pacijenata koji idu na zračenje, a ako nastanu promjene, potrebna je kirurška terapija, terapija hidrobaričnim kisikom (HBO) te uporaba Marxova protokola. Prikaz niza primjera iz naše prakse prikazuje koliko su kliničke smjernice implementirane.

Do We Know Everything about Radioosteonecrosis?

Irina Filipović Zore[1], Joško Grgurević[2]
[1]Department of Oral Surgery School of Dental Medicine University of Zagreb
[2]Clinical Department of Oral Surgery, University Hospital Centre Rebro, Zagreb

Summary

According to data of the World Health Organisation, malignant diseases, apart from cardiovascular diseases, are the most prevalent diseases of today.

As one form of therapy for malignancy radiation in 63% of patients has the primary task of destroying tumour cells, while minimally damaging the surrounding tissue.

The greatest and most dangerous complication in radiotherapy of the head and neck is without doubt osteoradionecrosis (ORN). It occurs most frequently when the dose of radiation is more than 60 Gy or in the case of patients who receive combined radio and chemo-therapy. ORN occurs in 5-22% of such irradiated patients. ORN can occur spontaneously, although in 60% of cases it occurs as a response to tissue injury, usually after tooth extraction, but also after other manipulations in the oral cavity. Because of the radiation the bone becomes acellular, avascular and hypoxic, and clinically can be interpreted as the occurrence of ulceration, mucous membrane necrosis and exposure of necrotic bone, with pain and eventual paresthesia. Predilective sites are the posterior parts of the mandible. For diagnosis of ORN, apart from a medical examination, orthopantomogram, computerised tomography and magnetic resonance are needed. In the future SPECT (single-photon emission computed tomography) will have an important role.

Clinical indicators in the therapy of ORN are first and foremost a good preventive programme and periradiational care of the patient undergoing radiation, and in the case that changes do occur surgical therapy is needed, therapy with hydrobaric oxygen (HBO), and the use of Marx's protocol. Presentation of numerous examples from our practice shows how many clinical indicators are implemented.

Mukokele

Leonard Bergovec, Davor Brajdić, Darko Macan
Klinički zavod za oralnu kirurgiju, Klinika za kirurgiju lica, čeljusti i usta, KB "Dubrava", Zagreb

Sažetak

U ambulanti oralne kirurgije gotovo se danomice susrećemo sa salivarnim cistama. Liječimo ih kirurškim putem - izljuštivanjem ili marsupijalizacijom.

Smatrali smo vrijednim te promjene raščlaniti klinički, patohistološki i patogenetski.

Postoje dva tipa salivarnih cisti: retencijske ciste (histološki žlijezda slinovnica s dilatiranim izvodnim kanalićima obloženima krupnim stanicama sa saćastom citoplazmom) i ekstravazacijske ciste (šuplja tvorba ispunjena staničnim detritusom i bakterijama, obložena cilindričnim i višeslojnim epitelom).

Mukokele su obložene stijenkom granulacijskoga tkiva i sadržavaju eozinofilni hijalini materijal. Raspoređene su po cijeloj sluznici usne šupljine, ali najviše na donjoj usnici. Najčešće nastaju mehaničkim ozljedama izvodnih kanala malih žlijezda slinovnica i retencijom. Promjera su oko 1,5 cm. Izazivaju laganu cijanozu područja i plavkasto-bijelo prosijavanje koje nastaje kao posljedica sužavanja krvnih žila i tanke stijenke mukokele.

Retrospektivno smo analizirali patohistološke nalaze s kliničkom dijagnozom "mukokela" u razdoblju od 1. siječnja 1995. do 31. prosinca 2000. godine. U tome razdoblju ukupno je operirano 9047 osoba. Od 1358 nalaza koji su poslani na patohistološku raščlambu (PHD) 89 je klinički dijagnosticirano kao mukokele. Od 89 navedenih lezija u samo je 72 slučaja patohistološki potvrđena dijagnoza mukokela. Razlike u spolu nisu bitno utjecale na nastanak mukokela, a prema istraživanju nalazimo da se mukokele javljaju u svim dobnim skupinama, no ipak češće u mladih ljudi u drugom i trećem desetljeću života. Mukokele su najvećim dijelom bile na donjoj usnici, 83,3% u našem istraživanju. Ostale

mukokele bile su u sublingvalnom prostoru, na obraznoj sluznici i u vestibulumu usne šupljine. Prema patohistološkom opisu zaključili smo da su 23 mukokele bile retencijskoga tipa, a dvije su bile ekstravazacijske promjene.

Mucocele

Leonard Bergovec, Davor Brajdić, Darko Macan
Department of Oral Surgery
Clinic of Maxillofacial and Oral Surgery, University Hospital Dubrava, Zagreb

Summary

In the Out-Patient Department of Oral Surgery we daily come across salivary cysts which we treat surgically - by scaling or marsupialisation.

We considered that it would be helpful to analyse these changes clinically, histopathologically and pathogenetically.

There are two types of salivary cysts: retention cysts (histologically a salivary gland with dilated secretory canals lined with large cells with honeycomb cytoplasm) and extravasation cysts (a hollow mass filled with cellular detritus and bacteria, coated with cylindrical and stratified epithelia).

Mucocele are coated with a lining of granulation tissue and contain eozinophyllic hyaline material. They occur throughout the whole of the mucous membrane of the oral cavity, although the majority are on the lower lip. They most frequently occur because of mechanical injury to the secretory canals of the small salivary glands and retention. They are approximately 1.5 cm in diameter. They cause slight cyanosis of the area and bluish-white surface which occurs as a result of the narrowing of the blood vessels and thin walls of the mucocele.

We retrospectively analysed histopathological findings with a clinical diagnosis “mucocele” during the period 1 January 1995 to 31 December 2000. During that period a total number of 9047 people were operated. Of 1358 findings sent for histopathological analysis (PHD), 89 were clinically diagnosed as mucocele. Of these 89 lesions in only 72 cases was the diagnosis of mucocele confirmed histopathologically. Differences in gender did not essentially have an effect on the occurrence of mucocele, and according to the results of the investigation we found that although mucocele occurs in all age groups, it is more frequent in younger people during the second and third decade of life. In our investigation mucocele were largely located on the lower lip, 83.3%. Other mucocele were located in the sublingual space, on the mucous membrane of the cheek and in the vestibulum of the oral cavity. According to the histopathological description we concluded that 23 mucocele were of retention type and two extravasation lesions.

Frenulektomije - kada i zašto?

Vlatko Kopić[1], Berislav Perić[2], Darko Macan[2]
[1]Odjel za maksilofacijalnu kirurgiju KB Osijek
[2]Klinički zavod za oralnu kirurgiju, Klinika za kirurgiju čeljusti i lica, KB Dubrava, Zagreb

Sažetak

Podatci iz literature često su dijametralno suprotni što se tiče potrebe da se izvede kirurški zahvat kod perzistentnoga frenuluma, bilo da se radilo o njegovoj izravnoj povezanosti s dijastemom medijanom ili ne.

Različita su mišljenja o najpovoljnijem vremenu za zahvat ili na redoslijed intervencije kirurga, odnosno ortodonta. Većina se autora slaže u tome da je zahvat potreban, ali i da se s njim ne treba žuriti. Pojedini autori smatraju kako treba pričekati da iznikne trajni očnjak, a drugi upozoravaju i na mogućnost spontanoga zatvaranja dijasteme još i u vrijeme nicanja drugoga trajnog molara. Prema navodima u literaturi frekvencija tektolabijalnoga frenuluma djece je 7,3%, a odraslih samo l,3%, što upućuje na neopravdanost ranih kirurških tretmana.

Naše istraživanje pokazuje sukladne podatke, jer je najveća zastupljenost frenulektomija (80%) u dobi do 20 godina. Od svih lokalizacija koje zahvaća hipertrofični frenulum njih 90% je u području gornje usne. Upravo ta povezanost između dobi i lokalizacije govori nam da se radilo o ortodontskoj indikaciji, zapravo o dijastemi medijani. Najveći broj dijastema zatvara se u vrijeme nicanja lateralnih sjekutića, pa ako dijastema i dalje perzistira, a popraćena je hipertrofičnim frenulumom, postoje male mogućnosti kasnijeg spontanog zatvaranja. Zato operativni zahvat izvodimo ne čekajući da niknu trajni očnjaci.