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LETTER TO THE EDITOR

Hybrid Central Odontogenic Fibroma/Central Giant Cell Lesion: A Missing Report

Fumio Ide[1,2] · Naoyuki Matsumoto[2] · Kentaro Kikuchi[1] · Kaoru Kusama[1]

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To the Editors,

We read with interest a recent study of hybrid central odontogenic fibroma/central giant cell lesion (hCOdF/CGCL) by Upadhyaya et al. [1], who searched the literature on the subject, including abstracts of professional meetings. Like the majority of other authors [2, 3], they mentioned that Allen et al. [4] in the United States are generally credited for the first description of hCOdF/CGCL in 1992. Few authors are aware that this hybrid lesion was initially documented in the German literature 7 years before that.

In 1985, Wangerin and Harms [5] in Germany reported a case of bilateral CGCLs, one of which developed in association with COdF, albeit under a different appellation "ungewöhnliche Kombination zweier Läsionen, ein ameloblastisches Fibrom und ein zentrales Riesenzellgranulom" (a rare combination of two lesions, ameloblastic fibroma and central giant cell granuloma). A 7-year-old patient had a well-defined, expansile, multilocular radiolucency affecting the left mandible, involving multiple unerupted molars (teeth #36–38). Within a 1-year follow-up period, a separate CGCL lesion surrounding the crowns of teeth #46–48 developed in the right mandible (within the phenotypic range of cherubism?). Of special interest was that, histologically, only the left-sided CGCL featured COdF. Their conclusion that CGCL was a secondary reactive process induced by a primary neoplastic COdF, was noteworthy. This pathogenetic theory was followed by Allen et al. [4], who were unaware of the original proposal. Although two published photomicrographs are not representative, it is apparent that Wangerin and Harms [5] were the first to coin the term "combined lesions" for hCOdF/CGCL. Until recently, differential diagnostic problems have sometimes been highlighted by cases of ameloblastic fibroma in German publications [6–10].

In (Table 1 of Upadhyaya et al. [1]), are cases 27 and 28 the same? Historically, the former was discussed in 2014 at the annual meeting of the American Academy of Oral & Maxillofacial Pathology as a clinical pathologic conference case [3, 11] and published in 2015 by Eliot and Kessler [3] as a full paper, and the latter was presented by Kessler [12] at the 2006 meeting of the Western Society of Teachers of Oral Pathology [1, 2]. If these cases are different, it is difficult for us to understand that Kessler [3] did not refer to his own example [12] in the 2015 report of hCOdF/CGCL. Unfortunately, the proceedings of Kessler's presentation are not available in Japan. By the way, further details of cases 22 and 23 in (Table 1 of Upadhyaya et al. [1]) have been reported in 2011 by Cortés Castillo et al. [13] and Bologna Molina et al. [14] respectively. Both hCOdF/CGCLs were diagnosed by one of the co-authors, Mosqueda Taylor [13, 14], who in 2011 included them in his report of COdF [15]. However, it is impossible for us to be sure that their clinical features (cases 6 and 7, Table II of Mosqueda-Taylor et al. [15]) are accurate because there seems to be much confusion in the local domestic literature about the patients' data [13, 14]. The same may be said of cases 22 and 23 tabulated by Upadhyaya et al. [1].

In summary, it comes as no surprise to us that Upadhyaya et al. [1] did not take into account a German-language report with a comparable content [5], which predated the earliest English-language article by Allen et al. [4], since American pathologists are not faithful readers of the European literature. Of course, it is not our intention to diminish in any way the role of Allen et al. [4] in popularizing the concept of hCOdF/CGCL worldwide.

✉ Fumio Ide
idef@dent.meikai.ac.jp

[1] Division of Pathology, Department of Diagnostic and Therapeutic Sciences, Meikai University School of Dentistry, 1-1 Keyakidai, Sakado, Saitama 350-0283, Japan

[2] Department of Diagnostic Pathology, Tsurumi University School of Dental Medicine, 2-1-3 Tsurumi, Tsurumi-ku, Yokohama 230-8501, Japan

Compliance with Ethical Standards

Conflict of interest The authors declare no conflict of interest.

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