

## Subarticular, cystlike lesion associated with avascular necrosis of the mandibular condyle: a case report

Jie Lei, DDS,<sup>a,b</sup> Mu-Qing Liu, DDS,<sup>a,b</sup> Adrian U. Jin Yap, PhD, MSc, BDS, GradDip Psychotherapy, FAMS,<sup>c,d,e</sup> and Kai-Yuan Fu, DDS, PhD,<sup>a,b</sup> Beijing, Peoples Republic of China, and Singapore  
Peking University, National University of Singapore, SIM University, and Alexandra Hospital and Jurong Medical Centre

Little is known about avascular necrosis of the mandibular condyle, which is necrosis of the epiphyseal or subarticular bone secondary to a diminished or disrupted blood supply in the absence of infection. We present a case of a large subarticular cystlike lesion that was found using cone-beam computed tomography (CBCT). There was an absence of osteoarthritis, and the condylar articular surface was relatively intact. The patient's history, physical examination, and magnetic resonance images supported the diagnosis of avascular necrosis of the mandibular condyle. After 4 months of conservative therapy, new bone was observed in the cystlike marrow lesion, and a smooth articular surface was reestablished. Subarticular cystlike lesions without the collapse of the articular surface of mandibular condyles may be an early indicator of avascular necrosis. (*Oral Surg Oral Med Oral Pathol Oral Radiol* 2013;115:393-398)

Avascular necrosis (AVN), also known as ischemic necrosis or aseptic necrosis, has been defined as necrosis of the epiphyseal or subarticular bone secondary to a diminished or disrupted blood supply in the absence of infection.<sup>1</sup> The condition affects vulnerable areas such as long-bone epiphyses and usually involves femoral heads and hip joints.<sup>1-3</sup> Although radiographic diagnostic criteria for AVN of the femoral head varies, one specific sign is a demarcating sclerosis and radiolucency that presents as a cystlike lesion without collapse of the femoral head.<sup>1,4</sup>

Seven stages of radiological involvement are identifiable in hips affected with AVN. The stages (0 to VI) are based on the severity of the AVN and involvement of the articular surface.<sup>5</sup> In stage II, radiographs indicate radiolucent, cystlike lesions and sclerotic changes. Normal bone is sometimes demarcated from affected bone by a sclerotic border. In stage IV, flattening of the spherical contour of the femoral head arises from collapse of the necrotic segment compromising the artic-

ular cartilage. This frequently results in hip osteoarthritis and progression to stage VI for which there is advanced degeneration and loss of the cortical bony plate of the articular surface. This corresponds somewhat to the Ficat classifications for femoral head: no radiographic abnormality (stage I) to osteoarthritis (stage IV) with the presence of cystlike lesions occurring in stage II.<sup>6</sup> Cystlike lesions may thus be an early indication of AVN with the joint having a radiographic normal contour at this stage.

For the present case, we found (with cone-beam computed tomography [CBCT]) a relatively large, subarticular, cystlike lesion with normal mandibular condyle contours. There was no radiographic evidence of osteoarthritis/collapse of the articular surface. After 4 months of conservative therapy, new bone was observed in the cystlike marrow lesion and a smooth articular surface was reestablished. Our diagnosis was AVN of the mandibular condyle. Treatment, as well as the differential diagnosis, are presented.

### CASE REPORT

In April 2011, a 25-year-old woman presented to the Center for Temporomandibular Disorders and Orofacial Pain, Peking University School and Hospital of Stomatology. The woman complained of pain and of a deviated mandibular opening that had persisted for 2 months. She also reported painless, right temporomandibular joint (TMJ) clicking and for approximately 2 years intermittent closed-locks. Her maximal mouth opening was 31 mm. Mandibular opening was associated with moderate, right-TMJ pain on translation, and mandibular excursion to the left was limited. Head-and-neck examination revealed no evidence of adenopathy, paresthesia, or motor nerve deficiency. The patient's general medical/dental history was unremarkable, and there was no history of trauma, alcohol abuse, previous TMJ surgery, or previous steroid injection into the TMJ.

The authors have no financial or personal relationships with other people or organizations that could inappropriately influence (bias) their work.

<sup>a</sup>Center for TMD and Orofacial Pain, Peking University School and Hospital of Stomatology, Beijing, Peoples Republic of China.

<sup>b</sup>Department of Oral & Maxillofacial Radiology, Peking University School and Hospital of Stomatology, Beijing, Peoples Republic of China.

<sup>c</sup>Faculty of Dentistry, National University of Singapore, Singapore.

<sup>d</sup>School of Science and Technology, SIM University, Singapore.

<sup>e</sup>Alexandra Hospital and Jurong Medical Centre, Jurong Health Services, Singapore.

Received for publication July 18, 2012; returned for revision Oct 10, 2012; accepted for publication Oct 19, 2012.

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2212-4403/\$ - see front matter

<http://dx.doi.org/10.1016/j.oool.2012.10.024>

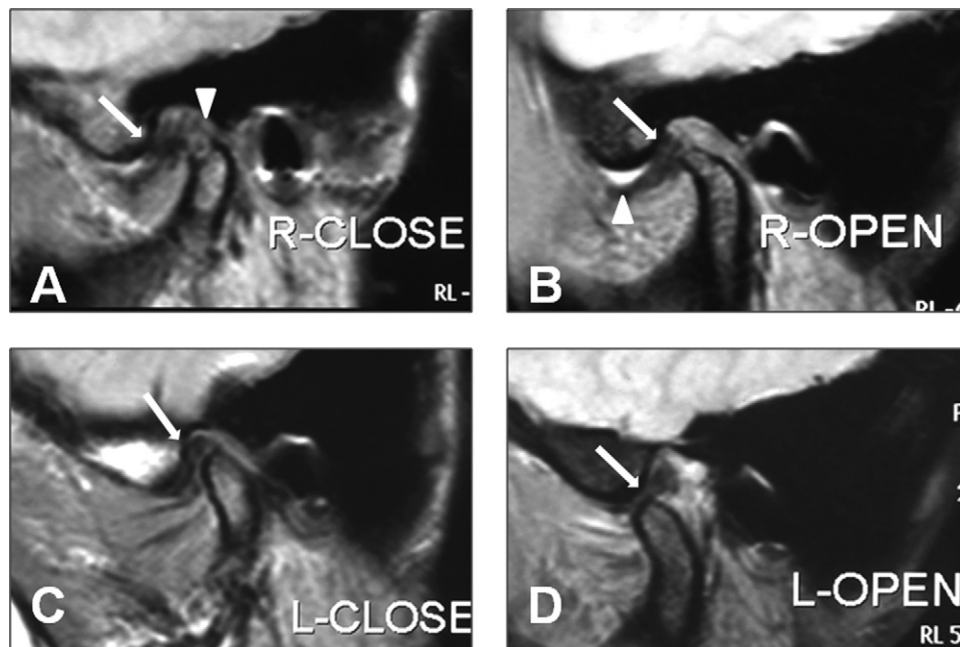


Fig. 1. MR proton-density-weighted images of the bilateral TMJs. **A**, Right TMJ in the closed-mouth position. The disk was anteriorly displaced (*arrow*) and the dark signal in condylar, articular, cortical bone was absent. A focal abnormal signal area in the subchondral region was observed with a low signal in the center. The round lesion was surrounded by a low-signal band demarcating a line with bone marrow of the condyle (*arrowhead*). **B**, Right TMJ in the opened-mouth position. The disk was still anteriorly displaced without reduction (*arrow*), and there was joint effusion in the upper compartment of the joint space (*arrowhead*). **C**, Left TMJ in the closed-mouth position; **D**, left TMJ in the opened-mouth position. Both show normal disk position (*arrow*) and condylar contours.

Magnetic resonance (MR) imaging (1.5 Tesla; Siemens Sonata, Erlangen, Germany) was performed in a local hospital. Proton-density (repetition time 3490 ms, echo time 17 ms) weighted images (3-mm thick, 16-cm field of view) formatted in oblique sagittal planes in both the closed- and open-mouth positions indicated anterior disk displacement without reduction in the right TMJ (Figure 1, A and B). The left TMJ was normal (Figure 1, C and D). A localized round abnormal area in the subarticular region (displaying intermediate signal intensity with a low signal in the center) was observed. The round lesion was surrounded by a low-signal band demarcating a line with the bone marrow of the condyle (Figure 1, A). As degenerative changes of the condyles were suspected, CBCT (3DX MultiImage micro CT; J. Morita Mfg Corp., Kyoto, Japan) of the bilateral TMJs was performed.

After scanning the TMJ, serial images (1.0-mm slice thickness and interval) of the condyle were axially, sagittally, and coronally reconstructed. All images were viewed digitally, and 2 typical images in axial, coronal, and sagittal sections were analyzed (Figure 2). CBCT images showed the bony structures, including the cortical bone on the articular surface, as well as the subcortical cancellous trabecular structure. A cystlike radiolucent lesion about  $5.0 \times 4.8$  mm in size (coronal images) was detected under the articular surface of the right condyle. A demarcating sclerosis was seen around the cyst, and the overlying cortical bone was discontinuous (Figure 2, A and B). The contour of the affected

condyle was, however, almost normal, and no other radiographic sign of osteoarthritis was found. There was also no radiographic evidence of osteoarthritis on the temporal side of the joint.

Based on all the information obtained and MR diagnostic criteria,<sup>7,8</sup> a diagnosis of AVN of the right mandibular condyle was made. The patient was treated by arthrocentesis,<sup>9</sup> using 0.9% saline under local anesthesia followed by pharmacotherapy with nonsteroidal anti-inflammatory drugs for a week. Physical therapy including laser therapy, home moist-heat treatment, and patient self-care instructions were given. Four months later, the patient re-visited our clinic and reported improvement of her jaw health with decreased joint pain, normal mandibular function, and a maximal mouth opening of 40 mm. Her follow-up CBCT indicated that the destructive changes of the condyle had almost resolved (Figure 3). A smooth articular surface was reestablished, and new bone formation was observed within the cystic lesion (Figure 3, A and B).

## DISCUSSION

AVN of the mandibular condyle was first reported in 1979.<sup>10</sup> Subcortical radiolucencies in lateral tomograms were later confirmed by histologic examination as AVN.<sup>10</sup> CBCT images provide superior reliability and greater accuracy than tomography and panoramic projections in the detection of condylar bone.<sup>11</sup> CBCT

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