided in diagnosis
Neuroma	• A large proliferation of nerve fibers; a portion of the unaffected nerve (showing *nodes of Ranvier* and axons highlighted by yellow and red arrows) is noted, as are minor salivary gland lobules; the history was that of excision of a mucocele, the neuroma resulted