原文題目(出處)：	Diagnostically challenging epithelial odontogenic tumors: A selective review of 7 jawbone lesion. Head and Neck Pathol 2009;3:18-26
原文作者姓名：	Ide F, Mishima AK, Saito AA, Kusama K
通訊作者學校：	Tsurumi University School of Dental Medicine
報告者姓名(組別)：	Intern B組 王聖堯
報告日期：	2009/11/10

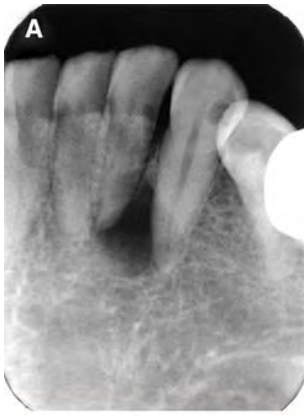
內文：

Introduction：

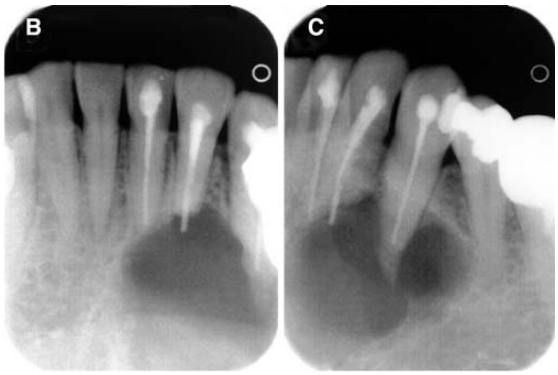
1. The differential diagnoses of radiolucencies that occur in the maxilla and mandible include a broad spectrum of cysts and tumors of odontogenic and non-odontogenic origin.
2. Many can be diagnosed accurately based on the distinctive clinical, radiographic and histopathologic aspects.
3. However, epithelial odontogenic tumors that present a diagnostic dilemma are encountered on occasion.

Report of cases：

Unicystic Ameloblastoma

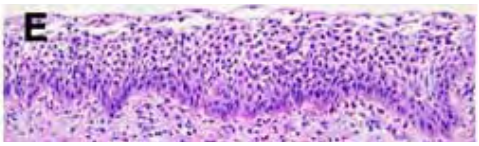


A 30-year-old man was referred for evaluation of a small, interradicular radiolucency between the lateral incisor and canine of the left mandible.

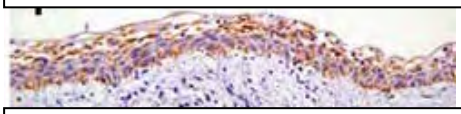


thin-walled cyst lined by flattened, non-keratinizing squamous epithelium, were compatible with the clinically presumed diagnosis of lateral periodontal cyst.

Six years postoperatively, the patient returned with a large multilocular radiolucency causing root resorption.



The recurrent cyst however revealed features diagnostic of unicystic ameloblastoma, luminal type.



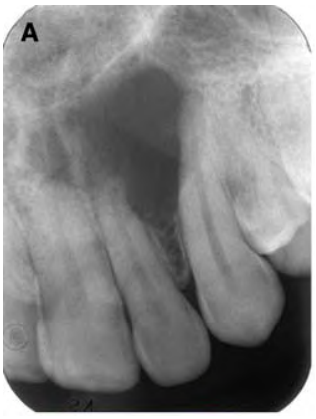
By immunohistochemistry, focal but intense reactivity for calretinin was evident in the lining epithelium.

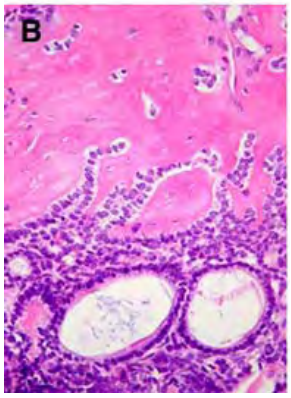
The patient is free from recurrence 8 years after marginal resection.

Discussion：

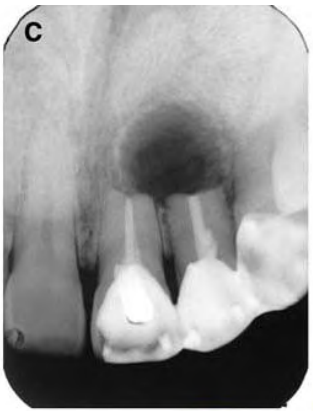
1. Underdiagnosed cystic tumor often comes from after recurrence
2. UA represents a unilocular cyst that has the ameloblastomatous lining with or without intraluminal and/or intramural tumor nodules
3. However, the cyst lining of UA often lacks any feature indicative of ameloblastoma as shown in our primary lesion.

Adenoid ameloblastoma with dentinoid





1988



1990

a 44-year-old man presented with a heart-shaped, unilocular radiolucency in the left globulomaxillary area involving the apex of the central incisor

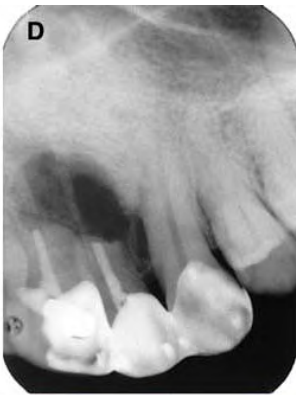
enucleation

histologic diagnosis：

the patient re-appeared with an apical radiolucent lesion in the incisor area

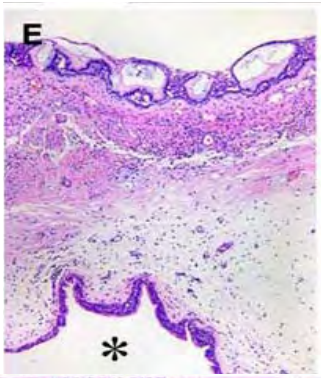
biopsy diagnosis：
AOT, recurrent

f/u



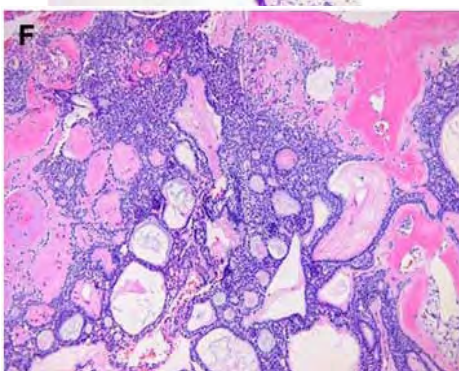
1995

During follow-up, recurrences were noted in 1995 and in 1998 and again reported to be AOT



1999

In 1999, partial maxillectomy was performed, because of the 4th recurrence involving the maxillary sinus



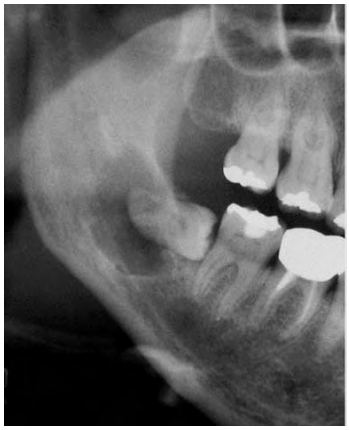
Both 1998 and 1999 tumors showed intense immunoreactivity for calretinin.

Typical feature of adenoid ameloblastoma with dentinoid

Discussion：

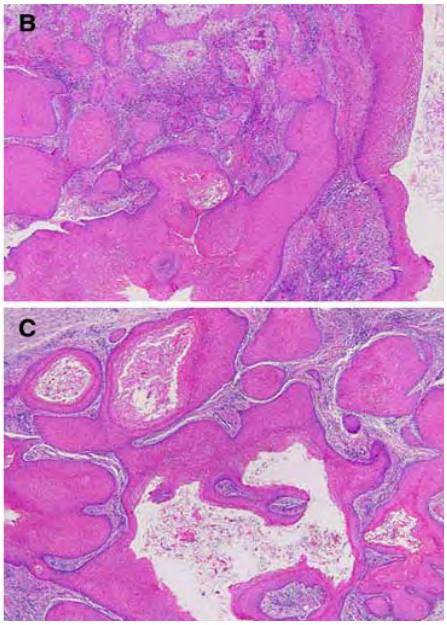
1. The 2004 literature review concluded that the reportedly recurrent AOTare almost certainly AAD
2. The term AAD is applied to a rare plexiform ameloblastoma with microscopic features of AOT including duct-like structures and dentinoid deposition
3. In brief, AAD contrasts with AOT by tending to occur in an older age group and to appear as an illdefined, extrafollicular radiolucency and encapsulation is less apparent in AAD.
4. Microscopically, immunopositivity for calretinin may be a rationale for the ameloblastoma nature, as evident in our AAD

Cystic squamous odontogenic tumor



A well-defined, unilocular radiolucency enclosing the root of a horizontally impacted right lower third molar was found in a 46-year-old woman.

Excision



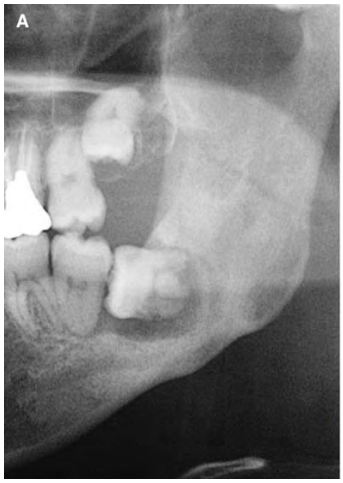
There were interconnected budding islands of bland squamous epithelium reminiscent of pseudoepitheliomatous hyperplasia, in addition to large cystic spaces containing desquamated keratin.

The cyst lining had neither basal palisading nor corrugated parakeratin layer and immunostaining for Bcl-2 was negative.

Discussion：

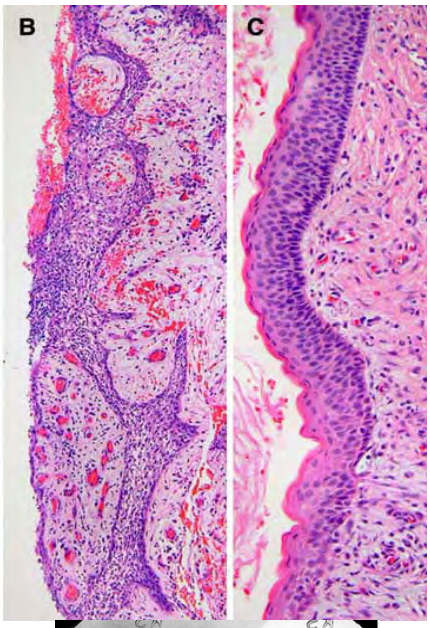
1. these cases appear to be a unique combination of large keratinizing cysts and solid squamous islands. It is likely that pure solid and solid-cystic tumors comprise a group of SOT.

2. cystic SOT should not lead to the diagnosis of non-neoplastic, mural SOT-like proliferations seen in several types of odontogenic cysts.
3. Microscopically there can be difficulty discriminating a biopsy of SOT, from pseudoepitheliomatous hyperplasia or a keratoacanthoma-like lesion.



39-year-old man who had several episodes of pericoronitis related to a horizontally impacted left lower third molar.

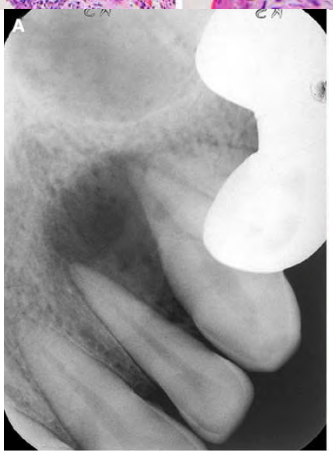
osteolytic changes extending to the root apices thought to be due to the pericoronal infection was noted.



(B) non-keratinizing, spongiotic squamous epithelium

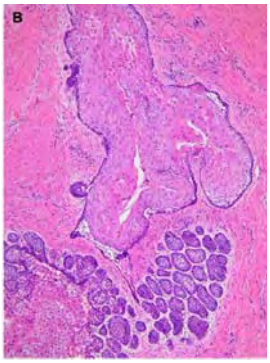
(C) diagnostic features of keratocystic odontogenic tumor

Because excised tissues were not submitted for microscopic examination, the underlying KCOT escaped early diagnosis until the lesion showed a destructive clinical course.

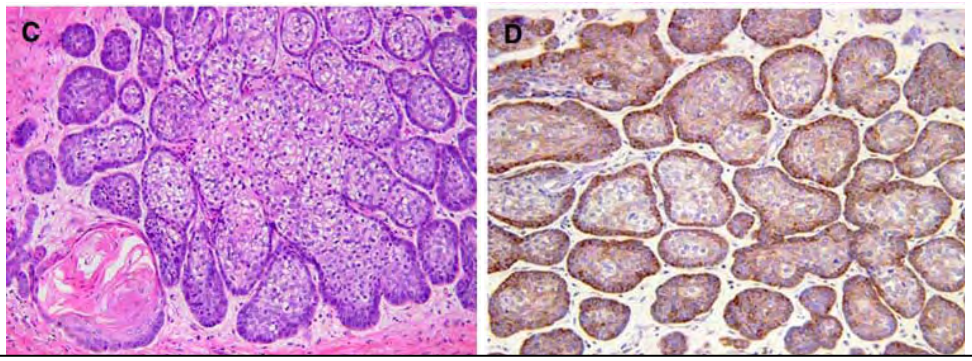


A 44-year-old man presented with a unilocular, radiolucency with ill-defined margins in the left globulomaxillary area.

en block excision



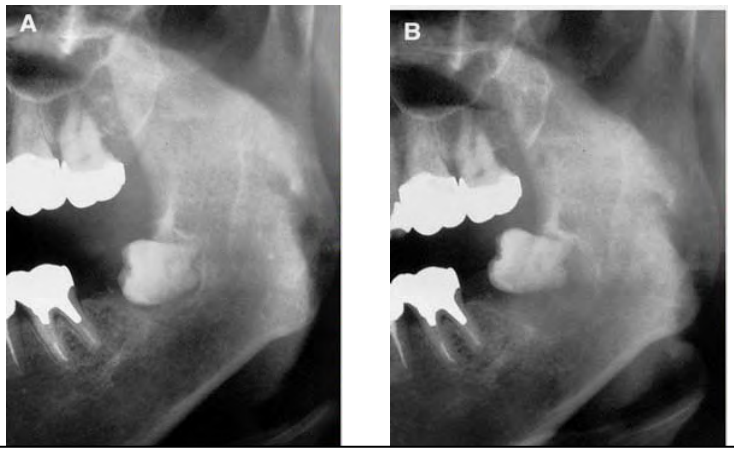
an unencapsulated fibrous mass consisted of solid islands of mature squamous epithelium.



In view of the characteristic budding of basal layer and its Bcl-2 immunoreactivity, the original diagnosis of squamous odontogenic tumor was revised to keratocystic odontogenic tumor of solid variant.

Discussion：

the original diagnosis of SOT in our case 2 is an avoidable error. As shown, Bcl-2 immunoexpression may serve as a clue to the KCOT phenotype of intraosseous squamous epithelial lesions.

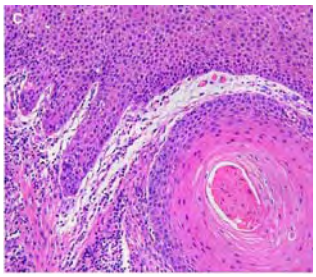


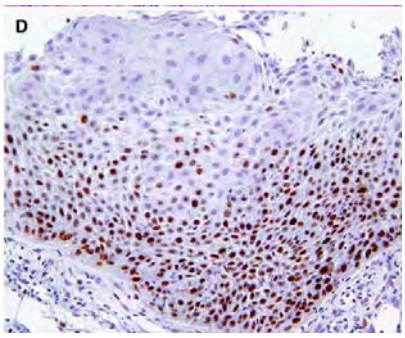
The patient, a 65-year-old woman, complained of a white surface speckling on the left retromolar alveolar mucosa. There was no significant radiographic change around a horizontally impacted third molar.

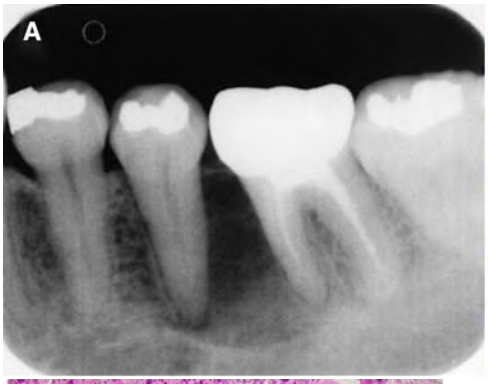
Within 2 years, she became aware of an eruption of the tooth. Radiographically, periradicular rarefaction with an ill-defined inferior margin extended deeply to the level of mandibular canal

Soft-tissues associated with the extracted molar revealed microscopic features of a well-differentiated squamous cell carcinoma (c).

Tumor cells were mostly immunopositive for Ki-67 and p53(d).

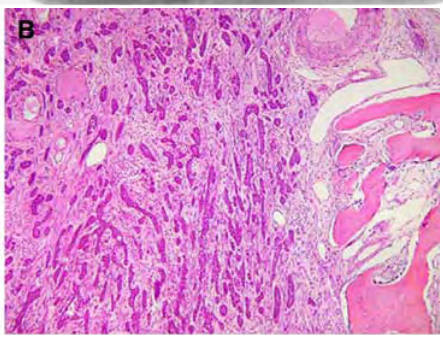




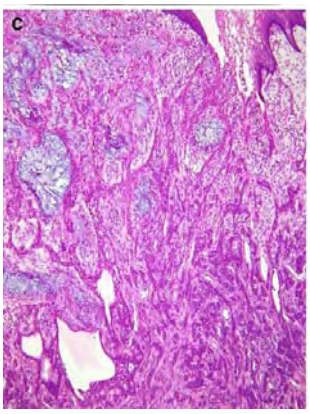


Surrounding the roots of the second premolar and first molar was a 1.5-cm, unilocular radiolucency with sclerotic inferior borders.

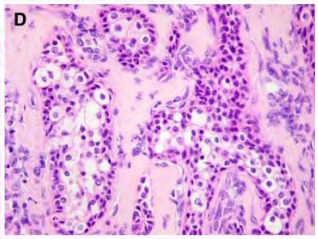
A superficial biopsy revealed clear cell carcinoma of uncertain origin and mandibular resection was performed with cervical lymph node dissection.



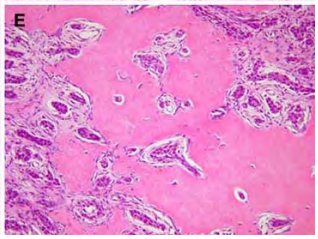
basaloid tumor occupying cancellous space



On the superficial aspect of the resected specimen, the carcinoma fused with the gingival epithelium and focally contained duct-like spaces.



clear cell population



dentinoid deposition

Discussion：

Our tumor lacks mature squamous phenotype and shares features with the recently described sclerosing odontogenic carcinoma. According to the 2005 WHO classification, we reluctantly use the term PIOSCC despite this fact. Significant amounts of dentinoid deposition are exceptionally rare in PIOSCC.

題號	題目
1	Which is not the clinical feature of unicystic ameloblastoma? (A) Are most seen in young p'ts. (B) More than 90% of unicystic ameloblastoma are found in maxilla. (C) The lesion is often asymptomatic. (D) Large lesion may cause a painless swelling of the jaws.
答案(B)	出處：Oral & Maxillofacial pathology p.616
題號	題目
2	Which is not histopathologic variant of unicystic ameloblastoma? (A) Luminal unicystic ameloblastoma (B) Extralumial unicystic ameloblastoma (C) Intraluminal unicystic ameloblastoma (D) Mural unicystic ameloblastoma
答案(B)	出處：Oral & Maxillofacial pathology p.617