

IIIrd Year

**Excel**



# DENTISTRY

Solved 85+ Question Papers of RGUHS



Dr Syed Ahmed Khadri  
Dr Junaid Ur Rahman Syed

**Previous 10 years Question Papers**

**1<sup>st</sup>**  
Edition

- Oral Pathology
- General Surgery
- General Medicine

Rajiv Gandhi University of Health Sciences Solved Question Papers

# Excel Dentistry

A complete question bank for 3<sup>rd</sup> year BDS students

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First edition:2022

**Dedicated to**

Our Parents  
Head of the Department  
Co - PGs  
Aspiring Students

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**You can either dream for success or hunt for success.  
You can either regret for failure or rectify failure**

Tahmina

**PREFACE**

The first edition of Excel Dentistry has been updated with recent advancements, hope the readers will find the book more informative and updated.

The material in the book is introductory for a beginner in dentistry.

Although there are many books in the market, but the speciality of this book is that we have solved 85+ question papers from the 10 years question papers of Rajiv Gandhi university of health and sciences, every topic has been discussed in detail keeping in mind the information required.

While writing the 1st Edition of Excel dentistry, suggestions and corrections which were received from the students and colleagues have been taken into deeply grateful consideration.

We are intensely grateful to all those friends & family members who were involved in getting this book ready.

We are immensely thankful to so many colleagues as well as to the readers of the previous edition.

Hopefully, the book provokes both positive and negative reactions. Despite many efforts, we accept imperfection in this book if any.

As the First edition of Excel dentistry, We genuinely welcome all the readers for any kind of suggestions or any mistakes and We'll look forward to further improvement which will be deeply cherished.

Finally, we extend our heartfelt thanks and acknowledge the pleasure of working with the EXCEL BDS TEAM.

**Dr Syed Ahmed Khadri**

**Dr Junaid ur Rahman Syed**

## **ACKNOWLEDGEMENTS**

First and foremost, we would like to thank Dr. Malik Aqueel, Dr. Ayub, Dr. Khaja Moinuddin for their prop up.

We are deeply grateful to my faculty and would like to owe a special note of thanks.

Under Almighty's guidance and blessings, it's a matter of pleasure to introduce 1st Edition of "Excel Dentistry"

We are so thankful to our parents, siblings, and well-wishers whose co-operation, encouragement and support which helped us during the complete preparation of this book.

We are thankful to the staff of EXCEL BDS, for their patience and continuous support.

Last but not least, we'd like to thank our parents.

Lastly, we acknowledge every person who helped us in some or the other ways has inspired us and has worked hard towards making the quality of this book.

**Dr Syed Ahmed Khadri  
Dr Junaid ur Rahman Syed**



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<b>NOVEMBER 2021</b>	
<b>LONG ESSAY</b>	<b>(2 x 10 = 20 Marks)</b>
1.	1. Describe pathophysiology of Wound Healing ( <b>July 2018</b> ) and mention its complications.
2.	Describe in brief types of Shock. Elaborate clinical features and management of Septic Shock. ( <b>Feb 2021</b> )
<b>SHORT ESSAYS</b>	<b>(6 x 5 = 30 Marks)</b>
3.	Compartment syndrome.
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5.	Hypokalemia. ( <b>Dec 2017</b> )
6.	Massive Blood transfusion. ( <b>Dec 2013</b> )
7.	Partial thickness burns.
8.	Dentigerous Cyst. ( <b>Nov 2020</b> )
<b>SHORT ANSWERS</b>	<b>(10 x 2 = 20 Marks)</b>
9.	Thyroid storm. ( <b>Dec 2016</b> )
10.	Sebaceous Cyst. ( <b>Dec 2013</b> )
11.	Xerostomia. (Oral Path) ( <b>Dec 2018</b> )
12.	Frey's syndrome. ( <b>Dec 2019</b> )
13.	Gas gangrene ( <b>July 2018</b> )
14.	Classify Ulcer. ( <b>Dec 2013</b> )
15.	Cancrum oris. (Noma)(Oral Path) ( <b>July 2012</b> )
16.	ABO system of Blood transfusion
17.	Thyroglossal Cyst. ( <b>Feb 2021</b> )
18.	Bone Cyst.

### ANSWERS

**LONG ESSAY** **2 x 10 = 20 Marks**

**Q1. Describe pathophysiology of Wound Healing (July 2018) and mention its complications.**

**Ans:**

**Complication of wound healing:**

- Surgical wound infection complications can be categorized into local and systemic.

**Local complications**

It includes

- Delayed and non-healing of the wound
- Cellulitis
- Abscess formation
- Osteomyelitis
- Deficient scar formation
- Infection
- Implantation
- Excessive contraction
- Pigmentation

**Systemic complications:**

It includes,

- Bacteremia with the possibility of distant hematogenous spread
- Sepsis
- Neoplasia

**Q2. Describe in brief types of Shock. Elaborate clinical features and management of Septic Shock. (Feb 2021)**

**SHORT ESSAY** **8 x 5 = 40 Marks**

**Q3. Compartment syndrome.**

**Ans:**

Acute compartment syndrome is a condition in which there is increased pressure within a closed osteofascial compartment, resulting in impaired local circulation.

- Without prompt treatment, acute compartment syndrome can lead to ischemia and eventually, necrosis.
- Symptoms of acute compartment syndrome (ACS) can include severe pain, poor pulses, decreased ability to move, numbness, or a pale color of the affected limb.

**Etiology**

- It is most commonly due to physical trauma such as a bone fracture or crush injury, but it can also be caused by acute exertion during sport.
- It can also occur after blood flow returns following a period of poor blood flow.
- It can develop after traumatic injuries, such as in automobile accidents or dynamic sporting activities.
- The most common cause of acute compartment syndrome is fracture of a bone, most commonly the tibia.
- There is no difference between acute compartment syndrome originating from an open or closed fracture.

**Clinical features**

- Compartment syndrome usually presents within a few hours of an inciting event, but may present anytime up to 48 hours after.
- The limb affected by compartment syndrome is often associated with a firm, wooden feeling or a deep palpation, and is usually described as feeling tight.
- There may also be decrease pulses in the limb along with associated parasthesia.
- Paresthesia (altered sensation) – A person may complain of “pins & needles”, numbness, and a tingling sensation.
- Pallor and pulselessness – A lack of pulse rarely occurs in patients, as pressures that cause compartment syndrome are often well below arterial pressures.
- The symptoms of chronic exertional compartment syndrome, CECS, may involve pain, tightness, cramps, weakness, and diminished sensation.
- This pain can occur for months, and in some cases over a period of years, and may be relieved by rest.
- Moderate weakness in the affected region can also be observed.

**Complications**

- Failure to relieve the pressure can result in the death of tissues (necrosis) in the affected

anatomical compartment.

- It leads to progressively increasing oxygen deprivation of the tissues dependent on this blood supply.
- Without sufficient oxygen, the tissue will die.
- Neurological deficits
- Gangrene
- Chronic regional pain syndrome
- Rhabdomyolysis

**Management****Acute cases should be treated as**

- Any external compression (tourniquet, orthopedic casts or dressings applied on the affected limb) should be removed.
- Cutting of the cast will reduce the intracompartmental pressure.
- After removal of the external compression the limb should be placed at the level of the heart.
- The vital signs of the patient should be closely monitored.
- If the clinical condition does not improve, then fasciotomy is indicated to decompress the compartments.
- An incision large enough to decompress all the compartments is necessary.
- This surgical procedure is performed inside an operating theater under general or local anesthesia.

**Chronic cases are treated as**

- Treatment for chronic exertional compartment syndrome can include decreasing or subsiding exercise and/or exacerbating activities, massage, non-steroidal anti-inflammatory medication, and physiotherapy.
- Chronic compartment syndrome in the lower leg can be treated conservatively or surgically. Conservative treatment includes

rest, anti-inflammatory medications, and manual decompression. Warming the affected area with a heating pad may help to loosen the fascia prior to exercise.

- Icing the area may result in further constriction of the fascia and is not recommended before exercise.

**Q4. Ludwig's Angina. (June 2013)**

**Q5. Hypokalemia. (Dec 2017)**

**Q6. Massive Blood transfusion. (Dec 2013)**

**Q7. Partial thickness burns.**

**Ans:**

Partial thickness burn involves the superficial layers of the skin.

- The whole of epidermis along with the superficial part of the dermis is destroyed.
- Few of the epithelial cells with hair follicles or sweat glands are still remaining that creates a possibility of regeneration
- Regeneration of epithelium can be done hence skin grafting is not much recommend.
- Contrary to this in full thickness burn it involves whole thickness of the skin with epidermis and the total depth of the dermis.
- In full thickness burn there is no chance of regeneration.

**Clinical appearance**

- Blisters
- Deep redness
- Burned area may appear wet and shiny
- Skin that is painful to the touch
- Burn may be white or discolored in an irregular pattern
- These wounds become erythematous because the dermal tissue has become inflamed.

**Examination**

- When pressure is applied to the reddened area, the area will blanch but demonstrate a brisk or rapid capillary refill upon release of the pressure, a hallmark of the superficial partial-thickness burn.

- Thin-walled, fluid-filled blisters will develop within minutes of the injury.

- As these blisters break, the exposed nerve endings transmit the senses of superficial pain, light touch, and temperature, making these wounds extremely painful.

- The wound will be moist because the characteristic waterproofing of the epidermis has been lost, allowing body fluid to leak on the wound surface. Due to dermal vascular network involvement in this type of injury, moderate edema is usually present.

**Management**

- Not all partial-thickness burns require specialized care in a burn center.

**1. Topical antibiotics**

- Silver sulfadiazine is the most common topical antibiotic used in burn care.
- In general, silver sulfadiazine is a good choice for deep partial-thickness burns because it may allow the wound to heal without the need for a skin graft.
- An ointment containing polymyxin B sulfate and bacitracin zinc is clean and useful for partial-thickness facial burns.

**2. Biologic dressings**

- Biologic dressings serve several functions, including closing a wound to contamination and reducing pain and fluid loss.

**3. Nonbiologic dressings**

- Closure of superficial burns can be safely performed with nonbiologic dressings.
- Nonbiologic wound coverage provides a moist wound environment and allows more rapid epithelialization.
- These dressing includes:
  - Petrolatum gauze.
  - Hydrocolloid.

**Q8. Dentigerous Cyst. (Nov 2020)**

## SHORT ANSWERS

10 x 2 = 20 Marks

Q9. Thyroid storm. (Dec 2016)

Q10. Sebaceous Cyst. (Dec 2013)

Q11. Xerostomia. (Oral Path) (Dec 2018)

Q12. Frey's syndrome. (Dec 2019)

Q13. Gas gangrene (July 2018)

Q14. Classify Ulcer. (Dec 2013)

Q15. Cancrum oris. (Noma)(Oral Path)(July 2012)

Q16. ABO system of Blood transfusion

Ans:

The four basic ABO phenotypes are O, A, B, and AB.

- After it was found that blood group A RBCs reacted differently to a particular antibody.
- The immune system forms antibodies against whichever ABO blood group antigens are *not* found on the individual's RBCs.
- Blood group AB is the least common, and these individuals will have neither anti-A nor anti-B in their serum.

**Landsteiner's Law**

- This law states that if a particular agglutinin is present on the red cell membrane of an individual, the corresponding agglutinin must be absent in his plasma.
- Conversely, if the agglutinin is absent in the red cells, the corresponding agglutinin must be present in the plasma.

Blood group	Antigen present on the red blood cells	Antibodies present in the serum	Genotype
A	A antigen	Anti-B	AA or AO
B	B antigen	Anti-A	BB or BO
AB	A antigen and B antigen	None	AB
O	None	Anti A and Anti B	OO

Q17. Thyroglossal Cyst.(Feb 2021)



**Q18. Bone Cyst.****Ans:**

Bone cysts are fluid-filled areas inside growing bone that have not developed into osseous tissue or actual bone.

- Bone cysts are fluid-filled spots that form in bone.
- Most go away on their own over time.
- Bone cysts are generally diagnosed through X-rays, often when a child is being seen for another condition.

**Types of Bone Cysts are:**

- a. Nonossifying Fibromas:
  - A nonossifying fibroma (NOF) is a central portion of the bone that has failed to form into hard bone but instead is fibrous in nature.
- b. Aneurysmal Bone Cysts:
  - Aneurysmal bone cysts are fluid- or blood-filled areas of bone that most commonly occur in adolescents. Since they are reactive bone lesions, these cysts can present with pain and swelling in the area.
- c. Solitary bone cyst:
  - It is a benign cavity in bone that is either empty or contains fluid.

NOVEMBER 2021	
<b>LONG ESSAY</b>	<b>(2 x 10 = 20 Marks)</b>
1.	Enumerate Potentially malignant disorders. <b>(July 2018)</b> Write in detail about Leukoplakia. <b>(Dec 2019)</b>
2.	Classify Neural tumors and describe Neurofibromatosis. <b>(Dec 2019)</b>
<b>SHORT ESSAYS</b>	<b>(6 x 5 = 30 Marks)</b>
3.	Radiological variants of Dentigerous cyst. <b>(Dec 2017)</b>
4.	Solitary bone cyst.
5.	Pindborg tumour. (Calcifying Epithelial Odontogenic Tumour) <b>(Dec 2012)</b>
6.	A, B, C, D, E Rule of malignant melanoma.
7.	Lipoma. (Gen Surgery) <b>(June 2014)</b>
8.	Reed-Sternberg cells. <b>(Dec 2012)</b>
9.	Primary Sicca syndrome. <b>(Dec 2015)</b>
10.	Histopathology of Fibrous dysplasia. <b>(Dec 2019)</b>
<b>SHORT ANSWERS</b>	<b>(10 x 2 = 20 Marks)</b>
11.	Thistle tube pulp chamber. (Dentin Dysplasia) <b>(Dec 2016)</b>
12.	Touton type giant cells. <b>(June 2012)</b> (Giant cell formation)
13.	Tadpole shaped cells.
14.	Snail track ulcer. <b>(June 2016)</b> (Oral manifestation of syphilis)
15.	Café-au-lait spots. <b>(June 2013)</b>

## ANSWERS

**LONG ESSAY** **2 x 10 = 20 Marks**

**Q1. Enumerate Potentially malignant disorders. (July 2018) Write in detail about Leukoplakia. (Dec 2019)**

**Q2. Classify Neural tumors and describe Neurofibromatosis. (Dec 2019)**

**Ans:**

**Neural tumour are classified as:**

**Benign tumors are:**

- Multiple endocrine neoplasia syndrome
- Neurilemmoma
- Neurofibroma
- Traumatic neuroma
- Melanotic neuroectodermal tumor of infancy

**Malignant tumors are:**

- Olfactory neuroblastoma
- Malignant peripheral nerve sheath tumor
- Metastatic tumors of jaws

**SHORT ESSAYS** **6 x 5 = 30 Marks**

**Q3. Radiological variants of Dentigerous cyst. (Dec 2017)**

**Q4. Solitary bone cyst.**

**Ans:**

Solitary bone cyst synonym is hemorrhagic cyst, extravasation cyst, unicameral bone cyst, simple bone cyst, idiopathic bone cavity, traumatic bone cyst.

- They are an uncommon nonepithelial lined type of pseudocyst.
- It involves many others bones of the body.

**Etiology**

- Cystic degeneration of a pre-existing tumor or of the fatty marrow in the area.
- Faulty calcium metabolism.

- Chronic infection.
- Hemorrhage followed by trauma.
- Disturbed synchrony between osteoclasts and osteoblasts due to trauma.

#### Clinical Features

- **Age:** Young individuals
- **Sex:** Males
- **Site:** Posterior portion of the mandible
- **Swelling:** Present
- **Aspirate:** Serosanguinous fluid, Necrotic blood clot or it can be empty.
- **Symptomatic:** Asymptomatic.
- **Tooth vitality:** Vital
- It is often accidentally discovered on routine radiological examination, usually as a unilocular radiolucent area with a “scalloping effect”.

#### Radiographic features

- Outline of the cyst: Smoothly outlined radiolucent area or sclerotic border.
- Few cysts are very much smaller in diameter.
- Few cystic cavities may contain lobulated or scalloped appearance.
- They are usually unilocular, non-expansile and radiolucent, typically above the alveolar canal.
- Large, expansile and multilocular traumatic bone cavities have been rarely described.
- Expansion is not characteristic of these cysts, but it is seen in few cases.
- The margins of these lesions range from very well defined to corticated to punched out radiolucency.

#### Histopathology

- Microscopic studies revealed a cancellous bone cavity lined with a cystic wall composed of a thin fibrous connective membrane with numerous collagen fibers.
- The cavity lacked epithelial lining and could be empty and without lining or with scarce liquid content.
- Scant, recent bone deposits could be observed.

- Cells such as fibroblasts with osteoclast like giant cells with cholesterol crystals and granulation tissue and erythrocytes are observed.
- Outer surface of cortical plate an extensive osteophytic reaction is seen.

#### Management

- Recommended treatment for mandibular solitary bone cyst is surgical exploration followed by curettage of bone walls.
- Hemorrhage within the cavity produces a clot which is eventually replaced by bone.
- It is believed that in some cases, spontaneous resolution will take place.
- Selected surgical procedures for treatment of this lesion include cavity exploration, fenestration, aspiration and condyle osteotomy.
- The prognosis is more favorable when lesions are treated with fenestration and cavity filling, even though no statistically significant differences were recorded.

#### Q5. Pindborg tumour. (Calcifying Epithelial Odontogenic Tumour) (Dec 2012)

#### Q6. A, B, C, D, E Rule of malignant melanoma.

##### Ans:

A melanoma is a tumor produced by the malignant transformation of melanocytes.

- Melanocytes are derived from the neural crest.
- They usually occur on the skin, and can arise in other locations where neural crest cells migrate, such as the gastrointestinal tract and brain.
- Melanomas may develop in or near a previously existing precursor lesion or in healthy-appearing skin.
- A malignant melanoma developing in healthy skin is said to arise de novo, without evidence of a precursor lesion.
- Solar irradiation induces many of these melanomas. Melanoma also may occur in unexposed areas of the skin, including the palms, soles, and perineum.

**The criteria helping the clinical diagnosis of melanoma follows ABCDE rule**

- A - Asymmetry – in which one half does not match the other half.
- B - Border that are irregular with edges and corners.
- C - Color pigmentation is not uniform. Few other colors seen in melanoma are brown black, tan, red, white, and blue.
- D - Diameter greater than 6 mm.
- E - Elevation – A raised surface.
- Metastatic melanoma may cause nonspecific paraneoplastic symptoms, including loss of appetite, nausea, vomiting, and fatigue.
- Metastasis (spread) of early melanoma is possible, but relatively rare; less than a fifth of melanomas diagnosed early become metastatic. Brain metastases are particularly common in patients with metastatic melanoma.
- It can also spread to the liver, bones, abdomen, or distant lymph nodes.

**Q7. Lipoma. (Gen Surgery) (June 2014)**

Ans:

**Histopathology**

- The lipoma is made up of of mature adipocytes with streaks of collagen.
- They have a fibrous capsule that gives a lobular pattern.
- The surrounding connective tissues shows fat cell infiltration that gives a long, thin extensions of fatty tissue appearance.
- There is a phospholipid vesicle in the center of the adipocyte, and cytoplasm and nuclei are observed at the border.
- An encircling fiber sac explains why they are well-defined in surrounding tissues.

**The various variants of lipomas are:**

- **Intramuscular lipoma:** It is located within striated muscle.
- **Fibro lipoma:** Extensive fibrosis in the fat cells.
- **Spindle cell or pleomorphic lipoma:** Spindle cells are seen as dysplastic.
- **Angiolipoma:** Numerous vascular channels are present.
- **Myxoid lipoma:** A lipoma with myxoid background stroma.

- **Myolipoma:** When spindled cells are of smooth muscle origin.
- **Chondroid lipoma:** Lipoma with chondroid or osseous metaplasia.
- **Myelolipoma:** Lipoma with bone marrow.

**Q8. Reed-Sternberg cells. (Dec 2012)**

**Q9. Primary Sicca syndrome. (Dec 2015)**

**Q10. Histopathology of Fibrous dysplasia. (Dec 2019)**

**SHORT ANSWERS**

**10 x 2 = 20 Marks**

**Q11. Thistle tube pulp chamber. (Dentin Dysplasia) (Dec 2016)**

**Q12. Touton type giant cells. (June 2012) (Giant cell formation)**

**Q13. Tadpole shaped cells.**

Ans:

**This appearance has been seen in two diseases.**

**a. The tadpole shaped cells are seen in embryonal rhabdomyosarcomas.**

- It consists of cells of many shapes and size, often strap- or tadpole-shaped, like rhabdomyoblasts.
- They are commonly seen in the early embryo.
- Sometimes muscle cross-striations can be seen in their cytoplasm to indicate their muscle nature.
- Rhabdomyosarcoma (RMS) is the most common soft tissue sarcoma in children and represents a high-grade neoplasm of skeletal myoblast-like cells.

**Q14. Snail track ulcer. (June 2016) (Oral manifestation of syphilis)**

**Q15. Café-au-lait spots. (June 2013)**

## NOVEMBER 2021

## LONG ESSAY 2 × 10 = 20 Marks

1. Definition, etiology, pathogenesis, clinical features and treatment of infective endocarditis. (DEC 2015)
2. Define anemia. Classification of anemia. (JUNE 2016) Causes, clinical features and treatment of Megaloblastic anemia. (JUNE 2019)

## SHORT ESSAYS 6 × 5 = 30 Marks

3. Clinical features and treatment of Bell's Palsy. (NOV 2020)
4. Clinical features and treatment of nephrotic syndrome. (JULY 2018)
5. Discuss briefly about causes of secondary hypertension. (MARCH 2021)
6. Clinical features and treatment of acute severe asthma. (JUNE 2017)
7. Discuss causes, clinical features and treatment of acute viral hepatitis. (DEC 2017)
8. Clinical features, complications and treatment of falciparum malaria. (FEB 2021)

## SHORT ANSWERS 5 × 2 = 10 Marks

9. Name four diuretics.
10. Four causes of iron deficiency anemia. (July 2018)
11. Name four calcium channel blockers.
12. Name blood tests for diagnosis of Syphilis.
13. Define hypoglycemia and two symptoms of hypoglycemia. (Dec 2015)
14. Name two second line antitubercular drugs.
15. Name four causes of thrombocytopenia. (DEC 2019)
16. Name four causes of bradycardia. (MARCH 2021)
17. Name drugs causing left ventricular hypertrophy.
18. Three clinical signs in congestive cardiac failure. (June 2017)

## ANSWERS

**Q9. Name four diuretics.**

**Ans.**

**A. High efficacy diuretics:**

- a. Furosemide
- b. Acetazolamide

**B. Moderate efficacy diuretics:**

- a. Thiazide
- Benzothiadiazines-  
Chlorothiazide

b. Thiazide relating drugs

-Indapamide

**C. Low efficacy diuretics:**

Potassium sparing diuretics:

-Spironolactone

**Q11. Name four calcium channel blockers.**

**Ans.**

- Amlodipine
- Nicardipine
- Nifedipine
- Isradipine
- Nisoldipine
- Nimodipine
- Diltiazem
- Verapamil

**Q12. Name blood tests for diagnosis of Syphilis.**

**Ans.**

- a. Serological test:
  - i. Non treponemal test
    - Venereal diseases research laboratory test (VDRL)
    - Rapid plasma reagin test (RPR)
  - ii. Treponemal specific antibody tests
    - Agglutination assays for antibody

- ies to *T. pallidum*
- Fluorescent treponemal antibody-absorbed test
  - *T. pallidum* hemagglutination test
- Nicardipine
  - Amlodipine
  - Verapamil
  - Diltiazem

**Q14. Name two second line antitubercular drugs.**

**Ans.**

**Second line drugs:**

- Thiacetazone
- Paraaminosalicylic acid
- Kanamycin
- Amikacin
- Capreomycin
- Ethionamide
- Cycloserine

**Newer antitubercular drugs**

- Ciprofloxacin
- Ofloxacin
- Clarithromycin
- Azithromycin
- Moxifloxacin
- Rifabutin

**Q17 Name drugs causing gum hypertrophy.**

**Ans.**

**a. Anticonvulsant drugs:**

- Phenytoin
- Phenobarbitone
- Sodium valproate
- Primidone

**b. Immunosuppressant drugs:**

- Cyclosporin
- Tacrolimus

**c. Calcium channel blockers:**

- Nifedipine
- Felodipine

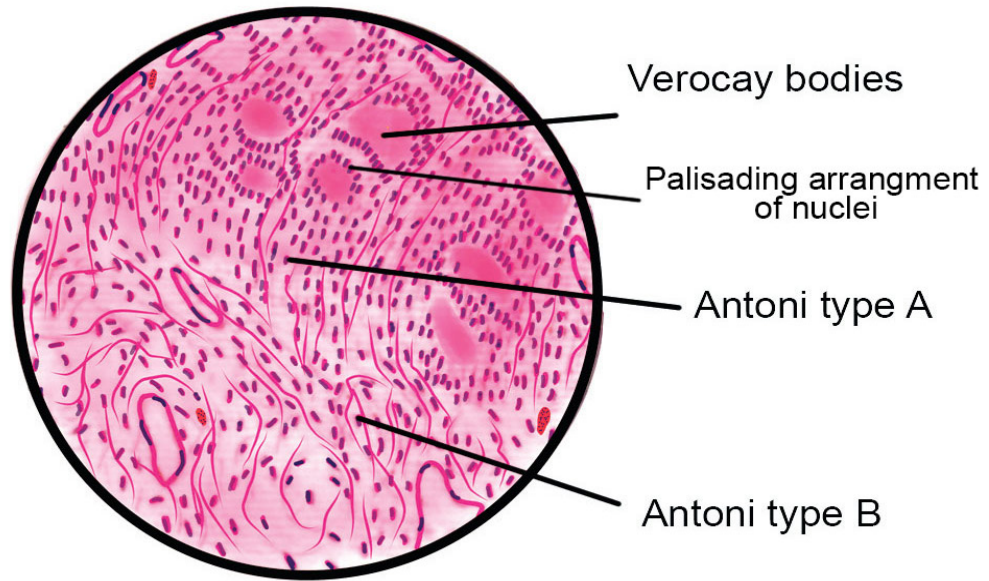


Fig 1 Neurilemmoma

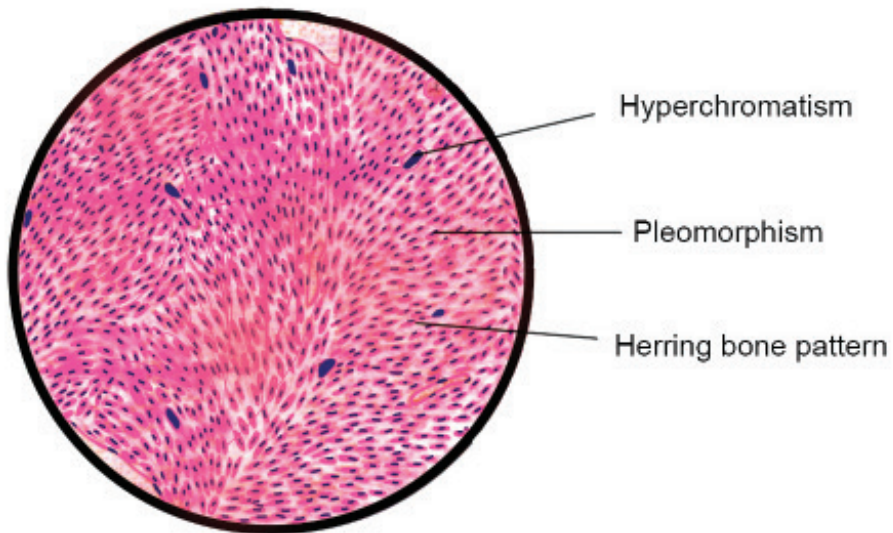


Fig 2 Fibrosarcoma



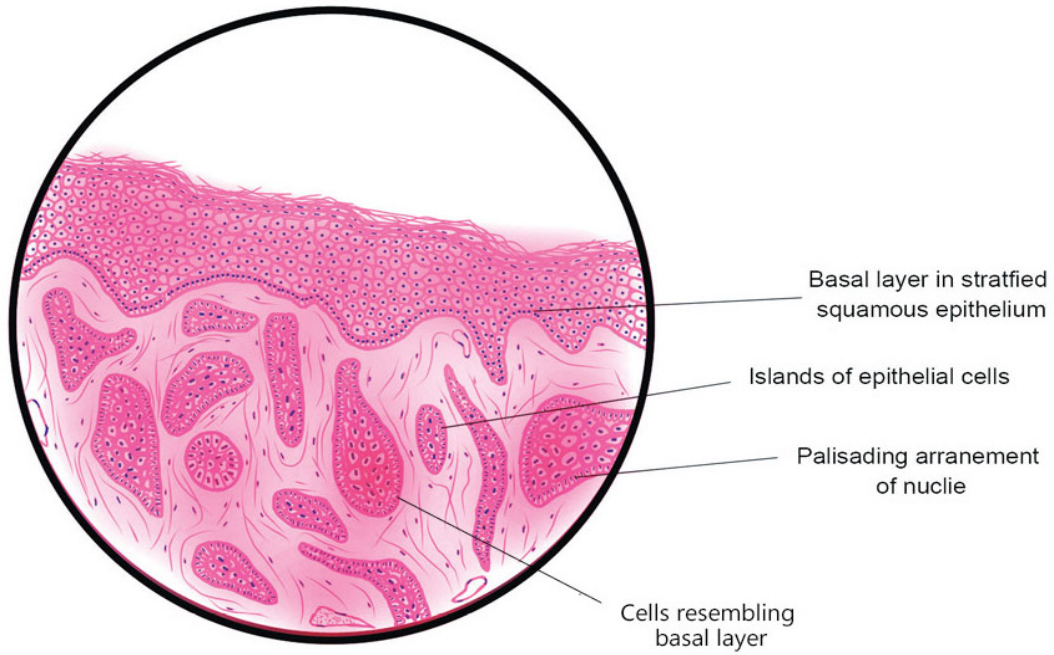


Fig 3 Basal cell carcinoma

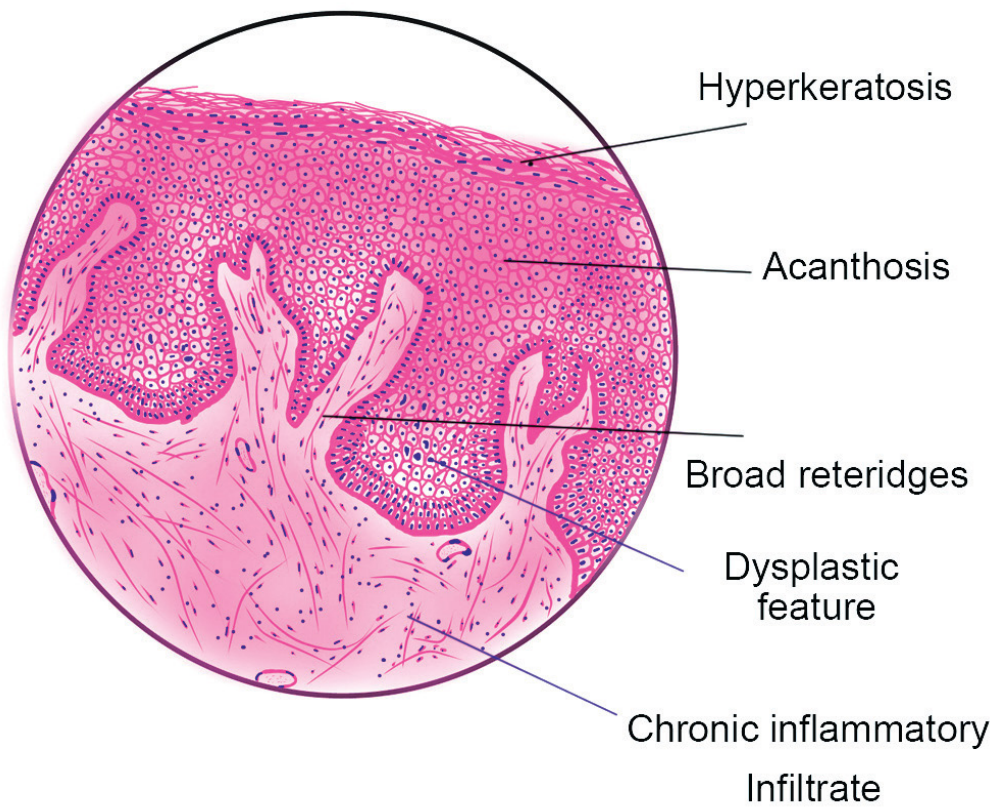


Fig 4 Leukoplakia



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