Adenoid Ameloblastoma: A new entity

Khadka S[1], Jain N1, Keshwar S[1], Shrestha A[1], Jaisani M[2]

[1] *Department of Oral Pathology, College of Dental surgery, B.P. Koirala Institute of Health Sciences*
[2] *Department of Oral and Maxillofacial Surgery, College of Dental surgery, B.P. Koirala Institute of Health Sciences*

Corresponding Address:

Saraswoti Khadka
Junior Resident-I
Department of Oral Pathology, CODS
B.P. Koirala Institute of Health Sciences, Dharan
saraswotikhadka24@gmail.com

Abstract

Background: Adenoid ameloblastoma is the new entity added to the odontogenic lesions. The name 'adenoid ameloblastoma with dentinoid' was introduced by the Armed Forces Institute of Pathology in 1994 by Brannon. There was no official recognition of this entity as shown in the WHO classification of odontogenic tumors from 1992 to 2017, which can illustrate the diagnostic challenges. It can be considered a hybrid odontogenic tumor showing histopathological features of both ameloblastoma and adenomatoid odontogenic tumor (AOT). The lack of BRAF mutation and the finding of nuclear β catenin reactivity doubt their relation to an ameloblastoma and currently WHO 2022 has identified it as a new entity classified under benign epithelial odontogenic tumors and defined as an epithelial odontogenic neoplasm composed of cribriform architecture and duct-like structures and frequently includes dentinoid. It usually presents as a painless swelling with prevalent in the 4th decade of life, and with a slight male predilection. The tumor shows more aggressive behavior and high recurrences rate due to a high Ki-67 proliferation index.

Case description: Here, we report a case of 35-years-old male who presented with a chief complaint of swelling in the lower anterior region of jaw since 1 month. Intraoral examination revealed localized swelling of 3x2.5 cm in diameter that extended from 33 to 43. Radiographic examination showed mixed radiolucent and radiopaque area.

Conclusion: Clinical and radiographic presentation of adenoid ameloblastoma is not diagnostic and a histopathological examination is necessary not only for confirmation but also for its identification of a new variant.

Keywords: Adenoid ameloblastoma, Dentinoid, Hybrid odontogenic tumor

An unusual presentation of Adenomatoid Odontogenic Tumor: A case report

Shrestha A[1], Maharjan IK[1], Regmee P[1], Luitel A[1], Shrestha A[2]

1. Department of Oral and Maxillofacial Surgery, College of Dental Surgery, BPKIHS, Dharan
2. Department of Oral Pathology, College of Dental Surgery, BPKIHS, Dharan

Corresponding Address:

aku.shrestha@gmail.com

Abstract

Background: Adenomatoid odontogenic tumor (AOT) is uncommon, nonaggressive neoplasms of odontogenic epithelium. It is also known as two-third (2/3rd) tumor as 2/3rd occur in maxilla, 2/3rd occur in females, 2/3rd cases are associated with unerupted/impacted tooth and 2/3rd teeth affected are canines.

Case description

A 17-years female reported to department with complaint of swelling in lower front region of jaw since 9 months which was sudden in onset, gradually progressive. On examination single, localized, well-defined, oval, firm, non-tender swelling present with no discharge on palpation. Size was approximately 8cm×4cm extending mesial of 35 to mesial of 44 and from crest of marginal gingiva to the depth of buccal vestibule. 33 was missing and grade 3 mobility w.r.t. 31, 32, 41, 42, 43. Expansion of buccal and lingual cortical plate with displacement of teeth present.

Panoramic radiograph revealed single, localized, well-defined, oval, corticated, unilocular radiolucency with flecks of radio-opacity interspersed within radiolucency. Tooth displacement and external root resorption present w.r.t. 32-43 with transmigrated 33. Discontinuity of inferior border of mandible seen w.r.t. 31-34 region. Provisional diagnosis of Dentigerous cyst (DC) w.r.t. 33 was made with differential diagnosis of Adenomatoid odontogenic tumor (AOT) and Calcifying odontogenic cyst (COC). Biopsy followed by histopathological examination confirmed the diagnosis of AOT.

Conclusion: Based on our clinical findings, provisional diagnosis of DC was given but histopathological examination diagnosed as AOT. So, whenever we encounter a lesion in young patients with unerupted tooth in anterior mandible region AOT should be kept as a part of differential diagnosis.

Key words: Adenomatoid Odontogenic Tumor, Mandible, Dentigerous cyst

Diffuse large B- cell lymphoma of oropharyngeal area: A case series

Neupane PR[1], Jain N1, Keshwar S[1], Shrestha A[1], Thapa S[2]

[1] *Department of Oral Pathology, College of Dental surgery, B.P. Koirala Insti tute of Health Science*
[2] *Department of Otolaryngology and HNS, B.P. Koirala Institute of Health Sciences*

Corresponding Address:

Dr. Padam Raj Neupane
Junior Resident
Department of Oral Pathology, CODS
B.P. Koirala Institute of Health Sciences, Dharan

neupanepadamraj15@gmail.com
9842350729

Abstract

Background: Lymphomas are a group of malignant neoplasms originated from lymphoid hematopoietic system and the second most common malignancy of the head and neck region. Extranodal Non-Hodgkin Lymphoma (NHL) was first described as a distinct entity by Isaacson and Wright in 1983. The head and neck are the second most common sites for extranodal NHL. Oral cavity is an uncommon site for NHL which accounts for 0.1 to 3% of the cases. Diffuse large B cell lymphoma (DLBCL) is the most common lymphoma in head and neck region.

Case description: We report three cases of Diffuse large B cell lymphoma a variant of NHL. Three patients within a age range of 6th to 7th decade, presented with a chief complaint of mass in oropharyngeal area associated with pain and swelling in neck. On histopathological examination of the provided incisional biopsies, Poorly differentiated carcinoma and non-Hodgkin lymphoma were given as the differential diagnosis. However immune-histochemical analysis confirmed the diagnosis as Diffuse large B-cell lymphoma.

Conclusion: Although non-Hodgkin's lymphoma is uncommon in the oral cavity, it should always be considered in the differential diagnosis of intraoral malignant diseases of head and neck swelling. Pertinent immuno-histochemical analysis is important for the early diagnosis and good prognosis of the disease.

Keywords:Diffuse large B cell lymphoma, Immunohistochemistry, Oropharynx

The usefulness of cervical island skin flap for intraoral repair of oral surgery

YOSHIGA Daigo[1], SASAGURI Masaaki[2], HABU Manabu[2], MISTGI Sho[2], TOMINAGA Kazuhiro[2], YOSHIOKA Izumi[1]

1 Department of Science of Physical Functions, Division of Oral Medicine, Kyushu Dental University, Kita-kyushu Japan
2 Department of Science of Physical Functions, Division of Oral and Maxillofacial Surgery, Kyushu Dental University, Kita-kyushu, Japan

Corresponding Address:

r11yoshiga@fa.kyu-dent.ac.jp

Abstract

Oral cancer is typically treated with surgical excision, and this frequently results in a large defect and severe functional problems. Local flap reconstruction is applicable to restoring appearance and function, and it causes less surgical stress than a vascularized free flap.

In 1969 Farr et al reported the cervical island skin flap for the reconstructions of oral cancer. This flap is due to short operating time, low morbidity, and good functional and aesthetic results. This flap is not only an alternative to microvascular flaps but also an excellent reconstructive choice especially in cases where free tissue transfer cannot be carried out.

We have also used this cervical island skin flap in selected cases. The operations that the wide broad platysma was included in the base of flap showed better results recently. Hence, cervical island skin flap should be considered as a choice of local flap for oral reconstruction depending on the defect size of oral cavity.

In this presentation, we would like to show some cases that we experienced recently.

Comprehensive management of a cleft patient: A multidisciplinary approach

Juna Gurung, Mahendra Maharjan, Basant K. Mathema

Department: Plastic, Cosmetic and Maxillofacial Surgery, B and B Hospital

Corresponding Address:

Juna Gurung, Consultant, Oral and Maxillofacial Surgery
Department of Plastic, Cosmetic and Maxillofacial Surgery,
B and B Hospital
junekgrg@gmail.com

9841751398

Abstract

Background: Management of a cleft patient is not limited to surgical repair of lip and palate. Nasoalveolar molding begins within a few days after birth followed by Cheiloplasty and Palatoplasty by age one. Orthopedic interventions and orthognathic surgeries will follow at different stages of life as the child grows into an adult. Thus surgical and non-surgical support continues as required till adulthood and further.

Description: Our goal is to provide as much of multidisciplinary interventions to a cleft patient as possible. Here is a series of cases to demonstrate the same.

Experience of secondary commissuroplasty for lip morphology and function after lip reconstruction

MATSUNGA Kazuhide, TAKESHITA Akinori, KATOU Yumiko, MORITA Yoshihiro, KAJIKAWA Hitomi, KASIMA Kana, KASHIWAGI Takafumi, MATSUMIYA Yuka, KINOSADA Hiroko, SUZUKI Mao,UZAWA Narikazu.

Department of Oral & Maxillofacial Oncology and Surgery, School & Graduate School of Dentistry, Osaka University, Osaka, Japan

Corresponding Address:

matsunaga.kazuhide.dent@osaka-u.ac.jp

Abstract

Introduction

Patients who have undergone lip reconstruction due to oral cancer often develop deformities of the oral commissure on