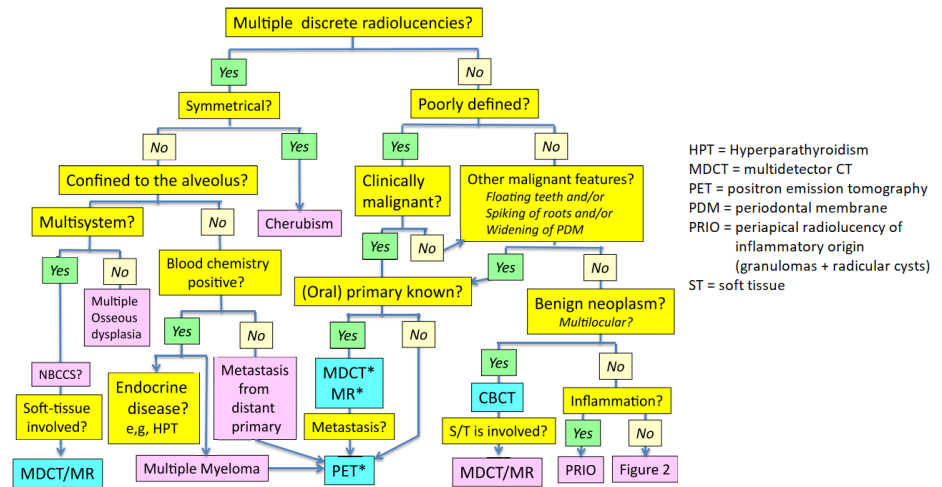
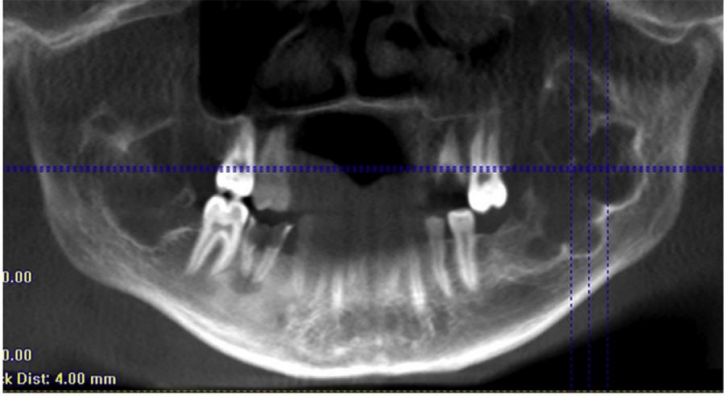


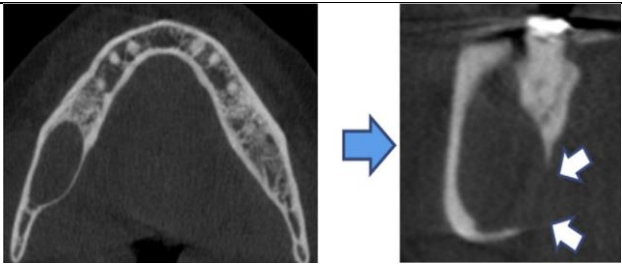
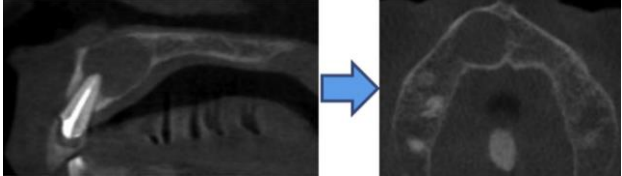
## Pre-reading - radiolucencies

- Multiple radiolucencies
  - Suggests a systemic cause
  - Most likely:** cherubism or KCOT's of nevoid basal cell carcinoma syndrome
  - Sometimes:** florid osseous dysplasia (if limited to alveolar process)
- Odontogenic neoplasms
  - Mainly benign, but have the potential to be malignant
  - Have the tendency to recur
  - Includes ameloblastomas, keratocystic odontogenic tumors, odontogenic myxomas, and glandular odontogenic cysts
- Cherubism

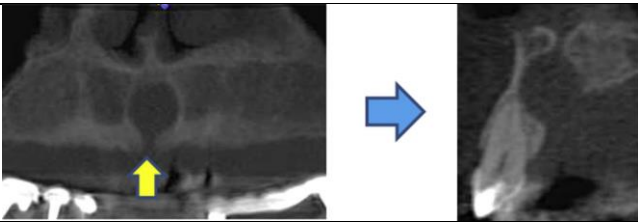


Imaging	 <p>cherubism</p>	<p>-Pan reconstruction of a CBCT</p> <p>-Bilateral RL on posterior mandible and on left posterior maxilla</p> <p>-A RL like this would prompt one to think ameloblastoma</p> <p>-If there is little evidence of B-L expansion, then think KCOT</p> <p>-Palmar pitting can be checked to see if it is multiple KCOT's due to NBCC</p> <p>-Also, ameloblastomas do not cross the midline unlike</p>
Background information	<p>-Autosomal dominant genetic disorder</p> <p>-During earliest and active stage, cherubism lesions contain giant cells</p> <p>-When cherubism inactivates, the lesions is replaced with woven bone first ("sketch line appearance") then back to lamellar bone (normal bone)</p> <p>-Earlier the onset, earlier the involution to normal bone</p> <p>-Europeans = onset in earlier 1<sup>st</sup> decade</p> <p>-East Asians = onset in later 1<sup>st</sup> decade</p> <p>-Could permanently affect tooth development, even after active phase is over</p>	
Clinical manifestation	<p>-Bilateral swollen cheeks</p> <p>-Tooth germs in affected areas are destroyed, already developed teeth are displaced</p> <p>-Could affect the airway, blockage of nasal passage, or even affect the orbits</p>	
Shade	-Radiolucency	
Shape	-Multilocular	
Site	<p>-Usually bilateral and almost symmetrical</p> <p>-Almost always the posterior mandible</p> <p>-Frequently the maxilla</p> <p>-Rarely affects the eyes</p>	
Size	-Variable	
Surroundings	-Corticated borders around radiolucent lesion	
Diameter		
Density		
Displacement	-Possible displacement of teeth	

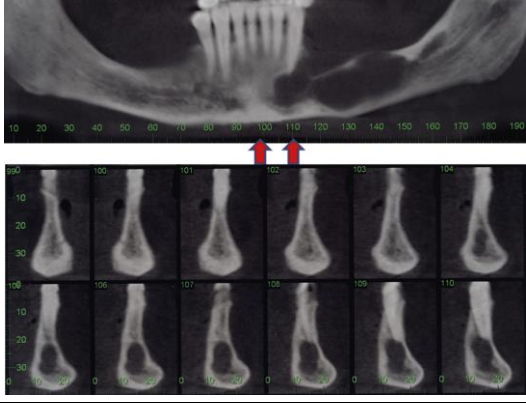
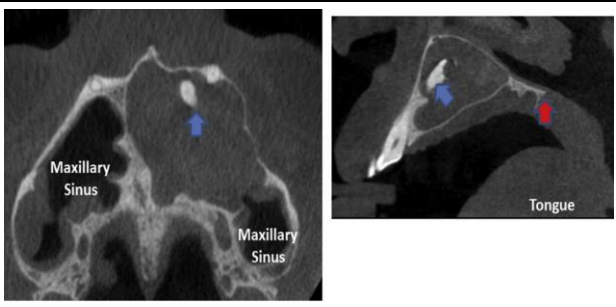
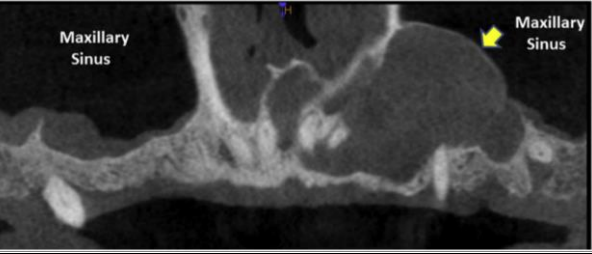
- Periapical radiolucency of inflammatory origin (PRIO)

Imaging		<ul style="list-style-type: none"> <li>-Axial view and sectional coronal view</li> <li>-Unilocular RL on patient's RIGHT side</li> <li>-Erosion of the lingual cortex and buccal cortex</li> <li>-Buccal cortex erosion is due to a fistula</li> <li>-Root resorption visible</li> <li>-<b>DDx:</b> radicular cyst, ameloblastoma, KCOT</li> </ul>
		<ul style="list-style-type: none"> <li>-Draining fistula makes it likely a lesion of inflammatory origin, but should never rule out ameloblastoma</li> <li>-Sagittal view and axial view</li> <li>-Lesion is not due to the nasopalatine duct, as it can be seen on the right image</li> <li>-Radiopacity on midline of right image is a maxillary torus</li> </ul>
Background information	<ul style="list-style-type: none"> <li>-Represents 3 histological diagnoses: granuloma, radicular cyst, and abscess</li> <li>-Happens to a tooth when there is caries or trauma</li> <li>-After RCT, most resolve within a year. If there is no resolution, likely a radicular cyst that is self sustaining regardless of infection</li> </ul>	
Clinical manifestation	<ul style="list-style-type: none"> <li>-Varies depending on histological diagnosis, but all associated with a non vital tooth</li> <li>-Toothache, tenderness on biting/percussion</li> </ul>	
Shade	-Radiolucent	
Shape	-Unilocular	
Site	-Associated with a tooth apex	
Size	-Any PRIO larger than 1.5cm is considered to be a radicular cyst	
Surroundings		
Diameter		
Density		
Displacement		

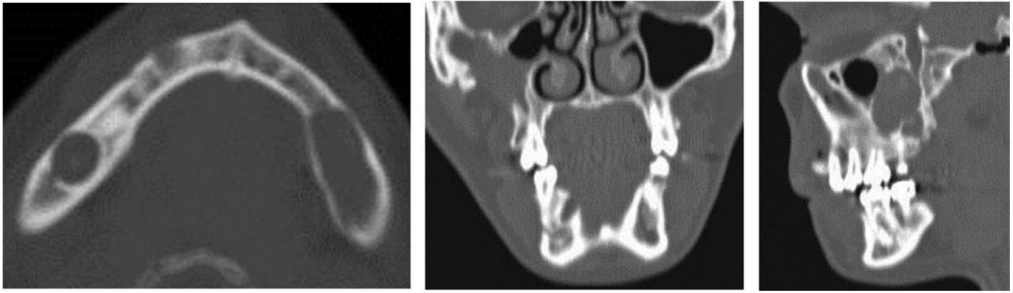
- Nasopalatine duct cyst (NPDC)

Imaging		<ul style="list-style-type: none"> <li>-Panoramic reconstruction and sagittal view</li> <li>-Well defined unilocular RL in anterior maxilla</li> <li>-Teeth are not seen in pano due to narrow width used on reconstruction</li> </ul>
Background information	<ul style="list-style-type: none"> <li>-Enucleation of NDPC's can be difficult due to proximity to the nasal mucosa</li> <li>-Adjacent teeth are usually vital</li> </ul>	
Clinical manifestation		
Shade	-Radiolucent	
Shape	-Unilocular	
Site	-Anterior maxilla on/near midline	
Size		
Surroundings	<ul style="list-style-type: none"> <li>-Nasal mucosa superiorly, roots of maxillary anterior teeth laterally</li> <li>-In the image above, a communication with the oral cavity can be seen in the panoramic image and a communication can be seen with the nasal cavity in the sagittal image</li> </ul>	
Diameter	-Enlargement of the nasopalatine duct, duct not visible elsewhere	
Density		
Displacement		

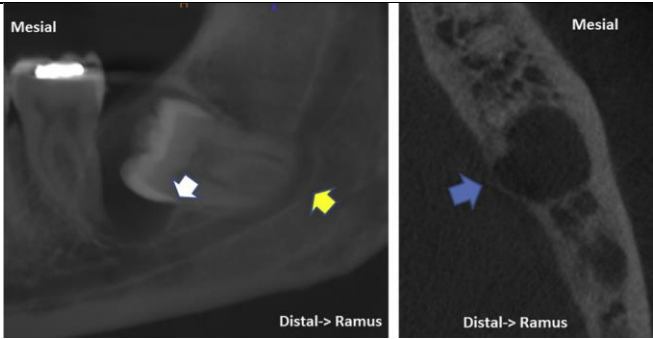
- Keratocystic odontogenic tumor

Imaging	 <ul style="list-style-type: none"> <li>-Pan reconstruction and transaxial sections</li> <li>-Multilocular radiolucency extending from the canine to the site of the 3<sup>rd</sup> molar</li> <li>-Transaxial sections below show a little displacement and erosion of the lingual cortex</li> <li>-Left canine has some root resorption on the apex</li> <li>-No B-L expansion</li> </ul>
	 <ul style="list-style-type: none"> <li>-Axial view and sagittal view</li> <li>-Well defined RL lesion extending from anterior midline to first molar site</li> <li>-Displaced and eroded anterior wall of the maxillary sinus</li> <li>-Infiltrating the lumen of the sinus</li> <li>-B-L expansion is half of M-D expansion</li> <li>-Unerupted tooth is seen (blue arrow)</li> <li>-Provisional diagnosis is KCOT, as it commonly starts at the lateral/canine region</li> </ul>  <ul style="list-style-type: none"> <li>-Panoramic reconstruction of a CBCT</li> <li>-Floor of maxillary sinus elevated</li> <li>-Growth is much less restricted in the maxilla due to thin bone and less cortical bone</li> <li>-Although this is KCOT, it may present with large B-L expansion in the softer maxillary bone</li> </ul>
Background information	<ul style="list-style-type: none"> <li>-Mean presentation age is 38 years</li> <li>-Used to be called "odontogenic keratocyst" which encompassed para-keratotic and ortho-keratotic lesions</li> <li>-Now, para-keratotic lesions are called KCOT's as they are neoplastic</li> <li>-Also, ortho-keratotic lesions are called OOC's as they are a true cyst             <ul style="list-style-type: none"> <li>-OOC's are unique radiographically. They have huge B-L expansion and no root resorption</li> </ul> </li> <li>-Mixed ortho/para keratotic lesions are treated as if they were KCOT's</li> <li>-Global recurrence rate of 28%. Anterior, smaller lesions are more likely to recur because they are thought to be non-neoplastic and enucleated conservatively by surgeons</li> </ul>
Clinical manifestation	<ul style="list-style-type: none"> <li>-Presents with swelling, pain (1/3 of pts)</li> </ul>
Shade	<ul style="list-style-type: none"> <li>-Radiolucent</li> </ul>
Shape	<ul style="list-style-type: none"> <li>-2/3 are well defined and unilocular</li> <li>-Older lesions are more likely to be multilocular and expand M-D</li> </ul>
Site	<ul style="list-style-type: none"> <li>-3/4 occurs in the mandible, overwhelmingly in ramus and posterior sextant</li> <li>-1/4 occurs in the maxilla, of which 2/3 is between the canine and lateral, and 1/3 is in anterior sextant</li> <li>-Spreads easier in the maxilla, likely due to less cortical bone</li> </ul>
Size	
Surroundings	<ul style="list-style-type: none"> <li>-Like ameloblastoma, 1/4 of KCOT's cause root resorption but to a lesser degree</li> </ul>
Diameter	
Density	
Displacement	<ul style="list-style-type: none"> <li>-2/3 had some fusiform B-L expansion, but nowhere near the extent of an ameloblastoma</li> </ul>

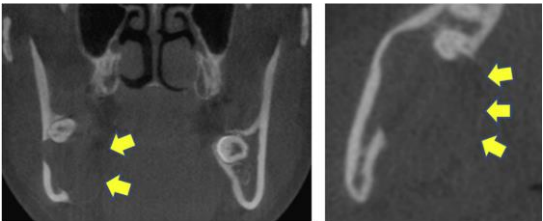



- Nevoid basal cell carcinomas

Imaging	 <p>-Left is axial view, middle is coronal view, right is sagittal view          -Lateral wall of sinus in coronal view: missing bone due to biopsy taken prior to radiograph          -Multiple radiolucencies resembling KCOTs</p>
Background information	<p>-A multi system disorder requiring treatment from maxillofacial + head + neck specialties          -NBCCs involve basal cell carcinomas, multiple KCOT's, and 4 other major criteria          -Most frequent in North Europeans          -Less frequent in East Asians (darker skin), but more frequently present with multiple KCOT's          -Syndromic KCOT's usually presents in 2<sup>nd</sup>~3<sup>rd</sup> decade, non syndromic KCOT's 3<sup>rd</sup>~4<sup>th</sup> decade          -Syndromic KCOT's are more likely to recur after surgery than non syndromic</p>
Clinical manifestation	-Swelling, pain
Shade	-Radiolucent
Shape	<p>-Maxilla: usually unilocular, small, and round          -Mandible: usually unilocular +/- scalloped margins. Could be multilocular</p>
Site	
Size	-Minimal B-L expansion (as seen in left image)
Surroundings	-Corticated borders around lesion
Diameter	
Density	<p>-In the middle and right image, the lesion has infiltrated the right maxillary sinus          -Buccal wall of sinus is missing as radiograph was taken AFTER the biopsy (don't do this!)</p>
Displacement	

- Dentigerous cyst

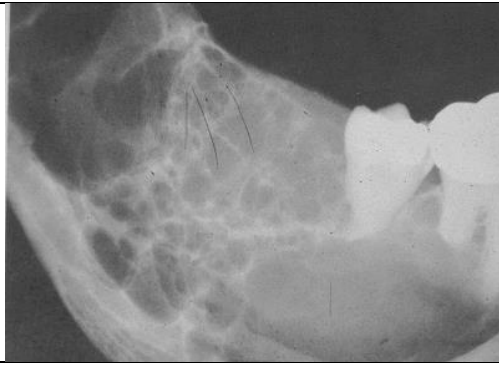
Imaging	
Background information	<p>-Most commonly seen with unerupted 3<sup>rd</sup> molars          -Also possibly seen on maxillary anteriors, supernumerary teeth, and premolars          -False myth: ameloblastomas arise from untreated dentigerous cysts          -Most common in white south Africans</p>
Clinical manifestation	
Shade	-Radiolucent
Shape	-Unilocular
Site	-Pericoronal with attachments to the CEJ of an unerupted tooth
Size	
Surroundings	
Diameter	
Density	-Lingual cortex becoming eroded, hence reducing density
Displacement	-In the image, we see a displacement of the lingual cortex and some erosion

- Ameloblastoma


Imaging			-Coronal and axial reconstruction of a CBCT -Unicystic ameloblastoma -Eroded lingual cortex is visible -Extension beyond lower border of the mandible is unique to ameloblastomas
			-Axial reconstruction of a CBCT -Large unilocular RL with extreme B-L expansion -Septae are visible in lesion -Solid ameloblastoma
			-Sagittal reconstruction of a CBCT -Desmoplastic ameloblastoma -Root resorption can be seen
			
Background information	-Usually presents before 25 years old -Ameloblastomas arising from the jaw bones are classified as: solid (multilocular), unicystic, or desmoplastic -Most ameloblastomas in Western countries are solid. Mostly treated by resection -Most ameloblastomas in Chinese are unicystic. Mostly treated by enucleation, Carnoy's, small surgery		
Clinical manifestation	-Expansion of jaw		
Shade	-Radiolucent		
Shape	-Unicystic may appear unilocular -Solid is usually multilocular		
Site	-Unilocular usually affects the ramus and posterior sextant of the mandible -Solid usually affects the anterior sextant of the mandible		
Size			
Surroundings	-Can cause root resorption		
Diameter			
Density			
Displacement	-Ball-like bucco-lingual expansion of the mandible		



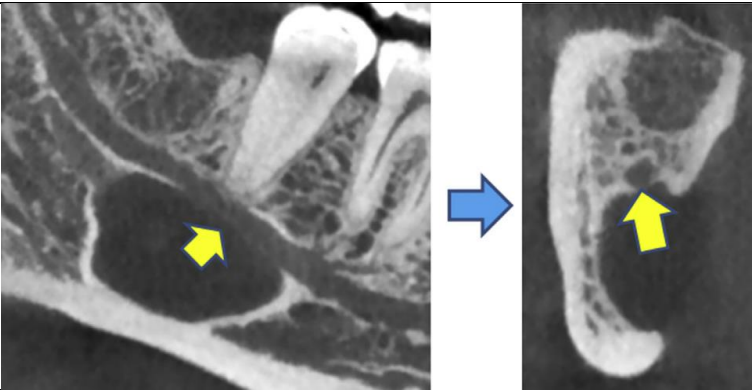
- Odontogenic myxoma

Imaging		-Took a random picture off google for sake of consistency
Background information	-First presents around 30 years -Cells infiltrate the bone around the lesion, so 1cm margins are recommended when resecting	
Clinical manifestation	-1/2 present with swelling and/or pain	
Shade	-Radiolucent septae	
Shape	-Multilocular "tennis racket" pattern is only seen in a minority of myxomas	
Site	-Mainly in the posterior sextants of max/mand	
Size		
Surroundings	-Only well defined half the time -Suggests that this lesion does not contain a capsule	
Diameter		
Density		
Displacement	-Fusiform B-L expansion in the body of the mandible -Will displace into the lumen of the sinus nearly every time it's near the sinus	

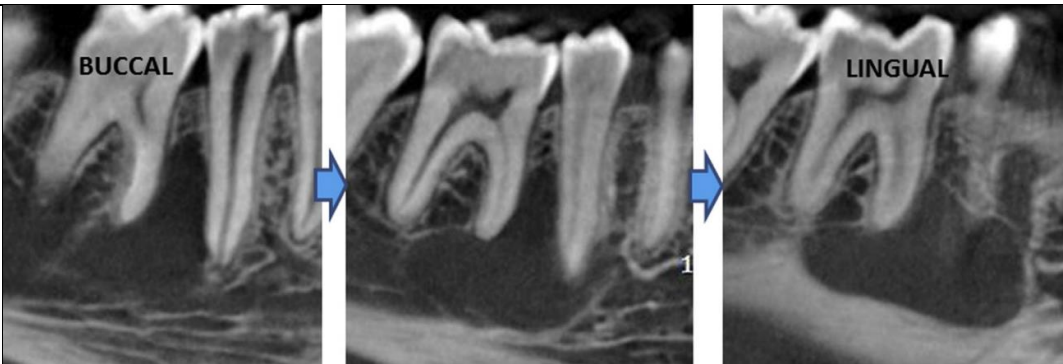
- Brown tumor

Imaging	<div data-bbox="500 1050 1315 1654">  <p>Figure 11 MacDonald © Wiley© DMFR &amp; OOOO 2012©</p> </div> <div data-bbox="373 1654 1421 1971"> <p>-Axial, coronal, and sagittal views</p> <p>-Unilocular RL affecting the anterior mandible</p> <p>-Erosion of B+L cortices</p> <p>-B-L expansion</p> <p>-Highest on the differential would be a solid ameloblastoma (solid because it is unilocular)</p> <p>-<b>Surprise:</b> CT scan showed calcifying arteries everywhere (calcified carotid can be seen on axial)</p> <p>-Pt had chronic renal failure and hyperparathyroidism</p> <p>-Lesion involuted after kidney transplant</p> <p>-Real Dx is actually a brown tumor due to hyperparathyroidism</p> <p>-Histologically will show giant cells, not ameloblastic cells</p> </div>	
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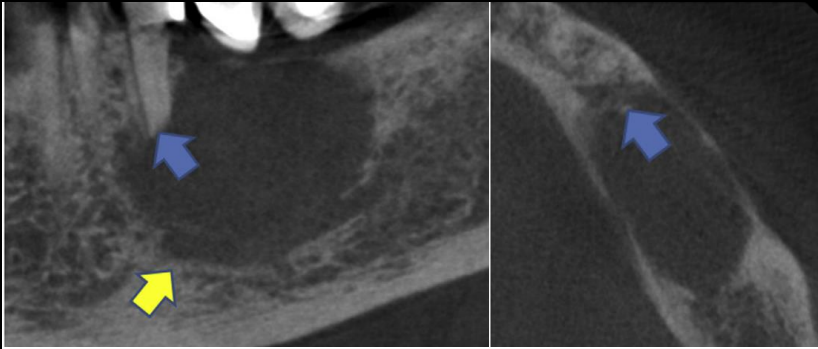
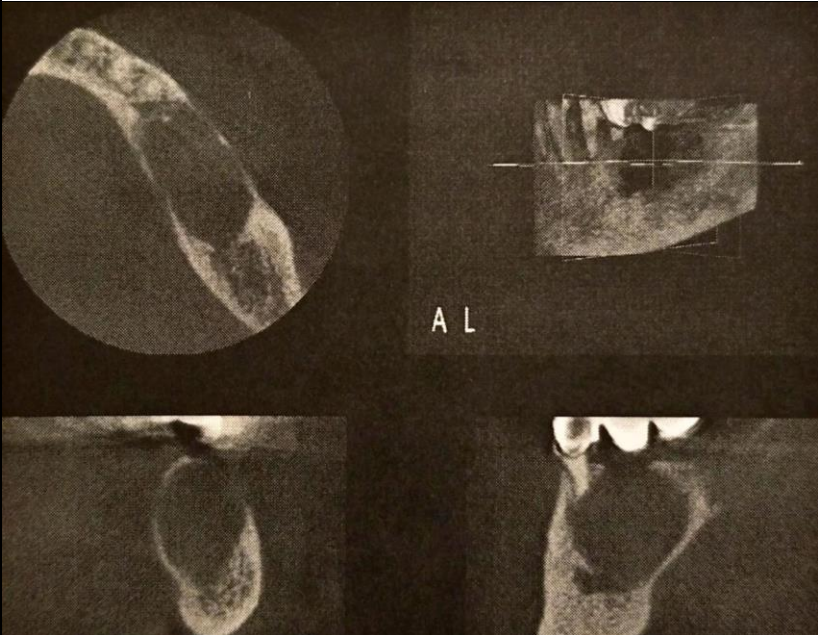
- Lingual bone defect (Stafne's bone cyst)

Imaging		
Background information	<ul style="list-style-type: none"> <li>-Must weaken the mandible, but no pathologic fractures have been reported</li> <li>-Likely because it is mostly found in older adults (~50), who rarely participate in contact sports</li> </ul>	
Clinical manifestation	<ul style="list-style-type: none"> <li>-Asymptomatic</li> </ul>	
Shade	<ul style="list-style-type: none"> <li>-Radiolucent</li> </ul>	
Shape	<ul style="list-style-type: none"> <li>-Ovoid</li> </ul>	
Site	<ul style="list-style-type: none"> <li>-Basal process of the posterior mandible</li> <li>-In relation to the submandibular gland or below the mandibular canal</li> </ul>	
Size		
Surroundings	<ul style="list-style-type: none"> <li>-Corticated, radiopaque</li> </ul>	
Diameter		
Density		
Displacement	<ul style="list-style-type: none"> <li>-Could erode the buccal cortex</li> </ul>	

- Simple bone cyst (traumatic, idiopathic, hemorrhagic bone cyst)

Imaging	 <p>Panoramic reconstruction of a CBCT</p> <ul style="list-style-type: none"> <li>-No displacement, resorption</li> <li>-Scalloped borders</li> </ul>	
Background information	<ul style="list-style-type: none"> <li>-Happens mostly in children, possibly related to orthodontics</li> <li>-Contains no epithelium, only lined with thin CT</li> <li>-Will yield no findings on an aspiration</li> </ul>	
Clinical manifestation	<ul style="list-style-type: none"> <li>-Usually asymptomatic</li> <li>-Affected teeth remain vital</li> </ul>	
Shade	<ul style="list-style-type: none"> <li>-Radiolucent</li> </ul>	
Shape	<ul style="list-style-type: none"> <li>-Unilocular</li> </ul>	
Site		
Size	<ul style="list-style-type: none"> <li>-May reach significant M-D dimensions, but very small B-L</li> </ul>	
Surroundings	<ul style="list-style-type: none"> <li>-Scalloping around roots</li> <li>-Well corticated borders</li> </ul>	
Diameter		
Density	<ul style="list-style-type: none"> <li>-Filled with nothing or blood</li> </ul>	
Displacement		

- Glandular odontogenic cyst

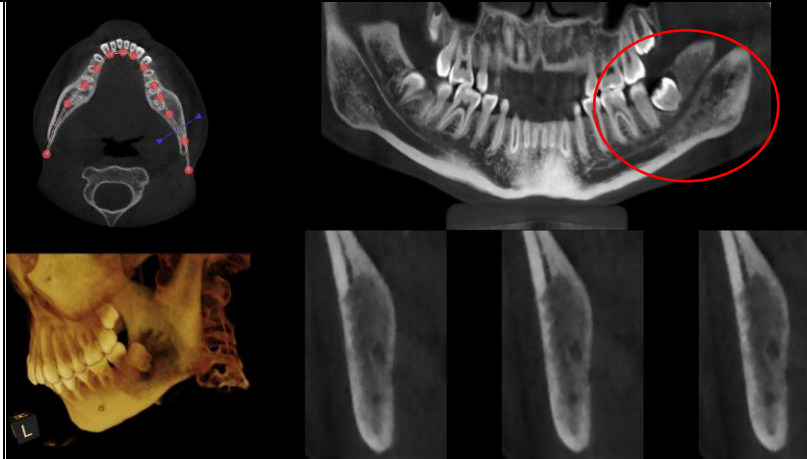
Imaging		<ul style="list-style-type: none"> <li>-Poorly defined unilocular RL</li> <li>-Root resorption of the 5</li> <li>-Some B-L expansion</li> <li>-IAN displaced inferiorly (yellow arrow), basal process affected</li> <li>-Superior cortex eroded</li> <li>-It is a GOC, but may be KCOT until proven otherwise</li> </ul>
		<ul style="list-style-type: none"> <li>-Axial, 3D, coronal, and sagittal views</li> <li>-Unilocular well defined radiolucency</li> <li>-No B-L expansion</li> <li>-Some extension into the basal process</li> <li>-Mandibular canal slightly placed downward</li> <li>-Root resorption visible</li> </ul>
Background information	<ul style="list-style-type: none"> <li>-Mean presentation age is 46 for westerners, decade earlier for East Asians + Africans</li> <li>-Can appear like an innocent dentigerous cyst to a well defined mucoepidermoid carcinoma</li> <li>-Wide range of radiological and histological presentations: we don't know enough about it yet, and it could even be a collection of unidentified lesions</li> <li>-Multilocular + root resorption should be treated as if it were neoplastic</li> </ul>	
Clinical manifestation	-90% have swelling, 33% with pain, 15% with numbness	
Shade	-Radiolucent	
Shape	-Varies from unilocular (small) to multilocular (large)	
Site	-80% in the mandible, nearly always in the anterior sextant	
Size		
Surroundings	-1/3 have root resorption	
Diameter		
Density		
Displacement	<ul style="list-style-type: none"> <li>-1/2 have tooth displacement</li> <li>-Minimal B-L expansion</li> <li>-Displacement of IAN (seen in picture above)</li> </ul>	



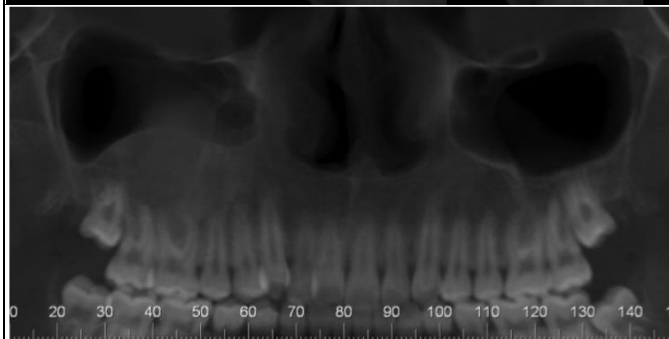
## Pre-reading – Radiopacities

- Fibrous dysplasia

## Imaging

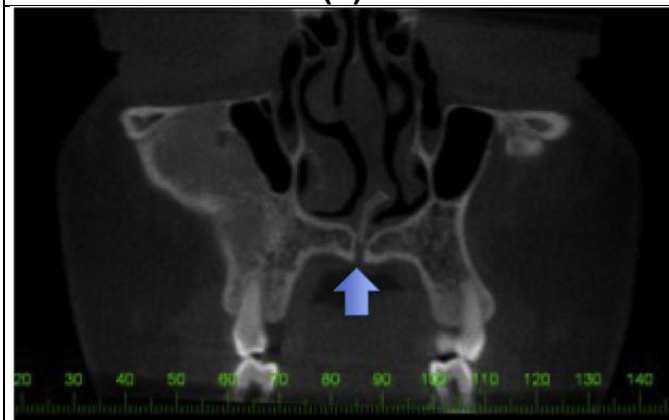


- Poorly defined radiopacity resembling a ground glass appearance on the posterior sextant of the left mandible
- Cortex surrounding the IAN on right side has been eroded
- Little B-L expansion
- Diagnosed as fibrous dysplasia



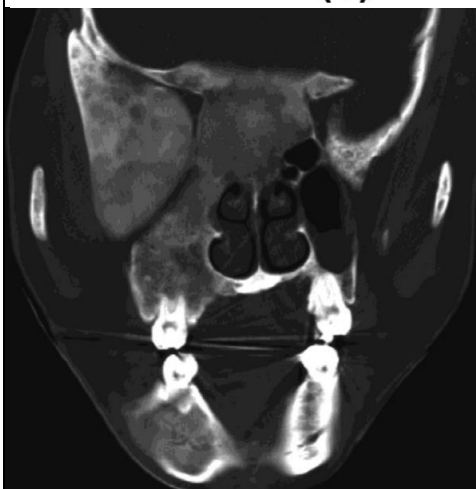
- Pan reconstruction of a CBCT (scale on the bottom, no superimposition of other structures, slightly worse resolution than a regular pan)
- Ground glass radiopacity in the posterior sextant of the right maxilla
- Poorly defined
- Displacement of the floor of the sinus is seen
- Dx: monostotic fibrous dysplasia

(a)



- Note: this is same patient as above
- Coronal reconstruction of a CBCT
- Appears to be somewhat well defined → FD in the jaw is poorly defined, but in other bones it is well defined. Possibly due to difference in embryonic bone formation
- Appears to stop right at the zygoma → only one bone affected
- Blue arrow points to the nasopalatine duct
- Dx: monostotic fibrous dysplasia


(b)



- Radiopacity resembling ground glass seen on mandible, maxilla, zygoma, and sphenoid
- Maxillary antrum has been completely obturated
- Buccal expansion of the zygoma
- Medially directed expansion of the lateral wall of the nasal cavity
- Substantial B-L expansion of the mandible

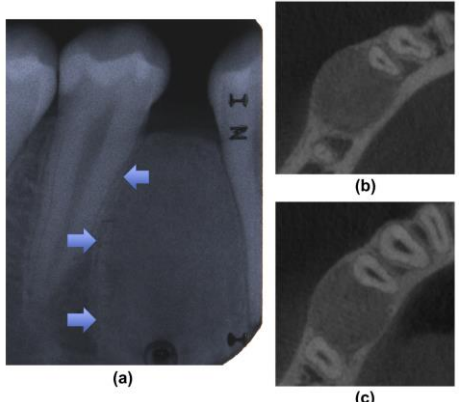
Background information	-Benign, non inheritable disease affecting 1:30,000 individuals -Overall, FD is seen on average at 15 years, but 25 years in the jaw -Can be a local lesion (monostotic, 93%) or systemic lesion (polyostotic, 7%) -Polyostotic + hormonal disorder + café au lait spots = McCune Albright syndrome -Hormonal disorders: precocious puberty, ovarian follicular cysts -Believed that all FD's arise in childhood, but remain undetected until it reactivates later in life -Earlier the mutation starts, the more severe the manifestations -If monostotic, not necessary to treat unless evident deformity or threat to vision -Can remain dormant after childhood, and reactivate during pregnancy -Monitor for reactivation or possible associated lesions (aneurysmal bone cyst, osteosarcoma)
Clinical manifestation	-Monostotic: affects one bone -Polyostotic: affects multiple bones throughout the body -90% presents with swelling, but only 18% reported pain
Shade	-Radiopaque -Ground glass appearance (seen 38% of the time on normal radiographs, 100% on CT)
Shape	
Site	-58% in maxilla, 42% in mandible, overwhelmingly in the posterior sextants
Size	
Surroundings	-Poorly defined with a 1mm zone of transition -This zone of transition is only found in jaw-related FD's, not FD's on other bones -Root resorption is rare
Diameter	
Density	-Sometimes see thinning of the lower border of the mandible -Possible loss of lamina dura of affected teeth
Displacement	-Maxillary sinus is completely or partially obturated in nearly every case of maxillary FD -Expansion seen (enlargement in maxilla, fusiform expansion in mandible) -Teeth were displaced in 35% of cases

- Dense bone island


Imaging	 <p>-Well defined RO at apex of 47          -Could be cementoblastoma, condensing osteitis, or a dense bone island          -Could also be osteomyelitis if it extended below IAN</p> <p>-No RL border = less likely cementoblastoma          -PDL space visible throughout the root = less likely cementoblastoma          -No B-L expansion = less likely cementoblastoma          -Tooth is vital = cannot be condensing osteitis</p>
Background information	-More prevalent in areas of high [F] in water -Seeing 5+ DBI's → suspect Gardner's syndrome -If associated with an infected, non vital tooth → it is called condensing osteitis -Does not regress
Clinical manifestation	-No symptoms
Shade	-Radiopacity
Shape	
Site	-Most common in posterior mandible
Size	
Surroundings	
Diameter	
Density	
Displacement	

- Ossifying fibroma

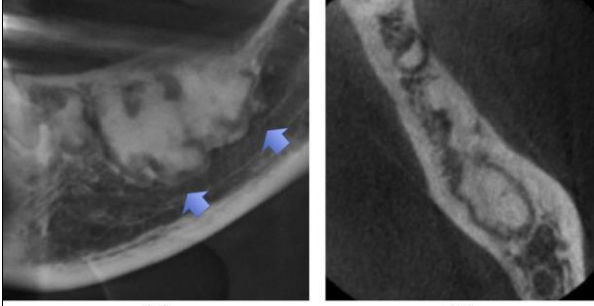
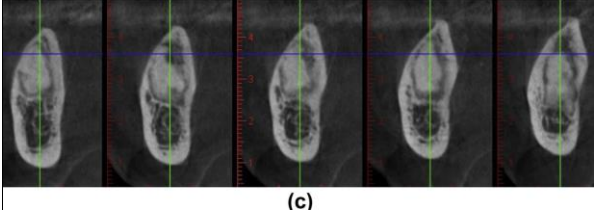
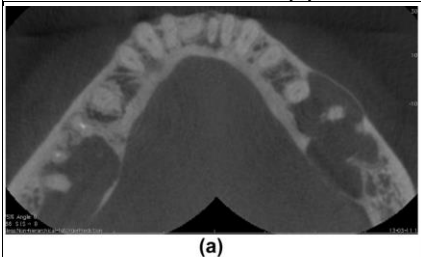
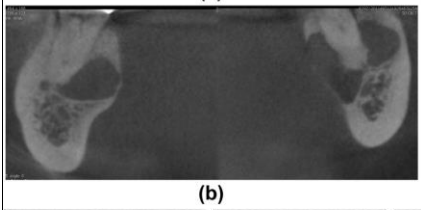
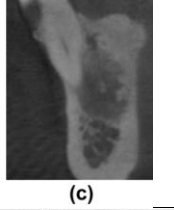
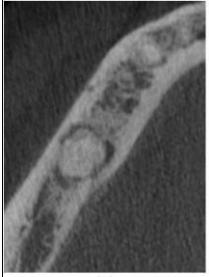


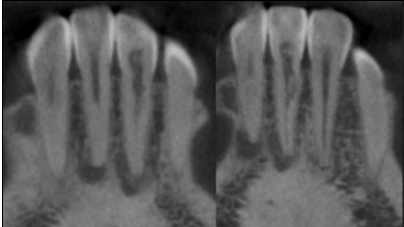
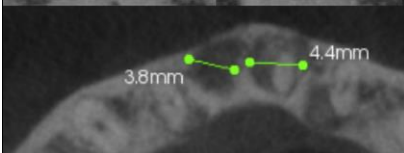
- FD can be distinguished from OF based on their margins, which are poorly defined for FD and well defined for OF

Imaging	 <p>(a) (b) (c)</p> <ul style="list-style-type: none"> <li>-Well defined ground glass radiopacity</li> <li>-Can trace the thin radiolucent outline (capsule) on A</li> <li>-Rounded B-L expansion is seen on B and C</li> <li>-Buccal and lingual cortices are thinned on B and C</li> <li>-If it was the juvenile type of OF, it would not have a capsule</li> <li>-The B-L expansion and displacement of the teeth make it less likely to be osseous dysplasia</li> </ul>
Background information	<ul style="list-style-type: none"> <li>-Usually seen in female (71%) adults (mean 31 yo) in teeth bearing jaws</li> <li>-Overall recurrence rate is 12% after careful surgery</li> <li>-Can re-activate or accelerate in growth at the onset of menopause</li> <li>-Secreting carcinoma is the underlying cause of OF's in 10~15%. An example of this is familial hyperparathyroidism (autosomal dominant disorder)</li> </ul>
Clinical manifestation	-31% of OF's are incidental findings, 66% present with swelling, 16% with pain
Shade	-Ground glass radiopacity
Shape	
Site	<ul style="list-style-type: none"> <li>-Mandible is affected 75% of the time</li> <li>-Even distribution of anterior or posterior segments</li> </ul>
Size	
Surroundings	<ul style="list-style-type: none"> <li>-Has an observable capsule (shell of radiolucency around lesion) most of the time</li> <li>-“Radiopacity within a radiolucency”</li> <li>-16% of the time, it is completely radiopaque</li> <li>-20% have root resorption</li> </ul>
Diameter	
Density	
Displacement	<ul style="list-style-type: none"> <li>-84% present with B-L expansion</li> <li>-27% have teeth displacement</li> <li>-If arising in the maxilla, the sinus is affected 90% of the time</li> </ul>

- MRONJ/osteomyelitis

Imaging	 <p>-2 dots in the center = genial tubercles</p> <ul style="list-style-type: none"> <li>-Coronal and axial reconstructions</li> <li>-Unilocular radiopacity surrounded by a radiolucent line on the right mandible</li> <li>-Erosion of buccal and lingual walls</li> </ul>
Background information	<ul style="list-style-type: none"> <li>-Happens on patients taking bisphosphonates</li> <li>-MRONJ and osteomyelitis often come hand in hand, and appear very similar</li> </ul>
Clinical manifestation	<ul style="list-style-type: none"> <li>-Visible necrotic bone</li> <li>-Fever, pain</li> </ul>
Shade	<ul style="list-style-type: none"> <li>-Necrotic bone with concurrent infection (osteomyelitis) can appear RL, RO, or both</li> <li>-Usually appears radiopaque and laminated</li> </ul>
Shape	
Site	-Spreads from alveolar process to basal process
Size	
Surroundings	
Diameter	
Density	
Displacement	-Expands the bone, similar to the way fibrous dysplasia does

- Osseous dysplasia
  - A tooth with a periapical radiolucency but tests vital may be a focal osseous dysplasia
  - Florid and focal osseous dysplasias are monitored and removed only if causing symptoms
  - Expansive osseous dysplasias need to be removed due to their aggressive nature

Imaging	 <p>(a) (b)</p>  <p>(c)</p>	<p>-A: Multiple well defined radiopacities in the alveolus of the mandible</p> <p>-B: Axial reconstruction show no B-L expansion</p> <p>-C: There is a clear boundary between dysplastic tissues and normal bone. All the dysplastic tissues are situated in the alveolus</p> <p>-Lesion is situated above the mandibular canal</p> <p>-Dx: florid osseous dysplasia</p>
	 <p>(a)</p>  <p>(b)</p>  <p>(c)</p>	<p>-A: Axial view presenting bilateral multilocular radiolucencies in posterior sextant of the mandible. There is significant M-D expansion but minimal B-L expansion. Cortices are eroded but intact. Radiopacities are seen within the radiolucencies, but it may also be a tooth root</p> <p>-C: Sagittal view or reconstructed transaxial image. one lesion also in the anterior sextant with a well defined radiopacity at the apex. Texture is ground glass</p> <p>-B: radiopacities are seen at the apices of the molars. This medium FOV cannot image the PDL, but small FOV's can.</p> <p>-Dx: florid osseous dysplasia</p> <p>-DDx: KCOT (2x), fibrous dysplasia, osseous dysplasia, ossifying fibroma</p>
	 <p>(a)</p>  <p>(b)</p>  <p>(c)</p>	<p>-A: Axial view showing unilocular radiopaque lesion with radiolucent border affecting left mandible. There is no B-L expansion</p> <p>-B: Sagittal view showing lesion is at the apex of 35/36, and no RR is seen</p> <p>-C: Coronal view, no RR is seen. 46 has some hypercementosis, but is unrelated to the lesion</p> <p>-Dx: focal osseous dysplasia</p> <p>-RCT on 46 was likely done when FocOD was in early stages and looked like a PARL</p>
	 <p>(a)</p>  <p>(b)</p>	<p>-Anterior sextant of the mandible</p> <p>-Multiple radiolucencies at the apices of the teeth</p> <p>-Depending on the view, it is evident that there are radiopacities within each radiolucency</p> <p>-Teeth were diagnosed as vital</p> <p>-Slight internal root resorption can be seen (irregular pulp outlines)</p> <p>-Dx: periapical osseous dysplasia</p>



	<b>Florid osseous dysplasia</b>	<b>Focal osseous dysplasia</b>	<b>Expansive osseous dysplasia</b>
Background information	-Confined to the alveolar process (above mandibular canal, below junction of hard palate), but are generally not considered to be odontogenic		
Clinical manifestation	-Females affected 97% of the time -Mean age 49 years old -50% are incidental findings, 31% swelling, 30% drainage or fistula	-Females affected 88% -Mean age 41 -64% incidental, 25% swelling, 28% pain, 17% numbness	-Expansion affects alveolar and basal processes -Affects males and females evenly -Presents in young ages
Shade	-Can be just a radiolucency or a radiolucency with >1 central radiopacities	-Radiolucency (31%) -Radiopacity within radiolucency (37%) -Complete radiopacity (32%)	
Shape			
Site	-More than 1 sextant needs to be affected to be considered FOD -Presentation is usually bilateral -Mandible affected in 100%, maxilla affected in 67% -Osseous dysplastic tissues (radiopacities) are positioned centrally within the lesion on CT	-Confined to a single sextant -Can be a single lesion or a group of juxtaposed lesions -85% in mandible -Posterior sextants more common	
Size			
Surroundings		-53% well defined -40% sclerotic periphery	
Diameter			
Density			
Displacement			-Extensive B-L expansion