Cemento-Bony Dysplasia of the Maxillary Bones (3 Cases Report)
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DOI: 10.36347/sjams.2020.v08i11.021 | Received: 30.03.2020 | Accepted: 06.04.2020 | Published: 16.11.2020

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Abstract
Cemento-bone dysplasia is a benign fibro-bone lesion of the maxillary bones, developed at the expense of the periodontal ligament. These cemento-bone dysplasia are subdivided into three forms, according to their extension and radiological aspect: periapical forms, florid and focal. FCBD is most often asymptomatic, which is found incidentally in a radiological examination. FCBD is characterized by several radio-opaque images with dented contours, sometimes surrounded by a clear border. Asymptomatic forms are monitored clinically and radiologically, taking care to maintain good oral hygiene. Debridement and sequestration are associated with appropriate antibiotic therapy in inflammatory or infected forms.

Keywords: Maxillary bones, bone dysplasia, florid, fibro-bone lesion.

INTRODUCTION
Cemento-bone dysplasia is a benign fibro-bone lesion of the maxillary bones, developed at the expense of the periodontal ligament. These cemento-bone dysplasia are subdivided into three forms, according to their extension and their radiological aspect: periapical forms, florid and focal [1].

Florid Cemento Bone Dysplasia (FCBD) mainly affects middle-aged and black women. Its diagnosis is clinical and radiological.

It is characterized by multiple sclerotic masses of the maxillary bones most often bilateral and symmetrical [2, 3]. We report two cases of FCBD revealed by their complications.

OBSERVATION 1
55-year-old patient admitted for labio-mentonniary dysmorphia associated with symphys-mandibular swelling. This swelling gradually increased in volume over the past two years, preventing the wearing of the removable prosthesis. The symphysar mass of hard consistency was 7 cm x 3 cm. The mucosa was normal and the patient was toothless.

The dental panoramic (Fig-1) retrieved multiple radio-opaque images occupying the four posterior segments with a huge sclerotic mass invading the symphysis. Before this table the diagnosis of FCBD was suspected. The concentration of alkaline phosphatases was normal.

The anatomopathological examination of the surgical removal piece confirmed the diagnosis.

Fig-1: Panoramic radiography. Multiple radio-opaque images almost symmetrically across the four quadrants and a voluminous symphysary opacity
**OBSERVATION 2**

A 45-year-old Black patient who has had permanent, throbbing pain in the lower right molar region associated with an alveolar fistula with suppurative secretion. The inflammatory and suppurative alveolar focal spot was located in the right postero-inferior quadrant, the bone was exposed, and the oral condition wasn’t good.

The dental pan (Fig-2A) and the denta-scanner (Fig-2B) found several radio-opaque mandibular images surrounded by a clear radio border and a right mandibular sequester. Histological examination of the sequestrectomy piece confirmed the diagnosis of complicated FCBD of chronic osteitis. The evolution has been good, without recidivism at 15 months.

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**DISCUSSION**

FCBD is a mild and rare fibro-bone lesion. It was first reported by Bhaskar and Cutright [4] in 1968 as multiple enostoses and then by Melrose [3] in 1975. These authors were the first to describe the clinical, pathological and radiological criteria of the lesion and to use the term florid bone dysplasia. It was not until 1985 that Waldron [5] introduced the term FCBD, characterized by the presence of bone and cementation tissue.

The FCBD is located only in the maxillary area. It is not associated with any other skeletal impairment or abnormality in the blood count [6]. It affects African women of middle and advanced age and their descendants [2]. Family cases were found, the transmission would be autosomic dominant [7]. FCBD is most often asymptomatic, which is revealed incidentally during a radiological examination. It sometimes manifests as pain, purulent sweat, and mucous and/or facio-cervical fistula (as in the second clinical case). This infection is due to endo-oral exposure of the bone-bone masses.

The revealing symptom is rarely facial dysmorphia (as in the first clinical case) [3, 7]. Radiologically, FCBD is characterized by several radio-opaque images with dented contours, sometimes surrounded by a clear radio readout. These images are located at the level of the four oral quadrants, more readily in the premolomolar region in an almost bilateral and symmetrical manner. But previous locations are frequent [1, 6, 8].

The sclerotic aspect of FCBD can be confused with that of Paget’s disease, chronic diffuse sclerotic osteomyelitis (CDSO) and Gardner’s syndrome. Paget’s disease is characterized by polyostotic disease and increased levels of alkaline phosphatases [9]. The CDSO manifests itself clinically by an inflammatory process localized to a segment of the mandible and radiologically by a single poorly defined opacity that infiltrates the entire mandibular body, from the alveolar bone to the basilar edge, sometimes extending to the ramus [10].
Asymptomatic forms are monitored clinically and radiologically to maintain good oral hygiene. Dental extractions and biopsy should be avoided as the ability to heal mucous membranes is reduced. A modelling resection may be proposed for aesthetic or functional reasons. Debridement and sequestration are associated with appropriate antibiotic therapy in inflammatory or infected forms [7, 9].

CONCLUSION
Cemento bony dysplasia is a mild and rare lesion, characterized by the presence of bone tissue and cementation, it sits only at the maxillary level. It affects African women of middle and advanced age and their descendants. Its diagnosis is clinical and radiological which is characterized by several bilateral and symmetrical.

The sclerotic aspect can be confused with that of Paget’s disease and chronic sclerotic osteomyelitis diffuse. Asymptomatic forms are monitored clinically and radiologically, while surgery is reserved for complicated forms.

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