UNIVERSIDADE FEDERAL DO RIO GRANDE DO SUL
FACULDADE DE ODONTOLOGIA
ESPECIALIZAÇÃO EM CIRURGIA E TRAUMATOLOGIA BUCO-MAXILO-FACIAIS

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CISTO DERMÓIDE EM SOALHO BUCAL

Porto Alegre
2014

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Trabalho de Conclusão de Curso apresentado ao Curso de Pós-Graduação, Especialização em Cirurgia e Traumatologia Buco-Maxilo-Faciais da Faculdade de Odontologia da Universidade Federal do Rio Grande do Sul, como requisito parcial para obtenção do título de Especialista em Cirurgia e Traumatologia Buco-Maxilo-Faciais.

Orientadora: Profª Drª Deise Ponzoni

Porto Alegre
2014

CIP – Catalogação na Publicação

Barreiro, Bernardo Ottoni Braga.
Cisto dermóide em soalho bucal / Bernardo Ottoni Braga Barreiro. – 2014.
39 f. : il.

Trabalho de Conclusão (Especialização) – Universidade Federal do Rio Grande do Sul, Faculdade de Odontologia, Curso de Especialização em Cirurgia e Traumatologia Buco-Maxilo-Faciais, Porto Alegre, BR-RS, 2014.

Orientadora: Deise Ponzoni

1. Cisto dermóide. 2. Soalho de boca. 3. Anormalidades da Boca.
I. Ponzoni, Deise. II. Título.

Elaborada por Ida Rossi – CRB-10/771

AGRADECIMENTOS

Aos meus pais, Elaine e Alfonso, pelo suporte absoluto e pelas oportunidades que me foram proporcionadas.

Ao meu irmão e colega de profissão, Frederico, pelo incentivo e por ajudar-me a descobrir a Odontologia enquanto ofício e paixão.

À Bruna Bier da Silva, pelo apoio incondicional pessoal e profissional nesses dois anos de especialização.

À Professora Doutora Deise Ponzoni, pela dedicação, atenção e profissionalismo com os quais me acolheu como seu orientado.

À ilustríssima Professora Doutora Edela Puricelli, pelo exemplo de conhecimento, liderança e conduta.

Aos excelentes demais componentes do corpo docente desse Curso de especialização, Professores Doutores Carlos Eduardo Baraldi, Angelo Luiz Freddo e Marcel Paris, pelas orientações e ensinamentos.

Aos meus colegas de especialização, pela cumplicidade, companheirismo e amizade.

A dor de um *não* pode durar alguns dias, alguns meses e até alguns anos. Entretanto, se você desistir, carregará esse *não* para sempre.

Bernardo Ottoni Braga Barreiro

RESUMO

BARREIRO, Bernardo Ottoni Braga. CISTO DERMÓIDE EM SOALHO BUCAL. 2014. 37 f. Trabalho de Conclusão de Curso de Cirurgia e Traumatologia Buco-Maxilo-Faciais (Pós-graduação) – Faculdade de Odontologia, Universidade Federal do Rio Grande do Sul, Porto Alegre, 2014.

Nesse trabalho de conclusão de curso foi realizada uma revisão de literatura sobre o tema “cisto dermóide em soalho bucal”. A base de dados consultada foi o MEDLINE/PubMed (via National Library of Medicine). Foram selecionados 38 artigos sobre o tema, publicados nos últimos dez anos. A revisão dos artigos serviu de subsídio para elaboração de um *brief clinical report* sobre esse tipo de lesão. O cisto dermóide de soalho bucal é uma lesão benigna, rara e que deve ser considerada no diagnóstico diferencial de lesões que acometem essa região anatômica. Clinicamente apresenta-se como uma massa nodular, não dolorosa, de crescimento lento. O tratamento para esta patologia é cirúrgico. A lesão, na maioria das vezes, por ser diagnosticada tardiamente e por apresentar grandes proporções, tem a indicação de anestesia geral para sua remoção. A relação anatômica da lesão em relação à musculatura do soalho bucal determina o tipo de abordagem cirúrgica (intra e/ou extra bucal).

Palavras-chave: Cisto dermóide. Soalho de boca. Anormalidades da Boca.

ABSTRACT

BARREIRO, Bernardo Ottoni Braga. DERMOID CYST IN THE FLOOR OF THE MOUTH. 2014. 37 f. Conclusion Work Course of Surgery and Traumatology Maxillofacial (Specialization) – Faculdade de Odontologia, Universidade Federal do Rio Grande do Sul, Porto Alegre, 2014.

This works aimed to be a literature review on dermoid cyst in the floor of the mouth. It was used 38 articles from MEDLINE/PubMed database published over the last decade. The review of these articles was the base for a brief clinical report on that type of lesion. Dermoid cyst in the floor of the mouth is a rare benign lesion that must be taken into consideration in the differential diagnosis of lesions in this area. Clinically it is a pain-free nodular mass of low growth, with a surgical treatment. Most of the times, this lesion may be late diagnosed, and because of its size, it is indicated general anesthesia for removing it. The floor of the mouth muscle anatomy in this region determines the type of surgical approach (intra or extraoral) to be used.

Keywords: Dermoid cyst. Mouth floor. Mouth abnormalities.

SUMÁRIO

1 INTRODUÇÃO

A partir da publicação de Meyer (1955), o termo “cisto dermóide em soalho bucal” passou a definir uma formação cística revestida por epitélio escamoso estratificado com anexos da pele, incluindo folículos capilares, glândulas sebáceas e glândulas sudoríparas presentes na cápsula de tecido conjuntivo. Essa patologia é rara em soalho bucal; contudo, deve ser considerada como diagnóstico diferencial de lesões nessa região área em crianças e adolescentes.

O cisto dermóide de soalho de boca é uma lesão benigna, de crescimento lento e indolor, cujo tratamento é cirúrgico. Quando não tratada, pode estar associada a complicações como disfagia, disfonia e até mesmo obstrução de via aérea.

2 REVISÃO DA LITERATURA

2.1 Definição

O cisto dermóide foi descrito pela primeira vez por Jourdain (1778). A lesão relatada era diferenciada da rânula por apresentar um conteúdo, caracterizado macroscopicamente pelo aspecto sebáceo (SEWARD, 1965).

Após a publicação de Meyer (1955), o termo “cisto dermóide” passou a definir uma formação cística revestida por epitélio escamoso estratificado incluindo anexos da pele, folículos capilares, glândulas sebáceas e glândulas sudoríparas presentes na cápsula de tecido conjuntivo (NEW; ERICH, 1937; MACNEIL; MOXHAM, 2010; GORDON, 2013). É uma patologia benigna que surge durante o desenvolvimento embrionário. Possivelmente ocorra um dobramento anormal da camada ectodérmica ao longo das linhas embrionárias normais de fusão dos processos faciais ou dentro do eixo neural. Na região craniofacial, o cisto dermóide desenvolve-se durante a fusão do primeiro e do segundo arco faríngeo, entre a terceira e quarta semanas de gestação (ERICH; JOHNSEN, 1953; GORDON, 2013).

2.2 Caracterização clínica

New e Erich (1937) revisaram 1.485 casos de cistos dermóides e destacaram que 7% de todos esses cistos ocorreram na região de cabeça e pescoço. O soalho bucal foi responsável por 23% dos cistos da região de cabeça e pescoço e, com relação ao corpo em sua totalidade, foi responsável por 1,6%. Ademais, de acordo com Brown e Baker (1972), o cisto dermóide representa cerca de 0,01% de todos os cistos da cavidade oral, caracterizando assim uma lesão de rara ocorrência.

Clinicamente, o cisto dermóide de soalho bucal aparece como uma massa indolor, exceto se estiver com infecção associada, que muitas vezes pode ser palpada por meio de manobra bidigital. O paciente pode apresentar significativos quadros de disfagia, disfonia e dispneia. A traqueostomia pré-operatória pode ser indicada para conforto e segurança do paciente (OLLERENSHAW, 1912; LONGO, 2003; MACNEIL; MOXHAM, 2010).

Há sugestão de distribuição bimodal de idade, porque as lesões são muitas vezes detectadas na infância, mas podem aparecer durante a puberdade, quando as

alterações hormonais levar a um aumento da produção de sebo (RAEWYN; PAUL, 2010).

2.3 Classificação Anatômica

Teszler (2007) sugere uma classificação do cisto dermóide de acordo com sua localização anatômica, baseado nos conceitos de Colp (1925). A Classificação de Teszler classifica o cisto dermóide de soalho bucal em sete localizações.

O cisto supra-genio-hióideo, tipo mais comum, situa-se profundamente, superior aos músculos genio-hióideo e milo-hióideo. A literatura refere esse tipo de lesão como cisto genioglosso, cisto mediano, cisto mediano do genioglosso e cisto sublingual (nº 1 no Quadro-1 e Figura-1).

O segundo tipo, o cisto infra-genio-hióideo, desenvolve-se entre os músculos genio-hióideo e milo-hióideo. Também denominado de cisto genio-hióideo, cisto sublingual laterais (um subtipo dos cistos submentuais), cisto genio-hióideo mediano ou cisto submental (nº 2 no Quandro-1 e Figura-1).

O terceiro tipo de cisto dermóide do soalho de boca na classificação original de Colp (1925) é uma entidade incomum e se desenvolve entre os músculos genioglosso, hioglosso e milo-hióideo. Ele também foi designado como sendo um cisto lateral verdadeiro, bem como um cisto lateral à musculatura da língua. “Cisto do espaço sublingual” deve ser o termo mais adequado para este tipo de lesão por encontrar-se nessa região (nº 3 no Quadro-1 e Figura-1).

Todos os três tipos de cisto dermóide no soalho de boca na classificação original (classificação de Colp) estão localizados superiormente ao músculo milo-hióideo, ou seja, supra-milohioideo, podendo ser considerados como lesões intraorais. No entanto, a literatura descreve outros cistos dermóides no soalho de boca em locais anatômicos que não se enquadram em qualquer uma das três classificações acima descritas. Uma localização tem sido descrita como estando superficial ao pescoço, abaixo ao genio-hióideo e milo-hióideo, e aparece como um inchaço no espaço submento-vértex. É o único tipo puramente submento-vértex devido a sua localização no espaço submento-vértex, recebendo assim o nome de sua localização submental, sendo assim, o quarto tipo (n° 4 no Quadro-1 e Figura-1).

O quinto tipo é localizado superficialmente e abaixo ao músculo milo-hióideo, mas fora da linha mediana, aparecendo como uma massa cervical lateral. Este é o

único tipo de cisto dermóide de soalho de boca que é classificado por Longo (2003) como cisto lateral. Esta localização anatômica é definida entre os músculos milo-hióideo e platisma, e é chamada de espaço submandibular; por conseguinte, ele tem sido corretamente referido como um cisto submandibular (nº 5 no Quadro-1 e Figura-1).

Tanto o submento-vértex, quanto o cisto submandibular encontram-se na sua totalidade superficialmente e abaixo do músculo milo-hióideo e não aparecem com quadro clínico intrabucal, mas puramente uma massa cervical.

O tipo de cisto dermoide intrabucal é o, originalmente, cisto sublingual que penetrou no músculo milo-hióideo ou propagou-se através de pequenas deficiências nesta musculatura para alcançar superficialmente o pescoço. Esta categoria inclui também cistos localizados superficialmente ao milo-hióide que penetraram através deste músculo e que também são intrabucais. Este cisto sublingual "em forma de ampulheta" ou tipo submental foi classificada por outros autores como um subtipo do verdadeiro cisto laterais. Na classificação de Teszler (2007), é considerado como um cisto medial denominado de cisto trans-milo-hióideo submental, sexto tipo. (nº 6 no Quadro-1 e Figura-1).

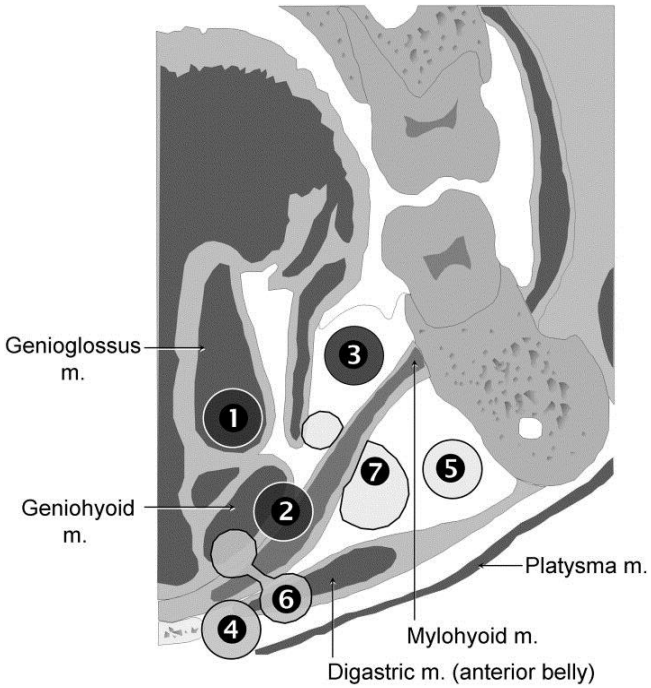
O último tipo cístico de soalho de boca é o lateral peri e trans-milo-hióideo, uma lesão cística intrabucal de cisto que se espalha lateralmente abaixo do músculo milo-hióide e clinicamente é observado, tanto no aspecto intra quanto extra-bucal, na região cervical (nº 7 no Quadro-1 e Figura-1).

Quadro1: Classificação da lesão por localização.

	Supra milohioideo (Intraoral ou Sublingual)	Infra milohioideo (Cervical)	Trans- milohioideo (Dual Intraoral e extraoral)
Medial	1. Supra geniohioideo	4. Submentoniano infra milohioideo	6. Submental trans milohioideo
	2. Infra geniohioideo		
Lateral	3. Espaço sublingual	5. Espaço submandibular	7. Lateral trans milohioideo

Adaptada de Teszler (2007).

Figura 1- Desenho esquemático de uma secção coronal através do assoalho da boca, que mostra as relações entre os planos musculares e possíveis localizações anatômicas de cistos dermóides.



Adaptada de Teszler (2007).

2.4 Classificação Histológica

O termo “cisto dermóide” é uma nomenclatura consagrada, embora atualmente consista em três diferentes patologias: o cisto dermóide, o cisto epidermóide e o cisto teratóide (NEW; ERICH, 1937; MEYER, 1955; MACNEIL; MOXHAM, 2010; GORDON, 2013).

Como já mencionado, o cisto dermóide é um cisto complexo revestido de epitélio escamoso estratificado incluindo anexos da pele, folículos capilares, glândulas sebáceas e glândulas sudoríparas que se apresentam na cápsula de tecido conjuntivo. Esta descrição representa o clássico cisto dermóide de soalho bucal (MEYER, 1955; LONGO, 2003; TESZLER, 2007; GORDON, 2013).

O cisto epidermóide é um cisto simples revestido por epitélio estratificado escamoso simples, cercado por uma cápsula de tecido conjuntivo e sem anexos cutâneos presentes. Seu lúmen apresenta-se cheio de material caseoso composto, em parte, por colesterol (MEYER, 1955; LONGO, 2003; TESZLER, 2007; GORDON, 2013).

O cisto teratóide possui complexidade de seus tecidos constituintes, podendo apresentar tecidos das três origens: endodérmica, mesodérmica e ectodérmica. São derivados do ectoderma o epitélio escamoso estratificado da pele e apêndices, incluindo folículos pilosos, glândulas sebáceas e sudoríparas; do mesoderma, tecido conjuntivo, incluindo o vascular habitual e elementos fibrosos presentes, músculo estriado e grandes áreas distintas de tecido adiposo; do endoderma, epitélio pseudoestratificado cilíndrico ciliado de origem respiratória (MEYER, 1955; LONGO, 2003; TESZLER, 2007; GORDON, 2013).

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2.5 Diagnóstico imaginológico

O diagnóstico definitivo dessa patologia é feito pelo exame anatomopatológico. Contudo, a ressonância magnética nuclear (RMN), a tomografia computadorizada (TC) e a ultra-sonografia (USG) são os exames imaginológicos mais empregados com finalidade diagnóstica e que orientam a abordagem cirúrgica. O exame radiográfico convencional pode ser indicado em locais onde não se tenha acesso a RMN, TC e USG (TURETSCHEK; HOSPODKA; STEINER, 1995).

O emprego da USG é particularmente útil em crianças, uma vez que a realização do exame não exige sedação ou exposição à radiação. Além disso, é menos onerosa do que a IRM e a TC (TURETSCHEK; HOSPODKA; STEINER, 1995).

Comparativamente, o exame da RMN é mais preciso e elucidativo do que a TC para o diagnóstico de cisto dermóide. No trabalho de Turetschek, Hospodka e Steiner (1995), a RMN obteve resultado superior à TC na identificação de lesões de tecidos moles em região de soalho bucal (SCHWANKE, 2013).

2.6 Diagnóstico diferencial

Por ser uma patologia rara e por estar localizado em uma região de ocorrência de muitas outras lesões, o cisto dermóide de soalho bucal pode ser de difícil diagnóstico. Desde 1959, Macgregor relata a importância do diagnóstico diferencial entre cisto dermóide, rânula e lipoma em soalho bucal. Atualmente o diagnóstico diferencial de lesões sublinguais inclui, além das já citadas patologias, hemangioma, linfangioma, malformação linfática (higroma cístico), neurofibroma, cisto gastrointestinal heterotópico e angina de Ludwig (JAIN; SINGH; SINGH, 2012; VERMA, 2012).

2.7 Tratamento

O tratamento da lesão é cirúrgico. O procedimento de remoção do cisto dermóide é feito sob anestesia geral na maioria dos casos. A localização e o tamanho da lesão determinam o acesso, se intra e/ou extrabucal (MEYER, 1955; LONGO, 2003; TESZLER, 2007; GORDON, 2013).

As recidivas da patologia são raras, acontecendo somente quando parte da massa cística não for removida totalmente. Casos de malignização da lesão são excepcionais. A transformação maligna de um cisto dermóide é extremamente rara (ACREE, 1999; BOKO; AMAGLO; KPEMISSI, 2013).

O diagnóstico da lesão é via exame anatomopatológico da peça cirúrgica, no entanto a biópsia por agulha pode ser feita (LONGO, 2003; TESZLER, 2007).

3 PROPOSIÇÃO

O trabalho de conclusão teve por objetivo revisar a literatura sobre o tema “cisto dermóide em soalho bucal”, com a finalidade de oferecer subsídios para a elaboração de artigo sobre o assunto a ser escrito na forma de *brief clinical report*.

Foram revisados somente artigos da língua inglesa, relatos de caso e/ou estudos retrospectivos, coletados na plataforma PubMed. As palavras de busca foram: *dermoid cyst and mouth* (215 artigos); *dermoid cyst and mouth floor* (140 artigos) e *mouth abnormalities and dermoid cyst* (35 artigos). Os artigos duplicados foram excluídos, resultando num total de 234 trabalhos datados do ano 1930 a 27 de Novembro de 2013. Além disso, todos os títulos foram analisados, tendo sido selecionados 147 artigos pertinentes. Desses artigos foram selecionados os trabalhos dos últimos dez anos, o que resultou numa amostra de 52 trabalhos. Desses, não foi possível o acesso a 4 artigos (DIN, 2003; YILMAZ, 2006; MARESH, 2010; ASSAF, 2012). Adicionalmente, dos 48 trabalhos que se teve acesso foram excluídos 9 artigos por não se tratarem de relatos de casos e/ou estudos retrospectivos com relação ao tema “cisto dermóide no soalho bucal”, resultando numa amostra de 38 artigos. O trabalho de Bonet (2012) não foi considerado, devido à impossibilidade de identificação da localização exata das lesões. As informações obtidas por meio da leitura dos 38 artigos estão compiladas no apêndice deste trabalho de conclusão de curso.

4 ARTIGO

Artigo a ser submetido no INTERNATIONAL JOURNAL OF PAEDIATRIC DENTISTRY, na modalidade de BRIEF CLINICAL REPORT (ANEXO 1).

Title

DERMOD CYST IN PAEDIATRIC PATIENT: A RARE LESION WHICH MUST BE CONSIDERED IN THE DIFFERENTIAL DIAGNOSIS OF FLOOR OF THE MOUTH LESIONS

Background

Dermoid cyst is a benign pathology presented during the embryonic development, and it consists in a cystic formation covered by stratified squamous epithelium with skin appendages in the connective tissue capsule. Dermoid cyst in the floor of the mouth is a rare pathology, although it must be taken into consideration in the differential diagnosis of lesions in this area.

Case report

Patient is a twelve-year old girl with a lesion in the dermoid cyst in the floor of the mouth. Previous removal of the dermoid cyst, history of intervention for removing the sublingual ranula. The treatment consisted in the excision of the lesion with a later anatomopathological analysis, and the patient was given general anesthesia.

Conclusion

The dermoid cyst must be considered in the differential diagnosis of lesions in the floor of the mouth of children and adolescents.

Introduction

Since 1955, when Meyer published an article on that subject, the term dermoid cyst in the floor of the mouth began to be used to define the cystic formation covered by stratified squamous epithelium with skin appendages, including hair follicles, sweat and sebaceous glands in the connective tissue capsule. Such pathology is considered rare, however it must be considered in the differential diagnosis of lesions

in the floor of the mouth of infants and adolescents, once the floor of the mouth may be affected by different pathologies from different origins.

Case report

A twelve-years old patient was sent to be assessed in the Oral and Maxillofacial Surgery-Maxillo-facial Unit, Hospital de Clínicas de Porto Alegre, Brasil. Her grandmother reported that the patient was under previous surgery intervention with local anesthesia to treat a lesion in the floor of the mouth, clinically diagnosed as ranula. This lesion, in the submentonian cervical region, presented a slow growth and progressive increase. Using clinical methods, it was observed soft, depressable, painless and free of adherences and adenopathies. The computerized tomography in the region revealed a lesion in the median tongue base. The hypodense and homogeneous lesion presented liquid density, with thin, defined walls, measuring approximately 3.8 x 2.5 x 2.0 cm, and no space for the submandible. Some hypotheses were discussed: simple ranula in the sublingual glandule, dermoid or epidermoid cyst. The intraoral exam indicated an increase in the volume of the floor of the mouth, and the extraoral exam depicted an increase in the volume of the neck, suprahioidea region. The patient was submitted to general anesthesia for the excision of the lesion. A nasotracheal intubation and intraoral surgical access was performed. The cyst was removed and submitted to a histopathological examination to confirm the diagnose of dermoid cyst.

Discussion

The dermoid cyst is a benign pathology presented during the embryonic development between the third and fourth weeks of pregnancy[1].

Clinically, the dermoid cyst in the floor of the mouth seems like a pain-free mass, except when it is associated with an infection, which most of the times may be palpable using a bi-digital method. The lesion increases gradually and slowly. The patient may present significant symptoms of dyspnea, dysphagia and dysphonia. It may be indicated a preoperative tracheostomy [2]. The definite diagnosis of that pathology is made under an anatomopathological exam. However, the Magnetic Resonance (MRI), the Computerized Tomography (TC) and the Ultrasound are the most common exams to diagnose and guide the surgical approach. The conventional radiographic imaging may be indicated when there is no access to MRI, CT or

Ultrasound. The ultrasound exam is specifically useful in children, as this exam does not require sedation or exposure to radiation. Besides, it is less expensive than MRI and CT[3].

The dermoid cyst in the floor of the mouth is a rare pathology, and it is located in an area where many other lesions may occur, thus, it may be difficult to diagnose through clinical examination, especially in children. Currently, the differential diagnosis of sublingual lesions includes dermoid cyst, ranula and lipona in the floor of mouth, hemangioma, lymphangioma, lymphatic Malformation (cystic hygroma), neurofibroma, heterotopic gastrointestinal cyst and Ludwig's angina [2,3].

The treatment for this lesion in done under surgery and normally performed under general anesthesia[4]. Patients in younger age and little weight, as newborn infants, may defer the treatment[2]. Regarding the muscle, the anatomic location and the size of the lesion are crucial in deciding whether an intraoral or extraoral approach by the surgeonf[5]. The rate of post-operative infections is low, and recurrences are rare, occurring only when part of the cystic mass is not completely removed[3].

Why is this clinical report importante to paediatric dentists

The pediatric dentists must know the characteristics of this lesion and consider it as a differential diagnosis, because the dermoid cyst in the mouth floor, although rare, can be confused with numerous other injuries.

Conflict of interest

The authors declare that they have no conflicts of interest concerning this article.

Figures

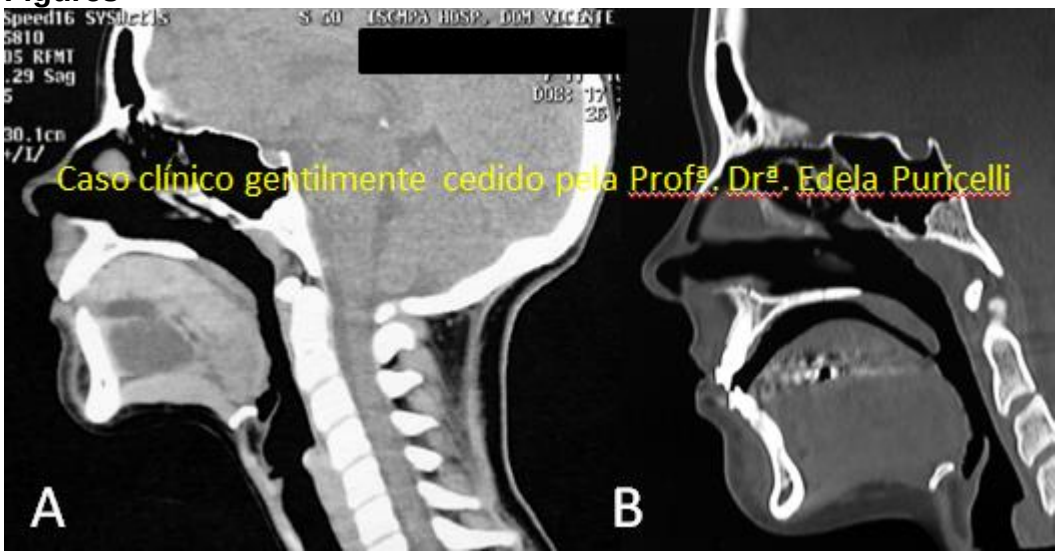

Figure 1: Sagittal computed tomographic images show midline. A - Well-defined unilocular cystic mass in the floor of the mouth that measured 3,8 x 2,5 x 2 cm (craniocaudal, anteroposterior, and transverse dimensions). B - Postoperative.

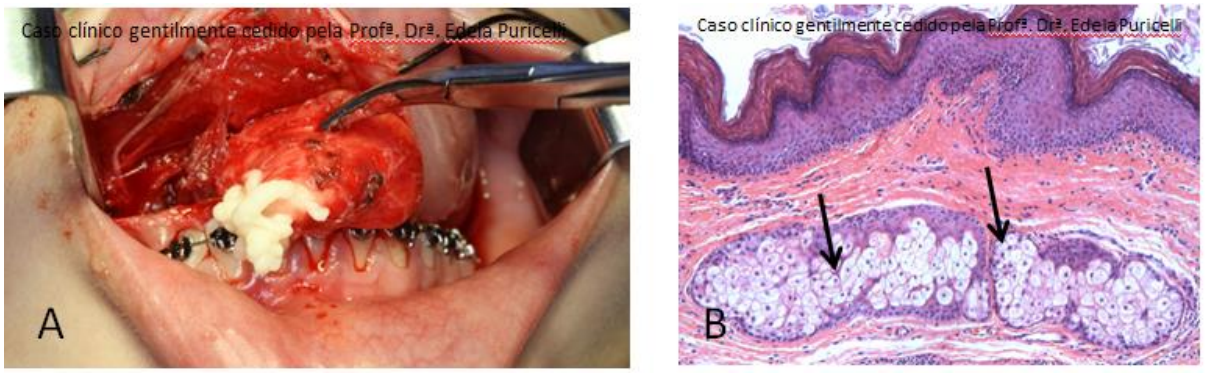

Figure 2: a - Intraoral sublingual approach. Excision of dermoid cyst. The cyst lumen is generally filled with a mixture of desquamated keratin and sebum. B - the cyst is lined by orthokeratinized squamous epithelium. Underlying connective tissue stroma consisted fibroblast and collagen fibers. The connective tissue exhibiting variable numbers of sebaceous glands (→) and blood vessels. Keratinous debris could an also be seen in the lumen. H&e, original magnification 100x.

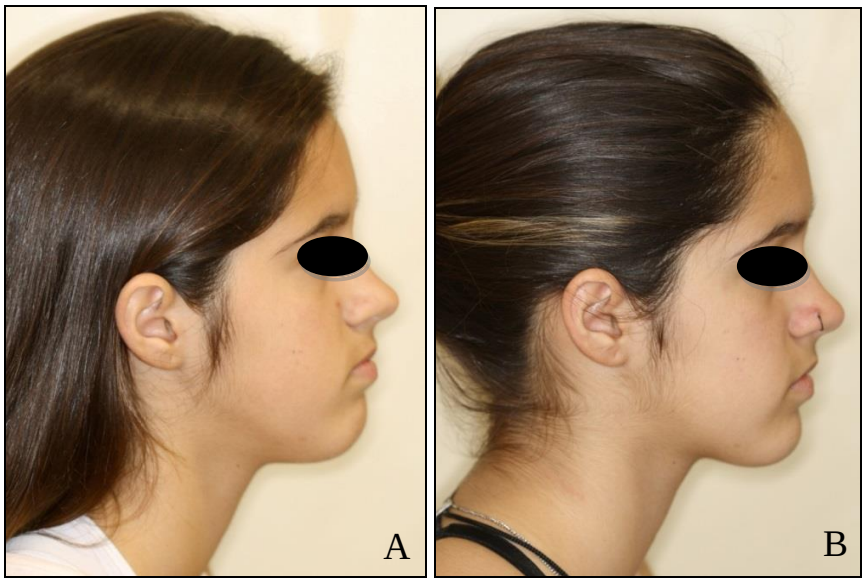

Figure 3: Lateral photografic study. A - Preoperative profile showing a compressible mass in the submental area. B - Post operative profile. Caso clínico gentilmente cedido pela Profª. Drª. Edela Puricelli.

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CONSIDERAÇÕES FINAIS

As lesões em soalho bucal podem ser de diversas origens, tais como infecciosas/ inflamatórias, tumorais, anomalias de desenvolvimentos e relacionadas às alterações em glândulas salivares e estruturas anexas.

O cisto dermóide deve ser considerado como possibilidade diagnóstica de lesões envolvendo o soalho bucal. Além disso, é uma lesão rara, benigna, de crescimento lento, diagnosticada em diferentes faixas etárias. O comprometimento da via aérea pode estar presente, especialmente diante de lesões de grandes proporções.

Os exames imaginológicos são essenciais para caracterização da lesão, localização da lesão e planejamento do tratamento cirúrgico. O diagnóstico definitivo é estabelecido pelo exame histopatológico.

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ANEXO - AUTHOR GUIDELINES

International Journal of Paediatric Dentistry

Int J Paediatr Dent

Edited By: Chris Deery

Impact Factor: 0.924

ISI Journal Citation Reports © Ranking: 2012: 60/83 (Dentistry Oral Surgery & Medicine); 86/122 (Pediatrics)

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Twetman S, Axelsson S, Dahlgren H et al. Caries-preventive effect of fluoride toothpaste: a systematic review. Acta Odontologica Scandivaica 2003; 61: 347-355.
Paulsson L, Bondemark L, Söderfeldt B. A systematic review of the consequences of premature birth on palatal morphology, dental occlusion, tooth-crown dimensions, and tooth maturity and eruption. Angle Orthodontist 2004; 74: 269-279.

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3. Al-Mughery AS, Attwood D, Blinkhorn A. Dental health of 5-year-old children in Abu Dhabi, United Arab Emirates. Community Dent Oral Epidemiol 1991; 19: 308-309.

4. Al-Hosani E, Rugg-Gunn A. Combination of low parental educational attainment and high parental income related to high caries experience in preschool children in Abu Dhabi. Community Dent Oral Epidemiol 1998; 26: 31-36.

If more than 6 authors please, cite the three first and then et al. When citing a web site, list the authors and title if known, then the URL and the date it was accessed (in parenthesis). Include among the references papers accepted but not yet published; designate the journal and add (in press). Please ensure that all journal titles are given in abbreviated form.

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Disponível em: < http://onlinelibrary.wiley.com/journal/10.1111/(ISSN)1365-263X/issues>. Acesso em: 14 Mar. 2014.

APÊNDICE

Tabela dos artigos selecionados de 2003 a novembro de 2013.

Cabeçalho: Autores; ANO - Ano de publicação; PAÍS - País de origem do artigo; SEXO - Sexo do paciente; TEMPO - Tempo de evolução da lesão; EXAME - Exames imaginológicos; ACS - Acesso cirúrgico; DIG – Diagnóstico; TAMANHO – Tamanho da peça cirúrgica; F UP – Follow up; RES – Recidiva; BPA – Biópsia por punção aspirativa.

Siglas: a – ano; m – mês; d – dia; M – masculino; F – feminino; TC – tomografia computadorizada; MRI – exame de ressonância magnética; USG – ultrassom; RX – raio X; EXT – acesso externo; INT – acesso interno; CD – cisto dermóide; CE – cisto epidermóide; CTE – cisto teratóide; S – sim; N – não.

TCC CISTO DERMÓIDE												
AUTOR	ANO	PAÍS	IDADE	SEXO	TEMPO	EXAMES	ACS	DIG	TAMANHO	FUP	RES	BPA
Boko, E.	2013	TGO	23a	M	23 a	RX	INT	CD	13 cm	3	N	XX
Gordon PE	2013	USA	79a	F	25 a	TC	INT	CE	5,3x2,9x2,7 cm	12	S	XX
Gordon PE	2013	USA	16m	M	16 m	MRI	INT	CD	3,5 cm	12	N	XX
Gordon PE	2013	USA	17a	M	6 m	TC e MRI	INT	CD e CTE	3x4,2 cm	12	N	XX
Iannessi A	2013	FRA	66a	M	XX	MRI	XX	CD	XX	XX	N	XX
Kudoh M	2013	JPN	69a	M	2a	TC e MRI	EXT	CE	3,5x3,0 cm	28	N	XX
Mammen S	2013	IND	57a	M	3 m	USG e TC	EXT	CE	4x5 cm	XX	N	XX
Schwanke TW	2013	USA	1a	M	XX	XX	INT	CD	XX	XX	N	XX
Schwanke TW	2013	USA	6d	M	XX	USG e MRI	INT	CTE	XX	XX	N	XX
Schwanke TW	2013	USA	5a	F	XX	XX	EXT	CE	XX	XX	N	XX
Schwanke TW	2013	USA	11a	F	XX	XX	INT	CE	XX	XX	N	XX
Schwanke TW	2013	USA	9a	M	XX	XX	EXT	CD	XX	XX	N	XX
Schwanke TW	2013	USA	13a	F	XX	XX	INT	CD	XX	XX	N	XX
Jain H	2012	IND	17a	M	3a	CT	INT	CD	9x9 cm	XX	N	sim
Verma S	2012	IND	16a	F	5 m	CT	INT	CE	7,0x5x4,5 cm	2	N	sim
Baisakhiya N	2011	IND	16a	M	2a	USG e TC	XX	CE	XX	XX	N	XX
Bonet-Colona C	2011	ESP	4d	M	4 d	XX	XX	CD	2 cm	5	N	XX
Bonet-Colona C	2011	ESP	12a	F	2a	XX	XX	CD	4 cm	6	N	XX
Bonet-Colona C	2011	ESP	2a	F	4 m	XX	XX	CD	1,5 cm	1	N	XX
Lin HW	2011	USA	60a	M	xx	TC e MRI	EXT	CD	4,4x3x3,5 cm	XX	N	sim
Pan M	2011	USA	4 m gestação	M	5 m gestação	USG e MRI	XX	CD	3x2x1 cm	XX	N	XX
Pirgousis P	2011	USA	30a	M	xx	XX	EXT	CD	XX	XX	N	XX
Pirgousis P	2011	USA	34a	M	XX	RX e TC	EXT	CD	XX	XX	N	XX
Welte FJ	2010	USA	4a	F	XX	MRI	XX	CD	XX	XX	N	XX
Eken M	2009	TUR	31a	F	XX	USG e TC	INT	CD	XX	6	N	sim
Eken M	2009	TUR	31a	F	XX	USG e TC	INT	CD	XX	6	N	sim
Eken M	2009	TUR	31a	F	XX	USG e TC	INT	CD	XX	6	N	sim
Jadwani S	2009	IND	22a	M	XX	XX	INT	CD	4x2 cm	XX	N	sim
EL-Hakin IE	2008	SAU	22a	M	22 a	TC	EXT	CD	12x12 cm	24	N	XX
EL-Hakin IE	2008	SAU	20a	F	XX	MRI	INT	CD	XX	36	N	XX
Fujimoto N	2008	JPN	75a	M	5a	MRI	EXT	CD	5 cm	XX	XX	XX

Graham RM	2008	GBR	31a	M	14 a	USG e TC	EXT	CD	XX	XX	XX	XX
Koca H	2007	TUR	20a	M	XX	XX	INT	CE	4x2 cm	XX	N	XX
Eken M	2007	TUR	52a	F	40 a	XX	INT	CD	5x4 cm	XX	N	XX
Ikeda	2007	JPN	15a	M	5a	USG e MRI	XX	CD	6 cm	XX	N	XX
Jham BC	2007	BRA	25a	M	XX	XX	INT	CE	5x5 cm	12	N	XX
Modolo F	2007	BRA	1m	M	1 m	RX	INT	CTE	2 cm	9	n	XX
Teszler CB	2007	ISR	16a	F	2 m	USG,RX e TC	EXT	CD	XX	XX	N	sim
Teszler CB	2007	ISR	12a	M	XX	USG, TC	EXT	CD	6x5 cm	XX	N	sim
Armstrong JE	2006	CAN	39a	M	10a	CT	DUP	CD	6,7x4x2,6 cm	0,5	N	XX
Burger MF	2006	USA	25a	M	2a	MRI	EXT	CD	7,1x4,5x2,9 cm	XX	N	sim
Kim IK	2006	KOR	3m	XX	3 m	MRI	DUP	CD	3x3x3 cm	XX	N	XX
Raveenthiran V	2006	IND	5a	M	XX	XX	INT	CD	10x10 cm	XX	N	XX
Göl IH	2005	TUR	4a	F	4a	USG, TC e MRI	INT	CTE	3,3x2,6x2,4 cm	XX	N	XX
Seah TE	2004	SIN	19a	M	XX	CT	INT	CD	3,5x2,6 cm	XX	N	XX
Akao I	2003	JPN	24a	F	XX	CT	INT	CE	7x4,5x3,5 cm	48	N	XX
Ariyoshi Y	2003	JPN	54a	M	40 a	USG, TC e MRI	EXT	CD	10x6 cm	XX	N	sim
Babuccu O	2003	TUR	7a	M	7a	USG	INT	CTE	4x3x2 cm	24	N	sim
Ho MW	2003	GBR	45d	M	45 d	USG e MRI	INT	CD	2,5x2x1,7 cm	6	N	XX
Lima SM Jr	2003	BRA	12a	XX	XX	RX e USG	EXT	CTE	3x2x1,8 cm	6	N	XX
Longo F	2003	ITA	51a	M	XX	USG, CT e MRI	EXT	CE	8x5 cm	XX	N	sim
Longo F	2003	ITA	28a	M	XX	USG	INT	CE	6,5x4,5 cm	XX	N	sim
Longo F	2003	ITA	15a	F	XX	CT	INT	CE	6x5cm	XX	N	sim
Longo F	2003	ITA	5a	M	XX	USG e CT	EXT	CE	5x3 cm	XX	N	sim
Longo F	2003	ITA	17a	M	XX	USG	INT	CE	6,5x5 cm	XX	N	sim
Longo F	2003	ITA	35a	M	XX	USG e CT	EXT	CE	5,5x3,4 cm	XX	N	sim
Longo F	2003	ITA	24a	F	XX	USG e CT	INT	CD	4,5x2,5 cm	XX	N	sim
Longo F	2003	ITA	31a	M	XX	USG	INT	CE	5,5x4 cm	XX	N	sim
Longo F	2003	ITA	39a	M	XX	USG e MRI	INT	CE	6,7x4,5 cm	XX	N	sim
Longo F	2003	ITA	19a	M	XX	USG	INT	CE	7,5x6,7 cm	XX	N	sim
Longo F	2003	ITA	27a	F	XX	USG e CT	INT	CE	6,5x5,4 cm	XX	N	sim
Longo F	2003	ITA	44a	M	XX	USG	EXT	CD	5,5x4,3 cm	XX	N	sim
Longo F	2003	ITA	37a	M	XX	USG e CT	EXT	CE	6,5x4,5 cm	XX	N	sim
Longo F	2003	ITA	32a	F	XX	USG	INT	CE	4x2,5 cm	XX	N	sim

Longo F	2003	ITA	21a	M	XX	USG e MRI	INT	CE	6x4,5 cm	XX	N	sim
Longo F	2003	ITA	30a	M	XX	CT	EXT	CE	5x3,5 cm	XX	N	sim
Tuz M	2003	TUR	23a	F	7a	USG, TC e MRI	EXT	CD	8,5x7,5x6 cm	1,2	N	XX