

A Novel Presentation of Fibro Epithelial Polyp: A Case Report

Antharam Arjun Kumar Goud^{1*} S Anvesh Kumar Reddy² Naveen M³ T Raghusai Ram⁴

¹Post Graduate Student, Department of Oral & Maxillofacial Surgery, SVS Institute of Dental Sciences, Mahabubnagar, Telangana, India.

²Post Graduate Student, Department of Oral & Maxillofacial Surgery, SVS Institute of Dental Sciences, Mahabubnagar, Telangana, India.

³Post Graduate Student, Department of Oral & Maxillofacial Surgery, SVS Institute of Dental Sciences, Mahabubnagar, Telangana, India.

⁴Post Graduate Student, Department of Oral & Maxillofacial Surgery, SVS Institute of Dental Sciences, Mahabubnagar, Telangana, India.

ABSTRACT

Background: Oral mucosal over growths (gingival) can leads to functional impairment and esthetic problems in the facial region. These are commonly reactive, developmental, inflammatory, or neoplastic in nature. The reactive being the result of trauma or chronic irritation.¹ Irritational fibroma is occurs in response to trauma from teeth or dental prostheses and was first reported in 1846 as fibrous polyp and polypus².

The size may vary from a few millimeters up to some centimeters with varied consistency. Surgical excision is recommended in order to restore form and function of oral cavity The present case report The present case of fibroepithelial polyp resembling the size of a benign neoplastic lesion needs biopsy and histological evaluation for the management.

Keywords: Fibro epithelial polyp, Oral Disease, Oral disease.

INTRODUCTION

Fibroma, oral fibroma or fibromatosis fibroma is the most commonly occurring soft tissue tumor in the oral mucosa. It is of connective tissue origin. Although, the clinical appearance and pathogenesis of this entity is described better by the term focal fibrous hyperplasia, it is not commonly used.³ It presents as a round to ovoid asymptomatic nodule which has a smooth texture and is usually pale pink in colour. It may also appear white due to hyperkeratosis because of continued irritation. It is firm in consistency and usually pedunculated, although sessile cases have also been reported. Cooke called all the pedunculated swelling from a mucosal surface as “polyp” (fibro epithelial polyp), where maximum number of lesions occurred on the mucosa in the line of occlusion, and the entire pedunculated and sessile lesion in the gingiva as “epulides” (fibrous epulides), which commonly occurred in the maxillary anterior region.⁴

Clinically, these reactive lesions often present diagnostic challenges because they mimic various groups of pathological processes. They are clinically similar to other benign epithelial hyperplasia's with histopathologically distinct features.^{5,6} we present a case report of fibro epithelial polyp in a 60 year old female patient.

CASE REPORT

A sixty-year-old female patient reported with the chief complaint of swelling in the upper left back tooth region, for the past 2 months.

It started as a small painless growth which was in the size of a pea nut initially, for this complaint she reported to a local physician, and took medication, but swelling was not subsided, instead it was gradually increased causing facial asymmetry and difficulty in mastication, speech.

Received: Apr. 21, 2015; Accepted: Aug. 4, 2015

*Correspondence Dr. Antharam Arjun Kumar Goud.

Department of Oral & Maxillofacial Surgery, SVS Institute of Dental Sciences, Mahabubnagar, Telangana, India.

Email: kishoromram88@gmail.com

Patient gave a history of mild pain over upper left back tooth region 1 year back which was subsided on its own, but the irritation persisted in the same region, especially in the gingiva region which led her to prick her gums between upper left back teeth region with different objects, like match sticks, metal pins, tooth picks and finger nails.

On extra oral examination, mild facial asymmetry noticed due to a well defined solitary swelling of size approximately 2X2 cms extending superiorly 3cm away from the inferior palpebrae to 2 cms above the inferior border of the mandible, antero posteriorly 1cm from the commissure of mouth to 2cm from the ala tragus of ear. Skin over the swelling was normal to the adjacent skin. On palpation it was nontender, firm in consistency and skin over swelling was pinchable.

Intraoral examination the oral hygiene status was poor and chronic generalized periodontitis was noted. There was palatally displaced 26 and missing 27 was noted. Examination of specific lesion proper revealed a large pedunculated well defined gingival growth with mild pebbled surface of size 3 X 3.5 cms in left lateral aspect of the posterior maxillary alveolus region, extending from distal surface of 25 to mesial of 28. Superiorly it extended into buccal vestibule of 25, 26 and 28, and inferiorly into edentulous space of 36 region, causing interference with occlusion. Tooth vitality test was done for 24, 25 and were found to be vital.



Fig 1: Preoperative view.



Fig 2 and 3: Colour over the lesion shows inflammatory changes, mild erythematous when compared with the adjacent mucosa with the normal mucosa.

Figure II and Figure III - Colour over the lesion shows inflammatory changes, mild erythematous when compared with the adjacent mucosa with the normal mucosa. On palpation all the inspectory findings regarding site, size, shape, surface and extent were confirmed. Swelling was soft to rubbery in consistency, Non tender, swelling was non fixed.

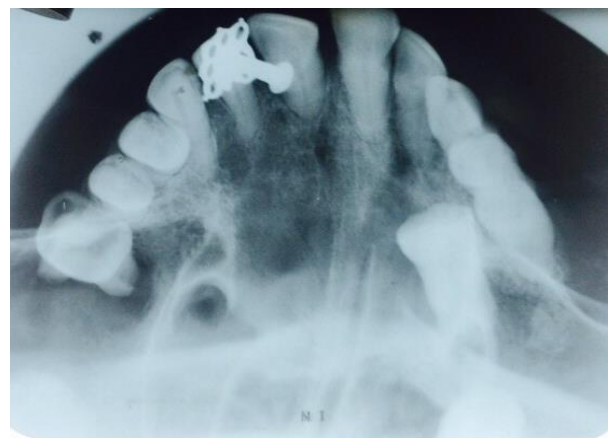


Fig 4: Shows no significant radiologic changes.

There was no significant radiologic change observed in occlusal view (**Figure: IV**) except palatally displaced left maxillary first molar.



Fig 5: Shows horizontally placed 26 associated with mild soft tissue opacification.

OPG (**Figure: V**) examination shows horizontally placed 26 associated with mild soft tissue opacification. Patient was advised to maintain good oral hygiene with Chlorhexidine mouth wash twice daily. Incisional biopsy was performed and biopsy specimen was sent for histopathological analysis, and it showed stratified squamous epithelium of varying thickness, with moderate to dense connective tissue and haphazardly arranged collagen fiber bundles. Moderate number of capillaries and few chronic inflammatory cells predominantly lymphocytes and plasma cells admixed with areas of haemorrhage at focal areas were evident.

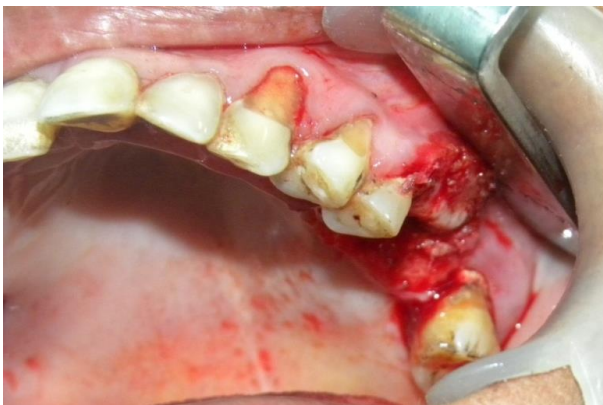


Fig 6: Excision done.

Figure VI - Excision of the lesion was carried out with the help of monopolar cautery. The palatally displaced maxillary left first molar was removed along with the lesion. Hemostasis achieved, primary closure done with 3-0 vicryl and patient shifted to post operative ward uneventfully. Excised specimen

(**Figure VII**) was sent for histopathological examination and it was diagnosed as “fibro epithelial polyp with secondary inflammation”.



Fig 7: Excised tumour.

DISCUSSION

Reactive lesions often occur in oral cavity with chronic irritation due to trauma, denture irritation, calculus these lesions presents with similar clinical features which create a diagnostic dilemma. Among all reactive lesions fibroma is most common soft tissue growth in the oral cavity, predominantly seen in buccal mucosa at the line of occlusion and tongue.⁷

Daley *et al.*⁸ suggested the term “focal fibrous hyperplasia”, rather than the term “fibroma.” Which is also known as irritation fibroma /traumatic fibroma/fibrous nodule/fibro-epithelial polyp.⁹ Among all these, “Irritational fibroma” is the most commonly used term.¹⁰ In the present case, based on history and clinical presentation the other lesions included in differential diagnosis were pyogenic granuloma, true fibroma, peripheral ossifying fibroma and peripheral giant cell granuloma. pyogenic granuloma and peripheral giant cell granuloma are vascular in nature and often bleed on manipulation. The present case appeared erythematous but bleeding was not observed. Peripheral ossifying fibroma commonly associates with tooth displacement and calcified deposits are evident radiologically and histopathologically. In this case, 26 was displaced palatally but calcification was not evident.

Histopathologically, fibroma show masses of fibrous connective tissue which is lined by stratified squamous epithelium. Underlying connective tissue is usually dense and collagenized and these collagen bundles are seen arranged in radiating, circular or haphazard fashion. Hyperkeratosis may be seen associated from secondary trauma. The connective tissue also shows few blood vessels and few inflammatory cells mostly lymphocytes and plasma cells which are usually seen beneath the epithelial cells. Similar features were also seen in our case. Treatment consists of conservative excision. At the same time any possible irritating factors should be removed. Recurrences are exceptional. The excision of fibroepithelial polyp can be carried out with the help of scalpel, monopolar cautery or laser diode, but according to the present literature cautery and laser diode shows good surgical control over the excision of this kind of lesions.⁶

In the present case excision was done with of mono polar electrocautery and excised wound was uneventful, risk for malignant transformation is unlikely and recurrence although rare can occur until the source of irritation is completely removed.^{11,12}

CONCLUSION

Although these reactive lesions are non aggressive they can cause functional and esthetic impairment, hence they should be surgically managed and source of irritation should be completely removed in order to prevent its recurrence.

CONFLICT OF INTEREST

No potential conflict of interest relevant to this article was reported.

REFERENCES

1. Agnihotri A, Sharma R, Sandhu AP, Gulati A. Giant Fibroepithelial Polyp: A Rare Case Report. *Indian J Multidiscip Dent.* 2013; 3(4):817-819.
2. Alam MN, Chandrasekaran SC, Valiathan M. Fibroma of the gingiva: A case report of a 20 year old lesion. *Int J Contemp Dent* 2010; 1:107-9.
3. Regezi JA, Sciubba JJ, Jordan RCK. *Oral Pathology: Clinical pathologic correlations.* Chapter 7, 6th Ed., Saunders. 2012:163-167.
4. Cooke BE. The fibrous epulis & the fibro epithelial polyp: Their histogenesis & natural history. *Br Dent J* 1952; 93:305-9.
5. Aboobakker A, Chatra L, Shenai P, Veena KM, Rao PK, Prabhu RV, TashikaKushraj Shetty P. Focal Fibrous Hyperplasia: A Case Report. *Pac J Med Sci.* 2014; 12(2):21-25.
6. Koppolu P, Mishra A, Kalakonda B, Swapna LA, Bagalkotkar A, Macha D. Fibroepithelial polyp excision with laser and scalpel: A comparative evaluation. *Int J Curr Microbiol App Sci.* 2014; 3(8):1057-1062.
7. Suryaprasanna J, Sehrawat S. Fibroepithelial hyperplasia: Rare, selflimiting Condition: Two case reports. *J Adv Oral Research.* 2011; 2(3):63-70.
8. Daley TD, Wysocki GP, Wysocki PD, Wysocki DM. The major epulides: Clinicopathological correlations. *J Can Dent Assoc* 1990; 56:627-30.
9. Toida M, Murakami T, Kato K, Kusunoki Y, Yasuda S, Fujitsuka H. Irritation fibroma of the oral mucosa: A clinicopathological study of 129 lesions in 124 cases. *Oral Med Pathol* 2001; 6:91-4.
10. Rangeeth BN, Moses J, Reddy VK. A rare presentation of mucocele and irritation fibroma of the lower lip. *Contemp Clin Dent* 2010; 1:111-4.
11. Halim DS, Pohchi A, Pang EE. The prevalence of fibroma in oral mucosa among patient attending USM dental clinic year 2006-2010. *Indonesian J Dent Res* 2010; 1:61-6.
12. Yeatts D, Burns JC. Common oral mucosal lesions in adults. *Am Fam Physician* 1991; 44:2043-50.
13. Burket LW, Greenberg MS, Glick M, Ship JA. *Burket's Oral Medicine.* Chapter 7, 11th Ed., PMPH- USA. 2008:132-133.

14. Marx RE, Stern D. Oral and Maxillofacial Pathology: A rationale for diagnosis and treatment. Chapter 2, 2nd Ed., Quintessence Publishers. 2012; 1:20-22.
15. Neville BW, Damm DD, Allen CM, Bouquot J. Oral and Maxillofacial Pathology. 3rd Ed., Saunders. 1995: 511-512.