8. Conclusions


The practical proposals arising from the results arrived at by the present study can be summarized as follows:

(1) Any lesion occurring in a cranio-facial bone should be subjected to clinical, radiological and histopathological examinations as a matter of course. Only those diagnoses which concur on all three counts can be considered totally reliable.

(2) Terms such as 'fibro-osteo-cemental lesion', 'ossifying fibroma', 'cemento-ossifying fibroma', 'aggressive fibrous dysplasia' and 'epulis' are confusing. They should be eliminated and replaced by clear and distinct terminology based on clinically, radiologically and histopathologically reproducible and observable characteristics: Histogenetic features rather than tumor tissue content and product alone should be regarded as the basis for nomenclature.

(3) The investigations carried out for the purposes of this study appear to have isolated three tumorous entities, which have been defined by the terms 'benign periodontoma', 'psammous desmo-osteoblastoma' and 'tra-tbecular desmo-osteoblastoma'. A fourth entity, whose origins appear to be of a repara-
tive nature, has been termed 'osseous keloid'. The entities described differ in their clinical behavior and therefore require different types of therapy.

(4) (a) The aggressive way in which they behave and the fact that they tend to recur means that psammous and trabecular des-
mo-osteoblastoma require a relatively radical therapeutical approach, especially since ini-tial misdiagnosis can result in recurrence with all the unnecessary surgery that that implies. Recurrence can be avoided only if a sufficiently thorough approach is taken right from the start. (b) Conservative surgical inter-vention appears to be indicated for peri-odontomas, since in all cases recorded to date a single shelling out has been sufficient. There are no records of lesions of this type having recurred. (c) Since osseous keloids are not in fact tumors, but deformatory processes whose origins are reparative, intervention in such cases should be restricted to cosmetic re-contouring of the affected bone. It is vital that this condition be distinguished from fi-brous dysplasia. When osseous keloid occurs in a child, immediate surgical intervention of the type just described is necessary, whereas, were the lesion to be fibrous dysplasia, it would be normal and justified to postpone surgical intervention until skeletal growth had been completed.

Points 2 and 3 require some explanation. The fact that the present study proposes enti-ties and pathological characteristics which are at variance with the descriptions con-tained in the WHO publication of Pindborg and Kramer [1971] should not be interpreted as an attempt to question the value and use-fulness of such an internationally recognized classification. The approach used by the present study is essentially based on the bio-
logical behavior of the lesions it considers and it tends to suggest that fewer rather than more pathological entities exist in this area than is at present believed. If, on examination, the terminology proposed were found to be acceptable, it is hoped that it would simplify rather than complicate further the nomenclature used for pathological entities occurring in the cranio-facial and jaw bones. Furthermore, it should be stressed that the four entities proposed here cover only a small portion of the spectrum of lesions defined by the WHO classification just mentioned. These proposals are not intended to put in question the validity of classifications of this kind, though admittedly, acceptance of them would imply a readiness to restructure a part of the present WHO classification. What this restructuring would involve is essentially this:

1. The lesions at present covered by the term 'cementifying fibroma' would be divided into two groups. Some would fall within the parameters for the aggressive lesion described in the present study as 'psammomous desmo-osteoblastoma' (a condition for which the terms 'aggressive cementifying fibroma', 'aggressive cemento-ossifying fibroma' and 'cementifying fibroma located outside the tooth-bearing regions of the skeleton' have frequently been used in the
literature), while others would then be classified as the benign entity which this study has defined as 'periodontoma'. The term 'cementifying fibroma' would thus become redundant.

(2) The lesions covered by the term 'osifying fibroma' would likewise be divided into two groups. Some would fall within the parameters of the benign lesion which this study has defined as 'central periodontoma', while the remainder would then be classified as the aggressive entity which this study has
termed 'trabecular desmo-osteoblastoma' (a lesion for which such terms as 'aggressive juvenile ossifying fibroma' and 'aggressive fibrous dysplasia' have been used in the literature).

(3) The literature contains cases of lesions which are described as 'fibrous dysplasia' occurring in elderly patients and others termed 'Paget's disease' which occur in children. The present WHO classification does not explicitly exclude either of these possibilities. The clinical, radiological and histological characteristics of these 'atypical' cases of fibrous dysplasia and Paget's disease suggest that they are in fact cases of the entity presented in this study as 'osseous keloid'. In this connection, it should also be mentioned that the WHO classification presents an entity which it terms 'periapical cemental dysplasia' or 'periapical fibrous dysplasia'. This occurs predominantly in female patients aged 45 or more. The lesion, which appears on X-ray as an area of radiolucency normally located in the apical region of the front of the mandible, does not cause any serious complications and does not require surgical therapy. In view of the fact that it occurs in older patients exclusively, the use of the term 'dysplasia' is somewhat infelicitous. Strictly speaking, the term dysplasia refers to lesions occurring in tissue which is still developing and whose development process has been in some way disturbed or arrested, so that its use in the nomenclature...
ture of what is in fact a self-limiting lesion of reparative origin occurring exclusively in ma-ture tissue is perhaps a little inappropriate. From a purely biological point of view, the lesion seems out of place in the table entitled 'Characteristics of Four Types of Cemento-

ma' [Findborg and Kramer, 1971, p. 32].

In conclusion it should be stressed that lesions of the type discussed in the present study are rare and that the present state of knowledge in this area is undoubtedly far from complete. There is an immense necessity for further research in this field to be carried out and for as much international and interdisciplinary discussion as possible to be held. The WHO classification has assisted this author's work in this field enormously and the part that it has played in facilitating interdisciplinary and international communication is undoubtedly inestimable. It is
hoped that the terminological alterations proposed here will be considered as a possible way not only of promoting and clarifying such discussions further, but also of reinforcing the WHO classification which has so greatly facilitated them since its introduction in 1971. It is also hoped that the Suggestions put forward in the present study will be considered by other members of the profession, and their criticisms and reactions are avidly awaited.