Cartilaginous Choristoma of Gingiva

SIR,

Choristoma is a tumor-like mass consisting of normal cells in an abnormal location. Oral choristomas were first described by Berry in 1890. Cartilaginous choristomas usually arise in adults as asymptomatic submucosal masses in the distal extremities but rarely in the soft tissue of oral cavity. Cartilaginous choristoma is histologically composed of mature hyaline cartilage.

A 27-year lady presented with a painless swelling of gingiva, extending from mandibular right first premolar to mandibular left lateral incisor, measuring 3 x 3 cm, from 1 year (Figure 1). The swelling was initially small and increased slowly in size. On palpation, it was hard in consistency. Radiological examination did not reveal any bone loss. On the basis of all these findings, a provisional diagnosis of pyogenic granuloma was given with the differential diagnoses of fibroma, peripheral giant cell granuloma, peripheral ossifying fibroma, neurofibroma, granular cell tumor, etc.

Surgical excision was performed under local anaesthesia and the tissue was sent for histopathological examination. Histopathological examination revealed nodules of mature chondrocytes placed in a cartilaginous matrix with mild atypia, separated by fibrous septa (Figure 2). The surrounding stroma showed numerous dilated blood vessels lined by endothelial cells and few areas of myxoid degeneration (Figure 3). The diagnosis of cartilaginous choristoma was given and the follow-up period of 6 months was uneventful.

The etiology of cartilaginous choristoma is not clearly understood but two different theories have been proposed. The embryonic remnants theory depicts that these lesions derived from embryonal remnants, and the metaplastic theory suggests that these lesions derive from metaplasia of chondroid tissue due to trauma and/or chronic inflammation. Intraorally, 85% of the cases are reported in the buccal mucosa. Gingiva is considered as one of the rarest sites; only 4 cases have been reported in the literature so far. The treatment of choice is surgical removal. The lesions do not recur.

This case highlights the need to consider this lesion in the differential diagnosis of hard intraoral masses.

REFERENCES

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