ABSTRACT

Irritation fibroma is a gingival lesion of reactive nature with unknown etiology. This paper reports a case of Irritation fibroma in a 36 year old female in relation to the upper right posterior teeth. It was managed by an excision biopsy and was diagnosed as irritation fibroma after histological analysis.

Keywords: Irritation fibroma; Oral Fibroma; Epulis.

Introduction

Local reactive focal overgrowths are frequently found in the oral cavities. Different types of localized reactive lesions may occur on the gingiva, including focal fibrous hyperplasia, pyogenic granuloma, peripheral giant cell granuloma and peripheral ossifying fibroma (POF). The causative etiology for this lesion can be attributed to the local irritants like plaque, calculus, overhanging margins, trauma and dental appliances. Irritation fibroma represents a reactive focal fibrous hyperplasia due to trauma or local irritation. This paper reports a case of Irritation fibroma in a 36 year old female in relation to the upper right posterior teeth.

Case Report

A 36 years old female patient reported to the outpatient department with a chief complaint of a mass in right upper posterior teeth region for last 6 to 7 months. The medical history was not contributory. The lesion started as a small painless nodule from the interdental papilla of right lower canine and first premolar and gradually increased in size with no history of bleeding, paraesthesia and pain. Intra-oral clinical examination revealed a multilocular exophytic growth in relation to upper right premolar region along the buccal side, measuring approximately 1.5 cm x 1 cm in diameter, extending mesio-distally from middle third of right upper canine to middle third of right upper first premolar and from marginal gingiva above and approximately 1 cm below the occlusal level of the involved teeth supero-inferiorly. The overlying mucosa was normal in color, ulcerated and showed no vascular markings. The mass was firm in consistency, sessile, non-tender and no bruit or pulse was felt. On the basis of history and clinical findings a provisional diagnosis of irritation fibroma was given. The list of differential diagnosis included chronic fibrous epulis, peripheral giant cell granuloma, osteosarcoma, chondrosarcoma, pyogenic granuloma and peripheral odontogenic fibroma. The investigations included complete hemogram, intraoral radiographs and excisional biopsy of the lesion. Routine haematological investigation values were also found to be within normal limits. No radio graphical changes related to the bone were seen. The excisional biopsy was performed under local anaesthesia and H&E stained section revealed parakeratinized stratified squamous epithelium with elongated rete ridges. Irregular multiple foci of homogenous calcified areas were evident within the connective tissue. Thus, a final diagnosis of Irritation fibroma was given.

Discussion

The term “inflammatory hyperplasia” is used to describe a large range of commonly occurring nodular growths of the oral mucosa that histologically represent inflamed fibrous and granulation tissue. The size of these reactive hyperplastic masses may be greater or lesser, depending on the degree to which one or more of the components of the inflammatory reaction and healing response are exaggerated in the particular lesion. On the gingiva, a similar lesion is often referred to as an epulis. Focal fibrous hyperplasia is also known as irritation fibroma, oral fibroma or as fibromatosis fibroma. Irritation Fibroma occurs more frequently in females than in males between third and fourth decade of life. As in our case Irritation Fibroma occurred in a 36 year old female. The high female predilection and a peak occurrence in the second decade and declining incidence after third decade of life suggested hormonal influences.

Approximately 60% of Irritation Fibromas occur in the maxilla and they are found more often in the anterior region, with 55-60% presenting in the incisor-cuspids region. In our case, lesion was present in right maxillary bicuspid region. It usually measures less than 1.5 cm but occasionally may reach more than 3 cm in diameter, but lesions of 6 cm and 9 cm have also been reported. The surface may be either intact (34%) or ulcerated (66%). The reported case was of 1.5 cm × 2 cm in diameter with an ulcerated surface. The lesion represents varying stages of a fibroma with ossification, however, ossification or calcification may not be evident in all cases, particularly in earlier stages of growth.

Foci of radiopaque material, bone formation or dystrophic calcification may be seen, particularly in large lesions or lesions with overt mineralization. Irritation Fibroma can produce migration of teeth with interdental bone destruction. Histopathologically, irritation fibroma can exhibit as an intact or ulcerated stratified squamous epithelium along with shortening and flattening of rete pegs. Treatment of irritation fibroma consists of elimination of etiological factors, scaling of adjacent teeth and total aggressive surgical excision along with involved periodontal ligament and periosteum to minimize the possibility of recurrence. Any identifiable irritant such as an ill-fitting dental appliance and rough restoration should be removed. Long-term postoperative follow-up is extremely important because of the high growth potential of incompletely removed lesion.
Conclusion
Irritation fibroma clinically resembles as pyogenic granuloma, peripheral giant cell granuloma or odontogenic tumors, so radiographic and histopathological examination is essential for accurate diagnosis.

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