Ameloblastoma of Gingiva - A Case Report
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Abstract
Peripheral ameloblastoma is a rare, but develops in the soft tissues of the gingiva and mucosa and exhibits an innocuous clinical behavior. This paper reports a case of peripheral ameloblastoma in a 35-year-old female that presented as a painless swelling on the mandibular anterior labial attached gingiva. This report emphasizes the need for submitting all excised tissue for microscopic examination and to include ameloblastoma in the differential diagnosis a gingival lesion which clinically resembles a pyogenic granuloma, peripheral giant cell granuloma, or parulis/gumboil.

Keywords: Ameloblastoma; Odontogenic tumor; gingiva
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Introduction
Ameloblastoma is a rather rare tumour occurring in the jaws. The first detailed description of this lesion was by Falkson in 1879, but the term ‘ameloblastoma’ was coined by Churchill in 1933. (1) It represents approximately one per cent of oral tumours, with 80 per cent of ameloblastomas occurring in the mandible, and develops from the odontogenic epithelium and its derivatives or remnants. Sometimes it arises from a dentigerous cyst. (2, 3) Peripheral ameloblastoma, a rare and unusual variant of odontogenic tumour, comprises about 1% of all ameloblastomas. (4) The extraosseous location is the peculiar feature of this type of tumour, which is otherwise similar to the classical ameloblastoma. (5) The best treatment is an initial extended surgical excision. (6) However conservative treatment can lead to a high recurrence rate of about 90%. (1) This paper reports a case of peripheral ameloblastoma in a 35-year-old female that presented as a painless swelling on the mandibular anterior labial attached gingiva.

Case Report
A 35 year old woman reported in the OPD of periodontics with a chief complaint of a painless swelling of the gums since 6 months. The patient had a slight asymmetry of the face due to the swelling on the left side. There was no lymphadenopathy and the patient was in good health. Intraoral examination revealed a firm soft tissue mass measuring 2.5cmX2cmX1cm in the buccal vestibule extending from the left lower canine to the second premolar with a slight displacement of the teeth involved (Figure 1).

Radiological examination revealed a multilocular cystic lesion extending from the lower left central incisor to the first molar showing displaced canine and second premolar. Extended surgical excision of the soft tissue growth followed by curettage was carried out and the mass was sent for histopathological evaluation. Pathology report showed tumor mass comprising of islands and interdigitating cords lined by ameloblastic epithelial cells with benign looking nuclei and proliferation of stromal cells in the islands. Foci of squamous metaplasia were present. The cords and follicles were separated by loose fibroconnective tissue and the diagnosis was a mixed follicular and plexiform type ameloblastoma (Figure 2).

Discussion
The peripheral ameloblastoma, also known as the extraosseous ameloblastoma, soft tissue ameloblastoma, ameloblastoma of mucosal origin, or ameloblastoma of the gingiva is a very uncommon odontogenic tumour. (5, 7) Philipsen et al reported that several authors refer to Kuru as having reported on the peripheral ameloblastoma for the first time in 1911. (5, 7)

Histologically, it resembles the intraosseous common ameloblastoma but is limited to the soft tissue of the gingiva. It is believed to arise directly from the overlying epithelium or from the remnants of the dental lamina located in the extraosseous soft tissue. (5, 9)
Patients have been documented from 23 years to 82 years of age, and lesions occur on the mandible twice as often as on the maxilla. There was no difference in location between the left and right side of the jaws. Our patient was 35 years old. The lesion was a 2.5 cm painless, non-ulcerated growth on the buccal attached gingiva of the premolars of the left mandibular region. The lesion was covered by normal mucosa with a smooth surface. Thus, this lesion is similar to those described in the literature. There was no radiological evidence of bone involvement. The lesions had an inferior margin that was superficial to the cortical bone.

The types of treatment that can be used include both radical and conservative surgical excision, curettage, chemical and electrocautery, radiation therapy or a combination of surgery and radiation. In our case the ameloblastoma was treated conservatively in February 2009 and so far there has been no recurrence. The prognosis of patients afflicted with this form of neoplastic disease is favorable, since it is essentially a local problem.

Conclusion
In conclusion this reports emphasis the need for submitting all excised tissue for microscopic examination and to include ameloblastoma in the differential diagnosis a gingival lesion which clinically resembles a pyogenic granuloma, peripheral giant cell granuloma, or parulis/gumboil.

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