



Letter to the editor

An ulceration on the tongue: A case report



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Background

Among cancers with the highest incidence, oral cancer has one of the worst prognoses when diagnosis is delayed [1]. The most common malignancy of the head and neck is Oral Cavity Squamous Cell Carcinoma (OCSCC) [2] and its stage at diagnosis remains an important prognostic indicator for predicting patient survival [1]. Oral lesions precede these OCSCC [3] but the clinical form of early carcinoma can appear as a benign oral lesion and care may, therefore, be delayed dramatically. In this context, any persistent ulceration of the oral mucosa or tongue requires special attention and referral to a dentist for assessment and follow-up.

Case report

A man in his 70s suffering from multiple myeloma presented with a 5-month history of oral pain and difficulty in oral intake. He was referred to the oral medicine department by his haematologist for oral evaluation and management. He was receiving treatment by lenaleomide, dexamethasone and valaciclovir at the time and had no history of medication associated with oral ulcers. Five months earlier, following the placing of a prosthetic dental restoration, a persistent ulcer had developed on the left edge of his tongue and was still present. On intraoral examination, a single, painful, small punctiform fibrinous lesion with mild keratosis halo was found on the left free edge of the tongue (Fig. 1). The whole lesion appeared smooth and superficial. No induration in depth was detected on palpation. The rest of the oral mucosa had a subnormal aspect. Cervical palpation was normal. As far as his overall health was concerned, the man was afebrile and was a non-smoker and non-drinker. Recent biological assessment was normal. A biopsy was performed at three cross sections. The lesion was covered by Malpighian epithelium that was the site of ulceration coated with fibrinous leukocytic exudate. Cytonuclear atypia were visible over the whole height of this epithelium: mitoses and troubles of cell architecture (Fig. 2). P16 immunostaining was negative. OCSCC was diagnosed and clinically classified as stage T1 N0 M0 oral squamous cell carcinoma of the tongue in a patient without any history of smoking. It was well differentiated, keratinizing, 8 mm long and 1 mm thick. Imagery assessment did not find any metastatic lesion. A partial

glossectomy was performed with sentinel lymph node biopsy procedures. The edges of the resection were healthy, with an inferior minimum margin of 4 mm. The sentinel lymph node was examined microscopically at three section levels and an immunohistochemical study using anti-AE1/AE3 antibody was negative, with absence of invasive carcinomatous lesions.

Discussion

High-risk sites for development of OSCC include the lateral or ventral tongue and floor of mouth, but it may affect any intraoral surface [4,5]. OCSCC often presents as a non-healing ulcer but can also present as inhomogeneous leucoplakia and/or red patch [4]. Two other differential diagnoses may be suggested because of clinical similarities. First, pain reported by the patient could be considered as a consequence of a trauma. For example, the presence of a sharp segment of a tooth would be very strongly suggestive of a traumatic lesion. Ulceration, at a very early stage and with few specific characteristics, is easy to confuse with such a lesion. The characteristic white halo of a traumatic lesion is due to the generation of keratin filaments through chronic irritation [4]. Oral traumatic lesions typically reduce or resolve within 3–4 weeks once the causative agent is suppressed [4]. Aphthous stomatitis, a very common oral disease, is the second differential diagnosis [6]. The key to correct diagnosis of aphthous stomatitis is the appearance of round, symmetric ulcers covered with pseudomembrane and surrounded by an erythematous halo, and, generally, healing within 2 weeks, and the recurrent nature of the ulcers [6].

Overall, this case outlines the importance of considering OCSCC in the differential diagnosis of persistent progressive lesions that are unresponsive to medical and/or dental treatment.

More generally, the incidence of this cancer has been increasing, notably in younger patients, and the oral tongue is involved in this type of cancer [5,7]. It is fundamental to recall the notion of follow-up for a lesion/ulceration of the oral mucosa. This earlier detection can be expected to lead to a marked improvement in overall survival patterns. The need remains for early detection within the context of routine oral examinations and evaluation of any clinical abnormalities noted.

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Fig. 1. A non-removable white lesion on the left lateral surface of the tongue.

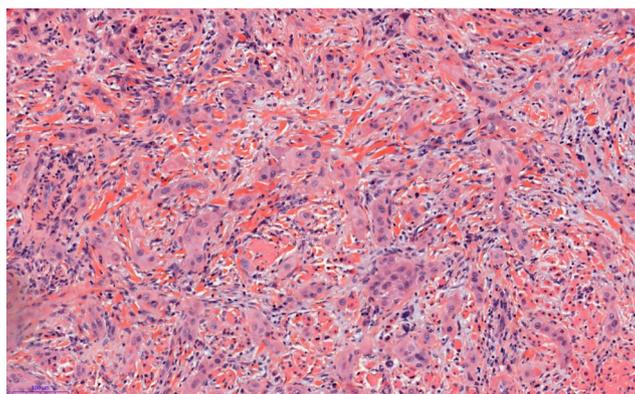


Fig. 2. Histologic image showing cytonuclear atypia: mitoses and troubles of cell architecture haematoxylin-eosin).

Declaration of Competing Interest

None.

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