

The New System for Attacker Cyst Treatment

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Abstract

Cystic lesion of the oral cavity relies on odontogenesis to odontogenic cysts and nonodontogenic cysts and is divided into two significant classes. The odontogenic cystic tissues, histologically similar to odontogenic structures and anatomic deliberation, are present. Nonodontogenic cysts include cysts from different organs in the mouth, such as salivary gland cysts, nasopalatine-level-cysts, medium-palate cysts, and nasolabial cysts. Many cysts, common in the other sections of the body, including dermoid cysts, lymphoepithelial cysts, and aneurysmal bone cysts, are also included within this group. The treatment either by enucleation or marsupialization. The type of surgical treatment depends on the size, the site of the cyst, and the age of the patient, besides that the general health. The aggressive cyst mainly in the body and ramus of the mandible, if enucleate the cyst leads to fracture of mandibular bone or damage to the inferior alveolar nerve. The treatment by marsupialization lead to severe infection due to exposure to oral microorganism. By change the marsupialization by drilling and due small opening and put the acrylic base with extension inside the hole to reduce the pressure on the wall of the cyst until the cyst healed without need the second operation.

Keywords: Cystic Lesion; Odontogenic Cysts; Marsuplization; Nasopalatine-Level-Cysts

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Introduction

The oral cavity basically has 6 types of offensive cysts of the both arches that need particular notice, to prevent repetition, or to be more complicated, to diffuse the lesion [1-4]. They contain, more or less in the invert matter of the recurrence with which they happen:

- A lateral periodontal cyst (cystic botryoid odontogenic)
- Cystic carcinoma
- Calcifying odontogenic cyst
- Unicystic ameloblastoma
- Keratocystic odontogenic
- Glandular odontogenic cysts

Those cystic evaluated according to several survey studies are drawn the range of offensive cysts as in table 1.

How do you ensure benign or potentially aggressive during the

treatment of a jaw cyst? It's essential to know how such cysts commonly arise to address this issue.

Treatment Planning

Each single cyst in the edentular area, The maxilla as well as the mandible, histopathology must be removed and permanently present to eliminate any of the diseases mentioned above. No incisional biopsy is required because of the treatment for these cysts, Adequate for all common odontogenic cysts, for example, would be delicate enucleation, others may give malignant degradation. It may also be a long way off if a firm or multicystic ameloblastoma is a rare lesion, Additional quantity is needful in which case. Glandular odontogenic cyst status, It may also be a keratocystic Odontogenic Tumor or unicystic ameloblastoma, However, due to the prospect of replication in the range of 30–40%, prolonged follow-up will be needed for all these lesions. One may also assume that Carnoy settling can treat these patients in a second phase [6], the purpose of repeating as a further degree. This entails some danger because it can damage the neighbouring teeth's periodontium. Multilocular cystic lesion biopsy is reported because specific injuries, ameloblastoma, central giant granuloma of the cell or myxoma may be present. If one of the cystic lesions mentioned above is involved, however, it may be a further step to treat Carnoy's solution. For the botryoid cyst, a limited or even segmental resection may be defined depending on the patient's age and other patients. Most of the cysts with an extended cyst spacial keratocyst or unicystic ameloblastoma in the corner of the mandible. For all single cysts and definitely for margin cysts with pellet. This is right. Stoelinga [7] found no traditional Cysts reach into the ascending range of the lower third molar area in a

Table 1: The average of the cystic lesion [5].

No.	Tumours	%
1	Keratocystic odontogenic tumour	7 and 10%
2	Unicystic ameloblastoma	0.7%
3	Calcifying odontogenic cyst	0.6%
4	Glandular odontogenic cyst	0.3%
5	Cystic carcinoma in the wall of a cyst	0.2%
6	lateral periodontal cyst	less than 0.1%



retrospective analysis of 486 cysts of the jaws. Nevertheless, a follicular cyst can reach into the ascending ramus. The distant potential emerges. But multilocular or multi-lobular, with a deep section, may represent an incision biopsy, or a solid tumour. An aspiration can either be performed to determine the protein content or a cytological test can be performed. There is no infection. Keratocysts are expressive for apoprotein total, not exceeding 4 grams per 100 ml [8]. An incision is more likely to occur, most often infection. The period of time between biopsy and critical intervention will strengthen the keratocyst wall, which changes the keratocyst's epithelial function, for inflammatory penetration as in figure 1. It's almost difficult to locate the latest diagnosis. To find the new diagnosis virtually unlikely. In the case of the keratocystic odontogenic tumour, biopsies may not at most only be deputy because of local inflammatory infiltrations or because of the darkness of the neo-plasma biopsy is taken on the wall as in figure 1. Unicystic ameloblastomas have established tumour areas and are not necessarily contained in the wall. Adequate preparation of the ameloblastoma histopathology linear in the cyst's wall is proper [8]. Nonetheless, which diagnosis requires an oral pathologist's expertise, which might not always be prepared.

The cussed treatment for both Keratocystic Odontogenic Tumor and unicystic ameloblastoma, enucleation and cure of the bony defect is complete with haydroxipitate crystals. For a keratocyst hypothesis, the region where the cyst is connected to the inflated mucosa will be found. This will still be at the front of the outward ramus and at the tip of the tuberosity, in the case of the maxillary cyst. To detect the present puncture, a fine needle can be used for this purpose [9]. Removal of the mucoperiosteum in this area shall create and clarify the lingual and bucal oscopic wall figure 2. For a keratocyst hypothesis, the region where the cyst is connected to the inflated mucosa will be found. This will still be at the front of the outward ramus and at the tip of the tuberosity, in the case of the maxillary cyst. The actual puncture can be identified using a fine needle for this reason. Removal of the mucoperiostic in that area shall detect and expose lingual and bucal oscopic walls. In cases where the bony wall is treated by marcopolization, the solution of Carnoy will then be used to treat the tiny gauze in the solution and the cooker clamp to isolate the fault [10,11]. The procedure needs to be repeated multiple

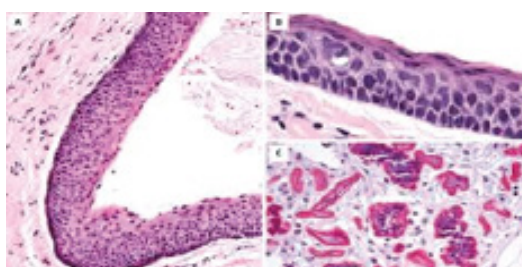


Figure 1: Keratocystic Odontogenic tumor [8].



Figure 2: Schematic construction of cyst incisions reaching through the assigning ramus in the mandible [10].

times to ensure that the whole ostrich wall is covered. Specific attention should be given to locations in which soft Tissues affected by the cyst, usually in the lingual position for keratocystic odontogenic tumour. Throughout these areas, electro-cauterisation may be used removing remains of a cyst wall that in these areas appears to break down. When osseous defects occur in the lower alveolar nerve, the canal should be separated prior to application of the Carnoy. Until a pad is used to fill the defect, the bone will be washed away with saline. This kit should be soaked with iodine or some other ointment in the Whitehead varnish. It can be left a week in place and replaced with a new box. The treatment will repeat for up to three weeks, depending on the severity of the loss, until the defect is completely epithelialized This very thin membrane quickly breaks, frequently leading to a smooth enucleation of the cyst; an overlying mucosal resection removes newly formed cysts in about 50% [12-14] of the epithelial islands or the microcysts. A prospectus analysis revealed the outcomes of the treatment for the above protocol [13]. Repetition again showed epithelial islands in an attached mucosa which in two cases overlap recurrent cysts. Research by both Gosau M, et al. (2010) and the systemic analysis by Blanas N, et al. (2000) supported the additional value of the Carnoy solution, though they did not recognise the location of the excised attachment mucosa [14,15]. The retrospective characteristics and the various follow-up periods have not been very difficult to differentiate between them from others. The findings of a Cochrane review are evident in this text [16].

Materials and Method

In our dental clinic managed 10 cases as dental cysts in 2018-2019, the patients have 6 male and 4 female. The age of patient between 25-40 year. They complain mainly swelling at the site of face 3 case in maxilla and 7 case in mandible, intraorally for mainly in labial mucosa anteriorly 3 for maxilla, and buccal mucosa 8 for mandible figure 3.

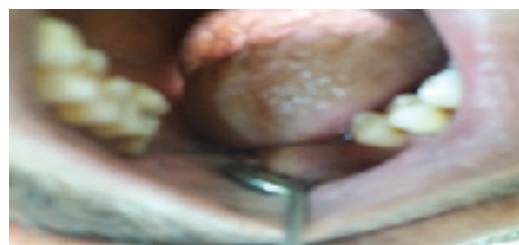


Figure 3: Labial and buccal swelling at right side of mandible.

The duration between 3 weeks to 16 months, the swelling increase gradually within the vestibule. Extraoral swelling in the upper labial vestibule 3, the lower buccal vestibule 6, extraoral at submandibular 2. The size of swelling is a very large range between 3-10 cm. The swelling is hard due to the increase in size gradually so lead to bony expansion but not perforation of the jaw. The swelling is not tender or fluctuant. The gingival and the skin is normal in colour, no lymph node enlargement. The diagnosis of the lesion depends on the clinical examination and radiographic investigation. The clinical examination was done under ordinary light of dental unite with a dental mirror. We examine the hardness, tenderness and fluctuation of the lesions. The lesion is too big the extraoral radiography used the orthopantography (OPG) figure 4 and figure 5.

Some maxillary lesion that related to maxillary sinus confirmed the lesion by the occipitomental view. We don't use laboratory investigation due to we don't open the lesion, but we depend on clinical examination and a radiographic sign of the cystic lesion. We take an impression for the jaw effected by cyst by alginate impression and cast it by stone. We

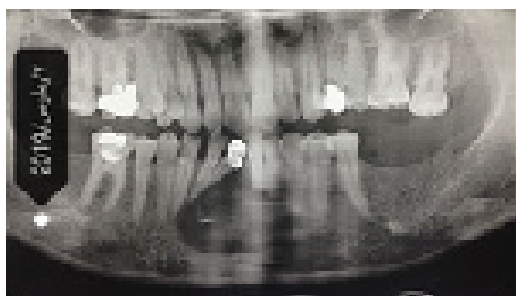


Figure 4: OPG seen big radiolucent cystic lesion at lower anterior segment between right 1st premolar to left 1st premolar.

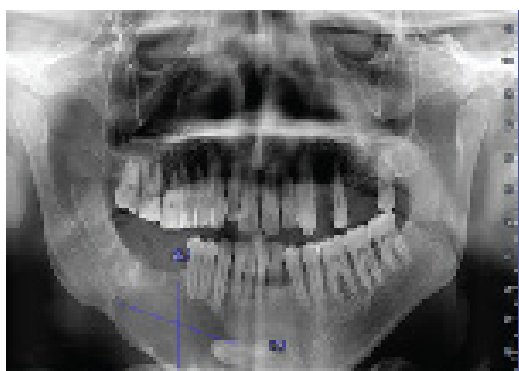


Figure 5: OPG seen big radiolucent cystic lesion with impacted lower right canine as in case figure 3.

make a hole in the site of the cyst conical in shape the base within the margin of the alveolar bone. The model cast power on it a base from hot cure acrylic to cover the occupying space. If edentulous the base has done to cover the edentulous space with retention clasp on the adjacent tooth to be stable during mastication and speech figure 6.



Figure 6: The acrylic appliance for case in figure 3.

We do an incision on the swelling area and open a window to insert the appliance figure 7.

The patient visited the clinic to investigated the case orally to diagnose if any infection or the size of the cyst is not smaller or any sign of failure base, and saint the patient for OPG to insure the radiographic finding of the cystic cavity, the duration between each visit two weeks until all sign of radiolucency change to normal radiopacity figure 8.

After that remove, the appliance and after seven days finale examination of the patient to have closed the opening figure 9.

Results and Discussion

The teen patients had treated in dental clinics in middle age between 20-40 year, will heath, the patients have systemic diseases not



Figure 7: The acrylic appliance inserted in the labial vestibule.

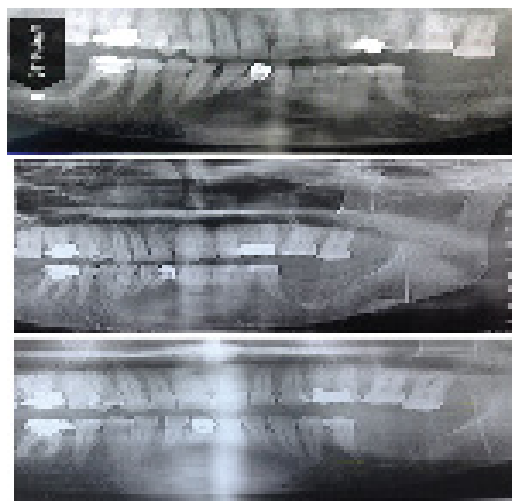


Figure 8: The patient at figure 4 serial radiography to see reduce in size of radiolucency.

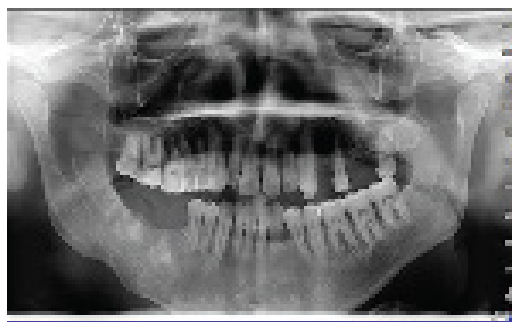


Figure 9: The patient at figure 3 and figure 4 finall radiography to see reduce in size of radiolucency.

included in the study. The gender of these cases, most of the male about 6 cases male and 4 cases female. The occupations of the cases were will dejected 5 cases student, other occupation, and only one case had a free job. The clinical features have all cases swelling in the vestibules and only 2cases had extraoral swelling. In the previous region of the maxilla, the radical cyst is more common; in ramus and corner of the mandible, odontogenic keratocysts and dentigerous cysts are more common. During the minimal follow-up time, no recurrences were observed [17]. The radiographic finding all cases odontogenic cysts, three cases with periapical lesions as will define radiolucency for the upper anterior teeth, one case for impacted teeth as the upper canine and 6 cases the third molar as will define radiolucency around the impacted teeth as a dentigerous cyst, cystic ameloblastoma, or cystic odontogenic keratocyst, and 2 cases with residual ridge as will define radiolucency as a residual cyst, cystic ameloblastoma, cystic



odontogenic keratocyst, or lateral periodontal cyst. We did not need to take biopsy due to the treatment depended on clinical and radiographic finding. The treatment of any odontogenic cyst by enucleation for the cyst within the jaw. Just by enucleation, the treatment of odontogenic keratocysts is more easily repeated. Adjunctive therapy may reduce the risk of recurrence. There is not a frequency of radical excision, but it has the highest morbidity rate and should be discreet after fusty medium for many recurrent cysts [18]. The odontogenic glandular cyst is an injury lesion. Lesions Treated either through enucleation or curettage, resulting in a high risk of recurrence. The first stage of a biopsy was recommended for large unicystic or multicystic lesions. The surgical treatment of multicystic cases is appropriate to induce peripheral ostectomy for unicystic case and marginal resections or partial jaw resections for broad lesions [19]. The marsupialisation of lesions approaching critical structures is an alternative, followed by a second-stage activity. In particular, with brows correlated with an increased peril [20]. Enable follow-up for at least three to seven years. The cyst size is effective in treating odontogenic cysts by decompression. For young patients, a shorter-term decompression is needed. Secondary primary procedure is recommended for attacking lesions. Our idea to decompress the cyst by put appliance with perforation to the cystic wall without need surgical operation. The result that formation of bone around the cyst till the cavity disappear clinically and radiographically. The patient had don't need any secondary surgery to remove the epithelial lawyer the remnant of the cystic wall. All cases were healed without any complication, and it is preferable for the patient and was not need for heavy dose of antibiotic or analgesic for a long period.

Conclusion

The attacker cysts of the jaws are common in the population that need surgical treatment with many complications as a recurrent cyst or not healed the site of cyst mainly if communicated with maxillary sinus, so the modification of marcepulization technique to be safer and less complication This method needs more cases to improve the result of an appliance which insert inside the patient mouth at the side of the cystic lesion reduce the cyst size and no need for a farther operation to remove the remnant part of the cyst.

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