was consulted, and physical examination of the patient demonstrated lingual gingival tissue swelling of the lower left molars. The mass was nonfluctuant with ulceration causing malalignment of tooth number 18. Bone biopsy revealed squamous mucosa with hemorrhagic foci, ulceration, and ectatic blood vessels with fragments of necrotic bone consistent with osteonecrosis. At the patient's 2-week follow-up visit, a small area of exposed necrotic bone was noted in the affected area. Maxillofacial CT without IV contrast showed mixed radiolucency and sclerosis with dehiscence along the lingual cortex of the posterior mandibular body and along the cortex of the retromolar trigone. Chlorhexidine gluconate 0.12% oral solution was prescribed, and debridement of the left posterior mandible and extraction of the lower left molars with local flap reconstruction were recommended by an oral and maxillofacial surgeon. The patient did not return for follow-up management.

Conclusions: Acute pain and chronic vasculopathy are significant complications of SCD. Jaw involvement in SCD is very rare, as illustrated in this case. It is important for oral health care professionals to understand the pathophysiology and clinical manifestations of SCD.

THE FIRST REPORTED CASE OF PROLIFERATIVE FASCIITIS IN THE ORAL CAVITY

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Background: Proliferative fasciitis is a benign and reactive lesion involving fibroblasts in the subcutaneous tissues and deep fascia, with a rare occurrence in the head and neck region. It is considered a variant of nodular fasciitis, which could involve trauma as an etiology. Proliferative fasciitis mostly occurs in adults, but cases in children have been reported. Clinically, it can present as an aggressive lesion with pain or no symptoms, mimicking sarcomas.

Case Summary: We report a case of a 53-year-old woman who presented to our clinic for an evaluation of a reddish lesion of the right mandibular gingiva around the molar areas with a relatively rapid onset. The patient had prediabetes with moderate oral hygiene and no other significant medical history. Intraoral examination revealed a poorly circumscribed gingival lesion on the posterior, <1 cm in diameter with no pain on palpation, and soft to firm in texture with no bleeding. A biopsy of the lesion was performed for histologic examination, and the microscopic differential diagnosis included benign and malignant spindle cell tumors; thus, immunohistochemistry was performed for more accurate diagnosis, and a specimen was sent to the pathology lab at Ohio (Central Ohio Skin and Cancer). The immunohistochemical findings were positive for vimentin and smooth muscle actin and negative for CD34, S100, and pancytokeratin. The lesion was diagnosed as proliferative fasciitis on the basis of histologic and immunohistochemical features. The feature that differentiates proliferative from nodular fasciitis is the basophilic component that closely resembles ganglion cells without Nissl substance. The treatment rendered was conservative surgical excision with 1-year follow-up, and no recurrence was observed.

Conclusions: Because proliferative fasciitis has not been reported in the oral cavity, to our knowledge, and because it poses a diagnostic challenge and can mimic malignancies, it is essential to know the salient diagnostic features to avoid aggressive treatment in patients presenting with such lesions in the oral cavity.

MASSON TUMOR OF THE LINGUAL TONGUE: A CASE REPORT

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Background: Intravascular papillary endothelial hyperplasia, or Masson tumor, is a benign lesion of the head and neck region. The etiology of the lesion arises within a blood vessel and is thought to be reactive and associated with vascular injury. Masson tumors comprise approximately 2% of all vascular tumors of skin and subcutaneous tissues; however, this is rarely seen intraorally. It is important to consider at the time of differential diagnosis to distinguish from malignancy and avoid aggressive surgery or unnecessary treatment.

Case Summary: We describe a case of a patient who presented to the Erie County Medical Center Department of Oral Oncology for evaluation of a soft, nontender, mobile mass in the right side of the ventral tongue. The patient first presented in June 2019 with an approximately 5-mm round mobile mass on the right side of the ventral tongue of 6 days' duration. The patient opted for no treatment in June 2019 and returned in December 2019 after the mass had grown in size and had begun to affect his everyday activities. Treatment options included excisional biopsy under general anesthesia or under local anesthesia. The patient opted for excision under local anesthesia. The vascular component was identified and tied off, and the tumor was removed in total. The tumor was a bluish lesion with a thick intact capsule. The final pathology revealed a thrombosed blood vessel with papillary endothelial hyperplasia consistent with Masson tumor. Immunostains for CD31 and D2-40 supported this diagnosis. The patient has some residual tethering of the right side of the tongue resulting from establishing primary closure.

Conclusions: The majority of tumors with this diagnosis have an excellent prognosis with complete excision. Malignant transformation and metastasis have not been reported.

"RINGLIKE HARD MASS" SURROUNDING THE ROOT OF A PRIMARY TOOTH IN A YOUNG CHILD: REPORT OF AN UNUSUAL CASE

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Background: Several lesions of diverse origin may be detected in the oral cavity of young children, affecting the oral mucosa, jaws, or teeth. Their clinicopathologic features may show considerable overlap. We present an interesting case of a "ringlike hard mass" of initially unknown nature around the cervical area of a primary tooth in a young child, and we discuss the diagnostic challenges.

Case Summary: A 2-year-old girl presented for evaluation of a painless lesion surrounding a primary tooth, first noticed before she was 5 months of age. Her medical history was unremarkable without any history of trauma. The clinical examination revealed a yellowish cylindrical mass, hard in consistency, completely surrounding the cervical area of the left first primary lower incisor. It was nonremovable, strongly adhered to the root surface. With a provisional clinical diagnosis of a tooth abnormality (eg, hypercementosis), a periapical radiograph revealed a