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ISOLATED IDIOPATHIC GINGIVAL HYPERPLASIA: A CASE REPORT

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ABSTRACT:

Gingival hyperplasia is a rare condition but it is important for cosmetic and mechanic reasons and because of its potential as an indicator of systemic disease. Gingival fibromatosis may exist as an isolated abnormality or as part of a syndrome. In this article a case that was diagnosed clinically and histologically as idiopathic gingival fibromatosis is presented. Patient with gingival hyperplasia should be examined to exclude other reasons to determine the idiopathic gingival fibromatosis or not. Treatment is not required in all cases of idiopathic gingival hyperplasia. Surgical excision is indicated if mechanical problems exist. Recurrence has not been reported.

KEYWORDS:

HYPERPLASIA, IDIOPATHIC GINGIVAL FIBROMATOSIS.

INTRODUCTION

Gingival Hyperplasia is a proliferative fibrous lesion of the gingival tissue which not only lead to cosmetic discrepancy but functional problems as well. Associative Factors include hereditary, medications, inflammation, and systemic disorders. It is generally diagnosed on the basis of medical history and clinical features. In cases of puberty and pregnancy, gingival hyperplasia can be seen due to **lack of oral hygiene maintenance, inadequate nutrition, abnormal hormonal stimulation.** A progressive fibrous enlargement of the gingival is a feature of Idiopathic Fibrous Hyperplasia. This massive enlargement appears to cover the tooth surfaces. Patients diagnosed with gingival hyperplasia should be examined to exclude other reasons to determine the idiopathic gingival fibromatosis or not. All cases do not require treatment, but surgical excision is prescribed if any mechanical or esthetical problem is reported.

CASE REPORT

CHIEF COMPLAINT

A 7-year old male patient reported to the Department of Pedodontics and Preventive Dentistry with the chief complaint of localized swelling in left lower back tooth region since last 15 days and multiple missing teeth in upper and lower tooth region.

ORAL EXAMINATION

On oral examination, localized gingival enlargement involving mandibular left first permanent molar extending up to its mesio-buccal surface was seen. The enlargement was red in color with firm and resilient consistency. Another features included bleeding on probing along with pain on tactile stimulation. Missing teeth with respect to 52,53,54,55,62,63,64,65, 73,74,75,83,84,85 were also present.

TREATMENT PLAN

A treatment plan was formulated on the basis of following treatment phases:

- Surgical Phase- Curettage followed by Gingivectomy
- Restorative Phase- Restoration with respect to 36 and Functional removable space maintainer in maxillary and mandibular arch

TREATMENT:

A consent form was signed by the patient and his guardian prior to surgery. The facial skin all around oral cavity was scrubbed with povidone iodine solution and patient was asked to rinse with 0.2% chlorhexidine. Patient was operated under local anesthesia. Curettage along with gingivectomy was carried out in the particular region. The excised gingival was sent immediately for biopsy. Patient was prescribed saline gargles and gum astringent thrice daily along with the use of proxa brushes after every meal. No recurrence of gingival enlargement occurred during this follow-up period. Patient was pleased with the treatment outcome

RESULT:

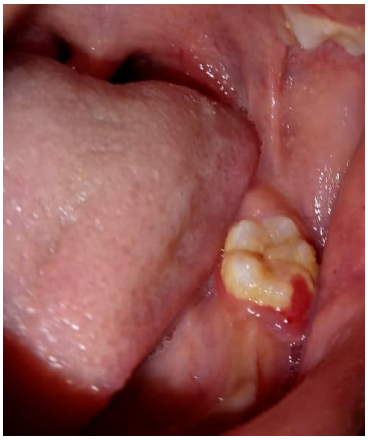

FIGURE1: PREOPERATIVE VIEW

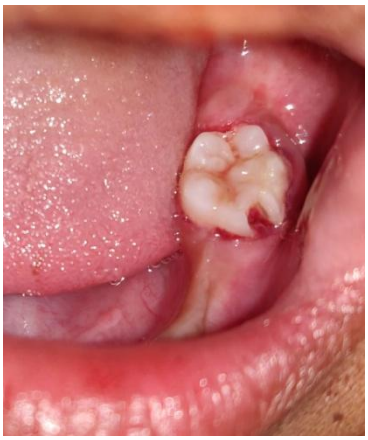

FIGURE 2: IMMEDIATELY AFTER GINGIVECTOMY

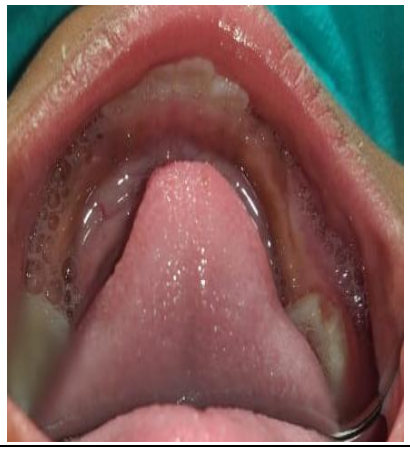

FIGURE 3: FOLLOW-UP AFTER 1 WEEK

HISTOPATHOLOGICAL EXAMINATION

Biopsy report confirmed the diagnosis of gingival hyperplasia. The excised tissue showed parakeratinized epithelium and underlying connective tissue. Epithelial layer revealed hyperplasia and elongated rete ridges deeply penetrating into the connective tissue stroma. The connective tissue stroma showed abundance of collagen fibre bundles, increased number of fibroblasts, reduced vascularity, and few inflammatory cells infiltrate.

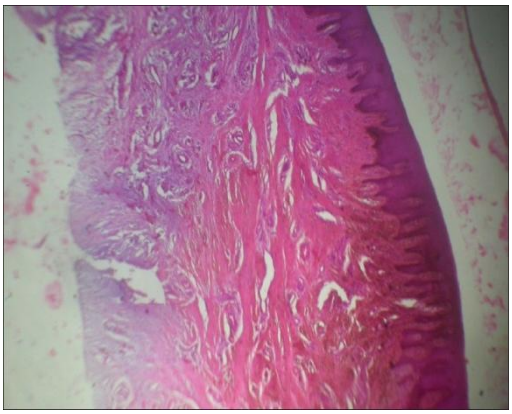

FIGURE: HISTOPATHOLOGICAL VIEW

DISCUSSION

Patients with gingival hyperplasia should be examined carefully and blood samples should be taken to exclude blood dyscrasias. While the gingiva may be the only tissue involved, some cases display gingival fibromatosis in association with hypertrichosis, and/or mental retardation, and/or epilepsy. It can be in association with other syndromes including Rutherfurd syndrome, Cross syndrome, Ramon syndrome. After excluding other reasons of gingival hyperplasia it is named as idiopathic gingival hyperplasia. Treatment is not required in all cases of idiopathic gingival hyperplasia. Maximal gingival enlargement occurs either during the loss of deciduous teeth or in the early stages of the eruption of permanent

teeth. It progresses rapidly during ''active'' eruption and decreases with the end of this stage. This correlates positively to the present case. Surgical excision is indicated if mechanical problems exist.

CONCLUSION

The gingival enlargement causes accumulation of food debris and plaque which aids periodontopathic bacteria to prolong and aggravate the disease leading to bone loss and root resorption. Dentist should pay close attention to such lesions and should ensure the timely management of such gingival overgrowth.

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