language literature revealed 52 cases of tonsillar lymphangiomatous polyp, including the current case.[5-29] Data from these cases are summarized in Table I. Age at diagnosis ranged from 3 years to 63 years, with an average age of 23.9 years. A slight male predilection was noted (31 males, 21 females). The lesion arose in the left tonsil in 27 cases and from the right tonsil in 22 cases. One patient had lesions in both tonsils. The size of the lesion was specified in 46 cases and ranged in size from 0.5 to 5 cm, with an average size of 2 cm. Duration of presence of the lesion was known in only 14 cases and ranged from 3 days to 20 years. All of the lesions were treated with conservative surgical excision, usually in combination with tonsillectomy. Follow-up information was available in 30 cases. No recurrences were recorded after an average length of follow-up of 4.4 years. This differs from oral lymphangiomas, in which recurrence after surgery is often seen.

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CLINICOPATHOLOGIC CONFERENCE CASE 2: RECURRENT RIGHT MANDIBULAR RADIOLUCENCY

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Clinical Presentation: In 2012, a 59-year-old male was referred for oral and maxillofacial surgery to evaluate a well-circumscribed, multilocular radiolucency measuring approximately 3×4 cm in the right posterior mandible (Figure 1). Incisional biopsy was performed, and a diagnosis of ameloblastoma (AME) was made. Soft tissue alterations were not observed intraorally, and only minimal osseous change had occurred during the 3-month interval between the initial diagnosis of AME and the rendered treatment of partial mandibulectomy.

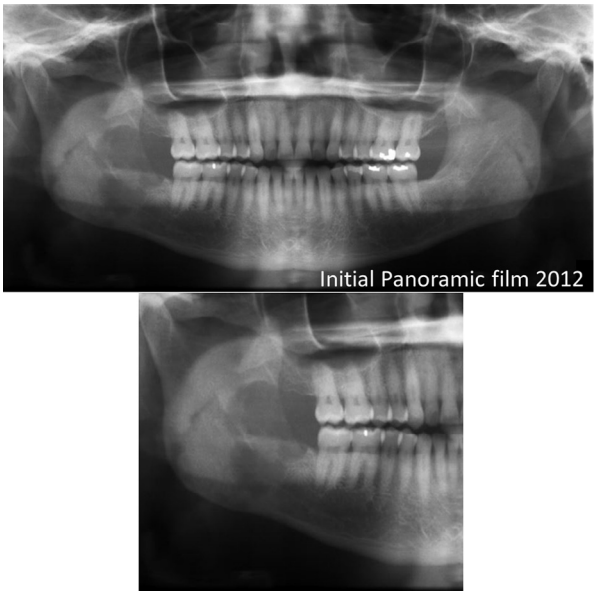

Fig. 1. Panoramic imaging of right posterior mandible revealing well-circumscribed, multilocular, radiolucency measuring approximately 3 × 4 cm.

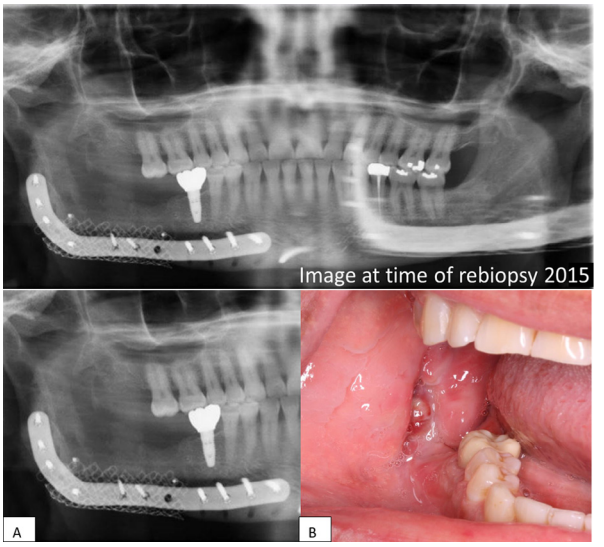

Fig. 2. (**A**) Panoramic imaging at time of biopsy in 2015. Panoramic and cone beam computed tomography (not pictured) imaging of limited diagnostic value. (**B**) Clinical photo of soft tissue swelling, right buccal mucosa/retromolar pad region, at the 2-week follow-up appointment.

From 2012 to 2014, postoperative healing was unremarkable until a continuity defect and associated hardware failure was discovered and corrected in 2014. Soft tissue obtained during correction of the continuity defect was negative for residual/recurrent AME.

Following another period of unremarkable healing, routine follow-up in 2015 revealed a distinct nonspecific soft tissue swelling, measuring approximately 1 × 1 cm and involving the right posterior buccal mucosa and retromolar pad region. This clinical finding was accompanied by a 2-week history of regional tenderness, decreased incisal opening, and diffuse swelling of the right mandible. Conventional and cone beam computed tomography were performed, but restorative hardware and previous surgical intervention decreased the image quality and limited interpretation (Figure 2A). Incisional biopsy of the soft tissue swelling was performed and histologic diagnosis rendered. Two weeks following the initial biopsy, the soft tissue mass had doubled in size (Figure 2B).

Differential Diagnosis: The differential diagnosis for a rapidly growing, tender soft tissue mass of the buccal mucosa/retromolar pad area is fairly extensive. In this case, the differential diagnosis is complicated by the previous histologic diagnosis of, and subsequent resection for, AME. When developing a differential diagnosis for a patient whose treatment spans multiple years and consists of significant surgical intervention, review of the previous material to confirm the original diagnosis is recommended.

Assuming that the provided diagnosis of AME is accurate, a primary consideration for the 2015 soft tissue presentation should be residual/recurrent AME. The presence of AME in a peripheral location could be explained either by direct soft tissue extension of residual/recurrent tumor or by tumor seeding that occurred during the original resection. Although AME is a benign odontogenic tumor, it is known to have a significant recurrence rate, even with wide and histologically negative surgical margins.[1] A diagnosis of recurrent/residual AME remains a reasonable diagnostic consideration, but the apparent change in biologic behavior is suggestive of a more aggressive process, such as high-grade transformation from AME to ameloblastic carcinoma (AMECA). AMECA is a rare malignant tumor of the jaws that demonstrates a unique histology comprising combined features of AME and malignancy. The clinical findings in AMECA include swelling, pain, ulceration, and rapid growth. It occurs more commonly in the mandible than in the maxilla, has the potential for metastasis, and has been reported to develop at sites of prior AME.[2]

Pyogenic granuloma (PG) is a common non-neoplastic lesion that can grow rapidly and have a worrisome clinical appearance because of ulceration, bleeding, lobulated/exophytic growth, and absence of pain in early lesions. PG can occur throughout the oral cavity and, as in this case, is known to recur if incompletely excised. Although there are similarities between PG and the lesion in this case, the overall clinical features, including diffuse swelling, made a diagnosis of PG unlikely.

Squamous cell carcinoma (SCC), which represents the most common malignancy of the oral cavity, is an aggressive disease, where the dysplastic epithelium invades the underlying lamina propria, connective tissues, and deeper structures. Similar to the lesion in this case, it may present as an ulcer, mixed red-white plaque, or polypoid mass.[3] Although the most common sites for oral SCC are the lateral border of the tongue and the floor of the mouth, the retromolar pad is also a known site of occurrence.[3] Intraoral involvement by SCC is commonly associated with the risk factors tobacco and alcohol.[4] Unfortunately, the provided clinical information in this case failed to mention the presence or absence of associated risk factors. Rarely, SCC arises in an intraosseous location.[3]

Salivary gland and odontogenic neoplasms (other than previously discussed AME and AMECA) could present with worrisome clinical features, such as tenderness, swelling, and limited mouth opening. Although these 2 neoplastic categories are not often discussed together, given the previous surgical intervention and uninformative imaging in this case, distinguishing between these 2 clinically was challenging. Both benign and malignant entities could be considered, but malignancy was favored. Although salivary gland and odontogenic neoplasms arise from underlying