Enucleation after Marsupialization: A case report of Globulomaxillary Cyst

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INTRODUCTION

Globulomaxillary cyst is a rare cyst found between lateral incisor and canine in maxilla. Also it is known as fissural cyst at the junction of maxillary process and medial nasal process. It starts from non-odontogenic epithelium constitutes about 17% of all non-epithelial and non-odontogenic cysts of maxilla and mandible. (1)

It is usually found clinically by routine radiographic examination. Sometimes presents as a soft reddish swelling in the labial aspect of maxilla at cuspid region. Swelling may extend also at palatal side. Crown of lateral incisor and canine may diverse and extraorally, obliteration of nasolabial fold is found. Radiographically, it is well-defined radiolucent lesion and most of the time the shape is inverted pear like. (2)

The established treatment of the jaw cysts is the enucleation that is excision of cyst with lining or can perform marsupialization before enucleation. Marsupialization is a procedure of creating a bony window in overlying mucoperiosteum and suturing the mucosal boarder with cystic wall which allows decreasing intra-cystic pressure and increasing bone growth before enucleation. Marsupialization is done when the cyst is large enough and enucleation might cause damage to adjacent tooth root and vital structures such as mental nerve, inferior alveolar nerve, maxillary sinus etc. It has also having the risk of pathological fractures. (3)

This article reports the treatment of a globulomaxillary cyst by marsupialization followed by enucleation as it is a large cyst and to preserve the dentition, avoid penetration into nose and prevent the injury to the nerves supplying the area.

KEYWORDS: Globulomaxillary cyst, Marsupialization, Enucleation, Jaw cysts, Non odontogenic cyst.
CASE REPORT:
A male patient of 18 years reported to a maxillofacial clinic with the complaint of left side of upper lip swelling for 1 year and it was painless. Swelling was initially small in size, but gradually enlarged into present condition. Patient has no history of trauma, missing teeth or infection. Associated symptoms were mobility of the left sided upper lateral incisor and canine and slight bleeding in the gingival margin of lateral incisor for last 7 days.

Extraorally found an ill-defined spherical swelling anteroposteriorly extending from philtrum to left corner of mouth and from left ala of the nose to vermilion border of upper lip superoinferiorly. Left nasolabial fold was obliterated and skin condition was normal. On palpation, we found local temperature was normal and swelling was non-tender, bony hard in consistency. (Fig: 1)

On intraoral examination there was a well-defined, rounded swelling about 3cm× 3cm in size. Buccally, the swelling obliterates the vestibule from distal of the upper left central incisor to the mesial of first premolar and palatally extending 2.5cm into the palate associated with upper left central incisor to first premolar. Overlying mucosa was normal in appearance. Both 22 and 23 are mobile and spacing was found in between them, slight bleeding was present in gingival margin of 22. (Fig: 2)

Panoramic view of radiograph (OPG) revealed a well-defined inverted peer shaped radiolucent lesion (Fig: 3) with displacement of the apex of the teeth 21,22,23,24. Chairside vitality test was done by hot gutta-purcha stick and found adjacent teeth vital. Provisional diagnosis was made as a globulomaxillary cyst and for surgical procedure informed written consent was taken. Routine hematological test was done to carry surgery and found no abnormality.

At first left lateral incisor was extracted due to severe mobility. Then a ready-made plastic obturator was placed through the socket and cyst lining was sutured with obturator and mucosa. Instruction was given to irrigate the cavity by diluted hydrogen peroxide (H₂O₂) and 1% Povidoneiodine solution after each meal through the opening and periodic weekly examination was done to see any dislodgement, infection and to measure the amount of bone regeneration. (Fig: 4)

Radiologically, globulomaxillary cyst looks like an inverted pear shaped well-defined radiolucent lesion in between lateral incisor and canine of maxilla. Histopathologically, lining composed of stratified squamous epithelium or pseudostratified ciliated columnar epithelium in globulomaxillary cyst. In our case stratified squamous epithelium found which suggests, it is a developmental cyst of non-odontogenic origin.

Clinical differential diagnoses of globulomaxillary cyst are anterior bony defect, inflammatory odontogenic cyst, adenomatoid odontogenic tumor, and giant cell granuloma.
CONCLUSION:
The case reported in this study was successfully treated by marsupialization followed by enucleation. By this, the cavity allows drainage of cystic fluid and regeneration of bone. After follow up, recurrence or any complication was not found. The successful outcome of this case shows that, marsupialization might be a good treatment option for management of globulomaxillary cyst.

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CONFLICT OF INTEREST:
We have no conflict of interest to declare.

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