Additional treatment with Carnoy solution in surgical therapy of ameloblastomas: Case report

Tratamento adicional com solução de Carnoy na terapia cirúrgica de ameloblastomas: Relato de caso

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Abstract

Introduction: Ameloblastoma is a benign neoplasm characterized by the proliferation of odontogenic epithelium that mainly affects the gnathic bones and, due to its invasive and expansive growth, presents high rates of recurrence to surgical treatment. Among the most conservative treatments are enucleation and marsupialization; among radicals, resections are more widespread. Objective: The objective is to present, through a case report, conservative surgical treatment with enucleation followed by the use of the Carnoy solution. Case report: A 24-year-old male patient arrives at the outpatient clinic of Hospital da Restauração with painful complaints of mild and constant intensity in the region of the left mandibular angle, with an evolution of three weeks. After a panoramic X-ray, the presence of the included
38 tooth was associated with an extensive unilocular radiolucent lesion, surrounding the angle and mandibular ramus. Preoperative examinations were performed for incisional biopsy. Histopathological diagnosis was unicystic ameloblastoma. In view of the histopathology obtained, we opted for enucleation of the lesion with concomitant use of direct Carnoy solution in the region of the lesion. Discussion: The choice of therapeutic behavior depends on the size, type of lesion, location and histopathology. After the surgical decision, a radiographic clinical follow-up is necessary to assess possible recurrences. Carnoy's solution is a cauterizing agent with moderate tissue penetration, rapid local fixation and hemostatic action, whose surgical use in cystic lesions has occurred since the beginning of the 20th century. Conclusion: Conservative treatment with the enucleation technique followed by complementary therapy using Carnoy's solution proved to be quite effective.

**Keywords:** Ameloblastoma; Complementary therapies; Neoplasms.

1. Introduction

Ameloblastoma is a benign, slow-growing, locally invasive and expansive tumor, presenting high rates of relapse to surgical treatment (Aragão 2014; Effiom et al., 2018; Sheela et al., 2019; Saraiya 2020; Palanisamy & Jenzer 2020; González-González et al., 2020; Chai et al., 2019). It is an epithelial odontogenic tumor and its frequency is equal to that of all odontogenic tumors together, excluding odontomas (Fregnani et al., 2010; Palanisamy & Jenzer 2020; Kreppel & Zöller 2018). Its predilection occurs in the mandible in 85% of cases and the posterior region, branch and mandibular angle are the most affected, comprising 75% of mandibular cases (Neville 2011; Palanisamy & Jenzer 2020; Chai et al., 2019). The tumor may
occur at any age; however, there is predominance between the third and fifth decade of life (Effiom et al., 2018; Palanisamy & Jenzer 2020; Sheela et al., 2019; Chai et al., 2019). In the initial phase, ameloblastomas present scarce clinical features, without symptomatology, making the early diagnosis rare (Kruschewsky et al., 2010). Usually, they present a slow growth, often associated with the expansion of the cortical bone, which leads to facial deformities (Paikkatt et al., 2007; Kreppel & Zöller 2018). When signs or symptoms are present, patients usually report painless swelling associated with paresthesia or malocclusion, but most cases are discovered by routine radiographs (Kruschewsky et al., 2010).

In radiographic studies, most of the lesions are found as radiolucent, multilocular with well-defined limits that may resemble "soap bubbles" or "honeycomb", however, due to their ability to infiltrate the spaces bone marrow, its limits sometimes do not reflect the actual impairment of the lesion (Aragão 2014; Krishnapillai & Angadi 2010; Palanisamy & Jenzer 2020). In this context, Ameloblastoma, according to its clinical and radiographic characteristics, is classified into three types (Neagu et al., 2019): multicystic, unicystic and peripheral (extraosseous). There is also the malignant form that has few cases described in the literature (Palanisamy & Jenzer, 2020). Histologically, multicystic ameloblastomas can be classified in follicular plexiform, acanthomatous, granular, baseloid and desmoplastic cells. The unicistics can be classified in intraluminal, mural and extramural (Neville 2011; González-González et al., 2020), the mural variant tending to repeat itself (Marimuthu et al., 2020).

The surgical therapy of ameloblastoma can have several types of approach, from the most conservative to the most radical and the professional who will do the approach should choose the best treatment option (Carvalho et al., 2010; Neagu et al., 2019). Among the most conservative treatments are enucleation and marsupialization (Chai et al., 2019); among radicals resections are more widespread. The choice of therapeutic behavior depends on the size, type of lesion, location and histopathology (Palanisamy & Jenzer 2020). Radical interventions have a lower recurrence rate (Saraiya 2020), but most of them create aesthetic and functional damages that are difficult to reconstruct (Effiom et al., 2018; Chai et al., 2019). All extirpular surgical procedures aim at total removal of the lesion and elimination of remaining cells, so conservative treatments have a lower spectrum of action compared to radicals (Pogrel & Montes 2009). However, some authors like Lee et al., (2004) believe that conservative treatment creates a better quality of life and Marimuthu et al., 2020 reports the importance of enucleation and the use of Carnoy’s solution even in pediatric patients, a population in which the occurrence of ameloblastoma is rare (Sheela et al., 2019).

On the other hand, for the multicystic variety, the conservative approach is not recommended, being this one more indicated in the unicystic variety, in all its variants. In order to give a greater safety to the conservative treatment, additional procedures like the use of chemical substances (carnoy solution) or thermal (cryotherapy) are recommended for the treatment of the bed with elimination of possible remaining cells. The ameloblastomas present high rates of relapses (Neagu et al., 2019), so after the treatment, it is necessary that the preservation is done for a period of at least 5 years (Lee et al., 2004).

Carnoy's solution is a cauterizing agent with moderate tissue penetration, rapid local fixation and hemostatic action, whose surgical use in cystic lesions has occurred since the beginning of the 20th century. Its application to the bone shop after invasive lesion removal provides safety margin by chemical necrosis of up to 1.5 mm depth (Williams & Connor 1994). Each 10 mL of solution contains 6 mL of absolute alcohol; 3 mL of chloroform and 1 mL of glacial acetic acid associated with 1 g of ferric chloride and can be used for three minutes after enucleation directly in the bone shop (Lee et al., 2004).

Therefore, the objective of this study is to present the resolution of the clinical case of unicystic ameloblastoma, in which it was decided to enucleate the lesion with concomitant use of a direct carnoy solution in the region of the lesion in order to guarantee an optimal prognosis for the patient.
2. Methodology

This is a clinical case study that is qualitative, descriptive and produced by the technique of direct observation. According to Pereira et al. (2018), research with this character aims to elucidate a particular subject and study it thoroughly, with the patient's permission, through access to medical records, clinical examination, laboratory and image exams available, with the researcher being the instrument paramount to this process. Here, we respect all the ethical principles proposed by the Declaration of Helsinki, upon the patient's consent to their clinical information. The patient in question consented to the study and disclosure of his case, signing the Informed Consent Form provided by our team.

3. Case Report

A 24-year-old male patient, brown, without systemic diseases, arrives at the outpatient clinic of the hospital of the restoration with painful complaints of light and constant intensity in a region of left mandibular angle, with evolution of three weeks. Physical examination showed no clinical change, only pain on palpation in the region of the mandibular vestibule. After a panoramic radiograph, the presence of the included 38 tooth was associated with an extensive unilocular radiolucent lesion with a diameter of more or less 6 cm surrounding the angle and mandibular branch (Figure 1).

![Figure 1 – Diagnostic radiography showing unilocular lesion associated with the tooth.](image-url)

The lesion was discovered, and after that, preoperative exams were performed for an incisional biopsy procedure. The histopathological diagnosis was unicystic ameloblastoma. In view of the obtained histopathology, it was chosen the enucleation of the lesion with concomitant use of direct carnoy solution in the lesion region (Figure 2).
Figure 2 – In the surgical approach, enucleation was performed with concomitant use of carnoy solution in the lesion region.

During the period of convalescence, it was necessary to maintain the patient with maxillary mandibular block for 30 days to reduce the risk of pathological fracture and remained in clinical radiographic follow-up for the following periods: immediate, 3 months, 6 months, 1 year and 2 years (Figure 3).
4. Discussion

Ameloblastoma is a benign neoplasm characterized by proliferation of the odontogenic epithelium (Neville 2011; Palanisamy & Jenzer 2020). Because it is a potentially invasive type of tumor and has a good number of histopathological variables, there is a need for additional histopathological and radiographic exams so that there is an accurate diagnosis and, from this, the best form of treatment is chosen (Paikkatt et al., 2007; Carvalho et al., 2010; González-González et al., 2020). The data found in the literature related to the location and prevalence of age are confirmed by the clinical findings described in the case, corroborating the work of Fregnani et al. (2010), where the majority of tumors occur between 20 and 30 years and mainly affect region of mandibular angle.

According to Neville et al. (2011) and Palanisamy and Jenzer (2020), ameloblastoma generally evolves without symptoms, since pain and paresthesia are rarely reported. In the present case, the clinical findings diverge from the literature, since the patient was taken to the hospital because of constant painful symptoms of mild intensity in the region where the tumor was located. Also important was the association of the tumor with the crown of an unbroken tooth, which is also characteristic of lesions such as dentigerous cyst and odontogenic keratocystic. Thus, it is important to perform a histopathological examination that, besides excluding differential diagnoses, is fundamental for the surgical planning and treatment of the lesion (Neagu et al., 2019).

The histopathological and radiographic exams were extremely important and served as the basis for the decision making regarding the treatment of the tumor. Because it is a unicystic ameloblastoma, it was chosen a conservative treatment, as is the case with enucleation. Because of the high rates of relapses consistent with the conservative treatment described in the literature (Chai et al., 2019), it was used carnoy's solution to provide a margin of safety, removing epithelial remnants that may promote recurrence of the lesion (Krishnapillai & Angadi 2010).

Placement of Carnoy solution used directly in the surgical shop for three minutes after enucleation may reduce the chance of relapse, as well as the use of cryotherapy (Williams & Connor 1994; Costa et al., 2019). Both methods promote
cauterization and bone necrosis. However, the carnoy solution is more resistant to cryotherapy in both its handling and postoperative complications (Lee et al., 2004).

Two-year follow-up did not reveal findings consistent with recurrence of tumor lesion, thus showing that the conservative treatment with safety margin used in this case is viable. However, there is still a need for radiographic and, when necessary, histopathological clinical follow-up for a period of 10 years to evaluate possible relapse (Kruschewsky et al., 2010; Aragão 2014).

5. Conclusion

The definitive treatment for ameloblastomas is surgical and the histopathological diagnosis of the type of ameloblastoma is fundamental for the surgical decision, and the conservative treatment of the unicystic lesions is effective with the enucleation technique followed by complementary therapy with the use of a solution of Carnoy.

References


