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**Den 2311/ D243**

**Tuesday group**

**Date: 12/4/14**

 **Multicystic(solid) Ameloblastoma**

Ameloblastoma is a benign odontogenic tumor. There are three types of

ameloblastoma based on their clinical presentation, treatment and prognosis. Those

are multicystic (solid), unicystic and peripheral ameloblastoma. The multicystic

ameloblastoma is a benign epithelial odontogenic tumor of the jaw. It accounts 10%

of all odontogenic tumors in the jaw. It is a slow growing, locally aggressive and has

a high recurrence rate if not adequately removed. This ameloblastoma lesion occurs

80% in the mandibular, usually on the posterior area. A notable exception is Black

African; it can occur in any area of the mandible for them. It can occur in maxillary

as well but very rare. Posterior maxillary tumors can invade sinus and extent

intracranially.

It is an expansile multilocular radiolucent cystic lesion of the posterior mandibular

extending from the mid region of the mandibular body to the upper ramus with

a “soap bubble-like” appearance. Clinically, patient may present with a slow-

growing mass, malocclusion, loose teeth, and more rarely paresthesia and pain.

Some patient may be asymptomatic to the lesion and so the detection can be done

through radiographs. It is an age related lesion but not a gender related lesion. Most

lesions are diagnosed during the early age, the median age is 35 years old.

Sometimes, the lesion is associated with unerrupted tooth in young adult age.

Histologically, most of ameloblastomas have the follicular and plexiform pattern.

Multicystic ameloblastoma shows anastomosing cords of odontogenic epithelium in a

fibrous stroma. There is no relationship between the individual patterns and the behavior

of the tumor or its prognosis. That’s why the pathologists do not report histologic pattern.

It may confuse the diagnostic findings among multicystic, unicystic and peripheral

ameloblastomas.

Treatment for this lesion is surgery. Wide resection surgery is recommended due to the

high recurrence rate of the solid/multicystic ameloblastomas. Surgery can include

removing of the lesion and reconstruction of the planes. The recurrence rate after

resection is 13-15%. Curettage treatment has 90-100% recurrence rate. Margin of 1.5-

2cm beyond the radiological limit is recommended to ensure all microcysts are properly

removed. Undertreatment is the main cause for the recurrence lesion. Thus, treatment is

the most important prognostic factor. Radiotherapy is also considered for the patients

with positive margins who are not compliant to re-excision or for patients with advanced

lesion. Unresectable lesions can be treated with radiation or combined radiation and

chemotherapy. There are some rare cases in which ameloblastoma can be

metastasized (malignant) through the lymphatic with the lungs being the most common

site, followed by cervical lymph nodes and spine.

As a Dental Hygiene professional, one should be able to distinguish the various lesions

that occur inter-orally such as ameloblastoma. Extra/Intra-oral cancer screening

assessment is the very first step we dental professionals do before we do any intervention

in the patient mouth. Clinical findings play critical role in the assessment of

ameloblastoma lesion along with the radiographs.

**References**

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(2) Bachmann, A. M., & Linfesty, R. L. (2009). Ameloblastoma, Solid/Multicystic Type. *Head and Neck Pathology*, *3*(4), 307–309. doi:10.1007/s12105-009-0144-z