



CAPILLARY LOBULAR HEMANGIOMA OF PALATE – A RARE ENTITY

Dr. Anshul Singla¹, Dr. Uma Garg², Dr. Balwan Biddu³

¹Senior Resident, Department of Otorhinolaryngology, BPS Government Medical College,
District Sonapat, Haryana, India.

²Professor and Head, Department of Otorhinolaryngology, BPS Government Medical
College, District Sonapat, Haryana, India.

³Medical Officer, Department of Otorhinolaryngology, BPS Government Medical College,
District Sonapat, Haryana, India.

Article Received on 24/07/2015

Article Revised on 15/08/2015

Article Accepted on 06/09/2015

***Correspondence for**

Author

Dr. Anshul Singla

Senior Resident,
Department of
Otorhinolaryngology, BPS
Government Medical
College, District Sonapat,
Haryana, India

ABSTRACT

The hemangiomas and pyogenic granulomas of oral cavity are a common occurrence, with the most common sites involved being cheeks, lips and buccal mucosa for hemangiomas and gingiva for pyogenic granulomas. But the occurrence of such lesions on palate are a rare entity. The present case has been reported to understand the diagnostic dilemma of such unusual occurrence.

KEYWORDS: hemangioma, capillary lobular, pyogenic granuloma.

INTRODUCTION

Hemangioma has always been a very widely used term in medical literature, referring to a variety of different benign vascular anomalies, which comes along with the massive confusion in the nomenclature of these lesions.^[1,2] Based on the histological appearance, they can be classified as – capillary, cavernous and mixed hemangiomas. A sclerosing variety may also be present.^[3] Some authors have suggested terms like pyogenic granuloma also.^[4]

Although hemangiomas are a common lesion of head and neck region, the most common site of occurrence are lips, cheeks and tongue. Pyogenic granulomas of the oral cavity commonly involve the gingiva.^[5] Both the lesions are rare on palatal mucosa.

The term 'pyogenic granuloma' is a misnomer as there is no pus formation and there is no histological presentation of a granuloma.^[6] So, the better histological term would be a 'lobular capillary hemangioma'.^[7]

The differentiation between a capillary hemangioma and a pyogenic granuloma is somewhat unclear. The main tool for diagnosis remains histopathology.

CASE REPORT



Figure 1 : solitary growth behind upper incisors

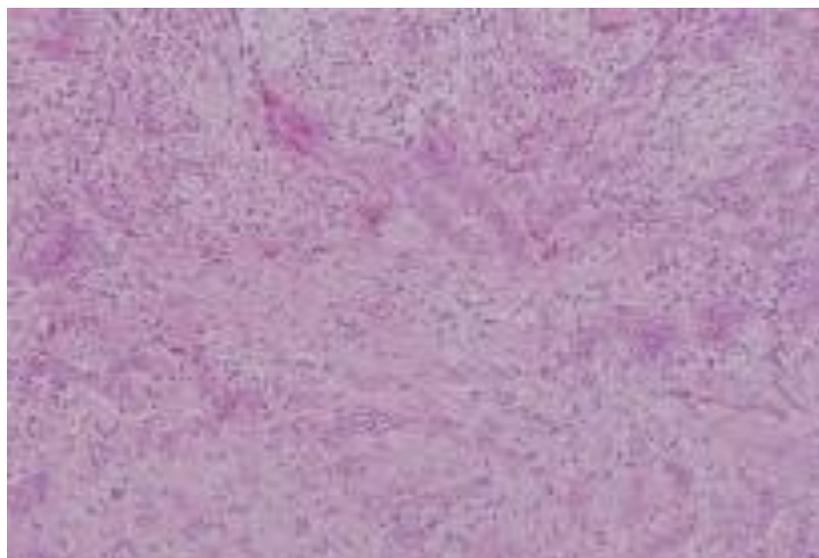


Figure 2: photomicrograph

A 11 year old male patient presented to the department of Otorhinolaryngology with a swelling behind upper central incisors. The swelling was of 2 weeks duration. Initially, the swelling was peanut sized, and has grown to the present size in 2 weeks . The swelling was

not painful. There was no history of bleeding. The patient noticed the swelling incidently as it caused foreign body sensation on chewing. There was no associated lymphadenopathy. The medical history was unremarkable.

On examination, the swelling was solitary, about 2 cm x 2 cm in size, spherical, with distinct borders, situated behind upper central incisors. The surface was irregular. The surrounding palatal mucosa was normal. The colour of the swelling was reddish blue. On palpation, it was firm in consistency and did not bleed on touch. There was blanching on pressure. (figure 1)

The occlusal and panoramic radiograph showed no loss of bone in relation to the lesion. A provisional diagnosis of capillary hemangioma was made.

Under aseptic conditions, excision of the lesion was done with wide margins, under monitored anaesthesia care (MAC). The lesion bled minimally on excision. The sample was sent for histopathological examination.

The histopathological report showed the presence of edematous granulation tissues with numerous small blood vessels and neutrophil infiltration. The lesion was reported as 'capillary lobular hemangioma'. (figure 2). The post operative follow up of the patient was uneventful and showed good healing of the wound.

DISCUSSION

Hemangiomas are common soft tissue tumours, composed of blood vessels. They are often congenital or develop in the neonatal period. They constitute 7 % of all benign tumors in infancy and childhood.^[4]

4-10% of Caucasian new born infants have hemangiomas, with a 3-5 fold increased incidence in females.^[10] A lower incidence is seen in dark skinned infants.^[11]

The hemangiomas of head and neck region are relatively common, but their occurrence in oral soft tissues is relatively rare.^[5] In oral cavity, hemangiomas commonly occur on lips, cheeks and tongue.^[10] Pyogenic granulomas occur more commonly on gingiva. The palatal occurrence of these lesions is extremely rare.^[10]

A pyogenic granuloma usually appears suddenly. A history of trauma may be present, but is usually missed as the patient is mostly a child, though adults may also be affected.

It may be associated with a portwine vascular birthmark, either intraorally or extraorally.

On histological basis, the term capillary lobular hemangioma has been given to pyogenic granulomas.^[7] Thus, a histological assessment is most important to come to a definitive diagnosis.

Hemangiomas may mimic other lesions clinically, histologically or radiologically, making the clinical diagnosis quite challenging. The various differential diagnosis include pyogenic granuloma, epulis, telangiectasia, Kaposi's sarcoma, squamous cell carcinoma and metastatic carcinoma.^[11]

X ray must be done to rule out any bony destruction, which is suggestive of either malignancy or central variety of hemangioma.^[7]

The various treatment modalities include curettage, embolisation and use of sclerosing agents, ligation and excision, artificial ulceration, electrolysis and thermocautery, radiation and compression depending on the clinical features and anatomical considerations.^[12,13]

Current management includes spontaneous involution, steroid therapy and chemotherapy.^[8]

The clinical diagnosis due to such presentation and resemblance to other conditions becomes a real challenging task.

Our case included a small lesion, which was limited and showed no bony invasion radiologically. A provisional clinical diagnosis of capillary hemangioma turned to be 'capillary lobular hemangioma' on histopathology. Treatment was done by simple excision. The follow up of the patient was done for 6 months. The wound showed complete healing and post operative period was uneventful.

CONCLUSION

The unusual presentations of hemangiomas should be kept in mind, along with the various differential diagnosis, to help making an accurate clinical diagnosis. The important role of histopathology cannot be overlooked, as the final diagnosis can be made only after a complete microscopic examination.

REFERENCES

1. Mueller BU, Mulliken JB. The infant with a vascular tumour. *Semin Perinatol* 1999; 23: 332-40.

2. Hand JL, Frieden IJ. Vascular birth marks of infancy: Resolving nosologic confusion. *Am J Med Genet* 2002; 108: 257-64.
3. Bharti V, Singh J. Capillary hemangioma of palatal mucosa. *J Indian Soc Periodontol* 2012; 16: 475-8.
4. Schoen FJ, Vessels B. In: Robbins and Cotran: Pathological basis of disease. 7th ed. Kumar V, Abbas AK, Fausto N, editors. 2004; 511–54.
5. Rachappa MM, Triveni MN. Capillary hemangioma or pyogenic granuloma: A diagnostic dilemma. *Contemporary Clinical Dentistry*. 2010; 1(2): 119-122.
6. Shafer WG, Hine MK, Levy BM. *A Textbook of Oral Pathology*. 4th ed. Philadelphia: WB Saunders, 1983; 359–60.
7. Patil K, Mahima VG, Ambika L. Extralingival pyogenic granuloma. *Indian J Dent Res*. 2006; 17: 199–202.
8. Mulliken JB. Cutaneous Vascular Anomalies. In: McCarthy JG, editor. *Plastic Surgery: Tumors of Head and Neck and Skin*. Vol. 5. Philadelphia: B Saunders Company Ltd; 1990; 3194–230.
9. Murthy J. Vascular anomalies. *Indian J Plst Surg*. 2005; 38: 56–62.
10. Mehrotra MC. Capillary hemangioma of hard palate: A case report. *J All India Dent Assn*. 1965; 37: 11–2.
11. Wood NK, Goaz PW. *Differential diagnosis of oral and maxillofacial lesions*. 5th Ed. Missouri: Mosby; 1997; 549–50.
12. Chin DC. Treatment of maxillary hemangioma with a sclerosing agent. *J Oral Surg*. 1983; 55: 247–9.
13. Greene LA, Freedman PD, Friedman JM, Wolf M. Capillary hemangioma of the maxilla. *Oral Surg Oral Med Oral Pathol*. 1990; 70: 268–73.