

It is, however, very important that the dentition be carefully monitored throughout the mixed-dentition stage, both clinically and radiographically. This demands more than the routine bite-wing radiographs that are taken for early diagnosis of dental caries. Suspicious clinical findings such as missing or tipped teeth, diastemata, or painless swelling must be further investigated using panoramic radiographs in order to detect early on any expansion of odontogenic cysts and tumors not clinically apparent. This will make possible early diagnosis, and possibly spare the patient extensive surgical intervention and consequences.

Ameloblastoma

The most frequent localization is the molar region of the mandible (80%), followed by the premolar region, and (less often) the mandibular anterior region. The ameloblastoma is rare in the maxilla, and when it occurs it is usually in the molar regions.

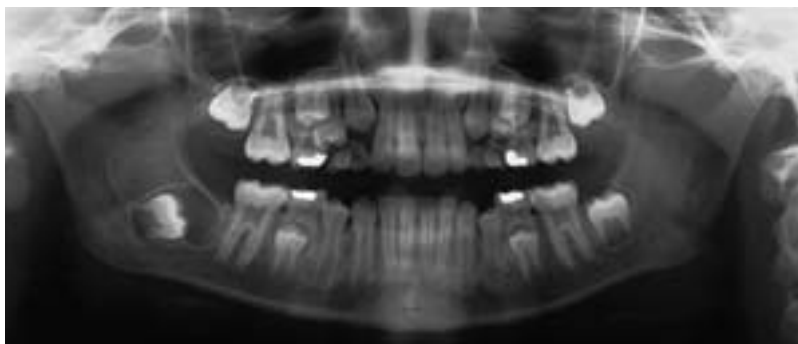
The ameloblastoma is the most frequently encountered odontogenic tumor. Its histologic picture may vary enormously. The most common radiographic appearance is one of multilocular (multi-chambered or multi-cystic),

soap bubble-like radiolucencies, compartmentalized by sharply demarcated septa. Unilocular forms are usually observed with the follicular ameloblastoma, such as those that occur during the active growth phase of the second decade of life. In many cases, an impacted tooth (usually a molar) is enclosed within the tumor. A less common variant is the honeycomb-like ameloblastoma that does not encompass teeth and whose septa are much thicker. The soap bubble-like structure usually creates a scalloped external contour. In later stages, the compact bone is distended and thinned; the dominant radiolucency demands a reduction of the normally employed exposure settings for a clear depiction of the structural details. The mandibular canal is often impinged upon, and is often no longer clearly visible within the radiolucency. In the maxilla, an ameloblastoma may impinge upon the maxillary sinuses and distend the sinus walls. The lesion grows slowly and develops with painless swelling and facial asymmetry whose etiology is frequently discerned only in very late stages. Peripheral variants of this lesion occur primarily in elderly patients, often with inclusion of oral mucosa.

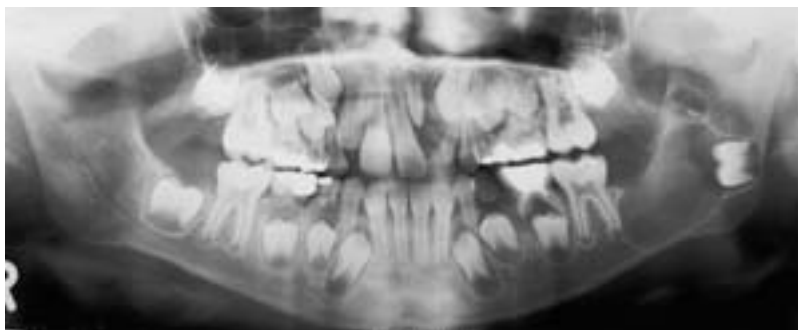
Fig. 382 Ameloblastic fibroma. The panoramic radiograph of an 8-year-old male reveals an early stage ameloblastic fibroma. In contrast to a follicular cyst, the well-demarcated radiolucency sits like a hat on the occlusal surface of the displaced third molar (47) and is not attached at the cementoenamel junction of that tooth. The pericoronal follicular sac appears in this radiograph to have not communicated with the oral cavity.

Fig. 383 Ameloblastic fibroma. In this 9-year-old female, the lesion is localized on the occlusal surface of the far distally displaced second molar (37). The pericoronal follicular sac has opened. With progressive tumor expansion, and displacement of tooth 37 and germ of tooth 38, the radiographic differentiation between a unilocular ameloblastoma and a follicular cyst becomes more difficult. Note also the remnants of nonvital teeth 75, 84, and 85, which may have elicited the pericoronal inflammation and premature resorption of the follicular sacs. Tooth 22 is only observed as a “peg lateral.”

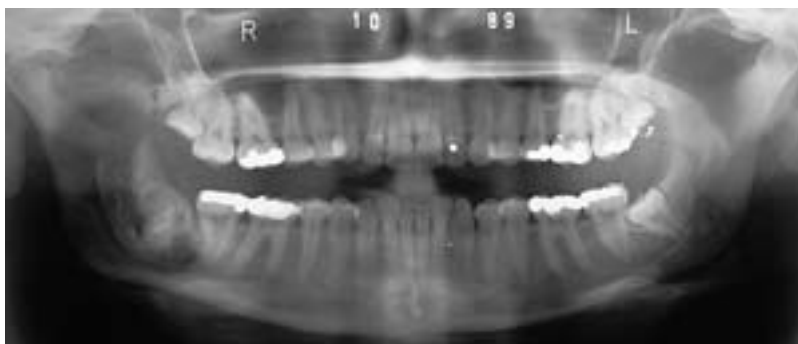
Fig. 384 Ameloblastic fibro-odontoma. The panoramic radiograph of a 20-year-old female reveals a dysplastic tooth 48 with irregular calcifications. Radiographic signs of the slow, nonaggressive expansion of the lesion include impingement of the mandibular canal and tooth 47. In contrast to the various shapes and forms of a complex odontoma, the demarcation in this case is not clearly defined around the lesion.



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