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Original Research Article

Prevalence and radiographic features of ameloblastoma at Hasanuddin University Dental Hospital: A retrospective study

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Abstract

Background: Ameloblastoma is one of the most recognized odontogenic tumors in many countries all over the world. It is an uncommon odontogenic tumor of the mandible and maxilla, with 80% arising in the mandible and 20% occurring in the maxilla. Ameloblastoma may arise from rests of dental lamina, enamel apparatus, the epithelial lining of an odontogenic (dentigerous) cyst, or from the basal epithelial cells of the oral mucosa.

Objectives: To analyze cases of ameloblastoma, with an emphasis on prevalence and radiographic findings. This study also briefly reviews the current literature and discusses the radiographic characteristics of ameloblastoma.

Materials and Methods: This research was a quantitative analysis with a descriptive retrospective design. Secondary data were obtained from the Hasanuddin University Dental Hospital from January 2023 to December 2023. A total of 13 cases, diagnosed both clinically and radiographically, were included in the study.

Results: The age of patients affected by ameloblastoma ranged from 15 to 67 years, with the most affected group being those between 20 and 29 years (46.15%). The male-to-female ratio was 1.2:1. All cases involved the mandible and exhibited unilateral involvement (100%). The multilocular and unilocular types of ameloblastoma were observed in 8 cases (61.54%) and 5 cases (38.46%), respectively. Among the multilocular variants, the soap-bubble pattern was the most common (62.5%), followed by the spider-web-like pattern (25%) and the honeycomb pattern (12.5%). Root resorption of varying degrees was observed in 8 cases (61.54%).

Conclusion: Ameloblastoma most commonly presents in the third decade of life, with a higher prevalence in men than in women, and is predominantly multilocular in appearance. Radiographs are a crucial diagnostic tool for oral lesions, particularly those involving bone. Clinicians should consider ameloblastoma as a key differential diagnosis when encountering radiolucent or mixed-density lesions in the mandible, especially when accompanied by cortical expansion and root resorption. Early detection and accurate diagnosis are essential for effective management.

Keywords: Ameloblastoma, Radiographic features, Prevalence, Mandible

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1. Introduction

Ameloblastoma is one of the most recognized odontogenic tumors in many countries from all over the world. It is an uncommon odontogenic tumor of the mandible and maxilla, with 80% arising in the mandible and 20% occurring in the maxilla. It is a relatively rare neoplasm derived from odontogenic epithelium and represents about 1% of all tumors and cysts of the jaws and approximately 10% of odontogenic tumors with an incidence of 0.5 per million inhabitants per year.[1,2] Ameloblastoma may arise from rests of dental lamina, enamel apparatus, the epithelial lining of an odontogenic (dentigerous) cyst, or from the basal epithelial cells of the oral mucosa.[3] Ameloblastoma usually present as a painless swelling, slow growing mass, expansion of jaw bones, perforation of mandible or maxilla cortical plates and infiltration to surrounding soft tissue or sinonasal structure. The World Health Organization (WHO) defines ameloblastoma as a locally invasive, polymorphic benign tumor with odontogenic epithelial growth over fibrous stroma. According to the WHO in 2005, there are four

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different classifications of ameloblastoma: solid or multicystic, unicystic, peripheral, and desmoplastic. The solid or multicystic ameloblastoma is the most common subtype of ameloblastoma (approximately 80% of cases) and has a predilection for the posterior side of the jaws, especially the body, ramus, and angle of the mandible.[4]

Ameloblastoma appears most commonly in the third to fifth decades of life, but it has been reported in patients with age ranging from 10–90 years. Ameloblastoma shows no clear sex predilection and is most commonly diagnosed in adults between the ages of 30 and 60 years. It commonly affects the mandible and only rarely the maxilla or the soft tissue (peripheral ameloblastoma). Over 80% of these lesions occur in the mandible, especially in the angle and ascending ramus with 70% of these arising in the molar-ramus area; they are occasionally associated with unerupted third molar teeth.[3,5] Ameloblastoma may be clinically asymptomatic and can be detected incidentally on radiological imaging. Radiological investigations provide an useful aid to diagnosis. However, these findings are not pathognomonic and must be confirmed with histological examination. The orthopantomogram (OPG) is a useful first-line investigation and may reveal lucency in the bone of varying size and shape associated with scalloped margins and resorption of the roots of involved teeth. Occasionally it can be a well-demarcated unilocular lesion, whereas often it presents as multiloculated expansile lucencies with a so-called soap bubble appearance.[6]

Ameloblastoma of the jaws is the most encountered odontogenic tumor in Asia and Africa and is referred to as the second most odontogenic tumor found in North and South America.[7] There was a study that showed the number of ameloblastoma was significantly higher in Asian or African hospitals compared to European or American hospitals.[8] In Southeast Asia alone, collective data of ameloblastoma has not been well analyzed or compared separately from other odontogenic tumors. The study of the tumor in these regions especially in Indonesia is still limited. In Indonesia, not many studies carried out regarding the distribution and frequency of ameloblastoma. Besides that, research on the ameloblastoma radiographic features is still incredibly scarce in Indonesia. The researchers are interested in performing to analyze cases of ameloblastoma, with emphasis on the prevalence and radiographic findings.

2. Materials and Methods

This research was a quantitative analysis with a descriptive retrospective design. The study utilized secondary data obtained from the Hasanuddin University Dental Hospital, covering the period from January 2023 to December 2023. Data were collected by reviewing clinical and radiographic records available in the archives of the department. A total of 13 cases, diagnosed both clinically and radiographically, were included in the study. Panoramic radiographs served as the primary basis for the analysis. Radiographs with artifacts or technical faults were excluded. All radiographs and images were acquired using standard techniques and processed under standardized conditions. Descriptive data from these patients were evaluated and compared with previously documented data in the literature. The collected data included age, gender, and radiographic features such as location, radiodensity, bony margins, locularity, multilocular appearance, effects on adjacent dentition, and cortical expansion.

The localization of lesions was categorized into two areas of the mandible. The first category included ameloblastoma involving a single region, while the second category included ameloblastoma involving multiple regions. Ameloblastoma involving a single region was further divided into: (1) the anterior mandible, extending from the left canine to the right canine, or in edentulous patients, from the left to the right mental foramina; and (2) the posterior mandible, extending from the canine to the angle of the mandible on either the left or right side. Ameloblastoma involving multiple regions included the following combinations: (1) anterior and posterior, (2) anterior, posterior, and ramus, (3) posterior and ramus, (4) posterior, ramus, and condyle, and (5) ramus and condyle.

Radiodensity was classified as radiolucent, radiopaque, or mixed (a combination of radiolucent and radiopaque). The bony margins adjacent to the lesion were described as either well-defined or unclear. Lesions were classified as unilocular (containing a single compartment) or multilocular (containing multiple adjacent compartments). Based on Worth's radiographic description (1963) of ameloblastoma, multilocular lesions were further categorized as soap-bubble, honeycomb, or spider-like in appearance.[9] The effects of the lesion on adjacent structures were assessed through signs of root resorption and/or tooth displacement. The size of the lesion was measured in millimeters across its widest diameter, between opposite borders. The expansile nature of the lesion was evaluated by examining its effect on the mandibular cortex. Data were analyzed and presented using Microsoft Excel.

3. Result

A total of 13 patient records with a radiodiagnosis of ameloblastoma were collected from the archives at the Hasanuddin University Dental Hospital. The records extended from January 2023 to December 2023.

3.1. Age and gender

In this study, the ages of patients at the time of diagnosis ranged from 15 to 67 years, with a mean age of 32.92 years. The majority of patients were under 50 years old (84.62%). The most affected group consisted of patients between 20 and 29 years of age (46.15%) (**Figure 1**). Only one patient (7.69%) was in the 60 to 69 years age group. The male-to-female ratio was 1.2:1, with 7 males (53.85%) and 6 females (46.15%) (**Figure 2**).

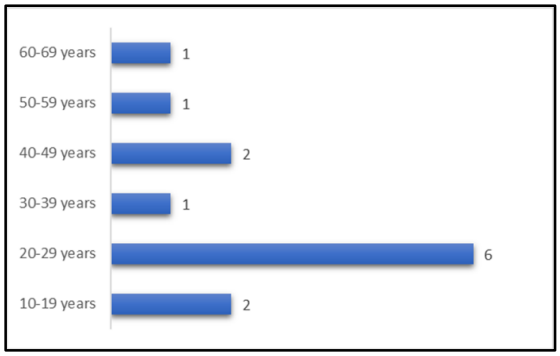

Figure 1: Age-wise distribution of patients

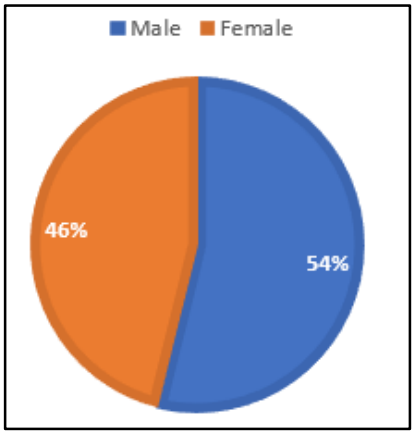

Figure 2: Gender-wise Distribution of Patients

3.2. Location

Among these 13 cases, all cases involved the mandible and exhibited unilateral involvement (100%). In the mandible, all cases extended across multiple regions (**Table 1**). The majority of cases (five cases, 38.46%) involved the posterior, ramus, and condyle regions. Only one case (7.69%) was confined to the ramus and condyle regions. The anterior and posterior regions were involved in three cases (23.08%), while the anterior, posterior, and ramus regions were involved in two cases (15.38%). Similarly, the posterior and ramus regions were involved in two cases (15.38%).

Table 1: Distributions of ameloblastoma in the mandible

Location	No. of lesions	Percentage
Ameloblastoma involving one region		
Anterior	0	0
Posterior	0	0
Ameloblastoma involving multiple regions		
Anterior and posterior	3	23.08
Anterior, posterior, and ramus	2	15.38
Posterior and ramus	2	15.38
Posterior, ramus and condyle	5	38.46
Ramus and condyle	1	7.69

3.3. Radiodensity

The orthopantomogram (OPG) examination revealed that two lesions (15.38%) exhibited a purely radiolucent appearance, indicating areas of complete bone resorption or cystic changes. In contrast, 11 lesions (84.62%) displayed mixed radiodensity, featuring both radiolucent and radiopaque components, which suggests a combination of bone destruction and new bone formation within the lesion (**Figure 3**). None of the lesions presented with a purely radiopaque appearance, highlighting the predominantly osteolytic nature of the observed pathology.

Figure 3: The orthopantomogram (OPG) showing both radiolucent and radiopaque appearance (mix density) of ameloblastoma in the anterior-posterior region right mandible

3.4. Margins and locularity

Ten lesions (76.92%) presented with well-defined, sharp margins that were clearly distinguishable from the surrounding unaffected bone, suggesting a more localized and less invasive growth pattern (**Figure 4**). In contrast, three lesions (23.08%) exhibited unclear or poorly defined margins, which may indicate a more aggressive or infiltrative behavior. Approximately eight lesions (61.54%) appeared as multilocular entities, characterized by multiple adjacent compartments or lobules, giving them a "soap-bubble" or "honeycomb" appearance (**Figure 4**). The remaining five lesions (38.46%) appeared unilocular, presenting as single, well-demarcated compartments (**Figure 6**). Among the multilocular variants, 50% were observed in patients aged 20–29 years, suggesting a higher prevalence of this pattern in younger adults. In contrast, 50% of the unilocular variants were observed in patients under 30 years of age, indicating that this pattern may also be relatively common in younger individuals but with a slightly different distribution.

Figure 4: The OPG showing the lesion multilocular presented with well-defined margins discernable from the surrounding unaffected bone

Figure 5: The OPG showing unilocular ameloblastoma in the posterior, ramus and condyle regions of the right mandible

3.5. Multilocular appearance

Based on the results, among the multilocular lesions, the soap-bubble appearance was observed in five cases (62.5%). This pattern was characterized by large, irregular compartments separated by bony septa, giving the lesion a bubble-like or cystic appearance. The spider-web-like pattern was seen in two cases (25%), featuring thin, radiating bony trabeculae that resembled a spider's web. The honeycomb pattern, observed in one case (12.5%), displayed small, uniform compartments resembling a honeycomb structure. Most multilocular lesions in this study exhibited a soap-bubble pattern and appeared as mixed-density lesions, combining both radiolucent and radiopaque features. This mixed density suggests varying degrees of bone resorption and new bone formation within the lesion, consistent with the dynamic nature of ameloblastoma.

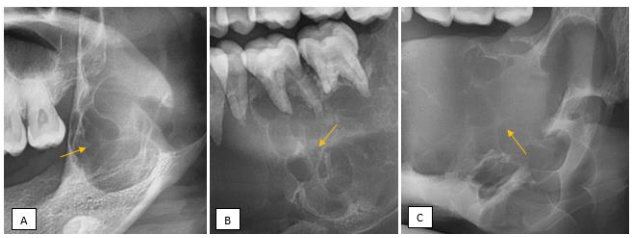

Figure 6: Cropped the OPG radiograph showing; **A:** Soap-bubble appearance type; **B:** Honeycomb type; **C:** Spider-web-like pattern type

3.6. Effect of lesion on adjacent dentition

Root resorption of varying degrees was distinctly observed in eight cases (61.54%). The impact on adjacent dentition included root resorption alone in two cases (15.39%) and a combination of root resorption and tooth displacement in six cases (46.15%). Only two lesions (15.39%) showed no effect on the adjacent dentition. In the remaining three cases (23.07%), no teeth were present adjacent to the lesion, either due to the lesion's location in edentulous regions or because the jaws were completely edentulous (**Table 2**).

Table 2: Distributions effects on dentition of ameloblastoma

Effect on Dentition	No. of lesions	Percentage
Root resorption only	2	15.39
Both root resorption and root/tooth displacement	6	46.15
No effect	2	15.39
No teeth next to the lesion	3	23.07
4.		

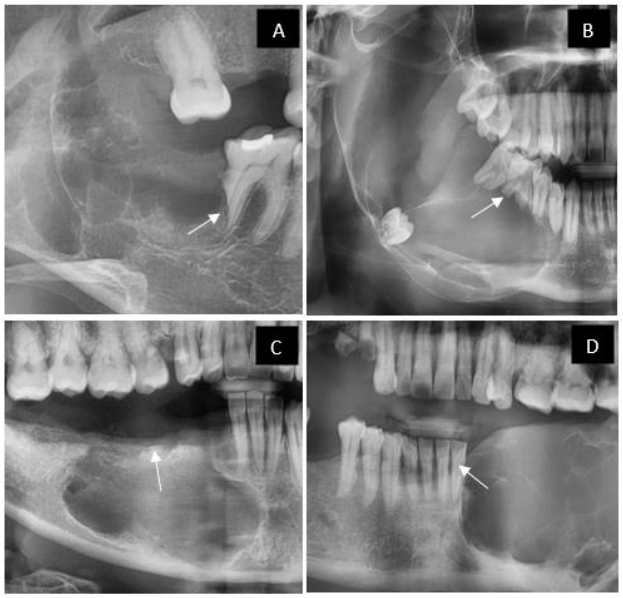

Figure 7: Cropped the OPG radiograph showing effect ameloblastoma on dentition; **A:** Root resorption only; **B:** Both root resorption and root/tooth displacement; **C:** No teeth next to the lesion, and **D:** No effect

3.7. Size of lesion

The size of each lesion was determined by measuring its largest diameter between opposite borders in millimeters (mm). The lesions varied significantly in size, ranging from 30.13 mm to 93.28 mm, with an average size of 67.93 mm. This wide range reflects the diverse growth patterns and stages of the lesions observed in the study.

Figure 8: The OPG radiograph measuring the size lesion of ameloblastoma

3.8. Effect on the cortex of the mandible

Based on the results show that Eleven lesions (84.62%) exhibited a noticeable effect on the mandibular cortex, manifesting as cortical expansion, thinning, or perforation. In contrast, two lesions (15.38%) showed no detectable impact on the mandibular cortex, suggesting a more contained or less aggressive growth pattern. The high prevalence of cortical involvement underscores the locally invasive nature of the lesions observed in this study.

5. Discussion

Ameloblastoma is a benign tumor that grows slowly but is locally invasive, painless, and may destroy the bone.[9] The characteristics of ameloblastoma based on radiographic examination and anatomical pathology are very diverse, and analysis is needed to determine the characteristics that often occur in patients at Hasanuddin University Dental Hospital. Based on the results of data collection, the incidence of ameloblastoma at Hasanuddin University Dental Hospital from January 2023 to December 2023 recorded 13 patients, ameloblastoma was observed to occur between the ages of 15 years and 67 years with the mean age being 32.9 years and patients between the ages of 20 and 29 years were the most affected group. This is consistent with the study's findings Ranchod et al, which showed that the average age distribution of ameloblastoma patients in Tygerberg Oral Health Centre was 32.9 years and patients between the ages of 20 and 29 years were the most affected group.[10] The other study of Darshani et al, showed that the age of occurrence for ameloblastoma of both jaws ranged from 5 to 80 years with a mean age of 33.26 years and the most cases occurred in decade of life with a peak in the third decade.[11] The peak incidence of ameloblastoma in Asia occurs in the third to fifth decade of life.[12] So, this supports the theory that the incidence of ameloblastoma is highest in the third to fourth decade.[2,13] Various studies show inconsistent findings regarding gender predilection. The present study showed a slight male predilection, with a male: female ratio of 1.2:1. This is similar to the findings of Chawla et.al which the male: female ratio was 1.2: 1.[14] Greater occurrence in men was also documented in studies from by Siar et al.[23] More et al.[15] and Krishnapillai et al,[16] with ratios of male and female patients being 1.4:1, 1.3:1 and 1.3:1, respectively. However, Singhal et al.[17] in the Puducherry populations found a female inclination of 1:1.3, and Deepthi et al.[18] in South Kerala observed a ratio of 1:1.13. Ogunsalu et al.[19] who reported a female predominance with a male-to-female ratio of 1:1.14.

Numerous studies have concluded that the mandible is more commonly affected with ameloblastoma than the maxilla. In this study, all of patients presented with ameloblastoma of the mandible and the majority involved posterior, ramus and condyle regions of the mandible. This finding was similar to those of the study by Singh et al.[20] who reported that the mandible, particularly the posterior region, was the most affected site. Selvamani et al.[21] showed ameloblastoma lesions were seen predominantly in the mandible that present in 96.8 % and posterior mandible was most commonly affected followed by anterior region. The other study of Nazir and Usman[22] concluded that the predominant anatomical distribution of ameloblastoma was in the mandible (86.7%) and in both jaws, posterior region was the most affected site. Most frequently involved anatomical site among the four quadrants was right posterior body-ramus-angle region followed by the same anatomical location on the left side of mandible.

This study showed mixed radiolucent-radiopaque lesion's appearance predominated. This significantly contrasts with the finding of Macdonald-Jankowski et al.[7] in their systematic review by, in which radiolucent appearance predominated. Siar et al.[23] also showed that a large proportion of lesions were radiolucent. A large percentage of lesions found in this study showed well-defined, corticated borders and were easily identifiable from the adjacent, unaffected bone. Malik et al.[24] and More et al.[15] also reported a high proportion of these lesions showing this feature. The majority of tumors that exhibited unclear margins were associated with larger lesions. These lesions appeared to destroy the cortices and involve the surrounding soft tissue. It may be argued that, due to the expansile nature of this tumor, larger lesions tend to destroy the cortex, which in turn gives rise to an unclear margin. In our study, eleven lesions (84.62 %) presented with effect on the cortex of the mandible. In this study, multilocular ameloblastoma was shown to be more predominant than unilocular pattern. This is comparable to studies Ranchod et.al[10] showed that 85.72% ameloblastoma were multilocular and 14.28% were unilocular. In comparison, Fregnani et al[25] and Adeline et.al[26] observed multilocular lesion in 60% and 83.2% of their cases, respectively. Some studies indicate the unilocular appearance is more prevalent. Further, a higher frequency of unilocular radiolucencies was also reported by Tatapudi et al.[27] and Bansal et al.[28] It is pertinent to note that among the 13 cases discussed here, 8 cases were multilocular; of these 8 cases, 5 showed the soap-bubble pattern, 2 cases showed the spider-web pattern and 1 showed the honeycomb pattern. According to Worth,[29] the "spider-like" pattern is the most common radiological appearance. This is followed by the "soap-bubble" pattern. However, in our study the "soap bubble" pattern predominated (62.5%). The "honeycomb" pattern was present in only a small percentage (12.5%). In addition, the "soap-bubble" pattern presented almost equally in both radiolucent and radiolucent-radiopaque (mixed) lesions.

There is a pronounced tendency for ameloblastoma to cause extensive root resorption. In our study, root resorption associated with tooth displacement amounted to a substantial proportion (46.15%). In a study by Struthers and Shear,[30] it was shown that the incidence of root resorption in association with ameloblastoma was high (81%). Therefore, the inclusion of ameloblastoma as part of a differential diagnosis is essential when root resorption occurs in them presence of a cystic lesion, especially if the posterior region of the mandible is involved. Root resorption is the progressive loss of cementum and dentin due to the continual action of osteoclastic cells. In 1976, Struthers et al. reported that ameloblastoma was associated with higher rates of root resorption than other cystic lesions.[30] Past reports have also suggested that root resorption is a result of the pressure caused by a locally invasive tumor-like ameloblastoma. A study by Fulco et al.[31] reported the average size of ameloblastoma as 43 mm. The results of this study showed

that the average size of the lesions (67.93 mm) was nearly than twice the average size reported in the literature.

6. Conclusion

Ameloblastoma most commonly presents in the third decade of life, with a higher prevalence in men than in women, and is predominantly multilocular in appearance. Radiographs play a crucial role in diagnosing oral lesions, particularly those involving bone, as they provide essential insights into the lesion's characteristics and extent. For practicing clinicians, understanding the salient features of ameloblastoma is vital for accurate diagnosis and management. Ameloblastoma should always be considered a key differential diagnosis when radiolucent or mixed-density lesions are observed in the mandible, especially when accompanied by cortical expansion and root resorption. These features, along with the lesion's locally aggressive behavior, highlight the importance of early detection and appropriate intervention.

7. Source of Funding

None.

8. Conflict of Interest

The authors declare no conflict of interest.

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