

## Bimaxillary and Bilateral Dentigerous Cysts: A Rare and First Reported Case

**T**he article 'Bimaxillary and Bilateral Dentigerous Cysts - A Rare and First Reported Case'<sup>[1]</sup> allows us, to reinforce the need for a systematic approach to clinical investigations. Without such an approach, the diagnosis of rare conditions may well remain undiscovered.

The authors report a full clinical investigation that corresponds exactly to that required where buccal (or lingually) placed swellings are found; the unusualness being in the antero-posterior extent of those swellings. The absence of syndromic clinical findings will restrict any tentative diagnosis. The second stage of investigation will normally be radiographic to allow the localisation of oral hard or soft tissue pathology. The initial radiographic investigation normally requires the use of two-dimensional (2D)

radiographs. As a result, such radiographs can be referred to as a clinician's main diagnostic aid.<sup>[2]</sup> In the context of this article, a main clinical indication for periapical and/or panoramic radiography includes assessment of the presence, and position of unerupted teeth and of root and bone morphology prior and subsequent to extraction.<sup>[3]</sup> The panoramic radiograph comes into its own, in the realm of oral surgery diagnosis, allowing a full pictorial radiographic overview of the maxillae, although only 2-dimensional. Such an aid will allow the justification of further 3D imaging.<sup>[4]</sup> The magnitude of the lesions certainly justifies the use of 3D imaging. The authors applied CT imagery, as their cross-sectional imagery 'of choice'. Today, it is questionable whether this should be the case - the prime choice is suggested to be that of CBCT.<sup>[5]</sup> However, this

application will be dependant on the corresponding costs of change.

Having established a radiographic diagnosis of the presence of dentigerous cysts, the authors established its validity via the histopathological examination of the obtained aspirates. Since it is reported that ameloblastomas<sup>[6]</sup> and squamous cell carcinomas<sup>[7]</sup> have occurred in the lining of dentigerous cysts, a histopathological examination is mandatory to eliminate these and other possible lesions in the locations. Further, since other malignant lesions can mimic the imaging appearances of dentigerous cysts,<sup>[8]</sup> it must be reinforced that a histological examination is carried out.<sup>[9]</sup>

The treatment of choice for the dentigerous cyst is enucleation<sup>[10,11]</sup> along with the extraction of the impacted teeth.<sup>[9]</sup> However, the potential for proliferation of lining residue remains. Therefore, long-term post-operative follow-up must be advocated. The authors show once again that the use of 2D panoramic imaging is the 'modality of choice', due to its ease of use and availability.

However, in the aid of advancement of techniques, what is missing here is the lack of application of other, now accepted, adjunctive surgical techniques that bring traditional oral surgery techniques into the modern arena. These are extreme surgical defects left following such enucleations and extractions. The potential for intra-wound healing infection and subsequent morphological anatomical anomalies is high, regardless of the surgical techniques employed. Today, some regard to the application of allografts or xenografts to the enormous wounds needs to be expressed in modern day oral surgery. Wound reduction decreases the potential for post-operative infection and aids in the more rapid attainment of natural anatomical morphology.<sup>[9]</sup>

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