

An unusual presentation of the myxoma of maxilla

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Introduction

Myxoma is a benign, but locally aggressive and rare skeletal neoplasm. It was first described by Thoma and Goldman in 1947. The lesion is defined by the World Health Organization (WHO) as a locally invasive neoplasm consisting of rounded and angular cells lying in an abundant stroma. Kim et al. (2002) reported two cases in mandible & maxilla each. Aquilino et al. (2005) has also reported a case of maxillary myxoma. This neoplasm probably arises from the primitive mesenchymal structures of a developing tooth including the dental follicle, the dental papilla or even the periodontal ligament and therefore is of interest for the periodontist. It is mostly located intraosseously and may cause cortical expansion. Usually occurring in second and fourth decades of life, it has a male: female ratio of 1: 1.6. It has a 2: 1 predilection for occurrence in the mandible rather than the maxilla, most of those occur in premolar and molar areas. Radiographically, the lesion appears as unilocular or multilocular radiolucency with or without wispy trabeculae. Complete surgical excision of the defect is advocated for smaller lesions. If removed incompletely the recurrence rate is up to 33%. The present case was a distinct presentation of maxillary myxoma occurring in its anterior region, perforating the bony cortex, in a male patient. He was managed conservatively with esthetic restoration.

Objectives

A painless gingival swelling in a 38 year old male patient since 16 months.

Material and Methods

Case presentation: A 38 years male, with gradually enlarging, painless gingival swelling since 16 months. On examination the lesion was localized to the buccal gingiva of tooth # 12 & 13, pink, firm, sessile, 2.5 cm x 2.5 cm in size. Tooth # 12 was grade II mobile. The associated teeth were vital. He had a 12 months old IOPA radiograph of the same lesion showing, unilocular radiolucency between teeth # 12 & 13.

Radiographic examination: Fresh IOPA radiograph was taken, it was showing unilocular radiolucency between the roots of tooth #12 & 13. Bone exhibiting wispy trabecular pattern. Borders of the lesion were well defined. The occlusal radiograph of maxilla showed limited palatal extension of the lesion and displacement of tooth # 12 & 13.

Incisional biopsy: Gross examination of gelatinous specimen revealed a glistening, homogenous cut surface with well delineated capsule. Microscopically, it showed myxomatous tissue immediately beneath the epithelium giving a false impression of a peripheral myxomatous lesion.

Surgical procedure: Under all aseptic precautions, under local anesthesia the lesion was excised en masse and the defect curetted. The tooth # 12 was extracted. The defect was then filled with Hydroxyapatite bone graft and covered with upper lip pedicle flap. The periodontal dressing was applied.

Histopathologic examination: Low magnification view revealed bony spicules overlying the myxomatous tissue at certain areas, which indicated its intraosseous origin. At higher magnification, it showed loosely arranged, evenly dispersed spindle shaped cells with lightly eosinophilic cytoplasm in mucoid rich matrix.



Fig 1: Clinical appearance of lesion

Fig 2: IOPA radiograph of lesion



Fig 3: Occlusal radiograph of lesion

Fig 4: Incisional biopsy

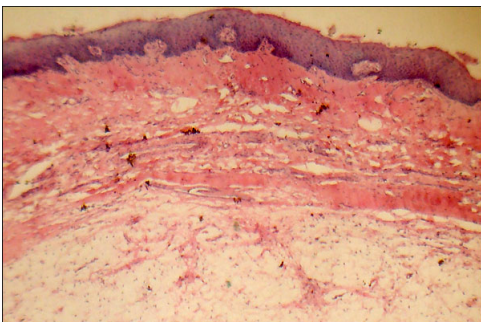


Fig 5: Microscopic examination

Fig 6: Surgical site preparation

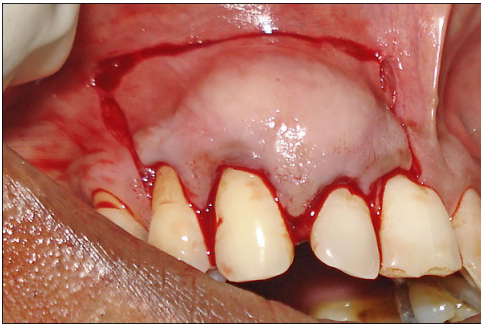


Fig 7: Placement of wide incision

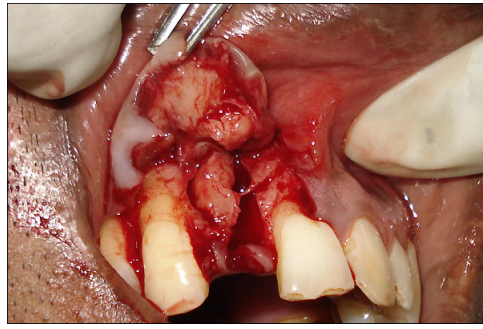


Fig 8: Tooth #12 and lesion removed

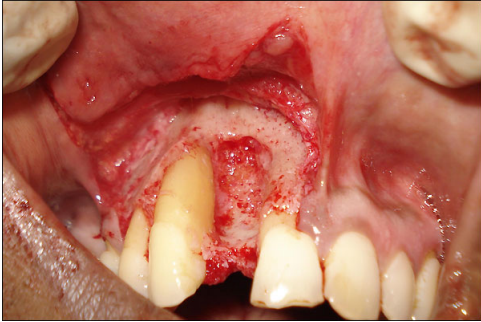


Fig 9: Defect thoroughly curetted

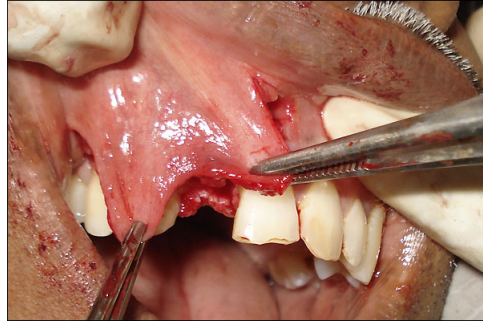


Fig 10: Upper lip pedicle flap raised



Fig 11: Defect filled with Hydroxyapatite



Fig 12: Lip pedicle flap sutured

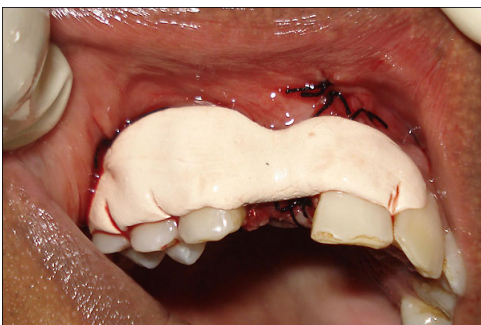


Fig 13: Periodontal dressing applied

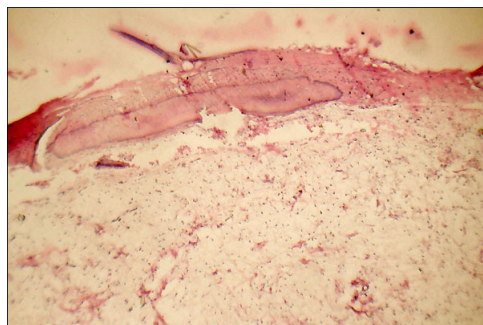


Fig 14: Low magnification view

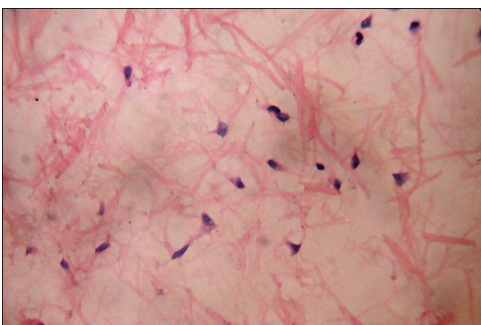


Fig 15: High magnification view

Results

An uneventfully healed operated site with a well accepted flap. No signs of recurrence till date. The prosthesis restored the esthetics of the patient.



Fig 16: Healing after 12 months



Fig 17: After prosthetic restoration

Conclusions

Myxoma is benign, locally aggressive lesion, rare in skeleton. Kim et al. (2002) reported two cases in mandible & maxilla each. Aquilino et al. (2005) has reported a case of maxillary myxoma. The lesion presented also occurred in the maxilla in the anterior region. Myxoma usually spreads within marrow causing cortical expansion. Unlike this the myxoma described here has perforated the cortex instead of only expansion. The clinical suspicion and early diagnosis has led to prompt management of the disease & proper esthetic restoration; thus avoiding a disfiguring surgery, had the lesion been discovered at a later stage. Every gingival enlargement should be viewed with a high degree of clinical suspicion for early diagnosis of an aggressive lesion beneath an indolent looking swelling. This may lead to offering the patient a conservative surgery with esthetic restoration rather than disfigurement due to an extensive surgery later.

Literature

1. Aquilino RN, Tuji FM, Eid NLM et al. Odontogenic myxoma in the maxilla: A case report. Oral oncology EXTRA. 2006 (42) 133-136.
2. Kim JY, Park GM, Cho BH. et al. Korean J Oral Maxillofac Radiol. 2002 (32) 231-4.
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Abbreviations

WHO - World Health Organization
IOPA - Intra Oral Peri Apical

This Poster was submitted by Dr Rashmi Dhale.

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AN UNUSUAL PRESENTATION OF THE MYXOMA OF MAXILLA

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Abstract

Introduction: Myxoma is a benign, but locally aggressive neoplasm that rarely appears in the skeleton. It usually occurs in 2nd and 4th decades of life, common in females, in mandibular premolar-molar region, spreading within marrow leading to expansion of cortex. The case in point shows a striking contrast as the myxoma occurred in a male, in the anterior maxilla & perforated the cortex instead of expansion.

Objective: To diagnose and surgically excise the maxillary myxoma along with esthetic restoration.

Materials and Method: The localized gingival enlargement of the anterior maxilla of was diagnosed as myxoma from clinical, radiographical and histopathological examinations. The lesion was surgically excised, defect was curetted and grafted with Hydroxyapatite. The lip pedicle flap was used to cover the defect. The restoration was given after complete healing.

Results: The wound healing was excellent. The lip flap was well accepted. The prosthetic restoration reestablished the esthetics of the patient.

Discussion: This case presentation exemplifies the importance of clinical suspicion, diagnostic evaluation and management including reconstruction issues in this unique case of maxillary myxoma.

Conclusion: Every gingival enlargement should be viewed with a high degree of clinical suspicion for early diagnosis of an aggressive lesion beneath an indolent looking swelling. This may lead to offering the patient a conservative surgery with esthetic restoration rather than disfigurement due to an extensive surgery later.

Key Words: Rare lesion, Maxillary myxoma, Gelatinous mass, Conservative excision, Lip flap, Esthetic restoration.

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Histopathologic examination: Low magnification view revealed bony spicules overlying the myxomatous tissue at certain areas, which indicated its intracortical origin. At higher magnification, it showed loosely arranged, evenly dispersed spindle-shaped cells with highly eosinophilic cytoplasm in mucoid rich matrix.

Photographic Illustration



Results



Discussion

Myxoma is benign, locally aggressive lesion, rare in skeleton. Kim et al. (2002) reported two cases in mandible & maxilla each. Aquilino et al. (2005) has reported a case of maxillary Myxoma. The lesion presented also occurred in the maxilla in the anterior region. Myxoma usually spreads within marrow causing cortical expansion. Unlike this the myxoma described here has perforated the cortex instead of only expansion. The clinical suspicion and early diagnosis has led to prompt management of the disease & proper esthetic restoration; thus avoiding a disfiguring surgery, had the lesion been discovered at a later stage.

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Bibliography

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