INTRODUCTION:
Peripheral ossifying fibroma (POF) is a non-neoplastic enlargement of the gingival, which is one of the main benign, reactive hyperplastic inflammatory lesions of the gingiva occurring in young adults. It has a very high recurrence rate of around 7-45%. For this reason, a longer patient follow-up is very important in POF. Peripheral ossifying fibroma comprises about 9% of all gingival growths. POF has similar clinical presentations with different lesions which makes it difficult to reach at a correct diagnosis. In this article, we are reporting a case of peripheral ossifying fibroma (POF) in a 16-year-old female patient.

CASE REPORT:
A 16-year-old female patient reported to the Department of Periodontology, People’s college of dental sciences and research centre, Bhopal, India with the chief complaint of gingival overgrowth behind her left side lateral incisor and canine.

There was no pain reported by the patient. Patient complained of occasional bleeding from the overgrowth during tooth-brushing. The gingival overgrowth was asymptomatic, non-ulcerated and overlying mucosa was also appeared normal. There

Figure 1: Intra-oral view

Figure 2: Measurement of lesion

ABSTRACT:
Peripheral ossifying fibroma (POF) is a non-neoplastic enlargement of the gingival, which is one of the main benign, reactive hyperplastic inflammatory lesions of the gingiva occurring in young adults. It has a very high recurrence rate of around 7-45%. For this reason, a longer patient follow-up is very important in POF. Peripheral ossifying fibroma comprises about 9% of all gingival growths. POF has similar clinical presentations with different lesions which makes it difficult to reach at a correct diagnosis. In this article, we are reporting a case of peripheral ossifying fibroma (POF) in a 16-year-old female patient. Key Words: Fibrous hyperplasia, Peripheral ossifying fibroma, Peripheral giant cell granuloma, Pyogenic granuloma

was no significant medical history and no other immediate family member had any similar sort of a problem. There was no past dental history and habit history (chewing tobacco or smoking cigarette).

**Investigations:**
Pre-operative orthopantamograph (OPG) was performed (figure 3).

**Figure 3:** Pre-operative OPG

OPG revealed no interdental bone loss. Blood investigations including bleeding time, clotting time and random blood glucose level were recorded before the treatment. They were found to be within normal range. Excisional biopsy of the excised lesion was done for histopathological findings.

**Differential Diagnosis:**
On the basis of clinical findings, a differential diagnosis of Peripheral ossifying fibroma. Pyogenic granuloma, Peripheral giant cell granuloma, Peripheral giant cell granuloma, and Fibrous hyperplasia were made. On histological examination of biopsy specimen showed a) high degree of cellularity b) Parakeratinized stratified squamous epithelium overlying connective tissue stroma. c) Calcifications in the hypercellular fibroblastic stroma. Based on history, clinical presentation and histopathological examination, the gingival overgrowth with respect to 22 and 23 regions confirmed as peripheral ossifying fibroma (POF).

**Figure 4:** Histophotograph showing calcifications in hypercellular fibroblastic fibroma

Calcifications in the hypercellular fibroblastic fibroma is the classical histopathological feature which differentiate POF from other fibrous proliferations. [5]

**Treatment:**
The patient had gone for conservative surgical excision under local anaesthesia (figure 5).

**Figure 5:** Surgical excision

Through scaling and root planning was done before performing the surgery. Also informed consent was taken from the patient before the start of the surgery. Surgical curettage was performed after excision of the lesion. Once stoppage of bleeding occurred, suturing was done followed by periodontal dressing. Patient was prescribed pain killer, antibiotic, and chlorhexidine mouthwash.

**Outcome and Follow-up:**
Since POF has fairly high recurrence rate, regular follow-ups were arranged (at 1 week, 1 month, 3 month, 6 month, 1 year and 2 year interval) to rule out any recurrence. Healing was uneventful. No Postoperative complications were found.

**DISCUSSION:**
Since the late 1940s, intraoral ossifying fibroma has been described.[6] Many synonyms have been given till date. Some of the important ones are Peripheral fibroma with calcifications, peripheral ossifying fibroma, epulis, calcifying fibroblastic granuloma, peripheral cementifying fibroma, peripheral fibroma with cementogenesis and peripheral cement-ossifying fibroma.[6] The term POF and PODF should be mixed, PODF is a rare counterpart of central odontogenic fibroma.[7] In North America, PODF is still used as a synonym for POF by many because they think that PODF is derived from periodontal ligament and hence to be odontogenic.[7] The POF is more commonly seen in young females than males.[8] Female to male ratio varies from 2:1 to 3:2 and the common site of occurrence for POF is anterior to molars in both maxilla and mandible.[9] Etiological factors for POF...
are trauma and irritation, mainly due to the calculus and plaque deposition around the lesion.\textsuperscript{[10]} In 3.8% of cases performed by Buchner and Hansen, POF was found to be associated with an orthodontic appliance.\textsuperscript{[11]} POF represents up to 2% of all oral lesions that are biopsied.\textsuperscript{[12]} Surgical excision with deep and peripheral margins including both periodontal ligament and the affected periosteal component.\textsuperscript{[12]} In addition to surgical resection elimination of surrounding plaque and calculus should also be considered with utmost care and precision.

**REFERENCES:**

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**Conflict of interest:** None declared