A sagittal split osteotomy approach for removal of a large cementoblastoma at the mandibular angle

Précis

This case report demonstrates the effectiveness of sagittal split osteotomy in the removal of a mandibular cementoblastoma.

Abstract

Benign lesions at the angle of the mandible are frequently removed by a conventional intra-oral approach to gain access and achieve complete visualisation. This method is quick and effective when dealing with small, benign lesions that are superficially located at the angle of the mandible. The removal of large and deeply located lesions with a conventional intra-oral approach, however, brings about a unique set of challenges, particularly when the third molar is displaced towards the inferior border of the mandible, including: lack of complete visualisation of the lesion; difficulty in identification and protection of the inferior alveolar nerve; and, the necessity of removing a considerable amount of osseous structure, thus increasing the risk of a mandibular fracture. Alternative techniques for such lesions include an extra-oral approach, but this could potentially create a cosmetic defect from cutaneous scarring and can result in facial nerve injury.

This case report describes the use of a unilateral sagittal split osteotomy (SSO) in the removal of a mandibular cementoblastoma. This is a safe and effective technique allowing optimal access to the tumour with complete visualisation, identification and protection of the inferior alveolar nerve, and with minimal bone removal, while maintaining mandibular integrity, strength and facial aesthetics.

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Oral lymphoma: a report of two contrasting cases

Précis

We highlight the varying manifestations of lymphoma in the oral cavity by presenting two contrasting cases. The journey from referral to diagnosis and management is discussed.

Abstract

Introduction: Non-Hodgkin's lymphoma (NHL) is a broad term for malignancies of the lymphoreticular system. NHL of the oral cavity is relatively rare and can manifest in a variety of ways, which can make initial diagnosis difficult.

Objectives: We discuss two contrasting cases of patients who initially presented with oral lesions to highlight the heterogeneity of lymphoma in the oral cavity and the importance of a thorough history and examination.

Methods: Case note review was undertaken for Case 1 and Case 2.

Results: Case 1 involves a 56-year-old male who was referred from his general practitioner to the oral and maxillofacial surgery (OMFS) emergency clinic with a three-week history of painful, intra-oral, ulcerated swellings in all four quadrants. He had recently developed fever, drenching night sweats and unexplained weight loss. The patient was admitted under OMFS until biopsy confirmed NK-T cell NHL. Case 2 involves a 68-year-old male who was urgently referred by his dentist, who had noticed a red patch on the left hard/soft palate junction at routine check-up. On examination, there was a 15mm erythematous, fixed submucosal lump on the left hard/soft palate junction. He was otherwise asymptomatic. Biopsy confirmed follicular B-cell NHL. Both patients were referred to haematology for ongoing care.

Conclusions: For intra-oral lesions, lymphoma should be considered as a differential diagnosis until ruled out by biopsy. Biopsies should be performed promptly in order to prevent delays in treatment. A thorough history may help to identify the presence of 'B symptoms'.

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