A Rare Location for a Dentigerous Cyst

Rasha Matouk*

Maxillofacial Department, Vergen Mary Hospital, Consultant at Al-Tal General Hospital, Syria

*Corresponding Author: Rasha Matouk, Maxillofacial Department, Vergen Mary Hospital, Consultant at Al-Tal General Hospital, Syria.

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Abstract

Dentigerous cysts, also known as follicular cyst, are the most common developmental cysts of the jaws and the second most common type of odontogenic cysts after radicular cysts [1]. They are commonly seen in association with impacted teeth with the following sequences lower 3\textsuperscript{rd} molars, upper 3\textsuperscript{rd} molars, and upper canine. Only 5 - 6\% of dentigerous cysts are associated with supernumerary teeth.

I present a case of DC associated with an impacted upper bicuspid in a 44 years old female. That was treated by enucleation procedures.

Keywords: Cyst; Dental; Impacted; Enucleation; Upper; Bicuspid; Treatment

Introduction

DC is caused by fluid accumulation between the reduced enamel epithelium and the enamel surface of a formed tooth and it originates by separation of the follicle from around the crown of an unerupted tooth [2]. A greater incidence in young men has been reported with a ratio of 1:6:1 [1,2]. It is usually associated with impacted or unerupted teeth. Mandibular third molars, maxillary canines and mandibular premolars are involved most frequently. Rarely, a dentigerous cyst is associated with odontoma, deciduous teeth and supernumerary teeth [2,3]. The association of a dentigerous cyst with supernumerary teeth constitutes only 5 - 6\% of all dentigerous cysts [4].

I hereby report a rare case of a 44-year-old lady with dentigerous cyst associated with an impacted maxillary bicuspid tooth.

Case Report

A 44-year-old woman came to my privet office, with chief complaint of a painless swelling of the left face. This swelling that was observed for the first time one year ago.

Her Medical History showed no any mentioned systemic disease. There was no history of any direct trauma to the maxillary bicuspid region where the swelling is; however, the patient noticed gradual enlargement of maxillary left buccal side.

Upon dental clinical examination, a firm, diffused, non-tender buccal swelling in the maxillary bicuspid region was found the overlying palatal and labial mucosa were normal (Figure 1).

Patient was treated with different kinds of antibiotics without any improvement.

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Her panoramic x-ray showed an impacted upper bicuspid surrounded with a clear 3 x 3 cm, well-defined unilocular radiolucent lesion with sclerotic borders in the bicuspid molar area of the left maxilla; no roots resorption was noticed. The lesion was causing smooth expansion of the alveolar cortex of maxilla and was abutting the posterior lateral wall and floor of maxillary sinus (Figure 2).

For further Investigation a needle aspiration was performed at the time of examination. I could aspirate more than 3cc of semi clear yellow color fluid that which could suggest that we were dealing with a cystic lesion.

With such Clinical and X-ray finding a deferential Diagnosis of a hypothesis of radicular cyst, dentigerous cyst, or cystic odontogenic tumor could be considered.

**Treatment**

The lesion was totally enucleated together with the impacted tooth. Nasotracheal general anesthesia was used. Flap was created as shown in figure 3. The cystic membrane was dissected and removed in Toto (Figure 4).

Upon examination of the bony cavity, I could see that the sinus walls were opened causing some kind of communication between the cystic bony cavity and the sinus cavity, even though the lining was intact (Figure 5).

The bony cystic cavity then was packed with a sponge gauze drain through an incision in the lateral wall of the left nostril. This drain was removed in separate two steps. One on the third day of surgery and the other was removed two days later.

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Surgically enucleated specimens with the tooth inside were sent to the Pathology Department for histopathological evaluation.

Outcome and follow-up

According to post-surgery evaluation after 3, 6, 16 months, everything was normal, and the healing process took place in a very good manner (Figure 6 and 7).

Discussion

Dealing with a chronic painless swelling in the oral cavity, where there are no symptoms of acute inflammation, should let us think of cysts, tumors or any other mucosal or bony abnormalities [2]. Our case had a missing tooth from the upper dental arch, leaving no space in this arch should lead us to think of an impacted tooth which might cause a Dentigerous cyst. It is a rare case finding an impacted upper bicuspid. Missing a tooth from the dental arch in a healthy mouth should make us wonder why that tooth was missing. Dentist should not treat chronic swellings with antibiotics unless becoming sure that a patient is dealing with infections.

Conclusion

Because the dental infection is the main cause of swelling in the oral cavity that does not mean that there is another kind and reason for swelling. In case of chronic swelling there is no need to hurry and start our anti-inflammatory treatment before making sure of what we are dealing with. Roentgenography, aspiration and sometimes biopsy will lead us to a definite diagnosis. Using antibiotics in this case before making a definite diagnosis was wasting of time and money and also destructive to the patient.

Bibliography