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Florid Osseous Dysplasia

 Florid osseous dysplasia is a group of fibro-osseous lesions involving multiple quadrants of the jawbones. It is most commonly seen in middle-aged black females, as well as Caucasian and Asian females. These lesions may be asymptomatic and present radiographically as radiopaque cementum-like masses surrounded by a radiolucent rim, located bilaterally in two or more quadrants of the jaw in edentulous areas. Over time, the lesions change from radiolucent to radiopaque. Histological findings show empty bone cavities with no vascular supply. Diagnosis of florid osseous dysplasia is based on localization of the lesion, patient’s age, gender, ethnicity, clinical findings, radiographic features and sometimes biopsy results. Long-term follow-up appointments are carried out to assess the progress of the condition.

 Florid osseous dysplasia usually does not involve bony expansion. However, in one case, a 35-year-old Turkish male had clinical expansion of bone and partially edentulous areas on both the maxilla and mandible. Some of the erupted teeth were malpositioned due to the bony expansion. The patient had no pain in the areas. When radiographs were taken on this patient, they revealed multiple, diffuse, lobular radiopacities near the edentulous areas of the maxilla and mandible. Impacted teeth were also evident on the radiographs. In this case of florid osseous dysplasia, surgery was required to allow rehabilitation of the jaw in order for prosthesis to be made. After the diagnosis was made, a bone biopsy was taken as a precaution. The biopsy revealed round cement bone-like structures showing fibrous tissue and fibroblastic cells. The patient has been followed up for 16 months and has had no complications since the surgical procedure.

 In another case, a 45-year-old female reported with pain in the left molar region of her mandible. She had a missing left mandibular second molar. Radiographs revealed well-defined irregularly shaped sclerotic masses corresponding to the roots of the first and second molar teeth region of the left mandible. A thin radiolucent border surrounded the masses. A biopsy was not done as it was diagnosed as a florid osseous dysplasia based on clinical and radiographic findings. A biopsy could have been a risk for fracturing the jawbone or spreading infection to the lesion.

 Lesions familiar to florid osseous dysplasia are found in Gardner’s syndrome and Paget’s disease. The difference between florid osseous dysplasia and Gardner’s syndrome is that florid osseous dysplasia does not present other skeletal changes and no skin tumors. Paget’s disease affects mostly Caucasian males, and shows an increase in serum alkaline phosphate levels; where as florid osseous dysplasia has normal serum alkaline phosphate levels. Radiographic features of exostosis may also confuse one in diagnosing florid osseous dysplasia. Exostosis has higher dense radiopacities with a common location of the buccal bone of the posterior maxillary teeth and facial bone of the anterior mandibular teeth, typically nodular with overlying mucosa.

 Since the condition is asymptomatic and benign, no surgical treatment is required. Some patients who have had a tooth extracted in florid osseous dysplasia present with poor socket healing, because there is no blood supply in the area, and sequestrum formation (a piece of dead bone that has become separated during the process of necrosis from normal bone.) This can cause further complications. Prognosis is good for florid osseous dysplasia because some patients typically do not need surgery and those who do, usually have no complications following surgery. In order to maintain a good prognosis, adequate oral hygiene should be stressed as well as hygiene appointments every 2-3 months to avoid any complications that would result in extracting teeth.

Citations

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