

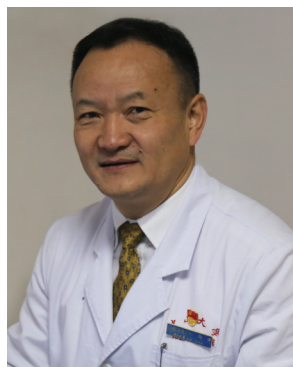
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· 专家论坛 ·

开窗治疗颌骨囊性病变的专家共识

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【摘要】开窗治疗颌骨囊性病变行之有效,具有创伤小、操作简单、减少术后复发,能最大程度地保留周围组织结构和功能等优点;但临床上由于适应证把握不当、操作不规范等原因,开窗治疗存在一定的失败率,文献报道的最高失败率为32.6%。为进一步完善和规范开窗术临床应用,提高治疗成功率,本文总结国内外文献和汇集部分国内著名专家的诊治经验,形成“开窗治疗颌骨囊性病变的专家共识”。此共识提出开窗术的3个要素为开窗口的建立、囊肿塞维持开窗口以及定期冲洗;开窗术的适用范围包括颌骨囊肿和囊性成釉细胞瘤等;需要规范开窗位置、开窗口大小以及囊肿塞制作与放置等重要操作步骤;对疗效评判采用全景片或锥形束CT观察术前、术后囊肿的变化较为客观;二期手术宜在病灶显著缩小>50%,或远离累及的重要结构5 mm左右时实施;对于病灶牙,应根据病灶与牙的关系以及牙的类型,分别予以处理。

【关键词】颌骨; 囊性病变; 开窗术; 适应证; 禁忌证; 疗效判定; 二期手术; 专家共识

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Expert consensus on marsupialization of cystic lesions of the jaw TAO Qian¹, HE Yue², LIU Bing³, HOU Jinsong¹, NAN Xinrong⁴, ZHANG Bin⁵, ZHANG Leitao⁶, QIAO Bin⁷. 1. Department of Oral and Maxillofacial Surgery, Guanghua School of Stomatology, Hospital of Stomatology, Sun Yat-sen University, Guangzhou 510055, China; 2. Department of Oromaxillofacial Head and Neck Oncology, Shanghai Ninth People's Hospital, College of Stomatology, Shanghai Jiao Tong University School of Medicine, Shanghai 200011, China; 3. Department of Oral and Maxillofacial Surgery, School of Stomatology, Wuhan University. Wuhan 430072, China; 4. Department of Oral and Maxillofacial Surgery, The First Hospital, Shanxi Medical University, Taiyuan 030001, China; 5. Department of Oral and Maxillofa-

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【Abstract】 Marsupialization is effective in the treatment of cystic lesions of the jaw. It is a simple operation that can result in minimal trauma, the reduction of postoperative recurrence, and maximum preservation of the surrounding tissue structure and function. However, there is a certain failure rate in clinical treatment due to the improper grasp of indications and nonstandard operation. The highest failure rate reported in the literature is 32.6%. To further standardize the clinical application of marsupialization and improve the success rate of treatment, we put forward an expert consensus of marsupialization in the treatment of jaw cystic lesions by reviewing the domestic and foreign literature and summarizing the experience in marsupialization from some famous domestic experts. In this consensus, we propose three elements of marsupialization: the establishment of the opening, the maintenance of cyst plugs and regular washing. The scope of application of marsupialization includes jaw cysts and cystic ameloblastomas. It is necessary to standardize the position of the opening, the size of the opening and the manufacture of the cyst plug, and a panoramic film or cone beam computed tomography(CBCT) should be used to observe the changes in the cystic cavity before and after operation. A second-stage operation should be performed when the lesion is significantly reduced by more than 50% or at least 5 mm from important structures; furthermore, the teeth of focus should be treated according to the relationship between the lesion and tooth and the type of tooth.

【Key words】 jaw bone; cystic lesions; marsupialization; indication; contraindication; effect evaluation; second-stage surgery; expert consensus

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开窗治疗颌骨囊性病变创伤小,操作简单,易于开展,能最大程度地保留周围组织结构和功能,充分体现了口腔颌面外科临床实践中“微创和功能并重”的理念。但是,由于适应证把握不当、操作不规范等原因,开窗治疗存在一定的失败率,文献报道的最高失败率为32.6%^[1-2]。本文作者们总结各自的诊治经验,借鉴和归纳近年来国内外专家的临床和研究成果,讨论形成开窗治疗颌骨囊性病变的专家共识,以科学选择开窗治疗的适应证,规范开窗的操作步骤和建立合理的诊治过程,减少治疗失败风险,进而指导开窗术的临床运用。

1 开窗术的定义

开窗术的临床应用历史十分悠久,1892年提出的“造口术(cystostomy)”或“袋型术(marsupialization)”:将囊肿内衬上皮与口腔黏膜缝合成袋型治疗颌骨囊肿;1958年因“开窗减小囊腔内压力”称之为“减压术(decompression)”,开口位置可位于口腔、鼻腔和上颌窦^[2-3]。自上个世纪90年代开始,临床上逐渐统一称为“开窗术”,开窗术的疗效得到众多临床医师的肯定^[1-8],经过多年来的实践,其基本理念、操作步骤以及适用范围都得到很大的发展。本共识建议“开窗术”应包括3个基本要素

和步骤:①手术去除部分囊骨壁及活检,建立囊腔内外相通的窗口;②囊肿塞保持窗口通畅;③从窗口进行定期的囊腔冲洗,以达到缩小甚至消灭颌骨囊性病灶和促进新生骨组织生成的目的。

2 开窗治疗的指征

开窗治疗需要患者的定期复诊,而且治疗周期较长,因此不推荐应用在单纯刮除术可治愈的范围局限的病灶,即病变范围不大、没有累及邻近牙齿或血管神经管等结构,简单的手术刮除即可获得满意效果者。开窗治疗的指征包括:①颌骨囊性病灶范围较大,最大径大于3.5 cm^[9];②病变发生在髁突等重要解剖部位,或累及恒牙胚、牙根、下牙槽神经管及上颌窦底等;③明确的病理学诊断。

病理学诊断是科学实施开窗治疗的基础和必要条件。医生可以借助术前影像学资料初步选择开窗术,术中切取病变组织供病理学检查,根据诊断结果及时调整治疗方案。

3 开窗术的适应证与禁忌证

回顾相关文献可以得出,适应证和禁忌证把握不当是导致开窗失败的主要原因^[6,10-11]。本共识

结合2017年第四版《WHO头颈肿瘤分类》中有关颌骨肿瘤新的分类,列出开窗术的适应证与禁忌证^[12-14]。

3.1 适应证

①炎症性囊肿,如根尖囊肿、牙旁囊肿和残余囊肿等;②发育性囊肿^[1,15-16],如含牙囊肿、鼻腭管囊肿和正角化囊肿等;③假性囊肿,如单纯性骨囊肿等。

3.2 相对适应证

①单囊型成釉细胞瘤^[6,12-13](单囊型成釉细胞瘤分为3类:单纯囊性型、囊腔内瘤结节型和囊壁内浸润型,其中囊壁内浸润型具有与经典型成釉细胞瘤相同的生物学侵袭特性和术后高复发率);②牙源性角化囊肿和牙源性钙化囊肿^[4-7,12-13];③经典型成釉细胞瘤。

3.3 禁忌证

①牙源性实性良性肿瘤和骨源性肿瘤等;②颌骨中心性血管瘤和动脉瘤样骨囊肿等;③颌骨恶性肿瘤。

4 开窗术的操作要点

①建议口腔内开窗,选择在龈颊沟底做一直径约为1 cm的开口,方便制作囊肿塞的同时利于放置囊肿塞和囊腔冲洗。去除足够的骨壁以保证通畅的引流通道,切取足够的病变组织以明确病理诊断,尽可能去除病灶内的骨性间隔。②囊肿塞可以有效维持开窗口,包括体部和翼部两部分,体部长度以囊腔前后径的1/2为宜,保证引流效果;翼部沿龈颊沟稍作外展,增强稳定性。建议使用硅橡胶印模材料制作囊肿塞,有可塑性好,舒适度好等优点^[2]。③囊腔冲洗可以去除分泌物、减少炎症反应和改善局部微环境、有利组织修复等优点。开窗早期建议1~3次/d的囊腔冲洗。

5 定期复诊和疗效评估

开窗术后1~2个月复诊一次。定期复诊有利于及时观察病灶变化和预判疗效,建议以术后6个月为时间节点,复查全景片并与术前资料对照,评估开窗疗效,对无效或失败病例及时修改治疗方案。必要时可以辅助CBCT或螺旋CT检查,多维观察病变情况。

①术后囊腔面积/体积缩小>20%者为有效,继续予以开窗治疗(囊腔面积/体积:为简单易行起见,囊腔的面积=全景片中囊性病灶的最大水平

距离×最大垂直距离^[17];囊腔的体积=CBCT中囊性病灶的最大高度×最大宽度×最大长度)^[18]。②术后囊腔面积/体积未见变化者为无效,应密切观察或及时更改治疗计划。③术后囊腔面积/体积增大者,或者病灶周围骨白线模糊消失者为失败,建议积极施行根治性外科手术,必要时配合修复重建。

6 治疗周期和二期手术时机

临床经验和文献资料都提示开窗术后的早期病灶缩小明显,后期变小的速度明显减慢^[18]。术后6个月的疗效评估后,何时或如何结束开窗治疗?是否需要二期手术等^[6,10,15,19]?目前均无定论。本共识建议:治疗周期一般不超过两年。对于成釉细胞瘤或角化囊肿等复发率较高的病灶,病灶显著缩小>50%,或远离累及重要结构5 mm左右时实施二期手术,而含牙囊肿等发育或炎症性囊肿,可待病灶充分缩小至稳定后,酌情施行二期刮除术,结束治疗。鉴于颌骨囊性病变更高的复发风险,仍需数年的随访。

7 开窗治疗中的几点考量

7.1 病灶内牙的处理

病灶内的功能牙应予保留,部分可以随骨质生长颌向移动萌出,年轻恒牙或可成功萌出,或形成正常牙齿形态,利于后期正畸牵引。多生牙或畸形牙建议开窗时拔除^[20-21]。

7.2 病变累及牙的处理

开窗术后病变累及牙的牙髓活力可以恢复,因此对具有咬合功能的受累牙应常规保留和保存牙髓活力,不必急于根管治疗^[22]。

7.3 牙槽嵴高度、骨量保存

对于接近牙槽嵴顶的埋伏牙,可先行开窗,待埋伏牙周围骨质生长后,二期手术再行拔除,以保留牙槽嵴高度、骨量。

7.4 患者良好的依从性

开窗治疗的过程比较长,定期复诊和冲洗必不可少,需要患者认识上、时间上和行为上的配合。因此在设计和制定开窗计划时,患者的依从性也是一个重要的考量因素。

开窗治疗颌骨囊性病变更成功实践,体现了口腔颌面外科治疗手段的丰富和理念的进步,其优点不言而喻,值得进一步推广。不可否认,开窗术临床应用的局限性和失败风险也是客观存在的。对开窗术过程中细胞因子、肿瘤微环境以及

肿瘤上皮去分化等应用基础研究,将有助于开窗术的精准应用^[23-24];此外,临床医生在开窗术前无法准确判断疗效,多根据其主观经验预测,对此,近来兴起的影像组学可术前提取颌骨囊性病的大量影像信息,结合人工智能的算法和深度学习,有望应用于术前预测开窗疗效,提高临床应用的准确性和成功率^[25-26]。

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