

Oral Anesthetics ODONTOGENIC TUMORS

AMELOBLASTOMA → most common clinically significant odontogenic tumor.

- ① Solid/multicystic (86%)
- ② UNICYSTIC (13%)
- ③ Peripheral or extrasosseous (1%)

SOLID or MULTICYSTIC AMELOBLASTOMA : POSTERIOR MANDIBLE

Radiolucent, well circumscribed U.L. or M.L. (soap bubble/honeycomb)

HISTO: microscopic subtypes - Granular Cell - aggressive Desmoplastic - islands/cords in collagen stroma

- May cause paresthesia if nerve is involved, can erode cortical plates.
- Should resect at least 1 cm of margin past clinical margin for less recurrence. If only curettage = big chance recurrence. So should do MARGINAL RESECTION.

UNICYSTIC AMELOBLASTOMA - Younger pt's, POSTERIOR MANDIBLE

- Radiolucency around crown of unerupted tooth (looks like dentigerous cyst)

HISTO: ① Luminal - tumor is confined to luminal surface of cyst
 ② Intraluminal - projects from cystic lining
 ③ MURAL - infiltrates fibrous cystic wall.

Treatment - cyst enucleation or local resection for mural

PERIPHERAL AMELOBLASTOMA → Extrasosseous - ~~look like same~~ but have same features as the others.

Posterior gingival/alveolar mucosa, a few have eversion of superficial alveolar bone
tx - innocuous clinical behavior, rare malignant change, excision w/ low recurrence.

MALIGNANT AMELOBLASTOMA : < 1% Ameloblastomas become malignant.

↳ look like typical ameloblastoma but metastasizes. Ameloblastic Carcinoma - looks malignant in histo

⚠ Know difference btw Malignant A. and Ameloblastic Ca.

Mets most often in Lungs or cervical lymph nodes.

Radiograph: Malignant A. looks just like typical Ameloblastoma, Ameloblastic Ca. has ill defined margins and is more aggressive w/ cortical destruction

AMELOBLASTIC FIBROMA - True neoplasm. 70% post. mandible. U.L. or M.L. RL. well defined and tend to be sclerotic. 50% assoc. w/ unerupted tooth (looks like dentigerous)

HISTO: tumor has cell-rich mesenchymal tissue that looks like dental papilla

- often encapsulated, can get quite large + expand cortex.

ADENOMATOID ODONTOGENIC TUMOR - an epith. tumor that induces odontogenic ectomesenchyme - dentinoid produced.

ANTERIOR Jaw (canine) 65% maxilla. 75% assoc. w/ crown of unerupted tooth

• Pericoronal RL, with opaque material (snowflake calcifications)

• Histo - Thick fibrous capsule, spindle shaped epith. cells that form sheets, strands or whorled masses with little connective tissue. Epith. cells may form rosette-like structures

ODONTOMA - Most common odontogenic tumor. NOT A TRUE NEOPLASM (just a developmental anomaly - hamartoma).

* Compound - Multiple small tooth-like structures

* Complex - Conglomerate mass of enamel + dentin - no resemblance to a tooth.

• age: 14 mean age. Location: Compound - anterior max. Complex - posterior mand or max.

go from RL w/ smooth contours to R.O. well defined.

- most are small - not bigger than normal tooth size, some can be big + cause jaw expansion.

Myxoma - RL multilobular (soap bubble), indistinct borders. Has loosely arranged cells in abundant/loose myxoid stroma

Cementoblastoma - Roots of post. teeth mand > max. R.O. lesion attached to + replacing roots, opaque radiating spicules

- local expansion, slow growth, usually asymptomatic. TX - Surgically extract tooth w/ mass.

HISTO - Sheets of thick trabeculae of mineralized material, basophilic reversal lines, Giant cells, resembles other osteoblastoma.

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