INTRODUCTION

Ameloblastoma is a slow growing persistent and locally aggressive neoplasm of epithelial origin accounting for 10% of 30% of all odontogenic tumors. According to WHO, ameloblastomas are classified into 3 types, conventional, unicystic and peripheral. Unicystic ameloblastoma refers to those cystic lesions that show clinical, radiographic, or gross features of a mandibular cyst, but on histological examination show a typical ameloblastomatous epithelium lining part of the cyst cavity, with or without luminal and/or mural tumor growth.

CASE REPORT

A 12 yrs old male patient reported to the department of oral medicine and radiology with the chief complaint of painful swelling on the left middle half of the face since 1 month.

The history of presenting illness revealed that the patient was suffering from painful swelling on the left middle half of the face region since 1 month. Initially patient experienced pain in the left upper back teeth region about 1 month back and 5-6 days after the onset of pain patient experienced swelling on the left middle half of the face. Pain was sudden in onset, moderate in intensity, intermittent in nature and was of dull and throbbing type. Pain used to aggravates on taking food and relieves only on taking medication. For this problem patient had visited to some private practioner 15 days back where he was prescribed some medicines after which he got some relief. Swelling got reduced in size, and since then swelling was not increasing in size. There was no history of trauma.

The patient was moderately built and nourished with no signs and symptoms of Pallor, Icterus, Cyanosis, Clubbing, and Edema, Toxemia or Organomegaly. All his vital signs were within normal limits.

Extra oral examination revealed that face of the patient was bilaterally asymmetrical with a solitary diffuse swelling measuring about 2-3 mm in diameter, irregular in shape was present on the left middle half of the face extending anterioposteriorly from the inner canthus of the eye to 0.5cm posterior to the outer canthus of eye and superioinferiorly from the infraorbital margin to the angle of the mouth. Borders were ill defined and the color of the overlying skin was normal. Extraoral examination also revealed obliteration of the left nasolabial fold. On palpation swelling was nontender and firm in consistency and had well defined borders. Swelling was noncompressible, nonfluctuant and nonmobile. Submandibular lymph nodes were palpable both on the right and left side, 2 in number ie one on each side, slightly tender, mobile and firm in consistency.

Intra oral soft tissue examination revealed the presence of well defined solitary dome shaped swelling measuring about 3-4 cm in diameter involving the left maxillary alveolar ridge extending anterio- posteriorly from the mesial surface of 22 to the distal surface of 26. There was expansion of both Buccal and palatal cortex and vestibular obliteration in relation to 63, 64, 65 and 26. Color of the overlying mucosa was normal.

Intraoral hard tissue examination revealed the presence of root stump in relation to 64, mesioproximal caries in relation to 55, 65, 75 and 85 and distoproximal caries in relation to 54. Other intraoral findings were midline diastema and palatally placed teeth in rt 12 and 22, and generalized stains and calculus. On palpation swelling was nottender, firm in consistency and had well defined borders. There was no vestibular tenderness and there was...
no pus discharge. Percussion of hard tissue revealed that it was not a root stump but it was erupting tooth in relation to 24.

Considering the history and clinical examination, provisional diagnosis of Dentigerous Cyst in Relation To 23 was given. Differential diagnosis of Unicystic ameloblastoma, Adenomatoid odontogenic tumor, Periapical cyst and calcifying epithelial odontogenic cyst were given.

INVESTIGATIONS
Which were performed are as follows Pulp vitality test: 22, 55 and 26 were vital, Complete hemogram. All parameter were within the normal limits. FNAC: Yellow colored fluid was obtained. Radiographs: IOPA, OPG, Occlusal view and Excisional Biopsy IOPAR revealed the presence of radiolucent lesion having thin corticated border in relation to 63, 64, 65 and 26. IOPAR also revealed the resorbed root in relation to 63 and malpositioned tooth in relation to 24. Occlusal radiograph revealed the expansion of both the Buccal and palatal cortex and malpositioned tooth in relation to 24.

OPG revealed the presence of well defined Unilocular Radiolucency in the left maxillary alveolar in the region of canine and premolar. Radiolucency has corticated border extending mesially upto the distal root surface of 22 to the distal surface of 26. Superiorly lesion has displaced the floor of the maxillary sinus upward and is inferiorly extending upto the alveolar crestal margin. OPG also revealed the presence of impacted left maxillary permanent canine in to the sinus. Lesion has displaced the root of 22 mesially and erupting second premolar distally. Radiographical differential diagnosis of Dentigerous cyst, Odontogenic keratocyst and Unicystic ameloblastoma were given. Enucleation and extraction of impacted tooth was done.

Microscopic section revealed the presence of multiple pieces of tissue showing cystic lining with luminal epithelium overlying fibrous connective tissue. In some areas cystic lining showed proliferations intraluminally in the form of sheets and nodules. Considering the history, clinical examination, radiographic examination and histopathological findings final diagnosis of unicystic ameloblastoma was given.

DISCUSSION
Unilocular ameloblastoma (UA) is a rare type of ameloblastoma, accounting for about 6% of ameloblastomas. It is a single cystic cavity which shows ameloblastomatous differentiation in the lining. First introduced in 1977, it contends on being a separate clinic pathological entity than the solid ameloblastoma.

CLINICAL FEATURES:
It occurs in second to third decades of life with the mean age of 22 years. It shows male predilection with a ratio of 1.5:1. It occurs more in mandible posterior mandible including the ramus of mandible it is usually asymptomatic, but sometimes there may be swelling, pain and signs of lip numbness as well as discharge or drainage in cases of secondary infection are common.

RADIOLOGY
Eversole and colleagues reported that 52% of cases were associated with an impacted third molar and 48% did not involve teeth. Among those associated with an impacted tooth, three radiologic pattern were observed. 1. A small Unilocular pericoronal Radiolucency less than 2 cm in diameter. In most cases the tooth was displaced. 2. A larger Unilocular expansile Radiolucency extending to the coronoid process. In many of their illustrations there was a slight hint of one or several septa, sometimes with loss of superior or anterior wall. 3. An expansile Radiolucency with scalloped margins or microlocules.

THE UNICYSTIC AMELOBLASTOMAS NOT ASSOCIATED WITH TEATH SHOWED THE FOLLOWING PATTERNS:
1. An expansile periapical Radiolucency with root resorption and an occasional tendency for the root to project into the lesion.
2. A pear-shaped Radiolucency interposed between contiguous teeth, causing divergence of the roots.
3. A periapical Multilocular Radiolucency with root resorption.

DIFFERENTIAL DIAGNOSIS INCLUDES
Dentigerous cysts, odontogenic keratocyst, other simple odontogenic cysts like residual cysts, adenomatoid odontogenic tumour, giant cell lesions and sometimes solid ameloblastoma.

The management of the unicystic ameloblastomas is enucleation or curettage and can be supplemented by physical means, such as liquid nitrogen cryotherapy or Carnoy's solution.

RECURRENCE
Recurrence after conservative treatment of unicystic ameloblastoma however is reported to be between 10 to 25%.

REFERENCES

Corresponding Address:
Dr. Nupur Agarwal
Email: rupun48@gmail.com
LIST OF PHOTOGRAPHS

Fig 1: Extra- Oral Photograph

Fig 2: Intra- Oral Photograph

Fig 3: IOPAR

Fig 4: Occlusal Radiograph

Fig 5: OPG