LETTER TO THE EDITOR

AMELOBLASTOMA OF THE MAXILLA

Dear Editor

A Kumar et al. have written an excellent article that includes nearly all aspect of ameloblastoma of maxilla.[1] We wish to comment on the management aspect of the maxillary ameloblastoma on the basis of certain background.

The term ameloblastoma, first described by Churchill in 1933, is a rare benign locally invasive odontogenic neoplasm[1]. Although, the commonest site of involvement is mandible, the maxilla is involved in one fourth of all cases. However, there is a clear difference in the growth pattern of maxillary ameloblastoma in contrast to those of mandible because the medullary bony structure of the maxilla is different from the compact bony structure of the mandible.[2] It is well known fact that the medullary bone is invaded by neoplasm; compact bones are eroded rather than invaded by the tumor. Because of the spongy osteoarchitecture of the maxilla, which facilitates spread of the tumor. Its close intimacy to the nasal cavity, orbit, infratemporal fossa, parapharyngeal space, vital structure of skull base and proximity to the middle cranial fossa provides it good opportunity to invade extra maxillary structures.[1,3]

Approximately 2 percents of ameloblastoma are malignant, with the diagnosis based upon histological atypia and distance metastasis. Repeated surgery may provide a chance to turn it into malignancy. The spread is more feasible for maxilla due to its rich blood supply that provides a way for hematogenous spread. The additional factors are the existence of tumor for a long period of time, its large size at the time of diagnosis and selection of more conservative previous surgery and radiotherapy.[1,2,4]

The key to successful management is accurate detection of the extent of the tumor, adequate initial approach, and the confinement of tumor within maxilla at the time of presentation. To know the accurate extent of the tumor, the magnetic resonance study is essential if any bony loss is suspected particularly in advance or recurrent tumor.[4]

It is true for every tumor that if any attempt is made to remove it without clearing healthy margin, it results in recurrence. Chances of recurrence are more if the bony boundary is destroyed by more conservative surgery. In such instance, ameloblastoma is lethal and uncontrollable even with most modern surgical method, chemotherapy, radiotherapy, or a combination. Thus most authorities recommend en- block and more radical surgery for maxillary ameloblastoma.[1,2,3]

More than 95% recurrence of ameloblastoma has been reported within 5 years of initial Maxillectomy. Although, half of the recurrence occurred with first year of operation, the second recurrence was earlier. However, the follow-up of less than one year is not adequate. It is too early to conclude that this tumor had been controlled.[4]

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NMA AND NEED OF PROFESSIONAL SOLIDARITY

Dear editor

I strongly agree with the editorial published in the last issue.[1] Everyone agrees with the Code of Ethics by Nepal Medical Council, which states, “I will not allow considerations of age, sex, religion, nationality, politics or social standing to intervene