UNIVERSIDADE FEDERAL DO RIO GRANDE DO SUL

FACULDADE DE ODONTOLOGIA

TRABALHO DE CONCLUSÃO DE CURSO DE ODONTOLOGIA

PERFIL DOS PACIENTES E DAS LESÕES BUCAIS DIAGNOSTICADAS NO LABORATÓRIO DE HISTOPATOLOGIA PROF. DR. J.J. BARBACHAN NO PERIODO DE 1995-2004.

Marina Mendez

Porto Alegre

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Trabalho de Conclusão de Curso,

Faculdade de Odontologia

Universidade Federal do Rio Grande do Sul

Orientação

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RESUMO

Diversos estudos têm buscado entender a relação entre determinadas patologias e as características da população afetada. O objetivo deste estudo foi determinar a distribuição das lesões submetidas ao laboratório de Patologia Bucal da FO-UFRGS em um período de 10 anos (1995-2004), segundo as características demográficas dos pacientes, bem como verificar se há associação entre elas. Além disso, avaliou-se a concordância entre diagnóstico clínico e histopatológico e se o preenchimento das fichas de biópsia foi realizado de forma completa. Foram coletados dados de 7.480 laudos histopatológicos, criando uma base de dados no software Microsoft Access. Cada diagnóstico foi classificado como uma das seguintes categorias: neoplasia, inflamatória ou outra. Dos casos analisados, 63,15% (n=4.646) eram de pacientes do sexo feminino. Em 87,96% dos casos (n=4.487) realizou-se biópsia do tipo excisional. As lesões inflamatórias foram as mais freqüentes (n=4.292 – 57,38%), enquanto as neoplasias benignas e malignas corresponderam a 6,99% (n=523) e 1,59% (n=130), respectivamente. Dentre todas as lesões, as lesões inflamatórias periapicais foram as mais comuns representando 25,83% (n=1.932). Homens mostraram maiores chances de apresentar tumores benignos de tecido mole e carcinoma espinocelular do que as mulheres, quando comparados com processos proliferativos não-neoplásicos e leucoplasias, respectivamente. A concordância entre os diagnósticos variou de 27,03 % em casos de patologia óssea à 67,86% em lesões de natureza incerta. Em torno de 40% dos casos, as fichas de biópsia estavam incompletas. Conclui-se que a maioria das lesões é de natureza inflamatória e que a concordância entre os diagnósticos clínico e microscópico varia com o tipo de lesão. Além disso, um número relativamente alto de fichas é encaminhado sem o fornecimento de todas as informações necessárias, o que pode dificultar o estabelecimento do diagnóstico definitivo.

Palavras chave: lesões maxilofaciais; patologia bucal; estudos retrospectivos; biópsia; histopatologia

ABSTRACT

Many studies have been trying to define the relationship between certain pathologies and its population characteristics. The aim of this study was to determine the range of histopatologically diagnosed specimens at an oral pathology laboratory in the south of Brazil on a period of 10 years (1995-2004), according to the population's demographic characteristics, as well as if there is an association between them. Furthermore, the agreement between clinical and histopathological diagnosis and the fulfillment of biopsy forms will also be evaluated. Data from 7,480 histopathological reports were retrieved, creating a database on Microsoft Access Software. Each diagnosis was categorized by nature (inflammatory or neoplastic). Lesions which not fulfilled criteria to be classified in these groups were included in Others group. From all specimens analyzed, 63.15% (n=4,646) were women and 87.96% (n=4,487) were excisional biopsies. Inflammatory lesions were the most frequent (n=4.292 – 57.38%) followed by others group (n=2,535 – 33.89%), benign tumors (n=523 – 6.99%) and malignant tumors (n=130 – 1.74%). The most common diagnosis was periapical inflammatory lesion (n=1,932 – 25.83%). Man showed more chances of having soft tissue benign tumor and squamous cell carcinoma than women when compared to non-neoplastic proliferative process and leukoplakia, respectively. The agreement between clinical and histopathological diagnosis ranged between 27.03 for bone pathology to 67.86% for lesions of unknown nature. Not more than 60% of the forms were completed. In conclusion, there was a higher frequency of inflammatory lesions, and the agreement between clinical and histopathological diagnosis vary according to the type of lesion. Besides that, a relatively high number of biopsy forms are sent to the laboratory without all information needed, which can harden the establishment of a correct diagnosis.

Keywords: maxillofacial lesions; oral pathology; retrospective study; biopsy; histopathology.

INTRODUÇÃO

O perfil dos pacientes muitas vezes está relacionado com a doença que os afeta. Alguns tipos de lesões têm maior prevalência em determinado grupo de pessoas. Essas distribuições podem variar de acordo com características físicas de cada indivíduo ou de acordo com sua história de vida e seus hábitos (NEVILLE et al., 2009). O conhecimento da relação do perfil dos pacientes com determinada lesão pode facilitar o cirurgião-dentista a elaborar seu diagnóstico.

Estudos que analisam a forma como os perfis dos pacientes os predispõe a ocorrência de um tipo de lesão são realizados em todo o mundo. No entanto, os resultados podem ser diferentes de acordo com os fatores demográficos de cada região. Fatores como sexo, idade, grupo étnico, nível socioeconômico e grau de instrução variam de acordo com cada país e região observada, podendo influenciar na prevalência e distribuição das diferentes lesões (NEVILLE et al., 2009).

Muitos estudos têm buscado definir a relação entre determinadas patologias e a população estudada a partir de dados e analise de grupos populacionais. Alguns utilizam prontuários, como estudos realizados em Instituições hospitalares (SMITH, KRUGER e TENNANT, 2006) e outros utilizam dados de fichas e exames provenientes de biópsias (CARVALHO et al., 2005)

O objetivo deste estudo foi determinar a distribuição das lesões submetidas ao Laboratório de Histopatologia Prof. Dr. J. J. Barbachan (Faculdade de Odontologia da Universidade Federal do Rio Grande do Sul, Brasil) em um período de 10 anos (1995-2004), segundo as características demográficas dos pacientes, bem como verificar se há associação entre elas. Além disso, avaliou-se a concordância entre diagnóstico clínico e histopatológico e se o preenchimento das fichas de biópsia foi realizado de forma completa.

ARTIGO

A retrospective study of specimens submitted to a Brazilian Oral Pathology Laboratory over a 10-year period[1]

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A retrospective study of specimens submitted to a Brazilian Oral Pathology Laboratory over a 10-year period

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Running Title

A retrospective study of oral lesions

Introduction

Oral lesions diagnoses usually requires biopsy and histopathological analysis. These procedures allow the establishment of the histological characteristics of suspected lesions, their differentiation, extension or spreading, and sometime are mandatory in order to choose the proper treatment modality. However, biopsy and histopathological analysis are complementary diagnostic tests which depend on and may be modified by clinical data [1]

There are many studies describing estimates of oral lesions. However, most of them focused on specific lesions as oral cancer [2,3,4], odontogenic tumors [5,6], salivary gland tumors [7,8,9] or are focused on children [10]. Few descriptive studies documented the frequency of histologically confirmed lesions of the maxillofacial complex on adults [11,12,13,14] . In Brazil, there are few reports regarding this type of study. Simões et al. [15] and Nascimento et al. [16] evaluated, respectively, 1,040 and 2,147 specimens in studies

conduced in oral pathologies laboratories from the northeast region. Volkweis et al. [17] reported 435 cases on a Dental Specialty Center at the southern region.

The aim of this study was to determine the range of histopatologically diagnosed specimens at an oral pathology laboratory in the south of Brazil on a period of 10 years (1995-2004), according to the population's demographic characteristics, as well as if there is an association between them. Furthermore, the agreement between clinical and histopathological diagnosis and the fulfillment of biopsy forms will also be evaluated.

Methods

Data from 8,168 histopathological reports were retrieved from 1995 to 2004, creating a database on Microsoft Access Software. Research material (animal tissues from experimental studies) was excluded, resulting on a total of 7,480 valid cases. Each diagnosis was categorized by origin or type according criteria adapted from Neville et al. (2009) [18]. Demographic characteristics as gender, age and skin color were also collected.

Depending on its type, the lesions were categorized as inflammatory, neoplasic or others. Neoplasic lesions were categorized in benign or malign and also in mesenquimal, epithelial (mucosal or glandular), odontogenic, nervous tissue, and bone tissue. The *Others* group included:

- Normal Tissue, corresponding basically with dental follicle;

- Potentially malignant lesion, which includes leukoplakia and actinc cheilitis;

- Descriptive report, when the amount of tissue was insufficient to determine the diagnosis);

- Unknown nature (Lichen Planus),

- Cysts, which includes odontogenic, non-odontogenic and unspecified ones. Inflammatory Cysts were classified as inflammatory lesions.

- Bone pathology (Peripheral Ossifying Fibroma, Periapical Cemento-Osseous Dysplasia and Traumatic Bone Cyst).

The agreement between clinical and histopathological diagnosis was also analyzed as well as the fulfillment of biopsy form. For the agreement of diagnosis, both of them had to be exactly the same or being part of one another, for example, it agrees when the clinical diagnosis is periapical lesion and the histopathological is periapical cyst. To be considered a complete biopsy form, all patient and procedure information had to be filled in.

The present study was approved by the Ethics Committee and Research Committee of the Federal University of Rio Grande do Sul, School of Dentistry (protocol number 269/08).

Data analyses were performed using a statistical package (SPSS 16 for Macintosh, SPSS Inc., Chicago, Illinois, USA). The unit of analysis was the individual and the significance level was set at 5%. Individuals were divided in two age groups using 50 years as the cut-off. Individuals were also categorized as whites and non-whites according to self-reported skin color. Descriptive statistics were generated for the occurrence of each type of lesion. The distribution of subjects with and without a condition according to gender, age and race was compared using the Fisher exact test. Uni and multivariable logistic regression models were performed to test the association between oral lesions with gender, age and race. Two central models were applied separately for soft tissue benign tumors and squamous cell carcinoma. For the benign tumors model, some inflammatory lesions, grouped as non-neoplastic proliferative processes - NNPP (inflammatory hyperplasia, pyogenic granuloma and giant cell lesion) were considered the comparison group. For the squamous cell carcinoma, leukoplakia was considered the comparison group. Odds ratios and 95% confidence intervals were reported.

Results

During the period of 1995 to 2004 the oral pathology laboratory received 8,168 specimens to be analyzed. Research material corresponded to 688 (8.42%) of the specimens, being excluded from the analysis. From a total of 7,480 human specimens, age was specified for 6,919 (92.5%) individuals. Gender was recorded for 7.356 (98.34%) samples, 63.15% (n=4,646) of them were females. The type of biopsy was specified in 5,101 (68.19%) reports, 4,487 (87.96%) were excisional and 614 (12.03%) were incisional biopsies.

Table 1 shows the distribution of the cases according to the diagnostic category. The most frequent lesions were inflammatory lesions representing 4,292 (57.38%) cases, followed by the others category (n= 2,535 – 33.89%), benign tumors (n=523 – 6.99%) and malignant tumors (n= 130 – 1.74%).

Table 1. Distribution of cases according to diagnostic category.

Diagnostic category	**Total cases**	**% of group**	**% total**
Inflamatory lesions	**4,292**	**100**	**57.38**
Benign tumors	**523**	**100**	**6.99**
Mesenquimal	286	54.64	3.82
Odontogenic	120	22.94	1.60
Epitelial (Squamous)	91	17.39	1.22
Epitelial (Glandular)	14	2.67	0.19
Bone	7	1.34	0.09
Nervous Tissue	5	0.96	0.07
Malignant tumors	**130**	**100**	**1.74**
Epitelial (Lining)	114	87.69	1.52
Mesenquimal	10	7.69	0.13
Epitelial (Glandular)	6	4.61	0.08
Others	**2,535**	**100**	**33.89**
Normal Tissue	1,507	59.45	20,15
Descriptive Material	649	25.60	8.68
Potentially malignant lesion	168	6.63	2.25
Cysts	146	5.76	1.95
Bone Pathology	37	1.46	0.49
Unknown nature	28	1.10	0.37
Total	**7,480**		**100**

Table 2 summarizes the most frequent diagnoses among each diagnostic group. Periapical lesions comprised the most frequent inflammatory lesion. Fibroma and squamous cell carcinoma were the most frequently observed lesions among benign and malignant tumors, respectively. The others group (n=2,535 – 33.89%) was represented by subgroups of Normal Tissue (n=1,507 – 20.15%), Bone Pathology (n=37 – 0.49%), Cysts (n=146 – 1.95%), Potentially malignant lesion (n=168 – 2.25%) and Unknown Nature (n=28 – 0.37%). Descriptive Material and Research Material were not considered since they don't have a specific diagnosis.

Table 3 shows the frequency distribution of biopsy types, agreement between clinical and histopathological diagnosis and the number of completed forms according to group of lesions. The most common type of biopsy was the excisional for all groups of lesions, except for the unknown nature group. Agreement between clinical and histopathological diagnosis ranged between 27.03 for bone pathology to 67.86% for lesions of unknown nature. Overall, not more than 60% of the forms were completed.

Table 2. Most Frequent diagnoses of each diagnostic group.

Diagnoses	Total Cases	% of group	% of total
Inflammatory Lesions	**4,292**	**100**	**57.38**
Periapical Inflammatory Lesion	1,932	45.01	25.83
Inflammatory Hyperplasia	719	16.75	9.61
Mucocele	185	4.31	2.47
Pyogenic Granuloma	166	3.87	2.22
Pericoronaritis	108	2.52	1.44
Giant Cell Lesion	49	1.14	0.66
Benign Tumors	**523**	**100**	**6.99**
Fibroma	216	41.30	2.89
Papilloma	76	14.53	1.02
Keratocystic Odontogenic Tumor	38	7.27	0.51
Hemangioma	34	6.50	0.45
Odontoma	30	5.74	0.40
Malignant Tumors	**130**	**100**	**1.74**
Squamous Cell Carcinoma	113	86.92	1.51
Undifferentiated Malignant Neoplasms	8	6.15	0.11
Mucoepidermoid Carcinoma	4	3.08	0.05
Plasmocytoma	1	0.77	0.01
Lymphoma	1	0.77	0.01
Adenocarcinoma	1	0.77	0.01
Adenoid Cystic Carcinoma	1	0.77	0.01
Basal Cell Carcinoma	1	0.77	0.01
Others - Normal Tissue	**1,507**	**100**	**20.15**
Dental Follicle	1,425	94.56	19.05
Others – Potentially Malignant Lesion	**168**	**100**	**2.25**
Epithelial maturation disturbances (Leukoplakia)	152	90.48	2.03
Actinic cheilitis	16	9.52	0.21
Others - Cysts	**146**	**100**	**1.95**
Odontogenic Cysts	122	83.56	1.63
Unspecified	16	10.96	0.21
Non-Odontogenic Cysts	8	5.48	0.11
Others - Bone Pathology	**37**	**100**	**0.49**
Peripheral ossifying fibroma	15	40.54	0.20
Benign Fibro-osseous lesion	11	29.73	0.15
Traumatic Bone Cyst	9	24.32	0.12
Periapical Cemento-osseous dysplasia	2	5.41	0.03
Others - Unknown Nature	**28**	**100**	**0.37**
Lichen Planus	28	100	0.37

Table 3. Biopsy type, agreement between clinical and histopathological diagnosis and completed forms by diagnostic category.

			Neoplasia				Others							
	Inflammatory		Benign Tumors		Malignant Tumors		Potencially malignant lesion		Cysts		Bone Pathology		Unknown Nature	
	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Biopsy														
Excisional	2,685	62.6	347	66.34	11	8.46	67	39.88	87	59.59	18	48.65	6	21.43
Incisional	220	5.1	40	7.64	97	74.61	61	36.31	13	8.90	4	10.81	13	46.43
Unwritten	1,387	32.3	136	26	22	16.92	40	23.81	46	31,51	15	40.54	9	32.14
Agreement														
Yes	2,273	53	313	59.84	79	60.76	106	63.10	69	47.26	10	27.03	19	67.86
No	2,019	47	210	40.15	51	39.23	62	36.90	77	52.74	27	72.97	9	32.14
Completed form														
Yes	1,718	40	259	49.52	75	57.69	96	57.14	65	44.52	14	37.84	16	57.14
No	2,574	60	264	50.47	55	42.3	72	42.86	81	55.48	23	62.16	12	42.86
TOTAL	4,292		523		130		168		146		37		28	

The distribution of subjects with proliferative lesions (non-neoplastic proliferative process –NNPP- and soft tissue benign tumors) according to demographic risk indicators is shown in Table 4. No significant differences were observed in the occurrence of NNPP and soft tissue benign tumors regarding age and skin color. The percentage of male patients with benign tumors was significantly higher compared to NNPP (p=0.02). Table 5 demonstrates the risk model for soft-tissue benign tumors. No multivariate analysis was performed, since only gender demonstrated to be significant associated to the occurrence of benign tumors (OR=1.52, p=0.01).

Table 4. Distribution of subjects with proliferative lesions (non-neoplastic proliferative process – NNPP - and soft tissue benign tumors) according to demographic risk indicators.

Risk indicator	**Non-neoplastic proliferative process N(%)**	**Soft tissue benign tumor N(%)**	**p***
Age			
30-49 years	116 (15.5)	29 (13.2)	
≥50 years	632 (84.5)	191 (86.2)	0.45
Gender			
Female	564 (75.4)	147 (66.8)	
Male	184 (24.6)	73 (33.2)	0.02
Skin Color			
White	652 (87.2)	194 (88.2)	
Non-white	96 (12.8)	26 (11.8)	0.73
Total	748 (100.0)	220 (100.0)	

Fisher's Exact Test

Table 5. Univariate logistic regression of the association between soft tissue benign tumor and demographic risk indicators (non-neoplastic proliferative process – NNPP- as the reference group).

Risk indicator	OR (95%CI)	p
Age		
30-49 years	1	
≥50 years	1.21 (0.78 – 1.87)	0.40
Gender		
Female	1	
Male	1.52 (1.10 – 2.11)	0.01
Skin Color		
White	1	
Non-white	0.91 (0.57 – 1.45)	0.69

The association between squamous cell carcinoma and leukoplakia with demographic risk indicators is observed in Tables 6 and 7. The percentage of males with squamous cell carcinoma (72%) was higher than on leukoplakia (51.1%) (p=0.001). There were no significant differences in age and skin color between carcinoma and leukoplakia. Men had 2.57 higher chance (CI=1.47-4.48) of having a squamous cell carcinoma rather than women when compared with leukoplakia (p=0.001). Patients over 50 years old also have 2.95 (1.12-7.79) more chances of having squamous cell carcinoma than women (p=0.03). Significant associations were also observed after adjustments.

Table 6. Distribution of subjects with leukoplakia and squamous cell carcinoma according to demographic risk factors.

Risk indicator	Leukoplakia N(%)	Squamous Cell Carcinoma N(%)	p*
Age			
30-49 years	20 (14.6)	6 (6.0)	
≥50 years	117 (85.4)	94 (94.0)	0.06
Gender			
Female	67 (48.9)	28 (28.0)	
Male	70 (51.1)	72 (72.0)	0.001
Skin Color			
White	123 (89.8)	88 (88.0)	
Non-white	14 (10.2)	12 (12.0)	0.68
Total	137 (100.0)	100 (100.0)	

Fisher's Exact Test

Table 7. Logistic regression models of the association between squamous cell carcinoma and demographic risk indicators (leukoplakia as the reference group)

Risk indicator	OR (95%CI)	p
Crude estimates		
Age		
30-49 years	1	
≥50 years	2.68 (1.03 – 6.94)	0.04
Gender		
Female	1	
Male	2.46 (1.42 – 4.27)	0.001
Skin Color		
White	1	
Non-white	1.20 (0.53 – 2.72)	0.67
Adjusted estimates		
Age		
30-49 years	1	
≥50 years	2.95 (1.12 – 7.79)	0.03
Gender		
Female	1	
Male	2.57 (1.47 – 4.48)	0.001

Discussion

In this sample the frequency of female patients was higher (63.15%) than males. This may be explained by the fact that women look for dental and medical treatment more frequently than man. It can also be related with the distribution of the population of the State. According to the Brazilian census of 2000 50.97% of the state's population are of women [19]. Excisional biopsies represented 87.96% of all biopsies informed, this can be explained by the higher number of periapical inflammatory lesions, which usually leads to excisional biopsy. [20]

Distribution of cases (Tables 1 and 2)

Inflammatory lesions were the most frequent group of lesions (n=4,292; 57.38%). As well as found by Gholahan et al [21]; Corrêa et al. [22]; and Simões et al.[15]. Periapical inflammatory lesions (n=1,932. 25.83% of total cases/ 45.01% of group) and inflammatory hyperplasia (n=719; 9.61% of total cases and 16.75% of the group) were the predominant. These results agree with the findings of the authors previously cited on this paragraph and also with Jones and Franklin (2006) [11] that found fibrous hyperplasia and chronic periapical granuloma as one of the most frequent diagnosis on mucosal pathology and tooth pathology groups. Inflammatory hyperplasia is a response of chronic trauma, very common on the oral cavity. This frequency can also be a response of the socioeconomic status of Brazil where people use the same prosthesis over decades, which usually unfit with the years [23]. Yet the great number of periapical inflammatory lesions can be related to the study being done on a dentistry school that frequently receive decayed tooth associated with periapical inflammatory lesions at the surgery disciplines.

Fibroma was the most frequent diagnosis on benign neoplasia group (n=216. 2.89% of total cases and 41.30% of the group). This finding disagrees with the one found by Jones and Franklin [11], which found more frequency of squamous papillomas. However, Weir et al. [12] and Simões et al. [15] also found more frequency on fibromas. Oral pathology reference text books also report fibromas as the most frequent benign tumor [18,24]. This result may be explained because besides epithelial cells, fibroblast are the most common type of cells found within the oral tissues, so the possibility of one of these cells becoming a tumor may be higher.

Dental follicle was the most common diagnosis at the group normal tissue as related by Kim and Ellis [25]. Dental follicles can lead the development of cysts and tumors [26]. As a pedagogic purpose of the faculty it is recommended that every follicle removed from teeth must be sent to histopathological evaluation, which explains the high number found.

Type of biopsy, agreement and forms (Table 3)

The findings of the relation between type of lesion and type of biopsy showed that benign tumors had more frequency of excisional biopsies and malignant tumors of incisional, according with recommended by literature [1]. Potentially malignant lesions had a similar number of incisional and excisional biopsies which could be explained by the sizes of lesions, some bigger and others smaller [1]. Cysts had more frequency of excisional biopsies which agrees with literature [18]. It can be explained by cysts having typical radiographic and clinical characteristics and not reaching big dimensions, which facilitates the removal in an only session.

Benign and malignant tumors and potentially malignant lesions had a high number of agreements between clinical and histopathological diagnosis probably because of its clinical

presentation. This result may also be explained since 86.92% of malignant lesions were squamous cell carcinoma (Table 2), and since many patients take a long time to look for help the lesions get bigger, becoming easier to diagnose by its typical characteristics [27].

Bone pathology lesions had a low number of agreements between clinical and histopathological diagnosis, only 27.03%. It also had a low number of completed forms. A possibility is that the professionals did not know a diagnosis hypothesis leaving it unfilled, raising the number of incomplete files and disagreeing diagnoses.

Risk estimate (Tables 4 to 7)

Female patients had more frequency of non-neoplastic proliferative process (NNPP) and soft tissue benign tumors than male patients (Table 4), which agrees with Carrard et al. [28] that explain the higher prevalence of proliferative lesions by the higher frequency of use of removable prosthesis in females. Male patients had more frequency on benign tumors than on non-neoplastic proliferative process ($p=0.02$), which agrees with the findings of Jones &Franklin, 2006 [11]. The authors found 6,458 cases of fibrous hyperplasia and 1,494 cases of benign tumors including squamous papillomas, lipoma and fibroma. Male patients also have more chances of having a soft tissue benign tumor than women when compared to NNPP.

Male patients have more chances of having squamous cell carcinoma than female patients (Table7) and are more likely to have it than having a leukoplakia (Table 6). Patients over 50 years old have also more chances of having squamous cell carcinoma than younger patients (Table 7), a result of the need of long time exposure to risk factors such as tobacco and alcohol to develop oral cancer. Jones and Franklin [11] found 986 cases of squamous cell carcinoma on man compared to 571 cases on women, representing a 1.73 male:female ratio, the mean age was 64.2 years. Rossi and Hirsch [13] found 61.4% of male patients on

malignant lesions and a mean age of 59.6 years on malignant lesions. Despite male patients having more chances of having a squamous cell carcinoma than women, this disparity between male:female ratio has been decreasing over the past years, probably because women have been exposing themselves to oral cancer carcinogens as men [27].

Although specific characteristics vary according to the population being analyzed, this type of study is usually helpful even to the general population. Besides that, descriptive studies that document the distribution of oral and maxillofacial lesions hardly follow the same method of lesions categorization.

It may be concluded that most lesion submitted to biopsy had inflammatory nature and that agreement between clinical and histopathological diagnosis depends on the type of lesion. Additionally, it was concluded that a relatively high percentage of cases had uncompleted biopsy forms, that may to become difficult the definitive diagnosis establishment. Since the survey was done at an oral pathology laboratory of a school of dentistry it reinforces the need of emphasizes the importance of filling all information at the biopsy forms by the undergraduate students.

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CONSIDERAÇÕES FINAIS

O conhecimento dos fatores demográficos associados às diferentes lesões bucais é importante, podendo ser um auxílio no momento de criar a hipótese diagnóstica em que determinará se há a necessidade da realização da biópsia para a sua confirmação ou se a cirurgia é o tratamento definitivo. No entanto as características clínicas da lesão são soberanas.

O total preenchimento das fichas de biópsia ainda é defasado. Novas fichas que induzam ao profissional preencher todos os campos deveriam ser criadas, ajudando então ao patologista definir o diagnóstico. Futuros trabalhos também seriam beneficiados se mais dados pudessem ser analisados.

É interessante a realização de mais estudos que façam uma análise por um maior período de tempo e se possível abranjam mais laboratórios para a realização de um estudo multicentro.

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