Traumatic ulcer or squamous cell carcinoma of the tongue? : Case report.

1Dr. Syed Ishaquddin*, 2Dr.Dalaya Maya , 3Dr.Mahesh Ghadage

1 Associate Professor, Dept.of Oral Pathology , Bharati Vidyapeeth Dental College , Navi Mumbai , India.
2Professor, Dept.of Prosthodontics , Bharati Vidyapeeth Dental College , Navi Mumbai , India.
3PG Student, Dept.of Prosthodontics, Bharati Vidyapeeth Dental College , Navi Mumbai , India.
*Corresponding author: Dr. Syed Ishaquddin

Abstract:
Ulcers commonly occur in the mouth. Their causes range from minor irritation to malignancies and systemic diseases. Innocent solitary ulcerations, which result from trauma and infections, must be distinguished from squamous cell carcinomas, which also typically present as solitary ulcers. Clinical criteria which are most useful in identifying the cause of oral ulcers are vesicles or bullae, which may not be seen because they rupture rapidly in the oral environment; constitutional signs and symptoms; and lesions on the skin and/or other mucosa. We reported a case of 75 years old female patient with a ulcerative lesion which was quite confusing either it was traumatic ulcer or squamous cell carcinoma?

Key words: Oral ulcers, gingival ulcers, mucosal ulcerations.

Introduction:
Traumatic ulcer is usually a single lesion with erythematous, non-everted margins and with a clean base covered with a pseudomembrane. They are usually painful and occur due to bite or trauma from sharp teeth or ill-fitting dentures. They disappear in 7–10 days following elimination of the cause. If there is any clinical suspicion, a BIOPSY is indicated.

Traumatic ulcerative granuloma with stromal eosinophilia is known by a number of other names, including traumatic granuloma, eosinophilic ulcer and eosinophilic granuloma of the tongue (7-9). (This condition is not related to eosinophilic granuloma of the bone as in Langerhan cell histiocytosis.) This is a reactive, self limiting condition of the oral cavity. It occurs most commonly by far on the dorsal and lateral tongue, followed by the lips and buccal mucosa (7-9).

Acute trauma in the form of a sharp puncture to the muscle is the main cause, but occasionally a history of trauma is absent and the etiology is unknown (7-9). The source of trauma can be a sharp tooth, a sharp filling, an ill-fitting partial denture, or a physical sharp bite (which may or not be due to a neurological disorder). Dorsal tongue TUGSE is usually due to trauma from the maxillary incisors or sharp Cusps of the posterior teeth.

Histologically, these ulcers are deep lesions involving the underlying muscle, which may explain the process of slow healing and the tissue eosinophilia. Healing may take up to eight weeks. Eosinophils are found in areas of muscle damage. The treatment of choice is surgery but elimination of the causative factor should come first, such as the filing of sharp teeth, the replacement of broken fillings, the use of a thin mouth-guard, or whatever else is necessary. Conservative surgical removal with clean margins is the treatment of choice. Sometimes, an incisional biopsy may lead to complete recovery, other times; it may recur and require further surgery with clean margins (7-9). Intra-lesional corticosteroid injections have been recommended for recurring ulcers (7) but with a mixed outcome. The overall prognosis is good if diagnosed early & treated early.
Case report:
We presented a case of 75 year old patient reported two weeks ago with a complaint of non healing ulcer and pain while eating on the left border of the tongue,since last one month . The patient had history of habits including Pan chewing with tobacco & betel nut approx. 5 to 10 times a day from last 20 to 30 years. Now she reported complaints ulcer with pain during eating along with throat pain, otalgia, dysphagia, odynophagia since one month.
On careful examination a definite ulcerative lesion 2 X1 cm in size, on the Left Lateral border of the tongue coming in contact with the sharp posterior teeth, which also shows attrition due to betel nut chewing . The margins of the ulcer were elevated showing rough base and cauliflower like appearance. No cervical lymph-node Enlargement. Base of the tongue and throat were normal.No other intra oral lesion detected.

Investigations:
Complete Blood Count –Normal
Liver function test-Normal
Blood sugar level-Normal
X ray chest -Normal
Sonography of head and neck region-Normal
CT scan of the neck and lungs -Normal.

Diagnosis:
Ulcers occur in the mouth with considerable frequency. Traumatic lesions usually resolve rapidly and are not seen by clinicians. For relatively common conditions such as recurrent herpetic vesiculo ulcers and aphthous ulcers, presumptive diagnoses are often made without recourse to laboratory tests. While the diagnosis of some types of oral ulcers is facilitated by their association with constitutional signs and symptoms or lesions on the skin and/or other mucous membranes, ulcers which are localized to the oral cavity may be more difficult to identify.

Most traumatic oral ulcers can be identified by their association with an identifiable mechanical, chemical, thermal or radio therapeutic cause. They may be single or multiple, symmetrical or irregular in shape, and are usually painful. Most are of recent onset, but some are chronic. Acute traumatic ulcers have a removable, yellow-white base and erythematous borders. Chronic traumatic ulcers may be non-painful with an indurated base and raised borders; consequently, they may be indistinguishable from squamous cell carcinomas on the basis of their clinical features.

Treatment:
Following treatment outline was planned.
1)…Oral prophylaxis
2)…Correction of sharp cusps of lower left molar and premolar teeth
3)…Anti oxidant and multivitamins
4)…Topical application of astringent gel
5)…Anti bacterial mouth wash
6)…Reassurance and follow up
1. BEFORE TREATMENT

2. AFTER TREATMENT

Prosthodontic consideration:

1. Any tongue ulcerative lesions caused either due to trauma from an overextended denture (complete or partial dentures) is of utmost importance to be considered in the diagnosis of the tongue lesion.
2. Any faulty clasp design can lead to ulcerative lesions on the lateral border of the tongue can be misleading to precancerous lesion.
3. Continuous trauma from sharp cusps of the teeth or faulty design of complete or the partial denture can lead to the ulcers of the tongue.

Precautions:

1. Hence during denture insertion the extension of the denture should be carefully examined and relived properly.
2. If any sharp cusps of the teeth existing, should be rounded off and smooth.
3. Discontinuation of the prosthodontic appliance till the lesion is heal.

Conclusion:

The various types of oral ulcers may appear clinically to be very similar. Features which are helpful in identifying the cause of ulcers are the associated constitutional signs and symptoms, presence of lesions on the skin and/or other mucosa, and the presence of bullae and vesicles.

In some cases, however, laboratory procedures are required to make the diagnosis. Biopsy is necessary in the management of several of these conditions, especially in multiple ulcers due to autoimmune diseases.

References:


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