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Traumatic Fibroma of the Gingiva in a Child: 4-Year Follow-Up

Tülin Taşdemir[1,a,*], Gizem Erbaş Ünverdi[2,b], Zafer Çehreli[3,c]

[1]*Department of Pediatric Dentistry, Faculty of Dentistry, Hacettepe University, Ankara, Türkiye.*
[2]*Department of Pediatric Dentistry, Faculty of Dentistry, İstanbul Health and Technology University, İstanbul, Türkiye.*
**Corresponding author*

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ABSTRACT

This case report presents a 3-year-old boy referred to the Department of Pediatric Dentistry with a hyperplastic soft tissue lesion in the maxillary anterior region, present for six months. The lesion began as small and gradually enlarged without pain or bleeding, as reported by the parents. The lesion was treated with surgical excision under local anesthesia. Histopathological analysis confirmed a diagnosis of traumatic fibroma, a benign reactive lesion often associated with chronic irritation. Postoperative recovery was uneventful, but recurrence was observed at one year, presenting as small punctate lesions. Over a subsequent four-year follow-up, no further growth was noted. This case highlights the importance of accurate diagnosis and long-term monitoring of reactive oral lesions in pediatric patients, given their potential for recurrence.

Keywords: Children, gingiva, recurrence, soft tissue lesion, traumatic fibroma

Üç Yaşındaki Çocuk Hastada Travmatik Fibroma: 4 Yıllık Takip

Araştırma Makalesi

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ÖZ

Bu vaka raporu, ailesi tarafından bildirildiği üzere altı ay içerisinde küçük başlayıp zamanla ağrı veya kanama olmadan ilerleyen maxiller ön bölgedeki hiperplastik yumuşak doku lezyonuyla Pediatrik Diş Hekimliği bölümüne yönlendirilen 3 yaşındaki bir çocuk hastayı sunmaktadır. Lezyon, lokal anestezi altında cerrahi eksizyon ile tedavi edilmiştir. Histopatolojik analiz, kronik irritasyonla ilişkili benign bir reaktif lezyon olan travmatik fibromu doğrulamıştır. Cerrahi sonrası iyileşme sorunsuz gerçekleşmiş, ancak bir yıl içinde küçük noktalar şeklinde nüks gözlenmiştir. Dört yıl süren takipler sonunda lezyonun büyümesi ilerlememiştir. Bu vaka, pediatrik hastalarda reaktif oral lezyonların doğru tanısı ve uzun süreli takibinin önemini vurgulamaktadır, çünkü bu lezyonların nüksetme potansiyeli bulunmaktadır.

Anahtar Kelimeler: Çocuk, diş eti, nüks, yumuşak doku lezyonu, travmatik fibroma

[a] *dt.tulintasdemir@gmail.com* *0000-0003-4884-4715*
[b] *erbasgizem@gmail.com* *0000-0002-8916-5949*
[c] *zcehreli@gmail.com* *0000-0003-0332-8653*
[d] *mail* *ORCID*

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Introduction

Traumatic fibroma is considered the most common soft tissue lesion found in the oral cavity, primarily affecting women and adults aged 20 to 59. While traumatic fibroma can occur in children, it is very rare during the first decade of life. The condition is also referred to as irritation fibroma, fibroepithelial polyp, focal fibrous hyperplasia, fibrous epulis, or fibrous nodüle.[1,2]

Traumatic fibroma presents as a protruding lesion that can be either sessile or pedunculated. It usually has a round or oval shape, is typically painless, and has a smooth surface with a texture that can be either firm or soft, depending on the degree of fibrosis. The lesion's size can range from 1 mm to 2 cm in diameter. It appears paler than the surrounding tissue due to reduced blood supply. Traumatic fibroma has a slow progression and can develop anywhere in the oral cavity. The buccal mucosa is the most commonly affected site, followed by the gums, lips, and tongue. It is a form of reactive hyperplasia, characterized by dense connective tissue, that occurs as a response to local trauma. Traumatic fibroma occurs following injury to a mucosal area in the oral soft tissue. Traumatic irritants include a range of behaviors and conditions that can cause irritation and damage in the oral cavity. These factors include habits like lip biting, which can lead to direct trauma, as well as occlusal trauma from misaligned teeth during biting and chewing. Poorly aligned teeth may create uneven pressure on the gums and soft tissues, while sharp or irregular tooth edges can cause cuts or abrasions. Other contributing factors are broken dental restorations, which can create rough surfaces that irritate surrounding tissues, and the build up of dental calculus, which can cause inflammation and additional discomfort in the oral area.[3-5] Some lesions occur without a prior history of trauma or injury, making them more likely to be neoplastic in nature.[1]

Gingival enlargements are primarily reactive in nature and rarely demonstrate true neoplastic potential. They are

commonly caused by local irritants such as dental plaque or calculus, trauma, orthodontic devices, or poorly fitting restorations and crowns, or medication-induced overgrowth. These lesions can be easily differentiated and classified into various diagnoses, including pyogenic granuloma (PG), peripheral ossifying fibroma (POF), peripheral odontogenic fibroma (POdF) and peripheral giant cell granuloma (PGCG). Although these reactive lesions often look similar clinically, they each have unique histopathological characteristics.[6,7]

PG appears as an exophytic, tumor-like growth of soft tissue, either pedunculated or sessile, typically arising as a reactive response to local irritation or trauma.[8,9] The most common intraoral site affected is the gingiva.[10] Clinically, PG presents as a red, erythematous nodule that tends to bleed easily, with a maximum size of about 2.5 cm. POF is a benign reactive lesion of mesenchymal origin that occurs solely on the gingiva.[11] It predominantly affects the anterior maxillary region and is more frequently seen in females, with the highest occurrence in the second decade of life.[12] Though it is a relatively rare lesion, POF represents about 3% of all oral biopsy specimens submitted for histopathological examination.[13] Clinically, POF manifests as a sharply defined, asymptomatic, slow-growing mass that feels firm or hard when palpated.[11,12] Its coloration can vary from pink, with normal mucosa, to red if surface ulceration is present.[12]

POdF is an uncommon benign tumor originating from odontogenic tissue, frequently found in areas of the oral cavity that contain teeth.[7] It can occur across a wide age range, with the highest prevalence observed in individuals in their second to fourth decades of life.[14] Clinically, it presents as an outward-growing, soft tissue swelling with the mucosa overlying it remaining intact.[15] The size of these lesions can vary, and reports have documented lesions reaching up to 3.4 cm in diameter.[14] POdF is more frequently observed in the anterior region of the mandible.[15] Unlike traumatic fibroma, POdF usually displays islands or strands of active odontogenic epithelium dispersed throughout the connective tissue matrix, a characteristic not seen in traumatic fibroma.[14]

PGCG is a reactive localized overgrowth that occurs on the gingiva of both tooth-bearing areas and the alveolar ridge in edentulous patients.[16,17] It can occur across a broad age spectrum, with a slight tendency to affect females more often. The mandible is the most frequently involved site, particularly in regions anterior to the molars. Clinically, PGCG appears as a deep red or purple sessile mass that can grow quite large, with reported sizes reaching up to 6.2 cm.[15,18] The multinucleated giant cells are a hallmark feature of PGCG and are rarely seen in other reactive lesions of the gingiva.[17,18]

Unique histopathological characteristics are essential for accurately distinguishing traumatic fibroma from other reactive lesions like PG, PGCG, POF, and POdF. The hallmark microscopic feature of traumatic fibroma is a prominent fibromyxoid stroma, which is accompanied by the absence of odontogenic epithelial islands and any calcified deposits.[19]

The management of traumatic fibroma in pediatric patients varies depending on the lesion's size and associated symptoms. Small, asymptomatic fibromas may simply be observed, as they can often resolve on their own. Conversely, if the fibroma causes discomfort, impairs oral function, or presents cosmetic concerns, several treatment options are available: surgical excision under local anesthesia, ensuring complete removal with a margin of healthy tissue to prevent recurrence; laser therapy or cryotherapy same as the treatment of other similar reactive natured gingival enlargements. In cases where habits like thumb sucking or lip biting contribute to the fibroma, behavioral interventions should be employed to eliminate the habit and prevent further trauma.[20,21] The prognosis for traumatic fibroma is generally favorable, and the recurrence is uncommon, but may occur if the source of trauma persists.[22]

The aim of this case report is to describe the management of an oral reactive fibroma in a 3-year-old patient, with an unusual location in the anterior maxillary gingiva. By detailing the clinical features, etiological considerations, and a four-year follow-up, the report provides valuable insights into the lesion's natural course, including its potential for spontaneous resolution. Readers will gain a better understanding of atypical presentations in young children, recognize the importance of considering alternative causes such as bruxism, and appreciate the role of long-term observation in guiding management. Ultimately, this report aims to inform more conservative and individualized treatment approaches for similar cases in clinical practice.

Case Description and Results

A healthy 3-year-old boy was referred to the Department of Pediatric Dentistry with the complaint of a hyperplastic soft tissue lesion located in the maxillary anterior region which had been present for 6 months. The clinical history indicated that the lesion began as small and gradually enlarged to its current size, without any reported pain or bleeding. The patient's medical history was unremarkable, and there was no family history of any genetic disorders or dental anomalies. The child had not experienced any trauma to the oral or facial region. According to the parents, bruxism was the only non-nutritive oral habit observed.

On intra-oral examination, a pale pink, solitary, well-defined, pedunculated, non-tender lesion was present on the bucco-gingival region of the maxillary right central primary incisor (Figure 1a). Extra-oral examination revealed no palpable regional lymphadenopathy or other abnormalities. Since the conservative treatment option for similar reactive gingival lesions is the same,[23] conservative surgical excision of the lesion was planned. Written informed consent was obtained from the parents after explanation of the treatment plan.

The surgery was performed under local infiltration anesthesia. The excised specimen, retrieved in one piece, was placed in 10% formaldehyde for pathological analysis.

Histopathological examination revealed a firm, white lesion measuring approximately 0.6 x 0.3 x 0.2 cm.

Following the minor surgical procedure, the excised soft tissue growth was sent for biopsy. Histopathological examination revealed atrophic stratified squamous parakeratinized epithelium without rete ridges, covering a collagenous connective tissue stroma. This stroma

contained dense collagen fibers, fibroblasts, plasma cells, and lymphocytes. The microscopic findings were consistent with a diagnosis of "Traumatic Fibroma," aligning with the clinical observations. The patient recovered without any problems at the 3rd month follow-up (Figure 1b).

Since there are currently no evidence-based guidelines for treating sleep bruxism in children; addressing related factors appears to be the most effective clinical approach for managing the condition.[24-26] The risk factors associated with bruxism were also assessed during the anamnesis, but no related causes were identified. Consequently, no further recommendations were provided to the patient. The recurrence was noted at one year (Figure 1c, presenting as three small punctate lesions. However, subsequent follow-up examinations over a 4-year period revealed no further growth in the size of the lesion (Figure 2a-c). During the check-ups, the parents reported that the patient's bruxism habit decreased over time and was no longer present at the most recent visit.



Figure 1. a. Intraoral photo showing a pedunculated mass in the maxillary anterior region. b. Intraoral photo at 3 months (post-operative). c. Intraoral photo at 1 year.



Figure 2. a. Intraoral photo at 2 years. b. Intraoral photo at 3 years. c. Intraoral photo at 4 years.

Discussion

An inflammatory hyperplastic lesion is characterized as a localized tissue reaction to injury, resulting in an increase in the size of an organ or tissue due to cellular hyperplasia. Although there are many irritants that can cause these lesions, the literature indicates that repetitive parafunctional oral habits, such as lip biting and bruxism, play a key role in developing and/or worsening of traumatic or irritation fibromas.[21,27] Traumatic events in the oral cavity elicit a disorganized reparative process, leading to excessive fibrous connective tissue deposition and subsequent nodule or mass formation.

The present case report details a traumatic fibroma in a 3-year-old boy, located on the maxillary anterior gingiva. This case report is particularly noteworthy given the patient's young age. While traumatic fibromas are predominantly found in adults, their occurrence in children, though less common, has been documented. The case reports of children with traumatic fibroma published in the literature are summarized in Table 1.

Table 1. Summary of published case reports of children with traumatic fibroma

Author	Year	Age	Gender	Location
Jeong et al.[28]	2016	7	Male	Area near the labial frenum
Mishra et al.[29]	2017	8	Male	Palatal mucosa
Kandya et.al.[30]	2018	10	Male	Buccal mucosa of the mandible
Silva Mancera et al.[20]	2019	13	Male	Buccal mucosa
Lalchandani et al.[31]	2020	13	Male	İncisive papillary region
Bhayade et al.[32]	2020	3	Female	Labial mucosa of the lower lip
Lapitskaya et al.[33]	2022	3	Female	In the palate around tooth 6.1
Asundaria et al.[34]	2023	11	Male	Tongue
Saad et al.[35]	2024	11	Male	Buccal mucosa

In this case report, the hyperplastic soft tissue lesion was diagnosed as a traumatic fibroma considered to have been caused by bruxism based on clinical and histopathological evidence. Another distinguishing feature of this case is the identified etiology. Many case reports link traumatic fibromas to direct, observable trauma or chronic habits such as lip biting. In this patient, however, the sole non-nutritive oral habit noted was bruxism, with no history of overt orofacial trauma. Lalchandani et al. also emphasized the significance of identifying the etiological factor, reporting a recurrent fibroma on the hard palate due to trauma from occlusion by lower incisors, which necessitated a multidisciplinary approach including orthodontic correction.[31] This highlights the importance of a thorough clinical history, including subtle parafunctional habits, in identifying the underlying irritant, especially in pediatric patients, where direct traumatic events might be overlooked or not readily apparent.

Bruxism is characterized by repetitive activity of the masticatory muscles.[36] Bruxism in children is a common condition that presents significant challenges for dental practitioners. Reported prevalence rates vary widely, ranging from as low as 3.5% to as high as 49%.[37,38] This variation is mainly due to the lack of standardized diagnostic criteria and the heterogeneity of research methods across different populations.[39-41]

Regarding the treatment of bruxism in children, the literature suggests a lack of strong, evidence-based recommendations. All three articles emphasize that there is insufficient evidence for specific treatment options. Treatment approaches generally focus on managing associated factors such as sleep duration and conditions, respiratory changes, personality traits, and psychosocial factors. Although various approaches like psychological and pharmacological therapies, occlusal appliances, physical therapy, and surgical interventions are mentioned, their efficacy is often supported by limited or low-quality evidence.[24-26] For example, the effectiveness of pharmacological agents like hydroxyzine has shown mixed results, indicating a need for further research.[42] While occlusal appliances are used to protect teeth, their effectiveness in treating bruxism in children is not fully supported. Sleep hygiene measures and surgical interventions like adenotonsillectomy have shown some efficacy in certain cases, but overall, it remains challenging to define a definitive treatment strategy for bruxism in children.[43] Furthermore, research indicates that the prevalence of bruxism tends to decline after the age of nine or ten, reinforcing the idea that many children with bruxism will outgrow the activity by adolescence and adulthood.[44,45] In the present case, the bruxism habit gradually decreased and ultimately resolved, which is consistent with the literature indicating that bruxism often diminishes with age and may cease over time. To the authors' knowledge, this is the first documented case of traumatic fibroma caused solely by bruxism.

While traumatic fibromas can occur in various oral locations, their occurence on the gingiva of pediatric patients is noteworthy. Here, the lesion exhibited significant growth over a six-month period despite the absence of pain or bleeding, which are typically associated with more aggressive pathologies. The absence of alarming clinical features is a key factor in this case, helping to distinguish the lesion from other, more serious conditions with similar presentations in children. Despite their benign nature, traumatic fibromas can lead to patient discomfort and esthetic concerns, thus emphasizing the importance of timely diagnosis and appropriate management.

Given the patient's unremarkable medical history and the absence of any familial genetic or dental abnormalities, the clinical examination provided valuable insight into the lesion's etiology. The absence of any reported orofacial trauma is of particular interest, as many reactive lesions are associated with local irritants or traumatic events. In the present case, bruxism was the sole non-nutritive oral habit noted, which may have contributed to localized gingival irritation. This underscores the importance of thoroughly evaluating a child's oral habits and environment when diagnosing oral lesions.

The primary diagnostic hypothesis focused on a reactive fibrous lesion of the gingiva and irritation fibroma was considered the most likely initial diagnosis based on the characteristics of the lesion and the patient's clinical history. Other differential diagnoses considered included pyogenic granuloma, peripheral giant cell granuloma, and peripheral ossifying fibroma, each characterized by unique clinical and histopathological features. For instance, pyogenic granulomas are usually linked with bleeding and often arise due to local irritation, neither of which were present in this case.[46] Similarly, peripheral giant cell granulomas typically present with more pronounced inflammatory signs, making them less likely in this scenario[23]. These lesions are not classified as tumors and can be distinguished through their unique histopathological features, which aid in accurate diagnosis. Although they are benign, there is a risk of recurrence, especially if the lesion or the contributing irritants are not entirely removed. Conservative surgical excision is the standard treatment for these lesions[23]. Surgical excision of reactive gingival lesions can be carried out using various methods, including traditional scalpel techniques, electrosurgery, infrared lasers (such as diode, erbium, neodymium, and CO_2 lasers), or cryosurgery. Among these options, lasers are considered to offer the most favorable postoperative outcomes, providing several advantages highlighted by Bornstein et al. and Rossmann et al.[47,48] These benefits include excellent visibility of the surgical site due to rapid soft tissue ablation, which also seals lymphatic and blood vessels, allowing for more precise removal of the lesion. Lasers minimize contact with diseased tissues and sterilize the area, thereby reducing infection risk. They significantly decrease postoperative pain, inflammation, and the likelihood of infection by sealing nerve endings, and they cause less wound contraction, reducing scarring.

Additionally, laser treatment causes less damage to surrounding tissues, and when used correctly, does not affect the dental pulp. This method also reduces the need for anesthetics and sutures, and minimizes the use of analgesics and antibiotics, promoting better healing and a more comfortable recovery. However, drawbacks of laser therapy include high equipment costs, the necessity of adhering to strict safety protocols such as the use of protective lenses, and the requirement for specialized training to properly manage this technology.[48,49] In the present case, as the laser or electrosurgery device was not present, conventional surgical excision was performed.

Histopathological analysis was essential in confirming the diagnosis. The findings of atrophic stratified squamous parakeratinized epithelium without rete ridges, along with a connective tissue stroma containing dense collagen fibers, fibroblasts, plasma cells, and lymphocytes, were consistent with traumatic fibroma. These results supported the clinical suspicion of a reactive lesion, highlighting the critical role of histopathological examination in providing a definitive diagnosis for oral lesions.

In the present case, recurrence was observed at the one-year follow-up, manifesting as three small punctate lesions in the original location. Although recurrence rates for irritation fibromas are generally low, recurrence is not infrequent, especially when underlying etiological factors are not addressed.[22] Bruxism is prevalent in children and may lead to chronic irritation of the soft tissues, potentially increasing the risk of recurrence of reactive lesions.[50] Parental education regarding this habit and its potential implications for long-term oral health may be beneficial in preventing future occurrences. Here, the persistent bruxism may have contributed to the recurrence, emphasizing the importance of identifying and managing associated oral habits or irritants in pediatric patients.

The stable size of the recurrent lesions during the four-year follow-up suggests a potential for self-limitation. The absence of growth over time may indicate stabilization of the child's oral environment, possibly attributable to improved oral hygiene or a reduction in bruxism frequency or severity. This aspect of the case highlights the changing nature of oral lesions in children and stresses the importance of long-term follow-up to track changes in size, number, and associated symptoms.

While uncommon, traumatic fibroma of the gingiva can develop during the first decade of life and has the potential to recur. This case highlights the understanding of reactive lesions in young children and emphasizes the importance of a multidisciplinary approach, combining surgical treatment with behavioral management strategies, for effectively handling such cases in pediatric dentistry

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Conflicts of Interest Statement

The authors declare no competing interests.

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