RICHMOND
ENDODONTIC CENTRE

NOT OKC TO PULL IT OUT

OCT 2013

Happy Hallowe'en! A few months ago, I received a referral from a general dentist who restricts his practice to accepting referrals for difficult extractions and implant dentistry. The 64 year-old male patient had been referred for extraction of 37 (see Pre-Op PA). Recognising the presence of the lesion he referred it for an endodontic evaluation since there was minimal probing (2-3mm), no symptoms nor mobility. The patient is being monitored by an oncologist for possible prostate cancer. Endodontic evaluation found the 37 to have a vital pulp with no unexpected pulp and periradicular test results for all quadrant three teeth. The apices of 37 appear abnormal; the 36 obturation was short on the D canal with an unobturated canal in the M root. Suspicious of a lesion of non-odontogenic origin I referred the patient to Orbit Wilson for a CBCT (see image on right) and radiology report.

The radiologist was so concerned that he insisted I personally confirm on the phone the receipt of his report. The description of the large multilocular lesion is summarised below:

- In body of mandible, vertically extends from the crest of the ridge to the inferior border.
- In the ramus, vertically extends to within 5mm of the sigmoid notch; laterally from the anterior border to the mandibular foramen and IAC.
- In region of 37 the IAC is displaced inferiorly.
- Large lesion with minimal expansion and a possible perforation of lingual aspect posterior to 37.
- Differential diagnosis: keratocystic odontogenic tumour (OKC), ameloblastoma, odontogenic myxoma, and central giant cell granuloma.

I referred the patient to Dr. Raymon Grewal, Oral Surgeon, who biopsied the lesion which was found to be OKC. Dr. Grewal will soon enucleate and curettage the lesion and extract the 37. The 36 may be extracted if the lesion extends to the roots of 36 and if root planing alone cannot reliably eliminate the OKC satellite cells. If the 36 is retained, it is necessary to consider orthograde retreatment and endodontic microsurgery. Any lesion at the apices of 36 will be treated aggressively as the possibility of OKC recurrence is high.

OKC has a 20% recurrence rate and this patient will require annual clinical and radiographic evaluations the rest of his life. It was fortunate the 37 was not extracted as the mandible could easily fracture and an emergency bleed could have occurred. Also, this would have further delayed identification of the pathology. Throughout the entire process the patient remained nonchalant; both Dr. Grewal and I had to stress the importance of following through with treatment. It is fortunate the referring dentist realised that 'When in doubt, pull it out' is not wise advice to follow blindly.

Regards,

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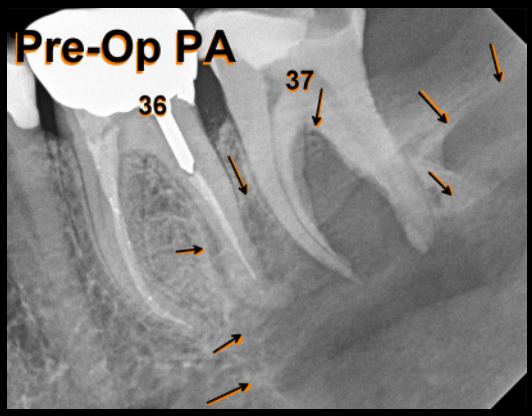
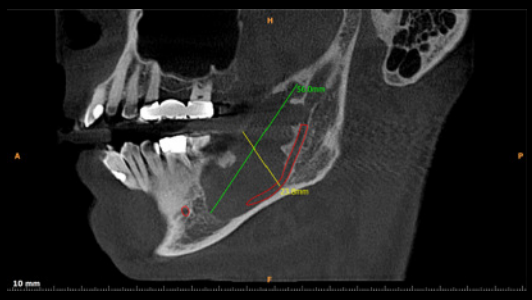
Certified Specialist in Endodontics



PRE-OP PA



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