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CASE REPORT

A rare bone tumor of the mandible: chondromyxoid fibroma

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Abstract:

Chondromyxoid fibroma is a rare benign chondrogenic neoplasm of bone characterized by chondroid and myxoid stromal components, multinucleated giant cells, and calcified deposits. A review of the literature from 1978 to 2023 identified 20 well-documented cases involving the jaws. We report a mandibular chondromyxoid fibroma in a 29-year-old woman presenting as an enlarging, well-defined mixed-density lesion with cortical thinning and mild expansion. Histopathological examination revealed characteristic lobulated chondroid and myxoid components with peripheral osteoclast-like multinucleated giant cells. Immunohistochemistry showed strong positivity for smooth muscle actin and vimentin in the myxoid component, whereas S-100, CD10, and p53 were negative and Ki-67 labeling was absent. Conservative marginal resection was performed with iliac crest bone graft, platelet-rich fibrin, and reconstruction plate. Six years after surgery, complete bone regeneration and no recurrence were observed.

Keywords: Chondromyxoid fibroma; Mandible; Immunohistochemistry; Chondrogenic neoplasms; Jaw neoplasms.

INTRODUCTION

Chondromyxoid fibroma (CMF) is a rare benign chondrogenic neoplasm of bone, first described by Jaffe and Lichtenstein in 1948, accounting for less than 1% of all primary bone tumors[1,2]. It predominantly arises in the metaphysis of long bones, particularly the proximal tibia, distal femur, and fibula, and is most frequently diagnosed during the second and third decades of life, without a definitive sex predilection[1,3].

Although CMF is more common in young adults, reported cases range from infancy to older adults[3,4]. According to the current World Health Organization (WHO) Classification of Soft Tissue and Bone Tumours (5th edition), CMF is defined as a benign chondrogenic neoplasm characterized by a distinctive lobulated architecture composed of chondroid, myxoid, and fibrous tissue containing spindle-shaped or stellate cells and scattered multinucleated giant cells[3,4].

Craniofacial involvement is exceedingly uncommon and represents a diagnostically challenging subset of CMF[5,6]. Reported sites include the mandible, maxilla, zygomatic bone, nasal septum, maxillary sinus, and temporomandibular joint (TMJ)[5-7]. The mandible appears to be the most frequently affected gnathic site[5,7,8]. Review of documented gnathic CMF cases highlights the rarity of this entity and the limited evidence available to guide diagnosis and management[6,8-11].

Statement of Clinical Significance
Because chondromyxoid fibroma is extremely rare in the jaws and may clinically and radiographically mimic other benign maxillofacial tumors, accurate diagnosis requires careful correlation of clinical, radiographic, and histopathological findings. Awareness of this entity helps prevent misdiagnosis and inappropriate management.

Clinically, CMF usually presents as a slowly enlarging intraosseous lesion that may remain asymptomatic for long periods, often resulting in delayed diagnosis[6,8]. When symptoms occur, pain, facial asymmetry, cortical expansion, tooth displacement, and paresthesia may be observed, particularly in larger mandibular lesions[8,9].

Radiographically, CMF typically presents as a well-defined unilocular or multilocular radiolucent lesion

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that may contain internal radiopaque masses and exhibit varying degrees of cortical thinning[5,8,9]. Computed tomography (CT) and cone-beam computed tomography (CBCT) are valuable for assessing the extent of the lesion and the integrity of the cortical bone[8,9]. However, imaging features are nonspecific and may resemble those of fibro-osseous lesions, particularly cemento-ossifying fibroma. Odontogenic myxoma, ameloblastoma, and other benign mixed odontogenic tumors should also be considered in the differential diagnosis[12-15].

Histopathologically, CMF exhibits a characteristic lobulated architecture composed of chondroid tissue containing stellate cells, myxoid areas with spindle-shaped cells, and multinucleated giant cells located predominantly at the periphery of the lobules[1,2,16,17]. Owing to its cellular heterogeneity and chondroid differentiation, CMF may be misdiagnosed as chondrosarcoma or other myxoid or cartilaginous neoplasms[1,16]. Immunohistochemistry plays an ancillary role in the diagnosis, whereas recurrent GRM1 gene rearrangements have emerged as a characteristic molecular alteration that may provide insight into the pathogenesis of CMF[5].

The present study describes a rare case of mandibular CMF in a 29-year-old woman and details its clinical, radiographic, histopathological, immunohistochemical, and therapeutic features in the context of verified gnathic CMF literature.

CASE REPORT

A 29-year-old woman was referred to the Oral and Maxillofacial Medicine and Pathology Service at the Faculty of Stomatology, Universidad Peruana Cayetano Heredia, with a slowly enlarging swelling adjacent to the basal mandibular cortex at the level of tooth 46, associated with mild tenderness on palpation. Clinical examination revealed obliteration of the buccal vestibular sulcus and slight expansion of the inferior border of the mandible in the affected area. The patient reported no spontaneous pain or paresthesia, and there was no history of trauma or odontogenic infection.

Panoramic radiography and cone-beam computed tomography (CBCT) revealed a well-defined, corticated, oval-shaped lesion of mixed radiodensity. A hypodense area surrounded a centrally located irregular hyperdense mass. Thinning and mild expansion of both the buccal and lingual cortical plates were observed. The mandibular canal was displaced superiorly; however, its cortical boundaries remained intact (Figure 1A–D). Based on the clinical and radiographic findings, a benign intraosseous lesion was suspected. The differential diagnosis included cemento-ossifying fibroma, benign odontogenic tumors with mixed radiolucent-radiopaque features, and osteoid osteoma.

Histopathological examination of the incisional biopsy specimen revealed a benign mesenchymal neoplasm composed of lobules containing chondroid and myxoid components, with multinucleated giant cells predominantly located at the interface between them. Distinctive calcified deposits of variable morphology, exhibiting a red-purple coloration, were identified within the chondroid component (Figure 2A). The chondroid component consisted of stellate cells embedded within a basophilic matrix. At the periphery of the lobules, a rim of osteoclast-like multinucleated giant cells was observed (Figure 2B, C). The myxoid component was situated between the chondroid lobules and was composed of eosinophilic spindle-shaped cells embedded within an abundant myxoid extracellular matrix, which appeared clear to slightly eosinophilic on hematoxylin and eosin staining (Figure 2D, E).

Immunohistochemical analysis demonstrated strong cytoplasmic positivity for smooth muscle actin (SMA) within the myxoid component (Figure 2F). Vimentin immunostaining was positive in both the myxoid and chondroid components (Figure 2G). S-100 protein expression was absent in both the chondroid and myxoid components; however, the stain enhanced visualization of the cellular morphology within the chondroid areas (Figure 2H). No immunoreactivity for CD10 or p53 was detected, and Ki-67 labeling was absent.

Based on the clinical, radiographic, and microscopic findings, particularly the characteristic features observed in H&E-stained sections, a diagnosis of chondromyxoid fibroma was established. Immunohistochemical analysis provided supportive information and contributed to the characterization of the histological components but was not essential for the diagnosis. Surgical treatment consisted of complete marginal resection of the lesion together with extraction of tooth 47. To preserve mandibular continuity and promote bone regeneration, reconstruction was performed using an autogenous iliac crest bone graft combined with platelet-rich fibrin and stabilized with a reconstruction plate.

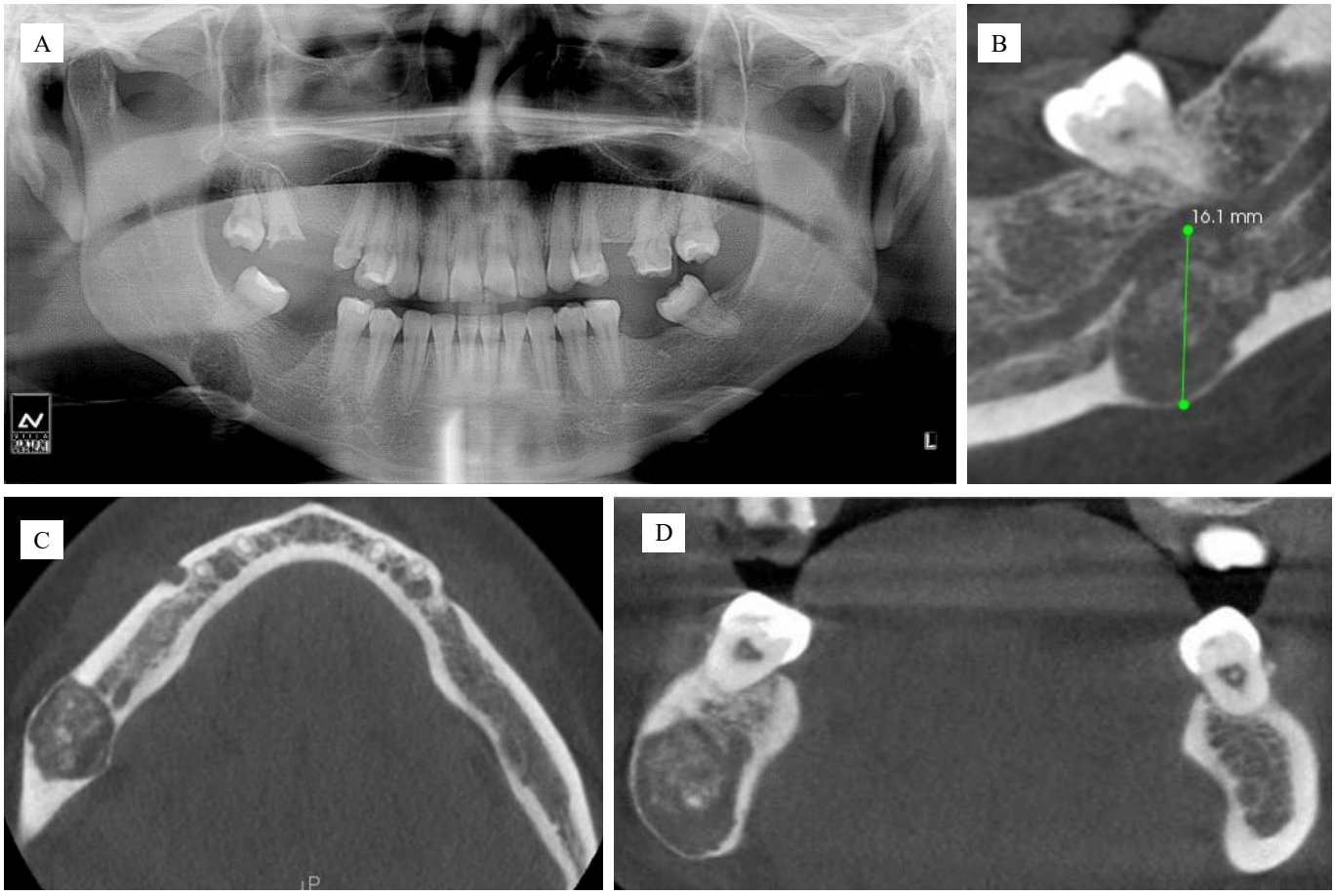
At the six-month follow-up, no postoperative complications were observed, and bone healing was satisfactory. The patient reported mild paresthesia in the right

mental region, which was considered possibly related to the reconstruction plate. Panoramic radiography and cone-beam computed tomography (CBCT) performed six years after surgery demonstrated complete regeneration of the affected mandibular bone, with no evidence of recurrence. No residual symptoms were reported at the six-year follow-up (Figure 3).

DISCUSSION

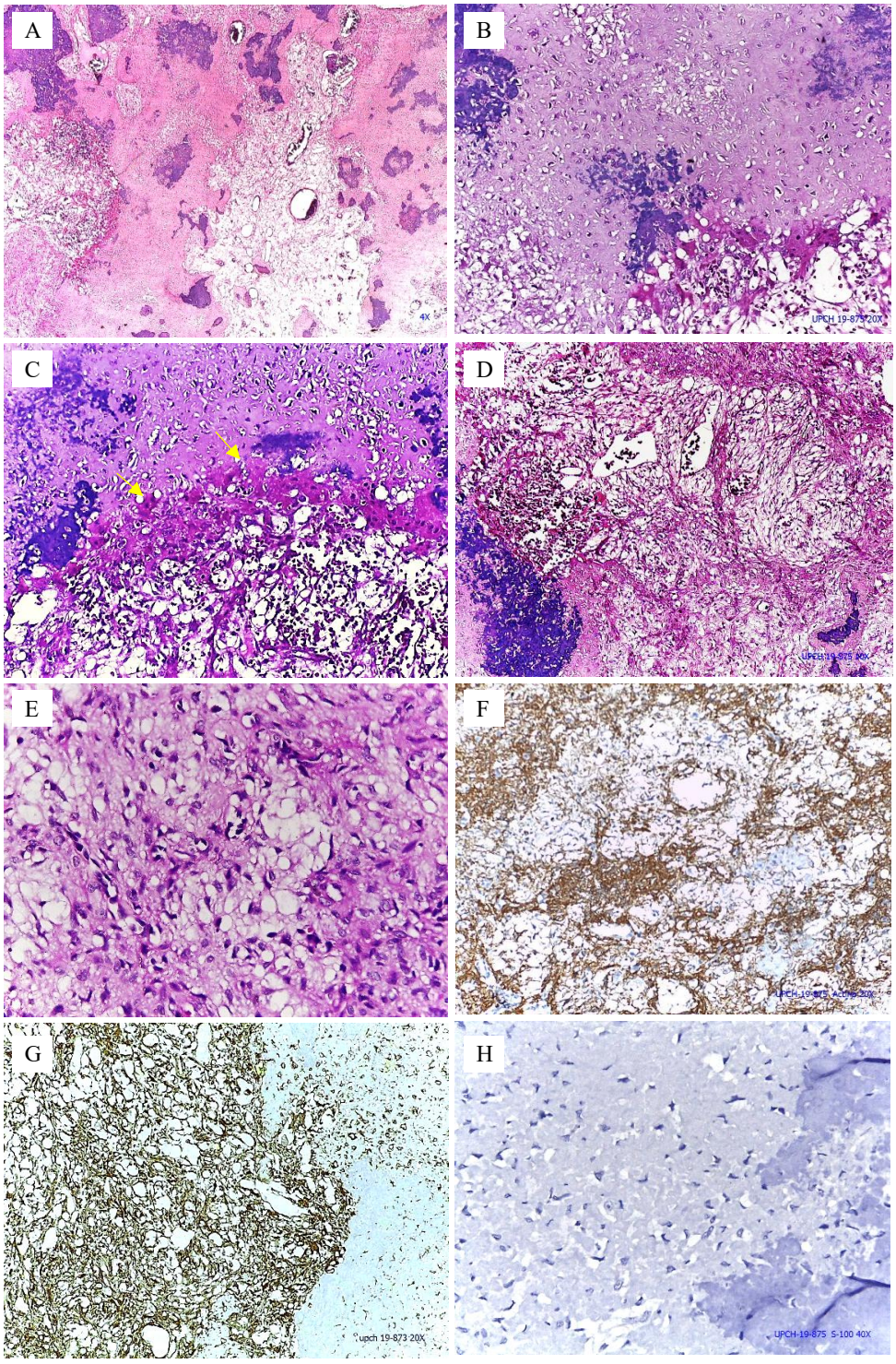
Chondromyxoid fibroma (CMF) of the jaws is an exceptionally rare benign chondrogenic neoplasm. A review of the literature published between 1978 and 2023 identified 20 well-documented cases involving the jaws (Table 1), including recent reports of mandibular CMF in children, adolescents, and adults[18-25]. The mandible was the most commonly affected site (16/20 cases, 80%), particularly the posterior body, angle, and ramus, whereas the maxilla accounted for the remaining four cases (20%). Patient age ranged from 1 to 50 years (mean, 21.5 years), with a relatively balanced sex distribution (11 males, 9 females) (Table 1). Most cases occurred during the second and third decades of life, consistent with the age distribution reported for CMF of the long bones[26]. The present case involved a 29-year-old woman with a slowly enlarging mandibular lesion.

Radiographically, the tumor appeared as a well-defined mixed-density lesion with cortical thinning and mild expansion, features suggestive of a benign fibro-osseous process. No radiographic signs of malignancy, such as ill-defined borders, cortical destruction, or periosteal reaction, were observed. Nevertheless, CMF may occasionally exhibit cortical erosion or bone destruction, thereby mimicking chondrosarcoma or osteosarcoma and posing diagnostic challenges, particularly when only limited biopsy specimens are available[18-20].



Source: Authors' personal collection.

Figure 1. (A) Panoramic radiograph showing a well-defined, corticated, oval-shaped lesion in the region of tooth 46. **(B, C)** CBCT images reveal a hypodense circular area surrounding a centrally located irregular hyperdense mass, associated with thinning and mild expansion of the buccal and lingual basal cortical plates. **(D)** The mandibular canal is displaced but remains corticated and intact.



Source: Authors' personal collection.

Figure 2. (A) Histopathological image showing chondroid areas with dark-purple calcifications, myxoid areas, and myxoid regions bordered by multinucleated giant cells. **(B)** Chondroid areas containing irregular dark-purple calcifications, with multinucleated giant cells located at their periphery. **(C)** Higher-magnification view of chondroid areas containing stellate cells, bordered by multinucleated giant cells, and adjacent myxoid matrix with a mononuclear inflammatory infiltrate. **(D)** Well-defined myxoid area located between two chondroid matrices. **(E)** Myxoid area composed of eosinophilic spindle-shaped cells embedded within an abundant clear to slightly eosinophilic extracellular matrix. **(F)** SMA immunohistochemical staining demonstrating strong positivity in the myxoid areas. **(G)** Vimentin immunostaining showing positivity in both myxoid and chondroid components. **(H)** S-100 immunostaining highlighting stellate cells within the chondroid areas.



Source: Authors' personal collection.

Figure 3. Panoramic radiograph taken six years after surgical treatment. Complete bone regeneration of the affected area is observed.

The final diagnosis in the present case was established primarily on the basis of conventional histopathological findings, with immunohistochemistry providing supportive ancillary information. Strong expression of SMA and vimentin within the myxoid component suggests myofibroblastic differentiation of the tumor cells, whereas the absence of p53 expression and Ki-67 labeling is consistent with the low proliferative activity typically observed in CMF[24].

The multinucleated giant cells identified at the interface between the chondroid and myxoid components exhibited an osteoclast-like morphology and may contribute to matrix remodeling during tumor growth. The distinctive calcified deposits observed within the chondroid matrix are a recognized histopathological feature of CMF[26] and may also be encountered in other benign and malignant cartilaginous neoplasms.

An additional finding of surgical relevance was the absence of a true capsule separating the lesion from the surrounding bone. Instead, a thin layer of vascularized connective tissue was present between the tumor and adjacent normal bone. Similar observations have been reported in CMF and support complete surgical excision with adequate osseous margins[26,27].

The radiographic and histopathological differential diagnosis of mandibular CMF includes fibro-osseous lesions and odontogenic myxoma. Odontogenic myxoma is particularly relevant because its radiolucent appearance and myxoid histological component may overlap with those of CMF[28]. Other jaw lesions may also exhibit overlapping radiographic or microscopic features, making clinicopathological correlation essential[29,30]. In the present case, the combination of the characteristic lobulated architecture, distinct chondroid and myxoid components, peripheral multinucleated giant cells, and calcified deposits within the chondroid matrix, together with the clinical and radiographic findings, supported the diagnosis of CMF.

Treatment approaches reported in the literature are heterogeneous, ranging from conservative procedures such as enucleation or curettage to marginal or segmental resection, depending on lesion size, local extent, and the feasibility of complete removal[20-23,27]. Conservative surgery has been successful for small, well-circumscribed lesions, with no recurrence reported in most cases[21-23]. Two recurrences were documented in the reviewed cases: the first occurred after initial curettage in a 10-year-old patient, whereas the second occurred 6 months after curettage in a 12-year-old patient and required subsequent resection with microvascular reconstruction[20,27]. These cases highlight the importance of complete tumor removal and adequate local control rather than supporting an age-related predisposition to recurrence.

In the present case, marginal resection was performed because complete excision could be achieved while preserving mandibular continuity. At six years of follow-up, complete bone regeneration and the absence of recurrence support the adequacy of this approach for anatomically favorable mandibular CMF.

CONCLUSION

Chondromyxoid fibroma of the jaws is a rare benign chondrogenic neoplasm that may mimic fibro-osseous lesions, odontogenic myxoma, and other cartilaginous neoplasms. The definitive diagnosis relies primarily on histopathological examination of H&E-stained sections, with immunohistochemistry providing supportive but nonessential information. This case highlights the importance of clinicopathological correlation and supports conservative marginal resection as an effective treatment for anatomically favorable mandibular CMF, with excellent long-term local control demonstrated by six years of follow-up without recurrence and with complete bone regeneration.

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Table 1. Cases of Chondromyxoid Fibroma of the Jaws (1978–2023).

Reference	Age/sex	Site	Imaging findings	Treatment	Recurrence/ follow-up
Davis & Tideman[6]	16M	Mandibular symphysis	Radiolucency with scalloped border and peripheral sclerosis	Local resection+iliac graft	No/7 months
Thompson et al.[7]	42F	Left mandibular body	Localized radiolucency	Curettage	No/15 months
Kearney[8]	12F	Right mandible (incisor-canine)	Diffuse radiolucency, loss of lamina dura	En bloc resection+costal graft	No/24 months
Damm et al.[9]	24F	Right maxilla (incisor-canine)	Vague, ill-defined radiolucency	Curettage	No/18 months
Lustmann et al.[10]	25F	Left anterior maxilla	Round, ill-defined radiolucency	Enucleation	No/18 years
Lustmann et al.[10]	23M	Mandibular symphysis	Multilocular radiolucency with trabecular pattern	Enucleation/curettage	No/NR
Pinholt et al.[11]	24M	Left mandible (molars)	Extensive radiolucency, pseudotrabeculation, opacities	Enucleation+iliac graft	No/5 years
Fujii & Eliseo[29]	38F	Left maxilla (incisor-canine)	Unilocular radiolucency, scalloped borders	Curettage	No/5 years
Müller et al.[30]	12M	Right mandibular ramus	Well-circumscribed radiolucency (4×2 cm), sclerotic border	Curettage	No/11 years
Lingen et al.[27]	10M	Right mandible (incisor-canine)	Initial: ill-defined radiolucency; recurrence: well-circumscribed	Curettage ×2	Yes/2 years
Hammad et al.[16]	12M	Right mandible (canine-premolar)	Ovoid radiolucency (6.5×3.5 cm), radiopaque foci	Mandibular resection+reconstruction	No/14 months
Macan et al.[17]	24M	Right mandible (premolars)	Mixed radiopaque-radiolucent (4×2 cm), circumscribed borders	Curettage	No/7 years
Khatana et al.[18]	10F	Right mandible (canine to 1st molar)	Ovoid radiolucency (5.5×4 cm), cortical expansion	Enucleation + curettage + transitional reconstruction	No/16 months
Fomete et al.[19]	30F	Right mandibular body	Expansile radiolucency, no calcifications	Mandibular disarticulation	No/NR
Khosla et al.[20]	12M	Right mandible (condyle to angle)	CT: extensive destructive lytic lesion, heterogeneous mass	Initial: curettage; recurrence: resection+vascularized flap	Yes/6 months
Ying et al.[21]	8F	Left mandible (32–36)	Bony expansion, "ground-glass" appearance	Curettage	No/NR
Vuletić et al.[22]	50F	Left mandible (vestibular)	CBCT: mixed mass (2.5×1.5×1 cm), defined borders	Local enucleation	No/NR
Elseyoufi et al.[23]	43M	Mandibular body (44–46)	CBCT: irregular unilocular radiolucency	Surgical excision	No/NR
Panucci et al.[24]	1M	Left anterior maxilla	CT: mass compressing nasal cavity	Conservative excision	No/1 year
Jadaun et al.[25]	13M	Right mandible (parasymphysis to condyle)	Unilocular lesion (15×12 cm)	Resection+reconstruction with plate	No/2 years

NR: not reported.
Totals: mandible 16/20 (80%), maxilla 4/20 (20%); sex 11M/9F; age 1–50 years (mean 21.5, median 13); recurrence 2/20 (10%) — cases 10 and 15, highlighted in bold.

AUTHORS' CONTRIBUTIONS

WADA: Investigation, Methodology, Supervision, Validation, Visualization, Writing – original draft, Writing – review & editing. JOHP: Resources, Validation. HDGM: Methodology, Validation. HAO: Methodology, Resources. MGCP: Resources, Visualization. NLGP: Resources, Supervision, Validation. KBTS: Conceptualization, Investigation, Methodology, Supervision, Validation, Visualization, Writing – original draft, Writing – review & editing.

CONFLICT OF INTEREST STATEMENT

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Data availability statement: The datasets used and/or analyzed during the current study are available from the corresponding author on reasonable request.

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