MANAGEMENT OF ERUPTION HEMATOMA IN A 7 YEAR OLD CHILD

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Abstract:
Eruption hematoma is usually associated with an erupting primary or permanent tooth which is in its soft tissue eruption phase i.e through the bone. It is mostly associated with delayed eruption. It is of clinical significance as the knowledge among general dentists is very essential regarding this developmental disturbance to reach a correct diagnosis and management. We are reporting a case of eruption hematoma in a 7 year old child.

Key words: eruption hematoma, delayed eruption.

INTRODUCTION

An eruption cyst or ‘eruption hematoma’ is in fact a dentigerous cyst occurring in the soft tissues. The pathogenesis is probably very similar to that of the dentigerous cyst. The only difference is that the tooth in the case of eruption cyst is impeded in the soft tissue of gingiva rather than in the bone. The presence of particularly dense fibrous tissue in the overlying gingiva could be a possible factor of pathogenesis. These cysts are found in children of different ages, and occasionally in adults in case of delayed eruption. Deciduous and permanent teeth may be involved, most frequent involvement is seen in anterior to the first permanent molar region. Clinically, lesion appears as a circumscribed, fluctuant and often translucent swelling of the alveolar ridge over the site of the erupting tooth. When the circumcoronal cystic cavity contains blood, the swelling appears purple or deep blue then it is termed as eruption hematoma.¹

CASE REPORT

A 7 year old girl reported to the Department Pedodontics and Preventive Dentistry, with a chief complaint of swelling on the upper front teeth region and mobility with the adjacent tooth since 5 days. Clinical examination revealed mobility with upper left deciduous central incisor (61) and clinically missing left primary lateral incisor (62). A 1 x 1 cm dome shaped raised swelling in the region of maxillary left lateral incisor and, which was bluish-brown in color, asymptomatic. (Figure1&2).
Occlusal view of maxillary arch shows the extent of swelling and presence of overretained 61. Intra oral periapical radiograph showed a soft tissue covering the erupting tooth (Figure 3). Based on the history and clinical findings a diagnosis of eruption hematoma was made.

After explanation of the condition to the parents. The patient was referred for routine hemogram which turn out to be normal and the patient was recalled for excision and removal. Surgical exposure was carried out to expose the erupting tooth and extraction to the deciduous central incisors 61 was extracted under local anaesthesia and eruption hematoma was excised (figure 4 & 5).

Pressure pack was given for 10 minutes to stop the bleeding and operated area was then reviewed. The excised lesion was send to oral pathology laboratory, report confirm the diagnosis of eruption hematoma. Recalled to review the eruption status of 22. After 2 month follow up 21 was erupting and adjacent area of 22 is

Figure 1: Preoperative Frontal view of teeth in occlusion

Figure 2: Occlusal view of maxillary arch showing bluish color swelling in left lateral incisors area.

Figure 3: Intra oral periapical radiograph showed a soft tissue covering the erupting tooth.

Figure 4: After extraction of central incisor (21)

Figure 5: After excision of hematoma
healed properly (figure 6&7). Intraoral radiograph showed 22 is following the path of eruption.

![Figure 6: 2 month follow up](image)

Figure 6: 2 month follow up

![Figure 7: Intra oral radiograph after 2 month follow up.](image)

Figure 7: Intra oral radiograph after 2 month follow up.

DISCUSSION

The prevalence of eruption cyst (EC) may be low due to the fact that many authors classify them among the dentigerous cysts. In addition, since they are benign, there are few studies in which the authors have done a definitive diagnosis using biopsy. Most often the dentist sees only symptomatic eruption cysts and the majority resolve unnoticed. EC most commonly are found in the mandibular molar region. The color of these lesions can range from normal to blue-black or brown, depending on the amount of blood in the cystic cavity. The blood is seen secondary to trauma. If trauma is intense, these blood-filled lesions sometimes are referred to as eruption hematomas. Most EC occur in the age group of 6-9 years, with the eruption of permanent first molars and incisors. In the present case the eruption cyst was found associated with permanent lateral incisor. Clinically, it appears as a dome shaped raised swelling in the mucosa of the alveolar ridge, which is soft to touch and the color ranges from transparent, bluish, purple to blue-black. Most often, eruption cysts are found to be asymptomatic but there can be pain on palpation due to secondary factors such as trauma or infection. Pain was reported as a secondary factor.

The eruption hematoma occurs because of bleeding from the gum tissue during eruption and the accumulation of blood is external to the epithelium of the enamel. While in the eruption cyst, it is the cystic fluid that mixes with the blood. The eruption cyst glows under transillumination but the hematoma does not glow. The exact difference between the two is still unknown. Other authors reported that if bleeding occurs within the cyst, due to trauma or local infection, the eruption cyst becomes bluish in color and is then known as an eruption hematoma, or a blue
stain, which may be the first sign of a follicular cyst. Interventional treatment may not be necessary because the cyst ruptures spontaneously, thus permitting the tooth to erupt. If this does not occur, simple excision of the roof of the cyst generally permits speedy eruption of the tooth. Simple incision or partial excision of the overlying tissue to expose the crown and drain the fluid is indicated when the underlying tooth is not erupting or the cyst is enlarging. The recall showed eruption of the 21 and the lesion was healed. Intraoral radiograph shows the 22 is following the path of eruption.

REFERENCES

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