



Oral pyogenic granuloma diagnosis and treatment: a series of cases

Diagnóstico y tratamiento del granuloma piógeno oral: serie de casos

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ABSTRACT

The present article purports the aim of showing, in a series of cases, the application of excisional biopsy with gingivoplasty technique as treatment of pyogenic granuloma. It can be observed that accurate excision as well as elimination of contributing factors considerably decreases recurrence probabilities. Presence of pyogenic granuloma has been described in this report of a series of cases related to pregnancy, local factors such as absence of interproximal contact, presence of calculi and poor oral hygiene indexes. Moreover, it is recommended that oral hygiene instruction be the first step in treatment of pyogenic granuloma, and that after lesion excision patients receive supporting periodontal therapy.

Key words: Pyogenic granuloma, inflammatory hyperplasia, gingival neoplasia.

Palabras clave: Granuloma piógeno, hiperplasia inflamatoria, neoplasia gingival.

RESUMEN

Este artículo tiene el propósito de mostrar en una serie de casos la aplicación de la técnica de biopsia excisional con gingivoplastia como tratamiento del granuloma piógeno. También se puede observar que la correcta extirpación; así como la eliminación de los factores contribuyentes disminuye considerablemente la probabilidad de recidiva. En este reporte de serie de casos se ha descrito la presencia del granuloma piógeno relacionado al estado de gestación, a factores locales como ausencia de contacto interproximal, presencia de cálculo e índices de higiene oral malos. Además, se recomienda que la instrucción de higiene oral sea el primer paso en el tratamiento del granuloma piógeno y que posteriormente a la extirpación de la lesión los pacientes reciban terapia periodontal de soporte.

INTRODUCTION

Pyogenic granuloma is a non-neoplastic tumor growth in the tissues of the mouth or skin. It is the most common type of hyperplasia in the mouth; its histology reveals proliferation of granulation tissue with inflammatory infiltrate and great angiogenic capacity; for these reasons, vascular neoformations of different diameter are normally present, these formations exhibit abrupt onset and completion within the tissue.¹ From the histological point of view, this lesion can be classified into two groups: when capillary vessels are found to be organized into granulomatous tissue lobes surrounded by a thin collagen band, the formation is called «capillary lobular hemangioma», whereas when vascular formations are intertwined in the tissue without apparent order, it is called «non lobular capillary hemangioma».²

Etiology of this type of lesions is still not very clear. It is considered to be a lesion reactive to several low-degree stimuli, among which we can count repeated trauma, aggressions, hormonal factors and certain drugs. High incidence of this lesion during pregnancy is associated to high levels of estrogen and progesterone.²

Hyperplastic reactive lesions are very frequent in mouth disease. Kadeh determined that pyogenic granuloma constitutes 37% of all gingival reactive lesions in patients aged 30.4 (\pm 14.9) years.³

Epivatianos et al reported higher prevalence in females (1:1.5) and presence of local etiologic factors in 16% of all cases.⁴

From the clinical point of view, pyogenic granuloma appears as a soft, rapid-growing mass, possibly pediculated, of variable lobulated surface size and reddish hue. It can be ulcerated and exhibits high propensity to bleeding.² Its main location is the gums (75% of all cases). It can appear less frequently on

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the lips, tongue, oral mucosa and palate. Lesions are more common in the upper jaw, in anterior areas and vestibular zone of the gingiva. Some lesions extend to the interproximal areas and involve lingual and vestibular aspects of the gingiva.^{1,2}

Traditionally, treatment of choice for this type of lesions is full surgical excision with sub-periosteal curettage. In order to avoid recurrence potential irritant factors must equally be removed (plaque, overflowing restorations etc.).¹ Therefore, the aim of the present article was to show a series of cases where application of accurate excision technique as well as removal of contributory factors, considerably decreased probabilities of recurrence.

CASE PRESENTATION

Case 1

A systemically healthy, 34 year old female patient was referred to the Periodontics Masters' Clinic of the San Martin de Porres University due to a gingival

lesion located next to teeth 3.4 and 3.5. The patient informed of a bleeding gingival growth of about one year, which was at the time treated with resection. She reported gradual growth of a new lesion, which led to discomfort and bleeding when eating and brushing her teeth, as the lesion reached occlusal plane. Patient informed she was not pregnant or in any hormonal treatment.

Clinical examination revealed an inflammatory gingival lesion at the level of teeth 3.4 and 3.5. Measuring approximately 15 x 9 mm. The lesion covered the vestibular side of the clinical crown, it was firm, lobulated, of rugged texture and bleeding upon stimulus (*Figures 1 and 2*). Periodontal assessment did not reveal periodontal pockets; presence of plaque



Figure 1. Front aspect of the lesion.



Figure 2. Occlusal view of the lesion.



Figure 3. Periapical X-ray of the lesion area. Absence of interproximal contact between teeth 3.4 and 3.5.



Figure 4. Lesion excision.

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