Non Odontogenic Cysts

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INFLAMMATORY CYSTS.

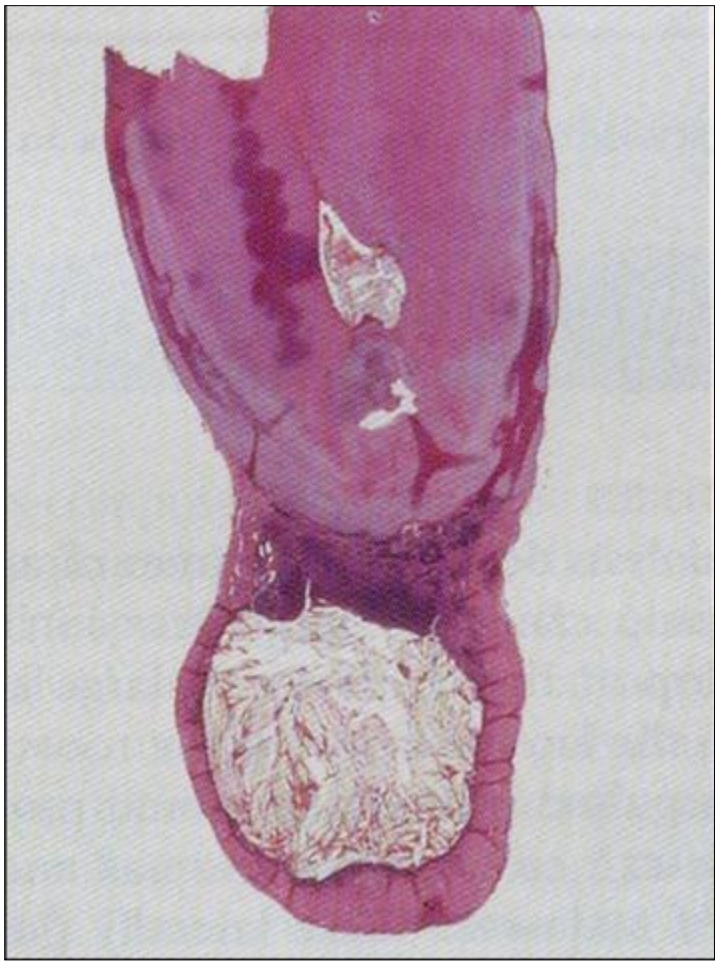
RADICULAR CYST.

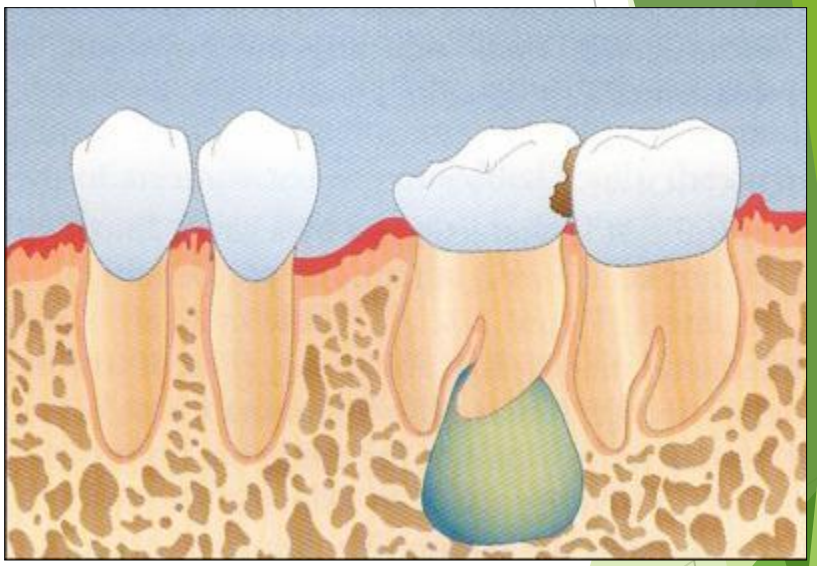
- Common among all the cysts.

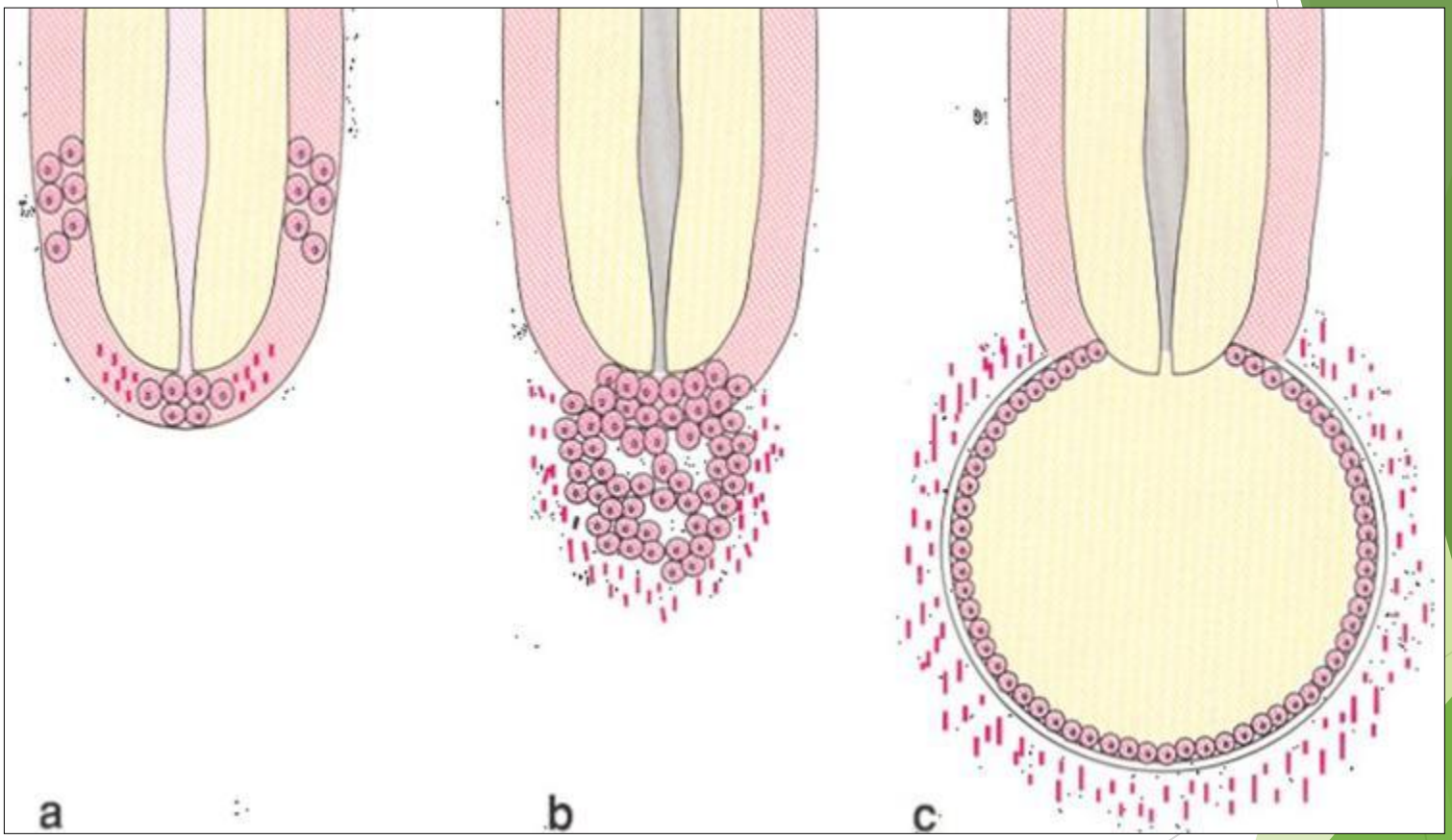
Pathogenesis:

- Results due to extension of infection from the pulp into the surrounding periapical tissue and initiation of cell rests of Malassez in the periodontal ligament.
- Based on location.
  - Periapical radicular cyst.
  - Lateral radicular cyst.
- Maxilla- most common.
  - Maxillary incisors.
- Mandible- molars.

- C/F:
  - Asymptomatic, slowly progressing lesion.
  - If infected causes pain and sinus tract is present.
  - In the maxilla palatal swelling is more common.
  - Initially the skin is normal but as the size of swelling increases blood vessels dilate and give a bluish tinge to the skin.
  - Patient may experience temporary paresthesia.



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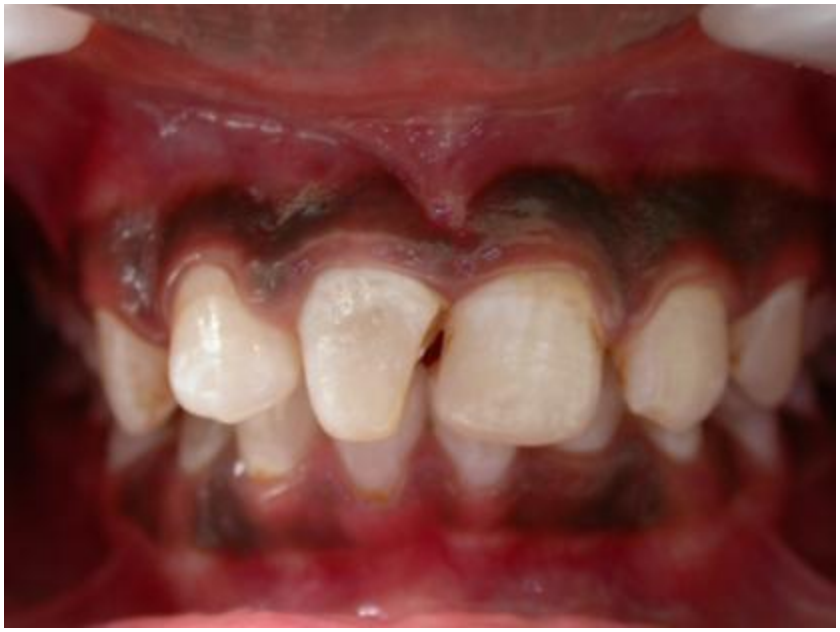
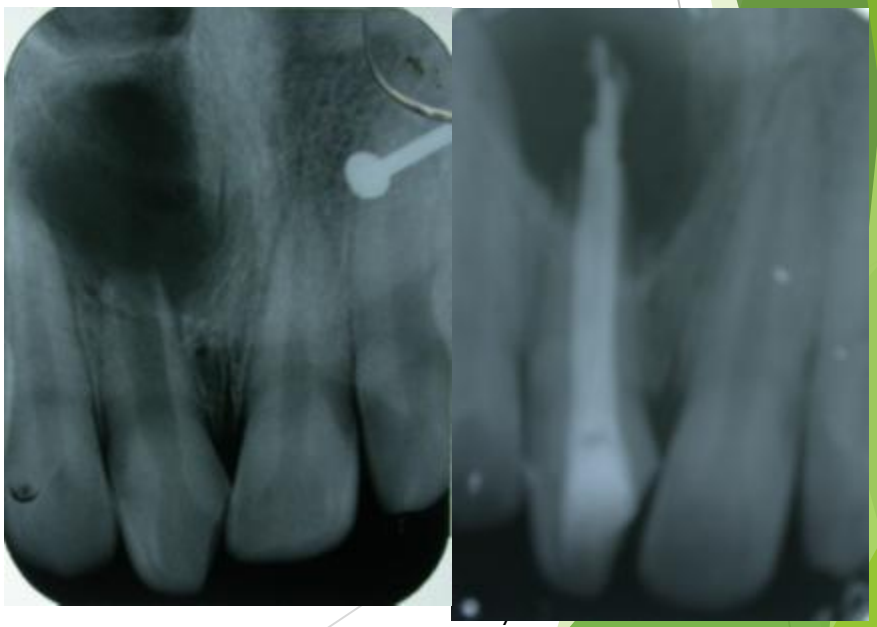
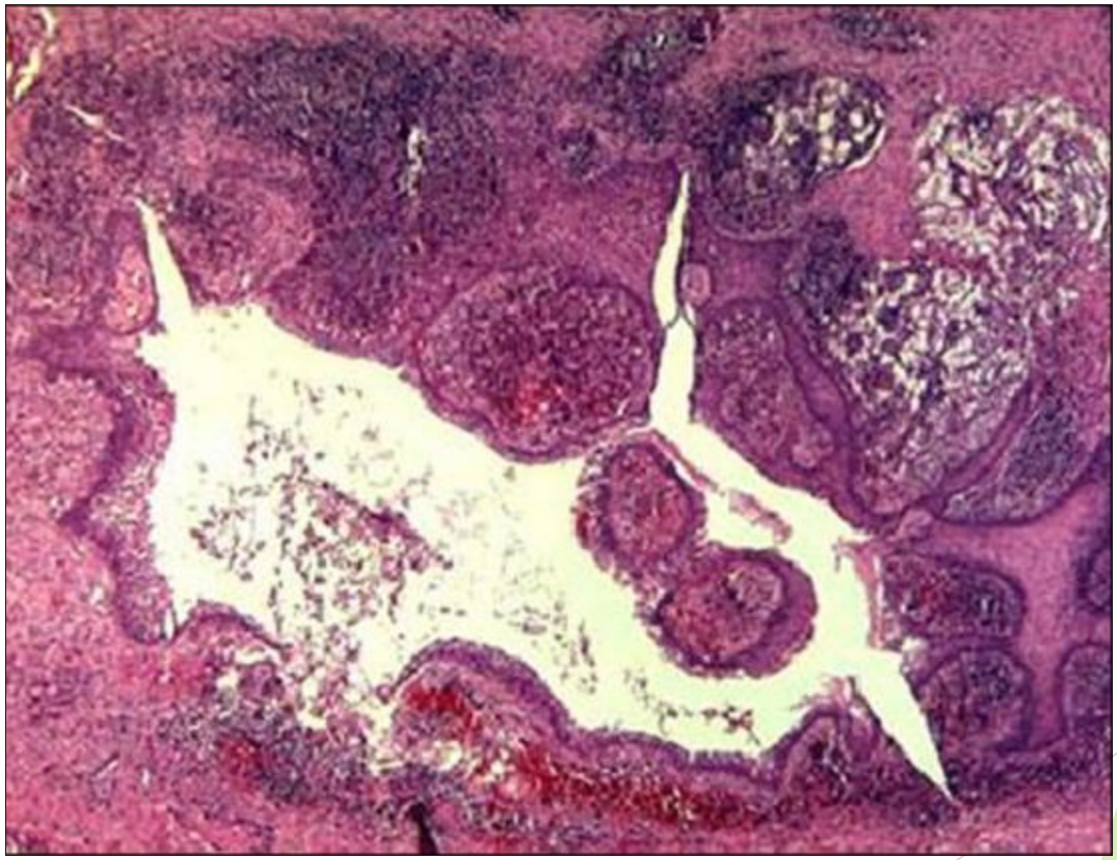
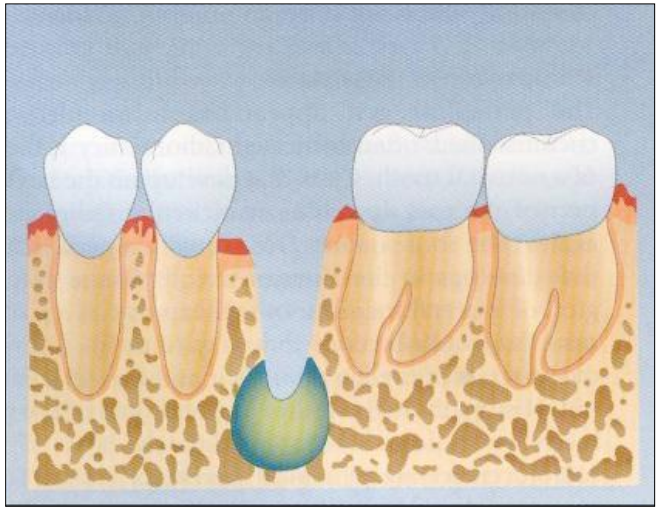
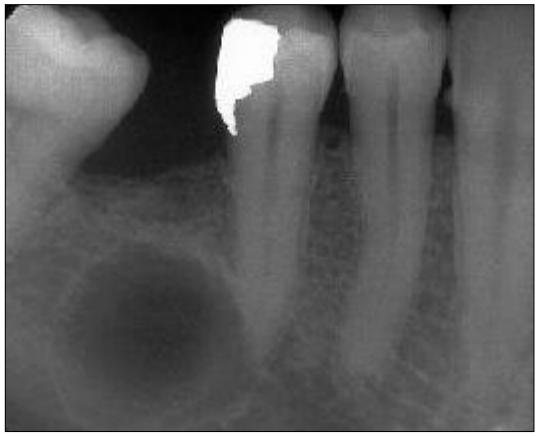






RESIDUAL CYST.





DEVELOPMENTAL CYSTS.

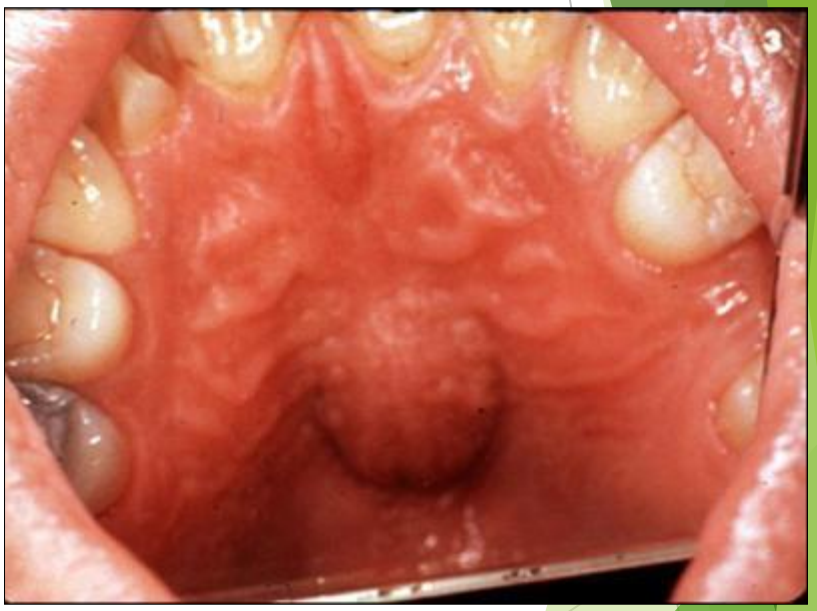
MEDIAN PALATAL CYST

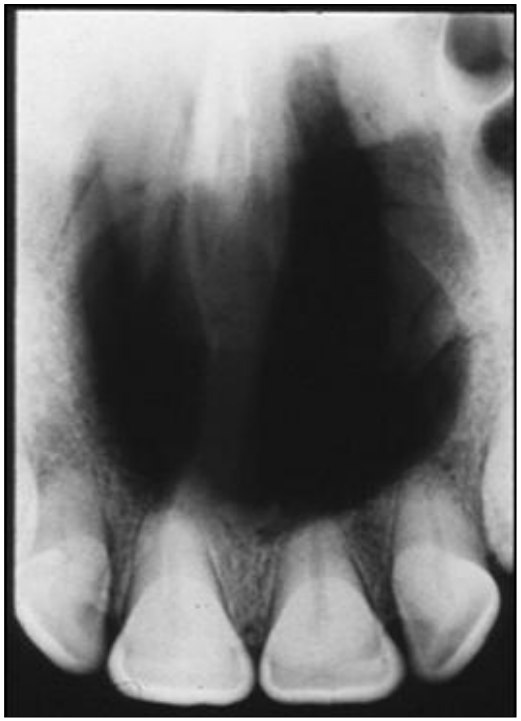
Pathogenesis:

- Occurs due to the inclusion of epithelial cells during the fusion of palatal processes.

C/F:

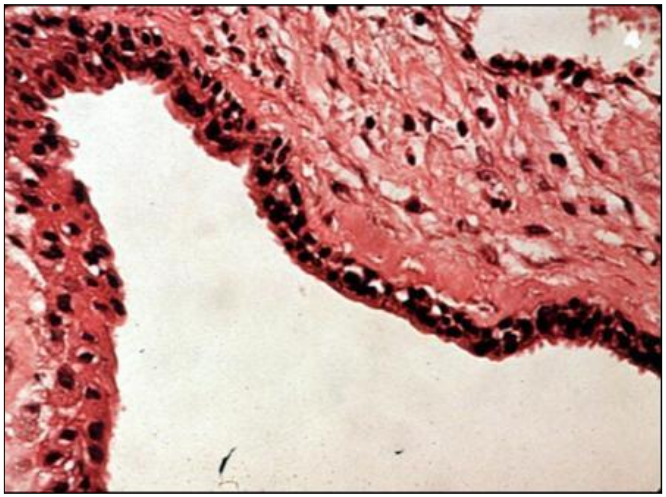
- Present in the midline of the palate.





R/F:

- Difficult to distinguish it from Nasopalatine cyst.



H/F:

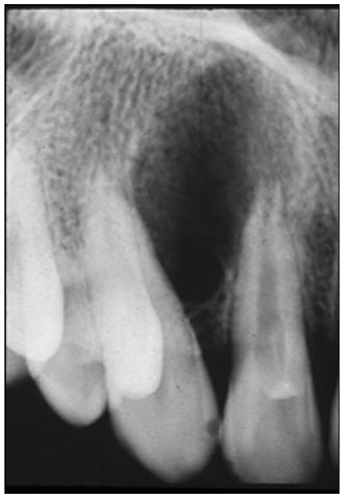
- Cyst is lined by Pseudo stratified ciliated columnar or cuboidal epithelium.

GLOBULOMAXILLARY CYST.

- THOMA 1937.

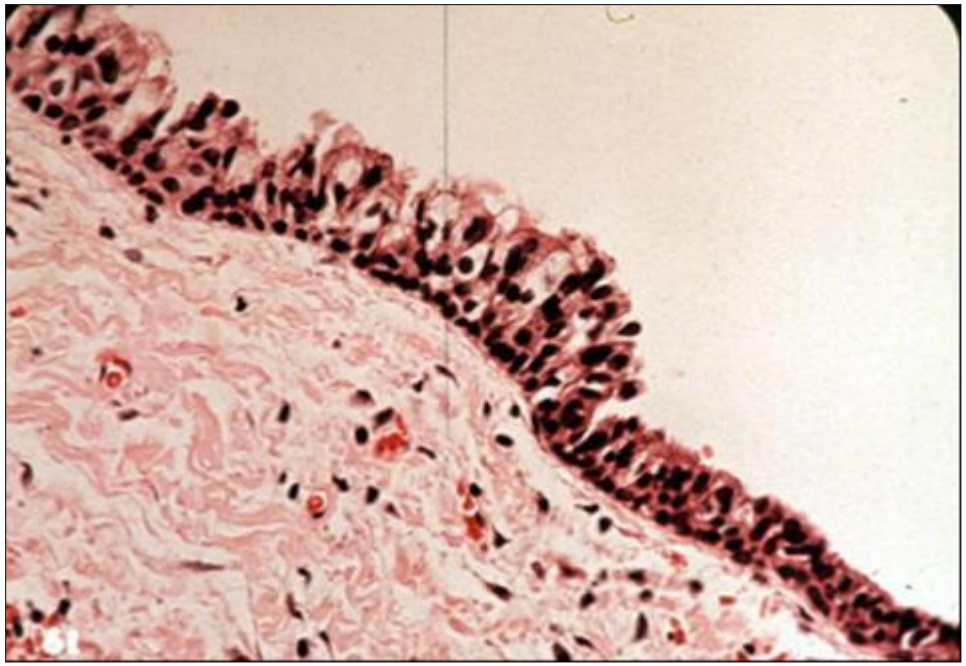
Pathogenesis:

- Caused by epithelial inclusions at the site of fusion of “Globular process of FN process” and the “Maxillary process”.
- Occurs very rarely .
- Usually seen b/w LI and Cuspids.
- Teeth are slightly tilted and are divergent.



R/F:

- Pear shaped radiolucency with its apex toward the alveolar process.



H/F:

- Cyst is lined by pseudostratified ciliated columnar epithelium derived from nasal mucosa.

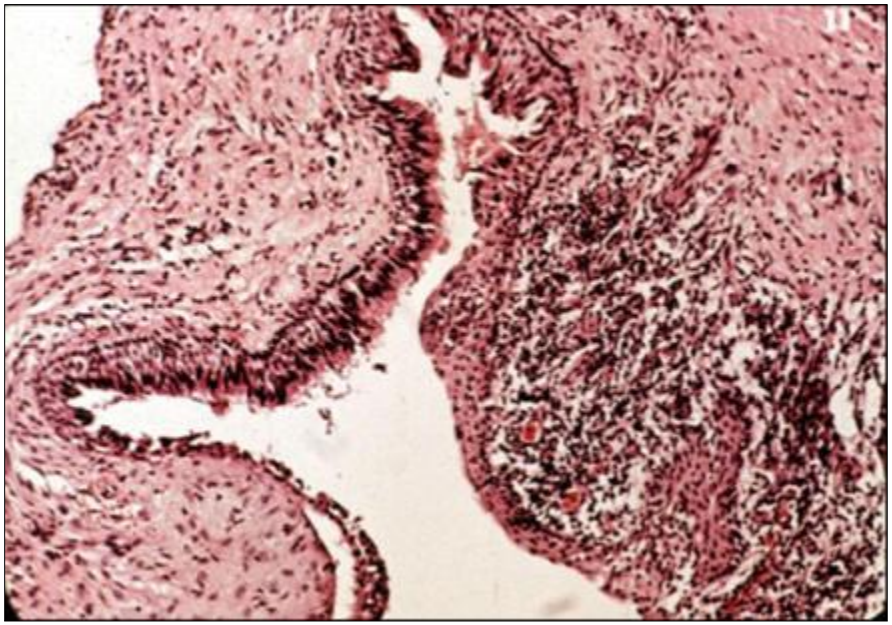
NASOPALATINE DUCT CYST/INCISIVE CANAL CYST.

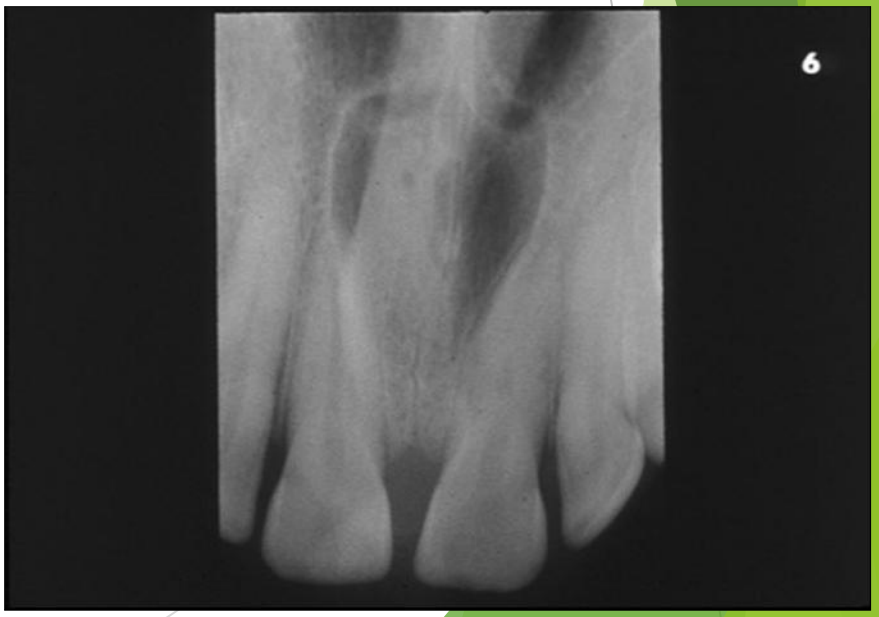
Pathogenesis:

- Occurs due to epithelial remnants with in the naso palatine canal.

C/F:

- Presents as swelling in the ant region of the palate.
- Commonly seen b/w the apices of CI.
- It does not grow beyond 1.5mm to 2mm.
- Causes displacement of teeth.
- Patient experiences salty discharge.

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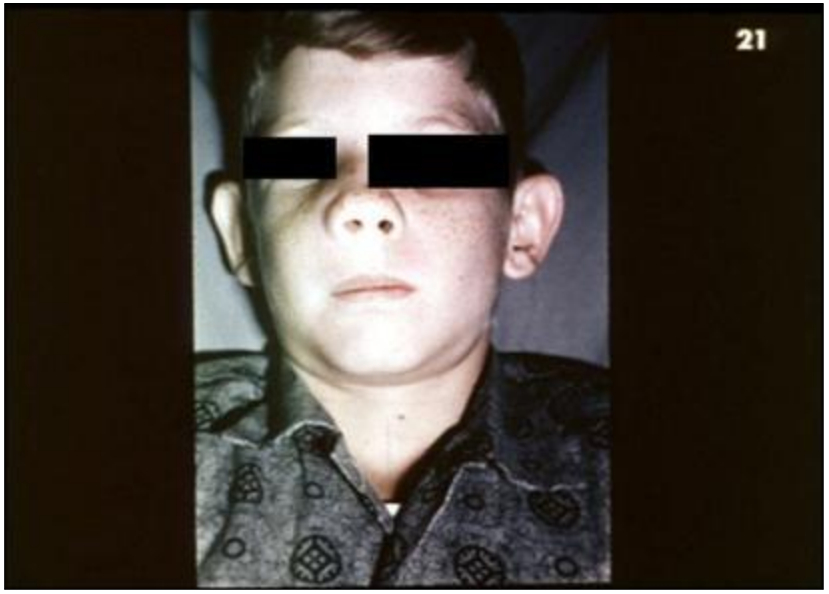
NASO LABIAL CYST/NASO ALVEOLAR CYST.

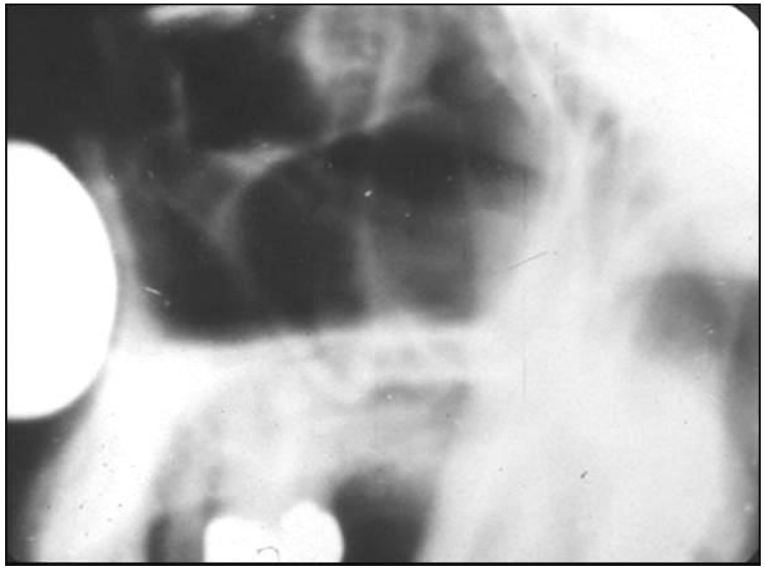


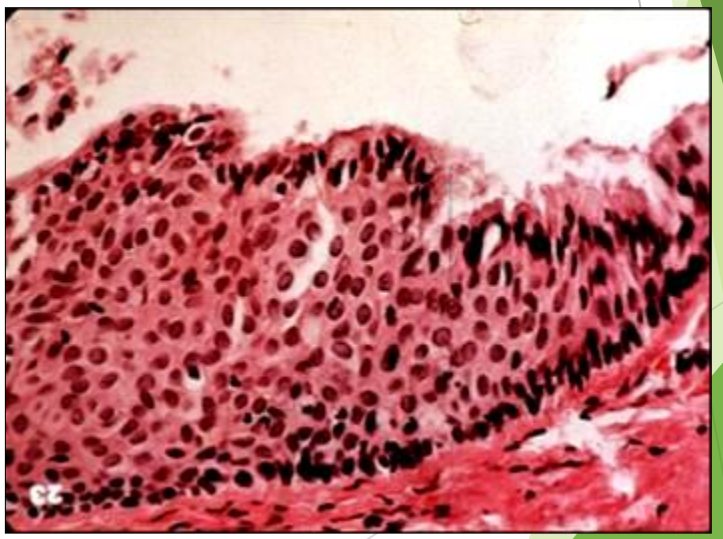
Pathogenesis:

- Occurs due to entrapment of epithelial remnants along the line of fusion of maxillary, medial nasal and lateral nasal processes.

C/F:

- Presents as a swelling lateral to midline.
- Swelling obliterates the muco buccal fold.
- Sometimes this expansion may cause nasal obstuction.

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PSEUDOCYSTS.

SIMPLE BONE CYST.

- Lucas 1829.
- Bony cavity with no epithelial lining and fluid content.

Etiology:

- Failure to organize hemorrhage.
- Sudden atrophy of central giant cell granuloma.
- Aberration in the development of osseous tissue.
- Chronic low grade infection.

Incidence:

- 1st 2 decades.
- Above inferior dental canal.

R/F:

- When enlarges pushes into interdental bone – scalloped outline.

ANEURYSMAL BONE CYST.

- Jaffe & Lichenstein 1942.

Etiology:

- Variation in homodynamics.
- Venous occlusion.

C/F:

- Firm swelling.
- Egg shell crackling.

R/F:

- Unilocular with subperiosteal layer of new bone.

STAFNE BONE CYST.

- Stafne in 1942.

Etiology:

- Caused by inclusion of salivary gland tissue.

R/F:

- Well defined unilocular radiolucency.

H/F:

REFERENES.

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