**TITLE PAGE**

1.original research

**2. ULTRASONOGRAPHY AND DOPPLER ULTRASONOGRAPHY IN THE EVALUATION OF INTRAOSSEOUS LESIONS OF THE JAWS.**

3.Saima Tariq Ashawari, Altaf Hussain Chalkoo, Rizwan Hamid

4.Dept of oral medicine &radiology Govt Dental College Srinagar

5.Dr Saima Tariq post graduate scholar

6.Email id:saima.ashawari5@gmail.com

7.ADDRESS FOR CORRESPONDENCE :Qamarwari sector 3 near masjid anjumn

8.9086407408

**ABSTRACT AND KEYWORDS**

ABSTRACT

Objectives: To evaluate the efficacy of ultrasonography and colour and power Doppler ultrasonography for diagnosis of intraosseous lesions of the jaws and to correlate the contents of the lesion with the histological findings.

Methods: This study included 30 patients with intraosseous jaw lesions in the maxilla or mandible. Ultrasonographic examinations were performed and, according to the ultrasonography findings, the jaw lesions were classified into three groups: cystic, semisolid and solid. Additionally, colour Doppler ultrasonography examinations were performed to evaluate blood flow in all patients following which surgical treatment was done. The correlation between ultrasonography and Doppler ultrasonography findings of the lesions and histological findings was investigated.

Results: Thirty intra-osseous lesions from twenty nine patients were evaluated in this study. Twenty two lesions were located in the the mandible and eight were in the the maxilla. Of the thirty lesions, the ultrasound examination was inconclusive in one lesion because of the thick cortical vestibular bone plate and for two lesions histopathology was not available.

Conclusions: Ultrasonography can provide accurate information on the content of intraosseous lesions of the jaws before any surgical procedure. Additionally, Doppler ultrasound can show vascularization of the lesion. Also, there was a correlation between the ultrasound findings and the definitive histological diagnosis.

KEY WORDS:Intraosseous, ultrasonography, Doppler ultrasonography,histopathology

INTRODUCTION

Odontogenic cysts and tumors are a commonly occurring lesions in jaws owing to the embryological origin of jaws from ectomesenchyme.[1]some of these lesions show aggressive behaviour and even neoplastic transformation in some cases prompting their correct early diagnosis and treatment. [2]Diagnosis of bony lesions of jaw is often confusing owing to similar radiographic appearance.[3]Imaging ,thereby, plays an important role in the diagnosis of these lesions.Various imaging modalities include radiography, computed tomography, magnetic resonance imaging, ultrasonography with Nuclear Medicine, Positron Emitting Tomography (PET), Single-photon emission computed tomography (SPECT)among advanced modalities.Although computed tomography (CT) is of immense importance in diagnosing bone lesions but the radiation hazard and high cost limits its use.[4]

Ultrasonic imaging is one of the most important, developing diagnostic tools today. State-of-the-art ultrasonic scanners offer real-time gray scale images of anatomical details with millimeter spatial resolution superimposed on which a map of Doppler blood flow information is displayed in full color.[5]Use of ultrasonography in dentistry has been limited to soft tissue lesions despite its use in medicine for years.[6] It is useful in differentiating soft-tissue tumors, cysts, salivary stones, relationship of swelling to adjacent structures, consistency whether solid or cystic, and also it is extremely suitable for follow-up examination of tumor patients.[7] Due to overlying cortical bone diagnosis of Intraosseous lesions of jaw using ultrasonography becomes difficult thereby limiting its use,but the thin cortical bone in case of well grown and expanding lesions makes ultrasonograhy useful in diagnosis of such lesions.it is useful in differentiating solid and cystic components of the Intraosseous lesions of jaws and in guiding the site of biopsy.[8]Improvements in the ultrasound technology and the introduction of high resolution ultrasonography have led to routine use of USG in examination and diagnosis of bone pathology.[9]

The use of color Doppler in ultrasound allows evaluation of the presence, nature and velocity of blood flow in ultrasound images of the examined tissue. It can also reveal the progressive formation of new vessels in bone during the initial healing period.10

MATERIALS AND METHODS

**AIMS &OBJECTIVES OF THE STUDY**

1. To evaluate the efficacy of ultrasonography and colour and power Doppler ultrasonography for diagnosis of intraosseous lesions of the jaws .
2. To correlate the contents of the lesion with the histological findings.

**STUDY DESIGN;** Cross sectional

After getting approval from the Institutional Ethics Committee,the study was conducted in the Department of Oral Medicine &Radiology ,Govt. Dental College ,Srinagar over the period of a one and a half year commencing on 1st june 2016.

**MATERIALS AND METHODS**

1. A total of 30 patients visiting the Department of Oral Medicine and Radiology, Govt. Dental College and Hospital, Srinagar with intraosseous jaw lesions based on their symptoms, clinical and panoramic radiographic findings were included in the study.
2. After the confirmation of an intraosseous lesion, an ultrasound examination was performed in all patients to detect the lesions and to evaluate their content, size, and the relationship with anatomical structures. All patients were informed about the study and signed an informed consent.
3. All patients underwent Doppler ultrasound evaluation by the same radiologist and the images were analysed at the same time the examination was done. The examinations were performed with a colour-coded duplex scanner (GE LOGIC S-8) with a 7-12 MHz linear-array transducer.
4. There was no histological result at the time of the examination and the radiologist did not have access to the radiographs before ultrasound examination.
5. The ultrasound probe was positioned outside the mouth on the skin overlying the intraosseous lesion. Its position was changed several times to obtain good quality transverse, oblique and longitudinal scans.
6. After ultrasound examination, colour and power Doppler ultrasound examinations were performed to evaluate blood flow within or surrounding the examined lesion in all patients.
7. Histopathological examination of the lesions was done and the results were correlated with ultrasound examination.

**PATIENT SELECTION**

**INCLUSION CRITERIA:**

1. Patients of either gender presenting with intraosseous lesions in either maxilla or mandible.

**STATISTICAL METHODS** : The recorded data was compiled and entered in a spreadsheet (Microsoft Excel) and then exported to data editor of SPSS Version 20.0 (SPSS Inc., Chicago, Illinois, USA). Continuous variables were expressed as Mean±SD and categorical variables were summarized as frequencies and percentages. Graphically the data was presented by bar and pie diagrams.

**RESULTS**

Thirty intra-osseous lesions from twenty nine patients were evaluated in this study. Twenty two lesions were located in the the mandible and eight were in the the maxilla. All lesions had a radiolucent appearance with well-defined borders in panoramic radiographs, except for two lesions. These lesions, histologically diagnosed as central giant cell granuloma & round cell tumour , had a mixed appearance on panoramic radiography. Of the thirty lesions, the ultrasound examination was inconclusive in one lesion because of the thick cortical vestibular bone plate and for two lesions histopathology was not available.

|  |  |  |
| --- | --- | --- |
| **Table 1: Age distribution of study patients** | | |
| **Age (years)** | **Frequency** | **Percentage** |
| < 20 | 5 | 16.7 |
| 20-34 | 9 | 30.0 |
| 35-49 | 8 | 26.7 |
| 50-64 | 8 | 26.7 |
| Total | 30 | 100 |
| Mean±SD=35.4±16.04 | | |

|  |  |  |
| --- | --- | --- |
| **Table 2: Gender distribution of study patients** | | |
| **Gender** | **Frequency** | **Percentage** |
| Male | 17 | 56.7 |
| Female | 13 | 43.3 |
| Total | 30 | 100 |

|  |  |
| --- | --- |
| **Table 3:The lesions ultrasound and Doppler findings and histological diagnosis** | |
| **Ultrasound and Doppler findings (n)** | **Histological diagnosis (n)** |
| Simple cyst- no evidence of vascularisation(2) | Radicular cyst (1)  Traumatic bone cyst (1) |
| Simple Cyst with limited internal echoes-no evidence of vascularisation(6) | Radicular Cyst (2)  Residual cyst (1)  Dentigerous cyst (3) |
| Complex Cyst- no evidence of vascularisation(8) | Odontogenic keratocyst (7)  CGCG(1) |
| Semisolid –no evidence of vascularisation(8)  Semisolid –with internal vascularisation(1) | Radicular cyst (4)  Dentigerous cyst(1)  Ameloblastoma (1)  No HPE available (2)  Round cell tumor(1) |
| Solid –internal vascularisation(4) | CGCG(2)  OSCC(1)  Angioleomyoma(1) |
| Inconclusive(1) | Ameloblastoma(1) |

CGCG,central giant cell granuloma; OSCC, Oral squamous cell carcinoma

Table 3 shows the ultrasound and Doppler findings along with histological diagnosis. ultrasound examination showed a simple cystic appearance in 8 lesions, complex cystic appearance in 8 lesions, semisolid appearance in 9 lesions, solid appearance in 4 lesions. of the 1 lesion, ultrasound examination was inconclusive due to thick vestibular bone plate. vascularisation was not detected on color Doppler ultrasound in 24 lesions.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Table 4:Showing Correlation between histopathologic finding and US examination in cystic lesions** | | | | |
| **PATIENT** | **SITE** | **RADIOLOGY** | **ULTRASONOGRAPHIC**  **IMPRESSION** | **HISTOPATHOLOGICAL FINDINGS** |
| 01 | Mandible | Radiolucent | Cystic | Dentigerous cyst |
| 02 | Mandible | Radiolucent | Cystic | Traumatic bone cyst |
| 03 | Maxilla | Radiolucent | Semisolid | Radicular cyst |
| 04 | Mandible | Radiolucent | Cystic | Radicular cyst |
| 05 | Maxilla | Radiolucent | Semisolid | Radicular cyst |
| 06 | Mandible | Radiolucent | Semisolid | Dentigerous cyst |
| 07 | Maxilla | Radiolucent | Cystic | Dentigerous cyst |
| 08 | Mandible | Radiolucent | Cystic | Radicular cyst |
| 09 | Mandible | Radiolucent | Semisolid | Radicular cyst |
| 10 | Maxilla | Radiolucent | Cystic | Radicular cyst |
| 11 | Mandible | Radiolucent | Cystic | Radicular cyst |
| 12 | Mandible | Radiolucent | Cystic | Dentigerous cyst |
| 13 | Mandible | Radiolucent | Semisolid | Radicular cyst |

Table 4 shows the correlation between histopathologic findings & ultrasound examination in cystic lesions. Of the 13 histologically confirmed cystic lesions ultrasound confirmed cystic lesions in 8(61.5%) cases. semisolid appearance of remaining cystic lesions was attributed to these cysts being infected.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Table 5:Correlation between histopathologic finding and US examination in solid lesions** | | | | |
| **PATIENT** | **SITE** | **RADIOLOGY** | **ULTRASONOGRAPHIC IMPRESSION** | **HISTOPATHOLOGICAL FINDINGS** |
| 01 | Mandible | Mixed | Solid | Central giant cell granuloma |
| 02 | Mandible | Radiolucent | Solid | Squamous cell carcinoma |
| 03 | Maxilla | Radiolucent | Solid | Central giant cell granuloma |
| 04 | Mandible | Radiolucent | Solid | Angioleomyoma |
| 05 | Mandible | Radiolucent | Inconclusive | Ameloblastoma |
| 06 | Maxilla | Mixed | Semisolid | Round cell tumor |
| 07 | Mandible | Radiolucent | Semisolid | Central giant cell granuloma |

Table 5 showing correlation between histopathologic finding and ultrasound examination in solid lesions.out of 7 histologically confirmed solid lesions ultrasound showed solid lesions in 4(57.14%) cases. For round cell tumour ,usg showed areas of cystic degeneration within solid lesion hence semisolid impression was obtained. In case of central giant cell granuloma, the lesion was infected hence appeared semisolid on ultrasound. For ameloblastoma usg was inconclusive because of thick cortical bone plate.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Table 6:Correlation between histopathologic finding and US examination in mixed lesions** | | | | |
| **PATIENT** | **SITE** | **RADIOLOGY** | **ULTRASONOGRAPHIC IMPRESSION** | **HISTOPATHOLOGICAL FINDINGS** |
| 01 | Maxilla | Radiolucent | Semisolid | NO HPE AVAILABLE |
| 02 | Mandible | Radiolucent | Semisolid | Ameloblastoma |
| 03 | Maxilla | Radiolucent | Semisolid | NO HPE AVAILABLE |

Table 6 shows the correlation between histopathological findings and ultrasound examination. histologically only one lesion diagnosed as ameloblastoma was found to be semisolid on usg .for 2 lesions hpe was not available ,hence correlation could not be ascertained.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Table 7:Correlation between histopathologic finding and US examination in keratocysts** | | | | |
| **PATIENT** | **SITE** | **RADIOLOGY** | **ULTRASONOGRAPHIC IMPRESSION** | **HISTOPATHOLOGICAL FINDING** |
| 01 | Mandible | Radiolucent | Cystic;thick viscid | Keratocyst |
| 02 | Mandible | Radiolucent | Cystic;thick viscid | Keratocyst |
| 03 | Mandible | Radiolucent | Cystic;thick viscid | Keratocyst |
| 04 | Mandible | Radiolucent | Cystic;thick viscid | Keratocyst |
| 06 | Mandible | Radiolucent | Cystic;thick viscid | Keratocyst |
| 07 | Mandible | Radiolucent | Cystic;thick viscid | Keratocyst |
| 08 | Mandible | Radiolucent | Cystic;thick viscid | Keratocyst |

Table 7 shows the correlation between histopathologic findings and ultrasound examination in keratocysts.out of 7 histologically diagnosed cases of keratocysts usg showed thick viscid cystic contents in all lesions giving a 100% correlation.

DISCUSSION.

Intraosseous lesions of jaws are commonly encountered lesions whose diagnosis poses a challenge owing to their similar clinical and radio graphic presentation. Conventional radiographs, although serve as primary diagnostic imaging modality but being two dimensional only limits their use. Moreover, they lack the ability to reveal the nature and content of the lesions. The cost and being not readily available limits the use of advanced imaging modalities like CT & MRI . Among the advanced imaging modalities USG is an inexpensive, readily available and non hazardous modality that gives information not only about the location & size of lesion but also provides information about the nature & contents of lesions .Additionaly color Doppler provides information about the vascularity of lesion that further aids in the diagnosis. Although ultrasound is indispensabily being used for soft tissue pathologies ,very little has its use in diagnosing Intraosseous lesions been explored.

US can also be used for diagnosis of many other cysts in the head and neck regions both hard and soft tissue cyst extending to hard tissues or soft tissues or vice versa. It can provide accurate information on the pathological nature of the lesion, content of lesion, inflammatory process, and capsular thickness of lesions. It can also differentiate between simple and complex cyst, and on nature of the content differentiate into solid and semisolid cysts. Simple cysts appear totally anechoic lesions with limited or without internal echoes, e.g. radicular cyst. Complex cysts appear with dense internal echoes or high echo, e.g. OKC. Semisolid cysts when cystic and solid areas are combined in the same lesions. Solid lesions have no liquid components and posterior enhancement and have a moderate echo.[11]

The present study evaluated the efficacy of ultrasound &color Doppler in diagnosing Intraosseous lesions of jaw. The study revealed that ultrasound along with color Doppler was able to show the contents & vascularity of almost all Intraosseous lesions except one lesion where ultrasound was not able to detect the lesion because of thick cortical bone. Also a correlation was found between ultrasound findings and histological diagnosis. Among the Intraosseous lesions odontogenic cysts (66.6%) were most commonly diagnosed.

The age of patients ranged from 6-64 years with a mean age of 35.4±16.04 years . In astudy conducted by ***Benjamin et al,12***similar age range of patients 4-64 years was observed. *In this study*seventeen (56.7% )lesions were in males and thirteen ( 43.3% ) in females with a M:F ratio of 1.3. This is in accordance with the study conducted by ***Benjamin Fomete et al*** ,12 where thirty-five (54.7%) lesions were in males and twenty- nine(45.3%) in females giving a M:F ratio of 1.2:1. The greater frequency in adult males may be because they are more likely to neglect their teeth or they are more likely to sustain trauma to their teeth, compared to females, all of which may be the etiology for cyst formation

The lesions were more common in mandible ,twenty -two (73.3%),than maxilla , eight (26.7%).This is in accordance with the study conducted by ***Fabio et al ,13*** where the mandible was affected more frequently (71.43%) than the maxilla (28.57%) and ***Kambalimath et al*** 14where they found that the most common locations of the odontogenic cysts were the mandibular (49.33 %) and posterior region (33.33 %). A study by ***sumer et al15*** revealed that 50% of lesions were in mandible and 50% in maxilla.

Twenty eight(93.34%)lesions had radiolucent appearance and two (6.66%) had mixed appearance on panoramic radiograph. Study by **Javadian Langaroodi A et al16**,reported that cysts and benign tumors had a radiolucent appearance as opposed to tumor-like lesions with a dominant radiopaque presentation. Cysts and benign tumors were well-defined with corticated borders, while tumor-like lesions were equally well-corticated and sclerotic.

In the study Odontogenic cyst was diagnosed by histological examination in nineteen (63.3%) specimens. Rest of the lesions were diagnosed as CGCG three (10%),ameloblastoma two (6.6%),round cell tumour 1(3.3%),oral squamous cell carcinoma one (3.3%),angioleomyoma one (3.3%)and traumatic bone cyst one(3.3%).This finding of our study is similar to **sumer et al study15**  where seventeen (77.2%) out of twenty- two specimens were diagnosed as odontogenic cysts.

Among the odontogenic cysts eight (26.7%) were Radicular cysts, seven (23.3%) were OKC, four (13.3%) dentigerous cyst. A study by ***jones et al*** 17 showed that Radicular cyst was the most common diagnosis (52.3%), followed by dentigerous cyst (18.1) and odontogenic keratocysts (11.6%). A study by ***Manor et al18*** showed that out of 322 patients with cystic lesions of the jaw 155 (48%) were radicular cysts, 80 (25%) were dentigerous cysts, 23 (7%) were odontogenic keratocyst (=keratocystic odontogenic tumor), 19 (6%) were eruption cysts, 16 (5%) were traumatic bone cysts, and 29 (9%) were non-odontogenic cysts.A study by ***Kambalimath et al14***showed that Radicular cyst was most prevalent histological type (48.67 %) followed by dentigerous cyst, odontogenic keratocyst, lateral periodontal cyst, paradental cyst, residual cyst, adult gingival cyst, glandular odontogenic cyst, calcifying odontogenic cyst. Study by ***Benjamin Fomete et al*** 12 reported dentigerous cyst (n = 21; 32.8%) was the most predominant lesion followed by periodontal (n = 12; 18.8%) and radicular cysts (n = 10; 15.6%). Study by **Javadian Langaroodi A et al, 16** reported OKC to be the most prevalent cyst**.** Our study is in partial agreement with above mentioned studies and in complete contrast to **Benjamin Fomete et al12**

The size of the lesions ranged from 2.38cm3 to 52.98 cm3 with a median of 21.51cm3. A study by ***Gad et al 19*** showed that lesion sizes ranged from 0.019 to 40.856cm3 with a median of 0.622cm3. Most lesions(71%) were smaller than 5cm3.

ultrasound examination showed eight lesions as simple cysts . These lesions were anechoic to hypoechoic and had no vascularity on color Doppler. In all these cases ,the findings of ultrasound and Doppler ultrasound were compatible with the content of the lesion. These findings are in accordance with **sumer et al 15** where in case of simple cysts , USG findings were compatible with the content of the lesions. Study by **Shahidi et al20** reported complete agreement between the USG and histopathologic results regarding content assessment

Cysts are usually anechoic due to their liquid content that produce no internal echoes.If the cyst becomes infected then the content of the lesion can produce echoes producing a hypoechoic picture as described by ishikawa,pogrel,osama&corney.77

The sensitivity of ultrasound examination in case of cystic lesions was found to be 61.5%.This implies that out of 13 histopathologically diagnosed cysts ,ultrasound examination showed 8(61.5%) lesions to be cystic .Semisolid contents on ultrasound examination in the remaining 5 cystic cases can be explained on the basis of the associated inflammatory process seen in them on HPE. Study by **Lauria et al21** showed that ultrasound examination was compatible with histological examination in 73.9% of cases in case of cystic lesions. **chandak et al22** reported that for cystic swellings sonographic diagnosis had a sensitivity of 100% and a specificity 98.3%.

In the study complex cystic lesions on ultrasound examination showed dense hypoechoic cystic content with no evidence of vascularisation. These cystic lesions were mainly found to be odontogenic keratocysts. Studies by **sumer et** **al** 15and **Lauria et al21** also showed that okc had dense cystic content. **pallagi et al23** in their study found that okc exhibited hypoechoic pattern on usg examination.

In case of keratocysts USG examination was in complete agreement with A histopathological findings. out of 7 histologically diagnosed cases of okc,usg examination showed all of them to be complex cysts.In the study by **Lauria et al21** 77.7% of cases were diagnosed as complex cystic on ultrasound examination.

In the study semisolid content was found on ultrasound examination in nine cases with vascularity in only one case on color Doppler . Histopathologically these lesions were diagnosed as Radicular cyst(4),dentigerous cyst(1) and ameloblastoma(1). For two lesions HPE was not available. All these lesions had no vascularity on color Doppler. One semisolid lesion diagnosed as Round cell tumour was vascular on color Doppler. Study by **Sumer et al15** found 6 lesions to be semisolid with no evidence of vascularisation [Radicular 2,residual 2,dentigerous cyst 2].In a study by **Lauria et al** 21mixed lesions were mainly found to be ameloblastoma on HPE.

Round cell tumour was seen as semisolid lesion on ultrasound examination. This may be attributed to cystic degeneration within solid component as seen on ultrasound examination. Ameloblastoma was seen to have semisolid content on ultrasound examination which may be attributed to its association with an impacted tooth. Ameloblastomas occur in association with an impacted or unerupted tooth (mostly the mandibular third molar).24 Thick cortical bone led to inconclusive ultrasound examination in one case only.

In the study solid content on ultrasound and vascularity on color doppler was found in four cases .These were diagnosed to be CGCG(2),OSCC(1) and angioleomyoma(1) respectively. Study by **Sumer et al15** showed 2 solid lesions with internal vascularisation on ultrasound examination .

For solid lesions the sensitivity of ultrasound examination was 57.14% which implies that out of 7 histopathologically diagnosed solid cases, ultrasound examination showed only 4 (57.14%)cases to be solid .

Ultrasound examination was inconclusive for one lesion that was diagnosed to be ameloblastoma on HPE. This was because of thick cortical bone plate. Studies by **Sumer et al** 15**and Lauria et al21** also showed that ultrasound examination was inconclusive in some cases due to thick cortical bone plate.

CONCLUSION

The results of our study show that ultrasound alongwith color Doppler was able to reveal the contents and vascularity of the lesion with a definitive correlation between ultrasonographic findings & histological diagnosis .Odontogenic cysts comprised the most common group of Intraosseous lesions. Ultrasonography showed most of the lesions to be hypoechoic and non vascular.Although the purpose of ultrasonography of intraosseous lesions is not to establish the definitive diagnosis, it will facilitate the differential diagnosis between solid and cystic lesions and is an excellent guide to biopsy in a more representative area.

BIBILOGRAPHY

1. Slootweg P J. Lesions of the jaws. Histopathology 2009;54:401–418.

2. Baghaei F, Zargaran M, Najmi HR, Moghimbeigi A. A Clinicopathological Study of Odontogenic Cysts and Tumors in Hamadan, Iran. J Dent Shiraz Univ Med Sci., December 2014; 15(4): 167-172.

3. R Raitz, L Correa, MM Curi, LL Dib and M Fenyo-Pereira. Conventional and indirect digital radiographic interpretation of oral unilocular radiolucent lesions. Dentomaxillofacial Radiology 2006 ;35: 165–169 .

4. C.N.J Mallorie, S.D Jones,N.A Drage, S.D Shepherd: The reliability of high resolution ultrasound in the identification of pus collection in head and neck swellings.Int. J. Oral Maxillofac. Surg. 2012;41:252-255.

5. K Kirk Shung. High Frequency Ultrasonic Imaging. J Med Ultrasound 2009;17(1):25–30.

6. Imbeau J. Introduction to through-transmission alveolar ultrasonography (TAU) in dental medicine.Cranio2005;23: 100–112.

7. Mukhi PU, Mahindra UR. The use of ultrasonography in diagnosis and management of superficial fascial space infections. Indian J Dent Res 2012;23:313-9.

8. Gaurav Pratap Singh, Shikha Dogra, Ekta Kumari ULTRASONOGRAPHY: MAXILLOFACIAL APPLICATIONS. Annals of Dental Specialty 2014; 2(3).

9.W. L. Adeyemoa , O. A. Akadirib. A systematic review of the diagnostic role of ultrasonography in maxillofacial fractures. Int. J. Oral Maxillofac. Surg. 2011; 40: 655–661.

10. Tikku AP, Kumar S , Loomba K, Chandra A, Verma P and Aggarwal R. Use of ultrasound, color Doppler imaging and radiography to monitor periapical healing after endodontic surgery Journal of Oral Science2010; 52(3):411-416.

11. Dharti N, Neerjesh P., Richa Wadhawan et al. Ultrasonography; A boon as a diagnostic & therapeutic aid in dentistry: A review. IJBAR (2014) ;05 (10).

12.Benjamin Fomete et al. A 10-Year Retrospective Analysis of 64 Cases of Cystic Lesions of the Oral and Maxillofacial Region in a Nigerian Tertiary Hospital. Oman medical Journal 2016; 31( 6): 434–438.

13.Araujo JP, Lemos CA, Miniello TG, Alves FA. The relevance of clinical and radiographic features of jaw lesions: A prospective study. Braz. Oral Res. 2016;30(1):e96.

14.D. H. Kambalimath, H. V. Kambalimath, S. M. Agrawal et al. Prevalence and Distribution of Odontogenic Cyst in Indian Population: A 10 Year Retrospective Study. J. Maxillofac. Oral Surg. (Jan–Mar 2014); 13(1):10–15.

15. Sumer AP, Danaci M, Ozen Sandikçi E, Sumer M, Celenk P. Ultrasonography and Doppler ultrasonography in the evaluation of intraosseous lesions of the jaws. Dentomaxillofac Radiol. 2009; 38: 23-27.

16. Javadian Langaroodi A et al. Intraosseous Benign Lesions of the Jaws: A Radiographic Study. Iran J Radiol. 2014 January; 11(1): e7683.

17. A. V. Jones, G. T. Craig, C. D. Franklin. Range and demographics of odontogenic cysts diagnosed in a UK population over a 30-year period. J Oral Pathol Med (2006); 35: 500–7.

18. Esther Manor , Leonid Kachko , Max B. Puterman , George Szabo , Lipa Bodner. Cystic Lesions of the Jaws – A Clinicopathological Study of 322 Cases and Review of the Literature. Int. J. Med. Sci. 2012**;**; **9**(1):20-26.

19. Khaled Gad , Mohamed Ellabban, James Sciubba . Utility of Transfacial Dental Ultrasonography in Evaluation of Cystic Jaw Lesions. JUltrasoundMed2017;00:00–00.

20.Shahidi Sh., Shakibafard A., Zamiri B., Mokhtare MR., Houshyar M., Mahdian S. The Feasibility of Ultrasonography in Defining the Size of Jaw Osseous Lesions. Dent Shiraz Univ Med Sci. December 2015; 16(4): 335-340.

21. Lauria L, Curi MM, Chammas MC, Pinto DS, Torloni H. Ultrasonography evaluation of bone lesions of the jaw. Oral Surg Oral Med Oral Pathol Oral Radiol Endod. 1996; 82: 351-357.

22.Chandak R, Degwekar S, Bhowte RR, et al. An evaluation of efficacy of ultrasonography in the diagnosis of head and neck swellings. Dentomaxillofac Radiol. 2011;40:213-221.

23. Pallagatti S, Sheikh S, Puri N, Mittal A, Singh B. To evaluate the efficacy of ultrasonography compared to clinical diagnosis, radiography and histopathological findings in the diagnosis of maxillofacial swellings. Eur J Radiol. 2012;81:1821-1827.

24. Hamed Mortazavi, Maryam Baharvand. Jaw lesions associated with impacted tooth: A radiographic diagnostic guide. Imaging Science in Dentistry 2016; 46: 147-57.