

Clinical, surgical management, and orthodontics's function in odontoma treatment

Andrea Palermo^{1*}
Danilo Ciccarese²
Irma Trilli²
Gerardo Cazzato^{2*}
Francesco Sabatelli²
Ioana Roxana Bordea^{3*}
Gustavo Vincentis Oliveira Fernandes⁴
Ahmed Abdelwahed Shaaban⁵
Edit Xhajanka⁶
Lwai Almasri⁷
Marwa Alkassab⁸
Islam Amer⁹
Maher Almasri⁸
Francesco Sampalmieri¹⁰
Fabrizio Bambini¹⁰
Lucia Memè^{11*}

¹ Department of Medicine, University of Salento, Lecce, Italy

² Department of Interdisciplinary Medicine, University of Bari "Aldo Moro" Bari, Italy

³ Department of Oral Rehabilitation, Faculty of Dentistry, Iuliu Hațieganu University of Medicine and Pharmacy, Cluj-Napoca, Romania

⁴ Missouri School of Dentistry & Oral Health, A. T. Still University, St. Louis, MO, United States

⁵ Prosthodontics Faculty of Oral and Dental Medicine, Future University, New Cairo, Egypt

⁶ Department of Dental Medicine, Medical University of Tirana, Rruga E Dibrës, Albania

⁷ King's College London, U.K.

⁸ The University of Buckingham, U.K.

⁹ Faculty of Medicine, Sohag University, Sohag, Egypt

¹⁰ D.I.S.C.O. School of Dentistry, Polytechnic University of Marche, Ancona, Italy

¹¹ Dipartimento di Scienze della Vita, della Salute e delle Professioni Sanitarie, Perugia, Italy

Corresponding author: Ioana Roxana Bordea
e-mail: roxana.bordea@gmail.com

*These authors contributed equally as first authors.

Abstract

Odontomas are the most prevalent benign odontogenic tumors, and they are frequently discovered by chance during standard radiography exams. They are categorized into complicated and compound types according to their radiological and histological features. Even though they are often asymptomatic, odontomas can result in serious dental issues such impaction, misalignment, and delayed tooth eruption, which calls for prompt surgical treatment. An extensive assessment of the clinical presentation, diagnostic techniques, and different therapeutic modalities such as orthodontic and surgical interventions is given in this article. The best possible results for patients are ensured by paying particular attention to post-operative orthodontic issues, less invasive surgical methods, and contemporary developments in diagnostic imaging.

Keywords: Odontoma, odontogenic tumors, Compound odontoma, Complex odontoma, Surgical management, Oral pathology, Tooth eruption, Orthodontic treatment

Authors

Andrea Palermo - Department of Medicine, University of Salento, Lecce, Italy

Danilo Ciccarese - Irma Trilli - Gerardo Cazzato - Francesco Sabatelli - Department of Interdisciplinary Medicine, University of Bari "Aldo Moro" Bari, Italy

Ioana Roxana Bordea - Department of Oral Rehabilitation, Faculty of Dentistry, Iuliu Hațieganu University of Medicine and Pharmacy, Cluj-Napoca, Romania

Gustavo Vincentis Oliveira Fernandes - Missouri School of Dentistry & Oral Health, A. T. Still University, St. Louis, MO, United States

Ahmed Abdelwahed Shaaban - Prosthodontics Faculty of Oral and Dental Medicine, Future University, New Cairo, Egypt

Edit Xhajanka - Department of Dental Medicine, Medical University of Tirana, Rruga E Dibrës, Albania

Lwai Almasri - King's College London, U.K

Marwa Alkassab - Maher Almasri - The University of Buckingham, U.K.

Islam Amer - Faculty of Medicine, Sohag University, Sohag, Egypt

Francesco Sampalmieri - Fabrizio Bambini - D.I.S.C.O. School of Dentistry, Polytechnic University of Marche, Ancona, Italy

Lucia Memè - Dipartimento di Scienze della Vita, della Salute e delle Professioni Sanitarie, Perugia, Italy



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Introduction

Enamel, dentin, cementum, and pulp tissue make up odontomas, which are benign odontogenic tumors (1–26). They are frequently identified in children and young adults and are hamartomas rather than actual neoplasms. In contrast to complicated odontomas, which manifest as a chaotic mass of dental tissue, compound odontomas have several tooth-like features (14,16,27–33). Although the exact cause is unknown, environmental and genetic factors may be involved. An overview of odontoma clinical features, diagnostic techniques, and surgical therapeutic approaches is the goal of this article (34–43,43–47,47–56).

Often asymptomatic, odontomas are discovered by chance on radiographs. When present, they could result in infection, edema, impaction, or delayed eruption (57–66). Cone-beam computed tomography (CBCT), histological analysis, and panoramic radiography are necessary for a precise diagnosis. Complex odontomas manifest as an uneven, radiodense mass, while compound odontomas exhibit as radiopaque features that resemble tiny teeth (Figure1) (67–89).

The size, location, and related oral issues all influence the surgical strategy. While larger lesions may require osteotomy for full excision, little odontomas can be treated with simple enucleation. It is crucial to preserve nearby structures, such as permanent teeth and nerves. Prophylactic antibiotic use, pain medication, and follow-up radiographic assessment to track the healing and eruption of impacted teeth are all part of postoperative care (84–123). The prognosis for odontomas is favorable, with little chance of recurrence after total excision. Delays in eruption, harm to neighboring teeth, and infection following surgery are possible side effects. In order to reduce these dangers and guarantee positive functional and aesthetic results, early detection and management are crucial (97–114,114–122,122–127).

Clinical Features

Regular radiographic examinations are often when odontomas are found, and they are frequently

asymptomatic. Nonetheless, in cases where they exhibit symptoms, they could show up as:

- Delayed eruption of permanent teeth.
- Adjacent teeth displacement or impaction.
- Pain or secondary infection in bigger odontomas
- Localized jaw enlargement and facial edema

Early detection and correction are essential since they have the potential to cause developmental abnormalities in the teeth (128–143).

Etiology of Odontomas

Although there is still no known etiology for odontomas, a number of factors have been suggested as potential contributing factors. Among these are:

- Genetic Factors: According to some research, there may be a hereditary propensity; cases involving family members have been documented (144–161).
- Developmental Disturbances: Tissue damage, infections, or inflammation during tooth development are frequently linked to odontomas.
- Syndromic Associations: It has been established that odontomas are more common in people with Hermann's syndrome and Gardner's syndrome.

The development of odontomas may be influenced by environmental variables, such as radiation exposure, malnutrition, and teratogenic factors during odontogenesis (58–16)).

Diagnostic Modalities

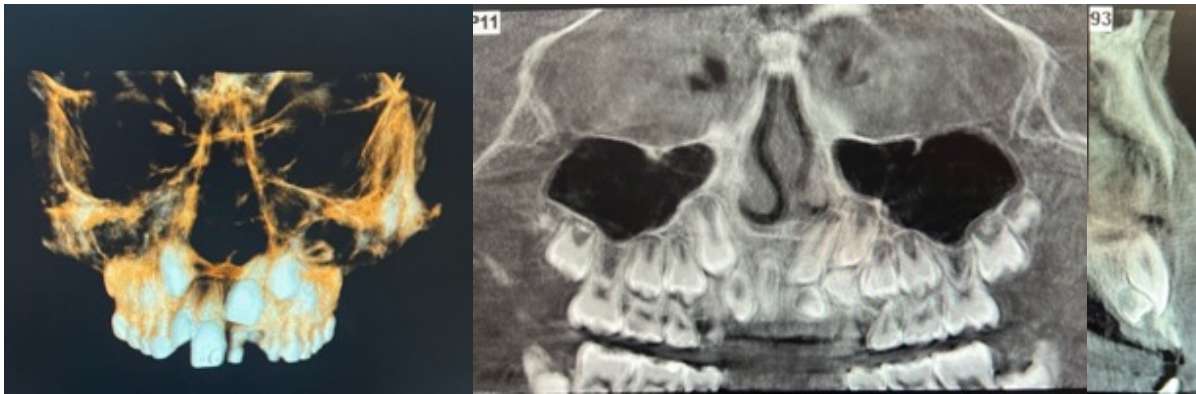
Radiographic Assessment

The primary method of diagnosing odontomas is radiographic evaluation because these lesions are frequently asymptomatic and unintentionally found during normal dental exams. Detecting odontomas, evaluating their position and size, and figuring out how they affect the surrounding anatomical structures all depend heavily on imaging).

Often the first imaging modality used in dental practice is panoramic radiography, sometimes called an orthopantomogram, or OPG. The broad view it provides of the craniofacial region makes it simple to spot odontomas and impacted teeth. Although panoramic



Figure 1. Orthopantomography illustrating radiopaque features that resemble tiny teeth



Figures 2.3.4. Cone-beam computed tomography (CBCT) preoperative

radiographs offer valuable initial information, they are not able to reliably detect the three-dimensional extent of the lesion because of their limitations (202–223,223–228,228–235,235–237,237–240,240–253,253,254,254,255,255,256,256–264,264,265,265–267,267,268,268–271,271–273,273–279).

Cone-beam computed tomography (CBCT) has transformed dental imaging by providing three-dimensional, high-resolution odontoma visualization. This method makes it possible to precisely locate the lesion and evaluate its connection to nearby teeth, alveolar bone, and important anatomical features including the maxillary sinus and inferior alveolar nerve. When surgical intervention is anticipated, CBCT is very helpful since it helps with preoperative planning and reduces intraoperative problems (296–298) (Figs 2, 3, 4).

Radiographic Features

Radiographic findings provide key insights into the classification of odontomas, which can be divided into two main types:

- **Compound Odontomas:** These lesions are characterized by multiple radiopaque structures resembling miniature teeth (denticles), typically surrounded by a radiolucent capsule. Compound odontomas are more commonly found in the anterior maxilla and are usually well-demarcated, making them relatively easy to identify on radiographs.
- **Complex Odontomas:** Unlike compound odontomas, complex odontomas appear as an irregular, radiodense mass with no identifiable tooth-like structures. They are often located in the posterior regions of the jaws and tend to be more challenging to differentiate from other odontogenic tumors or calcified lesions.

Accurate radiographic interpretation is essential for distinguishing odontomas from other odontogenic tumors and cystic lesions, ensuring proper diagnosis and treatment planning (299–340).

Histopathological Examination

While radiographic imaging is crucial for diagnosing odontomas, histopathological evaluation provides definitive confirmation by analyzing the tissue composition of the lesion. A biopsy and microscopic examination help differentiate odontomas from other calcified odontogenic entities. The histological features of odontomas vary based on their type:

- **Compound Odontomas:** These consist of well-formed denticles enclosed within a fibrous connective tissue capsule. The denticles exhibit an organized arrangement of enamel, dentin, cementum, and pulp, closely resembling normal tooth structures (Figure 5).
- **Complex Odontomas:** In contrast, complex odontomas contain a disorganized mass of dental tissues at various stages of development. Enamel, dentin, cementum, and pulp are present but lack the structural organization seen in compound odontomas. The random arrangement of these tissues gives complex odontomas their amorphous appearance

Histopathological analysis not only confirms the diagnosis but also ensures that the lesion does not exhibit any atypical or malignant features. In most cases, odontomas are benign hamartomas, but their removal is recommended when they interfere with normal tooth eruption or cause secondary complications (144–158). By integrating radiographic assessment with histopathological examination, clinicians can achieve a



Figure 5. Well-formed denticles and a fibrous connective tissue capsule after removal of Odontoma

comprehensive understanding of odontomas, allowing for accurate diagnosis, effective treatment planning, and successful patient outcomes.

Management Strategies

Indications for Surgical Removal

In a few of cases when odontomas impede the normal development and function of the teeth, surgical excision is advised. The main signs consist of:

- Delayed or impaired eruption of permanent teeth: In order to restore normal dental development, surgical excision is required if an odontoma blocks the eruption pathway of a permanent tooth, preventing it from entering into the oral cavity.
- Misalignment or displacement of nearby teeth: When an odontoma is present, it may put pressure on nearby teeth, causing them to move out of alignment. This might result in malocclusion and necessitate surgery.
- Development of cysts, discomfort, or secondary infection: Odontomas may occasionally result in pain and infection or be linked to cystic formations. In order to stop more harm to the surrounding tissues, removal is necessary if these concerns develop.
- Prosthetic rehabilitation interference: To guarantee proper prosthetic therapy, an odontoma must be removed if it impedes or makes it more difficult to fit a dental prosthesis (334).

Assessment of the Surgical Procedure Before Operation

Before proceeding with surgery, a thorough clinical and radiographic assessment is essential. The size, location, and nature of the odontoma must be carefully evaluated to determine the most appropriate surgical approach. Advanced imaging techniques, such as Cone Beam Computed Tomography (CBCT), provide a detailed three-dimensional view of the lesion, allowing for precise surgical planning. This preoperative assessment helps in minimizing risks and optimizing outcomes (365).

Procedures for Surgery

1. Anesthesia: The choice of anesthesia depends on the size and complexity of the lesion. Small odontomas can be removed under local anesthesia with minimal discomfort for the patient. However, larger or deeply embedded odontomas may necessitate general anesthesia to ensure a controlled and pain-free procedure.
2. Surgical Exposure: A mucoperiosteal flap is carefully elevated to gain direct access to the lesion. Proper flap design is crucial to ensuring adequate visibility and minimizing trauma to surrounding tissues.
3. Removal of Odontomas: The excision technique depends on the size and location of the odontoma. Small, well-defined odontomas are typically enucleated with minimal bone removal. However, larger or more complex cases may require an osteotomy to fully access and extract the lesion. Special care is taken to avoid unnecessary damage to adjacent structures.

4. Cavity Management: Once the odontoma is removed, the bone defect is smoothed and, if necessary, packed with bone graft material to promote healing and prevent complications such as postoperative bone loss.
5. Closure and Postoperative Care: After achieving primary closure of the surgical site, the patient is prescribed analgesics to manage discomfort and antibacterial medications to prevent infection. Follow-up radiographic monitoring is essential to track healing progress and ensure the successful eruption of any impacted teeth (370–383).

Considerations for the Postoperative Period and Possible Issues

Although the prognosis following odontoma removal is generally excellent, some potential complications should be considered, including:

- **Delayed eruption of impacted teeth:** Even after surgical removal of the obstruction, some teeth may take longer to erupt and may require orthodontic guidance.
- **Damage to neighboring teeth:** The surgical procedure, especially in cases where an osteotomy is required, carries a risk of trauma to adjacent teeth and their supporting structures.
- **Postoperative infection:** Proper wound care and antibiotic therapy help minimize the risk, but patients should be advised to watch for signs of infection such as swelling, pain, or pus formation.
- **Recurrence (rare):** Although odontomas typically do not regrow after complete excision, close postoperative monitoring is essential to detect any unusual developments early.

With careful planning, precise surgical techniques, and diligent postoperative care, the removal of odontomas is generally a safe and effective procedure, restoring normal function and dental alignment for the patient (Table 1).

The Role of Orthodontics in the Treatment of Odontomas

Often, odontomas interfere with normal dental eruption, requiring orthodontic treatment following surgical excision. A number of crucial actions must be taken in order to guarantee correct alignment and eruption of the impacted teeth while averting difficulties in orthodontic treatment.

Monitoring spontaneous emergence after odontoma removal is one of the main factors to take into account, since many teeth may erupt spontaneously after surgical excision. Frequent radiographic examinations, including CBCT scans and panoramic X-rays, are essential for determining tooth movement (384–387).

For impacted teeth that do not erupt on their own, orthodontic traction and surgical exposure are options. In order to do this, the impacted tooth is frequently fitted with orthodontic brackets or gold chains, and fixed appliances are used to exert controlled forces. To prevent ankylosis or root resorption, force must be applied carefully.

When awaiting eruption, space maintainers are used in juvenile patients to maintain arch integrity and avoid

Table 1. Surgical Approach to Odontomas

Stage	Details
Indications for Removal	<ul style="list-style-type: none"> - Delayed eruption of permanent teeth - Misalignment or displacement of adjacent teeth - Presence of cysts, secondary infection, or pain - Interference with prosthetic rehabilitation
Preoperative Assessment	<ul style="list-style-type: none"> - Clinical and radiographic evaluation (CBCT, panoramic X-ray) - Surgical planning to minimize damage to surrounding structures
Surgical Procedure	<ol style="list-style-type: none"> 1. Anesthesia: Local anesthesia for small odontomas, general anesthesia for larger lesions. 2. Surgical Exposure: A mucoperiosteal flap is elevated to access the lesion. 3. Odontoma Removal: - Small odontomas are enucleated - Larger lesions may require osteotomy for complete excision 4. Cavity Management: Bone defect is smoothed to minimize complications. 5. Closure and Postoperative Care: Wound closure, administration of analgesics and antibiotics, and radiographic follow-up.
Potential Complications	<ul style="list-style-type: none"> - Delayed eruption of impacted teeth - Damage to adjacent teeth - Postoperative infection - Rare recurrence

malalignment. Lingual arch wires and band and loop maintainers are examples of custom devices that assist preserve the space needed for healthy tooth eruption (24,168,271,272,274,275,277–279,362–372,372–378,378–396,396–404,404–417,417–424,424–433,433–435,435–437,437–439).

To rectify crowding and malocclusion, orthodontic equipment were fixed to straighten teeth that had been moved by the odontoma. The employment of aligners or multibracket systems may depend on the complexity of the issue. In more severe situations, segmental arch mechanics could be necessary to gradually realign the teeth that are impacted.

Monitoring the occlusion, root growth, and general dental alignment over an extended period of time. For the first two years following therapy, routine follow-ups 3-6 months apart aid in identifying recurrence or the need for additional improvement (161,358–361,440–446) (Figure 6) (Figure 7).



Figure 7. CBCT scans routine follow-ups for the first two years following therapy



Figure 6. Panoramic X-rays monitoring for additional improvement

Table 2. Role of Orthodontics in Odontoma Management

Stage	Details
Monitoring of Spontaneous Eruption	- Some teeth may erupt naturally after odontoma removal (Figs 8, 9). - Regular radiographic follow-ups with CBCT and panoramic X-rays.
Treatment for Impacted Teeth	- If a tooth does not erupt spontaneously, orthodontic traction is used. - Brackets or gold chains are attached to the impacted tooth, and controlled forces are applied using fixed appliances.
Space Maintenance	- In young patients, space maintainers prevent arch collapse. - Devices such as lingual arch wires or band and loop maintainers help preserve space for proper eruption.
Correction of Dental Alignment	- If teeth are displaced by the odontoma, fixed orthodontic appliances (brackets) or aligners are used. - In complex cases, segmental arch mechanics may be required for gradual tooth realignment.
Long-Term Follow-Up	- Follow-ups every 3-6 months for two years post-treatment - Monitoring of occlusion, root development, and potential recurrence. (Figs 8, 9).



Figures 8, 9. Teeth in erupting naturally after odontoma removal

Conclusion

The successful eruption of impacted teeth and long-term stability are best achieved through a combination of advanced orthodontic techniques and interdisciplinary collaboration. By integrating expertise from orthodontists, oral surgeons, and other dental specialists, treatment outcomes can be significantly improved, leading to both functional and aesthetically pleasing results.

A personalized approach is essential for optimizing patient care. Treatment plans should be tailored to each individual, taking into account critical factors such as age, the degree of displacement, the risk of spontaneous eruption, and overall dental and skeletal development. Early diagnosis and intervention play a crucial role in minimizing complications and ensuring a smooth treatment process.

Additionally, ongoing monitoring and follow-up during the course of treatment aid in making the required modifications, enabling more consistent outcomes. Patients can improve both function and beauty by achieving long-term oral health and stability in addition to optimal tooth alignment with a well-coordinated interdisciplinary approach.

Abbreviation

CBCT: Cone-Beam Computed Tomography
OPG: Orthopantomogram (Panoramic Radiography)

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Data are contained within the article..

Conflicts of Interest

The Authors declare no conflicts of interest.

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