

## Oral Histopathology

David E. Klingman, DMD

Diplomate, American Board of Oral and Maxillofacial Pathology

Diplomate, American Board of General Dentistry

### Series 39 (12 cases)

Case	Features
Mucoepidermoid carcinoma, low grade	<ul style="list-style-type: none"> <li>Largely cystic with numerous mucus cells and optically clear cells</li> <li>More solid forms (less cystic), perineural invasion, high mitotic activity, pleomorphic/anaplasia and necrosis all tend to lead to a higher 'grade' diagnosis (however, treatment and prognosis are more tied to clinical stage than histologic grade)</li> </ul>
Benign mixed tumor	<ul style="list-style-type: none"> <li>Moderately well defined, unencapsulated but uninvolved overlying mucosa</li> <li>Myoepithelial cells, some chondromyxoid stroma, intermixed with adipose (fat)</li> </ul>
Nasopalatine duct cyst	<ul style="list-style-type: none"> <li>Squamous to 'transitional' to respiratory type epithelium lining a cyst</li> <li>Location (radiolucency, midline anterior maxilla) and vitality (vital teeth) aid in diagnosis</li> </ul>
Radiesse®	<ul style="list-style-type: none"> <li>Non-polarizable dermal filler in the upper lip, with foreign body giant cell reaction</li> <li>These cases are typically compared to a library of known fillers in order to reach a more specific diagnosis</li> </ul>
Hemangioma	<ul style="list-style-type: none"> <li>Multiple dilated endothelial lined channels beneath an unremarkable squamous epithelium</li> </ul>
Angina bullosa hemorrhagica vs. varix vs. ITP	<ul style="list-style-type: none"> <li>This is a challenging case, consisting of hemorrhage beneath what appears to be an epithelial layer exhibiting a subepithelial split (consistent with a form of pemphigoid); angina bullosa hemorrhagica is a form of pemphigoid that manifests clinically as 'blood blisters'</li> <li>A varix is considered since this may represent an endothelial lined channel</li> <li>Idiopathic thrombocytic purpura (ITP) is considered in most cases where there is significant mucosal hemorrhage; these cases require further workup (immunofluorescence to exclude pemphigoid et.al., serology for ITP, etc.)</li> </ul>
Squamous cell carcinoma	<ul style="list-style-type: none"> <li>This is an invasive keratinizing carcinoma</li> </ul>
Squamous cell carcinoma	<ul style="list-style-type: none"> <li>This is a minimally invasive keratinizing carcinoma</li> </ul>
Dentigerous cyst, by frozen section	<ul style="list-style-type: none"> <li>There is some freeze artifact, but the cyst is lined by a simple to squamous epithelium and the clinical history was that of an impaction</li> </ul>
Dentigerous cyst, by permanent section	<ul style="list-style-type: none"> <li>This is the formalin fixed tissue from the previous case; evaluation of the entire lesion demonstrated this relatively simple cyst lining (features of other cysts such as odontogenic keratocyst, glandular odontogenic cyst, ameloblastoma were not identified)</li> </ul>
OKC, focally inflamed	<ul style="list-style-type: none"> <li>The classic features of OKC (basal palisading, 5-8 cell layers, parakeratin) are masked where there is focal inflammation, giving the appearance of an inflamed cyst only; this masking must be taken into account in cases that are exposed to the oral cavity (including those cases marsupialized) – this may be helpful in large lesions, as marsupialization may decrease the size of the cyst and alter the biologic behavior (reduce recurrences, etc.)</li> </ul>
OKC	<ul style="list-style-type: none"> <li>The classic features of OKC (basal palisading, 5-8 cell layers, parakeratin) are present</li> </ul>