Giant Cementifying Fibroma: A Case Report

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Summary

Although the literature contains numerous reports on ossifying and cementifying fibromas, only 4 cases of multiple occurrence of this lesion were reported. A case giant cementifying fibroma of both maxillae and both sides of mandible is reported because of its multiple site involvement and recurrence. Aetiology, clinical features, management are discussed.

Key words: Cementifying Fibroma, Multiple Jaw tumour

Introduction

Cementifying fibroma accounts a slow growing benign neoplasm commonly involving mandible for approximately 2% of odontogenic tumours. Some lesions behave aggressively. A case of giant cementifying fibroma involving multiple sites of both jaw is report.

Case Report

A 23-year-old male presented with the complaint of painless swelling on the right side of the upper jaw and left side of the lower jaw of one year duration. Swellings were gradually increasing in size. Patient was operated two times earlier for the swelling in the left side of the lower jaw; 3 years and 1 year ago. Histopathology report was suggestive of Cementifying Fibroma. After second operation patient remained symptom free for 1 year, later developed swellings in the right side of the upper jaw and left side of the lower jaw. There was no nasal obstruction or proptosis.

There was a hard, non-tender swelling in the right upper gingivo-buccal sulcus extending from right central incisor to first molar region (Fig 1). Another hard, non tender swelling was present in the left side of the mandible extending from left lateral incisor to left 2nd molar, expanding both tables of the mandible.

Radiological examination (Fig 2) and CT Scan revealed lesions present on both maxillae and both sides of mandible (Fig 2 & 4). Lesion in the right maxilla was extending upto pterygoid plates. There was no orbital extension. Alkaline phosph...
Fig 2. Orthopantomogram revealing floating teeth within maxillary and mandibular lesion

Fig 3. CT Scan (axial cut) of mandible showing large lytic expansile lesion with flakes of calcification on left side. Small lesion is seen as the right side.

Fig 4. CT Scan (axial cut) showing a large space occupying lesion of right maxilla causing irregular destruction of medial wall and a few areas of calcification within it. Medial wall of the maxilla on left side shows widening and sclerosis.

Phosphate, serum calcium and other routine investigations were within normal limits.

Patient was operated under general anesthesia. Left side mandibular tumour was exposed through left sub-mandibular incision. Tumour was extending from midline to angle of mandible with intact inferior border. Tumour was excised completely. Tumor in the parasympyseal region and body of right side of mandible was excised through right submandibular incision. Right maxillary tumour was exposed by external approach and tumour occupying the whole maxillary antrum was excised completely. Orbital floor was intact. Left maxillary tumour was excised through labial sulcus incision. Post-operative period was uneventful.

Discussion

In 1842 Menzel first described the entity known as ossifying fibroma. Classification of cementifying fibroma, ossifying fibroma and cemento-ossifying fibroma is often subjective and based on the preponderance of cementum like material or osteoid products within the fibrous connective tissue stoma. The aetiology remains unknown. It is suggested that these lesions arise from multipotent mesenchymal blast cells present in the periodontal membrane that have the capacity to produce cementum, alveolar bone and fibrous tissue. Lesion exceeding 2x2 cm in size are arbitrarily defined as giant fibro-osceous lesions. These are benign neoplasms. Treatment is enucleation. Recurrence is rare.

In our case, in spite of tumour being benign in nature, it recurred twice and involved both maxillae and both side of the mandible. Clear demarcation between the tumour and surrounding structures enabled the removal of the tumour completely despite its size and multiple site involvement.

References


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