

Case Report

Irritation fibroma of tongue: a case report

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ABSTRACT

Reactive hyperplastic outgrowths are seen in the oral cavity due to chronic irritation by plaque, calculus, overhanging margins, trauma and dental appliances. Irritation fibroma represents a reactive focal fibrous hyperplasia due to trauma or local irritation. We report a case of irritation fibroma of right lateral border of tongue in a 46-year-old female.

Keywords: Irritation fibroma, Reactive fibrous hyperplasia, Fibrous nodule

INTRODUCTION

Local reactive focal overgrowths are frequently found in the oral cavities.¹ Different types of localized reactive lesions may occur in the oral cavity, including focal fibrous hyperplasia, pyogenic granuloma, peripheral giant cell granuloma and peripheral ossifying fibroma.¹⁻⁴ These may be caused due to the local irritants like plaque, calculus, overhanging margins, trauma and dental appliances.^{1,4} Oral fibroma is a common benign scar-like reaction to persistent long-standing irritation in the mouth. It is also known as traumatic fibroma, focal fibrous hyperplasia, fibrous nodule or oral polyp. We report a case of irritation fibroma of right lateral border of tongue in a 46-year-old female.

CASE REPORT

A 46-year-old female presented with a small growth of gradual onset on the right lateral side of the tongue since two years. The growth was round in shape and was measuring approximately 12 mm × 10 mm. It was smooth surfaced, normal mucosal colour and sessile. It was firm

in consistency and was also non-tender (Figure 1). There was no history of trauma. A clinical diagnosis of fibroma was considered and excisional biopsy was done.



Figure 1: Clinical picture of growth.

Histological examination showed stratified squamous epithelial lining with thin rete ridges. The subepithelial

stroma was composed of avascular fibrous connective tissue; no giant cells were noted (Figure 2). Based on these findings, a diagnosis of fibroma was given.

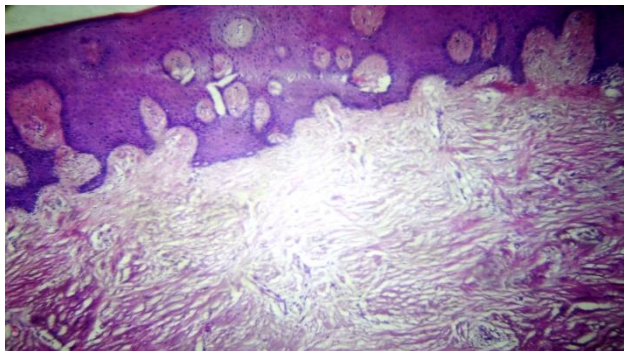


Figure 2: Fibrous stroma below the squamous epithelium.

DISCUSSION

Oral fibroma is most commonly seen in older adults but can occur at any age. It affects 1-2% of adults. It is usually due to chronic irritation such as cheek or lip biting, rubbing from a rough tooth, dentures or other dental prostheses.¹

Oral fibroma presents as a firm smooth lump in the mouth. It is usually the same colour as the rest of the mouth lining but is sometimes paler or, if it has bled, may look a dark colour. The surface may be ulcerated due to trauma, or become rough and scaly. It is usually dome-shaped but may be on a short stalk like a polyp (pedunculated). If it has developed under a denture it may be flat with a leaf-like shape.

The commonest location for an oral fibroma is on the inside of the cheek where the upper and lower teeth meet. Other common sites include the sides of the tongue, gums and inside the lower lip.

Apart from the feel and appearance, oral fibromas do not cause any symptoms. Oral fibromas develop over weeks or months to reach a maximum size usually about 1cm in diameter, but can sometimes be larger.

Oral fibroma is usually a solitary lesion. When multiple lesions are seen, associated diagnoses need to be considered including tuberous sclerosis, Cowden syndrome, familial fibromatosis and fibrotic papillary hyperplasia of the palate.

Differential diagnoses of oral fibroma are giant cell fibroma, myofibroma and myofibromatosis and

peripheral ossifying fibroma.⁵ Giant cell fibroma is characterised by giant cells below the epithelium. Myofibromas and myofibromatosis show myofibroblasts in the stroma. Peripheral ossifying fibroma shows bony trabeculae and foci of calcification.

The diagnosis of oral fibroma will be suspected clinically when it presents with the usual history and examination findings. A biopsy may be taken to exclude other conditions or to remove the lesion. Histology will then show typical dense fibrous tissue with relatively few cells. The overlying epithelium may be ulcerated, thinned or thickened.

Treatment is usually with surgical excision. It may recur after surgery if the source of irritation continues. It is therefore also important to manage the source of the irritation.

CONCLUSION

Irritation fibroma clinically resembles as pyogenic granuloma, giant cell fibroma myofibroma or odontogenic tumors, so histopathological examination is essential for accurate diagnosis.

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