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"Spectrum and Surprises: A Retrospective Evaluation of Odontogenic Lesions with Emphasis on Rare Occurrences and Diagnostic Implications"

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Abstract

Background: A broad category of lesions originating from tooth-forming tissues, odontogenic cysts and tumors display a variety of biological behaviors and clinicopathological characteristics. Their overlapping radiographic and clinical appearances can make diagnosis difficult. Particularly in tertiary care settings in developing nations, regional epidemiological statistics are crucial for enhancing diagnostic precision and treatment planning.

Materials and Methods: The present retrospective observational study was conducted in the Department of Oral Pathology and Microbiology at a tertiary care centre in Lucknow, India, over a one-year period (2024–2025). A total of 72 histopathologically confirmed cases were included of both odontogenic cyst as well as tumour. Data regarding age, gender, anatomical site and histopathological diagnosis were retrieved and analysed descriptively.

Results: Odontogenic tumors were less common than odontogenic cysts. The most prevalent type of cyst was an odontogenic keratocyst, which was followed by dentigerous and radicular cysts. Inflammatory changes were seen in a number of these cases. Odontoma and ameloblastoma were the most common types of tumors.

The posterior mandible accounted for the bulk of lesions, which peaked in the third decade of life. Unusual appearances and histological differences that presented diagnostic challenges were examples of rare discoveries.

Conclusion: The study highlights the wide spectrum and clinicopathological diversity of odontogenic lesions, with a predominance of cystic lesions over tumours. The identification of rare variants and atypical presentations underscores the importance of thorough histopathological evaluation. Such retrospective analyses contribute to improved diagnostic awareness and support evidence-based management strategies in clinical practice.

Keywords: odontogenic cyst, odontogenic tumour, trends and pattern, original article

Introduction

The epithelium and/or ectomesenchymal components of the tooth-forming apparatus are the source of a diverse range of diseases known as odontogenic cysts and tumors. From benign inflammatory cysts to aggressive neoplastic entities with a high potential for local invasion and recurrence, these lesions show a wide clinicopathological as well as histological spectrum. For oral pathologists and maxillofacial surgeons, diagnosing and treating them can be challenging due to their varied biological behaviour and overlapping clinical and radiological characteristics [1]. The classification of odontogenic cyst as well as tumours has been provided in 2022 WHO classification of head and neck tumours[2].

As per the classification, Odontogenic cysts are generally classified into inflammatory and developmental types, with radicular cysts being the most common inflammatory lesions associated with pulpal necrosis, while dentigerous cysts and odontogenic keratocysts (OKCs) represent key developmental entities [3]. Because of its aggressive growth manner, high recurrence rate, and correlation with syndromic disorders such nevoid basal cell carcinoma syndrome, OKC has attracted special attention among these. Moreover, changed histological characteristics may be present in infected cyst variations, making diagnosis even more difficult[4].

Despite being less common than cysts, odontogenic tumors exhibit a variety of biological behaviours. These have been classified as either benign or malignant odontogenic tumours. While lesions like odontomas and adenomatoid odontogenic tumors (AOT) are often hamartomatous and have limited growth potential, benign odontogenic tumors like ameloblastoma are recognized for their locally invasive characteristics and high recurrence potential [5]. Ameloblastoma histological subtypes, such as unicystic, plexiform and follicular variations, have unique clinicopathological traits and treatment consequences, requiring accurate identification [6]. Despite advancements in diagnostic imaging and histopathological techniques, variations in the epidemiological profile of odontogenic lesions persist across different populations and geographic regions. Factors such as age, gender, anatomical site, and genetic predisposition influence the distribution and presentation of these lesions. Notably, the posterior mandible is frequently reported as the most common site; however, unusual presentations involving the anterior maxilla or maxillary sinus are not uncommon and may pose diagnostic dilemmas [7].

The growing spectrum of odontogenic disease includes common lesions as well as uncommon ones such residual cysts, incisive canal cysts, and orthokeratinized odontogenic cysts (OOC). Cases exhibiting histological transformation, such as ameloblastomatous changes within dentigerous cysts, are particularly significant from a therapeutic standpoint since they may suggest a transition toward a more aggressive biological behaviour. These results emphasize the significance of thorough histological assessment and continuous monitoring [8].

In in the context of this, retrospective analyses are essential for comprehending the diagnostic variability and clinicodemographic patterns of odontogenic diseases within specific populations. Nonetheless, there is still a dearth of region-specific data from tertiary care facilities in developing nations, where illness patterns and patient profiles may vary considerably.

In order to retrospectively assess the range of odontogenic cysts and tumours identified at a tertiary care facility, the current study was conducted. With a focus on detecting uncommon presentations, rare occurrences, and diagnostic difficulties, the study intends to examine their demographic distribution,

anatomical preference, and histological features. The study aims to enhance diagnostic awareness and evidence-based therapeutic management of odontogenic diseases by emphasizing this "spectrum and surprises."

Material and Method

Study Design and Setting: This retrospective observational study was conducted in the Department of Oral Pathology and Microbiology at King George's Medical University, Lucknow. The study involved the analysis of archived case records and histopathological reports of odontogenic cysts and tumours. The study included cases diagnosed over a period of one year (2024-2025).The study was conducted in accordance with institutional ethical guidelines. As a retrospective study utilizing archived data, patient confidentiality was strictly maintained and no personal identifiers were disclosed.

Sample Selection: A total of 72 cases were included in the study, comprising:

- 42 cases of odontogenic cysts
- 30 cases of odontogenic tumours

Cases were selected based on confirmed histopathological diagnosis.

Inclusion Criteria

- Cases diagnosed histopathologically as odontogenic cysts or tumors
- Availability of complete clinical data including age, sex and lesion site

Exclusion Criteria

- Incomplete clinical or histopathological records
- Non-odontogenic cysts and tumors
- Recurrent cases lacking primary diagnostic details

Data Collection

Data were retrieved from departmental archives and patient records. The following parameters were recorded:

- Age and gender of the patient
- Anatomical site of the lesion
- Histopathological diagnosis

Results

Table.1. represents the histological distribution of odontogenic cyst with Table.2. depicting the demographic distribution of the same. Table.3. represents the histological distribution of odontogenic tumours with Table.4. represents the demographic distribution of the same. Table.5. represents the comparison of both odontogenic cyst as well as tumour based on demographic attributes taken.

Discussion

Different loco-regional as well as spatial (geographic and temporal) populations have different prevalence as well as incidence rates of oral and maxillofacial lesions with different clinic-radiologic as well as histological presentations[9]. The reported incidence of oral and maxillofacial lesions in the general population range from 4.9% to 64.7%, with considerable regional and national variations[10]. Physicians may be more competent to establish differential diagnoses and develop preventative strategies if they are aware of their prevalence patterns and traits. Oral and maxillofacial lesions include a range of conditions that impact both general and oral health. They may be entirely asymptomatic or induce a variety of symptoms, including as discomfort, infections, and abnormalities of the mucosa[11]. Because of physiological changes in the oral cavity, the incidence of oral and maxillofacial lesions generally increases with age. Additionally, characteristics like

gender and the anatomical location of the lesions affect their incidence [12,13,14]. The many histological tissue types in the area can lead to a variety of disorders, ranging from malignant to inflammatory as per the WHO classification . According to Kaur et al.[15], there was a higher incidence of odontogenic tumors reported between 2005 and 2016 than in earlier years, which may have been influenced in part by modifications to the classification criteria. The same has also been seen in our tertiary centre as well, where the incidence of both odontogenic cyst as well as tumours have been reported in concordance with the epithelial malignancy (Oral Squamous cell carcinoma) , in the past one year data as collected for the analysis. At the hospital under study in Chennai, India, Sudarsan et al.[16] rarely came across odontogenic tumors, highlighting their relative rarity among this particular demographic location. Moreover, published data across various countries has reported the incidence of odontogenic cyst to be 0.8-49% of all the submitted specimens which is in alignment with the findings of the present study where odontogenic cyst were reported more than odontogenic tumours, with wide range of histological presentations, the developmental cyst presenting with superfluous inflammation [17,18,19]. Similar histologic images of non-keratinized, hyperplastic epithelial lining were seen in inflamed OKC, DC, and radicular cyst (RC). Such similarities in the appearance of odontogenic cyst linings (RC, DC, and OKC) linked to inflammatory areas would make it difficult to diagnose OKC because it might be confused with DCs. Since the biological actions of OKC are different from those of RC or DCs, such misdiagnosis should be avoided [20]. It has been hypothesised that both the subpopulation of this inflammatory infiltration and the involvement of inflammation may be essential to the likely manner by which these apparatus would react. For a complete knowledge of the inflammatory potentials on the genesis of developmental odontogenic cysts, it is therefore essential to compare the proliferation values and inflammatory cell populations between inflamed OKC and inflamed DC and to correlate the inflammation with both the diagnostic as well as prognostic implications requires further studies as well as validation.

In the present study, Odontogenic Keratocyst (33.3%) has been reported to be the most common odontogenic cyst, with superfluous inflamed component also reported as separate histological variant (14.3%) , which is in contrast to the study conducted by Shear et al [21], Killey et al [22], where radicular cyst were reported in higher incidence. The difference may be attributed to the geographical variations. The same incidence of the prevalence of odontogenic keratocyst was seen with a study conducted by Corso et a. [23]. The next most commonly reported cyst was Dentigerous cyst with inflamed counterpart, followed by Radicular cyst, which is in concordance with the various studies performed across worldwide nations [24,25,26]. The male: female prevalence of the reported cases were 16:1 in our study which is different from the one reported in a study conducted by Kambalimath et al., which also reported the most common site was posterior mandible (49.33 %) , similar to our study[27]. Even in short-term institutional data, the inclusion and detection of uncommon lesions as orthokeratinized odontogenic cyst, residual cyst, and incisive canal cyst within a comparatively limited sample size supports the idea of a wide "spectrum. “Although this study was conducted in Indian population, the reported cases did not involve separate lesions of Orthokeratinized Odontogenic Keratocyst (OOC), which was included in our study as well as inflamed variants of OKC as well as DC. The age range of presentation in our study was broad from first till 7th decade , with mean age range within 3rd decade , which is consistence with the studies reported from UK as well as Italy [28,29].

The high incidence of odontogenic cysts highlights the necessity of effective coordination between general dentists and oral and maxillofacial specialists in order to properly recognize and manage these disorders. While marsupialization followed by enucleation may be beneficial for larger multilocular lesions, enucleation is frequently effective for smaller unilocular lesions. Long-term follow-up is essential in many cases [30].

Moreover, identifying unusual locations like maxillary sinus involvement and simultaneous maxilla-mandible presentation brings consideration to diagnostic difficulties that could go unnoticed in standard practice. When taken as a whole, these results highlight the clinical significance of combining anatomical, histological, and demographic data to enhance diagnostic accuracy and customize treatment plans.

The odontogenic tumours has been reported on an increasing trend in studies conducted in Asia as well as Africa [31,32]. Odontoma and ameloblastoma were shown to be the most common benign odontogenic tumours in our study which is consistent with the incidence reported by Izgi et al.[33]. A total of According to Almazyad et al. and AlSheddi et al., ameloblastoma accounts for 25–63% of cases, making it the most common benign tumor, similar to the ones reported in our study as well , although none of them reported the different histological variants as reported in our study [34,35]. The peak age incidence in our study was reported to be between 2nd to 7th decade , which is in contrast with other studies [36,37] ,with an almost equal predilection between male and female, is in contrast to the same study conducted in southern Indian population

by Govind et al. [38]. However , the equal male and female predilection was reported in some studies [39,40]. The occurrence of the cases has been reported in the posterior mandible, which Is consistent with the previous reported cases [41,42,43]. Next most common reported type of benign odontogenic tumour was Adenomatoid Odontogenic tumour (AOT), which is similar to the aforementioned studied epidemiological studies.

The preponderance of unicystic ameloblastoma (36.7%) over other histological types is a significant novel finding, in contrast to numerous prior reports where solid/multicystic ameloblastoma was more commonly found. This finding raises the possibility of a trend toward earlier diagnosis or a greater identification of cystic variations that are less aggressive, which has significant ramifications for the adoption of more conservative treatment strategies. The study also confirms that the posterior mandible is the most prevalent site (66.7%), but the existence of tumors in less common places like the anterior maxilla and ramus regions emphasizes the importance of being vigilant when atypical presentations occur. All things considered, this integrated analysis of tumor variations, demographics, and site distribution within a single institutional cohort emphasizes small epidemiological changes that may impact diagnostic and treatment approaches and adds important region-specific information.

These statistics are crucial for evaluating regional variations in lesion occurrence and for enabling medical professionals to make practical decisions when advising patients prior to biopsy regarding the likelihood of a diagnosis and the dangers of vague clinical or radiographic abnormalities.

Conclusion

The present study highlighted the epidemiological trends and patterns of odontogenic cyst as well as tumour in Eastern Uttar Pradesh population with geographical variation reported both locally as well as across the world. The present study reported OKC and Unicystic variant of ameloblastoma to be the most commonly reported odontogenic cyst as well as tumour respectively and is the first amongst its kind of retrospective descriptive analysis done in Eastern Uttar Pradesh, which further requires large sample size as well as multi-centric collaborative studies.

DECLARATIONS

Conflicts of interest: None

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LEGENDS

Table.1. Distribution of Odontogenic Cysts

Table.2. Demographic Distribution of Odontogenic cyst

Table.3. Distribution of Odontogenic Tumours

Table.4. Demographic Distribution of Odontogenic tumour

Table.5. Comparative analysis of cyst and tumour

References

1.Etebarian, A., Derakhshan, S., Babaiekia, M., Borhani, H. (2024). Odontogenic Lesions. In: Keyhan, S.O., Bohluli, B., Fallahi, H.R., Khojasteh, A., Fattahi, T. (eds) Handbook of Oral and Maxillofacial Surgery and Implantology. Springer, Cham.

2. Soluk-Tekkesin M, Wright JM. The World Health Organization Classification of Odontogenic Lesions: A Summary of the Changes of the 2022 (5th) Edition. Turk Patoloji Derg. 2022;38(2):168-184.

3.Rioux-Forker D, Deziel AC, Williams LS, Muzaffar AR. Odontogenic Cysts and Tumors. Ann Plast Surg. 2019 Apr;82(4):469-477.

4. Bilodeau EA, Collins BM. Odontogenic Cysts and Neoplasms. Surg Pathol Clin. 2017 Mar;10(1):177-222.

5. Siwach P, Joy T, Tupkari J, Thakur A. Controversies in Odontogenic Tumours: Review. Sultan Qaboos Univ Med J. 2017 Aug;17(3):e268-e276.

6. Ghai S. Ameloblastoma: An Updated Narrative Review of an Enigmatic Tumor. Cureus. 2022 Aug 6;14(8):e27734.

7. Alzahrani S, Wazzan T, Almaghrabi A, Alkhudran A, Aljereb H, Elsayed S, Alolayan AB. The Prevalence and Diagnostic Patterns of Oral and Maxillofacial Lesions: A Seven-Year, Retrospective, Single-Center Cone Beam Computed Tomography and Histopathology Study in Saudi Arabia. J Clin Med. 2024 Dec 19;13(24):7774.

8. Chi, Angela & Neville, Brad. (2011). Odontogenic Cysts and Tumors. Surgical Pathology Clinics. 4. 1027–1091.

9. Lauritano D., Moreo G., Carinci F., Borgia R., Lucchese A., Contaldo M., Della Vella F., Bernardelli P., Moreo G., Petruzzi M. Aging and oral care: An observational study of characteristics and prevalence of oral diseases in an Italian cohort. Int. J. Environ. Res. Public Health. 2019;16:3763.

10. Feng J., Zhou Z., Shen X., Wang Y., Shi L., Wang Y., Hu Y., Sun H., Liu W. Prevalence and distribution of oral mucosal lesions: A cross-sectional study in Shanghai, China. J. Oral Pathol. Med. 2015;44:490–494.

11. Shahzad A., Kiyani A., Paiker S. Prevalence of oral anomalies and pathologies in the Pakistani population—A cross sectional study. J. Pakistan Dent. Assoc. 2018;27:13–17.

12. Shabir H., Irshad M., Durrani S.H., Sarfaraz A., Arbab K.N., Khattak M.T. First comprehensive report on distribution of histologically confirmed oral and maxillofacial pathologies; A nine-year retrospective study. J. Pak. Med. Assoc. 2022;72:685–690.

13. Singh H.P., Thippeswamy S.H., Gandhi P., Salgotra V., Choudhary S., Agarwal R. A retrospective study to evaluate biopsies of oral and maxillofacial lesions. J. Pharm. Bioallied Sci. 2021;13:S116–S119.

14. Oivio U.-M., Pesonen P., Ylipalosaari M., Kullaa A., Salo T. Prevalence of oral mucosal normal variations and lesions in a middle-aged population: A Northern Finland Birth Cohort 1966 study. BMC Oral Health. 2020;20:357.

15. Kaur H., Gosavi S., Hazarey V.K., Gupta V., Bhadauria U.S., Kherde P. Impact of changing classification systems on prevalence and frequency distribution of odontogenic tumors in tertiary care center of Nagpur. Braz. J. Otorhinolaryngol. 2022;88:S3–S13.

16. Sudarsan R., Abilasha R. Prevalence of odontogenic tumours in association with age and gender—An institutional study. J. Popul. Ther. 2020;29:e222–e231.

17. Mosqueda TA, Irigoyen MF, Diaz MA, Torres MA. Odontogenic cysts. Analysis of 856 cases. Med Oral. 2002; 7:89- 96.

18. Ledesma-Montes C, Hernandez-Guerrero JC, Garces-Ortiz M. Clinicopathologic study of odontogenic cysts in a Mexican sample population. Arch Med Res. 2000; 31:373-76.

19. Jones AV, Craig GT, Franklin CD. Range and demographics of odontogenic cysts diagnosed in a UK population over a 30-year period. J Oral Pathol Med. 2002; 35:500-7.

20. Singh H, Shetty D, Kumar A, Chavan R, Shori D, Mali J. A molecular insight into the role of inflammation in the behavior and pathogenesis of odontogenic cysts. Ann Med Health Sci Res. 2013 Oct;3(4):523-8.

21. Shear M. Cysts of the oral regions, 3rd ed. Oxford: Wright. 1992; 56-75.

22. Killey HC and Kay LW. Benign cystic lesions of the jaws. Edinburgh and London: Churchill Livingstone. 1972; 139-44.

23. Del Corso G., Righi A., Bombardi M., Rossi B., Dallera V., Pelliccioni G.A., Marchetti C., Foschini M.P. Jaw cysts diagnosed in an Italian population over a 20-year period. Int. J. Surg. Pathol. 2014;22:699–706.

24. Kebede B., Tare D., Bogale B., Alemseged F. Odontogenic tumors in Ethiopia: Eight years retrospective study. BMC Oral Health. 2017;17:54.

25. Winters R., Garip M., Meeus J., Coropciuc R., Politis C. Safety and efficacy of adjunctive therapy in the treatment of odontogenic keratocyst: A systematic review. Br. J. Oral Maxillofac. Surg. 2023;61:331–336.

26. Tamiolakis P., Thermos G., Tosios K.I., Sklavounou-Andrikopoulou A. Demographic and clinical characteristics of 5294 jaw cysts: A retrospective study of 38 years. Head Neck Pathol. 2019;13:587–596.

27. Kambalimath DH, Kambalimath HV, Agrawal SM, Singh M, Jain N, Anurag B, Michael P. Prevalence and distribution of odontogenic cyst in Indian population: a 10 year retrospective study. J Maxillofac Oral Surg. 2014 Mar;13(1):10-5.

28. Jones AV, Craig GT, Franklin CD. Range and demographics of odontogenic cysts diagnosed in a UK population over a 30-year period. J Oral Pathol Med. 2006;35:500–507.

29. Tortorici S, Amodio E, Massenti MF, Buzzanca, Burruano F, Vitale F. Prevalence and distribution of odontogenic cyst in Sicily: 1986–2005. J Oral Sci. 2008;50:15–18.

30. Güler N., Şençift K., Demirkol Ö. Conservative management of keratocystic odontogenic tumors of jaws. Sci. World J. 2012;2012:680397.

31. Siriwardena BSMS, Tennakoon TMPB, Tilakaratne WM. Relative frequency of odontogenic tumors in Sri Lanka: analysis of 1677 cases. Pathol Res Pract. 2012;208:225–230.

32. Luo HY, Li TJ. Odontogenic tumors: a study of 1309 cases in a Chinese population. Oral Oncol. 2009;45:706–711.

33. Izgi E., Mollaoglu N., Simsek M.B. Prevalence of odontogenic cysts and tumors on Turkish sample according to latest classification of World Health Organization: A 10-year retrospective study. Niger. J. Clin. Pract. 2021;24:355–361.

34. AlSheddi M.A., AlSenani M.A., Aldosari A. Odontogenic tumors: Analysis of 188 cases from Saudi Arabia. Ann. Saudi Med. 2015;35:146–150.

35. Almazyad A., Alamro M., Almadan N., Almutairi M., Alquwayz T.S. Frequency and demographic analysis of odontogenic tumors in three tertiary institutions: An 11-year retrospective study. Diagnostics. 2024;14:910.

36. Jing W, Xuan M, Lin Y, Wu L, Liu L, Zheng X, et al. Odontogenic tumours: a retrospective study of 1642 cases in a Chinese population. Int J Oral Maxillofac Surg. 2007;36:20–25.

37. Osterne RL, de Matos Brito RG, Alves AP, Cavalcante RB, Sousa FB. Odontogenic tumors: a 5-year retrospective study in a Brazilian population and analysis of 3406 cases reported in the literature. Oral Surg Oral Med Oral Pathol Oral Radiol Endod. 2011;111:474–481.

38. Govind R.K. Nalabolu, Arif Mohiddin, Santhosh K.S. Hiremath, Ravikanth Manyam, T. Sreenivasa Bharath, P. Ramanjaneya Raju, Epidemiological study of odontogenic tumours: An institutional experience, Journal of Infection and Public Health, Volume 10, Issue 3, 2017,Pages 324-330.

39. Kubo H, Okamoto T, Yatani S, Horii K, Yasui H, Miya Y, et al. Clinicostatistical observation of odontogenic tumors based on the WHO histological classification of 2005. J Osaka Dent Univ. 2016;50:103–109.

40. Shibahara T, Morita S, Sugihara K, Minowa K, Yamaguchi A, Yamada T. Epidemiological study of odontogenic tumors according to the WHO classification in 2005. J Jpn Soc Oral Oncol. 2008;20:245–254.

41. Syed S, Carvalho KM, Spadigam A, Dhupar A. Clinico-pathological correlations of odontogenic tumors: some critical observations based on a 20-year institutional study and a comprehensive review of literature. Indian J Dent Res. 2019;30:516–520.

42. Koivisto T, Bowles WR, Rohrer M. Frequency and distribution of radiolucent jaw lesions: a retrospective analysis of 9,723 cases. J Endod. 2012;38:729–732.

43. Aregbesola B, Soyele O, Effiom O, Gbotolorun O, Taiwo O, Amole I. Odontogenic tumours in Nigeria: a multicentre study of 582 cases and review of the literature. Med Oral Pathol Oral Cir Bucal. 2018;23:e761–e766.

Table.1. Distribution of Odontogenic Cysts

S.no.	Lesion	Number	Percentage
1.	Odontogenic Keratocyst (OKC)	14	33.3%
2.	Infected OKC	6	14.3%
3.	Dentigerous Cyst (DC)	9	21.4%
4.	Infected DC	5	11.9%
5.	Radicular/Periapical cyst	7	16.7%
6.	Ortho keratinized Odontogenic Keratocyst (OOC)	1	2.4%
7.	Residual cyst	1	2.4%
8.	Incisive canal cyst	1	2.4%
Total:		42	100%

Table.2. Demographic Distribution of Odontogenic cyst

S.no.	Parameter	Observation
1.	Age range	6-65 years (mean =30 years)
2.	Gender Predilection	M: F ratio (16:1)
3.	Site Distribution	Posterior mandible (18 cases), Anterior maxilla (11 cases), Posterior maxilla (5 cases) Anterior mandible/ ramus and angle of mandible (3 cases each) Maxillary sinus(1 case) Simultaneous involvement of maxilla and mandible (1 case)

Table.3. Distribution of Odontogenic Tumours

S.no.	Lesion	Number	Percentage
1.	Unicystic Ameloblastoma	11	36.7%
2.	Plexiform Ameloblastoma	7	23.3%
3.	Follicular Ameloblastoma	5	16.7%
4.	Ameloblastoma (unspecified)	1	3.3%
5.	Odontome (Complex + Compound)	6	20.0%
6.	Adenomatoid Odontogenic Tumor (AOT)	3	10.0%
Total:		30	100%

Table.4. Demographic Distribution of Odontogenic tumour

S.no.	Parameter	Observation
1.	Age range	12-72 years (mean =40 years)
2.	Gender Predilection	M: F ratio (1:1)
3.	Site Distribution	Posterior mandible (20 cases), Anterior maxilla (2 cases), Posterior maxilla (2cases) Anterior mandible (2cases) ramus and angle of mandible (4cases)

Table.5. Comparative analysis of cyst and tumour

S.no.	Feature	Cyst	Tumour
1.	Prevalent site	Posterior Mandible (42.9%)	Posterior Mandible (66.7%)
2.	Gender predilection	Male predominance	No clear predilection
3.	Age incidence	2nd–4th decade	2nd–3rd decade
4.	Rare site	Maxillary sinus	None
5.	Distribution pattern	More widespread	More localized