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Review

Cementoblastoma: An updated analysis of 258 cases reported in the literature

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ABSTRACT

Purpose: To investigate the recurrence rate of cementoblastomas for different variables aside from the clinical/radiologic features.
Methods: An electronic search was undertaken in November/2016. Eligibility criteria included publications having enough clinical/radiological/histological information to confirm the diagnosis.
Results: 141 publications (258 cementoblastomas) were included. There was an equal sex distribution. There was a high prevalence in the second/third decades of life, in the posterior regions, and in mandibular first molars. Lesions were commonly associated with bone expansion (74.9%), presence of clinical symptoms (70.2%), vital teeth (78%), root resorption (59.8%). Observations not as frequent: cortical bone perforation (16.3%), inferior displacement of the mandibular canal (23.6%). Treatment was reported for 229 cases. Twenty (11.8%) out of 170 recurred. Preservation of the involved teeth and location seem to not influence the recurrence rate, but there was a 687% higher probability (odds ratio 7.875; $p = 0.048$) of recurrence for lesions associated with bone expansion, and a 217% higher probability (odds ratio 3.173; $p = 0.023$) of recurrence for lesions presenting cortical bone perforation.
Conclusions: Although the recurrence rate of cementoblastomas is not as high as previously believed, it is a relevant phenomenon (11.8%). The presence of bone expansion and cortical bone perforation seem to influence the recurrence rate.

1. Introduction

A cementoblastoma is a benign neoplasia characterized by the formation of cementum-like tissue in connection with the root of a tooth. The tumor consists of a rounded or nodular mass attached to one or more tooth roots, the criterion which differentiates the cementoblastoma from an osteoblastoma (WHO, 2005). Cementoblastoma is considered to be a relatively rare lesion. The epidemiological study of such lesions is of great importance because it provides information that can improve the diagnostic accuracy and allows pathologists and surgeons to make informed decisions and refine the treatment plan to optimize the clinical outcome. Different protocols for cementoblastoma treatment have been advocated in the literature, but no systematic review about this topic has been performed. The aim of the present study was to integrate the available data published in the literature on cementoblastoma into an updated comprehensive comparative analysis of their clinical and radiologic features, and investigate the probability of recurrence of the tumor for different variables and treatment approaches.

2. Materials and methods

This study followed the PRISMA Statement guidelines (Moher et al., 2009). A review protocol does not exist.

2.1. Search strategies

An electronic search without time restrictions was undertaken in November 2016 in the following databases: PubMed/Medline,

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Web of Science, and Science Direct. The following term was used in the search strategies:

(cementoblastoma)

Moreover, Google Scholar was also checked. A manual search of related journals, including *Acta Odontologica Scandinavica, Acta Oto-Laryngologica, Annals of Otology Rhinology and Laryngology, British Journal of Oral and Maxillofacial Surgery, Cancer, Head & Neck, Head and Neck Pathology, International Journal of Oral and Maxillofacial Surgery, Japanese Journal of Oral and Maxillofacial Surgery, Journal of Dental Research, Journal of Craniofacial Surgery, Journal of Cranio-Maxillofacial Surgery, Journal of Japanese Society of Oral Oncology, Journal of the Japanese Stomatological Society, Journal of Laryngology and Otology, Journal of Maxillofacial and Oral Surgery, Journal of Nihon University School of Dentistry, Journal of Oral and Maxillofacial Surgery, Journal of Oral Pathology and Medicine, Journal of the Stomatological Society, Laryngoscope, Oral Diseases, Oral Oncology, Oral Surgery Oral Medicine Oral Pathology Oral Radiology, Otolaryngology – Head and Neck Surgery,* and *Quintessence International*, was performed. The reference list of the identified studies and the relevant reviews on the subject were also scanned for possible additional studies. Publications with lesions identified by other authors as being cementoblastomas, even not having the terms "cementoblastoma" in the title of the article, were also re-evaluated by an author of the present study.

2.2. Inclusion and exclusion criteria

Eligibility criteria included publications reporting cases of cementoblastomas. The studies needed to have enough clinical, radiological and histological information to confirm the diagnosis of cementoblastoma (WHO, 2005). The tumors needed to show direct continuity with the root of a tooth. Randomized and controlled clinical trials, cohort studies, case-control studies, cross-sectional studies, case series, and case reports were included. Exclusion criteria were immunohistochemical studies, histomorphometric studies, radiological studies, genetic expression studies, histopathological studies, cytological studies, cell proliferation/apoptosis studies, *in vitro* studies, and review papers, unless any of these publications categories had reported any case with enough clinical, radiological and histological information.

2.3. Study selection

The titles and abstracts of all reports identified through the electronic searches were read independently by the authors. For studies appearing to meet the inclusion criteria, or for which there were insufficient data in the title and abstract to make a clear decision, the full report was obtained. Disagreements were solved by discussion between the authors. The clinical and radiological aspects, as well as the histological description of the lesions reported by the publications were thoroughly assessed by one of the authors of the present study, who is expert in oral pathology (R.S.G.), in order to confirm the diagnosis of cementoblastoma.

2.4. Data extraction

The authors independently extracted data using specially designed data extraction forms. Disagreements were solved by discussion. For each of the identified studies included, the following data were then extracted on a standard form, when available: year of publication, number of patients, patient's sex, age and race, follow-up period, duration of the lesion previously to treatment, lesion location (maxilla/mandible), anterior/posterior location (three categories: [a] anterior: lesions in the incisors/canine region; [b] premolar region; [c] posterior: lesions in the molars/retromolar region), recurrence, time between treatment and recurrence, lesion size, perforation of cortical bone, expansion of the osseous region adjacent to the tumor, presence of clinical symptoms, vitality of the tooth associated with the lesion, displacement (or lack of eruption) of a tooth because of the lesion, inferior displacement of the mandibular canal due to grow of the lesion, root resorption of the tooth involved, treatment performed (excision, partial resection, resection with continuity, other), and maintenance or not of the tooth associated with the lesion. The lesion size was determined according to the largest diameter reported in the publications. Contact with authors for possible missing data was performed.

2.5. Analyses

The mean, standard deviation (SD), and percentages were presented as descriptive statistics. Kolmogorov–Smirnov test was performed to evaluate the normal distribution of the variables, and Levene's test evaluated homoscedasticity. The performed tests for two independent groups were Student's t-test or Mann–Whitney test, depending on the normality. Pearson's chi-squared or Fisher's exact tests were used for categorical variables, depending on the expected count of events in a 2×2 contingency table. The probability of recurrence was calculated for four variables, in odds ratio (95% confidence interval). These four variables were 'preservation of the involved tooth', 'expansion of the osseous region adjacent to the tumor', 'perforation of cortical bone', and 'lesion location (maxilla/mandible)'. The degree of statistical significance was considered $p < 0.05$. All data were statistically analyzed using the Statistical Package for the Social Sciences (SPSS) version 23 software (SPSS Inc., Chicago, IL, USA).

3. Results

3.1. Literature search

The study selection process is summarized in Fig. 1. The search strategy in the databases resulted in 1115 papers. The search in Google Scholar resulted in 26 eligible papers not found in the three main databases. A number of 452 articles were cited in more than one database (duplicates). The reviewers independently screened the abstracts for those articles related to the focus question. Of the resulted 689 studies, 520 were excluded for not being related to the topic. Additional hand-searching of journals and of the reference lists of selected studies yielded 17 additional papers. The full-text reports of the remaining 186 articles led to the exclusion of 45 because they did not meet the inclusion criteria (see Supplemental Appendix). The excluded studies did not have enough clinical, radiological and histological information to confirm the diagnosis of cementoblastoma. Thus, a total of 141 publications were included in the review.

3.2. Description of the studies and analyses

Some studies reporting series of odontogenic tumors and including cementoblastomas were found, but their cases were not included here due to lack of enough clinical, radiological and histological information to confirm the diagnosis of cementoblastomas. These include, for example, Ross et al. (1973) with 49 cases, Tamme et al. (2004) with 6 cases, Jing et al. (2007) with 33 cases, Avelar et al. (2008) with 4 cases, and Luo and Li (2009) with 22 cases.

Table 1 presents demographic and clinical features of all 258 cementoblastomas reported in the 141 publications (Abrams et al., 1974; Adkins and Monsour, 1973; Agrawal et al., 2014; Ahmad et al., 2014; Aiyer and Rajagopal, 2000; Anjum and S., 2014; Anneroth

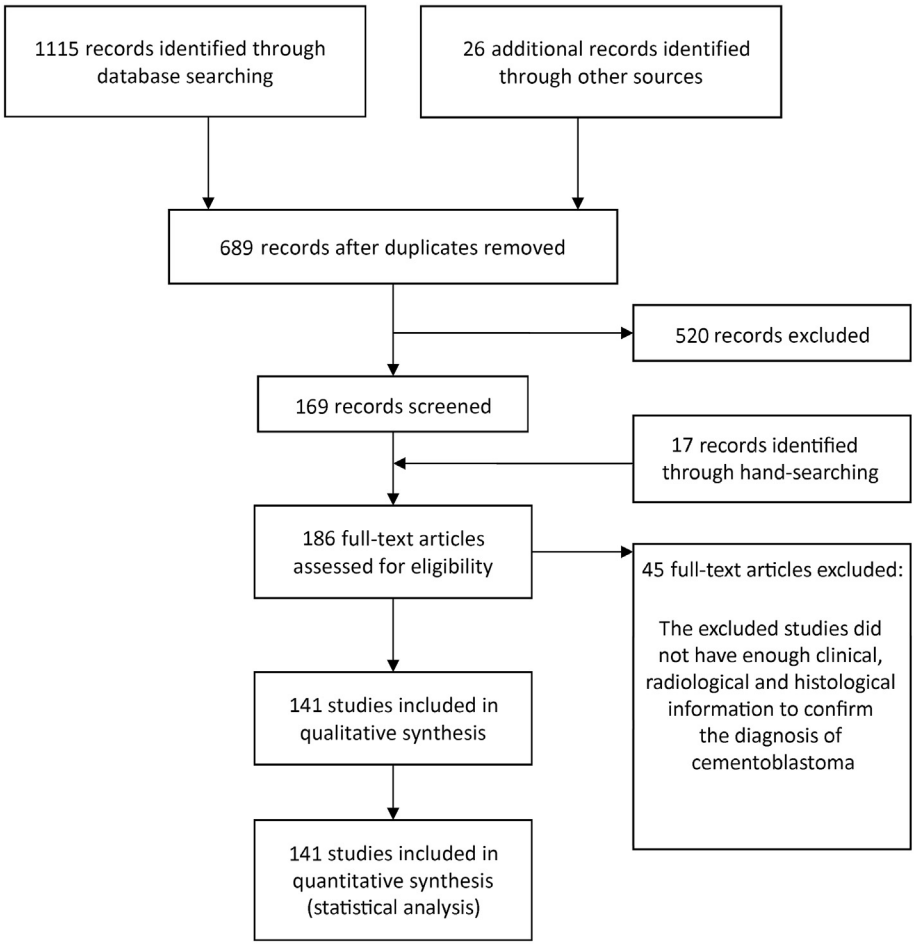

Fig. 1. Study screening process.

et al., 1975; Assis et al., 2014; Astacio and Mendez, 1974; Baart et al., 1991; Barker et al., 2009; Baughman, 2004; Berwick et al., 1990; Biggs and Benenati, 1995; Brannon et al., 2002; Brocheriou et al., 1979; Buyukkurt et al., 2010; Calb et al., 1998; Caliskan et al., 2016; Cannell, 1991; Carrion Zabarain et al., 1985; Cavadini and Cambiaggi, 1977; Cherrick et al., 1974; Collins and Asturias, 2011; Corio et al., 1976; Costa et al., 2016, 2011, 2012; Cundiff, 2000; Curran and Collins, 1973; da Costa Lomar, 1974; Dadhich and Nilesh, 2015; Damm, 2015; de Amorim et al., 2010; de Noronha Santos Netto et al., 2012; Dinakar et al., 2010; Donohue Cornejo et al., 2009; Esguep et al., 1983; Eversole et al., 1973; Fantasia and Damm, 2002; Farman et al., 1979; Flaitz, 1993; Fleming and Ryan, 2002; Forsslund et al., 1988; Fujii et al., 2016; Fujimoto and Tamaki, 1992; Fujita et al., 1989; Garlick et al., 1990; Ghom et al., 2010; Goerig et al., 1984; Gouvêa et al., 2016; Gulses et al., 2012; Hachimi et al., 2005; Hamdi et al., 2008; Harada et al., 2011; Herzog, 1987; Hirai et al., 2010; Huber and Folk, 2009; Hugar et al., 2013; Huvar and Butura, 1995; Hönig, 1991; Infante-Cossio et al., 2008; Ishida et al., 1994; Iwaki et al., 2001; Jelic et al., 1993; Jolehar et al., 2016; Kage et al., 1981; Kamikawa et al., 1994; Keyes and Hilderbrand, 1987; Kikuchi et al., 1986; Kitamura et al., 1992, 2000; Kline et al., 1961; Kumar et al., 2011; Langdon, 1976; Larsson et al., 1978; Lazarde et al., 1999; Lemberg et al., 2007; Levin et al., 1984; MacDonald-Jankowski and Wu, 1992; Mader and Wendelburg, 1979; Mahl et al., 2003; Makek and Lello, 1982; McNamara et al., 2010; Milani et al., 2012; Mogi et al., 1996; Moraes et al., 2009; Nair and Paul, 1986; Neelakandan et al., 2012; Neves et al., 2009; Nowparast, 1978; Nuvvula et al., 2016; Ohki et al., 2004; Oliveira et al., 2013; Orsini et al., 2001; Papageorge et al., 1987; Paranjyothi et al., 2013; Pattyn et al., 2007; Peña et al., 2010; Piattelli et al., 1990, 1998; Pontes et al., 2008; Prakash et al., 2013; Pynn et al., 2001; Revathi et al., 2016; Rezvani and Dehghani Nazhvani, 2012; Rubino et al., 1999; Ruprecht and Ross, 1983; Saito et al., 1985, 1990; Sankari and Ramakrishnan, 2011; Schafer et al., 2001; Sharma, 2014; Shastry et al., 2012; Shoji et al., 1992; Sirigala et al., 2015; Slimani et al., 2009; Slootweg, 1992; Souza et al., 2013; Stanimirov et al., 2014; Sumer et al., 2006; Takagi et al., 1978; Towns et al., 1979; Trivedi, 1986; Ulmansky et al., 1994; Urs et al., 2016; Wang et al., 2005; Watanabe et al., 1994; Wertheimer et al., 1961; Vieira et al., 2007; Wiggins and Karian, 1975; Vilasco et al., 1969; Vindenes et al., 1979; Xu et al., 2015; Yamaguchi et al., 1990; Yamasaki et al., 1977; Yasui et al., 1995; Yoshida et al., 1993; Zachariades et al., 1985; Zaitoun et al., 2007; Zanda et al., 2012) included in the present review. The mean age of the patients was 23.6 years, and women were affected at a higher mean age than men, even though the difference was not statistically significant. Fig. 2 shows the distribution of the lesions according to age, with a high prevalence in the second and then third decades of life. The patients were aware of the lesion for a mean ± SD of 16.6 ± 20.3 months (min–max, 1–96; n = 107) before seeking treatment. There was no sex predilection. The race was reported for 149 patients. Fifty-eight cases (38.9%) occurred in whites, 33 in Asians, 23 in Indians, 16 in blacks, 6 in Hispanics, 4 in Turks, 3 in Persians, and 6 in others. The lesions were more prevalent in the mandible in comparison to the maxilla (ratio

Table 1
Demographic and clinical features of cementoblastomas (n = 258) described in the literature.

Variable	
Age (year), mean ± SD (min–max)	23.6 ± 13.2 (4–75)
Men	20.9 ± 10.0 (4–64)
Women	25.8 ± 15.2 (7–75)
p Value[a]	0.075
Gender, n (%)	
Men	129 (50.2)
Women	128 (49.8)
Unknown	1
Jaw, n (%)	
Maxilla	57 (22.5)
Mandible	196 (77.5)
Unknown	5
Bone expansion, n (%)	
Yes	164 (74.9)
No	55 (25.1)
Unknown	39
Symptomatic, n (%)	
Yes	158 (70.2)
No	67 (29.8)
Unknown	33
Tooth response to pulp test, n (%)	
Yes (vital tooth)	71 (78.0)
No (non-vital tooth)	20 (22.0)
Unknown	167
Pulpal involvement, n (%)	
Yes	16 (30.8)
No	36 (69.2)
Unknown	206
Cortical bone perforation, n (%)	
Yes	35 (16.3)
No	180 (83.7)
Unknown	43
Radiopaque lesion, n (%)	
Yes	220 (98.2)
No	4 (1.8)
Unknown	34
Tooth displacement,[b] n (%)	
Yes	27 (13.4)
No	175 (86.6)
Unknown	56
Inferior displacement of mandibular canal, n (%)	
Yes	30 (23.6)
No	97 (76.4)
Unknown/lesion in maxilla/unknown jaw	68/57/6
Tooth root resorption, n (%)	
Yes	128 (59.8)
No	86 (40.2)
Unknown	44
Treatment, n (%)	
None	2 (0.9)
Endodontic treatment	1 (0.4)
Tooth extraction only	4 (1.7)
Excision	209 (91.3)
Marginal resection	6 (2.6)
Segmental resection[c]	7 (3.1)
Unknown	29
Tooth preserved?, n (%)	
Yes	26 (12.1)
No	189 (87.9)
Unknown/no treatment	41/2
Recurrence, n (%)	
Yes	20 (11.8)
No	150 (88.2)
Unknown	88
Follow-up time (months), mean ± SD (min–max) (n = 105)	30.6 ± 34.1 (1–132)
Lesion size (cm), mean ± SD (min–max) (n = 184)	2.2 ± 1.1 (0.5–8.0)

SD – standard deviation.
[a] Mann–Whitney test.
[b] Displacement or lack of eruption of a tooth because of the lesion.
[c] Resection with continuity defect.

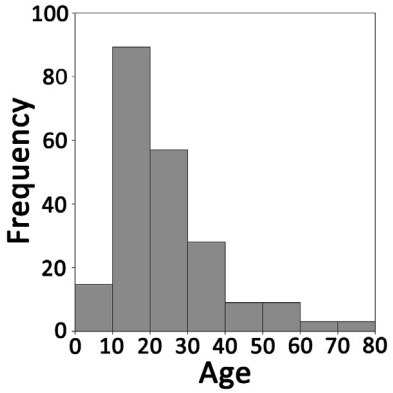

Fig. 2. Distribution of cementoblastomas according to age (for the cases which the patients' age were informed, n = 214).

3.4:1), and at the posterior region in comparison to the anterior region of the jaws (Fig. 3), with the highest occurrence in the region of the mandibular first molars. Only a few cases (n = 6) were reported in incisors. The lesions were usually associated with expansion of osseous region adjacent to the tumor (74.9%) and presence of clinical symptoms (70.2%). Few cases (n = 4) were purely radiolucent. Almost 80% of the teeth that were associated with the lesion presented vitality, nearly 60% of the teeth involved presented root resorption, and there was displacement or lack of eruption of a tooth because of the lesion in about 13% of the cases. About 16% of the lesions showed signs of cortical bone perforation, and there was inferior displacement of the mandibular canal due to growth of the lesion in 23.6% of the cases in the mandible. The mean ± SD lesion size was 2.2 ± 1.1 cm (min–max, 0.5–8.0; n = 184).

Treatment of the lesions was known in 229 cases, of which 216 were conservative surgery (209 excisions, 4 cases treated only by extraction of the involved tooth, 1 case with endodontic treatment, and 2 cases received no intervention), and 13 cases were treated by resection (6 marginal resections and 7 segmental resections). When the information was available, the tooth directly involved by the lesion was preserved in 26 (12.1%) out of 215 cases. Time of

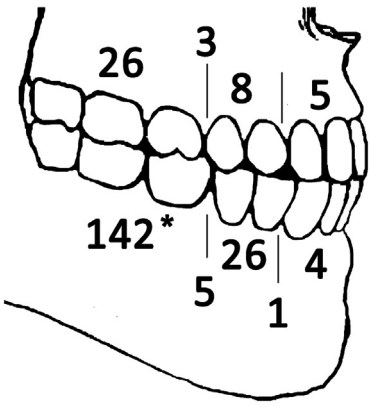

Fig. 3. Topographical distribution of the cementoblastomas with known precise locations (n = 220). Numbers at the top and bottom of the lines indicate cases involving both adjoining regions: anterior/premolar, premolar/molar. (*) 106 cases affected the mandibular first molar alone. For the rest of the lesions (n = 38), the location was the 'maxilla' (n = 13), 'right maxilla' (n = 2), 'mandible' (n = 9), 'left mandible' (n = 3), 'right mandible' (n = 4), 'anterior mandible' (n = 1), and 'posterior mandible' (n = 1). The location was not informed for 5 lesions. The maxillary sinus was clearly affected by the lesion in 5 cases.

follow-up was informed for 105 lesions, with a mean ± SD of 30.6 ± 34.1 months (min–max, 1–132). There was information about recurrence for 170 lesions, of which 20 (11.8%) recurred. The interval from initial treatment to recurrence ranged from 6 to 24 months, with a mean interval of 16.8 ± 9.0 months (n = 5).

Table 2 shows the recurrence rate according to some variables. Recurrences occurred only when the lesions were treated by excision, but this also was the most common treatment performed. The preservation of the involved teeth and the location of the lesion (maxilla/mandible) seem to not influence the recurrence rate. However, cementoblastomas tended to have a statistically significantly higher recurrence rate when the lesions were associated with expansion of osseous region adjacent to the tumor and when there was perforation of the cortical bone adjacent to the lesion. There was a 687% higher probability (odds ratio 7.875; $p = 0.048$) of recurrence for lesions associated with bone expansion in comparison to those with no bone expansion, and a 217% higher probability (odds ratio 3.173; $p = 0.023$) of recurrence for lesions presenting cortical bone perforation in comparison to those not presenting perforation of the adjacent cortical bone.

4. Discussion

The present review of the literature revealed that cementoblastoma is a rare lesion, with less than 300 cases described in the literature. The great majority of the cases described appear as isolated case reports or reports of a small series of cases. The lesion presents no sex predilection, and it mostly occurs in the second and third decades of life. It appears that incisor involvement by cementoblastoma is extremely rare, with only 6 cases being previously reported. On the other hand, the most involved tooth was the mandibular first molar, with approximately 40% of all cases. Radiographically, most cementoblastomas exhibit a central opacity surrounded by a radiolucent halo, but they rarely may be purely radiolucent (Brannon et al., 2002; Eversole et al., 1973; Langdon, 1976). When the intimate relation with roots is present, the radiographic picture is nearly pathognomonic (Ulmansky et al., 1994).

Some cases have exhibited signs of local aggressiveness and destruction, including bony expansion, perforation of cortical plates, displacement of adjacent teeth, maxillary sinus involvement, invasion of pulp chamber and root canals, and extension to and incorporation of adjacent teeth. Although about 60% of the cases reviewed here showed root resorption of the involved teeth, the authors of the present study believe that the prevalence can nearly reach 100% of the cases, as Brannon et al. (2002) have shown. The reason for that is because Brannon et al. (2002) performed a carefully histological assessment of this parameter for all their 44 cases, showing that this is an invariable characteristic of the tumor. Most of the other publications, however, reported this information based on radiological exams alone, which could have underestimated the actual figures.

Cases have also been treated successfully by root amputation in conjunction with endodontic therapy (Biggs and Benenati, 1995; Costa et al., 2016; Ulmansky et al., 1994). However, the literature has also shown that retaining the tooth by means of the aforementioned therapy has ultimately ended with subsequent extraction of the endodontically treated tooth (Adkins and Monsour, 1973; Wiggins and Karian, 1975). Even though the present results suggest that the preservation of the involved teeth seems to not influence the recurrence rate, it is difficult to say whether this may truly reflect the reality. As most of the lesions were treated in the same way (excision), the analysis of the best therapeutic approach was impaired.

Expansion of the osseous region adjacent to the tumor seems to be associated with a higher recurrence rate in comparison to the lesions with no bone expansion, as well as perforation of cortical plates in comparison to those not presenting this change. Future studies should address whether tooth preservation would not be appropriate in cases presenting the aforementioned alterations.

The study of Brannon et al. (2002), reported a high recurrence rate (37.1%) in their series, and the authors did not suggest the reasons of such high recurrence. They also reviewed the literature and came up with 69 cases with follow-up data, with a 21.7% recurrence rate. However, the consensus among investigators is that the cementoblastoma is a benign neoplasm with unlimited growth potential but with little tendency to recur. The results of the present review, including a greater amount of lesions, are more consistent with a lower recurrence rate (11.8%).

The results of the present study have to be interpreted with caution because of its limitations. First, all included studies were

Table 2
Recurrence – for the lesions with available information on both the variables and recurrence.

Variable	Recurrence/total (% recurrence)	*p* Value	Odds ratio (95% CI)	*p* Value
Treatment				
Endodontic treatment	0/1 (0)			
Excision	20/157 (12.7)			
Marginal resection	0/6 (0)			
Segmental resection[a]	0/4 (0)			
Total	20/168 (12.0)			
Tooth preserved?				
Yes	4/25 (16)[b]	0.356[c]	1.486 (0.449, 4.917)	0.517
No	15/132 (11.4)			
Bone expansion				
Yes	18/114 (15.8)	0.021[d]	7.875 (1.018, 60.932)	0.048
No	1/43 (2.3)			
Cortical bone perforation				
Yes	8/33 (24.2)	0.024[c]	3.173 (1.175, 8.567)	0.023
No	12/131 (9.2)			
Location				
Maxilla	5/39 (12.8)	0.504[c]	1.137 (0.385, 3.355)	0.816
Mandible	15/131 (11.5)			

CI – confidence interval.
[a] Resection with continuity defect.
[b] Not included the two cases for which no treatment/intervention was performed.
[c] Fisher's exact test.
[d] Pearson chi-squared test.

retrospective reports, which inherently results in flaws, manifested by the gaps in information and incomplete records. Second, many of the cases have a short follow-up, which could have led to an underestimation of the actual recurrence rate, because a longer follow-up period can lead to an increase in the recurrence rate. However, it is hard to define what would be considered a short follow-up period to evaluate the recurrence of cementoblastomas. Third, the great majority of the cases described were published as isolated case reports or small case series.

5. Conclusions

The recurrence rate of cementoblastomas was 11.8%. The preservation of the involved teeth and the location of the lesion seem to not influence the recurrence rate, but there was a high probability of recurrence for lesions associated with bone expansion and presenting cortical bone perforation.

Declaration of conflicting interests

There are no conflicts of interest to declare.

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Appendix A. Supplementary data

Supplementary data related to this article can be found at http://dx.doi.org/10.1016/j.jcms.2017.08.002.

References

Abrams AM, Kirby JW, Melrose RJ: Cementoblastoma. A clinical-pathologic study of seven new cases. Oral Surg Oral Med Oral Pathol 38: 394–403, 1974
Adkins KF, Monsour FN: Benign cementoblastoma in the maxilla. Aust Dent J 18: 99–101, 1973
Agrawal M, Weihsin H, Pandey A, Garg B: Benign cementoblastoma: a case report with review of the literature. Egypt J Oral Maxillofac Surg 5: 23–25, 2014
Ahmad F, Singh D, Gupta P, Lata J: A case report of cementoblastoma affecting mandibular molar. J Dentofac Sci 3: 55–59, 2014
Aiyer RG, Rajagopal S: Benign cementoblastoma – a rare odontogenic neoplasm. Indian J Otolaryngol Head Neck Surg 52: 272–273, 2000
Anjum S, S RV: Unusual presentation of cementoblastoma in anterior mandible of a 55 year old female. Ind J Med Case Rep 3: 101–104, 2014
Anneroth G, Isacssom G, Sigurdsson A: Benign cementoblastoma (true cementoma). Oral Surg Oral Med Oral Pathol 40: 141–146, 1975
Assis GM, Campos GBP, Da Silva JSP, Germano AR, Pinto LP: Atypical presentation of a cementoblastoma treated through a Weber-Ferguson approach. J Dent Sci 29: 96–100, 2014
Astacio JN, Mendez JE: Benign cementoblastoma (true cementoma). Oral Surg Oral Med Oral Pathol 38: 95–99, 1974
Avelar RL, Antunes AA, Santos Tde S, Andrade ES, Dourado E: Odontogenic tumors: clinical and pathology study of 238 cases. Braz J Otorhinolaryngol 74: 668–673, 2008
Baart JA, Lekkas C, van der Waal I: Residual cementoblastoma of the mandible. J Oral Pathol Med 20: 300–302, 1991
Barker GL, Begley A, Balmer C: Cementoblastoma in the maxilla: a case report. Prim Dent Care 16: 154–156, 2009
Baughman R: Testing your diagnostic skills. Case no. 1. Gingival cyst. Case no. 2. True cementoma (cementoblastoma). Todays FDA 16, 2004 20, 22
Berwick JE, Maymi GF, Berkland ME: Benign cementoblastoma: a case report. J Oral Maxillofac Surg 48: 208–211, 1990
Biggs JT, Benenati FW: Surgically treating a benign cementoblastoma while retaining the involved tooth. J Am Dent Assoc 126: 1288–1290, 1995
Brannon RB, Fowler CB, Carpenter WM, Corio RL: Cementoblastoma: an innocuous neoplasm? A clinicopathologic study of 44 cases and review of the literature with special emphasis on recurrence. Oral Surg Oral Med Oral Pathol Oral Radiol Endod 93: 311–320, 2002
Brocheriou C, Guilbert F, Matar A, Champion P, Couly G: Benign cementoblastoma of jaws. report of 6 cases and review of the literature (author's transl). Arch Anat Cytol Pathol 27: 29–34, 1979
Buyukkurt MC, Yalcin E, Aras MH: Benign cementoblastoma: a case report. J Dent Fac Atatürk Uni: 17–20, 2010
Calb I, Travin A, Robledo H: Cementoblastoma benigno. Prens Med Argent 85: 723–725, 1998
Caliskan A, Karoz TB, Sumer M, Acikgoz A, Sullu Y: Benign cementoblastoma of the anterior mandible: an unusual case report. J Korean Assoc Oral Maxillofac Surg 42: 231–235, 2016
Cannell H: Cementoblastoma of deciduous tooth. Oral Surg Oral Med Oral Pathol 71: 648, 1991
Carrion Zabarain E, Juarez A, Pablo Loyola J: Benign cementoblastoma. Report of a clinical case. Rev ADM: Organo Oficial de la Asociacion Dental Mexicana 42: 37–39, 1985
Cavadini OA, Cambiaggi JE: Recurrence of benign cementoblastoma (true cementoma). La Tribuna Odontologica 61: 106–110, 1977
Cherrick HM, King Jr OH, Lucatorto FM, Suggs DM: Benign cementoblastoma. A clinicopathologic evaluation. Oral Surg Oral Med Oral Pathol 37: 54–63, 1974
Collins RE, Asturias RF: An aggressive benign cementoblastoma. US Army Med Dep J: 91–94, 2011
Corio RL, Crawford BE, Schaberg SJ: Benign cementoblastoma. Oral Surg Oral Med Oral Pathol 41: 524–530, 1976
Costa FW, Pereira KM, Magalhaes Dias M, da Costa Miguel MC, de Paula Miranda MA, Studart Soares EC: Maxillary cementoblastoma in a child. J Craniofac Surg 22: 1910–1913, 2011
Costa FWG, Gois SR, Esses DS, Bezerra MF, Soares ECS: Cementoblastoma dos maxilares agressivo. Considerações sobre a escolha da terapêutica. Rev Cir Traumatol Buco-Maxilo-Fac 12: 9–12, 2012
Costa BC, de Oliveira GJ, Chaves M, da Costa RR, Gabrielli MF, Guerreiro-Tanomaru JM, et al: Surgical treatment of cementoblastoma associated with apicoectomy and endodontic therapy: case report. World J Clin Cases 4: 290–295, 2016
Cundiff EJ: 2nd: developing cementoblastoma: case report and update of differential diagnosis. Quintessence Int 31: 191–195, 2000
Curran JB, Collins AP: Benign (true) cementoblastoma of the mandible. Oral Surg Oral Med Oral Pathol 35: 168–172, 1973
da Costa Lomar I: Benign cementoblastoma. Case presentation. Rev Fac Odontol Sao Jose Dos Campos 3: 155–160, 1974
Dadhich AS, Nilesh K: Cementoblastoma of posterior maxilla involving the maxillary sinus. Ann Maxillofac Surg 5: 127–129, 2015
Damm DD: Apical lesion of mandibular bicuspid. Apical lesion of maxillary molar. Cemento-osseous dysplasia. Cementoblastoma. Gen Dent 63: 78–79, 2015
de Amorim RF, Silveira EJ, Franca MN, Guimaraes Mdo C, Lima Junior N, de Carvalho DR: A case of extensive maxillary benign cementoblastoma. J Contemp Dent Pract 11: 056–062, 2010
de Noronha Santos Netto J, Marques AA, da Costa DO, de Queiroz Chaves Lourenco S: A rare case of cementoblastoma associated with the primary dentition. Oral Maxillofac Surg 16: 399–402, 2012
Dinakar J, Kumar MSS, Jacob SM: Benign cementoblastoma associated with an unerupted third molar – a case report. Oral Maxillofac Pathol J 1, 2010
Donohue Cornejo A, de la Torre y Morán A, de la Torre Morán G, Sánchez Vargas LO: Reporte de un caso clínico de cementoblastoma y revisión de la literatura: literature review. Revista Cubana de Estomatología 46, 2009 0–0
Esguep A, Belvederessi M, Alfaro C: Benign cementoblastoma. (Report of an atypical case). J Oral Med 38: 99–102, 1983
Eversole LR, Sabes WR, Dauchess VG: Benign cementoblastoma. Oral Surg Oral Med Oral Pathol 36: 824–830, 1973
Fantasia JE, Damm DD: Mandibular radiopacity. Cementoblastoma. Gen Dent 50, 2002 202, 204
Farman AG, Kohler WW, Nortje CJ, Van Wyk CW: Cementoblastoma: report of case. J Oral Surg 37: 198–203, 1979
Flaitz CM: Cementoblastoma. J Gt Houst Dent Soc 65: 6, 1993
Fleming P, Ryan D: Benign cementoblastoma: a case report. J Ir Dent Assoc 48: 3–5, 2002
Forsslund HG, Bodin I, Julin P: Undiagnosed benign cementoblastoma in a patient with a 6-year pain condition. Report of a case. Oral Surg Oral Med Oral Pathol 66: 243–248, 1988
Fujii T, Ohnishi Y, Minamino Y, Yoshimoto H, Gotoh M, Kakudo K: A case of cementoblastoma showing growth in 5 months. Jpn J Oral Maxillofac Surg 62: 184–188, 2016
Fujimoto K, Tamaki H: A case of benign cementoblastoma. Jpn J Oral Maxillofac Surg 38: 1582–1583, 1992
Fujita S, Takahashi H, Okabe H, Watanabe C, Sonobe H: A case of benign cementoblastoma. Oral Surg Oral Med Oral Pathol 68: 64–68, 1989
Garlick AC, Newhouse RF, Boyd DB: Benign cementoblastoma: report of a case. Mil Med 155: 567–570, 1990
Ghom AG, Meshram V, Diwe A, Kolte V: Benign cementoblastoma. J Ind Acad Oral Med Radiol 22: 42–44, 2010

Goerig AC, Fay JT, King E: Endodontic treatment of a cementoblastoma. Oral Surg Oral Med Oral Pathol 58: 133–136, 1984
Gouvêa AF, Mannarino FS, Silva ARS, Jorge J, Vargas PA, Lopes MA: Cementoblastoma: oito novos casos, revisão da literatura e considerações sobre melhor manejo clinico. Rev Assoc Paul Cir Dent 70: 88–94, 2016
Gulses A, Bayar GR, Aydin C, Sencimen M: A case of a benign cementoblastoma treated by enucleation and apicoectomy. Gen Dent 60: e380–382, 2012
Hachimi H, Oudidi A, Benmansour N, Kadaoui H, Zaki Z, Ridal M, et al: Benign cementoblastoma. Apropos of a case and review of the literature. Odontostomatol Trop 28: 24–26, 2005
Hamdi MH, Hasni W, Ben Khelifa M, Ben Alaya T: Le cémentoblastome: à propos de 2 cas. Actual Odont Stomatol 241: 23–38, 2008
Harada H, Omura K, Mogi S, Okada N: Cementoblastoma arising in the maxilla of an 8-year-old boy: a case report. Int J Dent 384578: 2011, 2011
Herzog S: Benign cementoblastoma associated with the primary dentition. J Oral Med 42: 106–108, 1987
Hirai E, Yamamoto K, Kounoe T, Kondo Y, Yonemasu H, Kurokawa H: Benign cementoblastoma of the anterior maxilla. J Oral Maxillofac Surg 68: 671–674, 2010
Hönig JF: Benign cementoblastoma–trigger of the painful myoarthropathic syndrome. Overview and case report. Dtsch Stomatol 41: 386–391, 1991
Huber AR, Folk GS: Cementoblastoma. Head Neck Pathol 3: 133–135, 2009
Hugar D, Sajjanshetty S, Hugar S, Ranjan S, Tamagond S: Benign cementoblastoma and radiological differential diagnosis: a case report. Sch J Med Case Rep 1: 65–68, 2013
Huvar RJ, Butura CC: Benign cementoblastoma: report of case. CDS Rev 88: 36–37, 1995
Infante-Cossio P, Hernandez-Guisado JM, Acosta-Feria M, Carranza-Carranza A: Cementoblastoma involving the maxillary sinus. Br J Oral Maxillofac Surg 46: 234–236, 2008
Ishida S, Ishihara A, Adachi M, Isobe M, Arao M, Nakayama K: A case of benign cementoblastoma. Jpn J Oral Maxillofac Surg 40: 305–307, 1994
Iwaki LCV, Dezotti MSG, Ferreira JO, Sant'Ana E, Damante JH, Negrao RF: Cementoblastoma benigno: relato de caso y revisión de literatura. Rev Odontol Dominic 7: 45–49, 2001
Jelic JS, Loftus MJ, Miller AS, Cleveland DB: Benign cementoblastoma: report of an unusual case and analysis of 14 additional cases. J Oral Maxillofac Surg 51: 1033–1037, 1993
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 36: 20–25, 2007
Jolehar M, Khalili M, Baghaee F: A rare odontogenic tumor known as cementoblastoma; a case report. J Res Dentomaxillofac Sci 1: 41–45, 2016
Kage T, Murato S, Sakamoto S, Kitamura Y, Chino T, Kawakami T, et al: Benign cementoblastoma: report of two cases. Jpn J Oral Maxillofac Surg 27: 1612–1619, 1981
Kamikawa Y, Kawashima K, Mukai H, Yoshida M, Kuniyoshi H, Yamashita S: A case of benign cementoblastoma in the right molar region of the maxilla. Jpn J Oral Maxillofac Surg 40: 813–815, 1994
Keyes G, Hilderbrand K: Successful surgical endodontics for benign cementoblastoma. J Endod 13: 566–569, 1987
Kikuchi S, Ueno S, Shinbo T, Shinoki K, Fujita Y: Cementoblastoma in the mandible: a case report. Jpn J Oral Maxillofac Surg 32: 1438–1441, 1986
Kitamura K, Yamamoto G, Mori M, Yamaguchi Y, Hyo Y, Yoshitake K: Benign cementoblastoma arising in the maxilla: report of a case. Jpn J Oral Maxillofac Surg 38: 1329–1330, 1992
Kitamura E, Okada H, Kaneda T, Takeda Y, Yamamoto H, Nagura H: A case of benign cementoblastoma. Jpn J Oral Maxillofac Surg 46: 354–356, 2000
Kline SN, Spatz SS, Zubrow HJ, Fader M: Large cementoma of the mandible. Report of a case. Oral Surg Oral Med Oral Pathol 14: 1421–1426, 1961
Kumar S, Prabhakar V, Angra R: Infected cementoblastoma. Natl J Maxillofac Surg 2: 200–203, 2011
Langdon JD: The benign cementoblastoma – just how benign? Br J Oral Surg 13: 239–249, 1976
Larsson A, Forsberg O, Sjogren S: Benign cementoblastoma–cementum analogue of benign osteoblastoma? J Oral Surg 36: 299–303, 1978
Lazarde J, Montilla G, Rivera H, Padrón B: Cementoblastoma benigno. Reporte de un caso. Acta Odontol Venezol 37: 31–36, 1999
Lemberg K, Hagstrom J, Rihtniemi J, Soikkonen K: Benign cementoblastoma in a primary lower molar, a rarity. Dentomaxillofac Radiol 36: 364–366, 2007
Levin LS, North AF, Dent Jr GE, Ortel R: Benign cementoblastoma: a case report. J Md State Dent Assoc 27: 118–119, 1984
Luo HY, Li TJ: Odontogenic tumors: a study of 1309 cases in a Chinese population. Oral Oncol 45: 706–711, 2009
MacDonald-Jankowski DS, Wu PC: Cementoblastoma in Hong Kong Chinese. A report of four cases. Oral Surg Oral Med Oral Pathol 73: 760–764, 1992
Mader CL, Wendelburg L: Benign cementoblastoma. J Am Dent Assoc 99: 990–992, 1979
Mahl CEW, Gegler A, Fontanella VRC: Cementoblastoma benigno associado a segundo pré-molar inferior: relato de caso. Rev Fac Odontol Porto Alegre 44: 24–25, 2003
Makek M, Lello G: Benign cementoblastoma. Case report and literature review. J Maxillofac Surg 10: 182–186, 1982
McNamara KK, Kernig ML, Kreuter KS, Kalmar JR, Allen CM: Clinical-pathological conference: case 4. Head Neck Pathol 4: 230–233, 2010
Milani CM, Thomé CA, Kamikawa RSS, Silva MD, Machado MAN: Mandibular cementoblastoma: case report. Open J Stomatol 2: 50–53, 2012
Mogi K, Belal E, Kano A, Otake K: Benign cementoblastoma. Case report. Aust Dent J 41: 9–11, 1996
Moher D, Liberati A, Tetzlaff J, Altman DG, Grp P: Preferred reporting items for systematic reviews and meta-analyses: the PRISMA statement. Ann Intern Med 151: 264–269, 2009 W264
Moraes EJd, Benevides Moraes N, Farias Miranda D: Evolución de 1 año de un paciente rehabilitado con implantes oseointegrados de carga inmediata después de la resección quirúrgica de un cementoblastoma: reporte clínico. Rev Española Cirugía Oral y Maxilofac 31: 386–391, 2009
Nair B, Paul G: Cementoblastoma–a case report. J Indian Dent Assoc 58, 1986 25–26, 30
Neelakandan RS, Deshpande A, Krithika C, Bhargava D: Maxillary cementoblastoma – a rarity. Oral Maxillofac Surg 16: 119–121, 2012
Neves FS, Falcao AF, Dos Santos JN, Dultra FK, Rebello IM, Campos PS: Benign cementoblastoma: case report and review of the literature. Minerva Stomatol 58: 55–59, 2009
Nowparast B: Cementoblastoma of the maxilla. A clinico-pathologic review and case report. ICD Sci Educ J 11: 5–8, 1978
Nuvvula S, Manepalli S, Mohapatra A, Mallineni SK: Cementoblastoma relating to right mandibular second primary molar. Case Rep Dent 20162319890, 2016
Ohki K, Kumamoto H, Nitta Y, Nagasaka H, Kawamura H, Ooya K: Benign cementoblastoma involving multiple maxillary teeth: report of a case with a review of the literature. Oral Surg Oral Med Oral Pathol Oral Radiol Endod 97: 53–58, 2004
Oliveira LA, Pinto CMPX, Naves Neto VA: Cementoblastoma benigno na mandíbula: relato de caso. Rev Cir Traumatol Buco-Maxilo-Fac 13: 49–54, 2013
Orsini G, Fioroni M, Rubini C, Piattelli A, Zebra XXI: Part 2. Cementoblastoma. J Endod 27: 546–547, 2001
Papageorge MB, Cataldo E, Nghiem FT: Cementoblastoma involving multiple deciduous teeth. Oral Surg Oral Med Oral Pathol 63: 602–605, 1987
Paranjyothi MVL, Kumarswamy KL, Manjunath K: Cementoblastoma associated with maxillary first bicuspid: a case report. Int J Oral Maxillofac Pathol 4: 17–20, 2013
Pattyn E, Mermuys K, Lateur L: Cementoblastoma. Jbr-btr 90: 306, 2007
Peña CA, Luberti RF, Wenedikter DH, Freiperger MA, Peña DM: Cementoblastoma benigno: presentación de 1 caso. Rev Círc Argent Odontol 67: 24–29, 2010
Piattelli A, D'Addona A, Piattelli M: Benign cementoblastoma: review of the literature and report of a case at an unusual location. Acta Stomatol Belg 87: 209–215, 1990
Piattelli A, Di Alberti L, Scarano A, Piattelli M: Benign cementoblastoma associated with an unerupted third molar. Oral Oncol 34: 229–231, 1998
Pontes FSC, Carneiro Jr JT, Ribeiro ALR, Gonçalves Jr A, Fonseca FP, Pontes HAR, et al: Cementoblastoma previously misdiagnosed as fibrous dysplasia: report of an uncommon case and discussion of the differential diagnosis. Int J Pediatr Otorhinolaryngol Extra 3: 182–187, 2008
Prakash R, Gill N, Goel S, Verma S: Cementoblastoma. A report of three cases. N Y State Dent J 79: 41–43, 2013
Pynn BR, Sands TD, Bradley G: Benign cementoblastoma: a case report. J Can Dent Assoc 67: 260–262, 2001
Revathi S, Ramesh V, Balamurali PD, Oza N: Benign cementoblastoma: a case report. Int J Med Res Health Sci 5: 73–76, 2016
Rezvani G, Dehghani Nazhvani A: Cementoblastoma: report of a case with a long-term pain. J Dent Shiraz Univ Med Sci 13: 135–138, 2012
Ross B, Czerniawska A, Tyszkiewicz S, Sydor A, Grabowska S: Clinical and morphological evaluation of cementoblastomas. Czas Stomatol 26: 865–871, 1973
Rubino I, Cudia G, Ficarra G: Benign cementoblastoma. A case report. Minerva Stomatol 48: 539–541, 1999
Ruprecht A, Ross AS: Benign cementoblastoma (true cementoma). Dentomaxillofac Radiol 12: 31–33, 1983
Saito T, Takamori H, Mishiro F, Saotome M, Tomita S, Kumazawa Y, et al: Two cases of benign cementoblastoma. Jpn J Oral Maxillofac Surg 31: 2653–2663, 1985
Saito Y, Takeda Y, Sasaki O, Ohya T, Fujioka Y: Postoperative recurrence of a benign cementoblastoma: report of a case with review of the literature. Jpn J Oral Maxillofac Surg 36: 566–574, 1990
Sankari LS, Ramakrishnan K: Benign cementoblastoma. J Oral Maxillofac Pathol 15: 358–360, 2011
Schafer TE, Singh B, Myers DR: Cementoblastoma associated with a primary tooth: a rare pediatric lesion. Pediatr Dent 23: 351–353, 2001
Sharma N: Benign cementoblastoma: a rare case report with review of literature. Contemp Clin Dent 5: 92–94, 2014
Shastry SM, Ravikanti VK, Thoondla MK, Gupta SR: Benign cementoblastoma. Ind J Oral Sci 3: 165–167, 2012
Shoji T, Arika T, Nakajima M, Morita S, Okano H: A case of benign cementoblastoma. Jpn J Oral Maxillofac Surg 38: 801–802, 1992
Sirigala L, Dude Y, Gavada J, Sama B: Benign cementoblastoma of primary mandibular molars: a rarity. Sch J App Med Sci 3: 1312–1315, 2015
Slimani F, Elbouihi M, Oukerroum A, Lazreqh H, Mahtar M, Karkouri M, et al: Maxillary cementoblastoma. A case report. Rev Med Brux 30: 185–188, 2009
Slootweg PJ: Cementoblastoma and osteoblastoma: a comparison of histologic features. J Oral Pathol Med 21: 385–389, 1992
Souza LAS, Cardoso JA, Silva VP, Oliveira MC, Azoubel E, Farias JG: Cementoblastoma affecting the maxilla of a pediatric patient: a case report. Rev Port Estomatol Med Dent Cir Maxilofac 54: 43–47, 2013

Stanimirov P, Gateva N, Dimitrov M, Mihaylova HR: Cementoblastoma of the maxilla – case report. Int J Sci Res 3: 398–400, 2014
Sumer M, Gunduz K, Sumer AP, Gunhan O: Benign cementoblastoma: a case report. Med Oral Patol Oral Cir Bucal 11: E483–E485, 2006
Takagi M, Sakota Y, Oozeki Y, Suda A: Über einen fall von benignem zementoblastom. Dtsch Zahnärztl Z 33: 712–714, 1978
Tamme T, Soots M, Kulla A, Karu K, Hanstein SM, Sokk A, et al: Odontogenic tumours, a collaborative retrospective study of 75 cases covering more than 25 years from Estonia. J Craniomaxillofac Surg 32: 161–165, 2004
Towns TM, Marks RB, Carr RF: Benign (true) cementoblastoma: report of cases. J Oral Surg 37: 342–345, 1979
Trivedi DN: Infected cementoblastoma. A case report. Ann Dent 45: 33–34, 1986
Ulmansky M, Hjorting-Hansen E, Praetorius F, Haque MF: Benign cementoblastoma. A review and five new cases. Oral Surg Oral Med Oral Pathol 77: 48–55, 1994
Urs AB, Singh H, Rawat G, Mohanty S, Ghosh S: Cementoblastoma solely involving maxillary primary teeth – a rare presentation. J Clin Pediatr Dent 40: 147–151, 2016
Vieira AP, Meneses Jr JM, Maia RL: Cementoblastoma related to a primary tooth: a case report. J Oral Pathol Med 36: 117–119, 2007
Vilasco J, Mazère J, Douesnard JC, Loubière R: Un cas de cémentoblastoma. Rev Stomatol Chir Maxillofac 70: 329–332, 1969
Vindenes H, Nilsen R, Gilhuus-Moe O: Benign cementoblastoma. Int J Oral Surg 8: 318–324, 1979
Wang WZ, Zhong DR, Guo LN: Cementoblastoma: report of a case. Zhonghua Bing Li Xue Za Zhi 34: 253, 2005
Watanabe M, Kaneko T, Satomi T, Ono K, Watanabe H, Nagumo Y: A case of benign cementoblastoma of the lower molar region. Jpn J Oral Maxillofac Surg 40: 552–554, 1994
Wertheimer FW, Driscoll EJ, Stanley HR: "True" (attached) cementoma with root canal involvement. Report of a case. Oral Surg Oral Med Oral Pathol 14: 630–634, 1961
WHO: World Health Organization Classification of Tumours. Pathology and Genetics of Head and Neck Tumours. Lyon: IARC Press, 2005
Wiggins Jr HE, Karian BK: Cementoblastoma of the maxilla: report of case. J Oral Surg 33: 302–303, 1975
Xu L, Liu Y, Luo J, Jiang M, Guo W, Zheng G: Analysis of clinical and imaging findings in cementoblastoma. Hua Xi Kou Qiang Yi Xue Za Zhi 33: 419–422, 2015
Yamaguchi T, Sugihara K, Fujisaki M, Wakamatsu T, Ohkubo A, Yamashita S: Benign cementoblastoma of the mandibular molar region. Jpn J Oral Maxillofac Surg 36: 1519–1527, 1990
Yamasaki I, Tsutsui Y, Kawai H, Teramura Y, Iida T, Okano H, et al: Recurrence of mandibular cementoblastoma after extirpation: report of a case. Jpn J Oral Maxillofac Surg 23: 318–322, 1977
Yasui A, Tomida Y, Kinoshita Y, Hayase T, Kameyama Y: A case of benign cementoblastoma occurring in the mandibular molar region. Jpn J Oral Maxillofac Surg 41: 251–253, 1995
Yoshida H, Hyo Y, Shiraishi K: A case of benign cementoblastoma. Jpn J Oral Maxillofac Surg 39: 1075–1077, 1993
Zachariades N, Skordalaki A, Papanicolaou S, Androulakakis E, Bournias M: Cementoblastoma: review of the literature and report of a case in a 7 year-old girl. Br J Oral Maxillofac Surg 23: 456–461, 1985
Zaitoun H, Kujan O, Sloan P: An unusual recurrent cementoblastoma associated with a developing lower second molar tooth: a case report. J Oral Maxillofac Surg 65: 2080–2082, 2007
Zanda MJ, Poleti ML, Fernandes TMF, Sathler R, Sant'Ana E, Consolaro A: Cementoblastoma benigno: relato de caso. FOL 22: 55–59, 2012