A 22-year-old female noticed a 1.0x1.0 cm gingival mass of one-year duration. Two months prior to consult, a panoramic radiograph was performed, revealing a defined unicystic, mixed radiopaque and radiolucent lesion between the premolars on the right hemi-mandible, causing displacement on the roots of the premolar without signs of resorption and not associated with any unerupted tooth (Figure 1). Physical examination revealed a swelling at the right mandibular premolar area (Figure 2). Enucleation with peripheral ostectomy was performed and the mass was submitted for histopathologic examination. The patient was advised follow-up.

Histopathologic examination revealed a lesion composed of odontogenic epithelial islands with peripheral palisading columnar basal cells and central stellate reticulum. The basal cells have vacuolated cytoplasm with nuclei exhibiting reverse polarity (Figure 3). Microcysts and squamous differentiation were seen. (Figure 4). The morphologic features were consistent with an acanthomatous ameloblastoma.
Ameloblastoma is a benign odontogenic tumor that comprises about 1% of all oral tumors and 9-11% of odontogenic tumors. It occurs over 80% in the mandible and 20% in the maxilla. It has no sex predilection, has a wide age range, and appears as a lytic expansile lesion radiographically. Depending on the appearance of the central reticulum, the terms spindle cell, granular, basal cell, and acanthomatous are used. The term acanthomatous ameloblastoma is used when the central stellate reticulum displays squamous differentiation.

Ameloblastoma is placed under borderline (low-grade malignant) category, rather than benign, due to its aggressive properties and tendency to recur. Although rare, metastases have been documented.

REFERENCES

6. Rosai and Ackerman’s Surgical Pathology, 10th ed.; 2011.