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

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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?

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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.