MAVEN

CASE REPORT

RIGA FEDE DISEASE- A CASE REPORT

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ABSTRACT:

Riga Fede disease is a reactive mucosal disease as a result of repetitive trauma to the tongue by the anterior primary teeth during forward and backward movement. The nature of the lesion is relatively benign. The history and clin- ical features are most often so typical that there is seldom a need for addi- tional histopathological examination. Riga Fede disease can most often be treated with conservative measures only. Here we present a case of a 1- month-old infant with a natal tooth and an ulcerated lesion on the ventral surface of the tongue, leading to the clinical diagnosis of Riga- Fede Disease. (2017, Vol. 01; Issue 01: Page 46 - 49)

Keywords: Riga fede disease, natal tooth, tongue.

INTRODUCTION:

The eruption of the first primary teeth starts on average around six months. The presence of teeth at birth or within a month after deliv- ery is rare. In most cases these are not supernumerary teeth, but regu- lar primary teeth. Exact etiology of natal and neonatal teeth is not known. Some hypotheses are dom- inant autosomal inheritance; endo- crine disturbance resulting from pi- tuitary, thyroid, and gonads; exces- sive or increased resorption of over- lying bone resulting in early teeth eruption; poor maternal health, en- docrine disturbances, febrile epi- sodes during pregnancy and con- genital syphilis. The presence of the lower incisors at birth may lead to the possibility of swallowing and as- piration and the development of Riga-Fede Disease (RFD) (1). Riga- Fede disease is a chronic, benign, ulcerative granulomatous process that occurs as a result of continu- ous trauma on the ventral surface of the tongue most commonly

caused by neonatal or natal teeth in new born. It may also be associated with repetitive tongue thrusting habits in older infants after the eruption of primary lower incisors. This condition has also been re- ported in children with familial dysautonomia. The lesion was first described by Antonio Riga, an Italian physician in 1881. In 1890, Fede published the first histological studies. Subsequently, it was called as "Riga-Fede disease" (RFD). This condition may interfere with proper feeding which, in turn, may pose potential risks to infants due to nu- tritional deficiency. Intra-oral tu- mours in infancy often cause distress in both parents and doctors (2). The differential diagnosis includes several serious and potential lethal diseases, but also relatively benign disorders. It is important that professionals are able to recog- nize the injury and RFD's causal agent so that a proper assessment, diagnosis, and treatment can be performed. Consequently, proper dental management for these pa- tients must be considered (3). This report aims to present the occur- rence of Riga-Fede Disease associ- ated with a natal tooth and the treatment approach in a 1-month- old infant.

Fig 1: Intraoral view

Fig 2: Extracted natal tooth

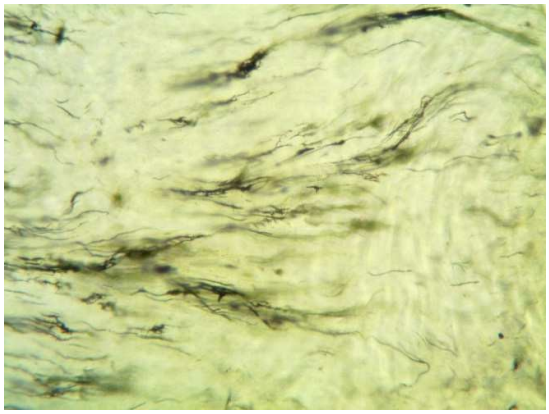

Fig 3: Photomicrograph of the na- tal tooth (20X magnification)

CASE REPORT:

A one month old patient came to the department due to an ulcerative swelling present on the ventral side of the tongue. Mother complained that the tooth was making breast- feeding difficult, irritating the infant who could not manage to suck and then cries continuously. The medical history did not reveal any abnormalities and the patient did not use any medication at present. In- traoral examination revealed one natal tooth in the mandibular ante- rior region and an ulcerated lesion on the ventral surface of the tongue (Fig 1). The lesion had a diameter of approximately 8 mm and was lo- cated at the midline in anterior por- tion of the ventral surface of the tongue and had the impression of the tooth on its centre due to repet- itive trauma resulting from raking movements of the tongue against the anterior natal teeth leading to the clinical diagnosis of Riga-Fede Disease. The tooth was extracted and the lesion was seen to have re- solved completely when the patient was recalled after 15 days (Fig 2). The extracted tooth was also subjected to histopathological exami- nation (Fig 3).

DISCUSSION:

Riga Fede disease is a reactive traumatic mucosal disease character- ized by persistent ulceration of the oral mucosa. It develops as a result of repetitive trauma of the tongue by the anterior primary teeth dur- ing forward and backward move- ment (4, 5). A broad variety of terms have been used to describe Riga Fede disease, such as eosinophilic ulcer of the oral mucosa, sublingual fibrogranuloma, sublingual growth in infants, sublingual ulcer, repar- ative lesion of the tongue, (neonatal) lingual traumatic ulceration, trau- matic atrophic glossitis, and trau- matic granuloma of the tongue (6). In 1983, Elzay coined the term 'traumatic ulcerative granuloma with stromal eosinophilia' (TUGSE) for those chronic ulcerative lesions of the oral mucosa that histopatho- logically consist mainly of eosino- phils. As TUGSE and Riga Fede dis- ease have the same histologic features and are often associated with a history of trauma, it was sug- gested by Elzay that they might be considered as one entity. Although TUGSE has been mainly reported to occur in late adulthood and not re- stricted in location to the tongue, it may occur in the buccal mucosa, the vestibule, gingiva, or palate. Riga Fede disease is almost exclu- sively restricted to the tongue (2). Once the clinician is familiar with the diagnosis Riga Fede disease, the history and clinical features are most often so typical that there is seldom a need for additional histo- pathological examination (7).

CONCLUSION:

In conclusion, Riga Fede disease is a benign reactive mucosal disease as a result of repetitive trauma of the tongue by the anterior primary teeth during forward and backward movement. Several treatments for Riga Fede disease have been de- scribed, all of which aim to elimi- nate the source of trauma so healing can take place. It is preferably to start treatment conservatively such as smoothening off the incisor edges, covering the rough incisor edges with composite resin, chang- ing feeding habits by using a bottle with a larger hole in the nipple,

placing a nasogastric tube, or re- lieving symptoms by application of a local corticosteroid. If conserva- tive methods fail to resolve the le- sion or when the child is severely dehydrated or malnourished, ex- traction of the incisors might be considered. Alternatively, excision of the lesion itself might be per- formed (8, 9).

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