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Scientific Editorial -Rehabilitation with Removable Partials

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Abstract

In the age of social media, most of the times we come across cases where the rehabilitation of the missing teeth is done with implants and hundreds of likes and comments follow. Rarely do we find removable appliances used to rehabilitate. In this case report the majority of the replacement is done by removable appliance. The result was acceptable aesthetics and non compromise on patient desires.

Key Words: Removable partial denture, Valplast denture, full mouth rehabilitation

Case Report

A 45 year old male reported to our clinic with multiple missing teeth. (Fig 1)The patient was not willing for any extractions, although his upper left central incisor was grade II mobile. The OPG (Fig :1) showed severe loss of bone. After discussion with the patient, it was decided to give a three unit bridge in relation to 25, 26, and 27.(Fig :3)

The remaining teeth were replaced by using a valplast™ flexible denture. After recording the jaw relations following the primary impression, a trail was done. The final denture was delivered in a week. (fig 3,4)

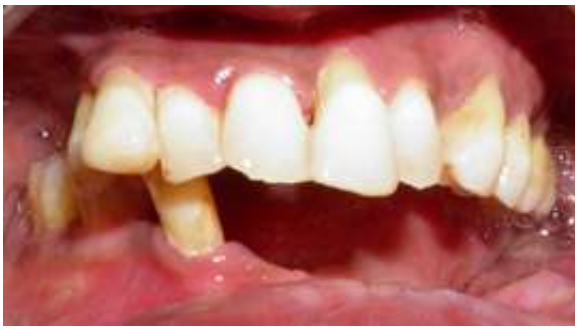

Fig 1 : Multiple missing teeth

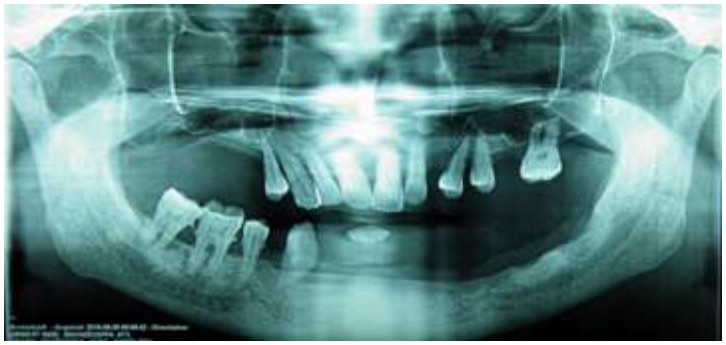

Fig 2 : OPG

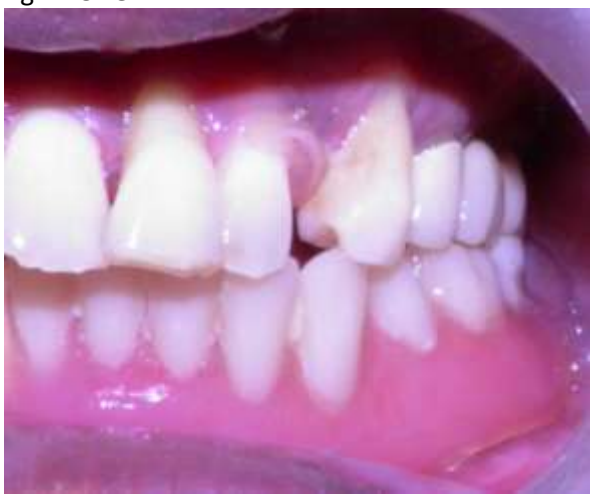

Fig :3 Replacement of 26 by a FPD and remaining by partial denture.

Fig 4 : The post op

Fig 5 : Smile before the treatment,

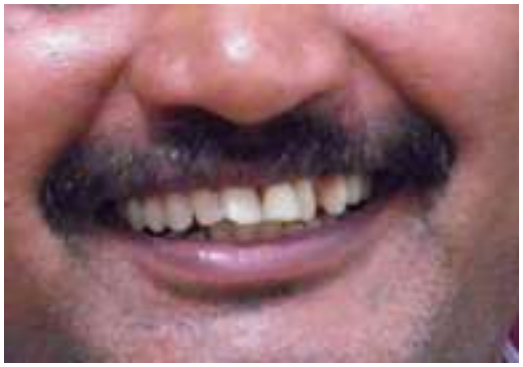

Fig 6: Smile after the treatment.

Discussion

Studies have proved that more than 50% of patients are extremely happy with RPD in five year follow ups. [1] In developing nations as India removable partial denture represents a satisfactory method of oral rehabilitation [2] for the individual with a reduced dentition. Affordability is another major factor in countries where there is no dental insurance and the patients have to spend on their health. The coming of the valplast ™ and sunflex ™ dentures has for surely revolutionized the oral healthcare delivery.

Conclusion

In conclusion acceptable aesthetics and functional restoration were achieved in the above case by flexible partial denture . (fig 5 and fig 6).More research is required in making flexible dentures more affordable to the patients.

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Anterior Aesthetic Fixed Space Maintainer - "Hollywood bridge"

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Abstract

A number of conditions can lead to aesthetically unacceptable primary dentitions like dental caries, discoloration, trauma, early loss of teeth, mal-alignment and any abnormality of shape and size.Sequence of not replacing these teeth can affect speech, aesthetics and self -image of the patient. The present paper describes full mouth rehabilitation including aesthetic rehabilitation of two patients of age 4 years with grossly carious deciduous maxillary anterior teeth.

Result: The treatment modality improved anterior aesthetics, speech and self-confidence of both the patients.

Key-words: Anterior aesthetics, Hollywood Bridge.

Introduction

Today, parents demand restoration of their children's teeth for aesthetics and function. Children, who have damaged, discolored and missing teeth sometimes have problems with self-esteem which can be improved with aesthetic dentistry [1]. When a child has one or more front teeth missing, the dentist can give the child a cosmetic and functional solution by fabricating an "aesthetic" space maintainer. The major consequence of early loss of maxillary primary incisors is most likely delayed eruption timing of the permanent successors as reparative bone and dense connective tissue covers the site. In addition, unattractive appearance and potential development of deleterious habits (e.g. tongue thrust swallow, forward resting posture of the tongue, improper pronunciation of fricative sounds- "s", "f") may be of concern following premature loss of primary maxillary incisors[2].

Hollywood bridge, a fixed anterior space maintainer, using primary incisor denture teeth secured from a rigid steel wire (0.036 or 0.040) extended to bands or stainless steel crowns on the primary molars [2].

In present paper, two patients of ages between 3-4 years were treated with "Hollywood" bridge to restore aesthetics, phonetics, function and prevention from deleterious oral habits. In both the cases, parents of the child demanded aesthetic rehabilitation in order to boost the self-confidence of the child.

Case Report

Case report 1: A 31/2 years old boy visited our clinic with a chief complaint of multiple abscessed molars and incisors.

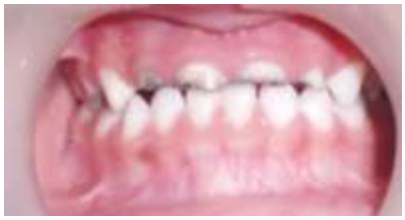

Fig 1: Intra-oral (Pre-treatment)

Fig 2: Extra-oral (Pre-treatment)

Treatment plan: Full mouth rehabilitation planned under local anesthesia. All abscessed and deep carious molars were endodontically treated and restored with stainless steel crowns. Incisors were planned for extractions followed by placement of "Hollywood bridge". (Figures 1, 2, 3, 4, 5)

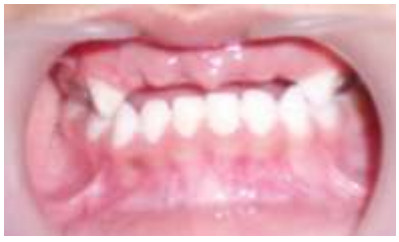

Fig 3: Extractions of deciduous incisors

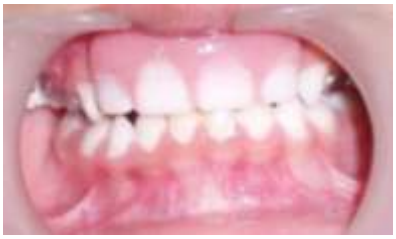

Fig 4: Replacement of anterior teeth with "Hollywood Bridge"

Fig 5: Extra-oral (Post-treatment)

Case report 2: A 4 year old girl visited our clinic with a chief complaint of multiple carious teeth in all over the mouth.

On examination: All incisors were grossly carious and draining sinuses were present with 51, 61, and 52. Primary molars were also grossly carious.

Treatment plan: Full mouth rehabilitation was planned under local anesthesia. All abscessed and deep carious molars were endodontically treated and restored with stainless steel crowns. (Figures 6, 7, 8, 9,10)

Fig 6:Extra-oral (Pre-treatment)

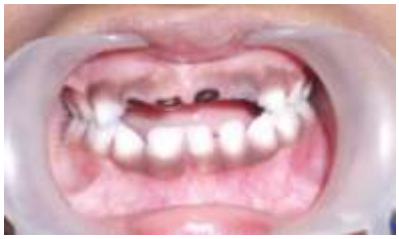

Fig 7:Intra-oral (Pre-treatment)

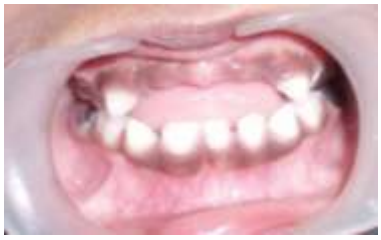

Fig 8: Extractions of deciduous incisors

Fig 9: Extra-oral (Post-treatment)

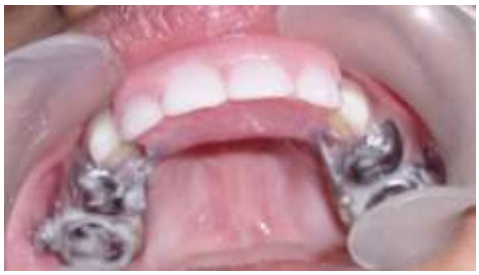

Fig 10: Intra-oral (Post-treatment)

Fabrication of appliance: Bands were adapted around the second deciduous molars and impression was taken. 19 gauge hard-round stainless steel wire was adapted along the palatal aspect of the maxillary model. Acrylic central and lateral incisors fixed with wire with help of heat cure acrylic resin (traditional denture fabricating procedure). The space maintainer was tried and cemented on deciduous maxillary second molars. (Figure 11)

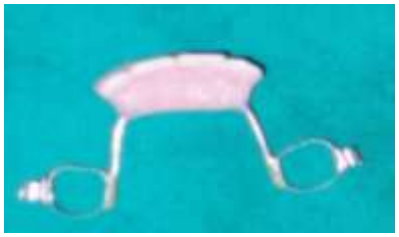

Fig 11: Fabrication of "Hollywood Bridge"

Discussion:

One of the key diagnostic features to future occlusion status is the relationships of the primary dentition. The exfoliation of the primary teeth, the permanent tooth eruption and the development of occlusion are independent, however, they occur in harmonious sequence [3,4]. There are lots of morphogenic and environmental influences which manage the occlusal development and a disorder in any of these elements may influence the occlusion [5]. One of these factors is the premature exfoliation of the primary teeth. Premature loss of a primary tooth has been known to cause space loss with resultant malocclusion. Thus, to avoid severe malocclusions due to premature loss of primary teeth, various types of space maintainer are fabricated. They depend on the child's stage of development, dental arch involved, missing primary teeth.[6-10]

Premature loss of maxillary primary incisors does not generally result in decreased upper inter-canine width, if the incisor loss occurs after the primary canines have erupted into occlusion at approximately 2 years of age. However extensive carious breakdown of primary anterior teeth to the cervical level and their loss in very young children invariably leads to lack of confidence and self-esteem and may cause psychological problems [2].

An anterior appliance incorporating artificial primary teeth may be considered to satisfy aesthetic and functional needs. Acrylic partial dentures have been successful in the replacement of single and multiple maxillary primary incisors. Given the demands of cooperation in wear and frequent appliance loss or damage, such removable appliances can be problematic in preschool age children [2].

Conclusion

"Hollywood bridge" has been found to have a much wider acceptability and compliance of wearing the appliance by pediatric patients. It solves the major consequence of early loss of maxillary primary incisors which gives an unattractive appearance, psychological trauma and potential development of deleterious habits (e.g. tongue thrust swallow, forward resting posture of the tongue, improper pronunciation of fricative sounds- "s", and "f").

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Systemic Sclerosis

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Abstract

Scleroderma, or progressive systemic sclerosis (PSS), an auto immune rheumatic condition effecting the connective tissues, has a profound impact on oral health. Its oral manifestations include features like restricted mouth opening, widening of periodontal ligament space, pseudoankylosis, malocclusion and mandibular resorption. here is a case of 40 years old female patient with the classical features of the diseases. This case reported for its rarity and variable expressivity. The objective of this paper is to report a case of systemic sclerosis in patients with oral and facial manifestations of the disease and considering oral facial involvement, necessitating adaptations in patient oral self care and influencing oral hygiene. Appropriate dental hygiene management of patients with this autoimmune disorder requires an understanding of clinical characteristics, the recognition of oral facial involvement, treatment considerations and pharmacological

Mesh Keywords: Systemic sclerosis, Localized Scleroderma, autoimmune diseases

Introduction

Scleroderma originates from the Greek word 'skleros,' meaning "hard" and 'derma', meaning "skin". Scleroderma is the initial manifestation of a disease process better described as progressive systemic sclerosis (PSS), which was named by Goetz in 1945 1. PSS, one of a group of chronic auto¬immune diseases that includes systemic lupus erythematoses and Sjögren's syndrome, can be subdivided into systemic sclerosis (SS) and localized sclerosis[2] Women are affected 3 to 4 times more frequently than men and the incidence rises through 4th decade through seventh decades of life[3]. Although SS is an uncommon autoimmune rheumatic condi¬tion affecting connective tissues, it presents great challenges to both medical and dental professionals and has a profound impact on oral health. The current article reviews the important features of PSS, including its patho¬genesis and clinical findings, and recommends ways dental practitioners can manage their patients with this disease

Case History

A 40 year old patient came to the department with pain in upper right back tooth region for past 1 week. On questioner patient revealed that she was on medication for arthritis for past 3 years and was also hypotensive and on medication for past 8years. She has developed stiffness over face and legs and had not checked for the same with physician. She also gave history of hypo pigmented areas on skin of her face, neck and arms.

Extra oral examination showed taut, thickened, mask like facial skin with focal areas of hypo pigmented areas on skin of her face, neck and arms (Fig- 1,2,3,4)

Fig -1 extra oral- mask like features, focal hypopigmentation

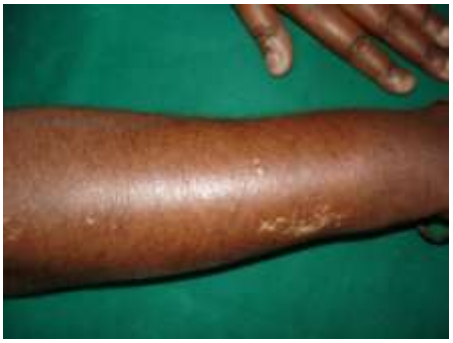

Fig -2 Area of depigmentation with fibrosis

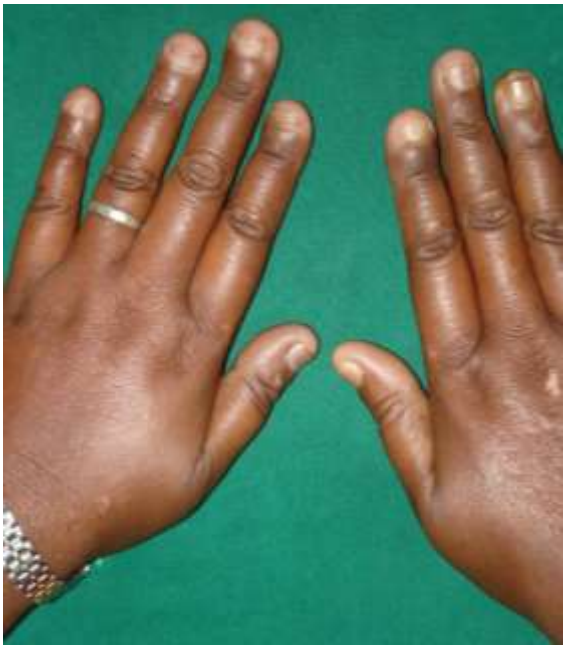

Fig-3 areas of fi brosis

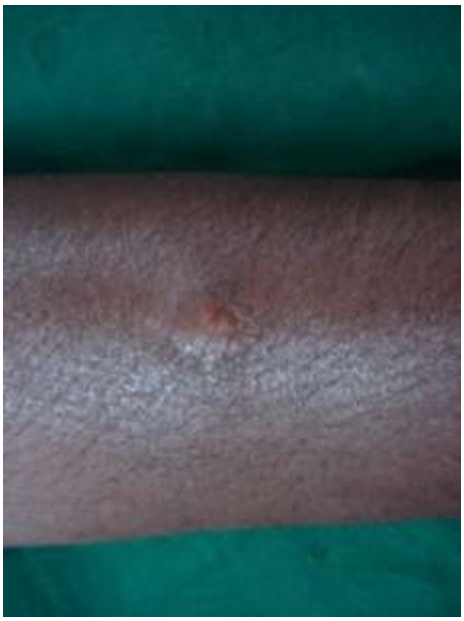

Fig - 4 focal areas of hypo pigmentation

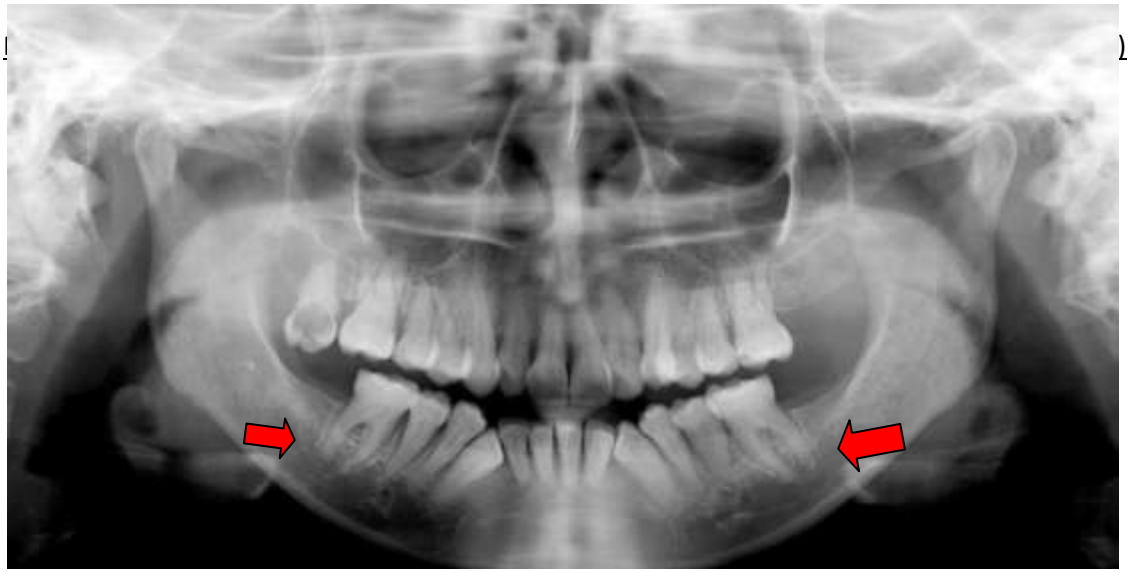

Fig- 5 IoPA – 14,15, 16

Intra oral examination showed blanching of buccal mucosa. Tongue had limited movement and mouth opening was approx of 30 mm. intra oral examination showed missing 18, 27, 28, 37, 38, 47 and carious teeth in relation to 17, 26, 36, 46 and 17 was tender on percussion.

Intra oral radiograph (Fig-5) showed enlargement of periodontal space with loss of coronal tooth structure. Panoramic radiograph (Fig-6) showed generalised widening of periodontal space particularly with respect to maxillary and mandibular molar. Biopsy was done to confirm the diagnosis of scleroderma.

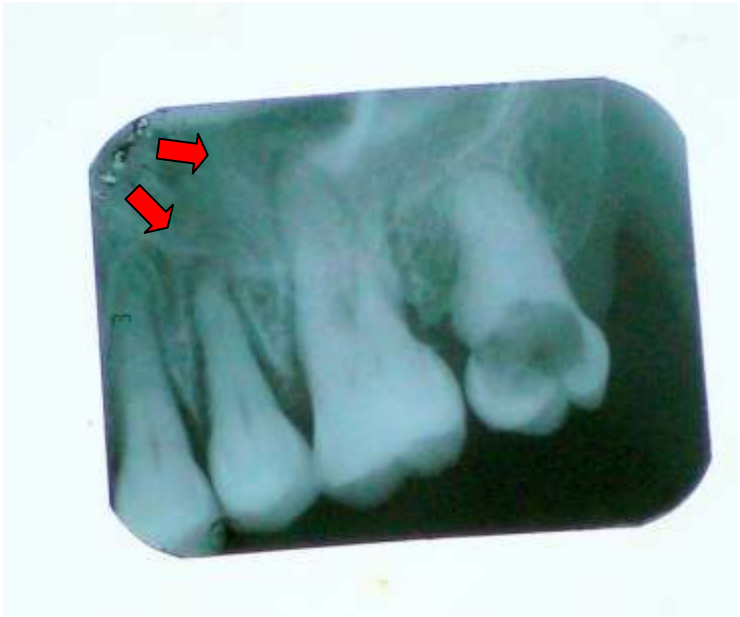

Fig- 6 OPG arrow indicates widening of PDL

Patient was sent to general physician for review of systems. Histological report revealed increased pigmentation in basal layer eosinophilic thickened collagen bundles seen in the dermis and also Sparse inflammatory infiltrate in dermis with high

uptake of ectopic sweat glands present. Features are compatible with early morpea. Oral prophylaxis was performed followed by restorative procedures for carious tooth. Patient was taught oral hygiene procedures and mouth stretching exercises to improve mouth opening.

Discussion

Scleroderma is a relatively uncommon condition with an average annual incidence of 6-12 patients per million populations. There are two clinical entities of scleroderma: localized scleroderma and PSS3. Systemic sclerosis differs from localized scleroderma because it is accompanied by Raynaud´s phenomenon, acrosclerosis, and internal organ involvement. PSS often affects oral and perioral tissues [4].

Table – 1 Common oral findings in patients with scleroderma[5]

Microstomia	Widening of the periodontal ligament space
Xerostomia	Enamel erosion
Dysphagia	Mandibular resorption
Fibrosis at the hard and soft palate	Trigeminal neuropathy
Increased risk of periodontal disease and caries.	Facial and mucosal telangectasis

Resorption of the mandible is another common oral manifestation. The mandibular resorption results from facial skin tightening, vessel constriction and the underlying taut musculature exerting continuous pressure on the mandible[5]. Often asymptomatic, the areas of mandibular resorption are of concern as they increase the risk of mandibular fractures and painful oral conditions such as trigeminal neuropathy and osteomyelitis[6]. The angle of the mandible, the condyles and coronoid process may be affected[7]

Since the clinical presentation of the disease has multiple components, research groups are focusing on the evaluation of the pathological markers as possible treatment targets.

Treatment options

Many drug regimens have been tried, with variable success, in the treatment of localized scleroderma, including D-penicillamine, cyclosporine, oral corticosteroids, low-dose methotrexate, psoralen, vitamin D analogs, tacrolimus, and mycophenolate mofetil[8] Experimental drugs, such as interferon-gamma and cyclophosphamide, and photophoresis have been used with varying degrees of success. Management of the systemic effects of this disease is not well estab¬lished, although some large uncontrolled series suggest that D-penicillamine has beneficial effects[9].

Treatment of localised scleroderma10	Treatment of systemic sclerosis 10
Morphea Corticosteroids(topical and intra lesional) Topical calcipotriene	Vasodilators Rynaunds phenomenon Nifedifine ,verapamil hydrochloride Losartan
Linear scleroderma Corticosteroids Psoralen – UV-A baths UV-A alone (340- 400nm) Oral calcipotriene Topical calcipotriene	Pulmonary hypertension Epoprostenol Iloprost Captopril, Enalapril maleate Kidney dialysis kidney transplant
Widespread morphea Psoralen- UV-A baths UV-A alone (340- 400nm) Oral calcipotriene Methotrexate Methotrexate + corticosteroids	Immunosuppressants Skin induration Methotrexate Cyclosporine Interstitial lung diseases Cyclophosphamide
	Antifibrotics Skin induration D- Pencillamine Colchicines Interferon gamma Relaxin

Raynaud's phenomenon can be treated with calcium channel blockers, prazosin, prostaglandin derivatives such as prostaglandin E1, aspirin and topical nitrates. In uncontrollable cases when digital loss is plausible, patients may benefit from pharmacologic cervical sympathectomy or from surgical digital sympathectomy to ablate sympathetic innervation to these end arterioles. Amputation of the involved digits may be indicated if severe ischemia and infection occur. Control of operatory temperature and patient comfort are crucial for preventing cold- or stress-induced vasospasm in the dental setting[9,14] Clinical research for better treatment is hindered by the condition's wide variability in severity among patients, to recruit large numbers of patients with similar symptoms and stages of the disease. Moreover, the course of the disease varies from rapidly progressive to prompt spontaneous remission

Of particular importance to oral healthcare professionals is the skin involvement affecting the hands and oral facial structures. Both impact the patient's ability to perform the activities of daily living including oral self-care, movement of oral structures and increased risk of oral disease. Instructing patients on simple stretching exercises of the mouth (Table 2) can significantly improve flexibility and opening and assist with a more productive dental hygiene appointment[11-12]. Likewise sharing with the patient some simple stretching exercises involving the fingers

(Table 3) have been found to improve function and could improve self care measures[12].

Table 2. Stretching exercises to increase range of motion of the mouth

Exercise 1

Instruct patient to:

1. Make an O with your mouth
2. Smile, grimace, smile, grimace
3. Open your mouth as wide as you can, and stretch as much as possible
4. Practice slowly 10 times a day

Exercise 2

Instruct patient to:

1. Stack four tongue blades together and secure with clean rubber band
2. Open mouth and slip stack between the upper and lower teeth
3. Determine the number of tongue blades that can comfortably fit between the teeth
4. Next add one additional tongue blade in the middle of the stack and let it gently stretch the mouth
5. Gradually increase the number of blades in the stack to stretch the mandibular opening
6. Repeat at least two times a day

Table 3. Finger stretching exercises to improve function

Instruct patient to:

1. Place arms at sides with fingers pointed toward the toes
2. Place palms facing your body
3. Curl fingers and attempt to touch your finger tips to your palm
4. Slowly uncurl and straighten fingers as much as possible
5. Repeat 10 times a day

The use of a daily 1.1% sodium fluoride prescription rinse or a 4% sodium fluoride brush on gel are important for reducing caries risk12. The application of fluoride varnish may be well suited for many of these patients as the small applicator brush allows for easier access into the oral cavity and provides excellent anticaries benefits13 To control oral infection, frequent re-care is highly advisable. Every 2- to 3-month re-care appointments are ideal to prevent the need for long, difficult appointments where more work and longer chair time may be needed. Importantly, early diagnosis can assist with more successful disease management. As the small blood vessels in the extremities are affected, patients with Raynaud's phenomenon. often become overly sensitive to changes in ambient temperature.

Conclusion

Survival of people with PSS mainly depends on the subtype of the disease. Limited cutaneous SS has a 10-year survival rate of 71%[15]; diffuse cutaneous SS, 21%[16]. Pulmonary hypertension and scleroderma renal crisis are important prognostic predictors. Instruction in and reinforcement of oral hygiene, along with frequent dental assessment and man¬agement by the dental practitioner are essential measures to preserve the oral health of those affected with PSS. Special care and attention must be paid to keeping the surrounding environment in the dental operatory warm for patients who have vasospasms to help avoid a vascular crisis.

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Multiple Dentigerous Cysts: Report Of 2 Rare Cases

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Abstract

Dentigerous cysts are common odontogenic cysts of the jaws. They are associated with the crowns of permanent teeth, most frequently associated with impacted mandibular third molars. Bilateral dentigerous cysts are rare and generally occur in association with a developmental syndrome or systemic disease[1]. Bilateral dentigerous cysts in the absence of syndrome are rare .The following is a report of two cases of unusual bilateral non-syndromic dentigerous cysts of maxillary and mandibular teeth.

Key words: Multiple Dentigerous Cyst, Odontogenic Cyst, Supernumerary teeth.

Introduction

Dentigerous cysts are odontogenic cysts which enclose the crown of an unerupted tooth. Thus, they generally appear during tooth development in young patients. The mandibular third molar and maxillary canine are most frequently involved. There is usually no pain or discomfort. When cysts are small, they are usually discovered in radiographic examinations that are taken to investigate other symptoms or a failure of tooth eruption, but when cysts enlarge there are asymptomatic facial swellings. The following are some of the rare complications of dentigerous cysts: maxillary cysts may displace and obliterate the maxillary antrum and nasal cavities; mandibular cysts may cause paraesthesia of inferior alveolar nerve, or metaplastic and dysplastic changes may occur[2].

The indicated treatment is surgical removal of lesion and involved teeth, or decompression to salvage the involved teeth[1]. Single dentigerous cysts are the second most common odontogenic cysts after radicular cysts. Bilateral and multiple cysts have been reported in patients with syndromes or systemic diseases, such as mucopolysaccharidosis and cleidocranial dysplasia[2].

Case Report – 1

A 19 year old boy presented with a history of swelling since 6 months & pus discharge from 15 days. Intraoral examination revealed , swelling in the right mandibular angle region with areas of decortication in first & second molar region . The right mandibular third molar, canine & left mandibular canine was impacted. Medical history ,not contributary.

Panoramic radiograph revealed 4 well circumscribed radiolucent lesions in the mandible. The first radiolucency

surrounded the crown of impacted right mandibular third molar & extended upwards to involve the coronoid process.The second radiolucency involved the impacted canine on the right side & extended to cross the midline till the left canine region. The third radiolucency involved the body of the mandible on left side extending from canine to first molar region. The fourth radiolucency was seen involving lateral aspect of impacted left mandibular third molar extending upward to involve the coronoid process. Radicular resorption of the first & second right mandibular molars was seen.

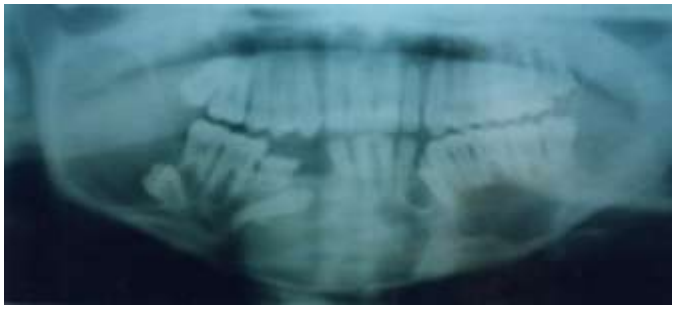

Figure 1 Panoramic radiograph shows bilateral well-defined radiolucencies involving right and left mandibular third molars and canines.

PNS radiograph revealed a well circumscribed radiolucent lesions surrounding the crown of partially formed supernumery para molar on the left maxilla.

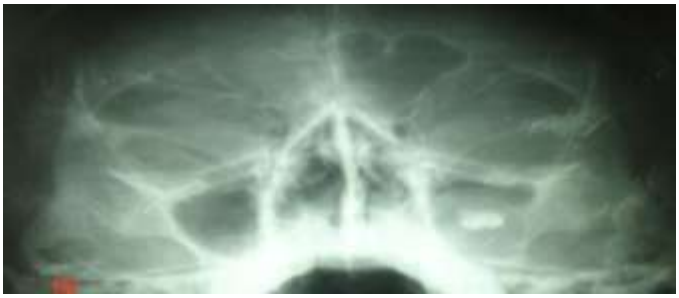

Figure 2: PNS radiograph revealed a well circumscribed radiolucent lesions. Surrounding the crown of supernumery para molar on the left maxilla.

Enucleation was done for all lesions in our hospital under general aesthesia. All specimens were sent for histological examination. Histopathologically all the 4 lesions were diagnosed as dentigerous cysts . Inferior lesion shows a thicker epithelial lining with rete ridges and fibrous capsule with a diffuse chronic inflammatory infiltrate.

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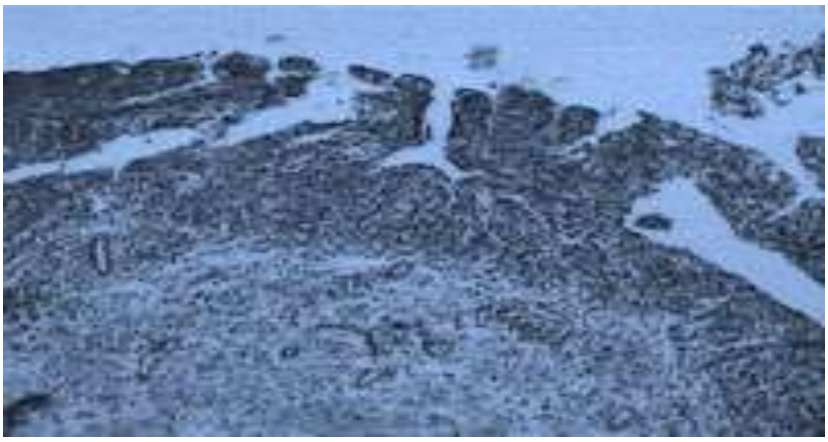

Figure 3 Photomicrography of the inferior lesion lined by thicker epithelial with rete ridges and fibrous capsule.

Figure : 4 Photomicrography shows the cystic lesion lined by non-stratified Squamous pithelium.

Case Report-2

60 year old female presented with a chief complaint of pus discharge in the maxillary anterior region. Intraoral examination revealed a draining sinus with areas of buccal decortication , extending bilateraly from canine to canine . Medical history was not contributory.

A panoramic radiograph revealed well circumscribed radiolucent cystic lesions surrounding mesiodens on right & left maxilla.

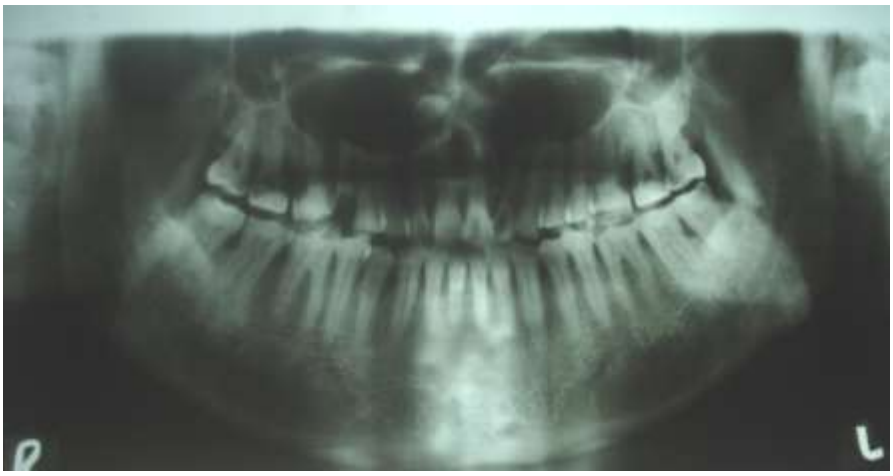

Figure : 5 Panoramic radiograph shows bilateral well-defined radiolucencies

Enucleation of two lesions and mesiodens was performed in our hospital under general anesthesia .The material was analysed histopathologicaly.Diagnosis of the lesions was dentigerous cysts.

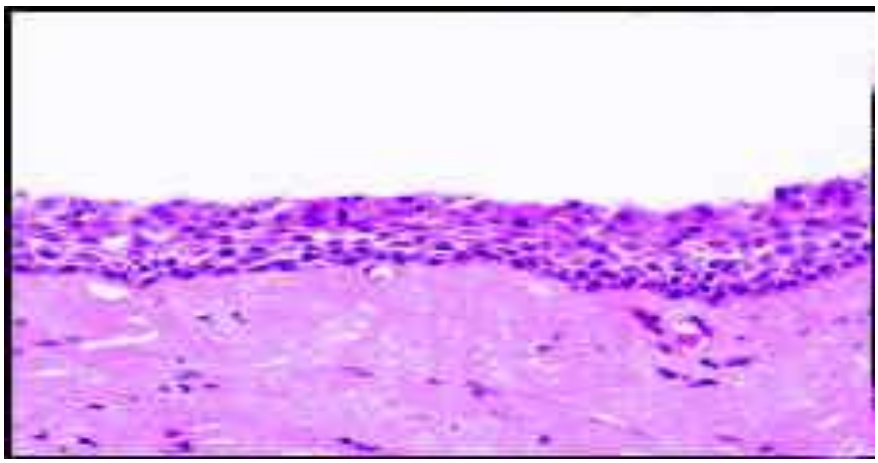

Fig.6 Photomicrograph showing cyst wall composed of fibrous tissue and lined by nonkeratinised stratified sqaumour epithelium.

Discussion

Although dentigerous cysts are common developmental cysts, reported bilateral dentigerous cysts are extremely rare. Bilateral or multiple dentigerous cysts are usually associated with syndromes such as basal cell nevus syndrome, cleidocranial dysplasia, mucopolysaccharidosis, Maroteaux–Lamy syndrome (MPS-VI) and Hunter's syndrome (MPS-II). Bilateral dentigerous cysts are extremely rare in the absence of a syndrome or systemic disease. After searching the literature, only 17 cases were identified from 1943 to 2005[3]. And very few presented with association of upper and lower molars, as in the present case , three dental quadrants were involved.

Basal cell nevus syndrome is anautosomal dominant condition with complete penetrance and variable expressivity. It is charectarised by five major components, including multiple nevoid basal cell carcinomas, jaw cysts, congenital skeletal abnormalities, ectopic clasifications, and plantar or palmar pits. Other features include a host of benign tumors, ocular defects, and cleft lip and palate. Guidlines for diagnosis include a family history, carefull oral and skin examination, chest and skull radiographs, panoramic radiographs of the jaw, magnetic resonance imaging of the brain, and pelvic ultrasonography in women4.

Cleidocranial Dysplasia also known as cleidocranial dysostosis and Marie-sainton disease, is a condition characterised by defective development of the cranial bones and by the complete or partial absence of collar bones charecteristics include delayed closure (ossification) of the space between the bones of the skull (fontanels) ,premature closing of the coronal suture , protruding jaw and protruding brow bone ,wide nasal bridge due to hypertelorism, high arched palate or possible cleft palate, short stature and scoliosis of the spine. Cleidocranial Dysplasia is transmitted as an autosomal dominant trait,the cause is yet known, but several chromosome abnormalities have been linked with this syndrome, including chromosome 6p21[5].

Mucopolysaccharide is a group of autosomal recessive metabolic disorders caused by the absence or malfunctioning of lysosomal enzymes needed to break down molecules called glycosaminoglycans - long chains of sugar carbohydrates in each of our cells that help build bone, cartilage, tendon, corneas, skin and connective tissue. Glscosaminoglycans (formerely called mucopolysaccharides) are also found in the fluid that lubricates our joints[6].

Childrens with MPS VI, Maroteaux-Lamy syndrome, usually have normal intellectual developmentbut share variable spectrum of severe symptoms. Neurological complications include clouded corneas, thickening of the dura (the membrane that protects and surrounds the brain and spinal cord), and pain caused by compressed or traumatised nerves and nerve roots.Growth is normal at first but stops suddenly around age 8. By age 10 childrens have developed a shortened trunk, cruuched stance, and restricted joint movement. In more severe cases, children also develop a protruding abdomen and forward-curving spine. Many childrens will also have umbilical or inguinal hernias. Nearly all children have some form of heart diseases, usually involving valve dysfunction. An enzyme replacement therapy was tested on patients with MPS VI and was successful in that improved growth and joint movement[6].

Hunter syndrome, or Mucopoly saccharidosis II (MPSII), is a serious genetic disorder that primarily affects the males. It interfears with the body ‘s ability to break down and recycle specific mucopolysaccharides, also known as Glycosaminoglycans (GAG). GAG build up in cells throughout the body due to deficiency or absence of the enzyme iduronate-2-sulfatase (I2S). This build up interferes with the way certain cells and organs in the body function and leads to a number of serious symptoms. Signs of syndrome include distinct facial features, a large head, and an enlarged abdomen, hearing loss, thickening of heart valves leading to a decline in cardiac function, obstructive air way disease, sleep apnea, and enlargement of the liver and spleen. Range of motion and

mobility is also affected. In some cases of hunter syndrome , central nerous system involvement leads to developmental delays and nervous system problems, Hunter syndrome is always severe, progressive, and life limiting[7].

In all reported cases, including the present case,radiographic examination showed a unilocular radiolucent lesion associated with the crown of an unerupted tooth and well-defined sclerotic margins. It is important to perform radiographic examinations in cases of unerupted teeth. Initially a panoramic radiograph may be used for this examination. However, in cases of extensive lesion, CT imaging becomes necessary.

Radiographic examinations provide valuable information.However, pathological analysis of the lesion is essential for the definitive diagnosis.Other lesions may share the same radiological features as dentigerous cysts, such as odontogenic keratocysts and unicystic ameloblastoma.In this case, these lesions were included in the differential diagnosis after the radiographies were observed. Although involvement of the tooth, cortical expansion and radicular reabsorption are characteristics more related to dentigerous cysts, other lesions were not excluded until the results of the pathological analysis were known. Odontogenic keratocysts do not expand the bone to the same degree as dentigerous cysts and are less likely to produce teeth resorption. According Tsukamoto et al,mean age of patients with odontogenic keratocyst was less than that of patients with dentigerous cyst; the mean area of the odontogenic keratocysts was larger than that of dentigerous cysts; and dentigerous cysts are more likely to have smooth periphery and odontogenic keratocysts are more likely to have scalloped periphery. It is not possible to differentiate unicystic ameloblastomas from dentigerous cysts with clinical and radiographic examinations.The lesions together with the associated tooth were enucleated in hospital under general anaesthesia and pathological analysis was obtained., although larger lesions may be surgically drained and marsupialized to relieve the pressure within the cysts and to prevent damage to the involved permanent teeth. follicular space of the left maxillary third molar will be observed in future radiographic examinations. The recurrence of dentigerous cysts is very rare[1].

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