Calcifying epithelial odontogenic tumor: a case report

Stylianos Zanakis, DDS, MSc,[a] Maria Faippea, DDS, MD,[a] Christina Dicoglou, MD,[a] and Christos Dendrinos, DDS, MD,[b] Athens, Greece
"HIPPOCRATION" GENERAL HOSPITAL OF ATHENS

Calcifying epithelial odontogenic tumor (CEOT) is a rare benign lesion. A case of CEOT in the left mandible of a 46-year-old man is presented. This case is exceptionally unusual because it was left untreated for 10 years, indicating in some way the course of the tumor. Histologic findings both at the time of first diagnosis and at the final treatment 9 years later were identical. **(Oral Surg Oral Med Oral Pathol Oral Radiol Endod 2011;112:e117-e120)**

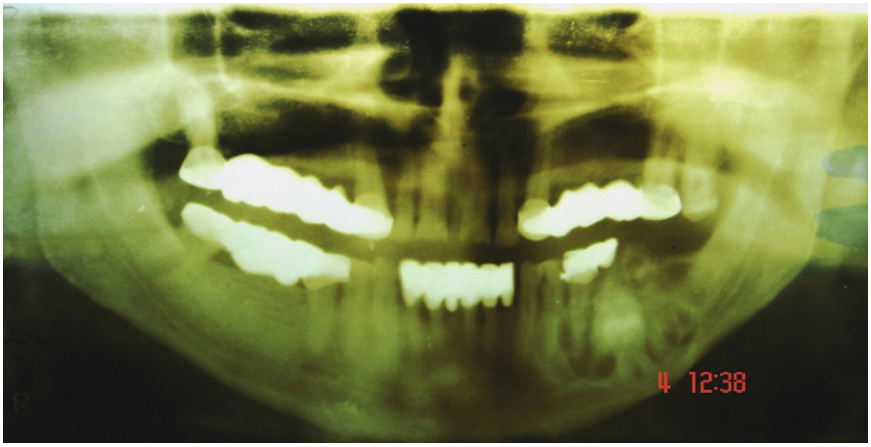

Fig. 1. Orthopantomogram depicting the lesion 9 years before.

The calcifying epithelial odontogenic tumor (CEOT), also named Pindborg tumor after the pathologist who described it in 1955,[1,2] is an uncommon benign locally invasive tumor. It usually involves the premolar-molar area of the mandible,[2] there is no gender predilection,[6] and the peak incidence is found between the fourth and fifth decades of life. A peripheral soft tissue variant of the lesion has been described as well as a malignant one.[7,8]

CASE REPORT

A 46-year-old caucasian male patient, an economic refugee, presented to the outpatient department complaining of a swelling in his lower left jaw. The mass was painless, increasing slowly in size over the years, and lately causing difficulty in mastication. The mass was first noticed by the patient more than 10 years before. The patient reported that a biopsy was taken from his lower left jaw 9 years before. The

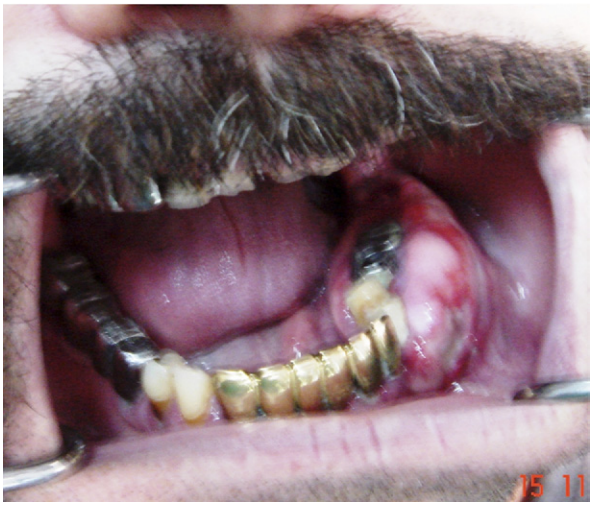

Fig. 2. Preoperative clinical appearance.

[a]Department of Maxillofacial Surgery.
[b]Department of Pathology.
Received for publication May 22, 2011; returned for revision June 9, 2011; accepted for publication June 14, 2011.
1079-2104/$ - see front matter

doi:10.1016/j.tripleo.2011.06.007

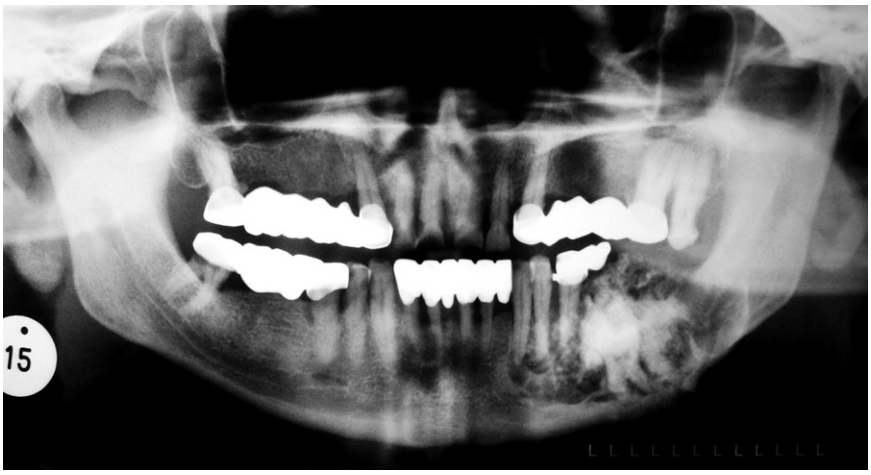

Fig. 3. Radiographic image of the tumor at the time of treatment.

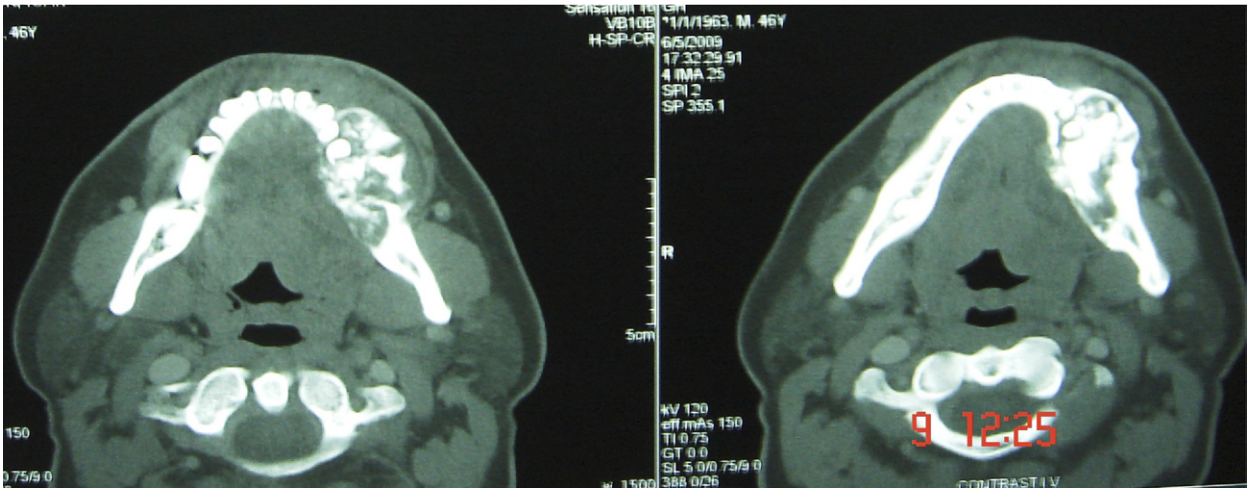

Fig. 4. Axial computerized tomographic scan depicting the bone lesion.

histopathology report confirming the presence of a CEOT and a pantomogram of bad quality, but still revealing the radiographic appearance of the lesion, could be retrieved from that period (Fig. 1). The patient refused treatment at that time.

Nine years later, extraoral examination showed slight fullness and asymmetry of his lower left face. The lower border of the mandible on palpation gave the impression of a dome-shaped expansion in the premolar area. There was no cervical lymphadenopathy clinically. Intraorally, the lesion, firm in palpation, occupied the left mandible from the canine to the retromolar region with expansion of the lingual and buccal plates. The bridge work on that side appeared almost sunk into the lesion. The inferior alveolar nerve was unaffected (Fig. 2).

The orthopantomogram revealed a mixed radiopaque-radiolucent endosseous lesion of the left mandible extending from the left lower canine to the area in front of the angle of the mandible. The lower border of the mandible was also affected

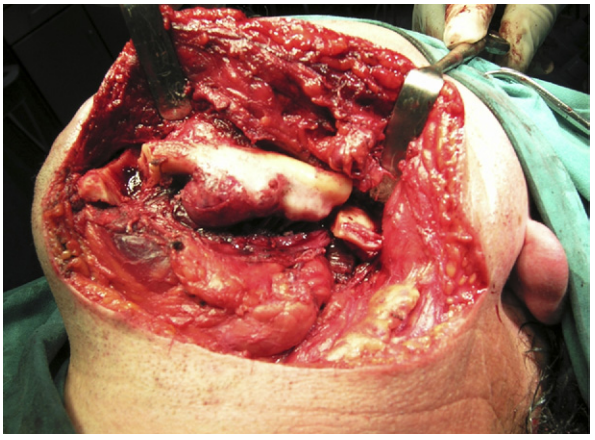

Fig. 5. Perioperative image showing the extend of mandibular resection.