An Unusual Large Erupting Complex Odontome in Posterior Maxilla: A Case Report

Abstract
Odontomas are the most common type of odontogenic tumor. The lesions are invariably asymptomatic. The lesions rarely grow to a large size and erupt into the oral cavity. Here we present a case of large complex odontome in the maxillary posterior area which erupted into the oral cavity.

Keywords: Odontome; Complex odontome; Benign odontogenic tumor

Introduction
Odontomas are the most common type of odontogenic tumor occurring within the jaws, commonly classified as compound and complex odontome. The Compound odontomas are more common in the anterior portion of the jaws resembling tooth-like structure. The Complex odontomas are more common in the posterior part of the jaws and consist of a disorganized mass with no morphologic resemblance to a tooth [1]. The lesions are invariably asymptomatic and are discovered on routine radiographic examinations; however, they may be associated with pathologic changes in adjacent teeth and structures such as malformation, impaction, delayed eruption, displacement, cyst formation and resorption of adjacent teeth [2]. In extremely rare instances odontome are larger than the tooth and may erupt into the oral cavity [3]. In this manuscript we have reported and discussed one such unusual case of erupting large complex odontome in the maxillary posterior area.

Case Report
A 25 year old female reported with the complaint of pain and swelling in left maxillary posterior region with feeling of a hard tooth-like structure since 1½ to 2 years. On examination, a large, well-circumscribed, non-capsulated, yellowish-white hard mass was noted in left maxillary posterior region (Figure 1). The mass was approximately 2.5 cm in size, was immobile and non-tender. On radiographic examination, a large well-defined radiopaque mass in left maxillary posterior region is seen (Figure 2 & 3). The left maxillary 3rd molar was located on the superior aspect of the mass. The clinical and radiological features were suggestive of complex odontome. Surgical removal of the lesion and impacted 3rd molar was planned under local anaesthesia. The lesion was enucleated as a single mass (Figure 4). The impacted left maxillary 3rd molar was also removed after enucleation of the lesion.

Discussion
The term ‘odontome’ was coined by Paul Broca in 1867. The etiology of odontome remains unknown. Majority of the cases are discovered before the age of 30 years and there is slight predominance in females [4]. They are usually asymptomatic but often associated with eruption disturbances, as seen in our case-a large complex odontome interfering with the eruption of maxillary 3rd molar. Odontome and the possible disturbances to the adjacent teeth can be detected on plain radiograph. However, in our case, a CT scan was advised to confirm the relationship with adjacent teeth, pterygoid plates and the maxillary sinus. The differential diagnosis of complex odontoma include cementifying or ossifying fibroma, adenomatoid odontogenic tumor, calcifying odontogenic cysts, periapical cemental dysplasia and calcifying epithelial odontogenic tumor. Odontomas erupting into the oral cavity are rare. The possible mechanism could be the enlarging size, causing resorption of the surrounding bone [5]. Another possible cause for eruption could be the eruptive forces of the apparently impacted maxillary 3rd molar teeth. The treatment of odontome, if required, is surgical removal. In our case the removal of impacted 3rd molar was also done along with the surgical removal of odontome due to its unfavorable api tally displaced position, anticipating its failure to erupt normally into the oral cavity.

Figure 1: Clinical examination of the lesion.
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References