once and 3 several times, which amounts to 50%. Thus the incidence of recurrence in this sample was equal to the values of recurrence in ameloblastoma (50 - 90%). The behaviour of odontogenic keratocysts is therefore similar to the behaviour of ameloblastomas, which is sufficient reason for caution in the method of treatment. The following is recommended:

- Odontogenic keratocyst should be considered an odontogenic tumour with tendency to recurrence, because in the latest classification it is included under the term keratinising cystic odontogenic tumour.
- Cases of osseous translucency with the above radiographic characteristics, resembling odontogenic keratocystic prior to or during the operation should be histopathologically checked.
- Cases of cystic lesions in Gorlin-Goltz's syndrome, even without prior histopathological verification, should be considered odontogenic keratocysts and thus treated, and patients continually monitored because of the constant possibility of new cysts forming.
- During the operation carefully denucleate the capsule and later whiten the bone with 3% hydrogen peroxide in order to see possible remains of the capsule and all places of eroded or perforated bone, and also undermined sites should be revealed and polished with a burr until the surface is smooth.
- Healing of the osseous cavity should be ensured by one of the usual methods (Partsch II+ decortication (Brosch), Partsch II+ postoperative suction).
- Marsupialisation should be applied in cases of exceptionally large cysts for drainage and eventual reduction of the osseous cavity, or in the case of patients with health risk, who are a risk for operation under general anaesthesia. Because of the determined changes in virility of the epithelia of marsupialized keratocysts wider application of the method is possible.
- Postoperatively the patient should be clinically and radiographically monitored until complete healing of the bone, from two to fifteen years after the operation. In cases with signs of recurrence surgical intervention should be immediate, in order to avoid uncontrolled expansion of the formation/mass.

Neobično metastaziranje melanoma lica nakon šesnaest godina - prikaz slučaja

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Sažetak

U radu prikazujemo slučaj neobična metastaziranja melanoma lica u limfni čvor vrata nakon šesnaest godina.

Pacijent M. Š., četrdeset godina, javlja se oralnom kirurgu zbog povećanoga limfnoga čvora desne strane regije jedan. S obzirom na činjenicu da ima dosta nesaniranih zuba i sijevajuću bol na desnoj strani lica, dolazi na pregled zbog sumnje na odontogeni limfadenitis. Anamnestički se utvrdi da je pacijent prije šesnaest godina u desnoj nazolabijalnoj brazdi operirao melanom. Pregledom se nađe postoperativni ožiljak na desnome obrazu, tvrd, bezbolan i pomičan limfni čvor veličine dva centimetra u regiji jedan, te dosta nesaniranih zuba. Pacijent se uputi prvo na citopunkciju čvora kojom se je utvrdilo da se radi o metastazi melanoma. Nakon učinjene preoperativne pripreme, učini se radikalna disekcija vrata desne strane te se izvade svi zubi koji nisu bili za sanirati. U PHD pripravku nađe se samo jedan pozitivan limfni čvor. Pacijent se uključi u protokol za melanom te se po kliničkim smjernicama učine sve pretrage.

Budući da su svi pacijentovi nalazi uredni, za sada nije potrebna nikakva druga terapija.

Slučaj prikazuje da ni takve situacije ne možemo zanemariti u diferencijalnoj dijagnostici povećanih limfnih čvorova vrata.