CASE REPORT

Torus mandibularis: A case report
Tejavathi Nagaraj, Soniya Kongbrailatpam, Ijum Doye, Devu Krishnan
Department of Oral Medicine and Radiology, Sri Rajiv Gandhi College of Dental Science and Hospital, Bangalore, Karnataka, India

Abstract
Torus mandibularis is an extra growth of bone mostly detected on the lingual aspect of the mandible which could be single or many. It is asymptomatic and sometimes result in complications include speech disturbance, position of tongue, prosthodontic treatment, poor oral care, and traumatic ulceration. It is roughly calculated that 10% of the people of United States shows mandibular tori. This case report is to present bilateral mandibular tori and its clinical features.

Keywords: Bony exostosis, tori, torus mandibularis

Introduction
Osteoma or hyperostosis is a non-pathologic, benign new bony growth. They are developmental anomalies and usually seen in adult and increase in size. They are asymptomatic, slow-growing, resolve without treatment and painless growth, but sometimes, may grow over several centimeters and create problem in the fabrication and wearing of removable dentures or prosthesis.[1,2] It is roughly calculated that the incidence rate of tori is roughly 40 in each 1500 populations and found mostly in Eskimos, American Indians and Asians, and Koreans. Torus is derived from Latin word, which means lump. Etiology is unclear but a genetic condition is expected. Tori which are located in the midline of the hard palate are called a palatal torus, or torus palatinus, and on the lingual aspect of the mandible are called a mandibular torus, or torus mandibularis.

Case Report
A male patient of 47 years old came to the oral medicine and radiology department with a chief complaint of crown placement in the lower right back tooth. The patient had a history of root canal treatment done 3 months back and also underwent removal of teeth in the upper and lower right and left back teeth region when he was 20 years old for orthodontic treatment. No relevant medical history was revealed. On clinical examination intraorally [Figure 1], there was nodular growth seen bilaterally crossing the midline extended from the distal of 36 to mesial of 46, measuring approximately 4×1 cm in size bilaterally and mucosa appears normal as compared to adjacent mucosal surface. On palpation, it was non-tender and bony hard in consistency, suggested of mandibular tori. The patient was explained about the incidental pathological finding. The patient reported that it was asymptomatic and started around 5–6 years back. He did not have any interference in speech or chewing food. The patient was sent to the department of conservative and endodontics for crown placement.

Discussion
The tori mean “bulge” or “lump” in Latin word which is defined as a benign new bone growth which leads exostoses, mostly observed on the hard palate, called palatal torus or torus palatinus, upper buccal aspect, called buccal exostoses, and lingual surface of mandible, called mandibular torus or torus mandibularis.[3] Although etiology is unclear, hereditary condition is suspected. The exostoses are organized by thick corticated bone enveloped by a thin and poorly vascularized mucosa which forms a hard mass in the oral cavity.[4] The prevalence of torus palatinus among the people of United States has been described as elevated as 25–40% and it is accepted that palatal tori are 2 times as prevalent in females than males. It is roughly calculated that 10% of the people of United States shows mandibular tori. However, there is no particular male
or female preference which is reported in torus mandibularis. Torus mandibularis mostly happens bilaterally near the canine and premolar region of the mandibular lingual aspect above the mylohyoid ridge. Sometimes, bilateral tori extend and encounter at the midline and it is termed as “kissing tori.” The peak prevalence of torus palatinus and torus mandibularis is in third decades of life. The incidence rate ranges from 9% to 70% for palatal torus and 1% to 60% for mandibular torus. They started developing after puberty and increased in size steadily over the years. Classification of tori clinically based on their morphology:

(i) Flat tori – It is slight rounded bony lump with a rolled surface for mandibular tori and it extends uniformly on both sides of the palate. (ii) Lobular tori: It arises from a single base which is pedunculated or sessile lobular lump seen on the mandible or palate. (iii) Nodular tori: They are many bony prominences each arising from individual bases and coalesce when they extend and form grooves between them. (iv) Spindle tori: It is elongated and seen next to the line of the mid-palatine region for palatal tori and bilaterally in the mandibular lingual surface.

Although there are no clear criteria for classification by size, but two group of sizes are given (1) 2 mm, 2–4 mm, and above 4 mm or (2) 3 mm, 3–6 mm, and above 6 mm. 2 mm and 3 mm have been found to be common sizes.

Usually, tori are 1.5 mm-4 cm in diameter and can be single growth or grouped together in a cluster, that is, nodular. Buccal exostosis occurs less frequently than tori. Buccal exostosis and tori are benign lesions and do not possess malignant potential. The etiology is unclear and the most believed theory of torus mandibularis at present is of genetic origin in 29.5% of cases and 70% of cases are related to increased masticatory forces to the teeth, that is, occlusal stress. No surgical management is generally needed for tori as it is symptomless and however it becomes so large that (1) it mess with function or denture placement, (2) suffers from recurrent traumatic surface ulcerations because of hard food, such as fish bones, and (3) contributing to a periodontal condition. In this case, we did not do the treatment as the patient came for other reason but we counseled him about the growth. Moreover, this case we suggested that the growth was lobular and nodular and also kissing tori as the growth meets in the midline of the lingual aspect of mandible.

**Conclusion**

Mandibular tori are an asymptomatic, non-neoplastic, slow-growing, self-limiting, and painless growth. Surgical treatment is not necessary but verbal counseling is required unless it is large size, interference in speech, and mastication.

**References**