

Gingival Overgrowth in Cheilitis Glandularis: A Case Report

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Abstract:- Originally called gingival hyperplasia, gingival enlargement is a typical feature of many disorders, including inflammation, drug-induced conditions, systemic ailments, pregnancy, diseases like leukemia, and treatment-induced situations like gingival enlargement caused by orthodontic therapy. Of them, the primary cause of inflammatory-induced gingival expansion is the deposition of etiological substances, specifically calculus and plaque.

Present case report is on a 24 years old male patient who has a history of cheilitis glandularis, and reported to the Department of Periodontology for gingival enlargement.

Keywords:- Cheilitis Glandularis, Gingival Hyperplasia, Gingivectomy, Diode Laser.

I. INTRODUCTION

A uncommon condition called cheilitis glandularis is characterized by hyperplasia of the labial salivary gland and swelling primarily of the lower lip.¹ It has been associated with a risk for the development of squamous cell carcinoma and actinic cheilitis. The condition mostly occurs between the fourth and seventh decade of life and frequently affecting the males⁴.

Most people believe that gingivitis is a site-specific inflammatory disease that develops when bacterial plaque builds up at and below the gingival edge without causing periodontal attachment loss. The first cause of irritation that led to the development of gingival hypertrophy was dental plaque bacteria. Gingivitis brought on by plaque manifests clinically as erythema, edema, bleeding, pain, and enlargement.³ Surgical treatment can be done if the initial phase still presents gingival enlargement with firm consistency with minimum inflammation.

II. CASE REPORT

A 24 year, old male patient undergoing treatment for cheilitis glandularis was referred to the Department of Periodontology Clinically, patient presented with the gingival overgrowth in the maxillary and mandibular anterior region (Figure: 1). On examination, it was found that the patient had a history of cheilitis glandularis and was under medications for the same, poor oral hygiene due of gingival overgrowth Diffuse erythematous gingival enlargement noted on

maxillary anterior region extending up to coronal middle third of 11,21,22 and 23 and entire crown of 12, which is smooth surfaced, with no stippling. Erythematous gingiva noted on the mandibular anterior region, and the presence of pseudo pockets.



Fig 1 Inflammatory Type of Enlargement Seen Wrt Upper and Lower Anteriors

After the completion of phase 1 therapy, and reinforcement of oral hygiene instructions, gingivectomy procedure was done after 1 week of phase 1 therapy. Procedure began by giving local anesthesia and marking of bleeding points. After marking of bleeding points, using diode laser of 840nm pocket wall was removed. After 1 week of follow up, there were no suprabony pockets present, and the healing was uneventful.



Fig 2 1 Week Post SRP



Fig 3 Pocket Lining was Removed using 840nm Laser



Fig 4 aImmediate Post-Op



Fig 5 Re-Evaluation after 1 Week

III. DISCUSSION

When cheilitis glandularis affects the lower lip, it frequently causes symptoms like ulceration, dryness, and persistent inflammation of the lip. The precise etiology is uncertain, though. Three subtypes of cheilitis glandularis exist: superficial suppurative, deep suppurative, and simple.⁴ A diffuse increase in gingival volume might indicate a variety of clinical alterations with different underlying causes. The physician is essential in diagnosing, defining, and guiding these individuals toward an individualized diagnosis and course of therapy using a multidisciplinary approach.

Chronic inflammatory gingival enlargement include significant fibrotic components that do not respond to and undergo shrinkage when exposed to scaling and root planing are treated with surgical removal of the excess tissue, most often with a procedure known as gingivectomy.¹¹ The

gingivectomy procedure is a simple procedure that most patients find acceptable. Better gingival contour is achieved by removing pseudopockets and gingival abnormalities with this surgery. Because of their long wavelength, high frequency lasers like the carbon dioxide laser can also be utilized to eliminate the gingival contour.

So, in this case report inability by the patient to maintain the proper oral hygiene lead to gingival enlargement that resulted in formation of pseudo pockets. In order to eliminate these pockets, gingivectomy procedure was planned as it was indicated for this case using laser since hemostasis is well achieved. After 1 week of follow up there was not any presence of pseudopockets, suggesting that gingivectomy can of the essential technique to be performed.

IV. CONCLUSION

One of the advantage of gingivectomy provides the transformation of periodontal pocket of difficult hygiene into an easily accessible gingival sulcus. contraindications for gingivectomy are based on existing local conditions and patients physical health .

This case report demonstrates that non-surgical periodontal therapy combined with laser therapy can be useful in treating gingival overgrowth as it offers many more advantages than the scalpel along with added benefits of lasers to reduce patient discomfort and accelerate healing.

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