use is a pseudovasculitis wich has been confused with Wegener granulomatosis or leukocytoclastic vasculitis.
Central midline destructive process can be caused by multiple conditions. Cocaine abuse can produce a severe destruction of the osteocartilaginous structures of nose, sinuses and palate, mimicking the clinical picture of other aggressive deseases such Wegener, angiocentric nasal NK/T-cell lymphoma, actinomycosis, tuberculosis or siphylis.
Case report: We present a case of cocaine-induced midfacial destruction in which the laboratory finding of elevated c-ANCA, MPO antibodies, antiPR3 and systemic clinical findings (anemia, infection, alterated renal funcion test) further complicated diagnosis, creating a disease presentation highly similar to Wegener's granulomatosis. CT revealed an aggressive destruction of central midface. Biopsy showed a fibrinoid necrosis, perivascular inflammatory infiltrates and microabscesses. Multiple biopsies, serologic testing, and close follow-up were necessary to arrive at the correct differetial diagnosis with Wegener disease.
Conclusion: Intranasal cocaine inhalation may be included into the differential diagnosis of centrofacial destructive process like Wegener desease, angiocentric nasal NK/T-cell lymphoma, tumors, chronic infections of nasosinusal tract and the idiopatic central midline destructive process. The ability to recognize and differentiate between vasculitis and pseudovasculitis is essential for the clinician because treatment options are totally different.

P.248 Complicated treatment of impacted wisdom teeth

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This report presents three cases of complications in the treatment of wisdom teeth.We describe three different patients who were refered to the Maxillofacial Department after unsuccessful attempts of third molar extractions.The first patient presented with pathological mandibular fractures 1 day post-extraction of impacted wisdom teeth. Another patient was referred 2 days after unsuccessful treatment due to dislocation of the impacted tooth into the pterygomandibular space during extraction. Last patient referred to our clinic 1 day after unsuccessful extraction of an impacted third molar,with diagnosis of dislocation of the left maxillary wisdom tooth into the maxillary sinus.Each patient was fully diagnosed and classified for treatment under general anaesthesia.In the first case the mandibular osteosynthesis was performed.The second patient required an operation of alien corps removal from the pterygomandibular space by oral approach, and the third patient involved revision of the maxillary sinus with removal of the tooth.Follow-up of the patients revealed healing with no complications.

P.249 Facial dermatology – The role of the maxillofacial surgeon

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A retrospective audit of 100 consecutive facial skin malignancies managed by the maxillofacial unit of Taunton and Somerset District General Hospital is presented. The increasing incidence of skin malignancies is leading to overburdening of specialties that previously may have provided the primary referral focus. Maxillofacial training provides for the surgical management of malignancy in the head and neck region. Some maxillofacial units have been a primary referral centre for skin malignancies for many years. However, this work does not form a significant percentage of the workload in many peripheral units. We have monitored the referral source, anatomical sites, surgical techniques, use of non-surgical treatment, excision margins and recurrence rates for skin malignancies managed in our unit. We suggest that an increasing role should be played by maxillofacial surgeons in the management of facial skin neoplasms in all units.

P.250 Loss of heterozygosity in a giant cell granuloma of a neurofibromatosis type 1 patient

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Neurofibromatosis type 1 (NF1) is an autosomal dominant inherited disease affecting about 1:3000 humans living at birth. Neurofibromas are benign soft tissue tumours. Giant cell granuloma (GCG) is a benign tumour-like lesion that is preferentially located in the jaws. GCG can develop in NF1 patients.
A 7-year-old female NF1 patient was successfully treated for a recurrent GCG of the right mandibular premolar region (follow-up control: 2 years). The serum levels for calcium and phosphate, alcalic phosphatase and parathormone were in the normal range. Genetic analysis of the tumour sample (GCG) and blood by 7 microsatellite markers (Kluwe et al. Hum Mutat 22: 420, 2003) revealed LOH of the NF1 gene in both sources. Inactivation of the NF1 gene may thus contribute to the development of GCG in NF1. To the knowledge of the authors this is the first report on LOH in NF1-associated GCG.

P.251 Giant cell containing lesions of jawbones treated in department of maxillofacial surgery in wroclaw

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Giant cell lesions occur in jawbones and may include granulomas (central and peripheral), brown tumour of hyperparathyroidism, osteoclastomas, cherubism and aneurysmal bone cyst.
We performed a study in case to investigate kinds of lesions, causes, methods and effects of treatment. A total 23 patients were hospitalized in Department of Maxillofacial Surgery University of Medicine in Wroclaw between 1999 and 2004 due to giant cell lesions of jawbones. We performed a retrospective study of medical files.
We found that the most common lesion in our group is peripheral giant cell granuloma and that histological study is the basic method to distinguish lesions.

P.252 Results of enucleation of large ameloblastomas of mandible in 3 young patients

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Ameloblastoma is rare benign tumour and occurs in 1% of all oral cavity neoplasms. It is the most common odontogenic neoplasms of local aggressiveness and recurrence prediction especially after unradical surgery. Ameloblastoma most often occurs at the age of 30 s or 40 s, and because it grows slowly and initially without any clinical manifestation, one supposes that disease begins in the childhood.