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CASE REPORT

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Osseous choristoma of the tongue in a pediatric patient: a case report

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Abstract

Background: Osseous choristoma is a rare benign lesion characterized by mature, histologically normal bone in an ectopic soft-tissue location. The tongue is its most common intraoral site, yet fewer than 70 cases have been reported worldwide, and pediatric cases remain especially scarce. **Case**: We report a case in a 15-year-old female with a firm, pedunculated posterior tongue mass first noticed by the patient at age seven and later identified incidentally during a routine primary care examination. The lesion's long-standing clinical course, together with the histopathology findings, supports an embryological rather than a traumatic origin. The mass was successfully managed with excisional biopsy under moderate oral conscious sedation in an outpatient pediatric dental setting, avoiding the need for general anesthesia, and the diagnosis was confirmed by histopathology. At 5-month follow-up, the patient remained asymptomatic with a well-healed tongue and no evidence of recurrence, documented photographically. **Conclusion**: This case adds to the limited pediatric literature on lingual osseous choristoma and reviews the available evidence on preoperative imaging and prior pediatric presentations, reinforcing that this rare entity can be safely diagnosed and definitively managed within pediatric dental practice.

Keywords

Osseous choristoma; Tongue lesion; Osteoma; Pedunculated mass; Surgical excision

1. Introduction

The term choristoma refers to the growth of histologically normal tissue in an anatomically abnormal location. It is distinct from a hamartoma, which represents a disorganized overgrowth of tissue elements native to the site. In the oral cavity, choristoma may be composed of osseous, cartilaginous, gastric mucosal, glial, or sebaceous tissue elements [1–3].

Osseous choristoma of the tongue is an exceptionally rare condition. Since its nomenclature was first established by Krolls *et al.* [1] in 1971, with subsequent early case reports further characterizing the entity [4], fewer than 70 cases have been reported worldwide. The lesion characteristically presents as a firm, sessile or pedunculated, mucosal-covered mass located on the posterior dorsum of the tongue near the foramen caecum or circumvallate papillae. It occurs more frequently in females, with a mean age at presentation in the second or third decade of life [2, 5].

The pathogenesis of osseous choristoma is unclear. Proposed theories include ectopic remnants of undescended thyroid tissue, traumatic induction of heterotopic ossification and most compellingly, an embryologic origin from pluripotential mesenchymal cells of the first and third branchial arches [5, 6]. Because the lesion is frequently asymptomatic and its clinical appearance overlaps with several other oral pathologies, definitive diagnosis requires histopathological examination. The treatment of choice is surgical excision, with no reported cases of malignant transformation or recurrence [2].

We present this case, adding to the limited pediatric literature on osseous choristoma.

2. Case report

A 15-year-old female presented to the pediatric dental clinic accompanied by her mother for a consultation regarding a soft tissue lesion on the tongue. The patient reported having first noticed the lesion at approximately seven years of age. She denies any change in size over time, associated pain or discomfort, history of oral trauma, or oral piercing. The lesion had been noted incidentally during a recent pediatric primary care visit, prompting referral to Pediatric Dentistry for evaluation and possibly biopsy. Human papillomavirus (HPV) vaccination was confirmed to be up to date through review of medical history.

The clinical timeline of presentation, treatment, and follow-up is summarized in Table 1.

Her medical history was notable for febrile seizures at age one and three years (with no subsequent episodes) and mild scoliosis under active evaluation. She was taking no medications and reported no known drug allergies. Family history was significant for breast and lung cancer on the paternal side,

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TABLE 1. Clinical timeline of presentation, treatment, and follow-up.

Date	Clinical Event
February 2026	Patient was referred to the Pediatric Dental Clinic for evaluation and consultation of a lesion on the tongue.
March 2026	Excisional biopsy of the tongue lesion was performed under moderate oral sedation. The tissue specimen was submitted for histopathological examination.
April 2026	Two-week postoperative follow-up demonstrated satisfactory healing of the biopsy site, and the histopathology results were reviewed with the patient and family.
August 2026	At the 5-month postoperative follow-up, the patient demonstrated continued healing of the posterior dorsal tongue with no evidence of recurrence.

breast cancer and amyloidosis on the maternal side.

Extraoral examination revealed no gross facial asymmetry, swelling, or lymphadenopathy. The inferior border of the mandible was palpable bilaterally without tenderness.

Intraoral examination revealed a pink, kidney-shaped, well-defined, pedunculated polyp with a smooth surface texture measuring approximately 0.9 × 0.9 × 0.3 cm located at the posterior dorsal midline of the tongue (Fig. 1). The lesion was firm on palpation and non-ulcerated. The patient denied any pain, dysphagia, or foreign body sensation. The floor of the mouth was soft, non-tender, and non-elevated. Tonsil grade was Brodsky I, and the Mallampati classification was II. The permanent dentition had fully erupted with no clinical caries detected.

Given the history and clinical presentation, the differential diagnosis at the time of initial evaluation was limited to benign entities including fibroma, pyogenic granuloma, prominent or hyperplastic circumvallate papilla, thyroglossal duct cyst, choristoma, and ectopic lingual tonsil and human papillomavirus (HPV) associated lesion.

Given the long-standing nature of the lesion, its firm consistency, and the need for a definitive histopathological diagnosis, excisional biopsy was recommended. In consideration of the patient's age, to minimize anxiety and untoward movement, the procedure was planned under moderate oral conscious sedation. Medical clearance was obtained from the patient's primary care physician. Written informed consent was obtained from the patient's mother.

On the day of the procedure in March 2026, the patient and parent confirmed no changes to medical history, and the review of systems was updated. The patient was classified as American Society of Anesthesiologists (ASA) physical status I (weight 55 kg, height 160 cm, body mass index (BMI) 21.5). Appropriate fasting status was confirmed prior to elective sedation. The pregnancy test was negative. Airway assessment was within normal limits. Preoperative vital signs were recorded. Moderate oral sedation was achieved with 15 mg of midazolam administered orally (approximately 0.27 mg/kg), within the standard recommended dosing range for pediatric oral conscious sedation. Nitrous oxide/oxygen was administered by inhalation and maintained at a 50%/50% concentration throughout the procedure. The patient was monitored continuously in accordance with American Academy of Pediatrics/American Academy of Pediatric Dentistry guidelines for pediatric sedation [7], including pulse oximetry, precordial stethoscope, blood pressure, and capnography; electrocardiography was recorded at baseline and every 10 minutes thereafter. A three-person clinical team was present throughout the procedure: the operating dentist, a dental assistant, and a third, dedicated team member responsible solely for continuous patient monitoring, independent of the operator. The patient remained hemodynamically stable throughout the procedure and was monitored for one hour prior to discharge, at which time all discharge criteria were met.

Topical anesthetic gel was applied, followed by infiltration anesthesia with 2% lidocaine with 1:100,000 epinephrine infiltration administered to the posterior two-thirds of the tongue. Stay sutures of 3-0 silk were placed at the anterior tip of the tongue for retraction. A stay suture of 3-0 chromic gut was placed through pedunculated lesion. Gauze packing was used to protect the airway, and the lesion was excised at its base using a #15 scalpel. Hemostasis was achieved (Fig. 1B), and the specimen was immediately placed in 10% neutral buffered formalin for histopathological examination (Fig. 2). Nitrous oxide was discontinued, and the patient received five minutes of 100% oxygen.

Recovery was uneventful. Modified Alderete post-anesthesia recovery score was 10/10. The patient was discharged with verbal and written post-operative instructions. Post-operative follow-up was scheduled for two weeks.

The excised specimen was submitted to the Department of Pathology at Brookdale Hospital Medical Center the same day.

Gross Description: The specimen was received in formalin labelled "tongue" and consisted of a bony/hard piece of tan-white tissue measuring 0.9 × 0.7 × 0.3 cm. The margin was inked, the specimen bisected, decalcified, and submitted in its entirety in one cassette.

Final Diagnosis (Surgical Pathology): Tongue mass, posterior, midline, excision: OSSEOUS CHORISTOMA IN THE DORSAL MIDLINE, POSTERIOR ONE THIRD OF THE TONGUE-NEGATIVE FOR MALIGNANCY (International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) pre-operative order diagnosis: D10.1, fibroma of the tongue). Well-circumscribed mass of mature lamellar bone surrounded by dense connective tissue and covered by stratified squamous epithelium (Fig. 3). The report was electronically signed and uploaded.

At the follow-up appointment two weeks post-procedure, the mother and patient reported an uneventful recovery. Intraoral examination revealed satisfactory healing of the posterior dorsal tongue without signs of infection, dehiscence, or abscess formation (Fig. 4). The confirmed histopathological diagnosis, the minimal risk of recurrence, and the absence of malignant potential were discussed in detail with the patient

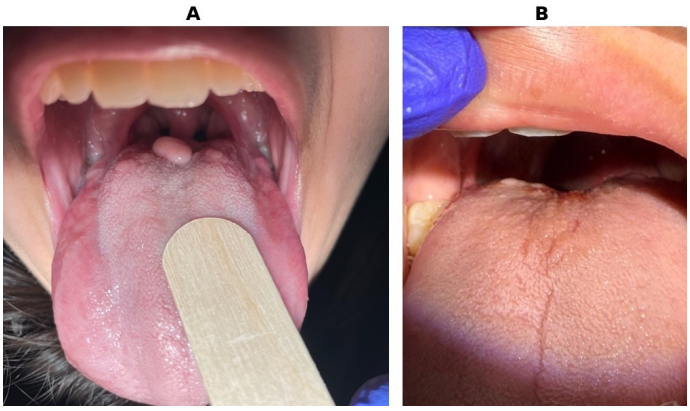


FIGURE 1. Composite intraoral photographs before and after surgical excision. (A) Preoperative intraoral photograph showing a firm, pedunculated mass on the posterior dorsal midline of the tongue. (B) Postoperative photograph immediately following excision, demonstrating hemostasis at the surgical site.

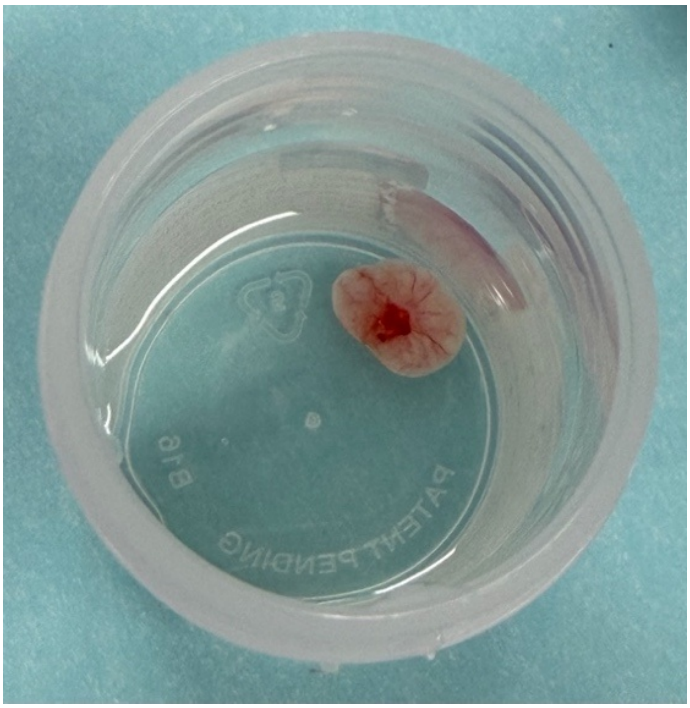


FIGURE 2. Specimen placed in 10% neutral buffered formalin.

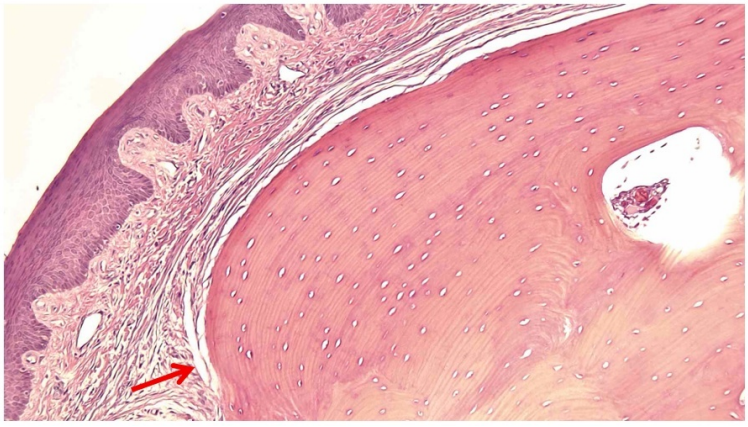


FIGURE 3. Osseous choristoma in the posterior one-third of the dorsal midline of the tongue (100×). The arrow indicates the tumor, composed entirely of mature lamellar bone situated beneath the squamous mucosa.

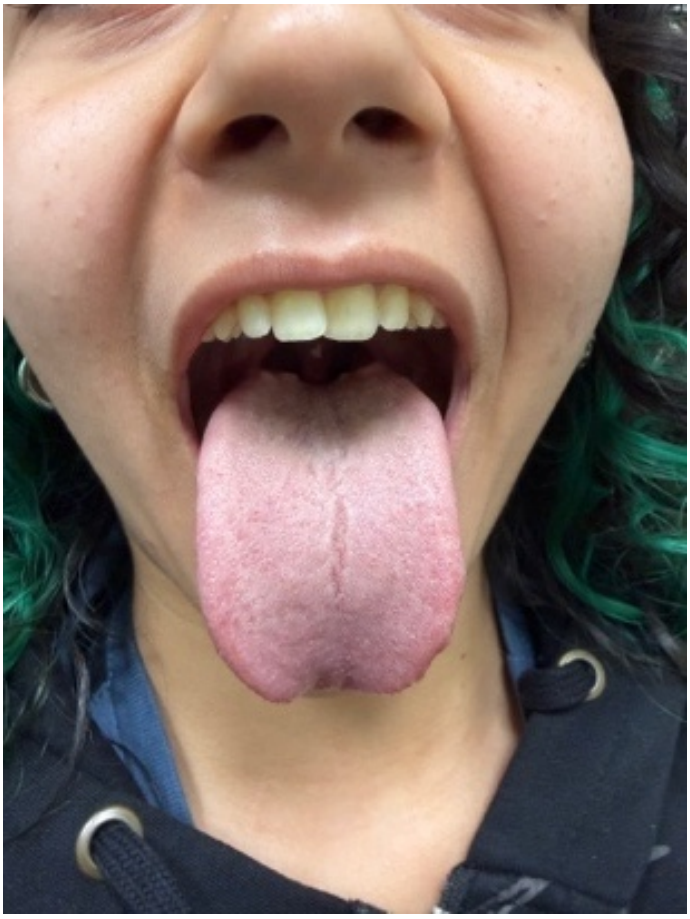


FIGURE 4. Two-week follow-up.

and her mother. The family expressed verbal understanding and satisfaction at the outcome. The patient was advised to continue routine dental recall with her primary dentist.

At the 5-month postoperative follow-up, intraoral examination showed a well-healed posterior dorsal tongue with normal mucosal contour and no evidence of recurrence (Fig. 5).

3. Discussion

The present case is noteworthy for several reasons. First, the age of onset, with the lesion recognized by the patient at age seven is consistent with a congenital or early developmental origin, supporting an embryological rather than traumatic or inflammatory pathogenesis. Second, the adolescent presentation of osseous choristoma in a pediatric dental setting underscores the importance of thorough intraoral soft tissue examination in routine pediatric dental visits, which in this case contributed to the incidental identification of the lesion during a primary care physical examination.

Osseous choristoma characteristically has a firm-to-stony-hard consistency on palpation, reflecting the underlying bone and helping distinguish it from softer lesions such as hemangioma or lipoma [8]. Reported ages range from 5 to 73 years with a female-to-male ratio of approximately 3:1, consistent with the present case [5, 8].

The differential diagnosis for a posterior tongue mass in the pediatric population encompasses a broad range of benign and malignant entities. Benign considerations include fibroma, pyogenic granuloma, hyperplastic circumvallate papilla, lymphangioma, hemangioma, hamartoma, leiomyoma, thyroglossal duct cyst, lingual thyroid, mucocele, and HPV-related lesion. Malignant entities, though rare in the pediatric population, include rhabdomyosarcoma, other sarcomas, and squamous cell carcinoma [9]. Cartilaginous choristoma and neurofibroma should also be considered. Because none of these entities can be reliably excluded on clinical grounds alone, histopathological examination remains the diagnostic gold standard.

Beyond simply enumerating differential diagnoses, evaluation of a pediatric tongue mass should first stratify the lesion as clinically benign- or malignant-appearing, since this distinction dictates the urgency and extent of subsequent workup. Features favoring a benign process, as seen in the present case, include a static or slowly progressive course, a well-defined and mobile lesion that is not fixed to underlying structures, an intact and non-ulcerated mucosal surface, and the absence of pain, bleeding, or cervical lymphadenopathy. Red flags for malignancy include fixation, firm or indurated consistency, size greater than 1.5 cm, ulceration, rapid growth, persistence beyond two to three weeks without fluctuation, pain or numbness, trismus, and dysphagia, with induration of the base and margins particularly concerning for squamous cell carcinoma; these warrant expedited imaging and biopsy [9, 10]. This criteria set is adapted in part from the American Academy of Otolaryngology–Head and Neck Surgery Foundation (AAO-HNSF) clinical practice guideline on evaluation of the neck



FIGURE 5. Five-month follow-up.

mass which, though developed for adults, is commonly extrapolated to pediatric practice given the lack of an equivalent pediatric-specific guideline [11]. Malignant pediatric tongue lesions such as rhabdomyosarcoma or squamous cell carcinoma may additionally present with bleeding or regional lymphadenopathy. In the present case, the long-standing, static, mobile, non-ulcerated, and entirely asymptomatic nature of the lesion was clinically reassuring for a benign process, subsequently confirmed on histopathology.

Oral cavity-specific literature adds non-healing ulcer beyond three weeks, induration, fixation, unexplained bleeding, rapid growth, pain or numbness, trismus, and dysphagia as red flags, with base/margin induration considered particularly concerning for squamous cell carcinoma [9, 10].

Tongue glial heterotopia (glial choristoma) is a key mimic: ectopic glial tissue staining glial fibrillary acidic protein (GFAP)- and S-100-positive but neurofilament-negative, in contrast to the mature bone of osseous choristoma [12–14]. It typically presents at birth or in early infancy, with a male predominance, near the foramen cecum, and often causes airway or feeding compromise; osseous choristoma instead presents later in childhood or adolescence as a slow-growing, asymptomatic mass, as here [12–14]. Because glial heterotopia can rarely retain a stalk connecting to the CNS, preoperative imaging to exclude this connection is recommended when it is suspected—a consideration that does not apply to osseous choristoma [15].

Several further entities, though not among those most classically cited, merit consideration and explicit exclusion. Granular cell tumor, a benign neoplasm of probable Schwann cell origin, typically presents as a firm, slow-growing, asymptomatic submucosal nodule of the tongue and has been reported in children as young as infancy; it can mimic squamous cell carcinoma histologically when the overlying epithelium shows pseudoepitheliomatous hyperplasia, but stains strongly for S-100 protein rather than showing osseous differentiation [16]. Dermoid and epidermoid cysts are midline developmental cysts that classically present as soft, compressible, "doughy" masses of the tongue base or floor of the mouth, often with characteristic fat- or keratin-containing cystic contents on magnetic resonance imaging (MRI) [17]. Schwannoma, a benign peripheral nerve sheath tumor that can arise intraorally, including the tongue, similarly presents as a firm, slow-growing, asymptomatic mass and requires histopathological distinction via S-100 positivity and the characteristic Antoni A/B architecture with Verocay bodies [18]. In the present case, gross and histopathological examination demonstrated a solid, non-compressible lesion composed unequivocally of mature lamellar bone, without granular S-100-positive cells, cystic or fat-containing spaces, or nerve sheath architecture, thereby excluding each of these alternative diagnoses.

Two further bone-forming lesions warrant brief mention, as both also produce ectopic bone. Myositis ossificans traumatica is benign heterotopic bone within muscle, usually following

identifiable trauma; it commonly causes trismus when the masticatory muscles are involved and shows histologic zonation, with immature bone centrally and organized mature bone peripherally [19]. Extraskeletal osteosarcoma is the key malignant mimic, distinguished by cytologically atypical tumor cells producing osteoid, infiltrative growth, and typically larger size or older age than reported for osseous choristoma [20]. Neither was suggested here: there was no trauma history, and histopathology showed only mature, well-organized lamellar bone without cellular atypia.

Although histopathological examination remains the diagnostic gold standard, preoperative imaging may aid clinical decision-making, particularly given the anatomic overlap between osseous choristoma and other developmental lesions such as lingual thyroid and thyroglossal duct cyst. Computed tomography (CT) is the most frequently reported imaging modality and typically demonstrates a well-defined, spheroid, bone-attenuation mass arising from the tongue base [21, 22]. Ultrasonography has been used less to characterize the choristoma itself than to exclude ectopic thyroid tissue as a differential diagnosis, since a normal, orthotopically located thyroid gland on neck ultrasound argues against a lingual thyroid [23]. Magnetic resonance imaging has also been reported, generally showing low signal intensity on both T1- and T2-weighted sequences without contrast enhancement, consistent with the ossific nature of the lesion. A recently reported adult case additionally identified a synchronous thyroglossal duct cyst on MRI and CT in a patient with lingual osseous choristoma, raising the possibility of a shared embryological origin along the thyroglossal duct-hyoid axis and underscoring the value of imaging the entire thyroglossal tract when an osseous lesion is identified at the tongue base [24].

Since the present case favors an embryological origin, it is informative to consider how preoperative imaging and associated anomalies have been reported specifically in pediatric patients. A literature review of 17 reported cases of lingual osseous choristoma in patients younger than 13 years found that diagnostic imaging, most often thyroid scintigraphy, computed tomography, or magnetic resonance imaging, was performed in only five cases, generally to exclude ectopic thyroid tissue or to characterize the mass before surgery [21]. No coexisting thyroglossal duct cyst or other tongue anomaly was reported in this pediatric series, and the review's authors noted that motion artifact from limited patient cooperation and concerns about radiation exposure may account for the more limited use of cross-sectional imaging in children [21]. In the present case, no preoperative imaging was obtained; given the lesion's characteristic clinical appearance and the absence of features suggesting an alternative diagnosis such as lingual thyroid, this approach is consistent with prior pediatric reports, although the literature reviewed above suggests that targeted ultrasonography to exclude ectopic thyroid tissue could reasonably be considered on a case-by-case basis, particularly when the clinical presentation is less classic.

Airway risk depends on lesion location: masses confined to the anterior two-thirds or dorsal midline, as here, rarely compromise the airway, whereas tongue-base or vallecular masses can displace the epiglottis or encroach on the glottic inlet, especially in infants [25]. Pediatric presentations include positional dyspnea, cyanosis, bradycardia, stridor, and feeding difficulty; adults more often report gagging, choking, nausea, or dysphagia [8, 22, 25, 26]. For tongue-base lesions, awake flexible fiberoptic laryngoscopy—not formal bronchoscopy, which is reserved for suspected lower-airway involvement—is the preferred initial tool, visualizing the tongue base, vallecula, epiglottis, and larynx [27, 28]. It is indicated when a lesion involves or approaches the tongue base/root, its posterior extent is uncertain on oral exam, or airway symptoms are present [27, 29]. In the present case, the lesion was small and anterior to the tongue base with no airway symptoms, so laryngoscopy was not performed; airway assessment was limited to visual and Mallampati examination, which was reassuring.

Taken together, we propose the following stepwise diagnostic and therapeutic approach for a pediatric tongue mass (Fig. 6), which was followed in the present case: (1) a thorough history and physical examination to characterize the onset, growth rate, associated symptoms, and airway status; (2) clinical risk-stratification into a benign- or malignant-appearing lesion based on the features discussed above; (3) selective use of imaging (ultrasonography, computed tomography, or magnetic resonance imaging, as discussed above) when the lesion is deep, poorly defined, extends toward the tongue base, or when an alternative diagnosis such as lingual thyroid or thyroglossal duct cyst cannot be excluded clinically; (4) fiberoptic laryngoscopy when the lesion involves or approaches the tongue base or root, or when airway symptoms are present; (5) excisional or incisional biopsy under sedation or anesthesia appropriate to the lesion size, location, and patient cooperation; and (6) histopathological confirmation, which remains the diagnostic gold standard, followed by surveillance appropriate to the eventual diagnosis. This stepwise approach allowed the present lesion to be safely diagnosed and definitively managed in an outpatient pediatric dental setting without the need for imaging or airway endoscopy, reflecting its small size, anterior location, and reassuring clinical features.

In this case, moderate oral conscious sedation was selected to minimize untoward movement and optimize the patient's comfort and cooperation during the excisional biopsy procedure, given her age and reported dental anxiety. The use of nitrous oxide/oxygen in combination with midazolam, administered under continuous multi-modal physiologic monitoring, facilitated a safe, effective, and patient-centered procedural experience. This approach aligns with current pediatric dentistry guidelines, which support the use of pharmacological behavior guidance techniques, when indicated, to reduce patient anxiety and improve procedural outcomes [30]. The patient's behavior score (FS-4) and modified Alderete score of 10 at discharge are consistent with successful moderate sedation.

Surgical excision remains the definitive treatment of osseous choristoma of the tongue. No case of recurrence or malignant transformation has been reported in the literature [1, 2, 5]. The present patient demonstrated uneventful healing at the follow-up visit. Given the benign and self-limiting nature of this lesion once excised, no further follow-up was deemed necessary beyond routine dental care.

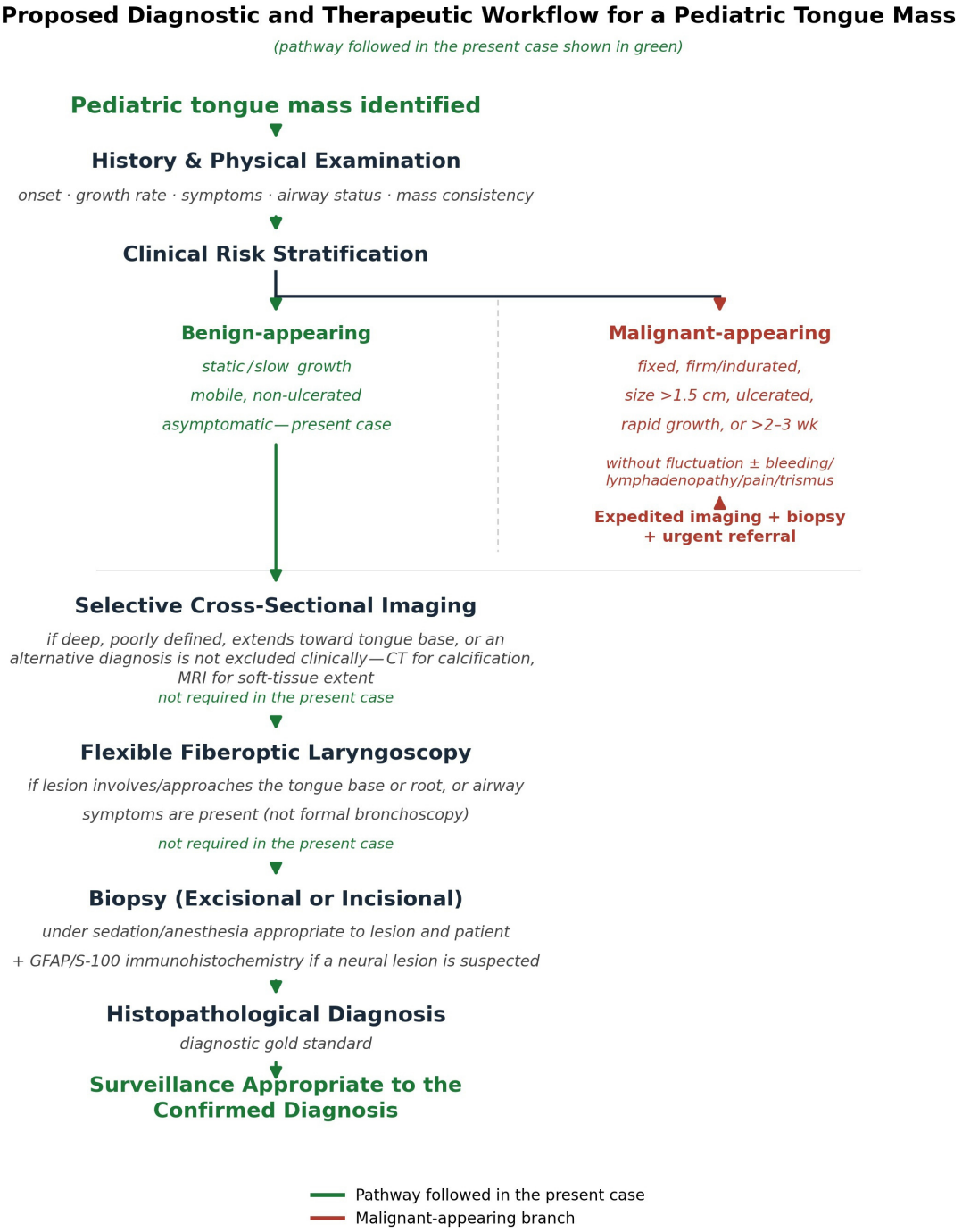


FIGURE 6. Proposed stepwise diagnostic and therapeutic workflow for a pediatric tongue mass. The pathway followed in the present case is highlighted in green. CT, computed tomography; MRI, magnetic resonance imaging; GFAP, glial fibrillary acidic protein; S-100, S-100 protein.

4. Limitations

This report has several limitations. As a single case report, the findings cannot establish generalizable conclusions regarding the natural history or optimal management of osseous choristoma, and comparisons with the existing literature may be subject to publication bias inherent to case-based reporting. No preoperative imaging was obtained; while this was consistent with the clinical presentation and prior pediatric reports, it precludes prospective radiologic characterization of the lesion. Follow-up to date is limited to five months; although no case of recurrence or malignant transformation has been reported in the literature, longer-term follow-up would further support the durability of this outcome. Finally, the sedation and surgical approach described reflect the practice and resources of a single institution and may not be directly generalizable to all pediatric dental settings.

5. Conclusion

We present a case of osseous choristoma of the tongue in a 15-year-old female patient, successfully managed with excisional

biopsy under moderate oral conscious sedation in a pediatric dental setting. The diagnosis was confirmed with histopathology. This case illustrates the importance of thorough intraoral soft tissue examination in the pediatric population and highlights that rare oral pathologies such as osseous choristoma, though uncommon in children and adolescents, can be safely diagnosed and managed within the scope of pediatric dentistry. Surgical excision is curative with no reported risk of recurrence or malignant transformation.

AVAILABILITY OF DATA AND MATERIALS

The data supporting the findings of this case report are available from the corresponding author upon reasonable request. Due to patient privacy and confidentiality considerations, the data are not publicly available.

AUTHOR CONTRIBUTIONS

SN and TC—conceived and designed the case report; drafted the manuscript; participated in the diagnosis, treatment planning, surgical management, and follow-up care of the patient. TC—critically reviewed and revised the manuscript for important intellectual content and performed all editorial revisions. Both authors read and approved the final version of the manuscript.

ETHICS APPROVAL AND CONSENT TO PARTICIPATE

Institutional Review Board at One Brooklyn Health approval was exempt for this single-patient case report in accordance with institutional policies. Written informed consent was obtained from the patient's parent/legal guardian for treatment and for the publication of clinical information, radiographs, and clinical photographs for educational and scientific purposes. All identifying patient information has been removed to protect patient confidentiality.

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CONFLICT OF INTEREST

The authors declare no conflict of interest.

REFERENCES

[1] Krolls SO, Jacoway JR, Alexander WN. Osseous choristomas (osteomas) of intraoral soft tissues. Oral Surgery, Oral Medicine, and Oral Pathology. 1971; 32: 588–595.

[2] Gorini E, Mullace M, Migliorini L, Mevio E. Osseous choristoma of the tongue: a review of etiopathogenesis. Case Reports in Otolaryngology. 2014; 2014: 373104.

[3] Tohill MJ, Green JG, Cohen DM. Intraoral osseous and cartilaginous choristomas: report of three cases and review of the literature. Oral Surgery, Oral Medicine, and Oral Pathology. 1987; 63: 506–510.

[4] Engel P, Cherrick HM. Extraosseous osteomas of the tongue. Journal of Oral Medicine. 1976; 31: 99–103.

[5] Supiyaphun P, Sampatanakul P, Kerekhanjanarong V, Chawakitchareon P, Sastarasadhit V. Lingual osseous choristoma: a study of eight cases and review of the literature. Ear, Nose & Throat Journal. 1998; 77: 316–325.

[6] Vered M, Lustig JP, Buchner A. Lingual osteoma: a debatable entity. Journal of Oral and Maxillofacial Surgery. 1998; 56: 9–13; discussion 14.

[7] Coté CJ, Wilson S; American Academy of Pediatrics; American Academy of Pediatric Dentistry. Guidelines for monitoring and management of pediatric patients before, during, and after sedation for diagnostic and therapeutic procedures: update 2016. Pediatrics. 2016; 138: e20161212.

[8] Andressakis DD, Pavlakis AG, Chrysomali E, Rapidis AD. Infected lingual osseous choristoma. Report of a case and review of the literature. Medicina Oral, Patología Oral y Cirugía Bucal. 2008; 13: E627–E632.

[9] Mody MD, Rocco JW, Yom SS, Haddad RI, Saba NF. Head and neck cancer. The Lancet. 2021; 398: 2289–2299.

[10] Ranganathan K, Kavitha L. Clinical aspects of oral cancer and potentially malignant disorders in South and Southeast Asia. Oral Diseases. 2025; 31: 1406–1419.

[11] Pynnonen MA, Gillespie MB, Roman B, Rosenfeld RM, Tunkel DE, Bontempo L, *et al*. Clinical practice guideline: evaluation of the neck mass in adults. Otolaryngology—Head and Neck Surgery. 2017; 157: S1–S30.

[12] Ramadass T, Narayanan N, Rao P, Parameswaran A. Glial heterotopia in ENT—two case reports and review of literature. Indian Journal of Otolaryngology and Head and Neck Surgery. 2011; 63: 407–410.

[13] Zhao J, Wang X, Yin F, Chu J. Early recurrent neonatal tongue glial heterotopia presenting with acute airway obstruction: the first case report. Frontiers in Pediatrics. 2026; 13: 1674740.

[14] Sun LS, Sun ZP, Ma XC, Li TJ. Glial choristoma in the oral and maxillofacial region: a clinicopathologic study of 6 cases. Archives of Pathology & Laboratory Medicine. 2008; 132: 984–988.

[15] Strome SE, McClatchey K, Kileny PR, Koopmann CF Jr. Neonatal choristoma of the tongue containing glial tissue: diagnosis and surgical considerations. International Journal of Pediatric Otorhinolaryngology. 1995; 33: 265–273.

[16] Shivamurthy A, Muniswamyreddy A, Basavaraj V. A rare case of granular cell tumour of tongue in a 13-year-old girl. Journal of Clinical & Diagnostic Research. 2024; 18: 11–13.

[17] Puricelli E, Barreiro BOB, Quevedo AS, Ponzoni D. Occurrence of dermoid cyst in the floor of the mouth: the importance of differential diagnosis in pediatric patients. Journal of Applied Oral Science. 2017; 25: 341–345.

[18] Amer SM, Ukudeyeva A, Pine HS, Campbell GA, Clement CG. Plexiform schwannoma of the tongue in a pediatric patient with neurofibromatosis type 2: a case report and review of literature. Case Reports in Pathology. 2018; 2018: 9814591.

[19] Abbasi AJ, Taheri MM, Asadi A, Bahrami R, Nikparto N. Myositis ossificans traumatica of masticatory muscles: a case report and review of the literature. Oral and Maxillofacial Surgery Cases. 2024; 10: 100361.

[20] Loyzaga JM, Fernandez Machin P, Sala J. Osteogenic sarcoma of the tongue. Case report and review of the literature. Pathology, Research and Practice. 1996; 192: 75–78; discussion 79–80.

[21] Arimoto S, Shigeoka M, Akashi M. Tongue osseous choristoma in an 11-year-old female: a case report and literature review focusing on pediatric cases. Case Reports in Dentistry. 2021; 2021: 8021362.

[22] Shareef ZJ, Shareef SJ, Kerndt CC, Aughenbaugh A, Di Ponio A. Lingual osseous choristoma: a comprehensive systematic review of lesion presentation, histology, and morphology. Spartan Medical Research Journal. 2020; 5: 17543.

[23] Turan Ş, Pınarbaşlı MÖ, Açıkalın M, Kaya E, Özüdoğru E. Lingual osseous choristoma. Turkish Archives of Otorhinolaryngology. 2016; 54: 86–88.

[24] Kim HJ, Jun SY, Lim HK. Case report: synchronous lingual osseous choristoma and suprahyoid thyroglossal duct cyst: insights into the embryological thyroglossal-hyoid axis. Frontiers in Surgery. 2026; 13: 1856644.
[25] Brennan T, Rastatter JC. Multilevel airway obstruction including rare tongue base mass presenting as severe croup in an infant. International Journal of Pediatric Otorhinolaryngology. 2013; 77: 128–129.
[26] Chai RL, Ozolek JA, Branstetter BF, Mehta DK, Simons JP. Congenital choristomas of the oral cavity in children. The Laryngoscope. 2011; 121: 2100–2106.
[27] Wei WI, Lau WF, Lam KH, Hui Y. The role of the fibreoptic bronchoscope in otorhinolaryngological practice. The Journal of Laryngology and Otology. 1987; 101: 1263–1270.
[28] Paradis TJ, Dixon J, Tieu BH. The role of bronchoscopy in the diagnosis of airway disease. Journal of Thoracic Disease. 2016; 8: 3826–3837.
[29] Yellon RF. Epiglottic and base-of-tongue prolapse in children: grading and management. The Laryngoscope. 2006; 116: 194–200.
[30] American Academy of Pediatric Dentistry. Behavior guidance for the pediatric dental patient. 2023. Available at: https://www.aapd.org/research/oral-health-policies--recommendations/behavior-guidance-for-the-pediatric-dental-patient/ (Accessed: 03 September 2026).

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