

Differential Diagnosis of Radiolucent Lesions

Lesions of endodontic origin (LEO) cause periradicular bone resorption which presents as a radiolucent lesion on a radiograph. Teeth with LEO's do not respond to cold or electric pulp tests.

What if a radiolucent lesion is detected on the radiograph, but the associated / adjacent teeth are vital? Here is a brief description of some of the more common non-endodontic radiolucent lesions.

Ameloblastoma: Usually posterior mandible. Can be uni / multi locular. Aggressive but benign. Patients are usually symptom free. May cause bony expansion and destruction of bone / tooth.

Ameloblastic Fibroma: Occurs in younger patients, primarily posterior mandible, uni / multi locular, slow growing lesion. Patients are usually asymptomatic.

Giant Cell Granuloma: Usually mandible (PM / anterior) teeth. Occurs in young adults. May be aggressive. Uni / multi locular. Causes bone destruction and/or expansion of mandible. May cause tooth resorption.

Dentigerous Cyst: Usually associated with unerupted/ impacted third molars and maxillary canines. Unilocular. Can be destructive.

Globulomaxillary Cyst: Fissural cyst. Occurs between maxillary lateral / canine. Unilocular.

Keratocyst (Odontogenic keratocyst): Occurs primarily in posterior mandible. Uni / multi locular. High tendency to reoccur. Causes bone destruction / root resorption.

Nasopalatine Duct Cyst: Occurs in the maxilla between the central incisors. Unilocular. Usually no resorption of teeth.

Residual Cyst: Cyst that remains after extraction of a tooth.

Traumatic Bone Cyst: Usually occurs in mandible. Uni / multi locular. Scalloped borders which extend between the teeth.

Referral to a specialist for evaluation / biopsy and treatment is advisable.

Next month we will review various radiopaque lesions.

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