tion in centers, which do not have access to specialized prosthetists.

The splint described in our letter is manufactured by us; it is a nasal splint for use after rhinoplasty, and its Food and Drug Administration approval status is investigational.

ALEXANDRE L. IVANOV, MD
Moscow, Russia

ROMAN H. KHONSARI, MD
Nantes, France

References

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KERATOCYSTIC ODONTOGENIC TUMOR VERSUS ODONTOGENIC KERATOCYST—THE ISSUE OF ADEQUATE NOMENCLATURE

To the Editor:—Recently, Boffano et al1 published an interesting article titled “Keratocystic odontogenic tumor (odontogenic keratocyst): Preliminary retrospective review of epidemiologic, clinical, and radiologic features of 261 lesions from University of Turin.” We read this article with great interest and compliment the authors for their thorough clinical analysis, and although their study could be of importance, we have several considerations when interpreting their findings. In response, we would like to highlight several important issues.

First, the keratocystic odontogenic tumor (KCOT), formerly classified as a cystic lesion called odontogenic keratocyst (OKC), was subsequently reclassified in 2005 by the World Health Organization Working Group2 as a neoplastic lesion. The microscopic criterium for KCOT clearly indicates that the spectrum of this tumor consists only of jaw lesions with a characteristic lining consisting of parakeratinized stratified squamous epithelium.2 OKC previously included both parakeratinized and orthokeratinized variants. Designation of an OKC is currently reserved for cystic jaw lesions that are lined solely by orthokeratinizing epithelium, and they do not form a part of the range of the KCOT.5 In accordance with the current World Health Or-
In reply:—We appreciate the interest that the article “Keratoctytic odontogenic tumor (odontogenic keratocyst): Preliminary retrospective review of epidemiologic, clinical, and radiologic features of 261 lesions from University of Turin” aroused and we thank Kaczmarzyk and Mojsa for the compliments to our article and for commenting on our initial treatment.5 Despite the limitation imposed by the treatment modality ranging from 25% to 56%,3) whereas orthokeratinized odontogenic cyst (previously orthokeratinized variant of OKC) has a significantly lower recurrence rate, ranging from 0% to 4%.4 Unintended consequence of clinico-pathological analysis on material consisting of these 2 entities allocated into 1 data set may be to draw false conclusions regarding the real recurrence rates of 2 different entities.

Third, the mean follow-up period in the conducted study is 36 months.1 With the argument for the overwhelming superiority of long-term follow-ups, it is important to note that relapses of KCOT may occur even 25 years after the initial treatment.3) Despite the limitation imposed by the relatively short follow-up period in the article, the authors rightly do not draw any conclusions on the basis of their findings concerning recurrence rates.

Finally, we believe that further analyses of the extensive clinical material of Boffano et al1 will exclusively concern data on patients who were followed up for at least 5 years after the initial treatment but, above all, will comply with the current valid definition of KCOT.

IZABELA MOJSA
TOMASZ KACZMARZYK
Department of Oral Surgery
Jagiellonian University
Medical College
Krakow, Poland

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