2-Developmental Defects of the Oral Mucosa

1- FORDYCE’S GRANULES
They represent ectopic sebaceous glands which are present in the oral mucosa in at least 80% of adults, particularly in elderly people. They grow in size with age and appear in the oral mucosa as soft, symmetrically distributed, creamy spots a few millimetres in diameter. The buccal mucosa is the main site, but sometimes the lips and rarely, even the tongue is involved. These glands are sometimes mistaken for disease but patients can be reassured that they are of no significance. If a biopsy is carried out it shows a normal sebaceous gland with two or three lobules.

2- LEUKOEDEMA
Leukoedema is a bilateral, diffuse, translucent greyish thickening, particularly of the buccal mucosa. It is a variation of normal, present in 90% of blacks and variable numbers of whites. Histologically, there is thickening of the epithelium with intracellular oedema of the spinous layer. Treatment is unnecessary but reassurance may be required.

3- WHITE SPONGE NAEVUS
A developmental anomaly inherited as an autosomal dominant trait.

Clinical features:
The affected mucosa is white, soft and irregularly thickened. The abnormality is usually bilateral and sometimes involves the whole oral mucosa. There are no defined borders and the edges fade into normal tissue. The anus and vagina can also be affected. No treatment is required only reassurance.

The retrocuspid papilla
A 2 to 4 mm slightly raised area of mandibular alveolar mucosa located lingual to the cuspids, between the marginal gingiva and the mucogingival junction. It is commonly bilateral but can also be unilateral, and it is prominent in children. Because retrocuspid papilla is commonly bilateral
and has a very specific location, it is logical to assume that it represents a normal anatomic structure. 

**Histologically:** a mass of vascular connective tissue with numerous large stellate fibroblast (with several nuclei) in the superficial connective tissue. No treatment is required.

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### 3- Developmental defects of the tongue

#### 1- Macroglossia
It is an abnormaly large tongue, it could be congenital or acquired.  
**Congenital macroglossia e.g.** Down's syndrome, Congenital haemangioma or lymphangioma.  
**Acquired macroglossia e.g.** Cretinism, Acromegaly, Amyloidosis, Lingual thyroid, Cancer.

#### 2- Microglossia:
It is an abnormally small tongue. It is uncommon, but mostly associated with a group of overlapping conditions known as (oromandibular-limb hypogenesis syndrome) which is characterized by limb abnormalities like absence of digits.

#### 3- Hairy tongue
The filliform papillae can become elongated and hair-like forming a thick fur on the dorsum of the tongue. The filaments may be up to half a centimetre long and pale brown to black in colour. Adults are affected but the cause is unknown. Heavy smoking, excessive use of antiseptic mouth washes and defective diet has been blamed, but their effect is questionable. The discoloration is probably caused by pigment-producing bacteria and fungi but not *Candida albicans*.  
**Treatment**
It is difficult. The measure most likely to succeed is to persuade the patient to scrape off the hyperplastic papillae and vigorously clean the dorsum of the tongue with a firm toothbrush. This removes large numbers of microorganisms mechanically and also, by removing the overgrown papillae, makes conditions less favorable for their proliferation.

#### 4- Black tongue
The dorsum of the tongue may sometimes become black without overgrowth of the papillae. This may be staining due to drugs such as iron compounds used for the treatment of anemia, but is then transient. Occasionally the
sucking of antiseptic lozenges causes the tongue to become black, and this may be due to pigment producing organisms, particularly Bacteroides strains.

5- FISSURED TONGUE (SCROTAL TONGUE)
Fissured tongue is relatively common. Numerous grooves, or fissures, are present on the dorsal tongue surface. The cause is uncertain, but heredity appears to play a significant role. Aging or local environmental factors also may contribute to its development. Fissured tongue also may be a component of Melkersson Rosenthal syndrome.

6- Furred tongue
The tongue becomes coated with desquamating cells and debris, in those who smoke heavily, in many systemic upsets, especially of the gastrointestinal tract, and infections in which the mouth becomes dry and little food is taken. A furred tongue is often seen in the childhood fevers, especially scarlet fever.

7- Lingual varicositis
Dilated tortuous veins may be seen along the ventral surface of the tongue and tend to become more prominent with age. They may be noticed by patients who need to be reassured that they are not abnormal.

8- Geographical tongue (erythema migrans linguæ)
It is the recurrent appearance and disappearance of red areas on the tongue. The cause is unknown but sometimes there is a clear family history of its presence in several generations. In many patients geographical tongue seems to be a developmental anomaly but there also appears to be an association with psoriasis.
Clinically: an irregular, smooth, red area appears, usually with a sharply-defined edge. It extends for a few days, and then heals, only to appear again in another area. Sometimes the lesion is annular with a slightly raised pale margin, and several of these areas may coalesce to form a scalloped pattern. Most patients have no symptoms but some adults complain of soreness.
Histologically: there is thinning of the epithelium in the centre of the lesion with mild hyperplasia and hyperkeratosis at the periphery, there are chronic inflammatory cells in the underlying connective tissue. Sometimes the changes are the same as those of psoriasis.
The Condition is considered important, because it can be confused with more serious form of **glossitis and even premalignant or malignant lesions**.

**9- Ankyloglossia**
It is characterized by a **short, thick lingual frenum** resulting limitation of tongue movement. The frenum sometime extends forward and attach to the tip of the tongue and there may be a slight clefting of the tongue. Occasionally, high mucogingival attachment of the lingual frenum may lead to local gingival and periodontal diseases in the regional frenal attachment.

**10- Lingual thyroid nodule:**
1- Accessory accumulation of thyroid tissue within the body of posterior tongue.
2- It represents a thyroid remnant in the region of the thyroid gland origin.
3- More common in females apparent during puberty and adolescence.
4- 2-3 cm, smooth, sessile mass on mid –posterior dorsum of the tongue in the region of foramen caecum.
5- Symptoms include dysphagia, dysphonia and hypothyroidism.

**11- Cleft tongue**: - disunion of tongue usually occurs due to failure of fusion of the two lateral part of the tongue (mainly anteriorly) and this will lead to bifid tongue or cleft tongue.

**4- DEVELOPMENTAL DEFECTS OF THE LIPS AND PALATE**

1-Orofacial clefts:

**A- Cleft lip and palate:**
Clefts can form in the lip or palate alone or in both. The aetiology is unknown but there is a genetic component in approximately 40% of cases. The risk of having such defects is greatly increased if one, and particularly if both, of the parents are affected.

**Cleft lip:** Developing defect usually of the upper lip characterized by a wedge-shaped defect resulting from the failure of two parts of the lips to fuse into single structure. Cleft lip (with or without a palatal cleft) is **more common in males**, while cleft palate alone is approximately twice as **common in females**. The incidence of cleft lip is about 1 per 1000 live births, while that of isolated palatal clefts is about 1 per 2000 live births.
In terms of relative frequencies, cleft lips form about 22%, combined defects of lip and palate form about 58% and isolated palatal clefts form about 20% of this group of defects. **The reason for the variations in the sites of clefts is that the lip and anterior palate (the primary palate) develop before the hard and soft palates (the secondary palate).**

Fusion of the secondary palate is from behind forwards. Isolated cleft lip is therefore the result of an early developmental disorder, while isolated cleft palate results from influences acting later, after the primary palate has closed. By contrast, a prolonged disorder of development can prevent both primary and secondary palates from closing and leaves a severe combined defect.

**Classification**
The main types of cleft lip and palate are:-

1. **Cleft lip**
   - **Unilateral** (usually on the left side), with or without an anterior alveolar ridge cleft
   - **Bilateral**, with or without alveolar ridge clefts, complete or incomplete

2. **Palatal clefts**
   - Bifid uvula, Soft palate only, both hard and soft palate

3. **Combined lip and palatal defects**
   - Unilateral, complete or incomplete
   - Cleft palate with bilateral cleft lip, complete or incomplete

In the worst cases there is complete separation of the anterior palate, which projects forward with the centre section of the lip and is attached only by the nasal septum.

**Environmental factors: - include**

1. Physiologic, emotional or traumatic stress.
2. Nutritional deficiency or excess of vitamin A and Riboflavin deficiency.
3. Mechanical obstruction by large tongue.
4. Relative ischemia to the area.
5. Substances like, alcohol, drugs and toxins.
6. Infections.

**B- Oblique facial cleft:**

It represents failure of fusion of the lateral nasal process with the maxillary process. It extends from the upper lip to the eye and always associated with cleft palate.
C- Lateral facial cleft:-
It results from lack of fusion of the maxillary and mandibular processes. Occurs as isolated defects or may be associated with other disorders as mandibular dysostosis. It is either unilateral or bilateral extending from the commissures toward the ear resulting in macrosomia.

2- Double lip: - this anomaly characterized by a horizontal fold of redundant mucosal tissue that is usually located on the inner aspect of the upper lip. Most often congenital in nature, but it may be acquired later in life.

3- Congenital lip pits: - developmental defects that may involve the Para median portion of the vermillion of the lower and upper lip (Para median lip pit), or the labial commissural area (commissural lip pit).
Para median lip pit: present as bilateral and symmetric fistulas on either side of the midline of the vermillion of the lower lip. It occurs as an isolated condition or may be associated with cleft lip or cleft palate.
Commissural lip pits: A small mucosal invagination that occur at the corner of the mouth on the vermillion border. It may represent a failure of fusion of the maxillary process and mandibular process. It is either unilateral or bilateral. Clinically it represents as blind fistula that may extend to a depth of 1-4 mm or it may be present as dilated ectopic salivary gland tissue.

5- DEVELOPMENTAL DEFECTS OF THE JAW BONES
1- BONY OVERGROWTHS( Bony exostosis)
Localised overgrowths of bone that arises from normal cortical plate (exostoses) are more common. Small exostoses may form irregularly on the surface of the alveolar processes and specific variants are torus palatinus and torus mandibularis. They differ from other exostoses only in that they develop in characteristic sites and are symmetrical. Torus palatinus commonly forms towards the posterior of the midline of the hard palate. The swelling is rounded and symmetrical, sometimes with a midline groove. It is not usually noticed until middle age and, classified according to their morphology into:
   1- Flat torus which have broad base.
   2- Spindle torus appears as a midline ridge.
   3- Nodular torus appears as multiple protuberances.
   4- Lobular torus appears as lobulated mass arises from single base.
It should be removed, if it interferes with the fitting of a denture.
**Torus mandibularis** form on the lingual aspect of the mandible opposite the mental foramen. They are typically bilateral, forming hard, rounded swellings. The management is the same as that of torus palatinus.

2- **Agnathia:** (nathia= jaw, Ag = Agenesis).
   It is developmental congenital absence of one of the jaws; it is a rare condition and mostly occurs as part of the mandible is absent.

3- **Macrognathia:**
   It is abnormally large jaw, some times called prognathism. This defect occurs either due to local cause, e.g. fibrous dysplasia of bone, reactive or neoplastic bone tumor, odontogenic cysts and tumors or associated with systemic diseases as Acromegaly and Pagets disease of bone.

4- **Micrognathia:**- very small jaw
   It is a developmental disturbance affecting one of the jaws and lead to abnormally small jaw. The condition gives rise to numerous dental problems.
   Micrognathia may be associated with other developmental defect like in Pierre Rboins syndrome which is characterized by cleft palate, micrognathia and glossoptosis (posterior displacement of the tongue, lack of support of tongue musculature and airway obstruction).

5- **Coronoid hyperplasia:**
   It is rare developmental anomaly which results in limitation of mandibular movement. The condition may be unilateral which result from osteoma and osteosarcoma or bilateral which may result from endocrine influence during puberty.

6- **Condylar hyperplasia:**
   Excessive growth of one condyle is of unknown cause but local circulatory problems, endocrine disturbances and trauma have been suggested as possible etiological factors.

7- **Condylar hypoplasia:**
   **Congenital:** - associated with mandibulofacial dysostosis and hemifacial macrosomia.
   **Acquired:** - result from disturbance of growth center of the developing condyle secondary to trauma, radiation or rheumatoid arthritis.
8- **Bifid condyle:**
Double-headed mandibular condyle of uncertain cause.
Anteroposterior bifid condyle may be traumatic in origin during childhood.
Mediolateral bifid condyle may result from abnormal muscle attachment.

9- **Hemifacial hypertrophy:**
Significant unilateral enlargement of the face as a result of an increased neurovascular supply to the affected side of the face.
Unilateral enlargement of the facial tissues, bones and teeth is usually present resulting in asymmetry of the face with malocclusion and deviation of the affected side of the face to the unaffected side of the face.

10- **Hemifacial atrophy:**
Uncommon poorly understood degenerative condition, characterized by:
1- Atrophic changes affecting one side of the face.
2- The mouth and nose are deviated toward the defective side.
3- The covering skin often exhibit dark pigmentation.

11- **Lingual mandibular salivary gland depression (Stafne defect)**
Developmental concavity of the cortex of the mandible in the molar area, that forms around an accessory lateral lobe of submandibular gland which has **radiographical appearance** of a **well-circumscribed cystic lesion** within the bone usually below the inferior alveolar canal.
In most cases biopsy revealed **histologically normal salivary gland** tissue suggesting that these lesions represent developmental defects containing portion of the submandibular gland.

12- **Mandibular Dysostosis (Treacher-Collins syndrome)**
Autosomal dominant disorder characterized by:-
1- Hypoplastic zygoma, resulting in narrow face with depressed check and downward slanting of palpebral fissures.
2- Underdeveloped mandible with retruded chin and cleft palate may be seen.

13- **Cleidocranial Dysplasia or Dysostosis**
It is rare familial disorder characterized by defective formation of the clavicles, delayed closure of fontanels and sometimes retraction of the
maxilla. Partial or complete absence of clavicles allows the patient to bring the shoulders together in front of the chest. This disorder is one of the few recognizable causes of delayed eruption of the permanent dentition. Many permanent teeth may remain embedded in the jaw and frequently become enveloped in dentigerous cysts. Supernumerary teeth may be seen radiographically.

DEVELOPMENTAL CYSTS OF THE ORAL AND MAXILLOFACIAL REGION

Cysts are epithelium-lined pathological cavities, usually filled with fluid, semi-solid material, or cellular debris. Also are called fissural cysts or occlusion cysts, because they arise from embryonic epithelium that becomes entrapped during embryogenesis. Clinically, they present as a soft or fluctuant swelling. Cysts of the oral and maxillofacial region are divided into odontogenic, nonodontogenic, pseudocysts, and neck cysts. Pseudocysts differ from true cysts in that they lack an epithelial lining.

**1-Nasolabial Cyst (Nasoalveolar cyst)** is a rare developmental soft-tissue cyst that develops in the upper lip in the canine region. **Etiology:** Unclear. Although there are two major theories:

One theory considers this cyst to be a fissural cyst arising from epithelial remnants entrapped along the line of fusion of the maxillary, medial nasal and lateral nasal processes.

A second theory suggests that these cysts develop from misplaced epithelium of the nasolacrimal duct.

**Clinical and radiographical features:** It appears as a soft-tissue swelling in the mucobuccal fold of the maxilla, lateral to the midline. Occasionally, the patient may complain of nasal obstruction, discomfort, or difficulties in wearing dentures. The cyst is more common in women, usually between 40 and 50 years of age. Because this cyst arises in soft tissues, in most cases there are no radiographic changes, but resorption of the underlying bone may occur.

**Histopathological examination** shows lining of the cyst by pseudo stratified columnar epithelium, often show goblet cells and cilia. The cyst wall is composed of fibrous connective tissue with adjacent skeletal muscle.
**Differential diagnosis:**
Soft-tissue abscess, tooth abscess, mucocele, radicular cyst, salivary gland neoplasms, and mesenchymal neoplasms.

**Treatment:** Surgical excision.

3- **Nasopalatine duct cyst (Incisive canal cyst):**
   It is the most common non-odontogenic cyst of the oral cavity.

**Etiology:** It arises from epithelial rests in the incisive foramen.

**Clinical and radiographical features:** It appears as a slow-growing soft swelling of the palatine papilla, covered with normal mucosa. The cyst, after mechanical irritation, may be inflamed and becomes painful due to local infection.

**Radiographically:** usually demonstrates a well circumscribed RL in or near the midline of the maxilla, between and apical to the central incisor teeth. **It may be difficult to distinguish a small nasopalatine duct cyst from a large incisive foramen.** It is generally accepted that a diameter of (6 mm) is the upper limit of normal size for incisive foramen. Therefore, a radiolucency that is (6 mm) or smaller in this area is usually considered a normal foramen unless other clinical signs and symptoms are present.

**The clinical diagnosis should be confirmed by histopathological examination that showed epithelial lining composed of either:**
   1- Stratified squamous epithelium.
   2- Pseudostratified columnar epithelium.
   3- Simple columnar epithelium.
   4- Simple cuboidal epithelium.

**Differential diagnosis:** - Tooth and periodontal abscesses, mechanical trauma of the palatine papilla, fibroma, lipoma.

- **N.B.** to distinguish between the nasopalatine cyst & P.A. cyst:
  - 1- N.P.cyst, the tooth is vital, but in case of P.A. cyst the associated tooth is nonvital.
  - 2- Because the N.P.cyst is not related (attached) to the apex of the root, so by changing the direction of the X-ray beam we see if the lesion remain attached to the apex of the root, so it mean it’s radicular cyst, if not it means N.P. cyst.

**Treatment:** Surgical removal.

3- **Globulomaxillary cyst**
Globulomaxillary cyst were once considered fissural cyst, located between the globular and maxillary processes. The former theory of origin related to
epithelial entrapment within a line of embryologic closure with subsequent
cystic change.
Embryologic evidence now shows that the premaxilla and maxillary
processes do not fuse in this manner, and thus there can be no fusion-related
mechanism to account for a distinct globulomaxillary cyst in this location
thats why a current theory holds that most of cysts that develop in the
globulomaxillary area, are of odontogenic origin.
Radiolucencies in this location, when reviewed microscopically, have been
shown to represent radicular cysts, periapical granulomas, lateral periodontal
cysts, OKCs, central giant cell granulomas, calcifying odontogenic cysts,
and odontogenic myxomas. Thus today the termglobulomaxillary can be
justified only in an anatomic sense, with definitive diagnosis of lesions
located in this area made by combined clinical and microscopic examination.
**Radiologically:** a globulomaxillary lesion appears as a well-defined
radiolucency, often producing divergence of the roots of the maxillary lateral
incisor and canine teeth. Radicular cyst and periapical granuloma can be
ruled out with **pulp vitality testing.**
Because of the array of potential diagnoses, the histology varies
considerably from case to case.
**Histologically:** - lining epithelium is stratified squamous and some times
pseudostratified ciliated columnar respiratory epithelium. Thin C.T. wall
which is free from inflammation.
**Treatment and prognosis** are determined by the definitive microscopic
diagnosis.

4-Lymphoepithelial Cyst
**Definition:** Lymphoepithelial cyst is an uncommon developmental lesion of
the oral mucosa.
**Etiology:** Probably caused by cystic degeneration of glandular or surface
epithelium entrapped in lymphoid tissue during embryogenesis.
**Clinical features:** It presents as an asymptomatic, mobile, well-defined
nodule, usually firm on palpation and elevated, with a yellowish or whitish
color. The size ranges from 0.5 cm to 2 cm in diameter. **The floor of the
mouth** is the most frequent location, followed by the posterior lateral border
and the ventral surface of the tongue.
Lymphoepithelial cysts are **histologically** similar to the branchial cleft cysts
that develop in the lateral neck.
**Histopathological examination** which showed epithelial lining of stratified
squamous that may or may not be keratinized. The wall of the cyst typically
contains lymphoid tissue often demonstrating germinal center formation.
**Differential diagnosis:** lymphoid tissue aggregation, dermoid cyst, mucocele, lipoma, fibroma and other benign tumors.

**Treatment:** Surgical removal.

5-**Thyroglossal Duct Cyst**

**Definition:** Thyroglossal duct cyst is a rare developmental lesion that may form along the thyroglossal tract.

**Etiology:** Remnants of thyroglossal duct epithelium.

**Clinical features:** The cyst is usually located under the hyoid bone but can be located anywhere from the suprasternal notch to the foramen cecum of the dorsal tongue. *Intraorally,* it appears as a painless, fluctuant swelling usually 1–3 cm in diameter, located in the midline of the dorsum of the tongue close to the foramen caecum. Occasionally, a fistula may form following infection. The cyst is most often diagnosed in patients less than 20 years of age.

**Histopathological examination,** showed a lining epithelium of stratified squamous, or columnar or small intestinal epithelium, or mixture of them. The C.T. tissue wall may contain normal thyroid tissue.

**Differential diagnosis:** Median rhomboid glossitis, benign and malignant tumors.

**Treatment:** Surgical removal.

6-**Median mandibular cysts:**

Like globulomaxillary cysts, were once considered fissural cysts, in which a fissural origin was based on the theory of epithelial entrapment in the midline of the mandible during the "fusion" of each half of the mandibular arch. There is now embryologic evidence of an isthmus of mesenchyme between the mandibular processes that is gradually eliminated as growth continues, and therefore no evidence of epithelial fusion. So recently it is thought to be of odontogenic origin.

**Clinical and radiographical features:** Swelling In the midline of the mandible. *In x-ray* it appears as a well circumscribed RL between the two lower central incisors in the midline.

**Histopathology:** Lining epithelium is mainly stratified squamous. C.T. wall is free from inflammation.

**Treatment:** surgical removal
7-Median palatal cyst (palatine cyst):
It is rare fissural cyst that develops from epithelium entrapped along the embryonic line of fusion of lateral palatal shelves. This cyst may be difficult to distinguish from nasopalatine duct cyst.

Clinical and radiographical features:
This cyst is present as firm or fluctuant swelling in the midline of the hard palate posterior to the palatine papilla. Most of these cysts are asymptomatic, but sometimes pain may be present.

X-ray: occlusal radiograph showed a well –circumscribed RL in the midline of the hard palate.

A midline RL without clinical evidence of expansion is probably a nasopalatine duct cyst.

Histopathology: - Cyst is usually lined by stratified squamous epithelium. Areas of ciliated pseudostratified columnar epithelium may be present in some cases. Chronic inflammation may be present in the cyst wall.

Treatment: surgical removal.

8-Oral lympho-epithelial cyst
It occurs intraorally and usually located in the posterior part of the tongue or in the floor of the mouth and sometime near the soft palate and the pharynx and in the tonsilar area (lymphoid tissue).

Clinically: asymptomatic swelling in the oropharynx area, lateral border of the tongue and floor of the mouth.

9-Dermoid & Epidermoid cyst
These represents a simple form of cystic teratoma derived from skin epithelium entrapped during embryonic development. Most of these cysts occur in the head & neck region, primarily in the skin around the eyes & the anterior upper neck, extending superiorly into the floor of the mouth.

Clinically: Mostly occur in young adults, present as painless swelling exhibiting a doughy consistency on palpation, & may cause elevation of the tongue & can interfere with eating & speaking.

Histopathology: The cyst lined by a layer of orthokeratinized squamous epithelium, surrounding by C.T. capsule. In dermoid cyst in addition to these, the lesion exhibiting variable numbers of dermal appendages including hair follicles, sebaceous glands.

Treatment: surgical excision.
**Dermoid cyst:**
These cysts probably form as a result of some abnormality of development of the branchial arches or pharyngeal pouches. It is generally classified as a benign form of Teratoma.

**Clinical features**
Dermoid cysts develop between the hyoid and jaw or may form immediately beneath the tongue. They are sometimes filled with desquamated keratin giving them a semi-solid consistency. If the cyst develops above the geniohyoid muscle a sublingual swelling may displace the tongue upward and create difficulty in eating, speaking or even breathing. Cysts that occur below the geniohyoid muscle often produce a submental swelling with a double chin appearance. Dermoid cyst is more deeply placed than a ranula; the latter is obviously superficial, having a thin wall and a bluish appearance. A dermoid cyst causes no symptoms until large enough to interfere with speech or eating.

**Pathology:**
The lining of epidermoid cysts is keratinising stratified squamous epithelium alone. Less often, cysts also have dermal appendages (sebaceous gland, hair follicle or sweat gland) in the wall and are then referred to as dermoid cysts. These cysts should be removed surgically.

**Stafne Bone Cyst (Stafne's mandibular lingual cortical defect)**
This entity is also known by several other terms including lingual mandibular bone cavity, static bone cavity, and lingual salivary gland defect. This is an asymptomatic lesion. It usually occurs in adults over the age of 25.

**Radiographically:** the lesion is a solitary radiolucency below the inferior alveolar canal near the angle region of the mandible. The lesion is usually oval and exhibits no growth over long periods of time. The periphery is smooth and symmetric. The lesion is benign, has no growth potential, and a classic radiographic appearance that makes diagnosis without biopsy possible and observation without active intervention is the treatment of choice. Submandibular salivary gland depression, Incidental finding, it is not a true cyst.

**Radiographs** - small, circular, corticated radiolucency below mandibular canal

**Histology** - normal salivary tissue

**Treatment** - routine follow up