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Case Report

Adenomatoid Odontogenic Tumor Involving Maxillary Dental Arch – Case Report

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Abstract: A rare adenomatoid odontogenic tumor (AOT) was reported by a young 14-year-old female student that was associated with missing teeth. The patient did not have any significant medical or dental abnormalities except for a swelling in the right side of the face. Radiographic investigations showed a mixed radiolucent and radiopaque lesion associated with few missing teeth. The maxillary sinus was obliterated. The lesion was surgically excised, and a histopathological examination confirmed the diagnosis of AOT. The patient was later successfully rehabilitated with a removable partial prosthesis.

Keywords: Odontogenic Cysts, Odontogenic Tumor, Ameloblastoma, Torus Palatinus, Odontoma.

INTRODUCTION

Adenomatoid odontogenic tumor (AOT) is a relatively rare, unique odontogenic neoplasm first identified by Steensland in 1905 [1]. Numerous terms such as adenoameloblastoma, ameloblastic adenomatoid tumor, adamantinoma, epithelioma adamantinum, and teratomatous odontoma have previously been employed to describe the lesion now referred to as AOT [2]. Philipsen (1971) characterised it as an odontogenic epithelial neoplasm that exerts an inductive influence on the odontogenic mesenchyme [1]. The lesion's nature is ambiguous and may be hamartomatous instead of genuinely malignant. Owing to the gradual growth and limited extent of the lesion, it is categorized as a hamartoma rather than a genuine tumor [3]. The histogenesis of AOT remains ambiguous; nevertheless, current evidence strongly suggests that AOT originates from a complex network of dental laminae or their remnants. Genetic and environmental factors may also play a role in its development. The tumor is characterized by its encapsulated nature and typically does not invade surrounding bone or soft tissue structures.[2] It can be categorized based on location as Follicular, Extra follicular and Peripheral [4]. Clinically it typically manifests in the second and third decades of life. More prevalent in females than in males (2:1) [1-4]. The majority of tumors originate in the anterior region of the maxilla, particularly in the canine areas [2], the patient generally reports the absence of a tooth [5]. The lesion typically manifests as an asymptomatic, gradually enlarging swelling, frequently linked to an unerupted tooth [2-4]. The uncommon peripheral variation predominantly manifests in the gingival tissue of tooth-bearing regions [6]. Unerupted permanent canines are the teeth most frequently associated with AOT [1-5]. The tumor rarely surpasses 3.0 cm in maximum diameter [4-7]. Extensive lesions may result in asymptomatic bone enlargement, which may then give a clinical picture of other bony pathological or physiological enlargements [8]. It is known for its slow growth and asymptomatic nature, often being discovered incidentally during routine radiographic examinations. Patients may exhibit facial asymmetry or swelling, but pain and other symptoms are rare unless the tumor reaches a considerable size. On radiographs, it exhibits a follicular association with the impacted tooth; nevertheless, it does not adhere at the cementoenamel junction but encircles the majority of the tooth, most frequently a canine. Recent advancements in imaging techniques also play a

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crucial role in the management of Adenomatoid Odontogenic Tumor. The advent of three-dimensional imaging, including cone-beam computed tomography, has enhanced the precision of diagnosing and planning surgical interventions. Enhanced visualization can lead to more refined surgical approaches, minimizing the risk of damaging adjacent structures [9]. Artificial intelligence enhanced radiographs show clear delineated, unilocular radiolucency with a corticated or sclerotic margin [10]. The multilocular variation is also documented, supporting the existence of numerous AOTs [11]. Radiopacities may manifest in two-thirds of instances [7]. It may be entirely radiolucent or may exhibit faint to dense clusters of indistinct radiopacities. Snowflakes like structures are observed near the perimeter [7]. The lesion may exhibit a characteristic target appearance, featuring a radiolucent circumferential halo surrounding a thick, central radiopaque mass [10]. As the tumor enlarges, it displaces adjacent teeth, inhibits the eruption of impacted teeth, induces hypoesthesia, and leads to root resorption [12]. The cortices may expand, although the outer cortex remains intact. When in the vicinity of the sinus, it will encroach upon the maxillary sinus [13].

The diagnosis is determined on the histopathological features observed in association with the structures involved. The tumor consists of typically dispersed ductal structures, eosinophilic substances, various forms of calcifications, and a fibrous capsule of inconsistent thickness [14]. Certain cells are organized in clusters, often surrounding microscopic foci of eosinophilic material, referred to as "hyaline droplets" or "tumor droplets." [15]. Ductlike or microcyst lumina are often bordered by an eosinophilic rim of variable thickness, referred to as the "hyaline ring." [14]. Lumina of duct-like structures is referred to as eosinophilic coagulum. The tumor consists of spindle-shaped or cuboidal epithelial cells arranged in a variety of patterns, including whorled, duct-like, and rosette formations [7-14]. These cells are embedded in a fibrous stroma, often containing areas of calcification. The presence of amyloid-like material and eosinophilic droplets within the epithelial cells is also notable. Immunohistochemical staining techniques can further assist in the diagnosis of AOT [16]. The tumor cells typically show positive staining for cytokeratins, particularly CK19, which is a marker for odontogenic epithelium [16, 17]. Other markers, such as vimentin and SMA (smooth muscle actin), may be variably positive, reflecting the tumor's complex histogenesis. AOT must be differentiated from other odontogenic lesions, such as dentigerous cysts, ameloblastomas, and calcifying epithelial odontogenic tumors (CEOT) [4-14]. Key distinguishing features include AOT's association with the crown of an unerupted tooth, its well-defined radiographic appearance, and the characteristic histopathological findings. Accurate diagnosis is crucial to avoid unnecessary aggressive treatment. The treatment of choice for AOT is conservative surgical excision. Enucleation of the tumor, along with the associated impacted tooth if present, is typically curative. The encapsulated nature of AOT facilitates complete removal, and recurrence is exceedingly rare. The defects should be covered with splints after surgery, and permanently with prosthetic rehabilitations depending upon the structures removed [18, 19]. Postoperative follow-up is recommended to monitor for any signs of recurrence, though the prognosis is generally excellent [7]. The prognosis for patients with AOT is overwhelmingly positive. The tumor's benign behavior, combined with effective surgical management, results in a high rate of cure and minimal complications. Long-term outcomes are favorable, with most patients experiencing no recurrence or functional impairments [2-7].

CASE REPORT (Figure 1A)

A 14-year-old female student reported swelling in her upper right back tooth region for three months. Initially asymptomatic, she noticed swelling growing and rounding her cheek 20 days ago, prompting her to seek medical help due to anxiety. The patient's past medical and dental history was not relevant to the condition. The patient followed a vegetarian diet, and involved daily oral hygiene maintenance after.

Figure 1: (A) Frontal view of the patient showing asymmetrical face (B) Right side of the face showing swelling (C) right lateral view of the face showing obliteration of nasolabial and other less prominent skin grooves (D) Intra oral view showing swelling in relation to posterior palate

Meals the individual had no significant debilitating or traumatic habits, no significant social history, was living in a nuclear family with a mother, father, and younger sibling. The patient's general examination revealed normal gait with ectomorphic build, nails, sclera, blood pressure, pulse of 84 bpm, temperature of 98.6 Fahrenheit, and no evidence of jaundice, cyanosis, skin lesions, clubbing, pallor and icterus. The patient's systemic history and examination revealed no abnormalities in the CNS, respiratory, GIT, bowel, or cutaneous areas, indicating good orientation, bilateral air entry, and no other sounds (wheeze). The extraoral examination revealed facial asymmetry on the right side of the face and unilateral swelling on the right side **(Figure 1 A, B, C)**. The angle of the right side of the mouth was not at the same level as that on the left side. The TMJ exhibits normal mouth opening, absent tenderness, no clicking, and no deviation, with lymph nodes being non-tender and non-palpable. Intraoral examination revealed no abnormalities in buccal mucosa, palatal, gingiva, alveolar mucosa, floor of mouth, and tongue in the mandibular arch. In the maxillary right region, there was a solitary swelling, while showing no abnormalities of alveolar mucosa, except for intense redness in the mucosa over the swelling **(Figure 1D)**. Stains and calculus were both present in significant amounts. Bleeding on probing was observed in relation to teeth 11, 12, 21, and 22. Any gingival recession, tooth mobility, root fragments, tooth hypoplasia were not present. The occlusal examination revealed a class I molar relationship, no defined canine relationship, no signs of trauma, no significant overjet/overbite, and no significant tooth wear pattern.

***Examination of Area of Interest*:**

The patient's extraoral examination revealed facial asymmetry, diffuse swelling in the right maxillary region, non-tender, hard-consistent swelling, and no sinus tract opening present. Intraorally, a unilateral solitary swelling was observed in the right maxillary premolar region, expanding buccally, measuring 3.83 cm by 3.62 cm in diameter. There were retained primary teeth lateral incisor and canine of that region. The teeth that were absent included permanent lateral incisor, canine, first and second premolar of that side. The swelling was non-tender and exhibited a firm consistency. The bucco-palatal enlargement concerning the first quadrant was occluding and obliterating the buccal vestibule. No tenderness on percussion, vestibular soreness, tooth mobility was noticed in the region of interest. A provisional diagnosis of a benign neoplasm of odontogenic origin was made with differential diagnosis like ameloblastic fibroma, ameloblastic fibro-odontoma, calcifying epithelial odontogenic tumor based on the specific clinical features.

***Investigations*:**

Tooth vitality assessment was conducted using an electric pulp tester (EPT) which indicated that all adjacent teeth were vital (#11, #42, #43, and #16). A complete blood count (CBC) and standard blood examinations were recommended which yielded normal results. Fine needle aspiration cytology (FNAC) was performed which expunged abundant red blood cells accompanied with scattered inflammatory cells, predominantly neutrophils and lymphocytes, within a homogeneous eosinophilic background. On an orthopantomogram (OPG) a mixed radiopaque and radiolucent lesion with indistinct boundaries was observed in the region of the right maxillary central incisor, canine, premolar, and molar **(Figure 2A)**. Lesion was extending from the mesial aspect of the maxillary right central incisor to the distal region of the second molar, with superior extension into the right maxillary sinus when observed under various sections of cone beam computed tomography (CBCT) **(Figure 2 B-E)**. The CBCT findings included a mixed radiopaque lesion with ill-defined margins with approximate size [30 mm anteroposteriorly, 40 mm mediolaterally, 39.2 mm superioinferiorly]. The affected teeth were found to be right maxillary incisor, canine, premolar and molar. Maxillary sinus was also affected causing its obliteration. Evidence for cortical plate thinning and expansion of alveolar bone was also observed. Radiographic differential diagnosis included odontogenic myxoma, calcifying epithelial odontogenic tumor, fibrosseous lesion, ossifying fibroma involving the right maxillary alveolus in relation to the affected teeth. Significant dense.

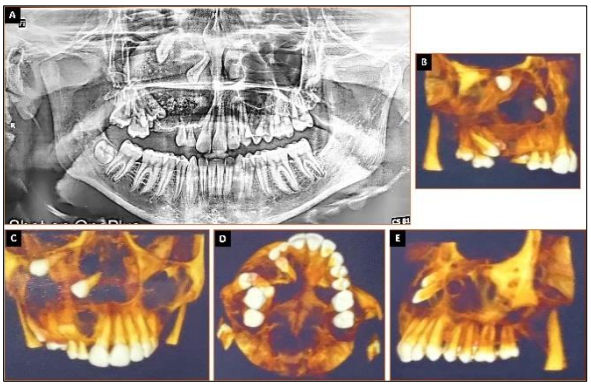

Figure 2: (A) Orthopantomograph showing lesion on the right side (B-E) cone beam computed tomography sections showing lesion and its relation with adjacent structures

Figure 3: (A, B) Two OPG (orthopantomograph) showing calcifications in relation to the lesion

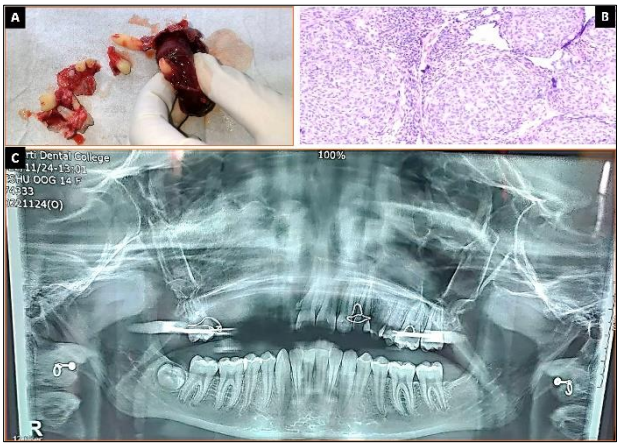

Figure 4: (A) The lesion removal along with teeth (B) Histopathological findings confirming the diagnosis (C) OPG post removal and healing showing loss of multiple teeth due to extraction

Calcifications were observed in the frontal view **(Figure 2C), (Figure 3 A, B)**. In the mandibular arch, the right mandibular last molar was impacted. The treatment plan consented by the patient was enucleation and curettage, which was performed under anesthesia **(Figure 4A)**. Surgery was performed using all guidelines for infection control of surgical instruments [20], while maintaining a strict aseptic surgical area during surgical removal of the lesion.[21] Surgical findings include expansion of the alveolar bone with intact cortex, with lump exhibiting a smooth, well-defined capsule of varied thickness **(Figure 4A)**. Cytosmear examination of the aspirate stained with hematoxylin and eosin and geimsa stain showed numerous red blood cells with dispersed inflammatory cells mainly neutrophils, lymphocytes with a homogenous eosinophilic background **(Figure 4B)**. All findings indicate the final diagnosis of adenomatoid odontogenic tumor. Due to the consistently benign biological behavior of almost all typical AOTs and the reliable existence of a well-formed fibrous capsule, conservative total surgical excision, typically performed through enucleation and curettage is the preferred treatment. With a recurrence rate being low, the patient was asked to follow up initially every three months for a year, later every year for 5 years. The patient was further referred to the department of prosthodontics, for prosthetic rehabilitation which was successfully done with a removable partial denture.

DISCUSSION

In contrast to ameloblastomas, AOT is a benign, nonaggressive neoplasm characterised by restricted growth and an absence of recurrence propensity. This is frequently misidentified as an odontogenic cyst and constitutes around 1% to 9% of all odontogenic tumors [22]. It primarily occurs in young female patients, is more frequently situated in the maxilla, and is generally linked to an unerupted permanent teeth [15]. AOT has several distributed or clustered radiopaque foci, in contrast to the calcification shown in calcifying cystic odontogenic tumors, which display a narrow radiopaque line and distinct radiopaque foci [7]. Consequently, radiolucency accompanied by multiple radiopaque foci, especially when the radiolucency encircles part of the root or the entire tooth, indicates an AOT rather than a calcifying cystic odontogenic tumor [12]. Hamartomas are abnormal tissue proliferations that are indigenous to the region and lack the ability for continuous growth, instead growing in tandem with the host's development. The differentiation between a hamartoma and a benign tumor is frequently arbitrary. AOT predominantly occurs in the maxilla (67.2%) as opposed to the mandible (32.8%), resulting in a maxilla-to-mandible ratio of

2.1:1, with a female-to-male ratio of 1.4:1 for the maxilla and 2.1:1 for the mandible [1-14]. The anterior portion of the jaw is significantly more affected (81.1%) than the mid (18.0%) and posterior regions (0.9%) [1-5]. Moreover, the right side (53.1%) was marginally more impacted than the left side (46.9%) [4-13]. The maxilla-to-mandible ratio of AOT previously reported is 2.3:1.10. Two analogous investigations conducted globally demonstrated a maxillary inclination, with maxilla-to-mandible ratios of 1.25:1, 1.8:1, 1.9:1, and 2:1 [23, 24]. Apical cysts, dentigerous cysts, calcifying epithelial odontogenic cysts, odontogenic keratocysts, periapical granulomas, and central giant cell granulomas are common non-neoplastic causes of jaw swelling in this age range [25].

The histology of the three clinicopathologic forms of AOT namely peripheral, intraosseus extrafollicular, and intraosseus follicular remains the same. An impacted tooth is associated with the follicular form of AOT, which is a central intraosseus lesion; an unerupted tooth is not related to the extrafollicular intraosseus type [1-4]. Regardless, you can find it positioned above, between, or even on top of the roots of neighbouring teeth that have erupted. A fibroma or epulis connected to the labial gingiva is the outward manifestation of the peripheral variation. Follicular AOT accounts for 71% of all occurrences, whereas extrafollicular AOT accounts for the remaining 96 the majority of diagnoses occur between the ages of 13 and 19, which accounts for more than two thirds of the total [1-7]. The highest occurrence was identified in Japan (3:1) and Sri Lanka (3.2:1), all of which are located in Asian populations [23-26].

From a broader perspective, the significance of Adenomatoid Odontogenic Tumor extends beyond its medical implications. The tumor serves as an informative marker in understanding odontogenic tissue behavior. It has a great academic interest, since the lesion may be interpreted by students as a tumor of odontogenic origin, because of the growth [27], patients who observe growth in and around the oral region often neglect the significance of seeking early intervention [28], which is generally life threatening if the tumor has a malignant potential. The research on this tumor has expanded in recent years, with studies investigating its molecular biology and genetic factors. These insights open new avenues for future investigation into the etiology and optimal management of odontogenic tumors. Natural formulations have been reported to be effective in cancer cell migration [29].

One of the significant findings of this case was that the lesion occurred in a student who was really concerned about the nature of the swelling inside her mouth. Students' perception about oral health have been reported to have a significant effect on the treatment outcomes [30], while young adults are more concerned about their oral health, elderly people have been reported to be more neglectful about oral health including oral cancers [31], additional nonspecific conditions also need to be taken into consideration during differential diagnosis, commonly seen in the region like bony exostoses or space infections [32, 33].

Looking into the future, the ongoing research may yield promising developments in biomolecular studies of Adenomatoid Odontogenic Tumor. Understanding the molecular pathways involved in its pathogenesis could lead to the identification of potential therapeutic targets. This knowledge could contribute to the development of targeted therapies, which would represent a significant shift in managing odontogenic tumors. Ongoing research aims to elucidate the molecular and genetic basis of AOT, which may uncover novel therapeutic targets and improve diagnostic accuracy. Advances in imaging techniques and minimally invasive surgical approaches also hold promise for enhancing patient outcomes. Collaborative efforts among dental professionals, oral surgeons, and researchers are essential to advancing the understanding and management of this rare tumor.

CONCLUSION

Adenomatoid Odontogenic Tumor is a unique benign neoplasm that presents interesting challenges in diagnosis and treatment. While it is characterized by its specific clinical and histological features, understanding its broader implications within odontology can contribute greatly to the field. The ongoing research into its biological behavior, coupled with advancements in surgical techniques and imaging modalities, suggests that clinicians will be better equipped to manage this condition in the coming years. As the field progresses, the insights gained from studying Adenomatoid Odontogenic Tumor could pave the way for improved practices and outcomes in the management of various odontogenic lesions.

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Conflict of Interest: None

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