LETTER TO THE EDITOR

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Comment on "An unusual presentation of peripheral ameloblastoma in the maxilla"

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To the Editor,

We have read with interest the article titled, "An unusual presentation of peripheral ameloblastoma in the maxilla," by Acevedo Ocaña et al.[1] We congratulate the authors for presenting this interesting case in this prestigious journal; however, wishing to contribute to the diagnostic criteria, we would like to make some comments.

First, the histopathological criteria for diagnosis of ameloblastoma, regardless of type, were initially proposed in 1970[2], and were strictly followed by the current World Health Organization[3]. Therefore, ameloblastoma microscopically presents with hyperchromatism of basal cell nuclei, surrounded by polarized and subnuclear vacuolation of basal cells. The central epithelium is reminiscent of stellate reticulum, with discohesive angular cells and often cystic change[2,3]. These criteria were well accepted upon proposal[4]. Second, we think that an inflammatory component is unusual in (peripheral) ameloblastoma; however, we agree that such a component can be observed focally or in peripheral areas. Regardless of this, the microscopic criteria must be met[4]. Third, we recently published a study in which microscopic analysis efficiently distinguished ameloblastomatous epithelium from nonneoplastic (reactive) proliferative epithelium[5].

In the current study, the microscopic findings were assessed using Masson's trichrome staining. We believe that hematoxylin and eosin staining is routinely the first histochemical stain in histomorphological analysis. Despite this, Fig. 4[1] does not show the required criteria for ameloblastoma[2-5], and the connective tissue stroma harbors a major inflammatory component (please see page 162, last sentence of the description of Fig. 4, 5[1]). Fig. 5[1] also highlights the inflammatory component, indicating that peripheral ameloblastoma may be connected to the surface epithelium, as well as other lesions of reactive or inflammatory origin[5]. Thus, the clinicopathological correlation is consistent with an inflammatory fibrous lesion associated with reactive proliferative epithelium.

Finally, we believe that the distinction between these two lesions is critical. Peripheral (extraosseous) ameloblastoma is the soft tissue counterpart of intraosseous ameloblastoma, comprising about 10% of all ameloblastomas. This type of lesion exhibits more indolent behavior than conventional ameloblastoma, with recurrence rates varying from 9% to 20%. Malignant transformation is extremely rare[3].

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Authors' Contributions

H.A.S. and M.B.M. were involved in critically appraising the article and drafting the manuscript. J.E.L. helped with the critical appraisal and final review of the manuscript.

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Conflict of Interest

No potential conflict of interest relevant to this article was reported.

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