

Telangiectatic Granuloma: A Case Report and Review

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Abstract

The telangiectatic granuloma develops as a generally solitary, pediculated, granuloma-like, easily bleeding tumor. The staphylococci are chiefly found on the surface and not in the typical arrangement in globules. It is one of the various names given to the entity pyogenic granuloma depending on its etiopathogenesis. Pyogenic granuloma was first thought to be a mycotic infection contracted from horses. Subsequently, it was claimed that pyogenic granuloma results from a purulent change within benign oral tumors. Causation by human papilloma virus has been ruled out, and no definite infectious microorganism has yet been found to be responsible for the etiology of pyogenic granuloma. Here, we present a case of telangiectatic granuloma and its review.

Keywords: Human botryomycosis, Pyogenic granuloma, Telangiectatic granuloma

INTRODUCTION

Pyogenic granuloma is a common reactive neoformation of the oral cavity, which is composed of granulation tissue and develops in response to local irritation or trauma. Various different names have been given to this entity, reflecting, in part, mistaken concepts about its etiopathogenesis; botryomycosis hominis, botryomycoma, telangiectatic granuloma, benign pedunculated granuloma, pseudobotryomycosis, fibroangioma, croker and Hartzell disease, septic granuloma, hemangiomas, lobular capillary hemangioma, Eruption capillary hemangioma.¹⁻³

CASE REPORT

A 41-year-old male patient presented with a 3-month history of a "swollen gum in upper left back teeth region." The lesion was asymptomatic, grew slowly and present on the posterolateral part of the hard palate. Medical history revealed history of diabetes since 2-3 years, under medications for the same. Patient also had a habit of pan chewing (without tobacco) for 2-3 years, 2-3 times daily. Clinical examination revealed a solitary, pedunculated, spherical-shaped, reddish pink overgrowth with distinct borders and irregular surface

(Figure 1). Surrounding palatal mucosa was normal and it was located in the posterior part of hard palate lateral to the midline on left side in area between maxillary permanent first and second molar measuring 3 cm × 2 cm in size. On palpation, it was non-tender, soft to firm in consistency, with no blanching on pressure. Provisional diagnosis of pyogenic granuloma was given. Differential diagnosis of benign lesions like epulis, peripheral giant cell granuloma, peripheral ossifying fibroma, bacillary angiomatosis, telangiectasia, squamous cell carcinoma, kaposi sarcoma, AIDS-related complex, non-Hodgkin's lymphoma, metastatic carcinoma was considered.^{4,5}

Hematologic and radiographic investigations were advised. Intra-oral periapical radiograph with 16 regions revealed mild crestal bone loss interdentally in the region of 16, 17 (Figure 2). Hematologic investigations including complete blood cell, random blood glucose were performed and were within limits. Under local anesthesia, the growth was probed to check its bleeding tendency (Figure 3). When it was confirmed that very little blood was aspirated, and the lesion bleeds minimally, an excisional biopsy (Figure 4) with a wide margin down to the periosteum with curettage was performed. Microscopic analysis of the specimen (Figure 5) showed an oral mucosa consisting of continuous,



Figure 1: Reddish pink solitary overgrowth



Figure 4: Excisional biopsy



Figure 2: Intra oral periapical radiograph with 16 region



Figure 5: Histopathological findings



Figure 3: Probing to check bleeding tendency

parakeratinized epithelium. The underlying granulation tissue was rich in blood vessels (Figure 6). The diagnosis was telangiectatic granuloma. Post-treatment follow-up was performed (Figure 7).

DISCUSSION

Telangiectatic granuloma was formerly described under the heading “human botryomycosis” by Poncet and Dor, who first described these little granulomata in man and claimed to have found the typical cocci (1879). Already in 1899, however, Sabrazes and Laubie denied a relation with botryomycosis and created the name telangiectatic granuloma. The staphylococci are chiefly found on the surface and not in the typical arrangement in globules. Nevertheless, recently authors again tend to accept the pathogenetic role of staphylococci, expressed in the name granuloma pyogenicum (Hartzell).⁶

The telangiectatic granuloma develops as a generally solitary, pediculated, granuloma-like, easily bleeding tumor. It feels rather solid, at least, is not as soft as an ordinary granuloma. It may grow to the size of a pigeon’s or chicken’s egg in weeks, months or years and, though benign, shows a marked tendency to recurrence if not carefully excised. It especially develops in the uncovered

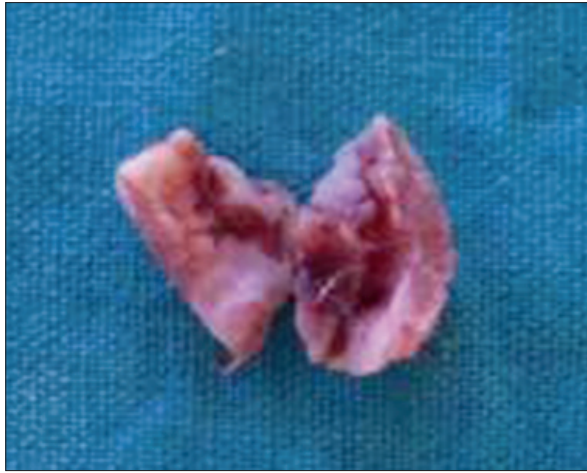


Figure 6: Post treatment

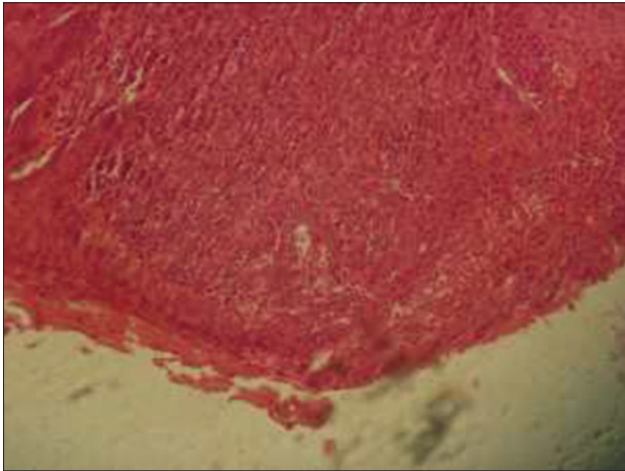


Figure 7: Follow-up after 15 days

parts of the skin; 1/3 is found at the fingers, 1/4 at the lips and mucous membranes of the mouth. The diagnosis is easily missed, and a malignant growth suspected.⁶ Treatment modalities include nonconventional surgical modalities, cryosurgery in the form of either liquid nitrogen spray or a cryoprobe, Nd: YAG, CO₂, and flash lamp pulsed dye lasers as well as surgical excision of the lesion.⁷

CONCLUSION

Telangiectatic granuloma is clinically, a rather sharply marked off, not uncommon variety of granuloma. It is a form of pyogenic granuloma, non-neoplastic growth. The dilated vessels in the gingivae and other oral mucosa may be explained by the same phenomenon that causes telangiectasia on the skin.

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