Common Lesions and Conditions of the Oral Cavity

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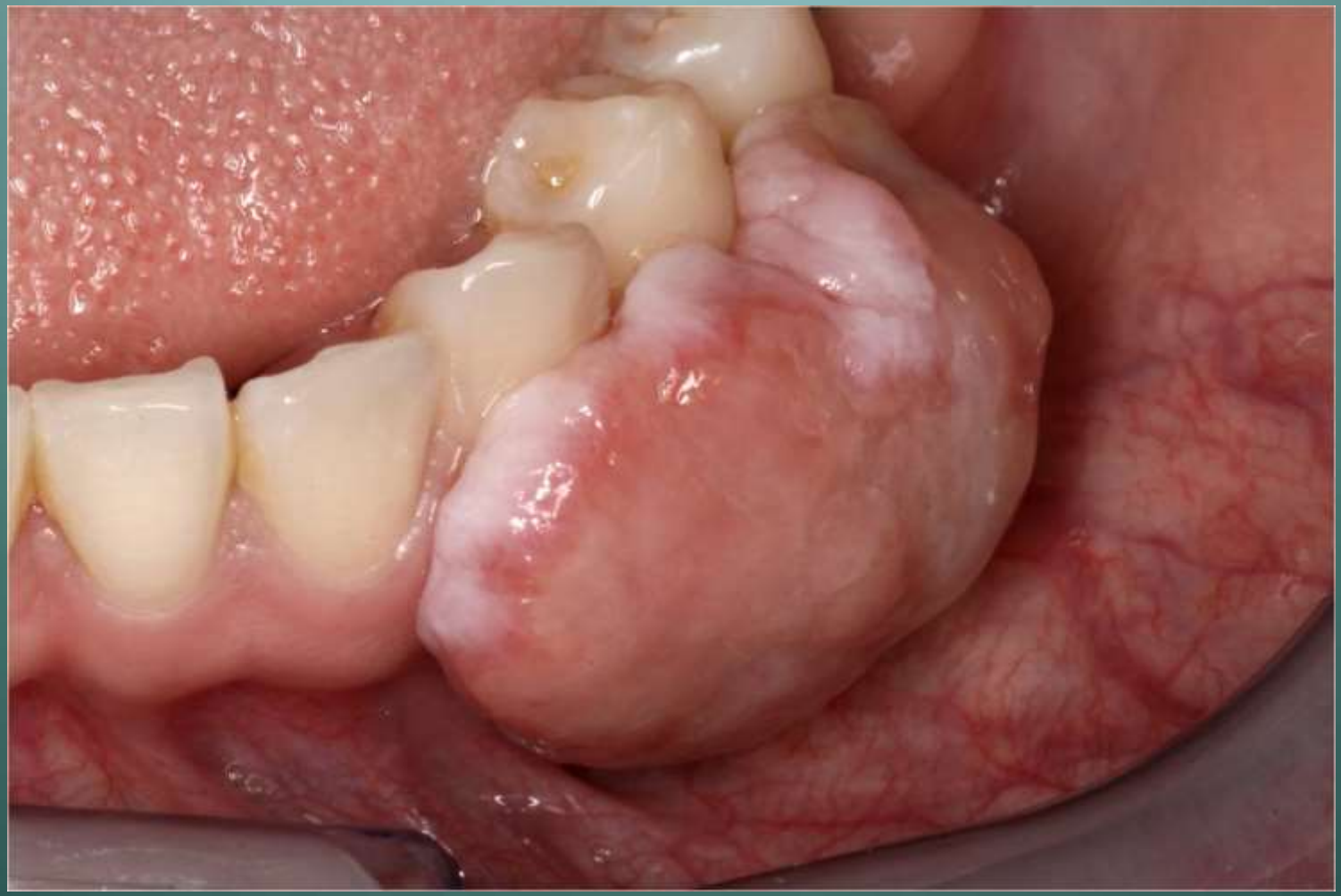
University of Tennessee College of Dentistry

Everyday Lumps and Bumps

Case #1

- This patient presented with the gingival swelling seen here

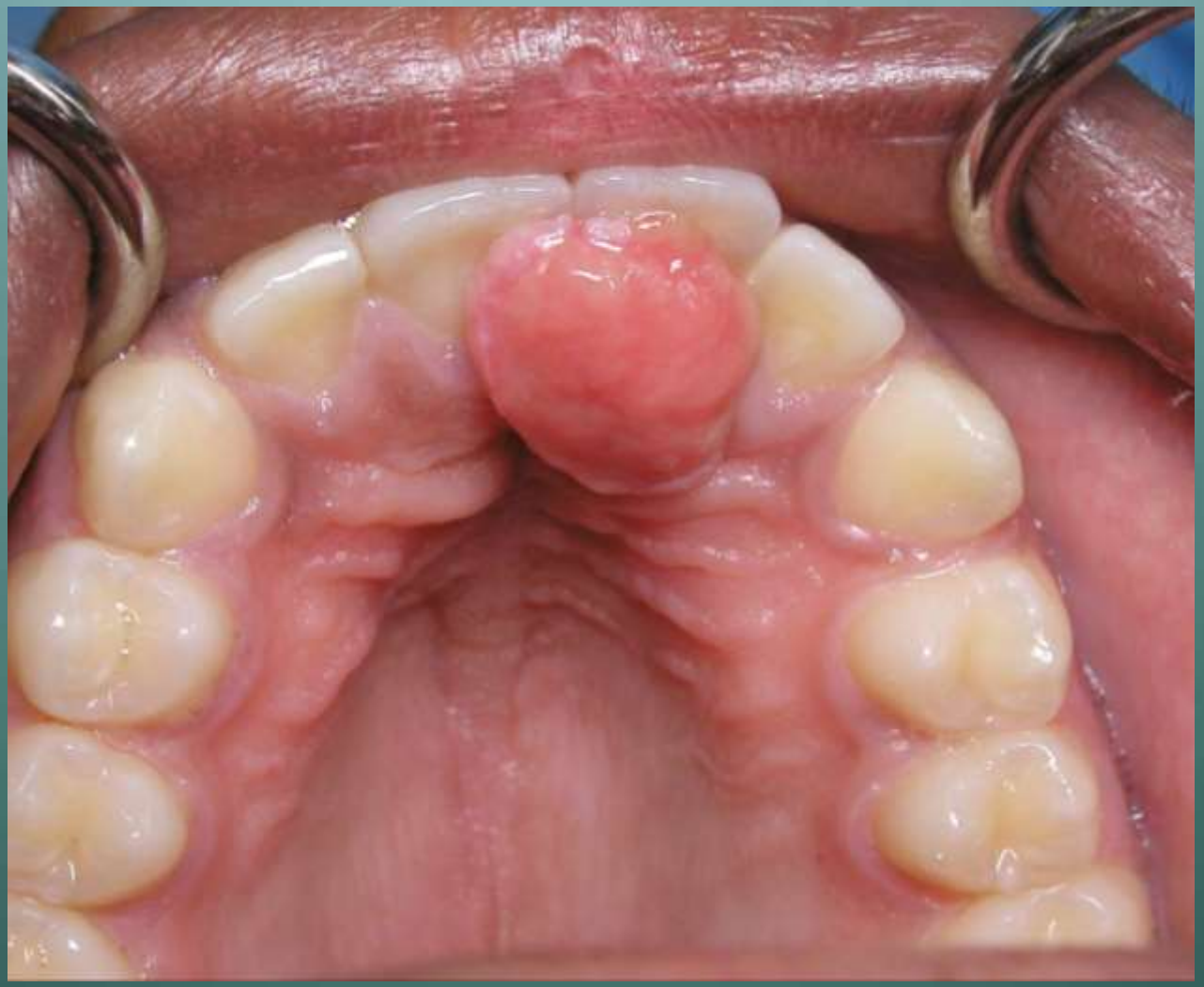
Case #1



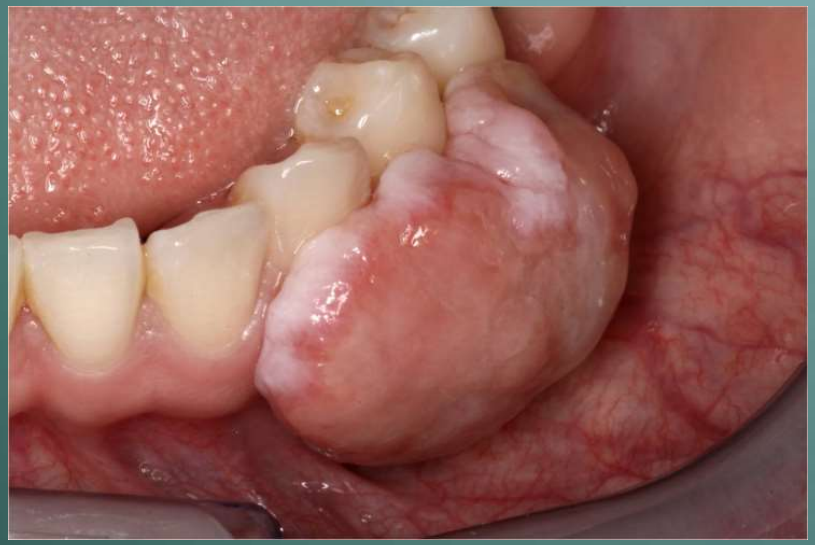
Case #2

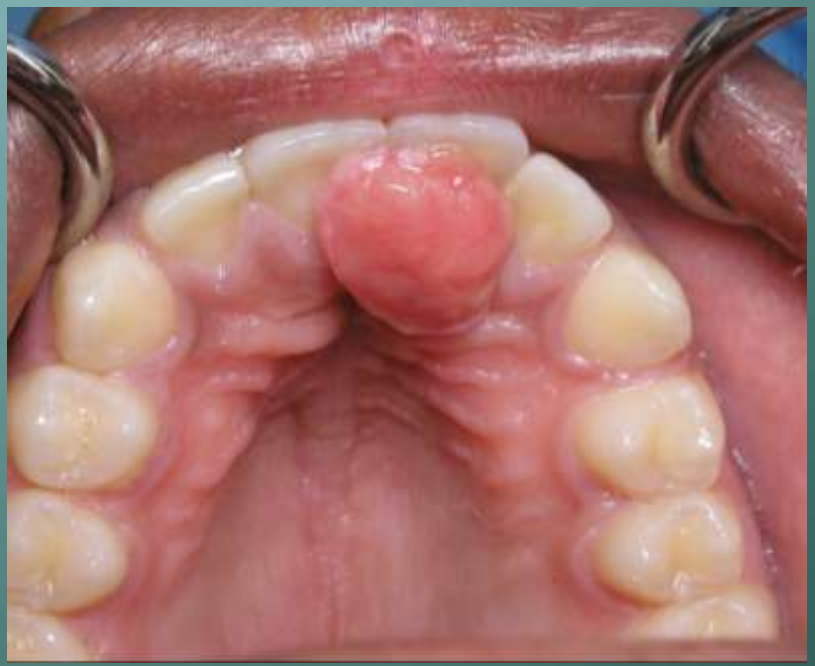
- A 14 year old female presented with this lesion of the gingiva

Case #2



Cases 1 and 2





Differential Diagnosis – “The 3 P’s”

- Pyogenic Granuloma
- Peripheral Ossifying Fibroma
- Peripheral Giant Cell Granuloma

Pyogenic Granuloma (Pregnancy Tumor)

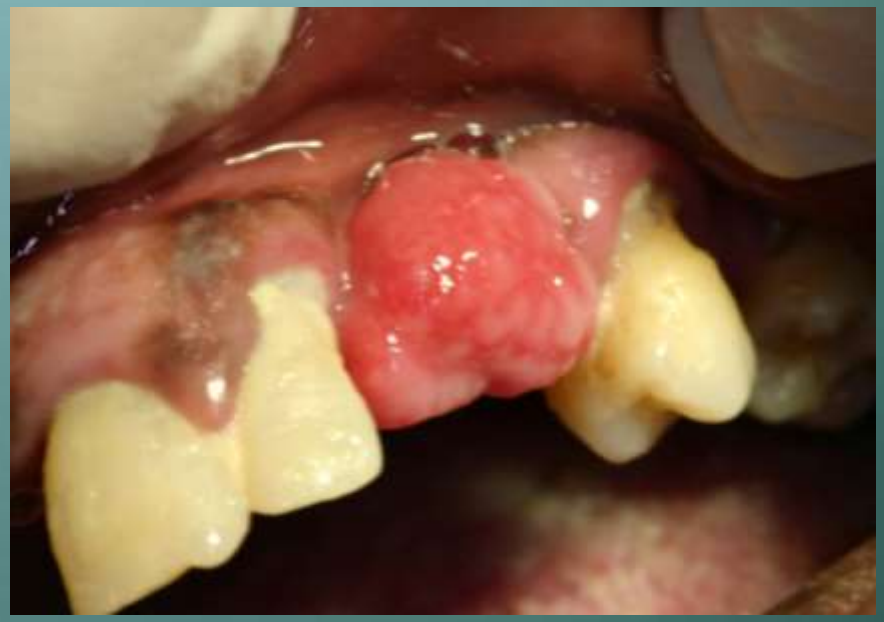
- Common non-neoplastic proliferation of granulation tissue
- Not a true granuloma
- Response to local irritation or trauma

Pyogenic Granuloma – Clinical Features

- F>M, children and young adults
- Common during pregnancy

Pyogenic Granuloma – Clinical Features

- Rapidly growing, smooth or lobulated, ulcerated mass
- Easily bleeds
- Any mucosal surface, with most involving the gingiva



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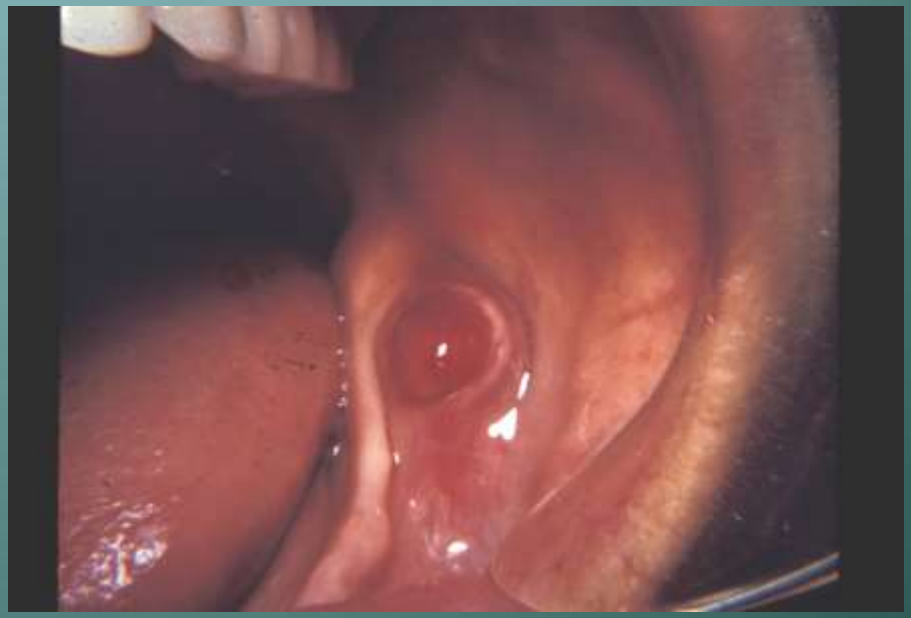

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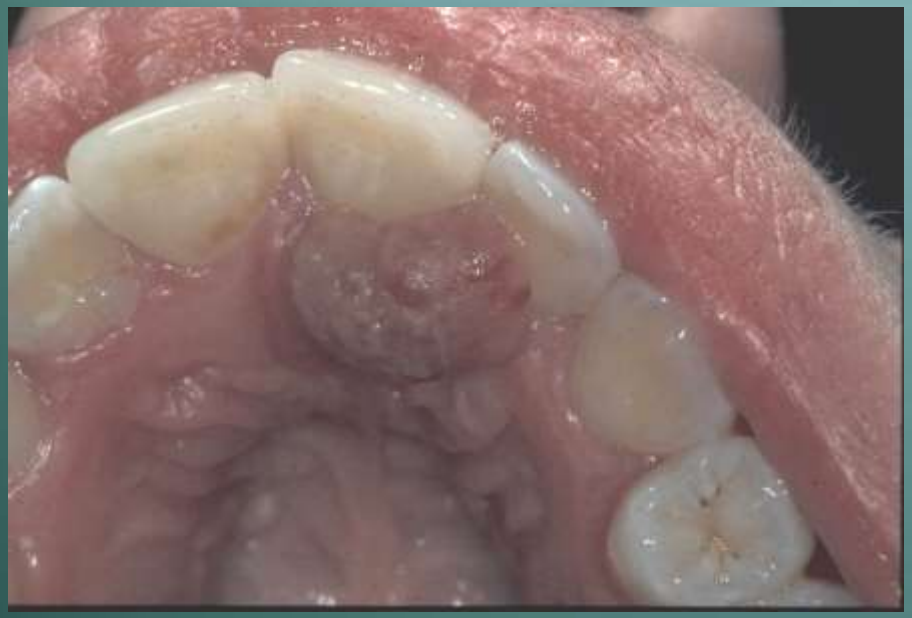

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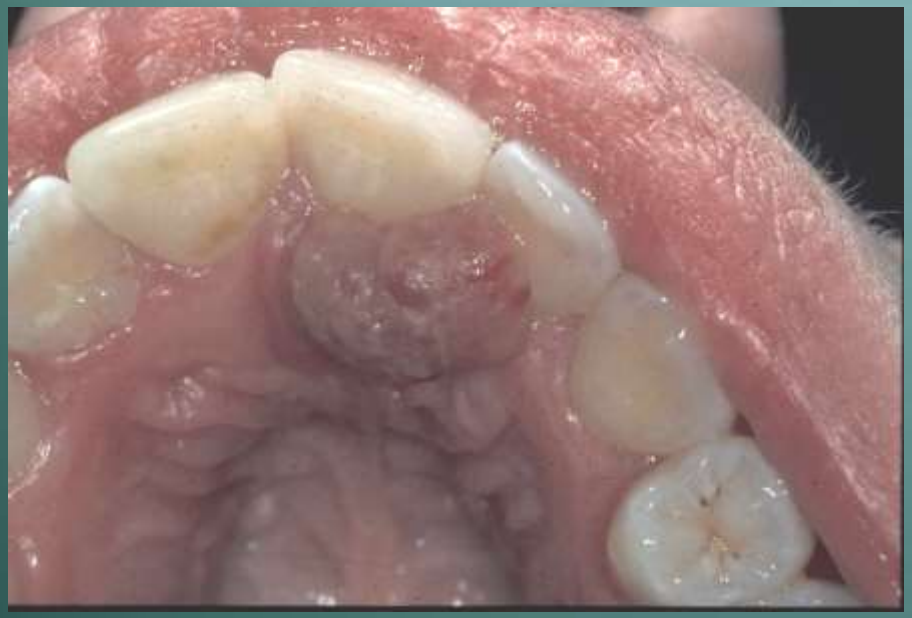

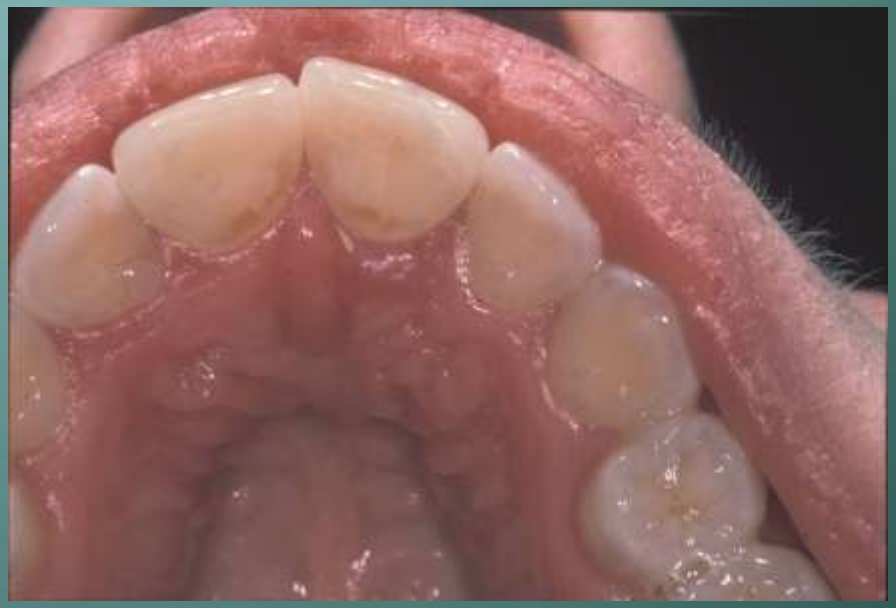

Pyogenic Granuloma – Treatment and Prognosis

- Conservative surgical excision with removal of any local factors
- Lesions associated with pregnancy may spontaneously regress postpartum
- Recurrences occur due to remaining local factors (calculus)

Peripheral Ossifying Fibroma

- Relatively common reactive lesion, probably arising from periodontal ligament
- This lesion is unrelated to the central ossifying fibroma

Peripheral Ossifying Fibroma – Clinical Features

- F>M, teenagers and young adults
- Maxilla > mandible
- Exclusively on the gingiva
- Frequently ulcerated

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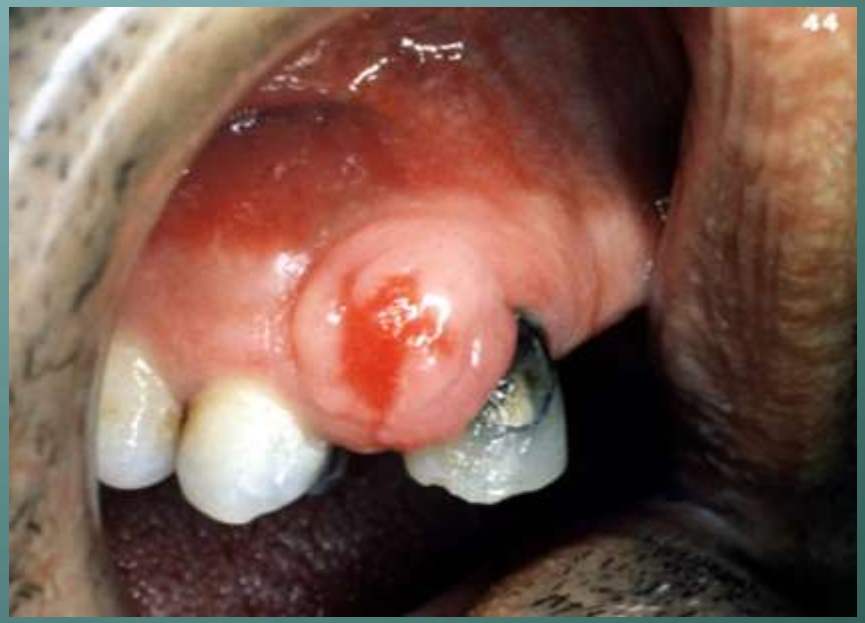

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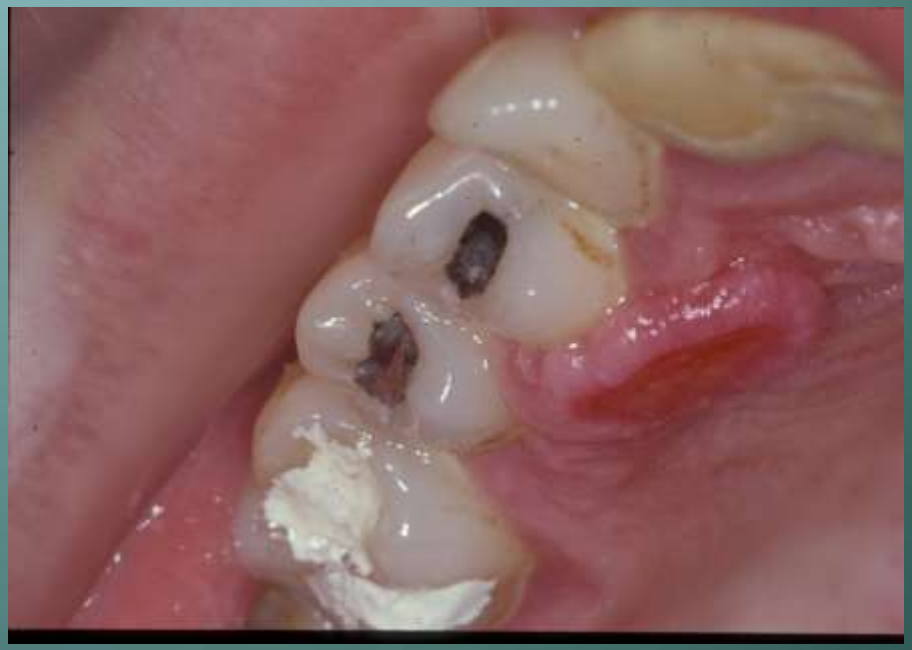

Peripheral Ossifying Fibroma – Treatment and Prognosis

- Local excision down to the periosteum
- Elimination of local factors or irritants
- Approximately 16% recurrence rate

Peripheral Giant Cell Granuloma

- Relatively common reactive lesion of the gingiva
- Histologically identical to the central giant cell granuloma

Peripheral Giant Cell Granuloma – Clinical Features

- F>M, 5th and 6th decades
- Bluish-purple lesion, exclusively on the gingiva or alveolar ridge
- Radiographic – May cause "cupping" resorption (saucerization)

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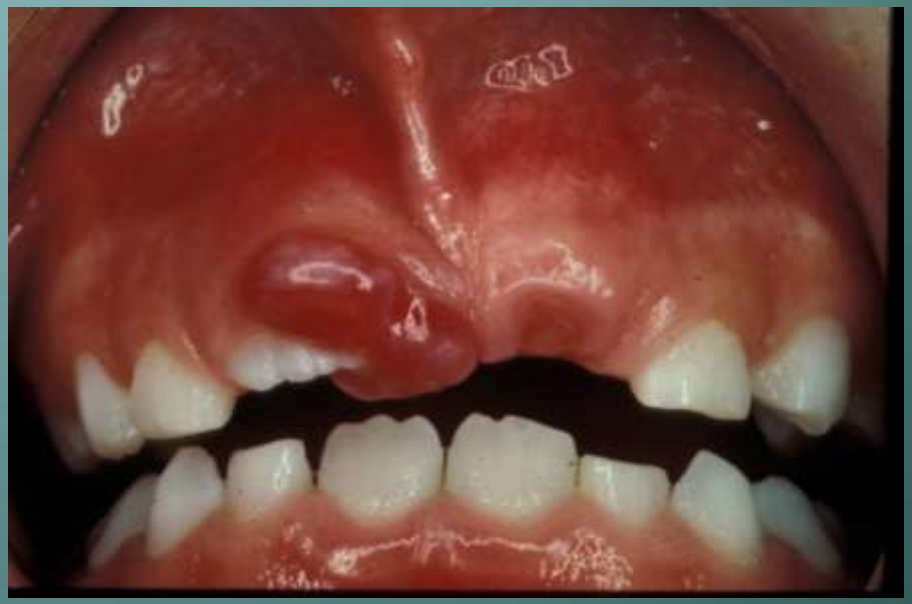

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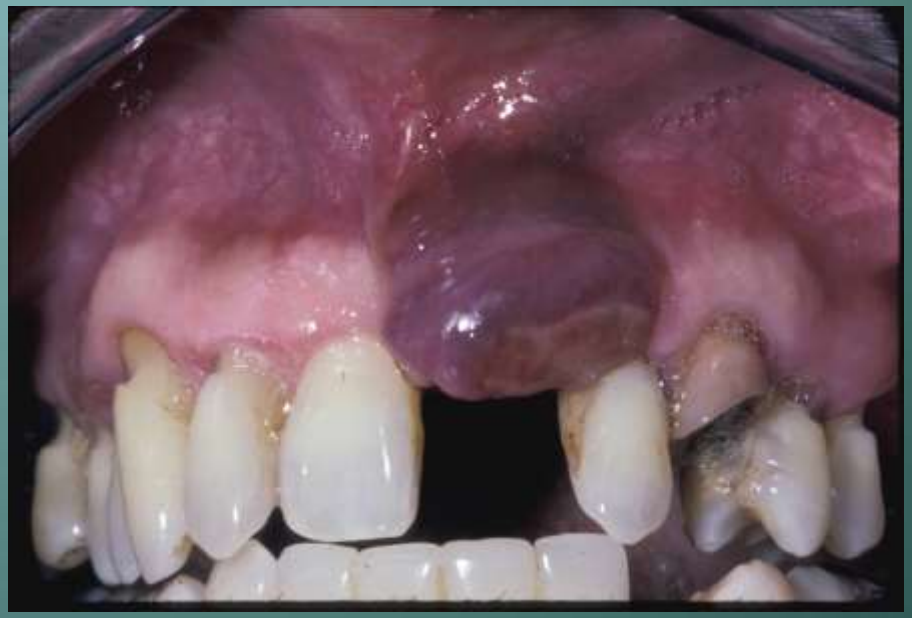

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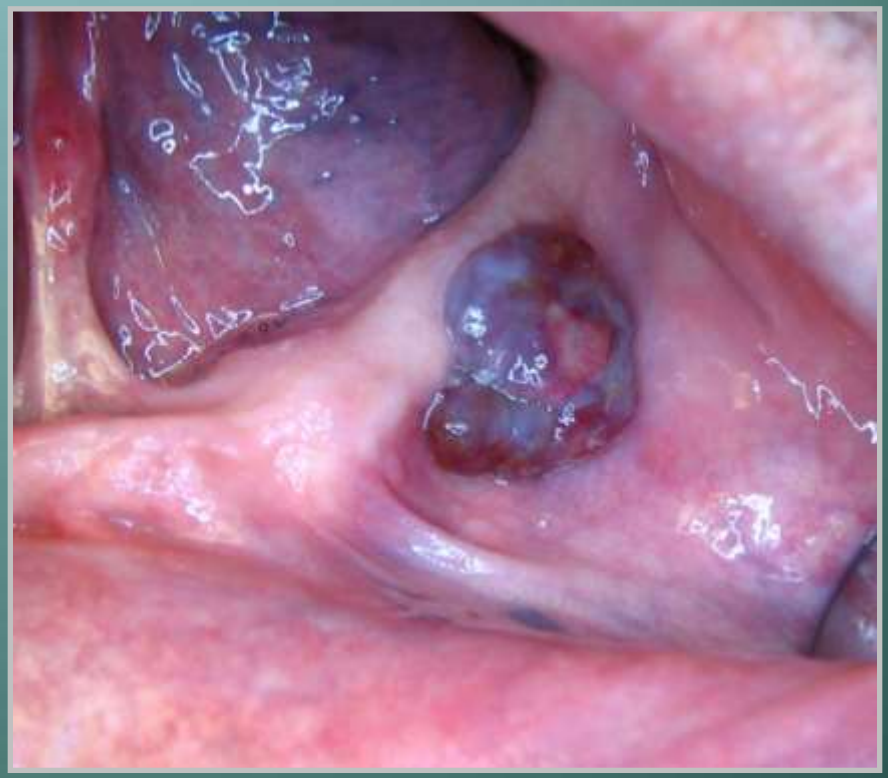

Peripheral Giant Cell Granuloma – Treatment and Prognosis

- Local excision down to underlying bone
- Removal of local factors
- Approximately 10% recurrence rate

Additional Considerations

Fibroma (Irritation Fibroma, Traumatic Fibroma)

- The most common tumor of the oral cavity
- Probably not a true neoplasm
- Reactive lesion, secondary to trauma or chronic irritation

Fibroma – Clinical Features

- F>M, 4^{th}-6^{th} decade
- Commonly located along the bite line of the buccal mucosa
- Sessile, smooth-surfaced pink nodule

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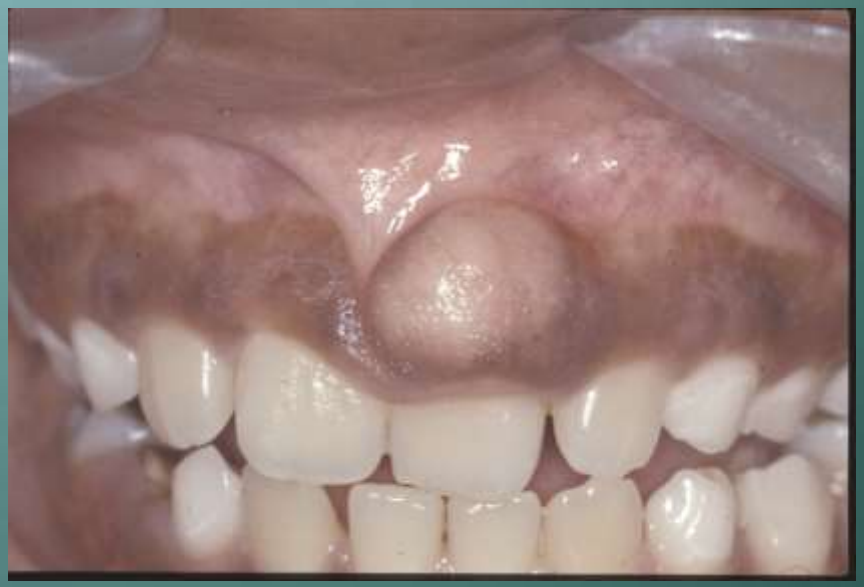

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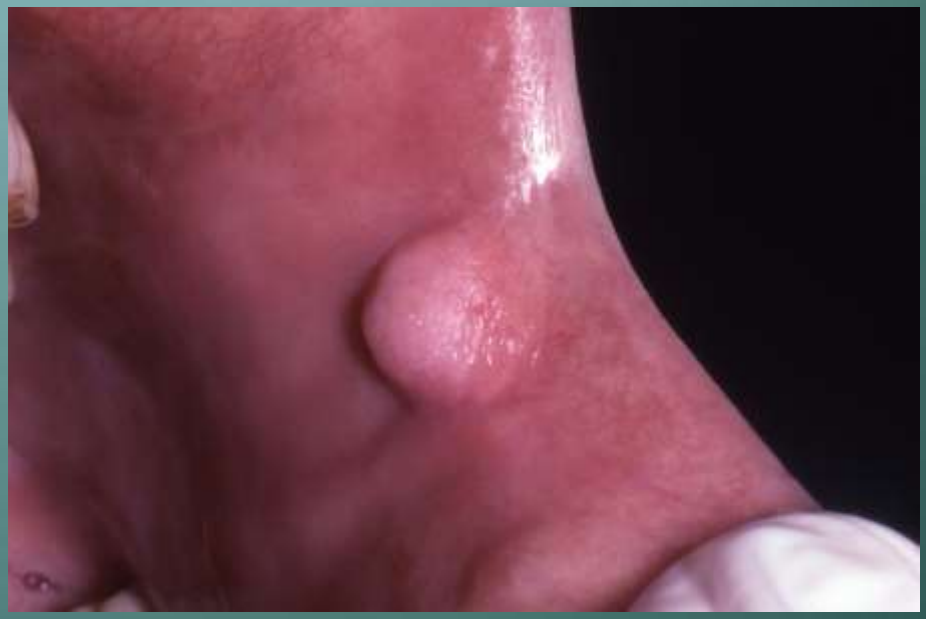

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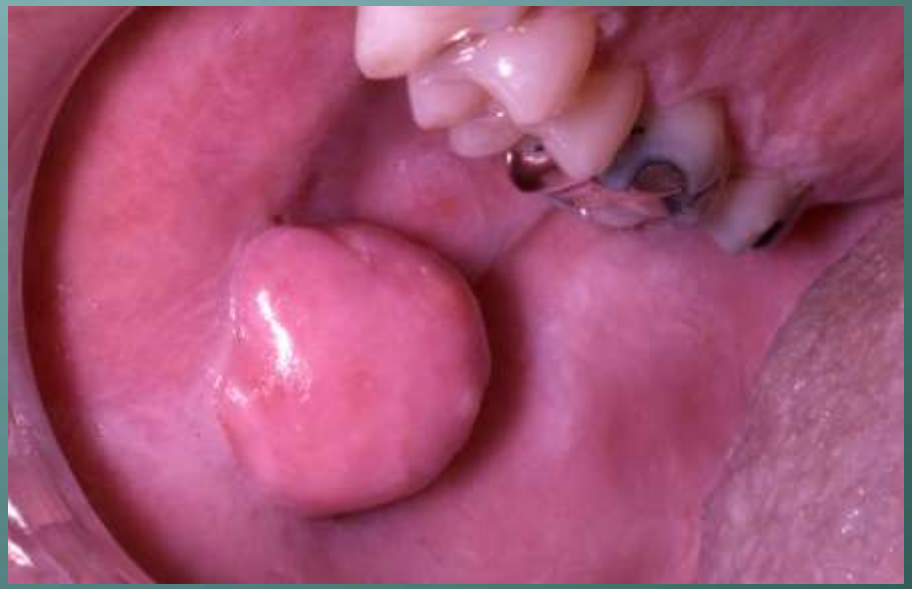

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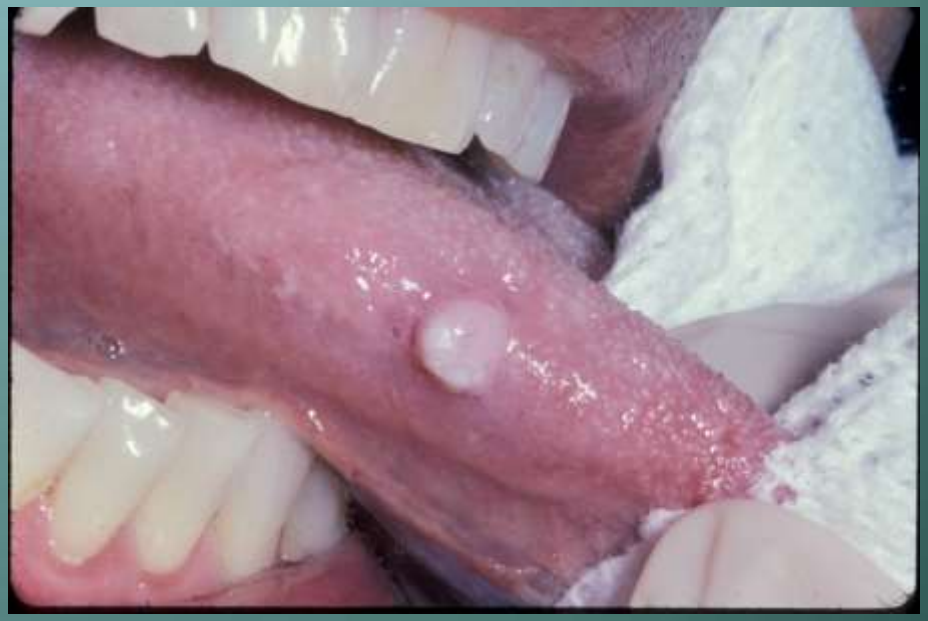

Fibroma – Treatment

- Conservative surgical excision
- Prognosis – Recurrence is rare

Differential Diagnosis

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- Peripheral Ossifying Fibroma
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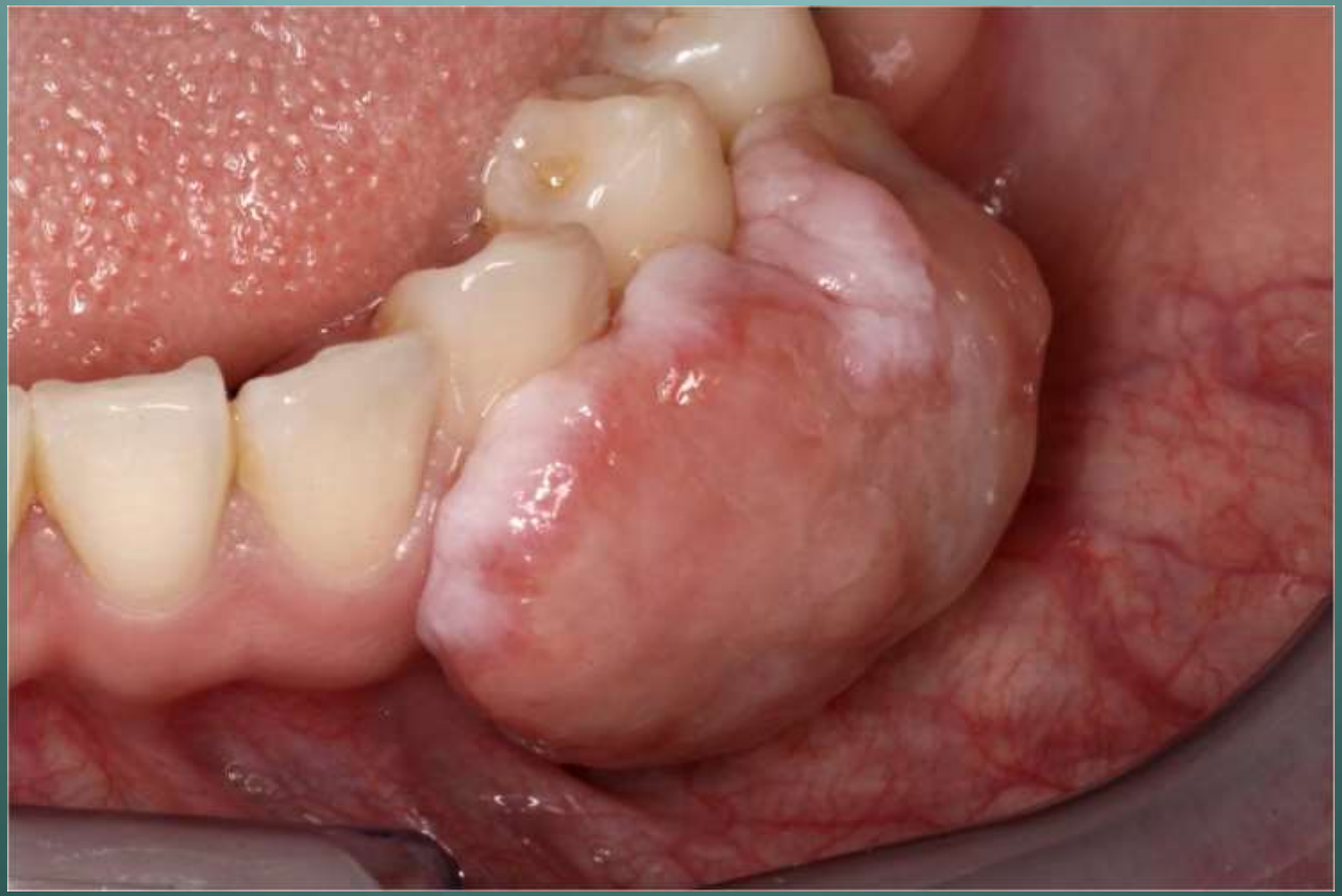
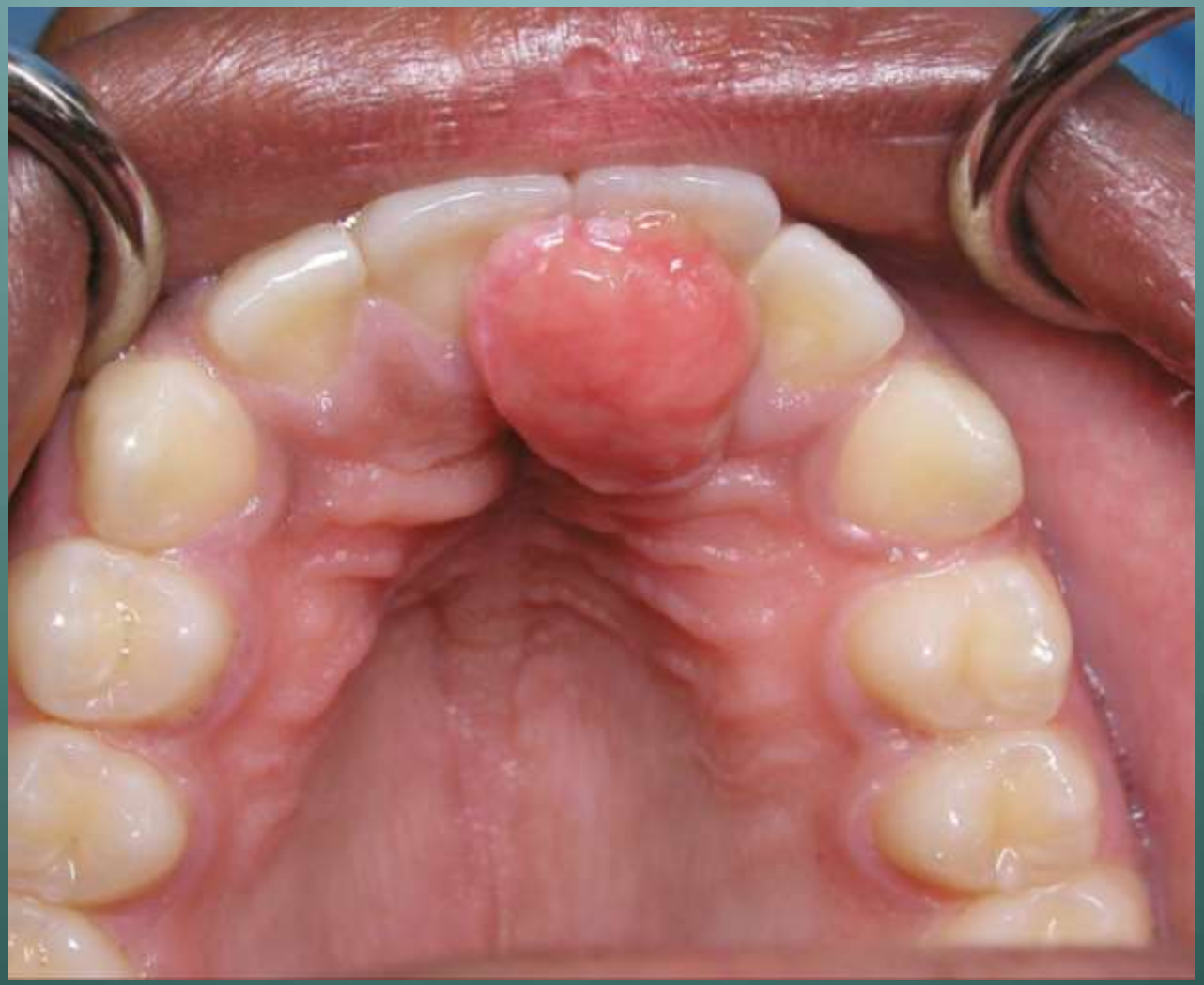
Diagnosis Case #1 – Pyogenic Granuloma



Diagnosis Case #2 – Peripheral Ossifying Fibroma



Other Soft Tissue Considerations

Lipoma

- Benign tumor of fat
- Although rare in the oral/maxillofacial area, the lipoma is the most common mesenchymal neoplasm
- Unrelated to metabolism/body fat

Lipoma – Clinical Features

- F>M
- Soft nodule, most commonly involving the buccal mucosa
- Normal or yellow in color

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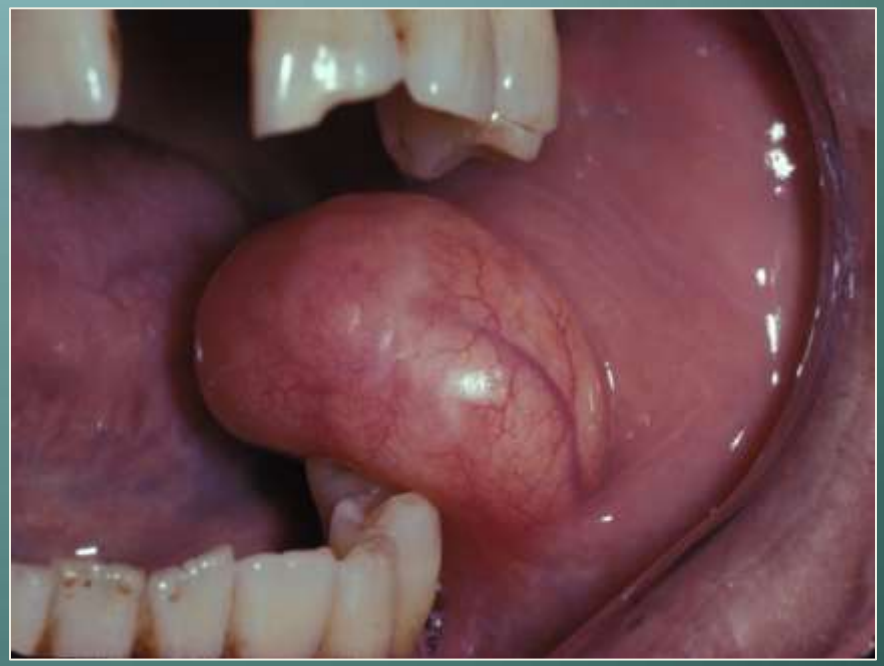

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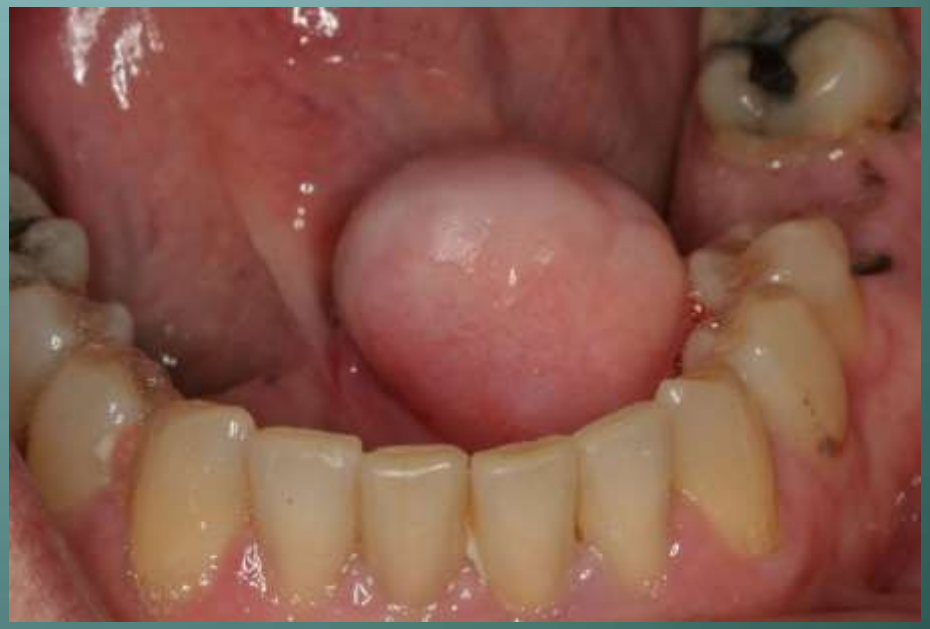

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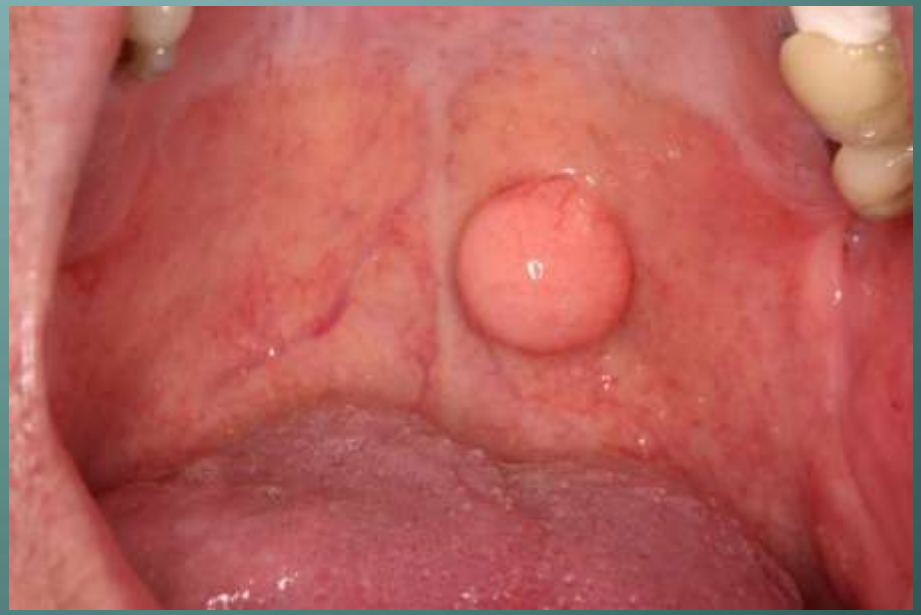

Lipoma – Clinical Features

- F>M
- Soft nodule, most commonly involving the buccal mucosa
- Normal or yellow in color

Lipoma – Treatment and Prognosis

- Conservative surgical excision
- Recurrence is rare

Granular Cell Tumor

- Uncommon tumor that appears to be of Schwann cell origin
- Significant predilection for the oral cavity

Granular Cell Tumor – Clinical Features

- F>M, 4th to 6th decade
- Solitary lesion, primarily involving the dorsal tongue
- Asymptomatic sessile nodule

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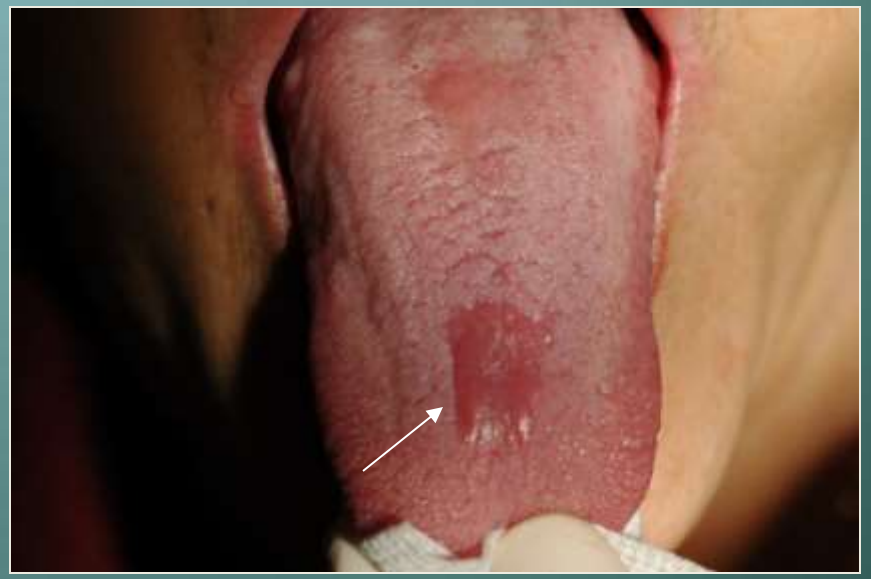

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Granular Cell Tumor – Treatment and Prognosis

- Conservative surgical excision
- Recurrence is rare, even with incomplete removal

Traumatic Neuroma

- Reactive proliferation of neural tissue
- Not necessarily a true neoplasm
- Secondary to disruption of Schwann cell tube

Traumatic Neuroma – Clinical Features

- F>M, middle-aged adults
- Smooth surfaced, submucosal nodule
- Commonly involve the mental foramen area
- May be symptomatic

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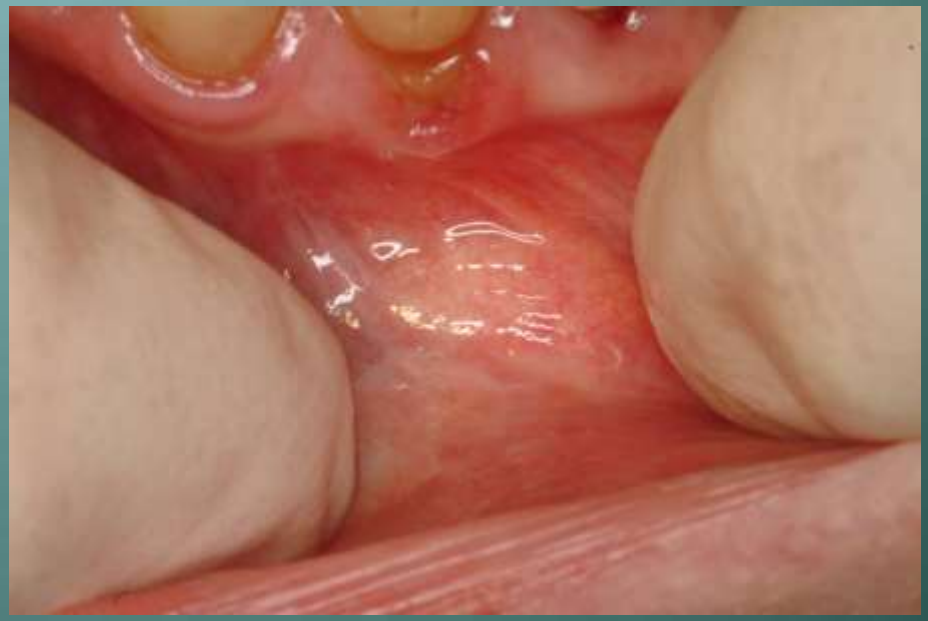

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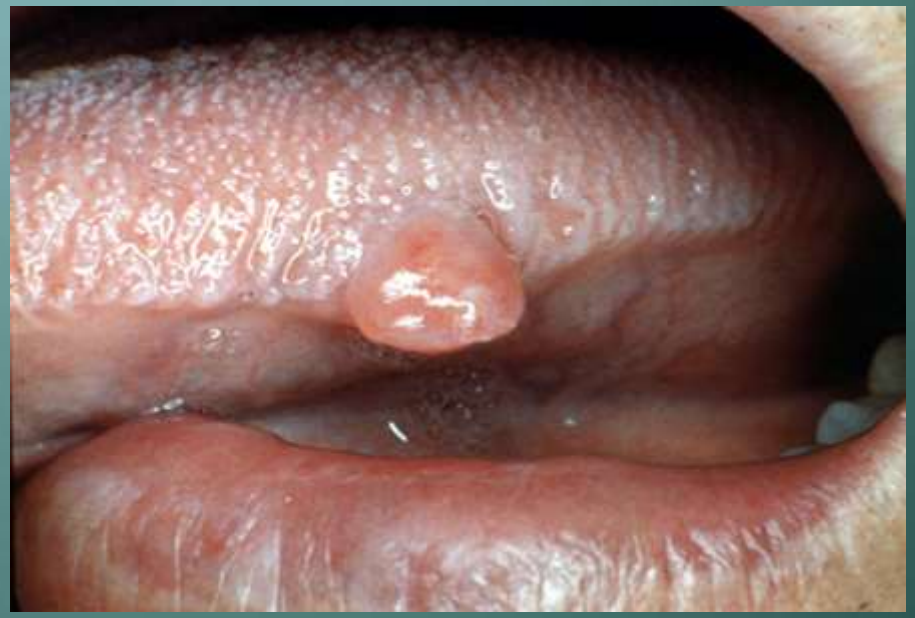

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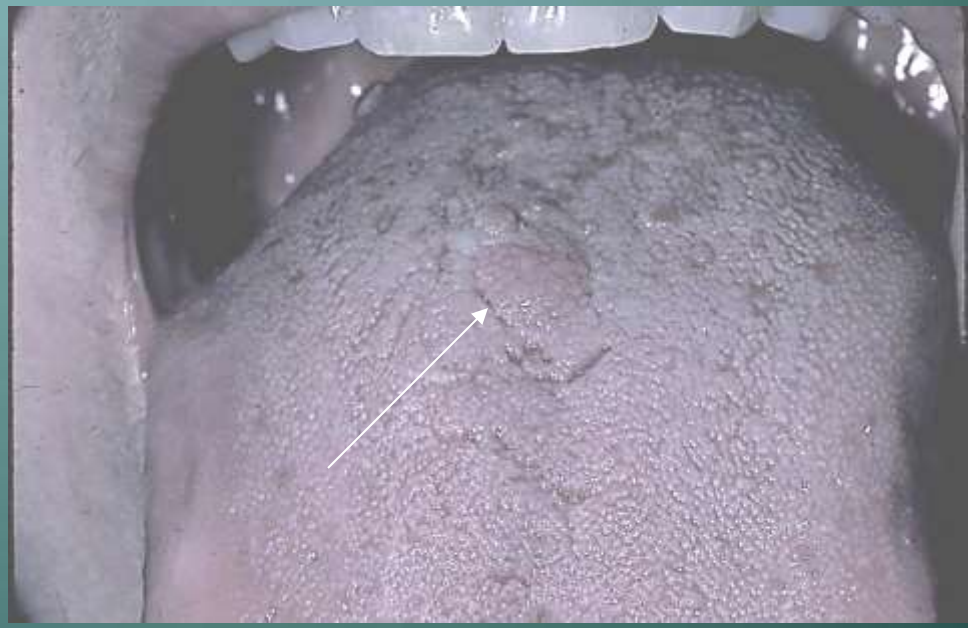

Traumatic Neuroma – Treatment and Prognosis

- Surgical excision, including a portion of the involved nerve bundle
- Recurrence is not expected

Schwannoma (Neurilomoma)

- Benign neural tumor of Schwann cell origin
- Uncommon, but often involve the head and neck

Schwannoma – Clinical Features

- Young and middle-aged adults
- Slow growing
- Variable symptoms

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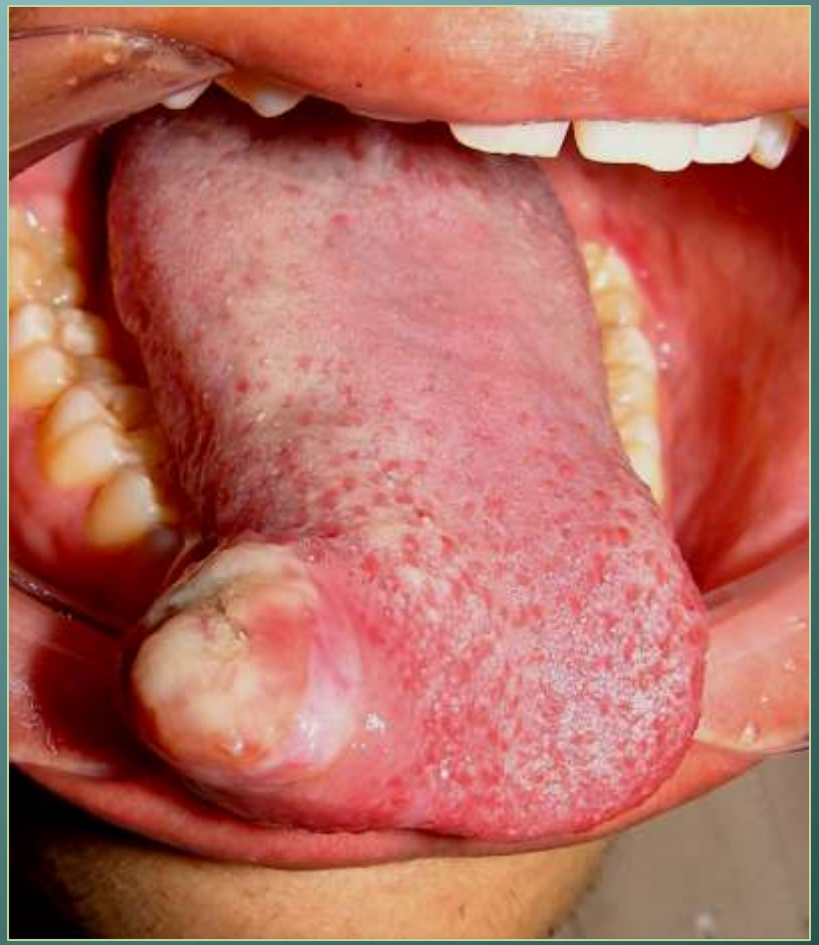

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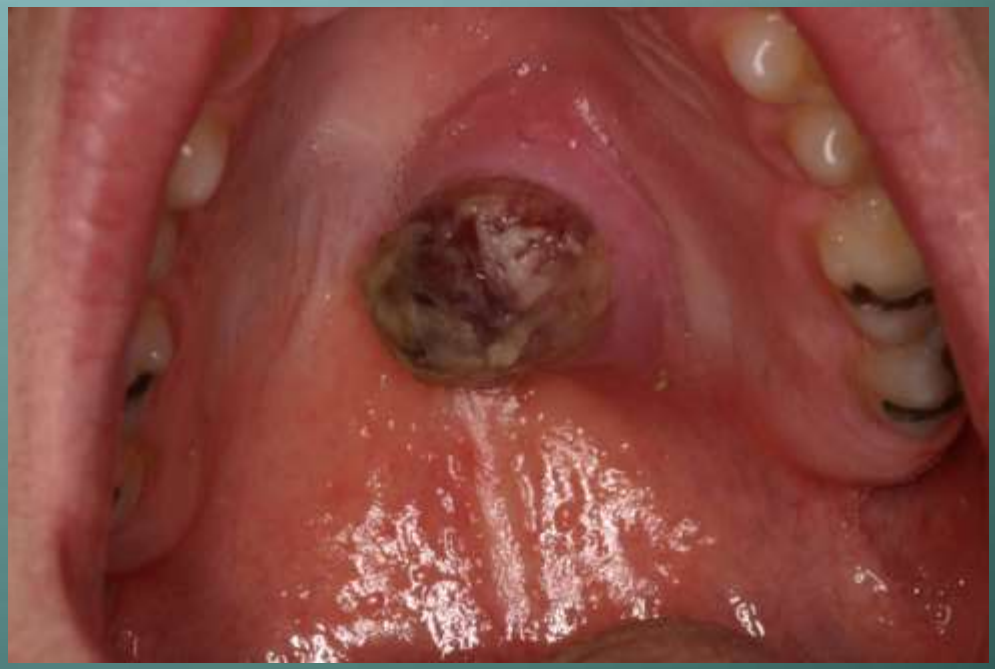
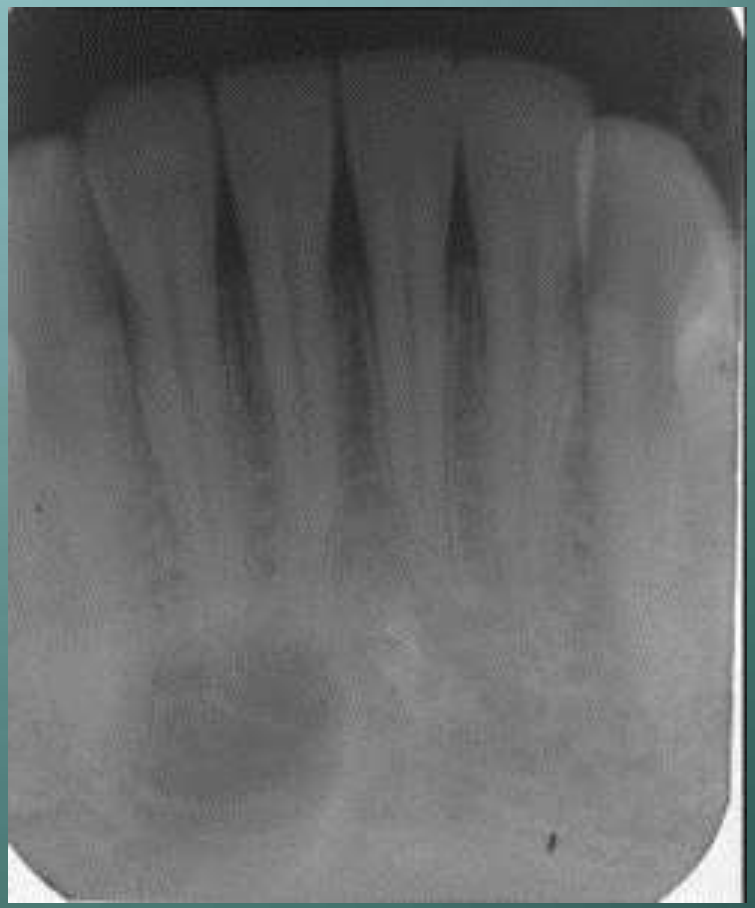


Schwannoma – Clinical Features

- Oral tumors most commonly involve the tongue
- May arise within bone, causing an expansile, unilocular radiolucency



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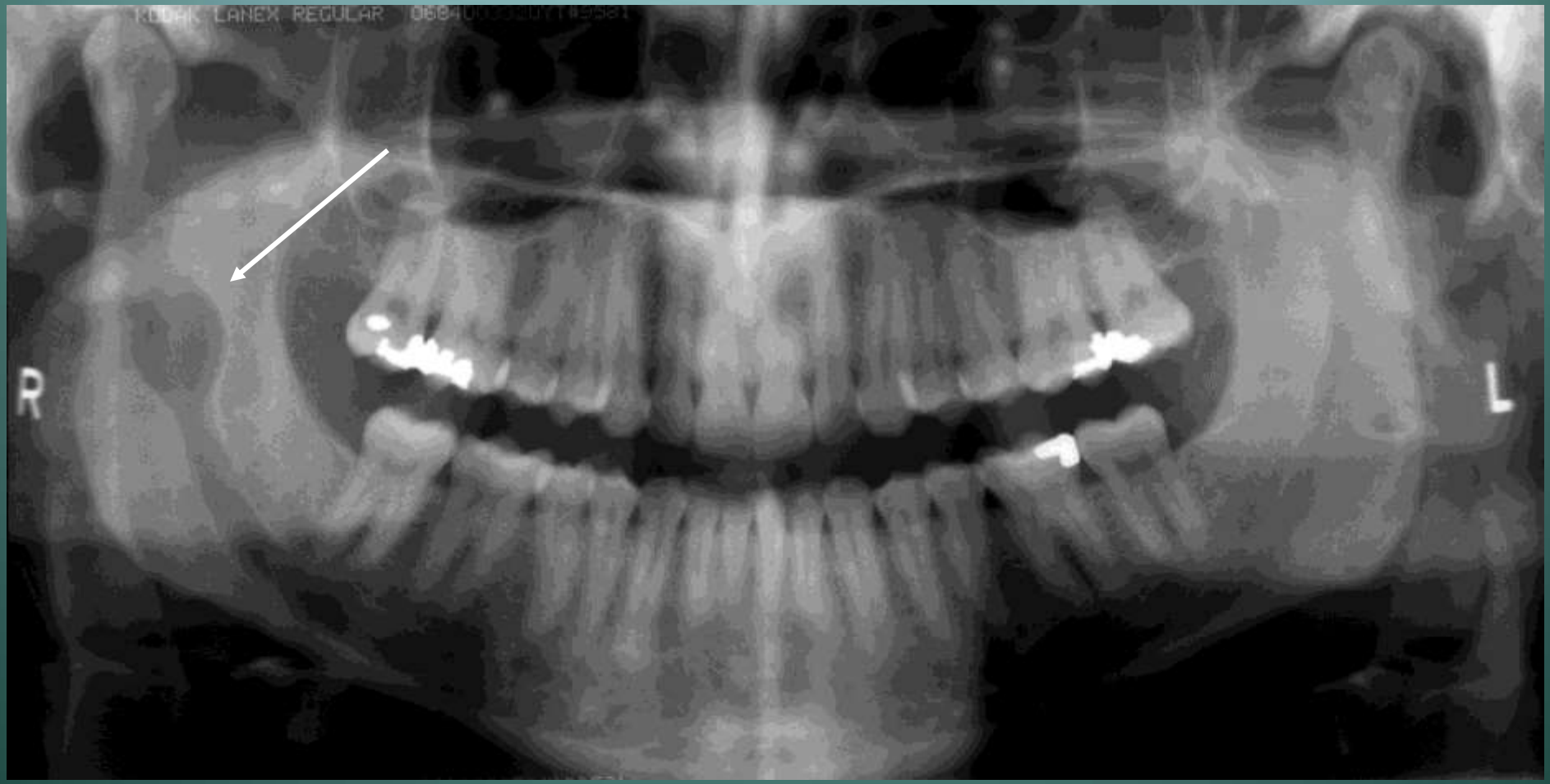

Schwannoma – Treatment and Prognosis

- Surgical excision
- Recurrence is not expected
- Malignant transformation is rare
  - Malignant peripheral nerve sheath tumor, malignant schwannoma, neurofibrosarcoma

Neurofibroma

- The most common peripheral nerve neoplasm
- Tumor cells are a mixture of Schwann cells and fibroblasts

Neurofibroma – Clinical Features

- Typically solitary, involving the tongue or buccal mucosa
- May occur in bone
- Multiple lesions associated with neurofibromatosis

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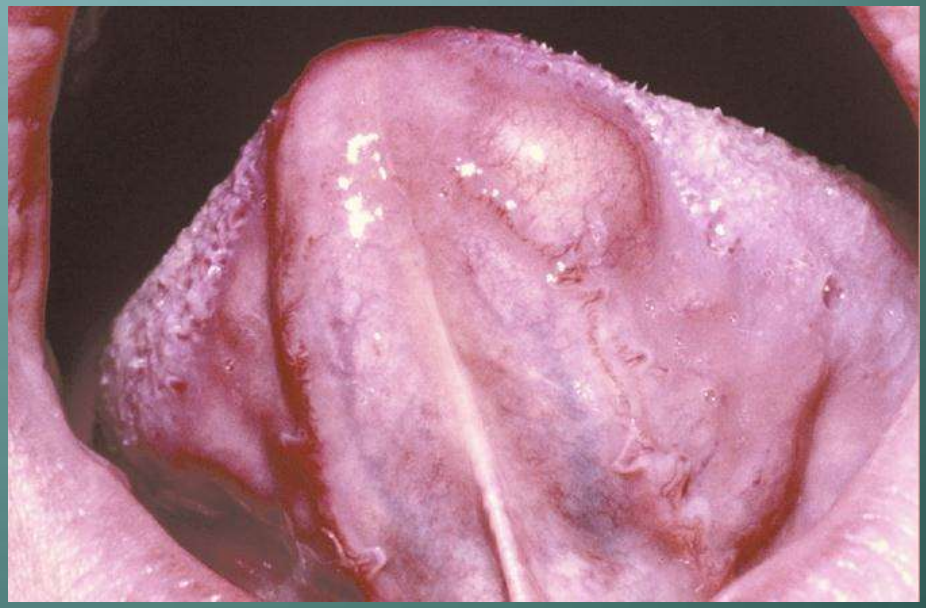

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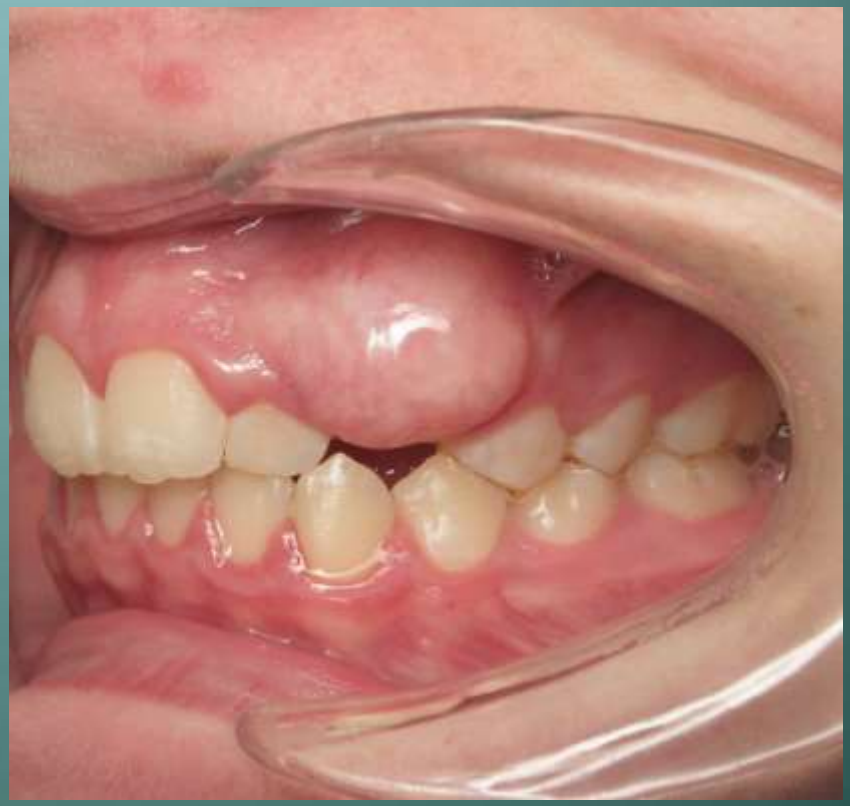

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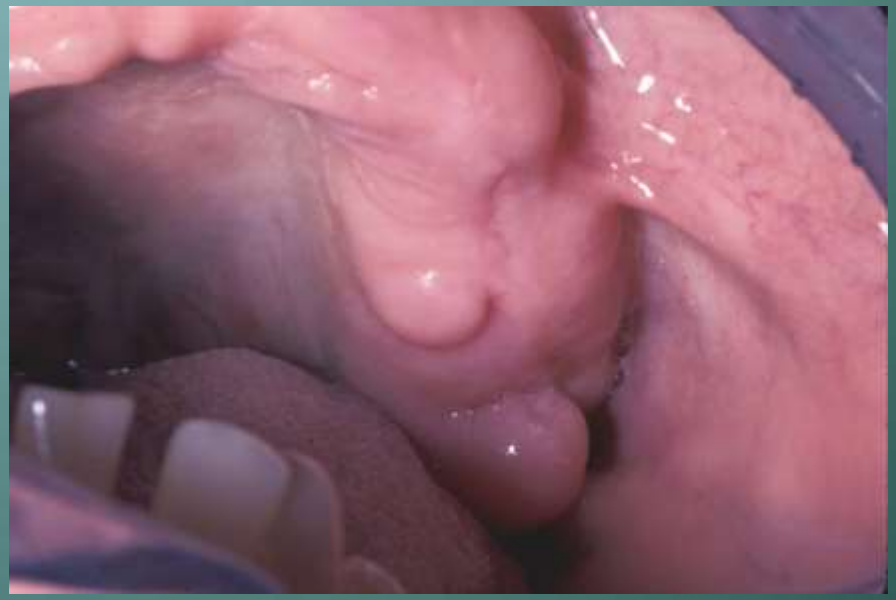

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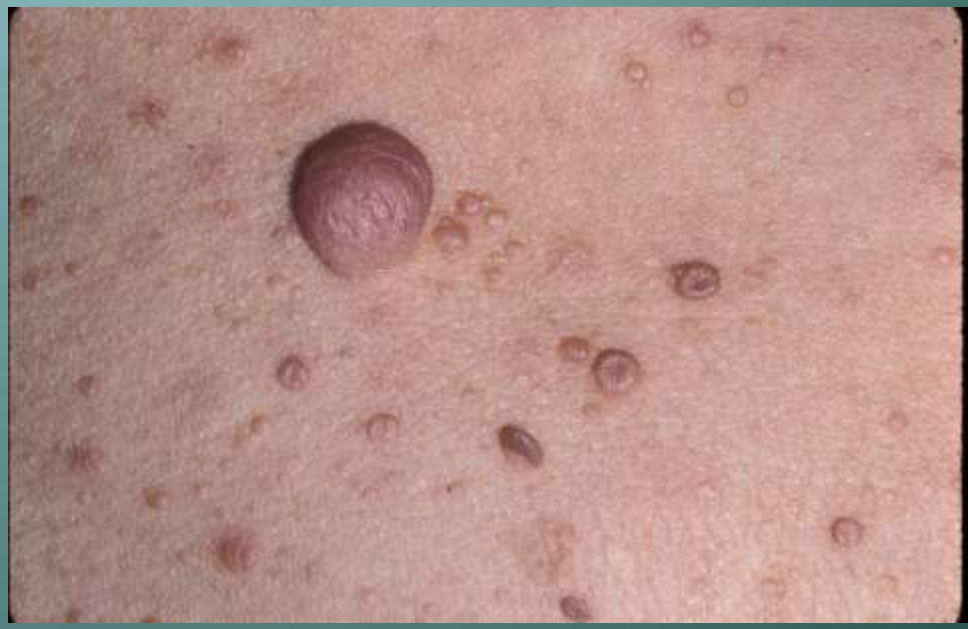

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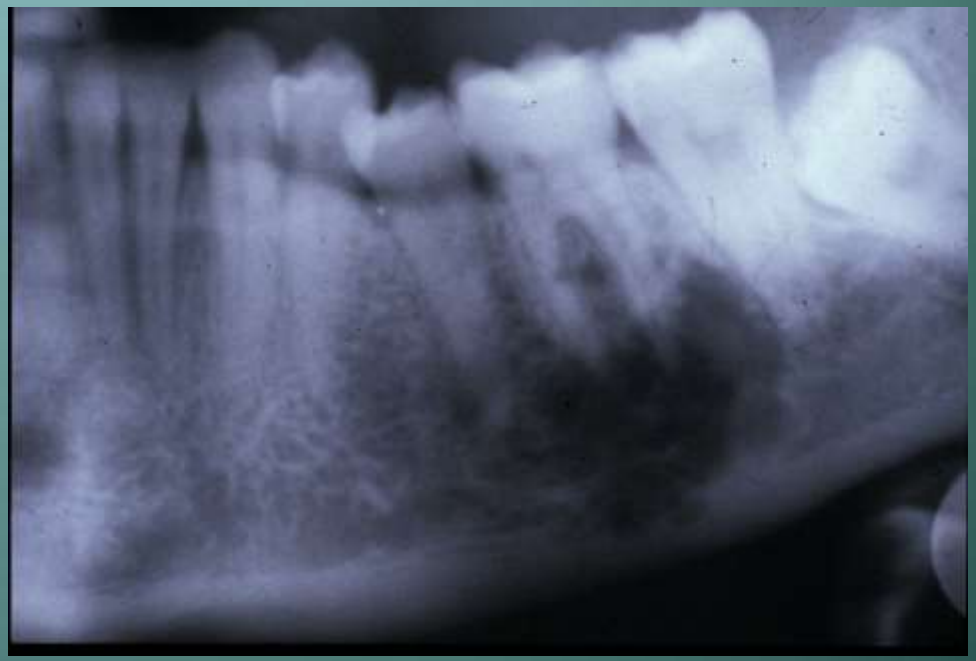

Neurofibroma – Treatment and Prognosis

- Solitary lesions – Surgical excision
- Multiple (neurofibromatosis) – Removal of symptomatic lesions
- Malignant transformation is possible, much more so in patients with neurofibromatosis

Epulis Fissuratum (Inflammatory Fibrous Hyperplasia, “Denture Epulis”)

- Reactive lesion that occurs secondary to irritation from an ill-fitting denture
- Epulis – Any tumor of the gingiva or alveolar mucosa

Epulis Fissuratum – Clinical Features

- F>M, middle aged and older
- Single or multiple folds of firm, fibrous tissue located in the alveolar vestibule (usually anterior)

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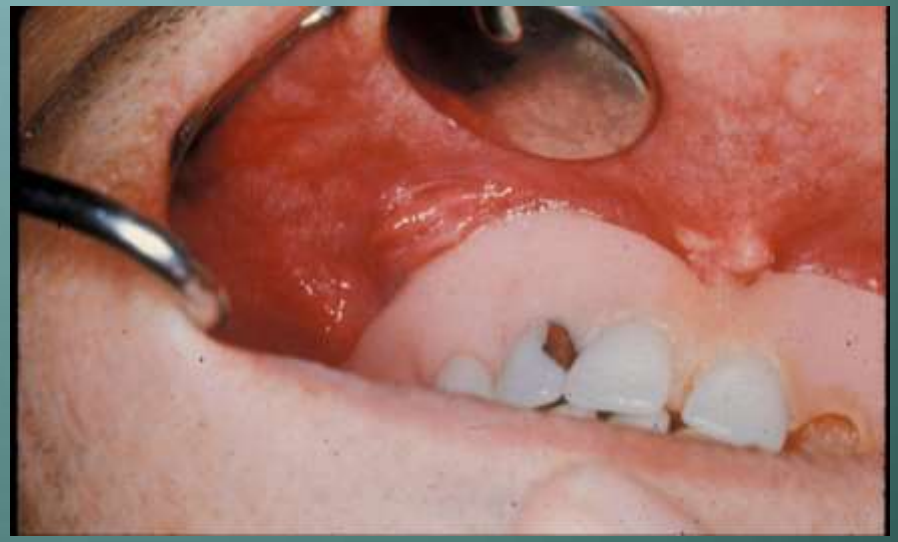
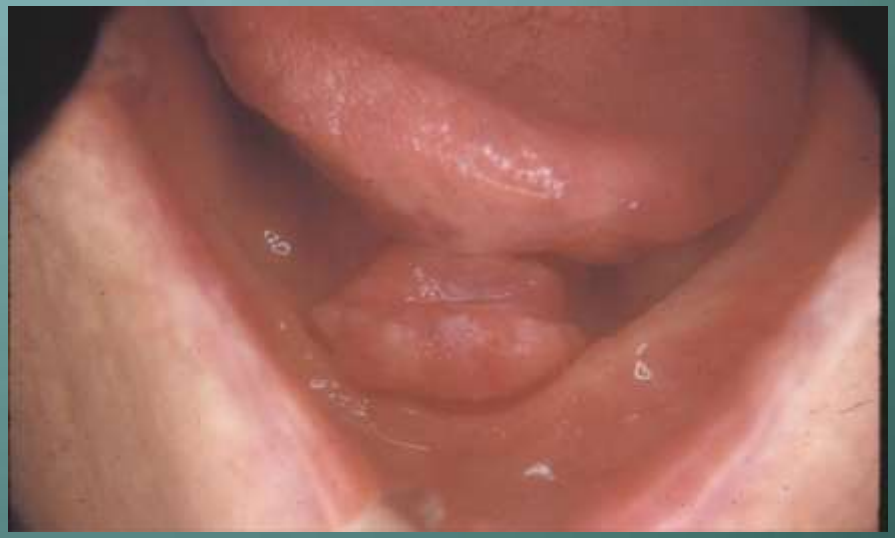


Epulis Fissuratum – Clinical Features

- Lesions can achieve large size
- May be ulcerated
- Fibroepithelial polyp – Pedunculated lesion of palate beneath maxillary denture



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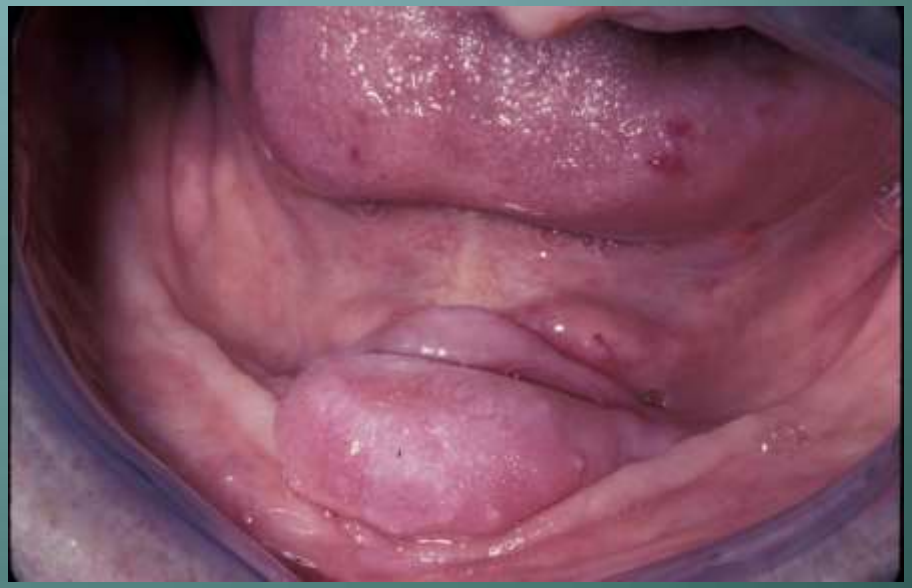

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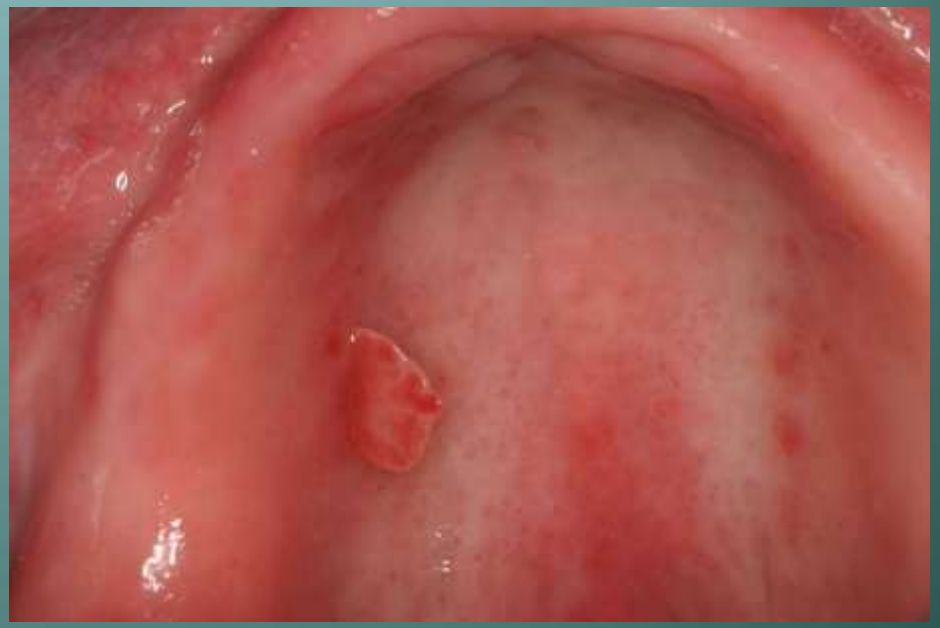

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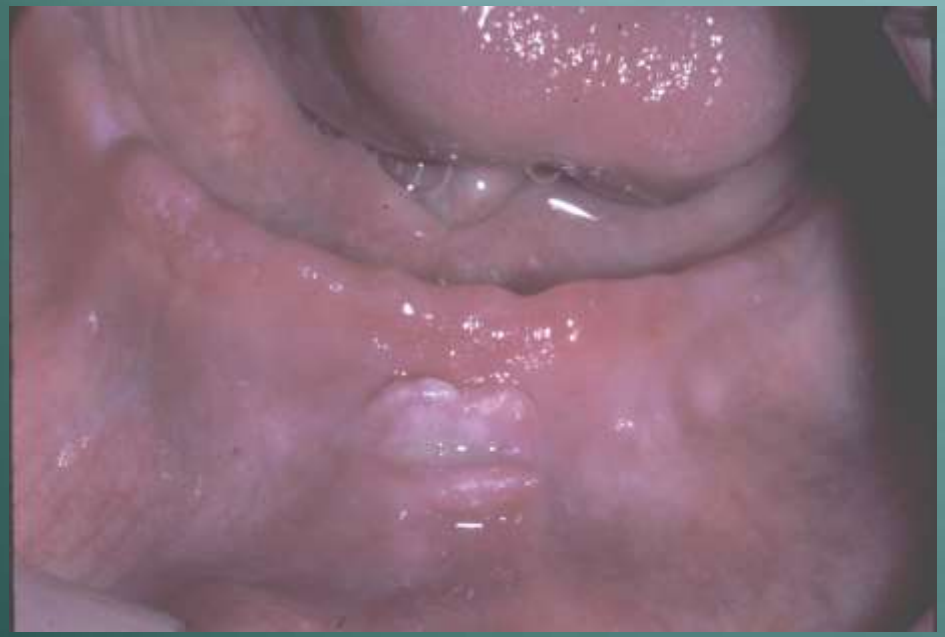

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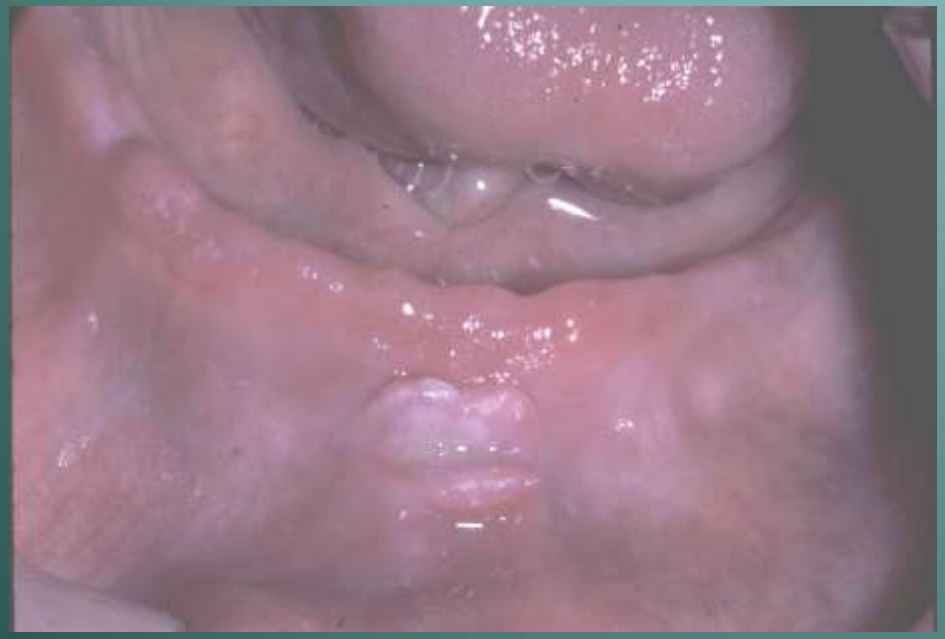
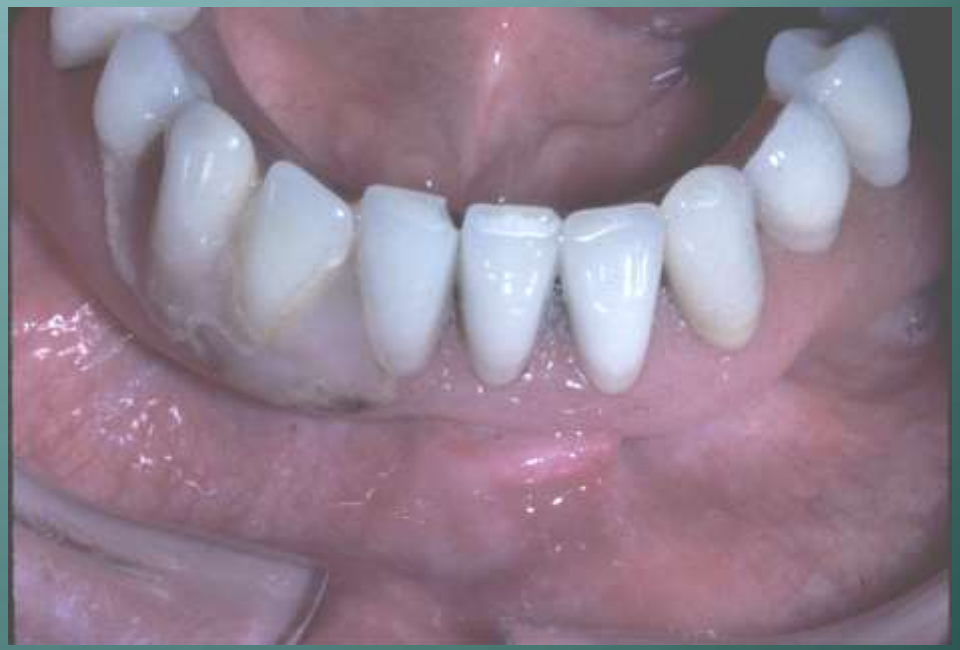




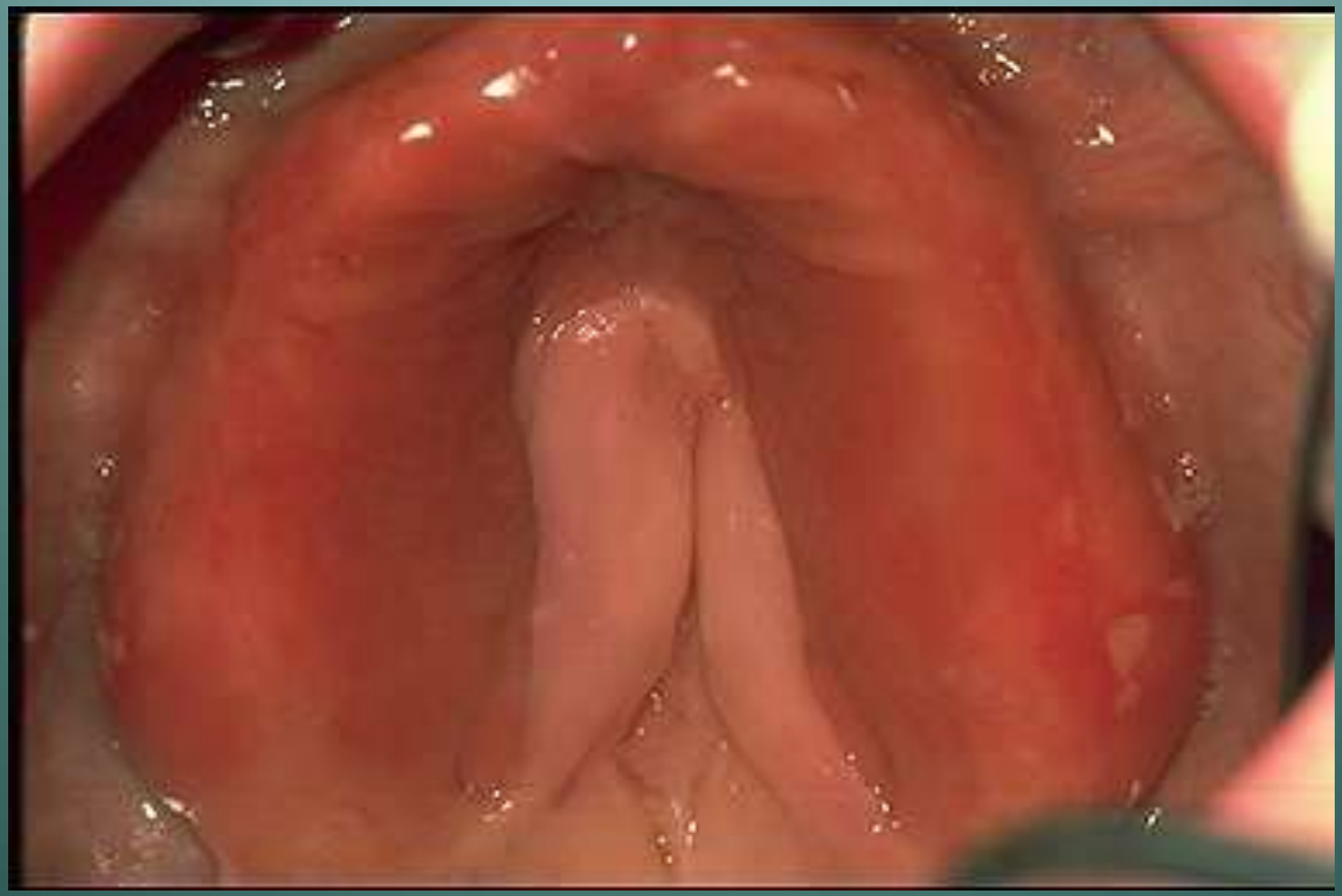
Epulis Fissuratum – Treatment and Prognosis

- Surgical removal
- Refabrication of the associated denture or relign

Erythematous Candidiasis - Denture Stomatitis

- Often referred to as “chronic atrophic candidiasis”
- Denture is often contaminated with candidal organisms, but no invasion of mucosa is seen
- Erythema of palatal denture-bearing area- typically asymptomatic

Denture Stomatitis



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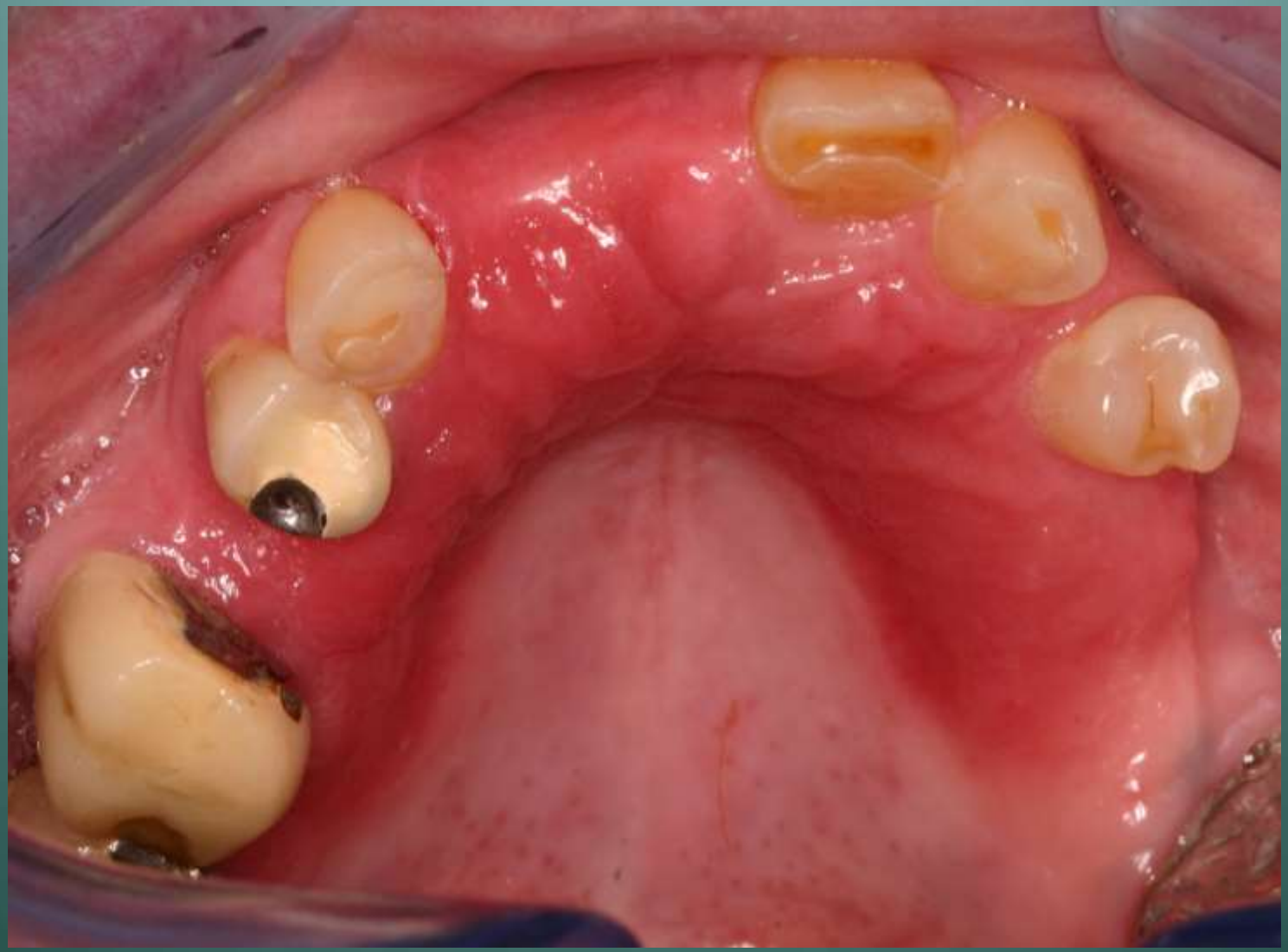
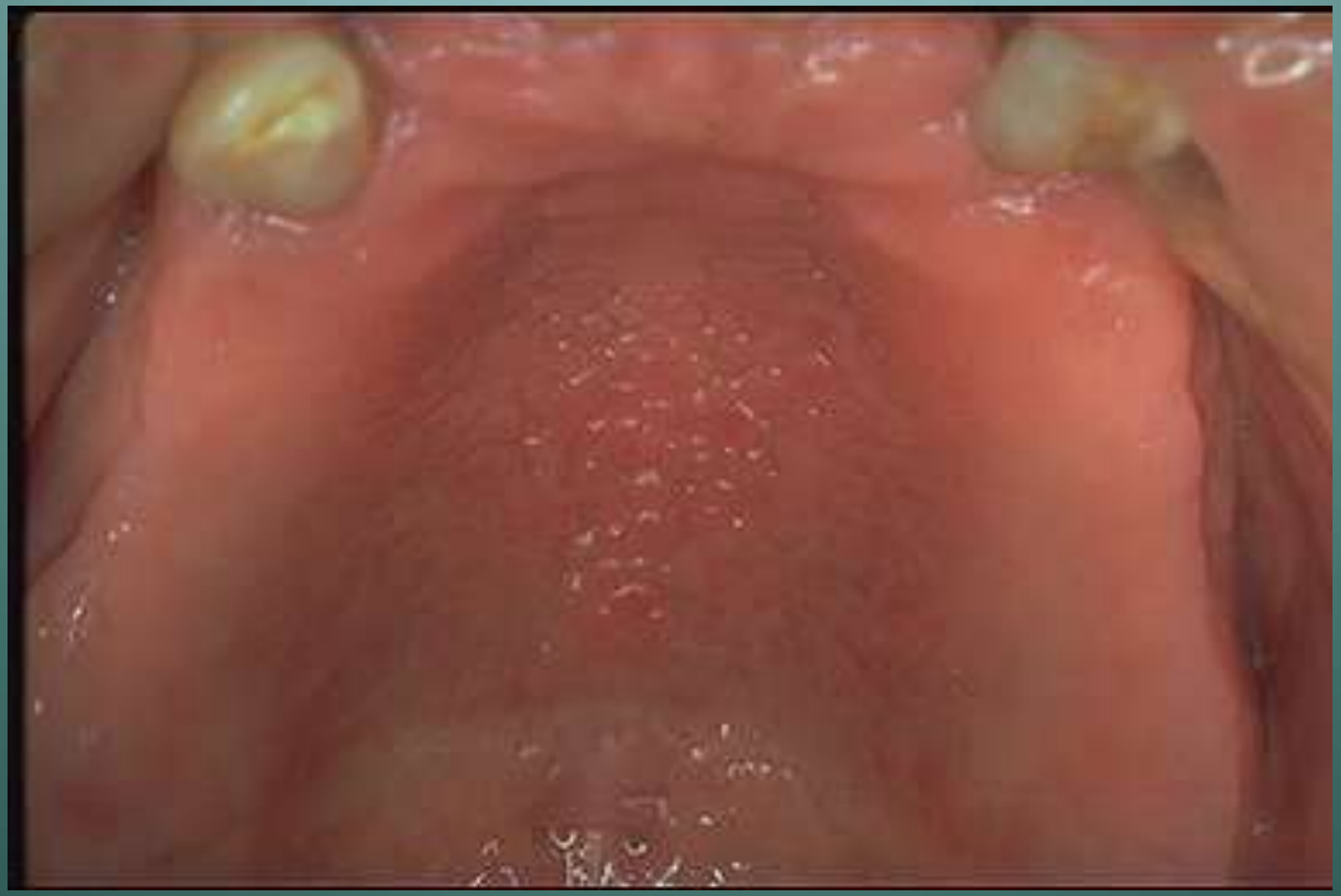


Inflammatory Papillary Hyperplasia

- Reactive process of the palate underneath a maxillary denture
- Variable involvement of the hard palate
- Asymptomatic, erythematous lesion with a pebbly surface
- Has been seen on edentulous mandibular ridge or on epulis

Inflammatory Papillary Hyperplasia – Clinical Features



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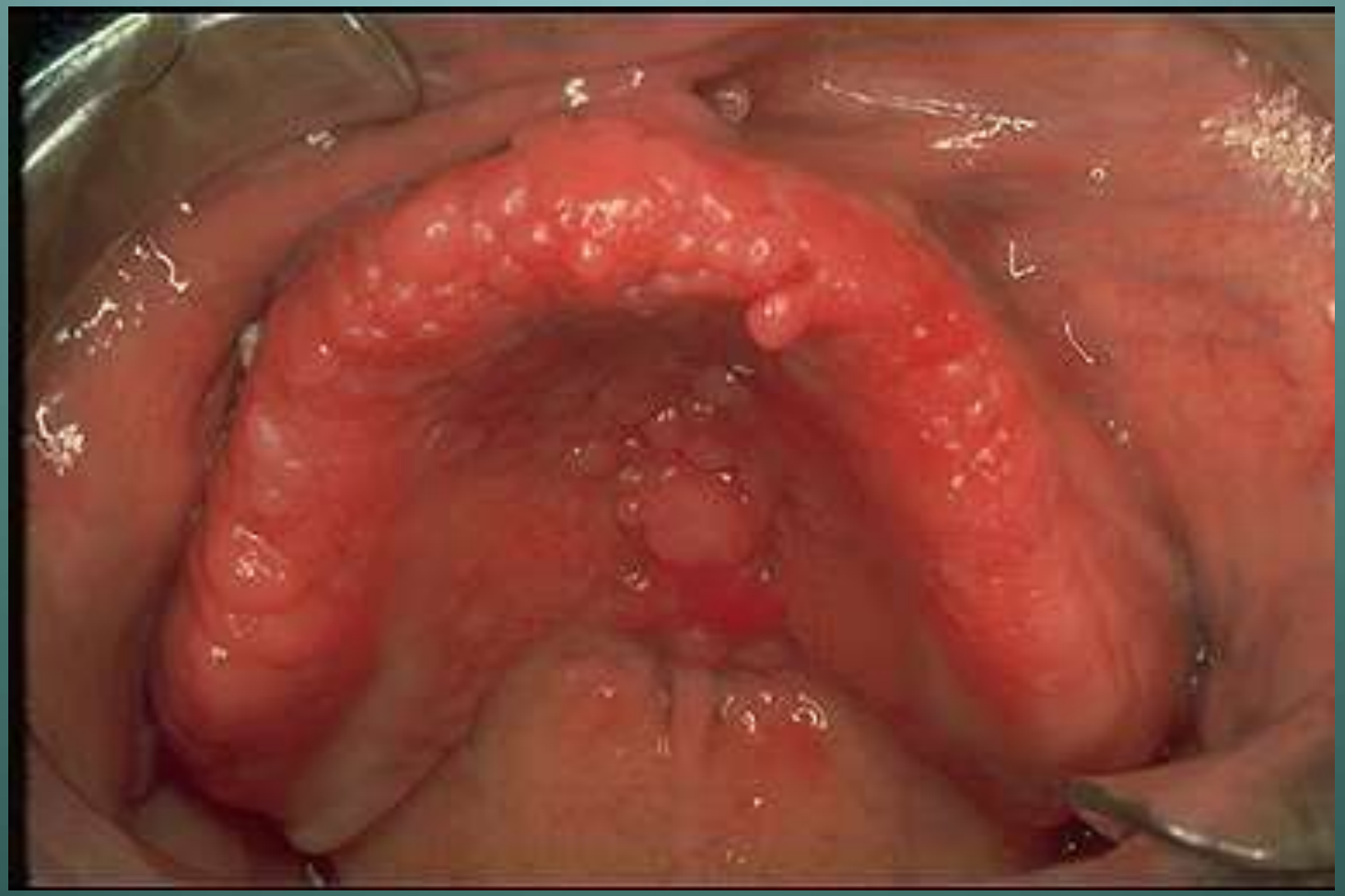

Oral Squamous Papilloma

- Probably caused by human papillomavirus (HPV)
  - Over 100 HPV types identified
  - Types 6 and 11 are most commonly associated with oral papillomas

Squamous Papilloma – Clinical Features

- Any site, with the tongue and soft palate most frequently involved
- Typically solitary
- Usually pedunculated
- Variable color

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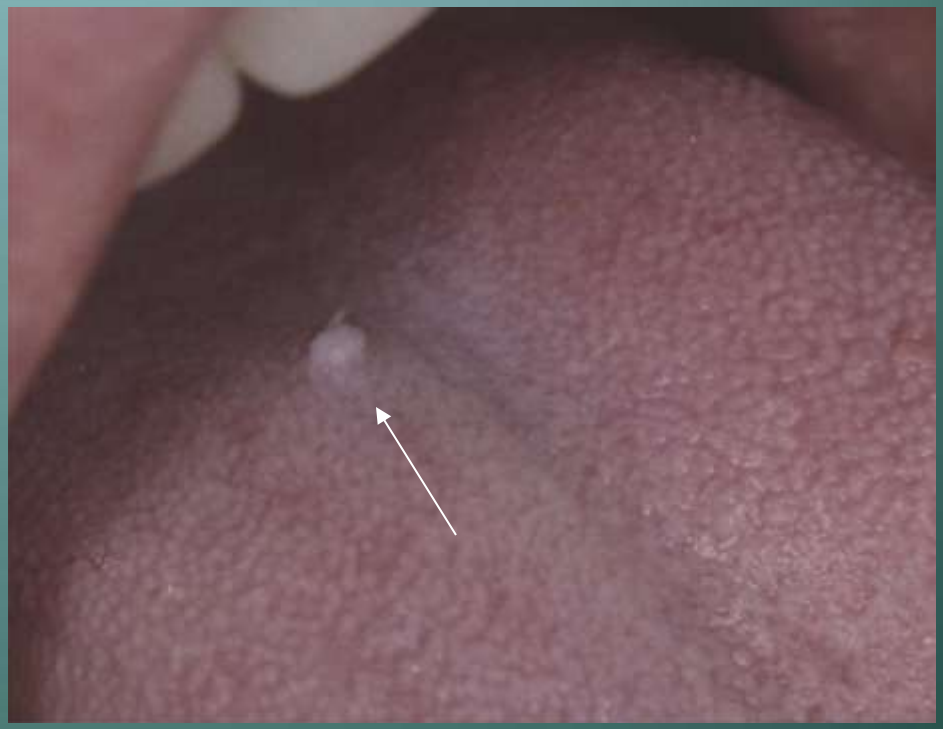

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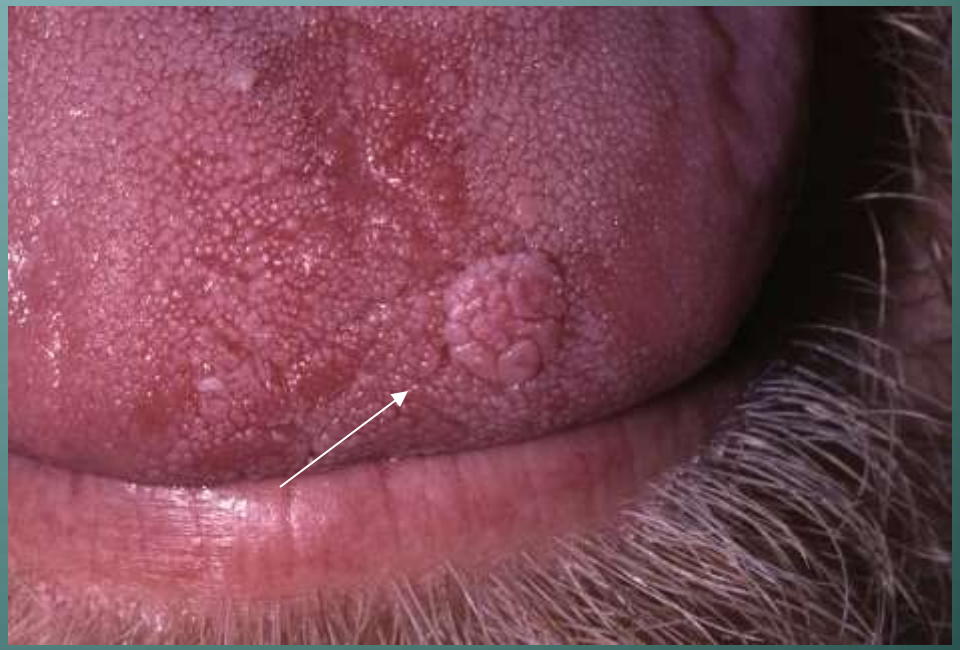

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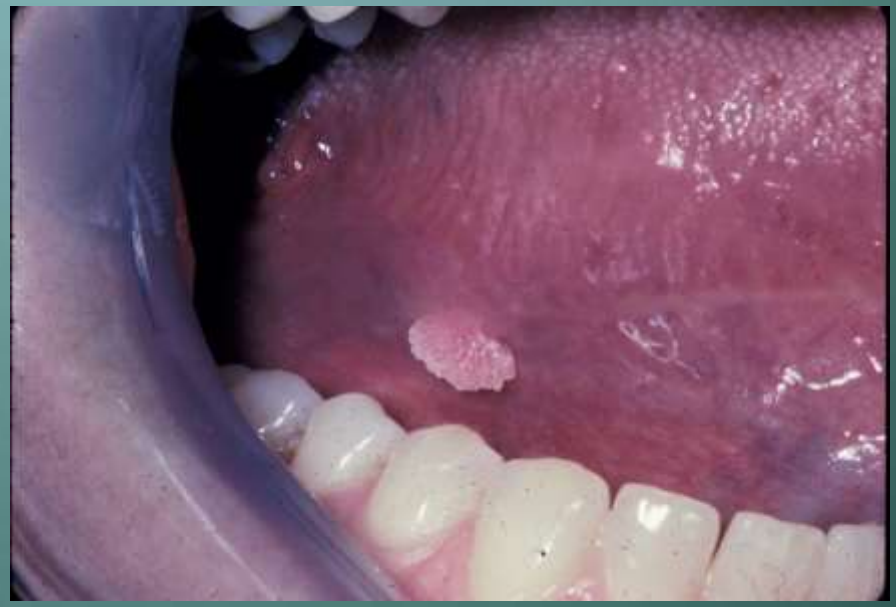

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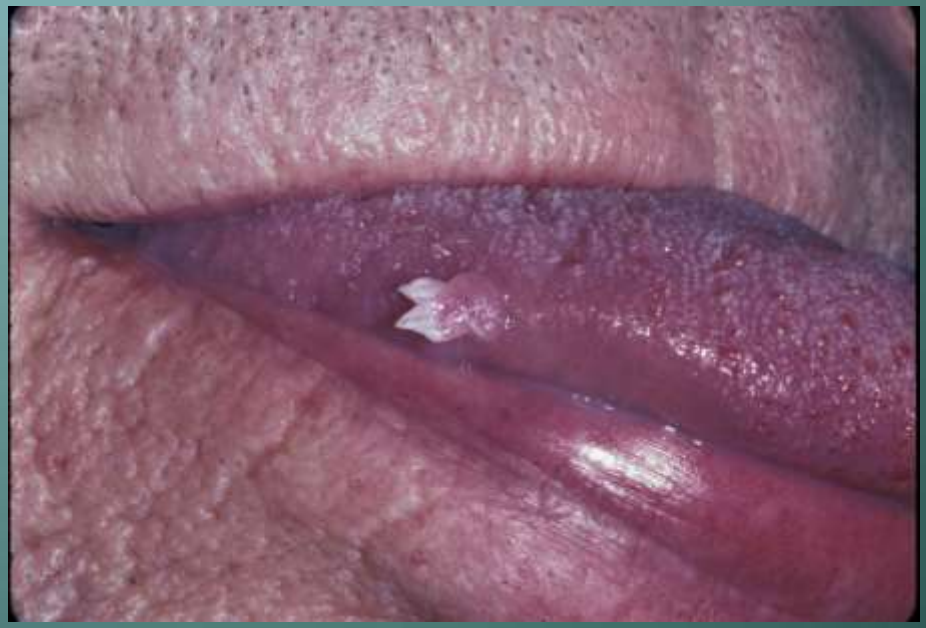

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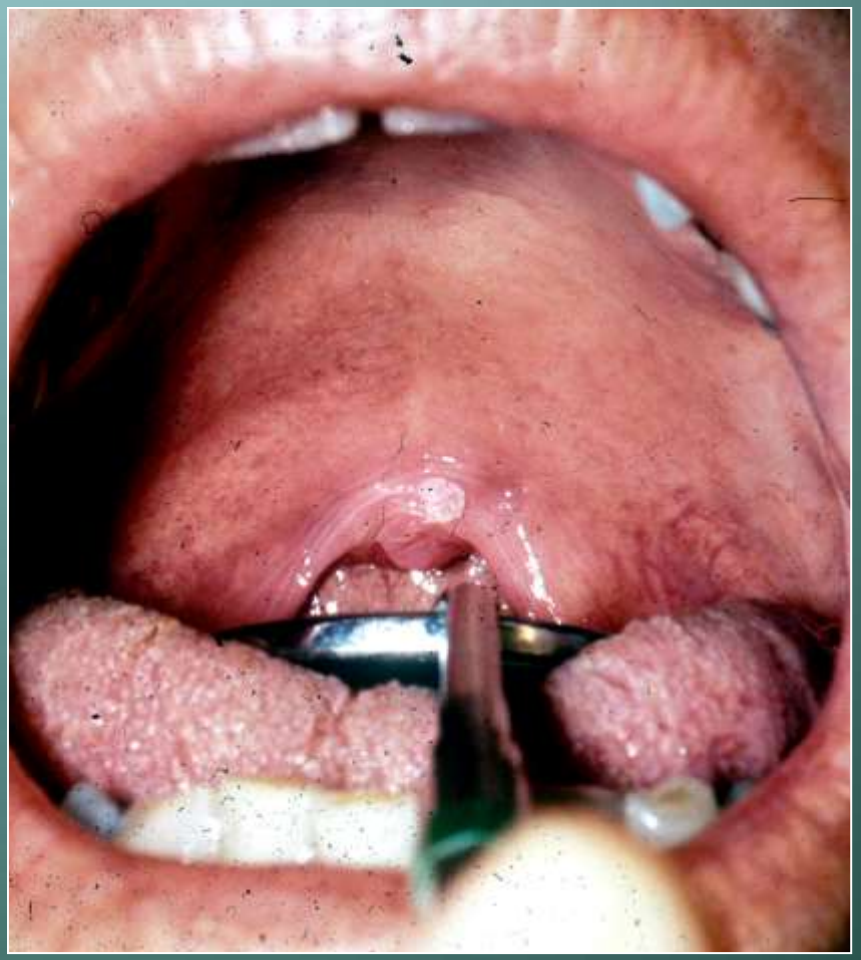

Squamous Papilloma - Treatment

- Surgical excision
- Recurrence is not expected, although lesions of the larynx may behave differently
  - Laryngeal papillomatosis

Verruca Vulgaris (Common Wart)

- Typically a benign skin lesion induced by HPV types 2,4, 6, and 40
- Relatively contagious, with potential for autoinoculation

Verruca Vulgaris – Clinical Features

- Most commonly in children
- Skin of hands
- More commonly sessile
- Variable color

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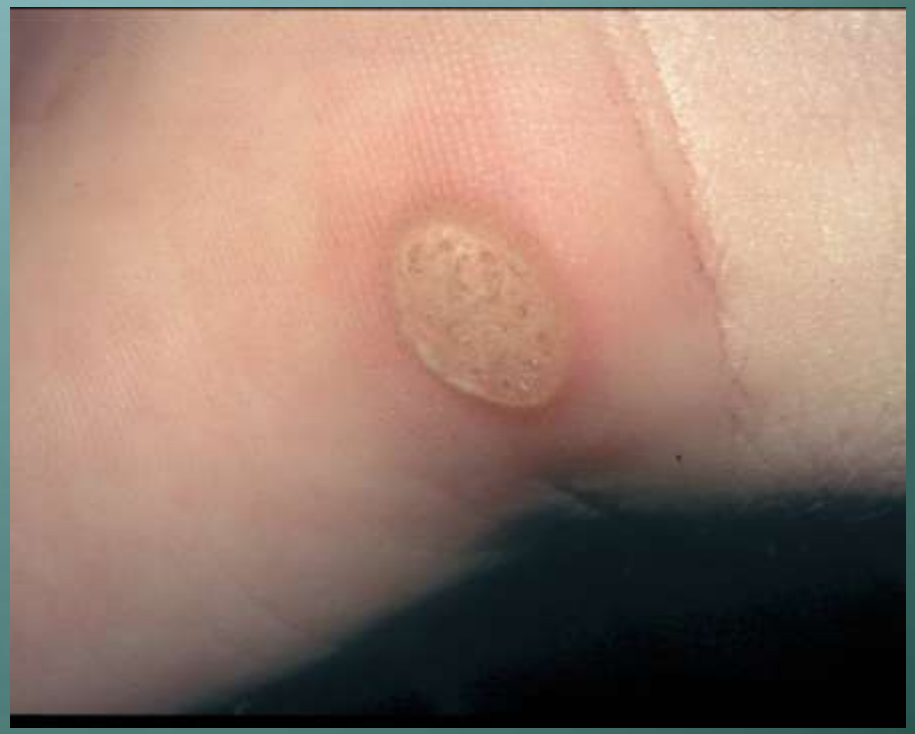
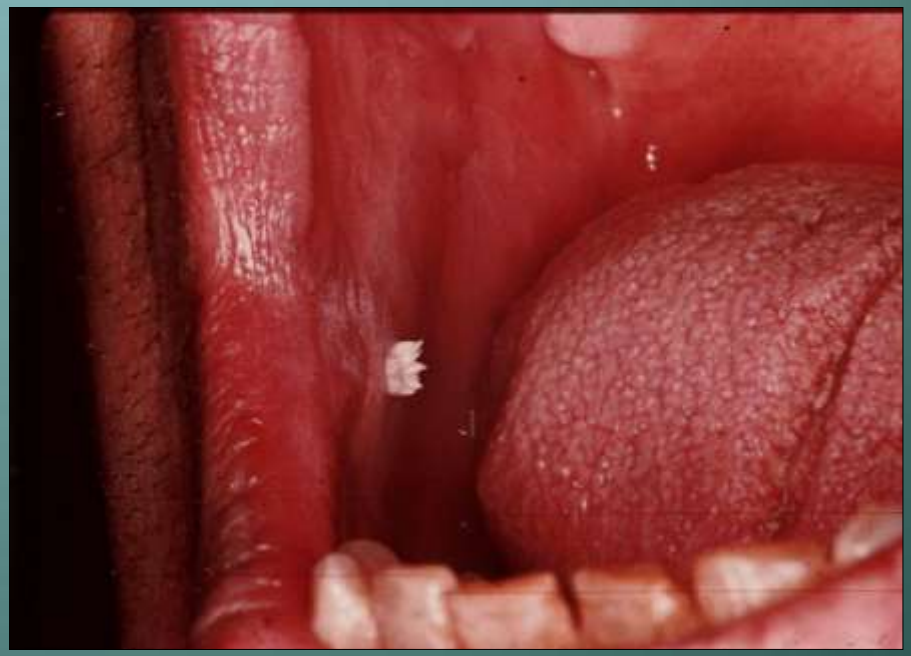


Verruca Vulgaris – Clinical Features

- Oral lesions uncommon
- Often indistinguishable from squamous papilloma
- Oral lesions typically appear white



Verruca Vulgaris - Treatment

- Surgical excision or curettage
- Liquid nitrogen, cryotherapy, or keratinolytic agents
- May spontaneously resolve
- Small rate of recurrence

Condyloma Acuminatum

- Also known as “venereal warts”
- Caused by several strains of HPV, including types 2, 6,11,16,18

Condyloma Acuminatum – Clinical Features

- Typically a genital lesion
- Oral lesions
  - Multiple, sessile, cauliflower surface

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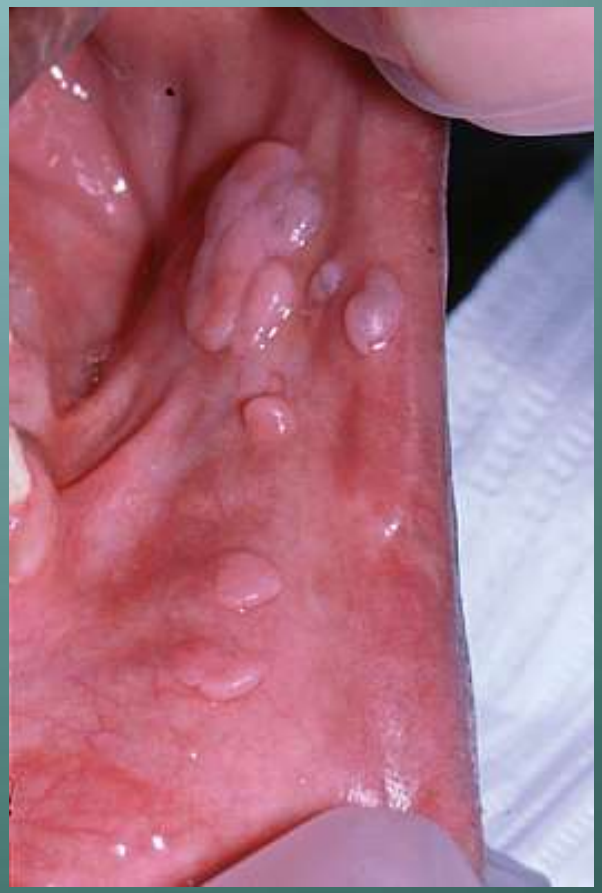

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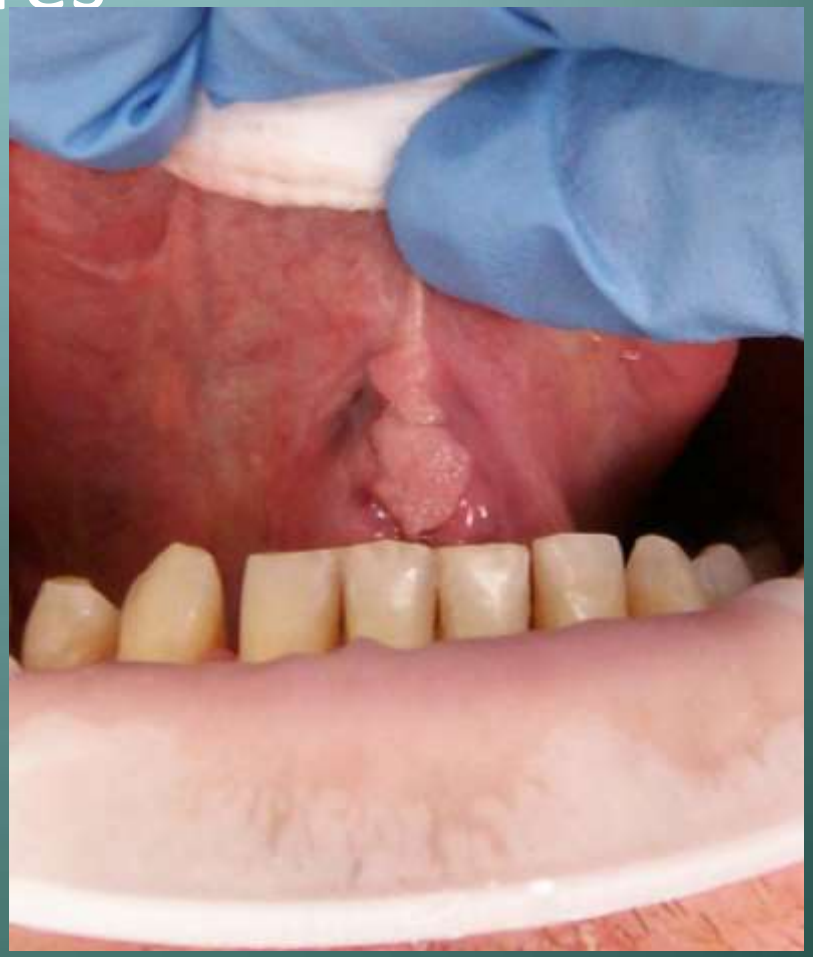

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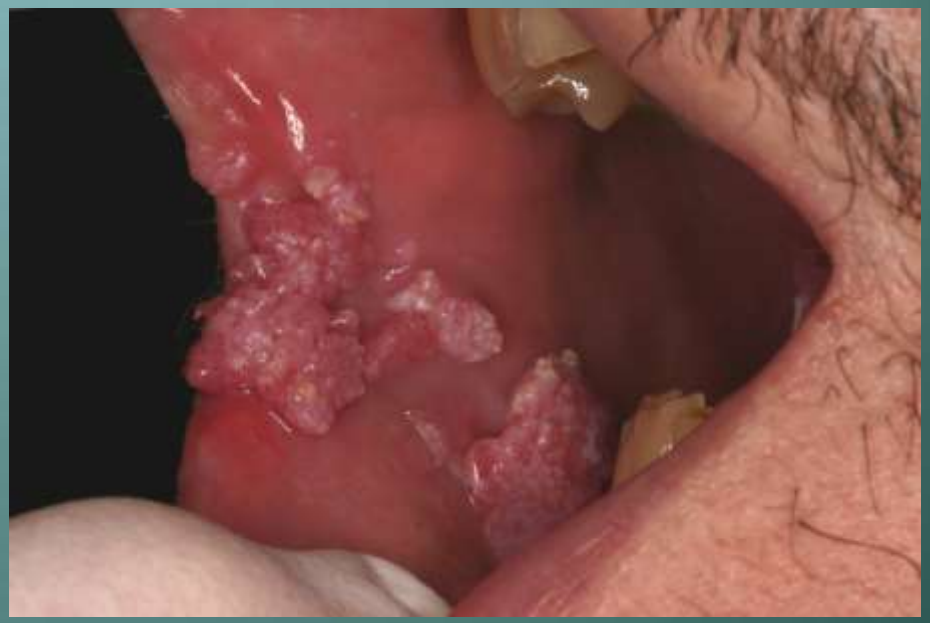


Condyloma Acuminatum

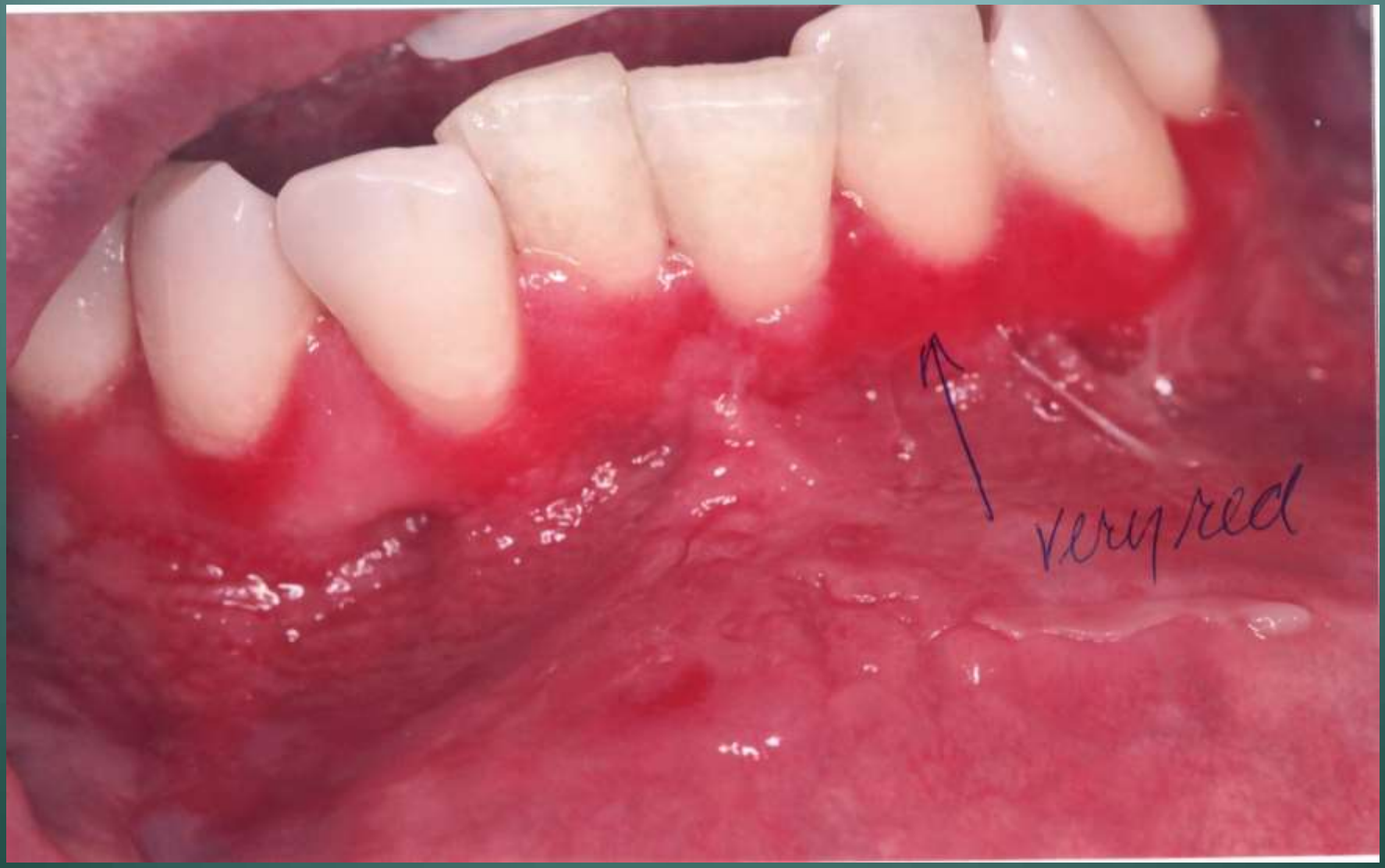
- Excision, cryotherapy, laser excision
- Recurrence is common-30% of patients have recurrent lesions after each treatment episode
- Associated with squamous cell carcinoma of the uterine cervix

Ulcerative Conditions of the Oral Regions

Case #3

- A 47 year old female presented with a history of these painful lesions

Case #3



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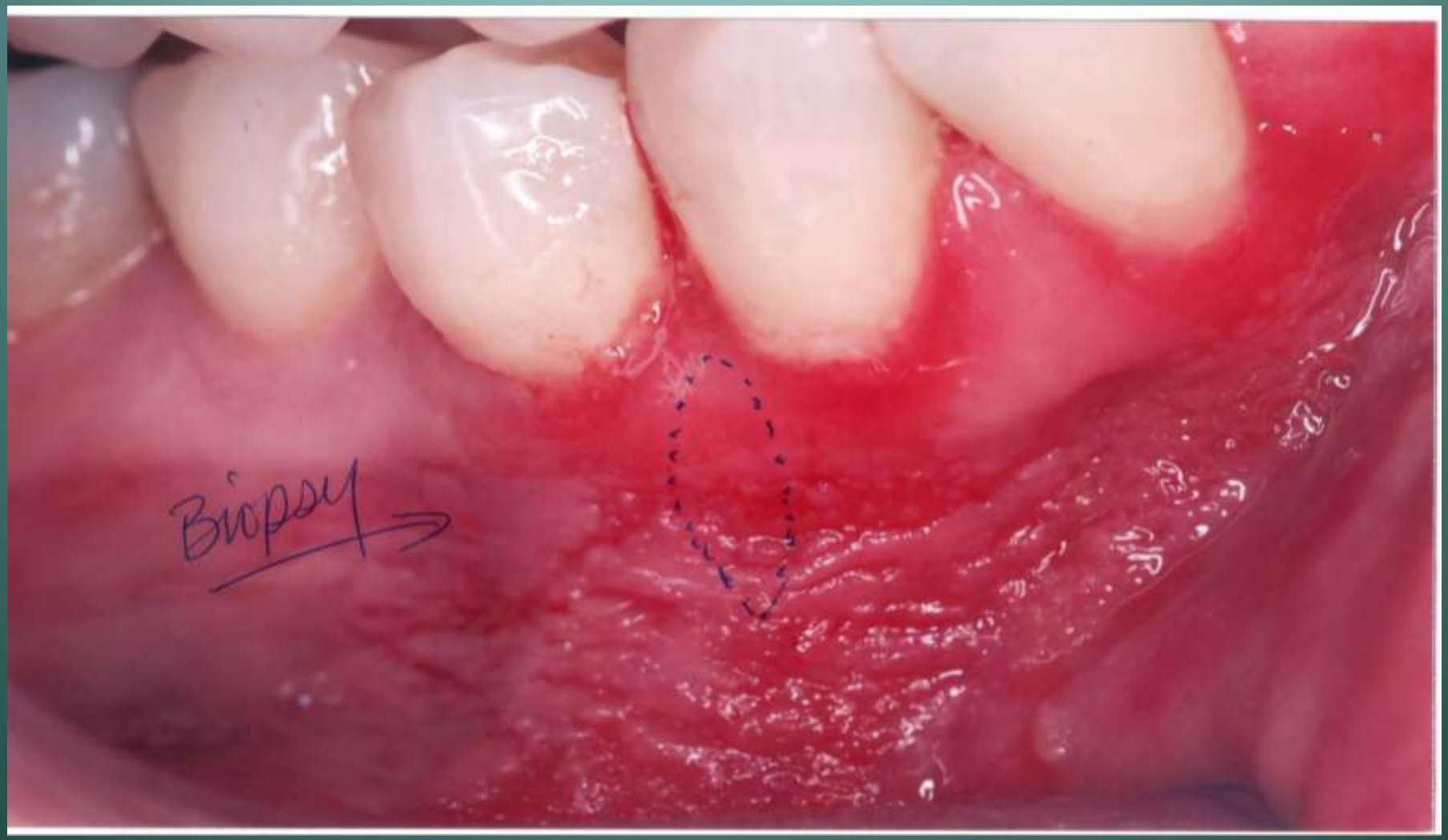

Case #3

- Clinical Diagnosis – “Desquamative Gingivitis”
- Differential Diagnosis
  - Lichen Planus
  - Cicatricial Pemphigoid
  - Pemphigus Vulgaris

Lichen Planus

- Common chronic mucocutaneous disease
- Probably immune-mediated
- May have only skin, only oral, or both

Lichen Planus – Clinical Features

- F>M, Adults
- Skin lesions-purple, polygonal, pruritic papules

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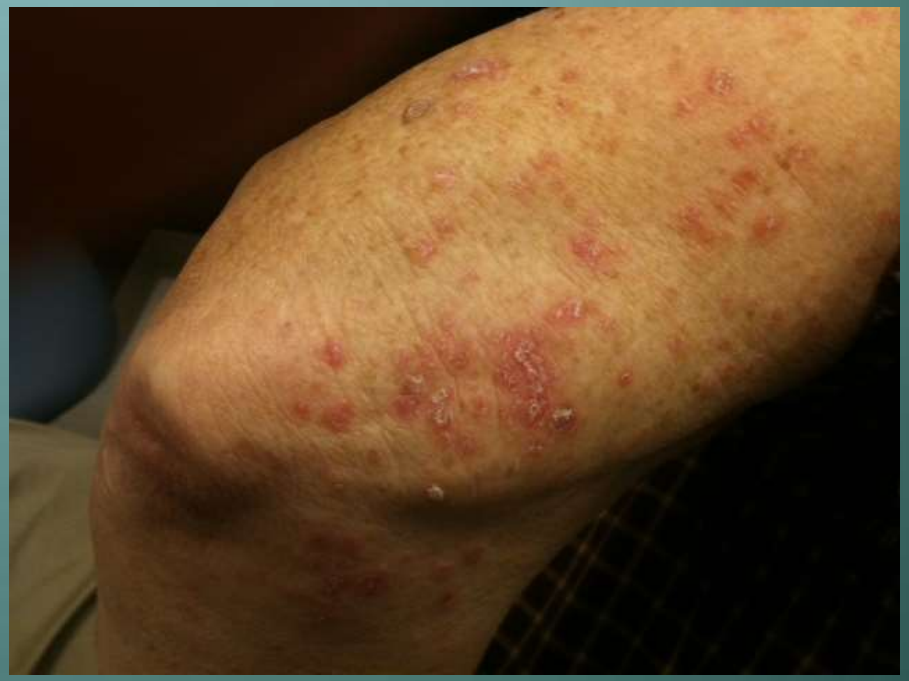
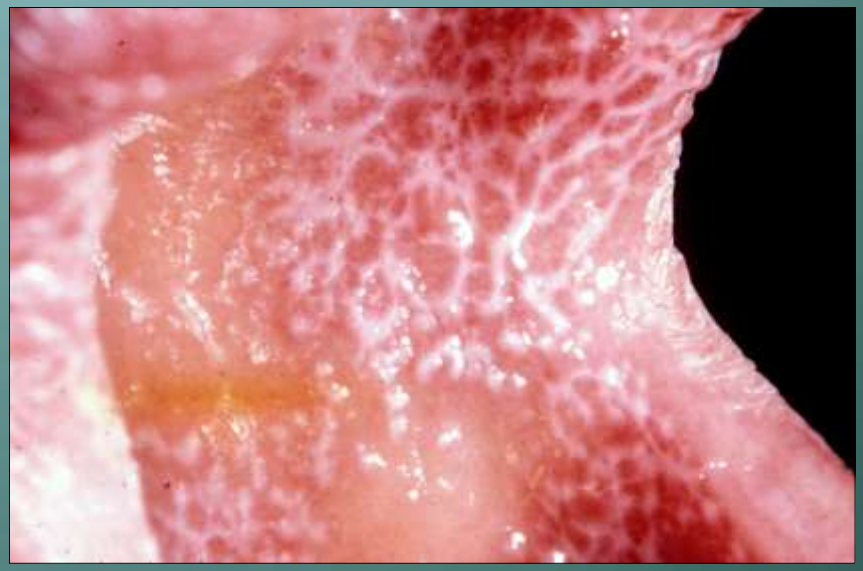


Lichen Planus – Clinical Features

- Oral lesions-reticular or erosive
- Reticular-interlacing white lines, buccal mucosa
- Erosive-ulcers with erythema and white streaks



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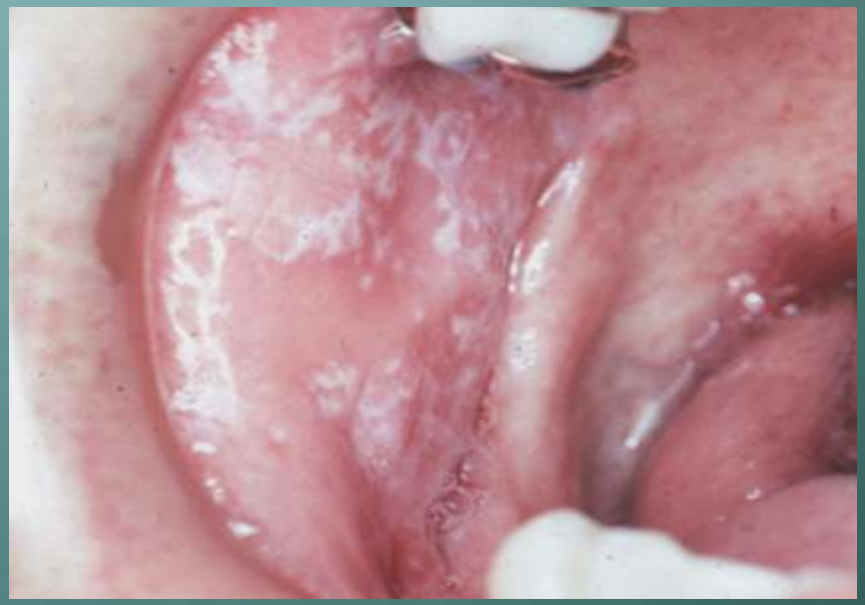

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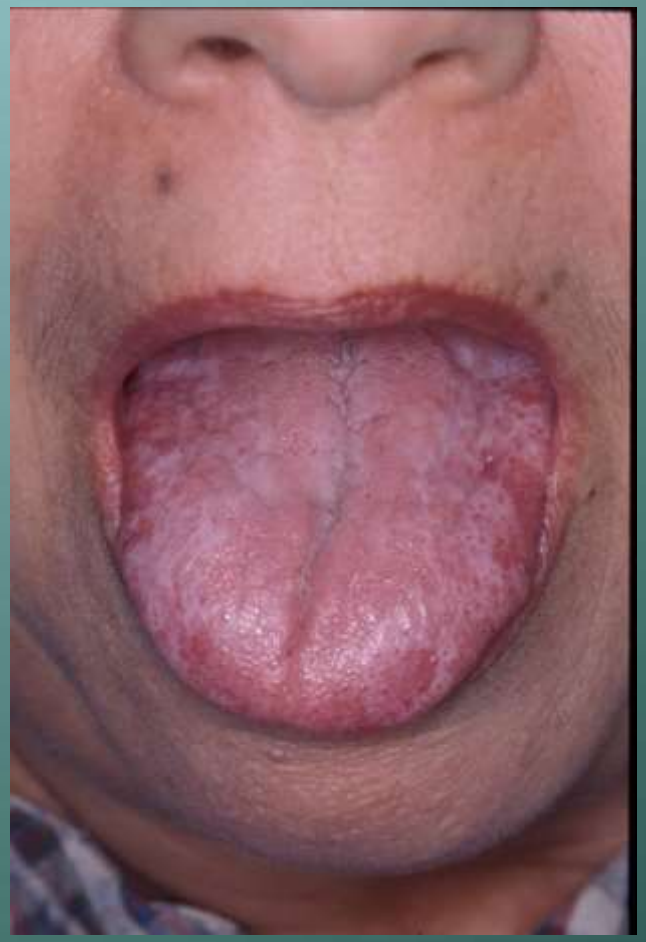
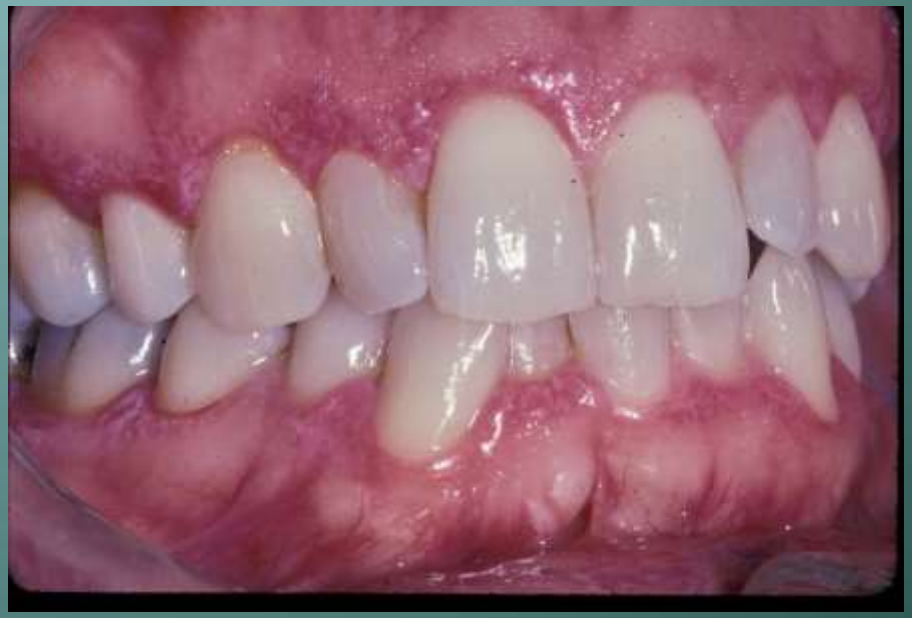


Lichen Planus – Clinical Features

- Desquamative gingivitis may be seen
- Any oral mucosal site susceptible



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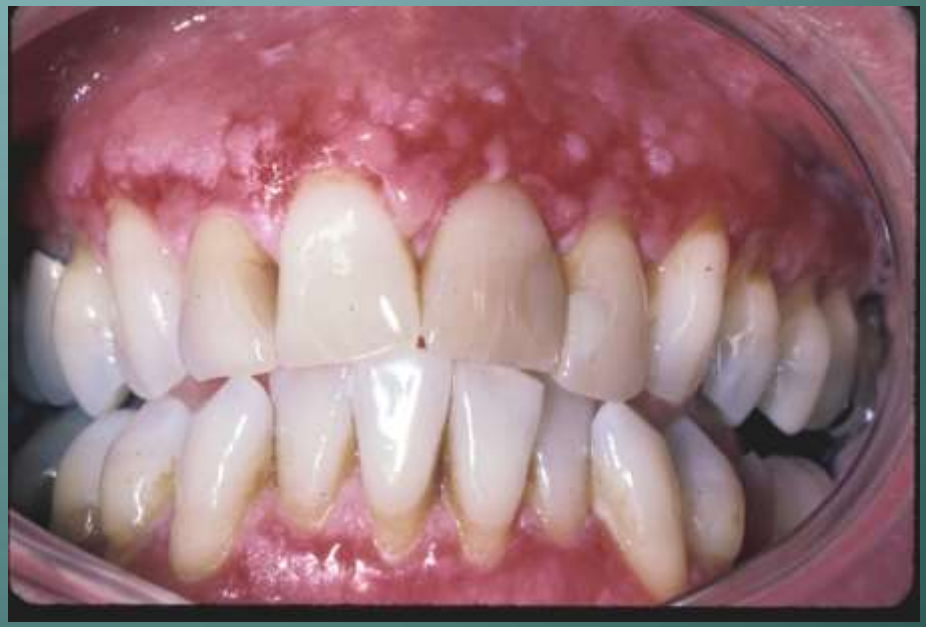

Lichen Planus -Treatment

- 25% have superimposed candidiasis, so anti-fungal Tx may be necessary
- No treatment for reticular
- Topical corticosteroids for erosive
  - Betemethasone Gel or Temovate (clobetasol) Gel

Lichen Planus -Prognosis

- Skin lesions may resolve spontaneously
- Oral lesions persist
- Malignant potential is controversial
- If premalignant, risk of transformation is probably small

Cicatricial Pemphigoid (Mucous Membrane Pemphigoid)

- Group of autoimmune disease characterized by antibodies directed against one or more components of the basement membrane
- Clinically resembles pemphigus due to blister formation
- About 2x more common than pemphigus

Cicatricial Pemphigoid – Clinical Features

- F>M, Avg. age 60
- Desquamative gingivitis
- May see intact blisters intraorally

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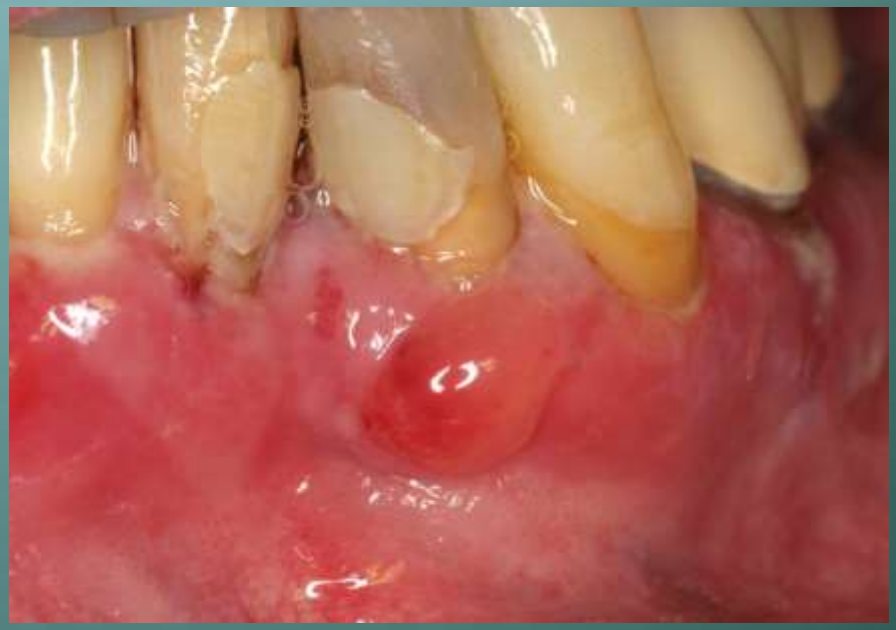

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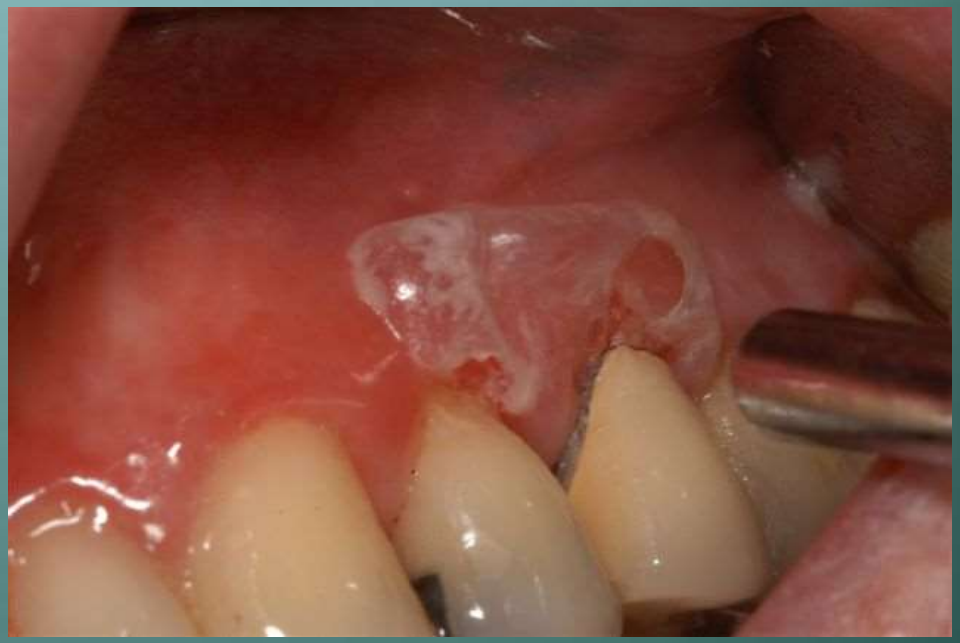
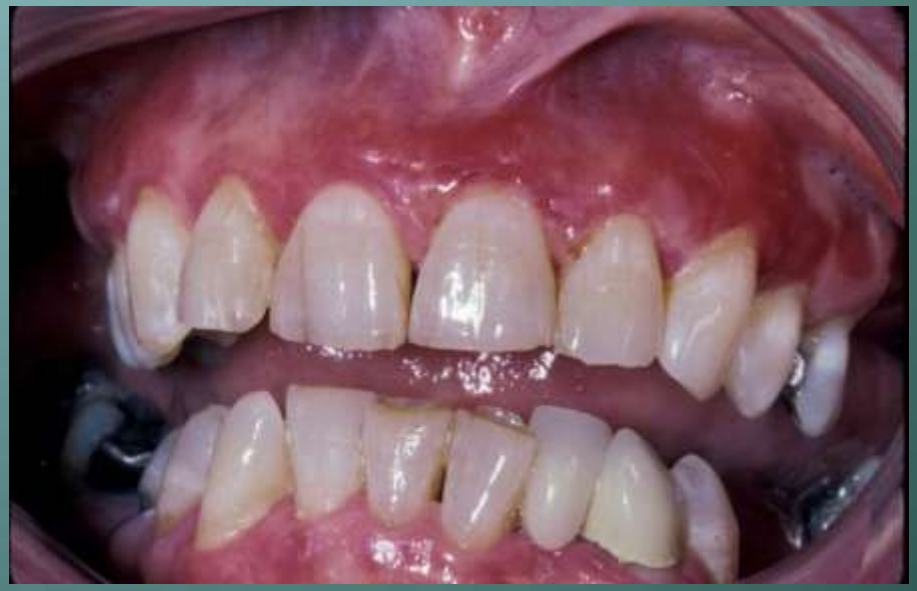


Cicatricial Pemphigoid – Clinical Features

- Affects any mucosal surface; occasionally skin
- Scarring usually refers to conjunctival mucosa (symblepharon)
- Entropian, trichiasis



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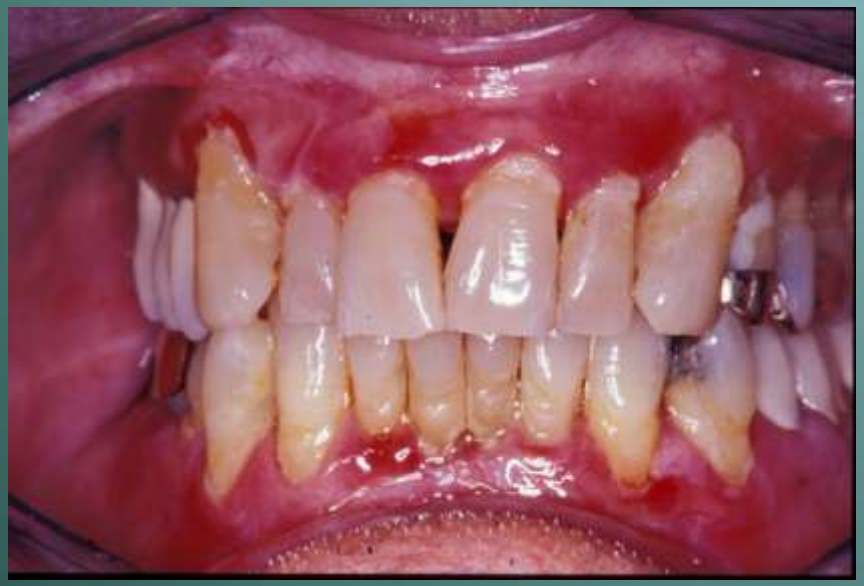

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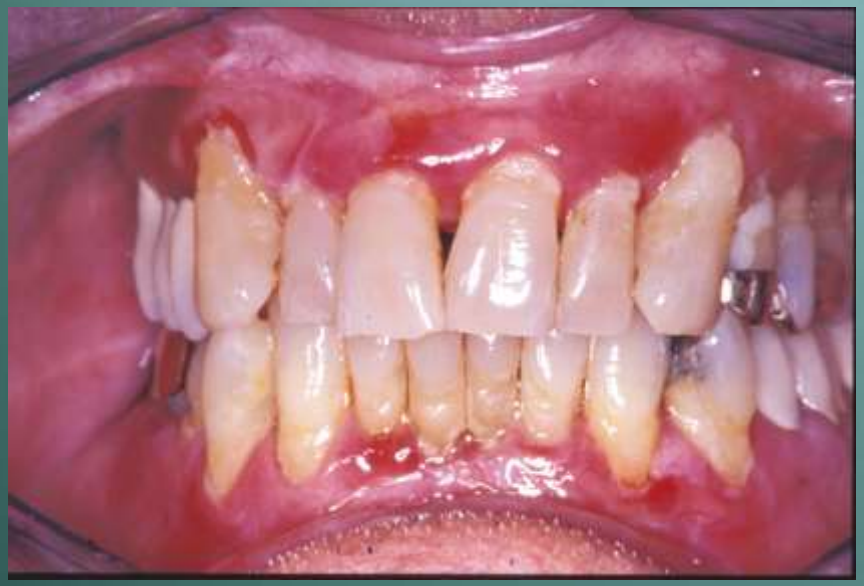
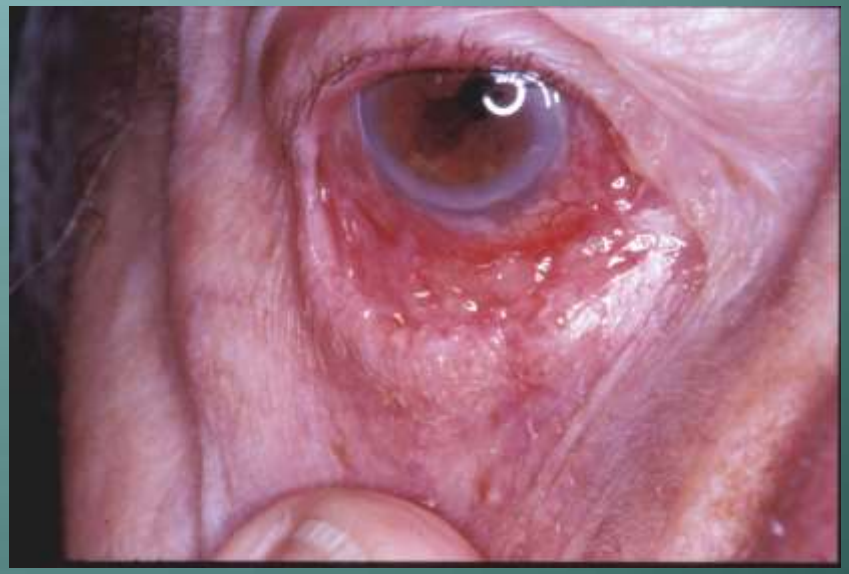
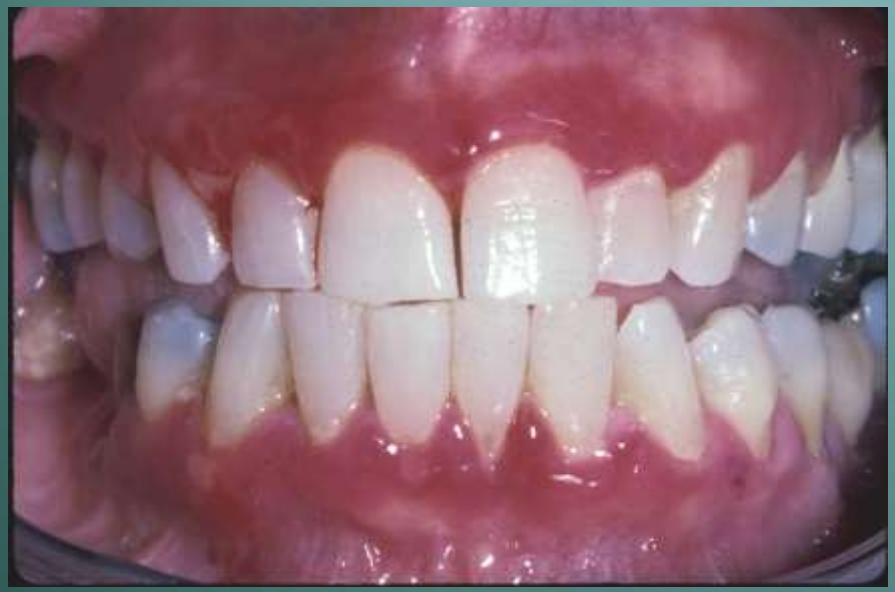




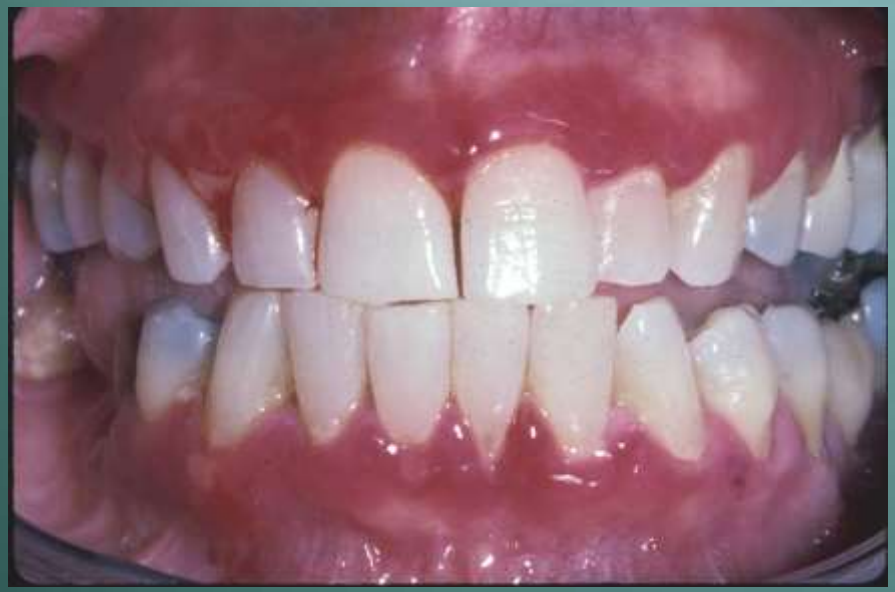
Pemphigoid-Treatment

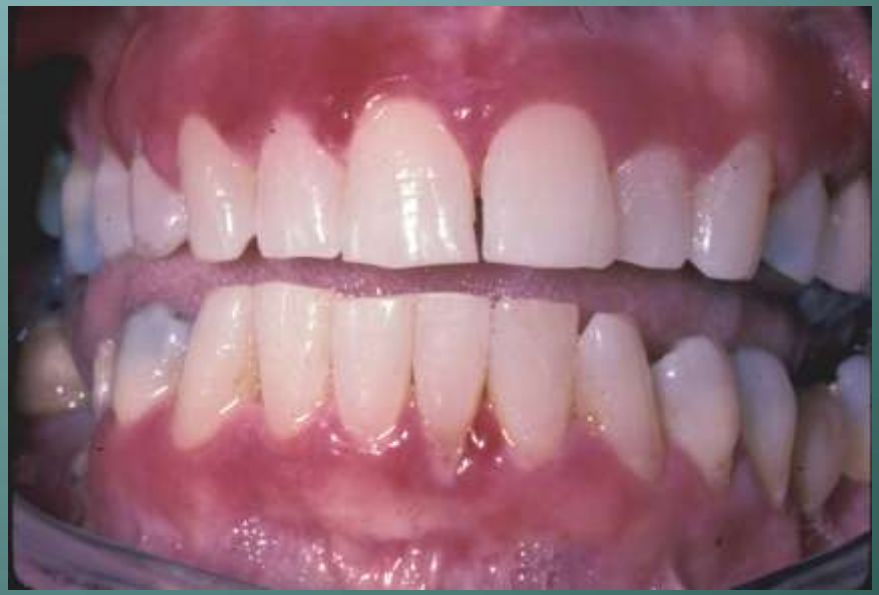
- Depends on extent of involvement
- Oral only-topical corticosteroids or dapsone
- Ocular lesions require systemic immunosuppressive therapy or human immunoglobulin therapy

Cicatricial Pemphigoid – Treatment



Cicatricial Pemphigoid – Treatment





Pemphigoid-Prognosis

- Rarely fatal
- Blindness results with untreated ocular disease
- Condition can usually be controlled
- Rarely undergoes spontaneous resolution

Pemphigus (Pemphigus Vulgaris)

- Autoimmune disorder characterized by antibodies directed against components of the epithelial desmosome complex

- Oral signs are often the first manifestations of the disease and the most difficult to resolve

Pemphigus-Clinical Features

- >50% present with oral lesions
- Ragged erosions and ulcerations
- Any oral mucosal surface
- Flaccid bullae on skin; oral blisters rarely seen
- Nikolsky's sign

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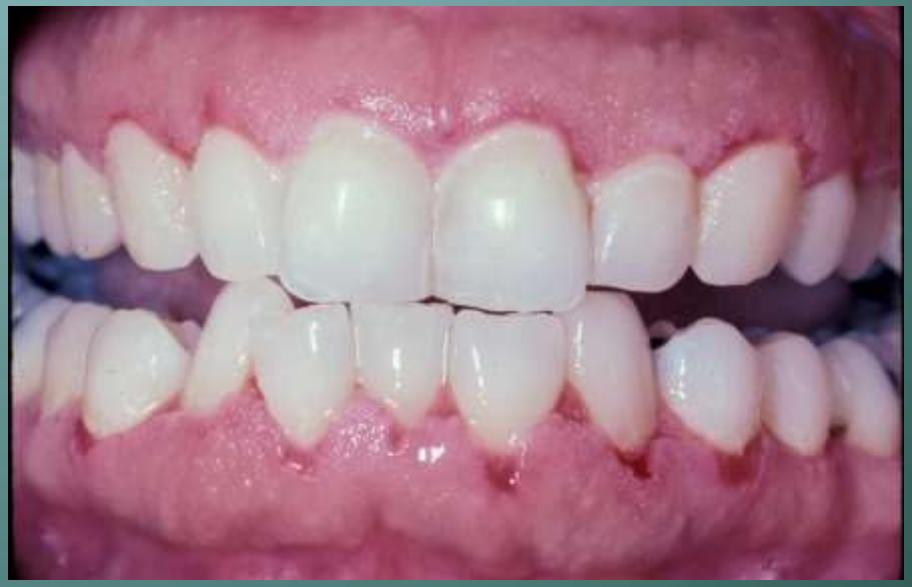

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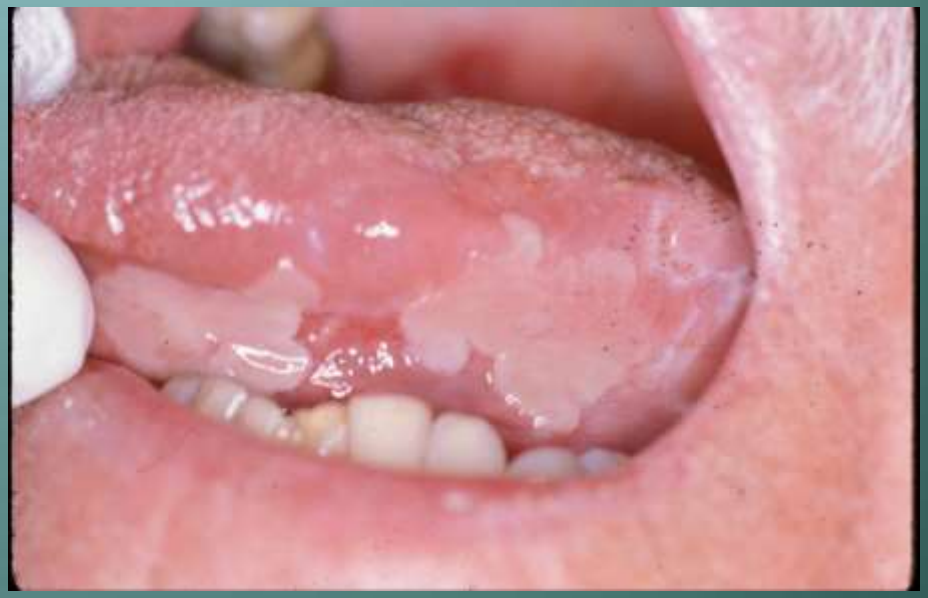

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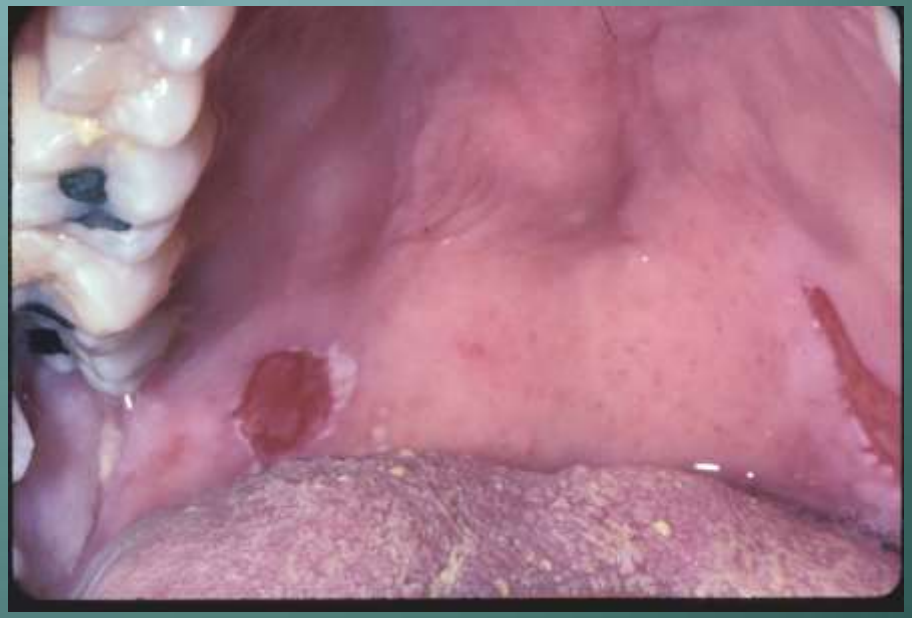


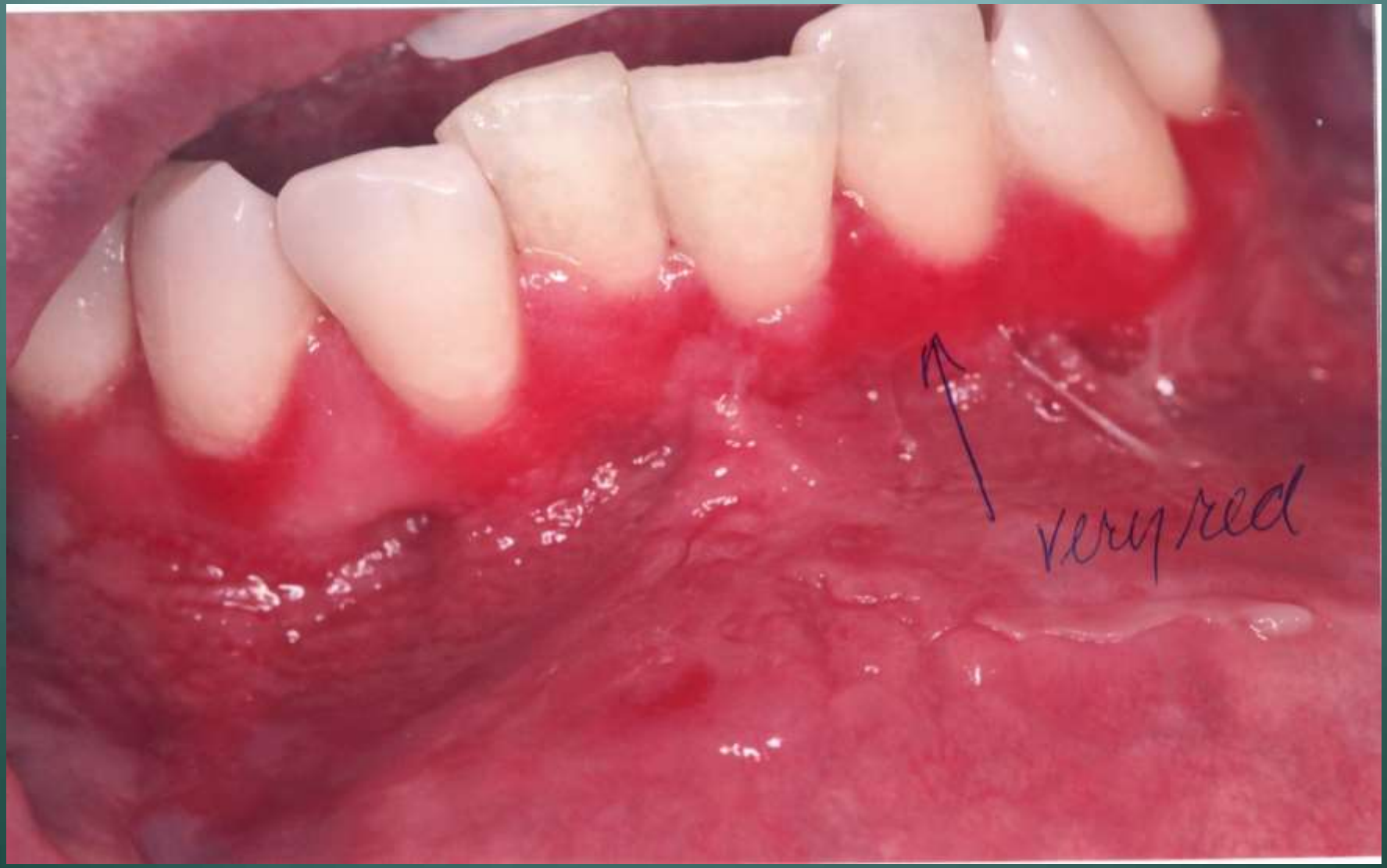
Pemphigus - Treatment and Prognosis

- Systemic corticosteroids, often with azathioprine
- Prior to corticosteroid therapy, 60-80% mortality
- Today, 5-10% mortality

Case #3

- Clinical Diagnosis – “Desquamative Gingivitis”
- Differential Diagnosis
  - Lichen Planus
  - Cicatricial Pemphigoid
  - Pemphigus Vulgaris

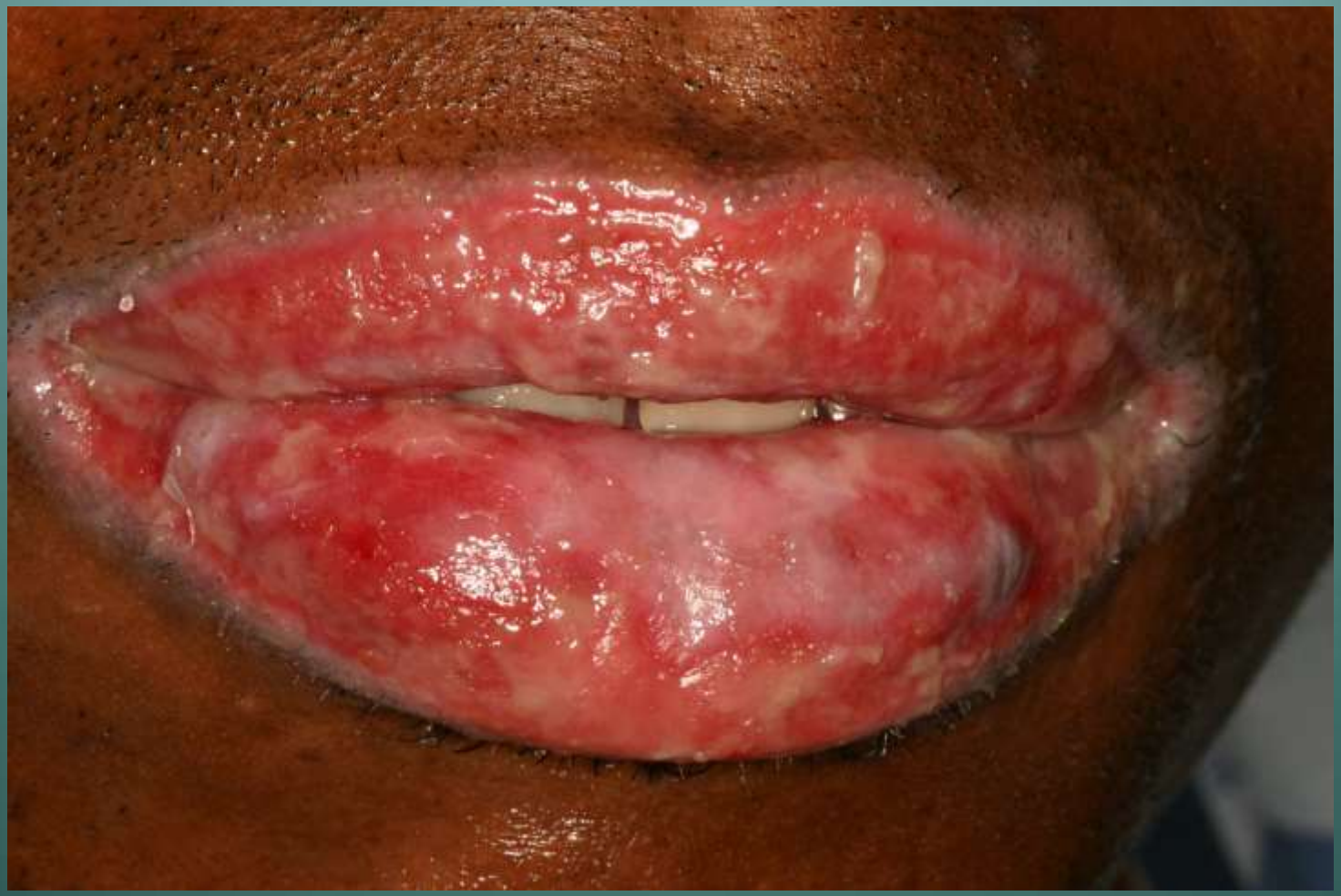
Diagnosis Case #3 – Pemphigus Vulgaris



Case #4

- A 42 year old male presented with the lesions seen here as well as genital lesions

Case #4



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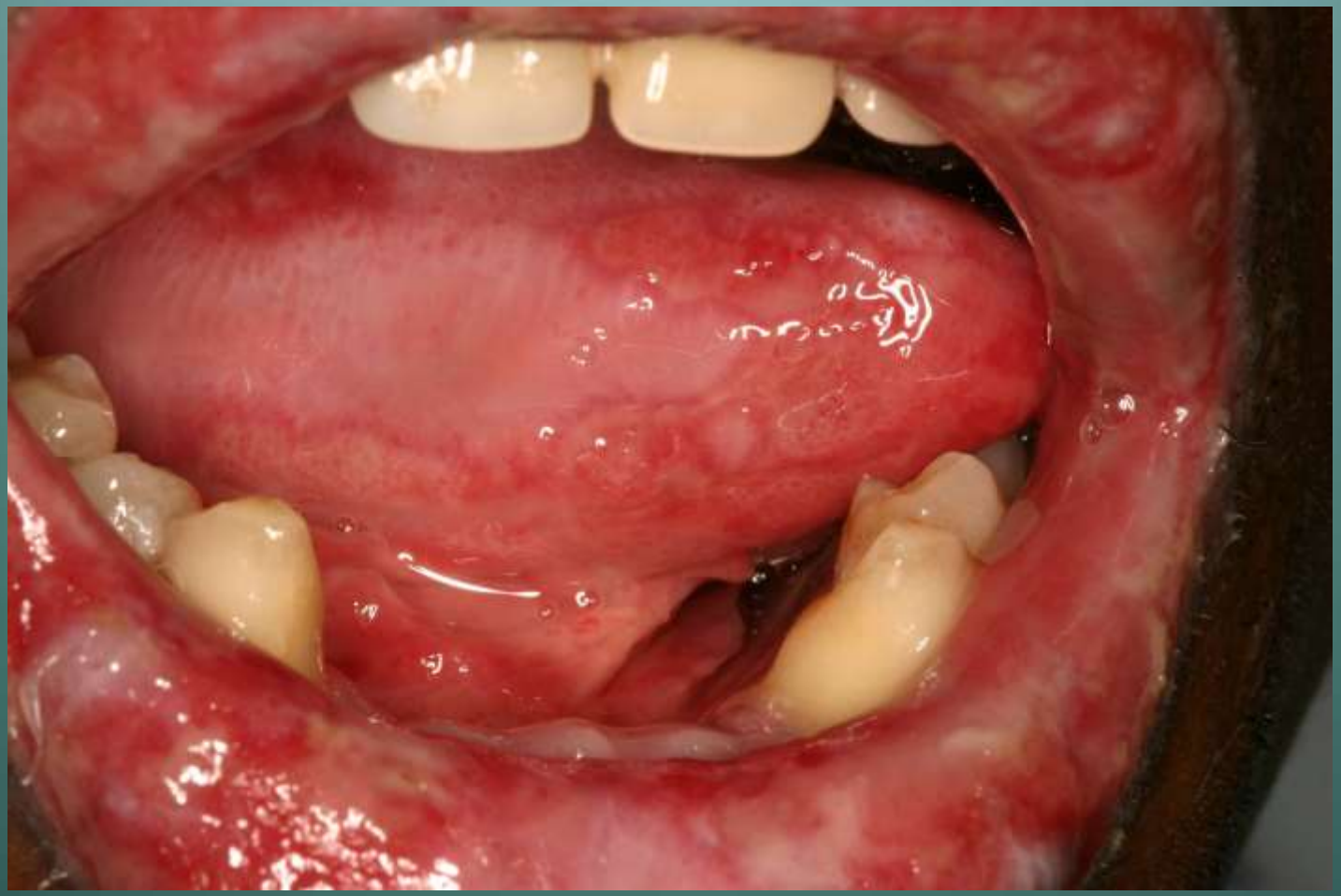

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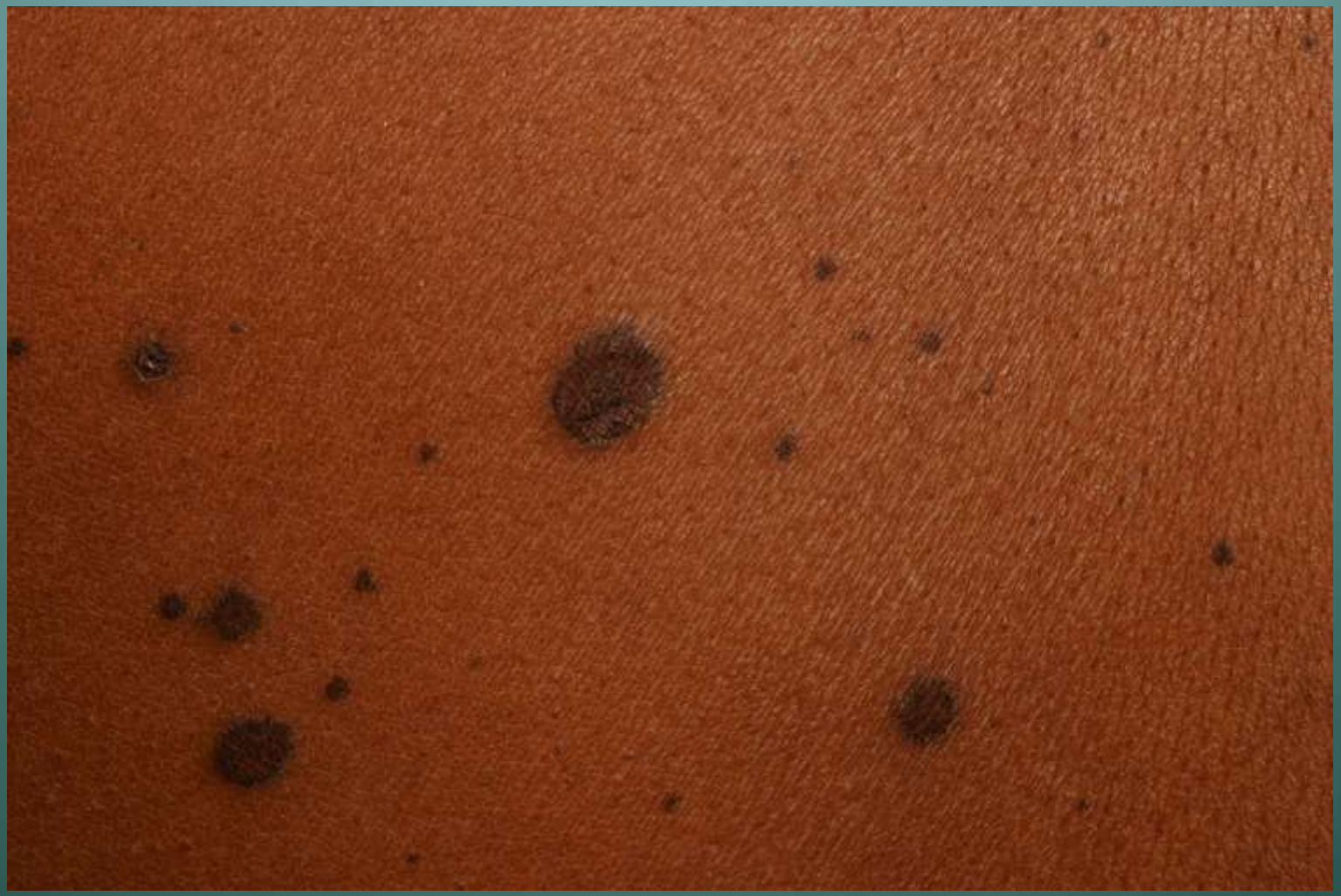

Case #4

Case #4 – Differential Diagnosis

- Erythema Multiforme
- Paraneoplastic Pemphigus

Erythema Multiforme (EM)

- Acute, self-limiting ulcerative disorder
- Probably immune-mediated
- 50%-unknown; 25%-drugs (particularly antibiotics or analgesics); 25%-infection (herpes/*Mycoplasma)*

EM - Spectrum of Clinical Disease

- Erythema multiforme minor - skin and/or mucosa only
- Erythema multiforme major (Stevens-Johnson syndrome)
  - At least two mucosal sites plus skin involvement
- Toxic epidermal necrolysis (Lyell's disease)

EM-Clinical Features

- M>F
- Young adults
- May experience prodrome

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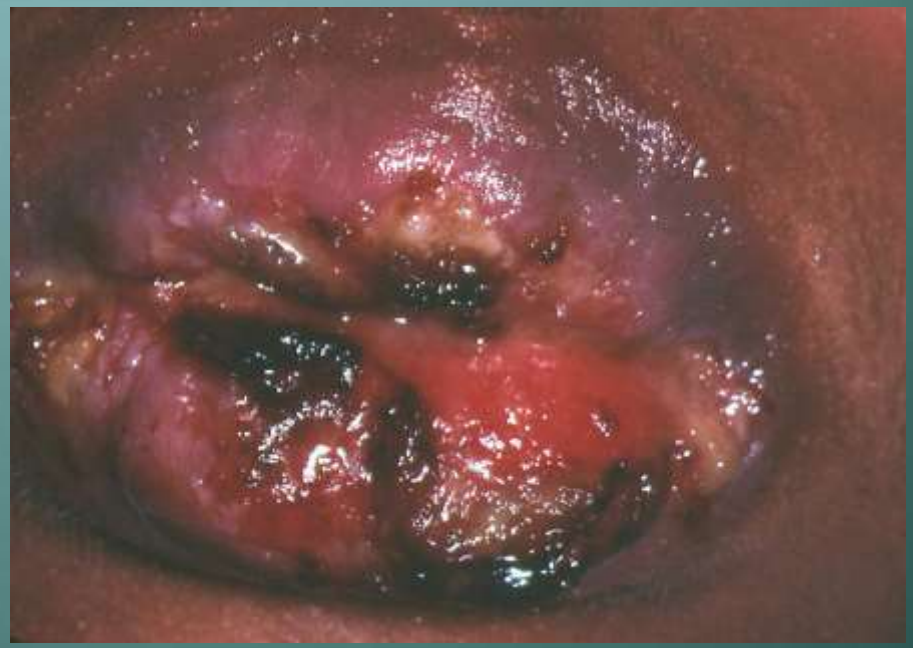
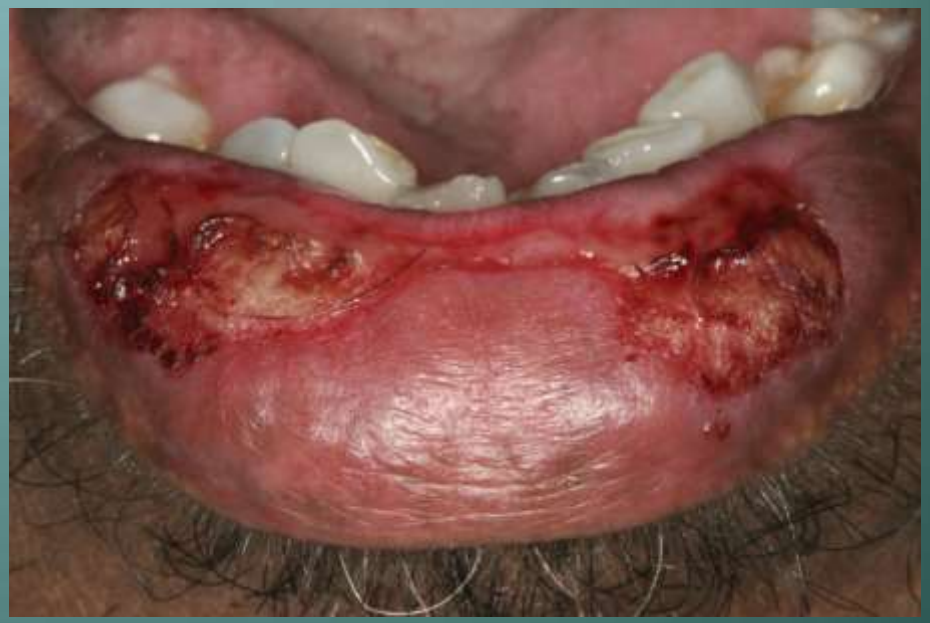


EM-Clinical Features

- Hemorrhagic crusting of lips
- Widespread oral ulcers with ragged margins
- Labial, buccal mucosa and tongue
- “Target” lesions of skin



EM-Clinical Features

- Outbreak typically clears in 2-6 weeks
- Often recurs in spring and fall

EM-Treatment

- Supportive or topical corticosteroids for mild cases
- Systemic corticosteroids for EM major
- TEN managed in burn unit, possibly with pooled immunoglobulin

EM Prognosis

- Good for mild to moderate cases
- EM major-2-10% mortality
- TEN-34% mortality

Paraneoplastic Pemphigus

- Serious vesiculobullous disorder affecting patients with neoplastic disease, typically a lymphoreticular malignancy (CLL and lymphoma)
- Antibodies in response to the tumor probably cross react with components of the epithelial layer
- Cytotoxic T lymphocytes may also play a role in cutaneous and mucosal damage

Paraneoplastic Pemphigus – Clinical Features

- Clinically resembles a number of conditions
  - Erythema multiforme
  - Pemphigus
  - Lichen planus
  - Pemphigoid

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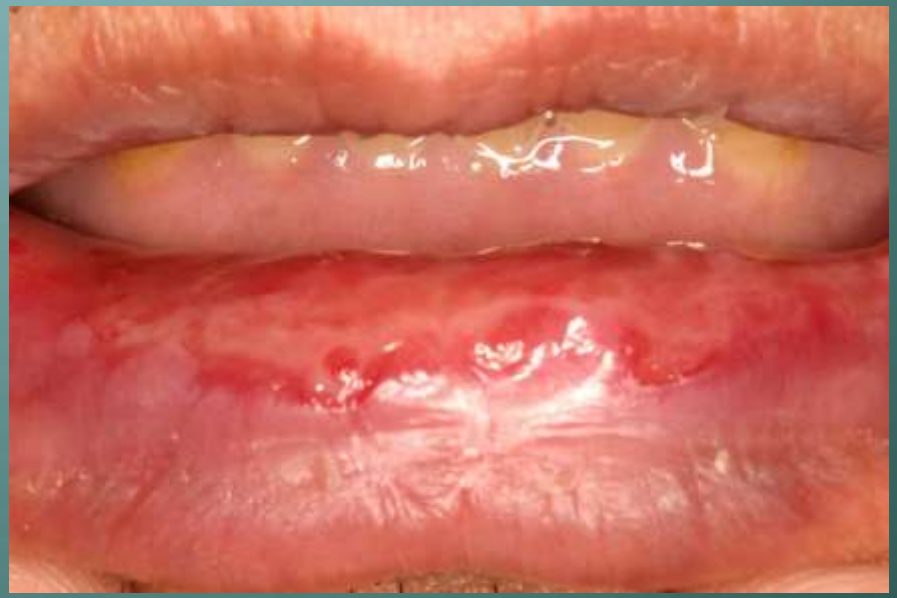
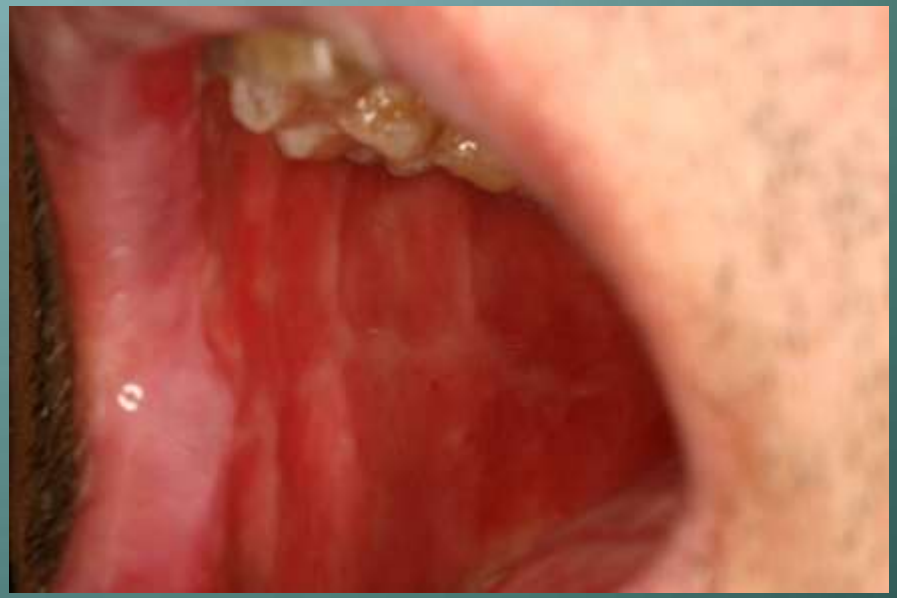


Paraneoplastic Pemphigus – Clinical Features

- Oral lesions
  - Hemorrhagic crusting of lips
  - Diffuse ulcerations



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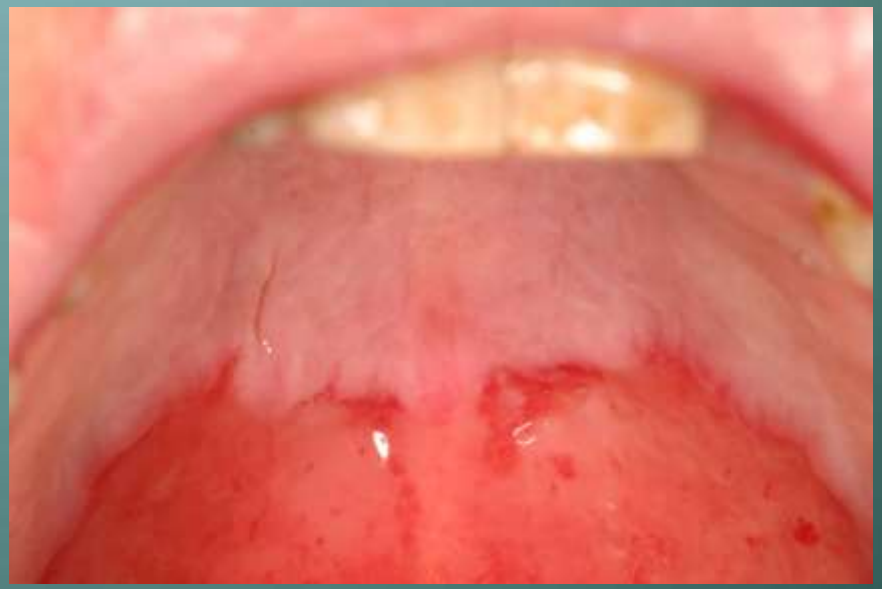

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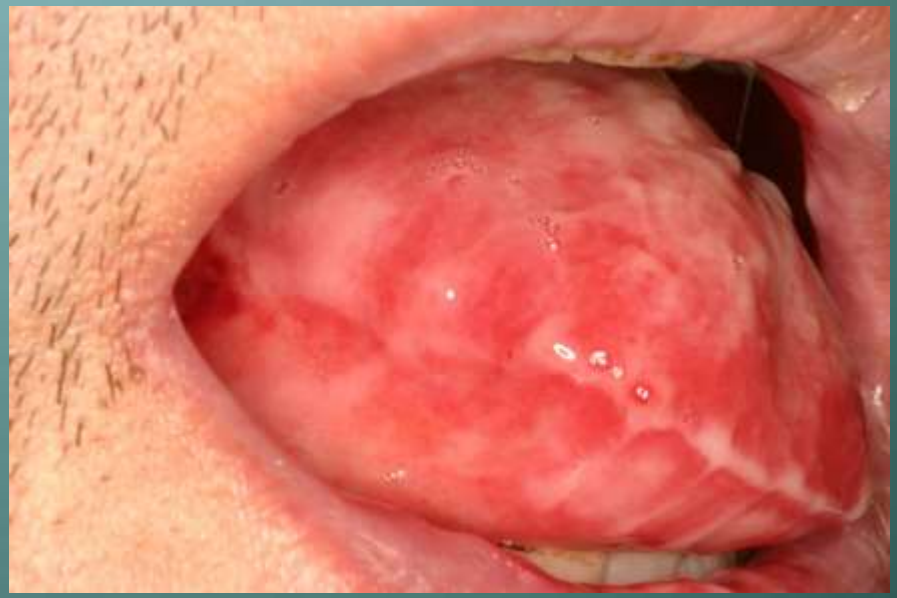

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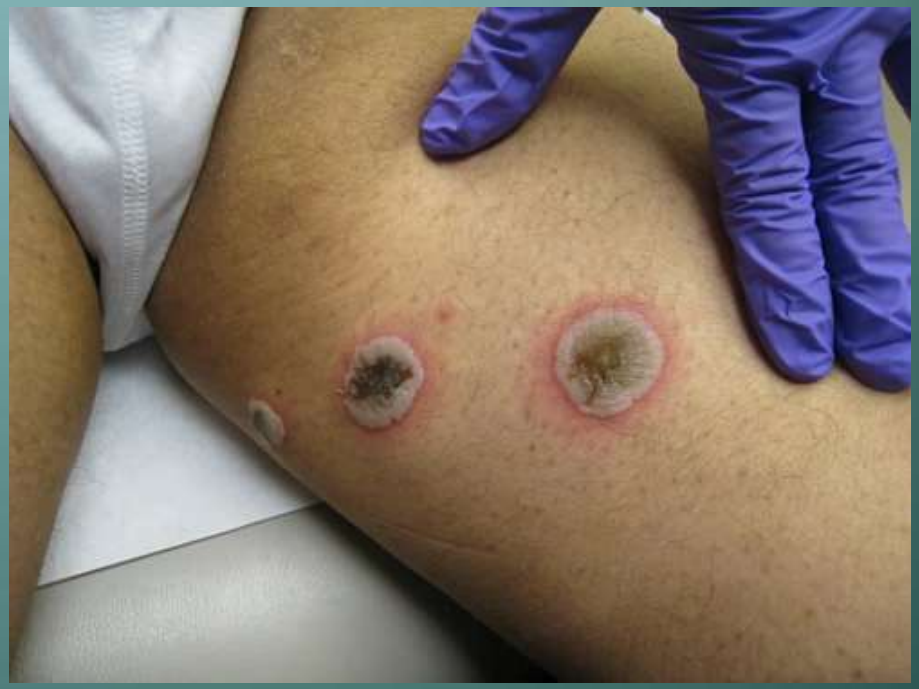


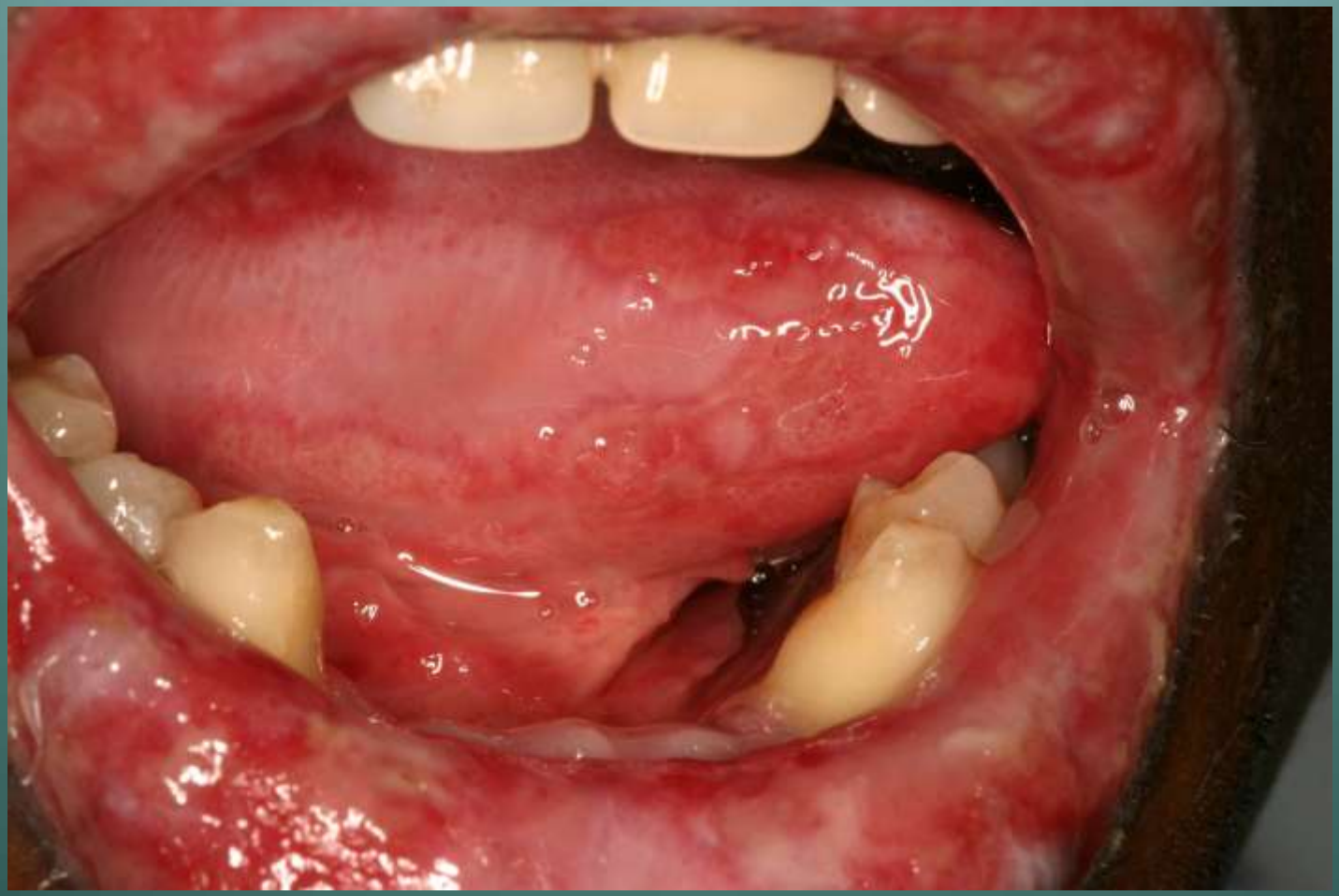
Paraneoplastic Pemphigus – Treatment and Prognosis

- Systemic corticosteroids plus azathioprine
- Topical corticosteroids
- Generally poor prognosis, high mortality due to sepsis or malignant progression

Case #4 – Differential Diagnosis

- Erythema Multiforme
- Paraneoplastic Pemphigus

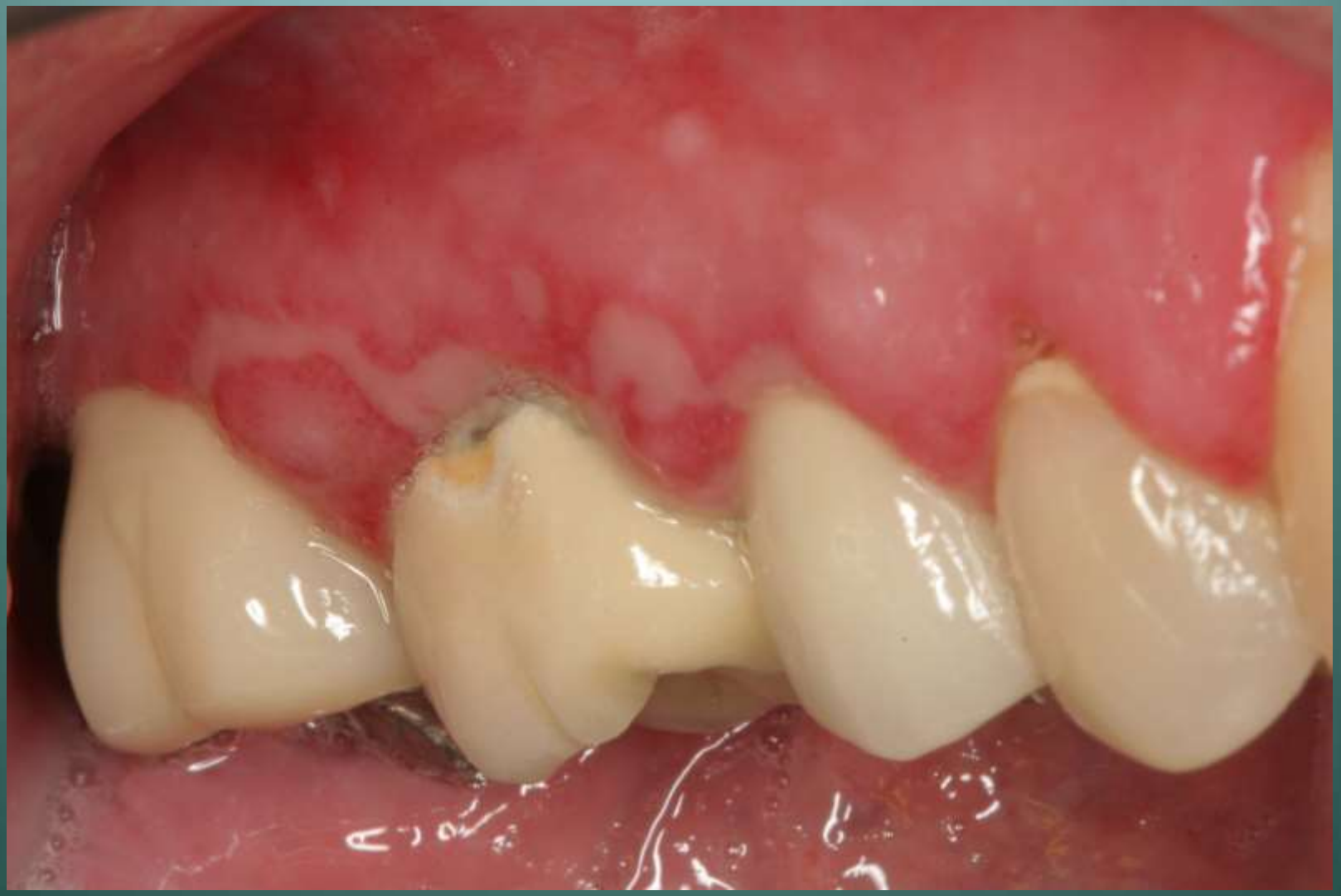
Diagnosis Case #4 – Erythema Multiforme



Case #5

- An adult male presents with ulcerations distributed as seen

Case #5



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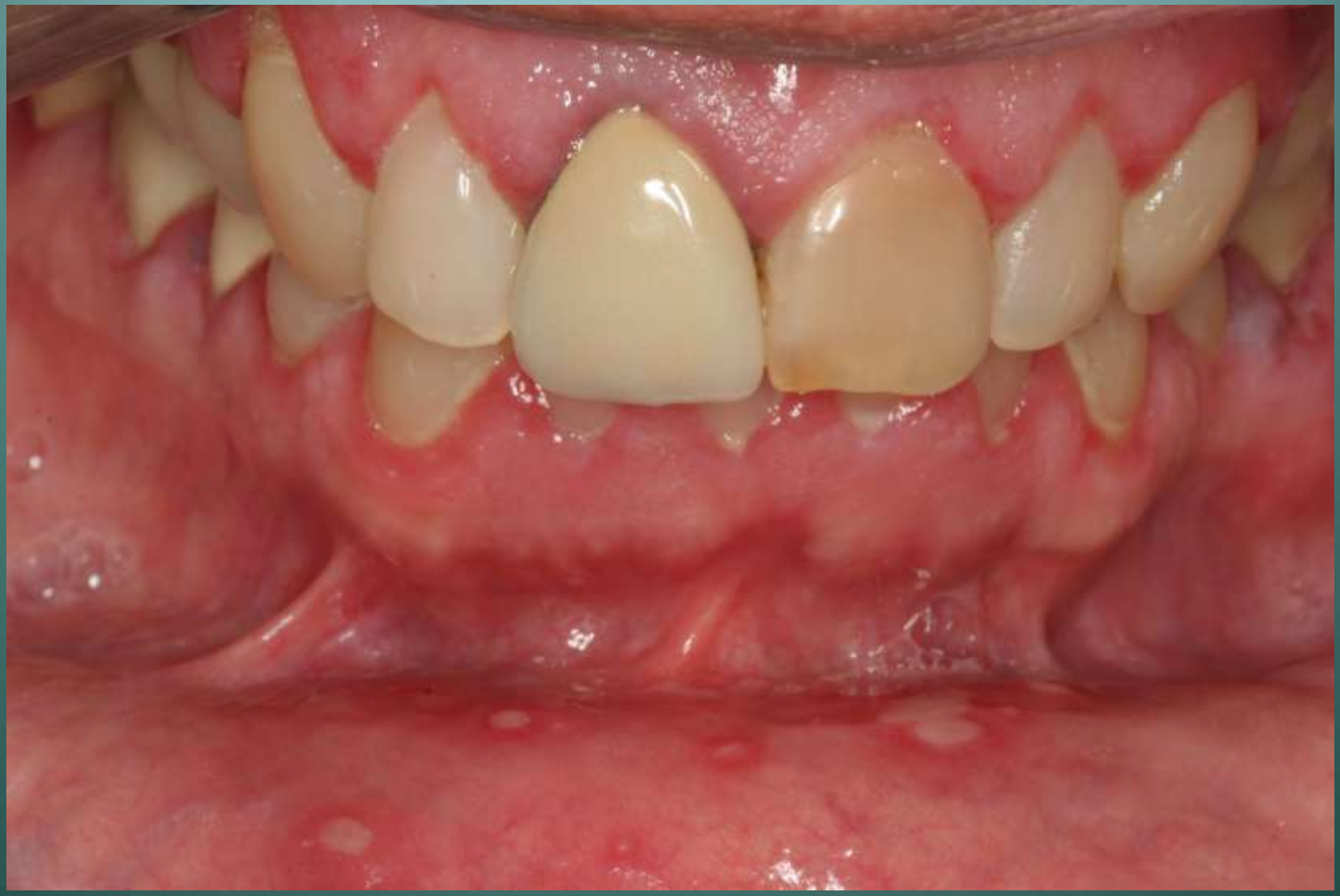

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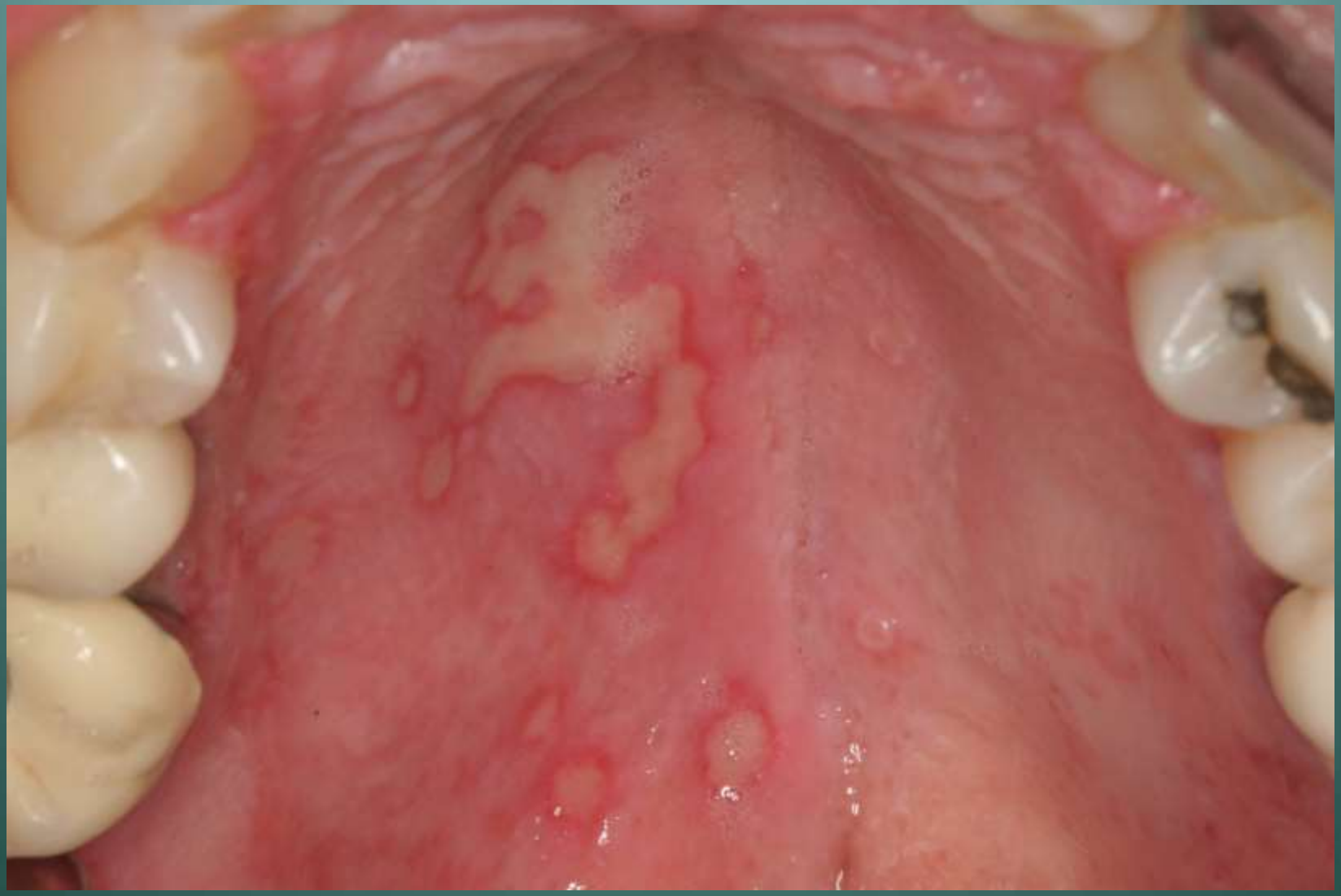


Case #7 – Differential Diagnosis

- Herpes Simplex Type 1
- Recurrent Aphthous Stomatitis
- Erythema multiforme

Herpes Simplex Virus (HSV)

- DNA virus in the herpesvirus family
  - HHV-1 – oral herpes
  - HHV-2 – genital herpes
  - HHV-3 – chicken pox and shingles (Varicella-Zoster virus)
  - HHV-4 – mononucleosis (Epstein-Barr virus)
  - HHV-5 – cytomegalovirus (CMV)
  - HHV-8 – Kaposi's sarcoma-associated

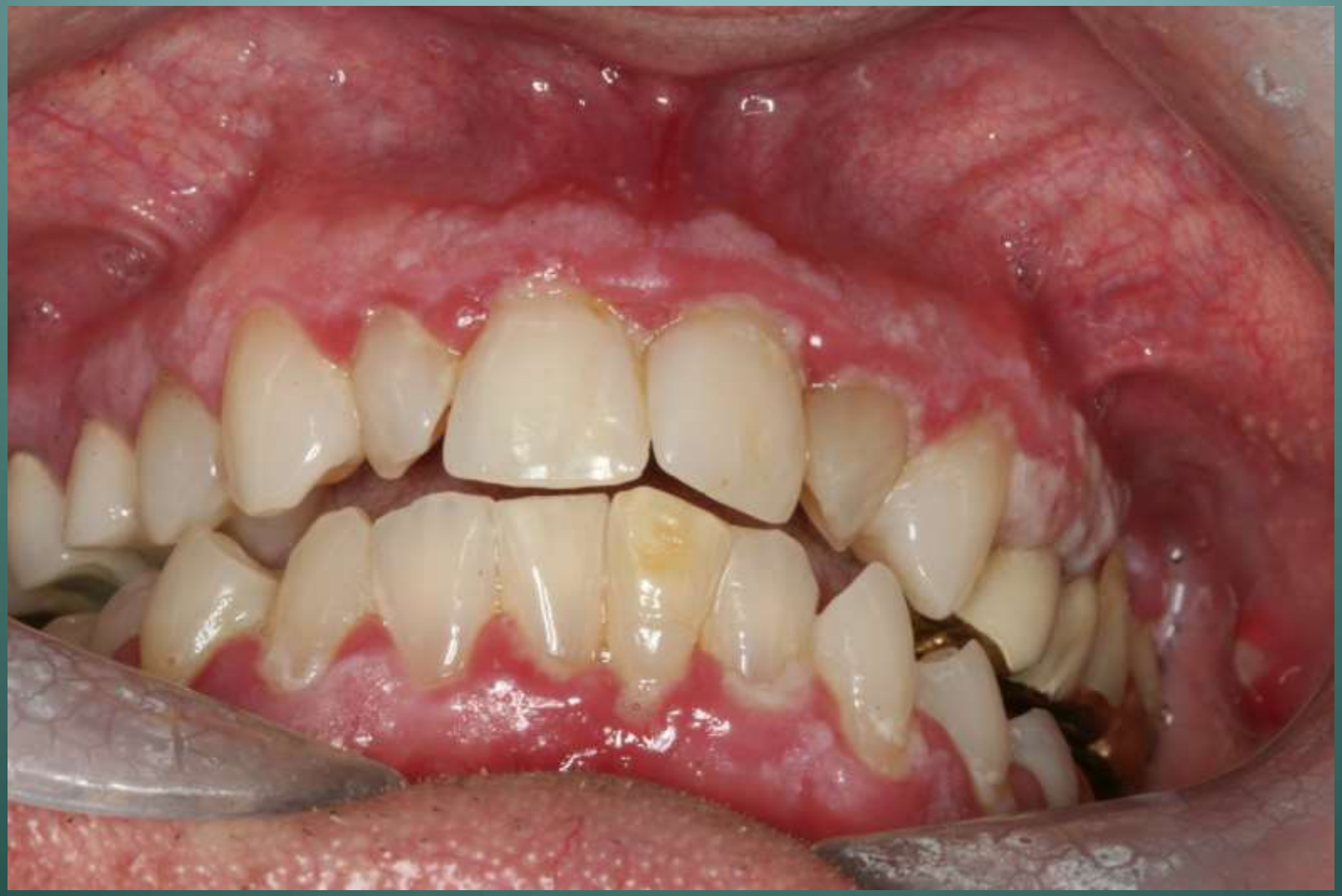
Herpes Simplex Virus

- Two clinical patterns
  - Primary herpetic infection
  - Secondary or recurrent HSV

Primary Herpetic Gingivostomatitis – Clinical Features

- Children, sometimes adults
- Diffuse painful shallow ulcers
- Fever, malaise
- Lymphadenopathy
- One episode-10 to 14 days
- Virus remains dormant in sensory or autonomic ganglia

Primary Herpetic Gingivostomatitis



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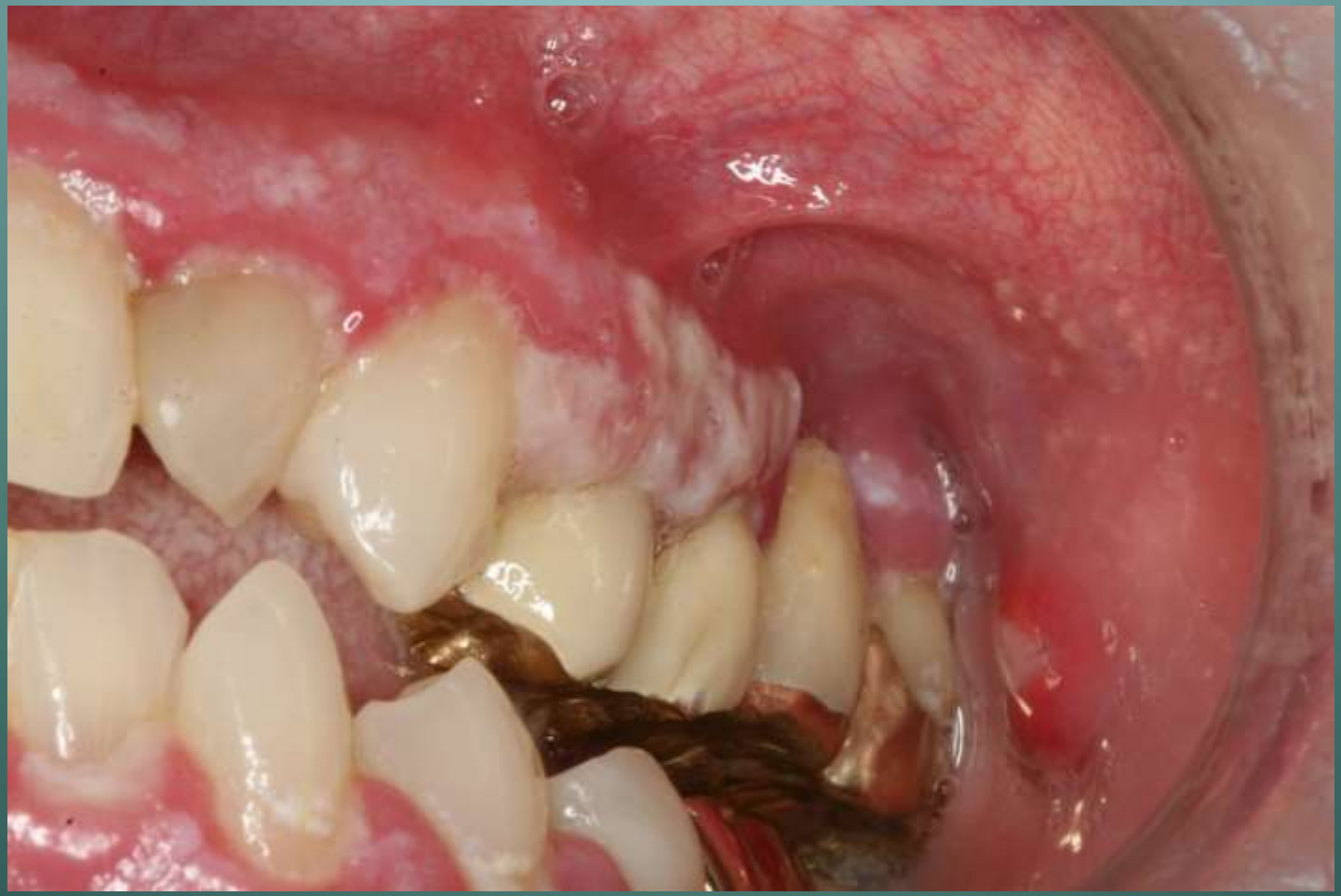

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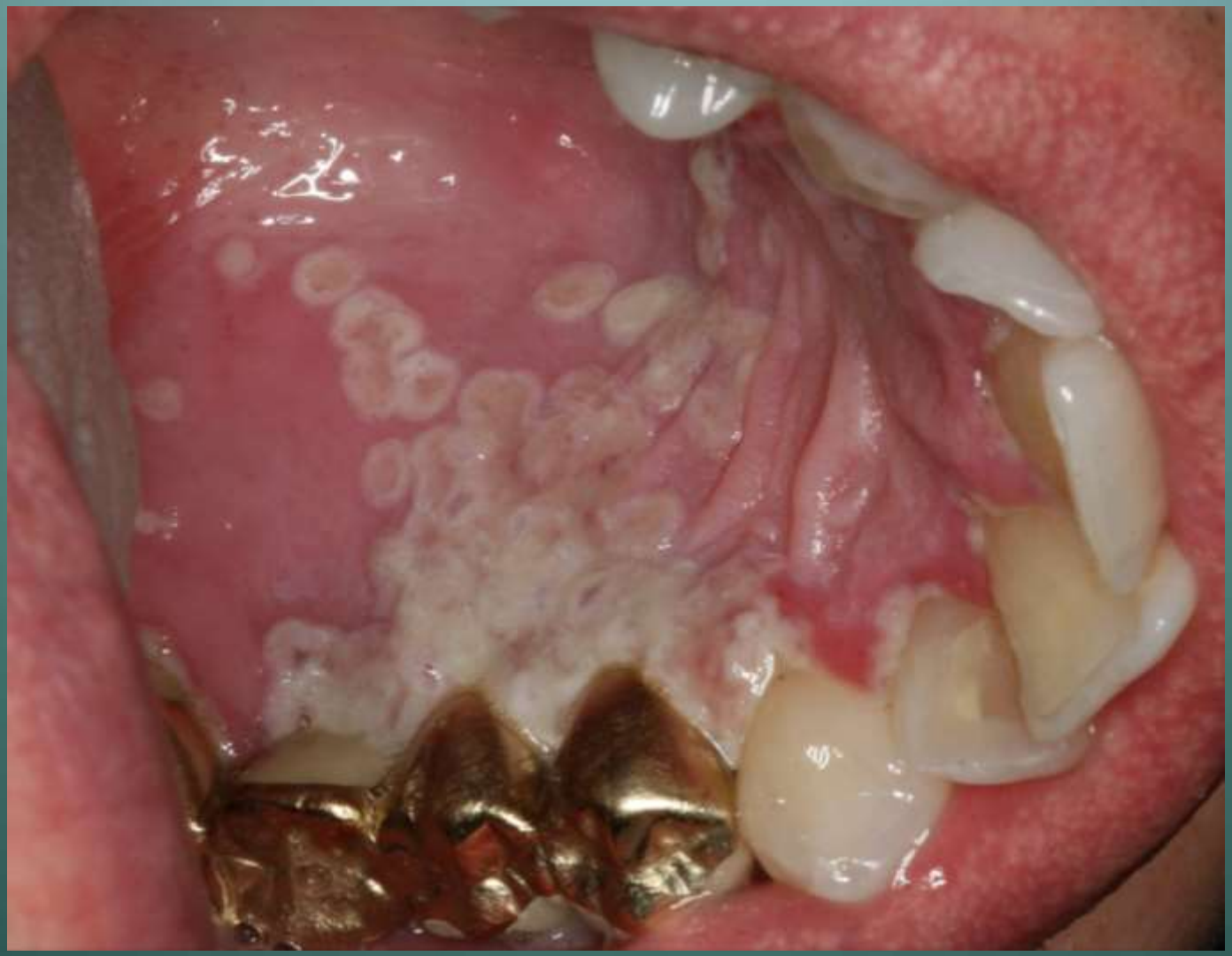

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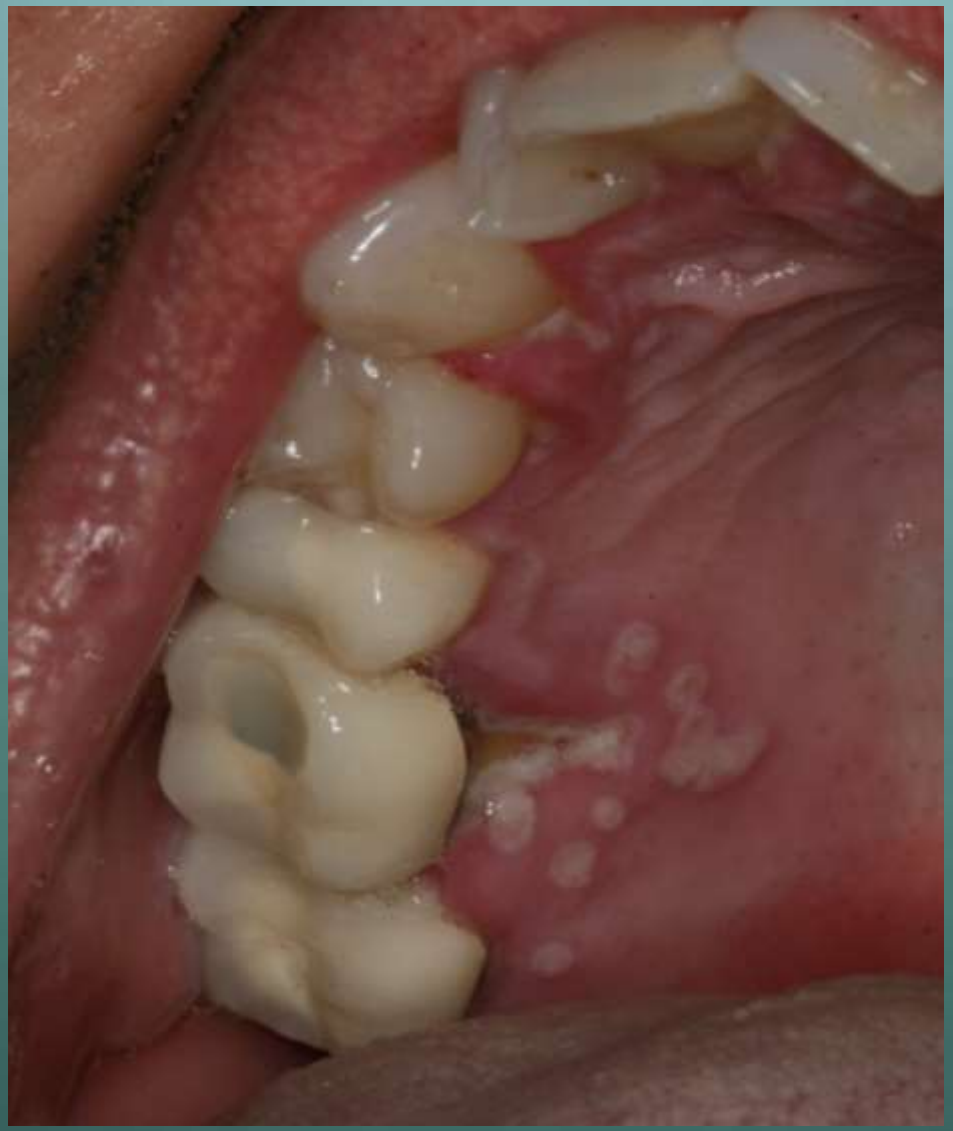

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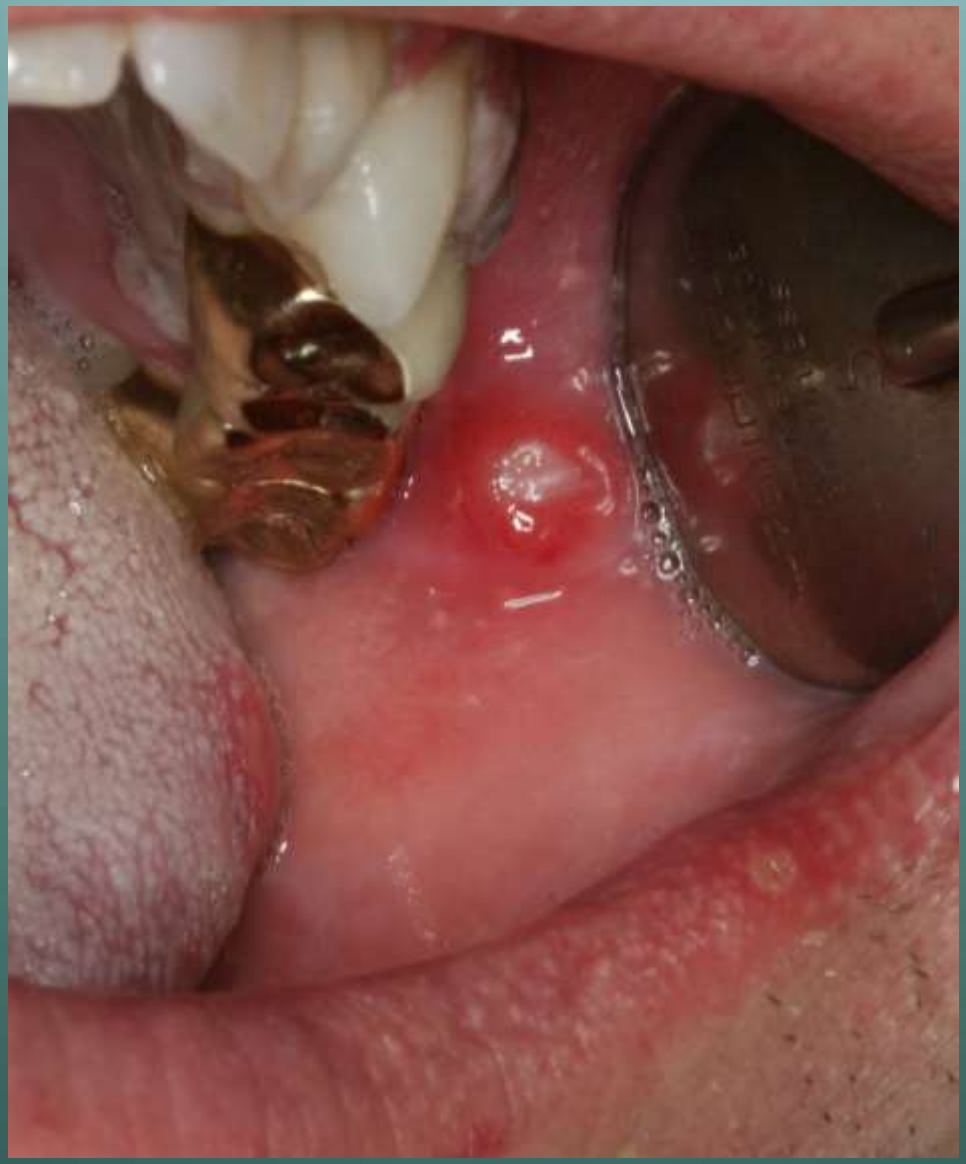

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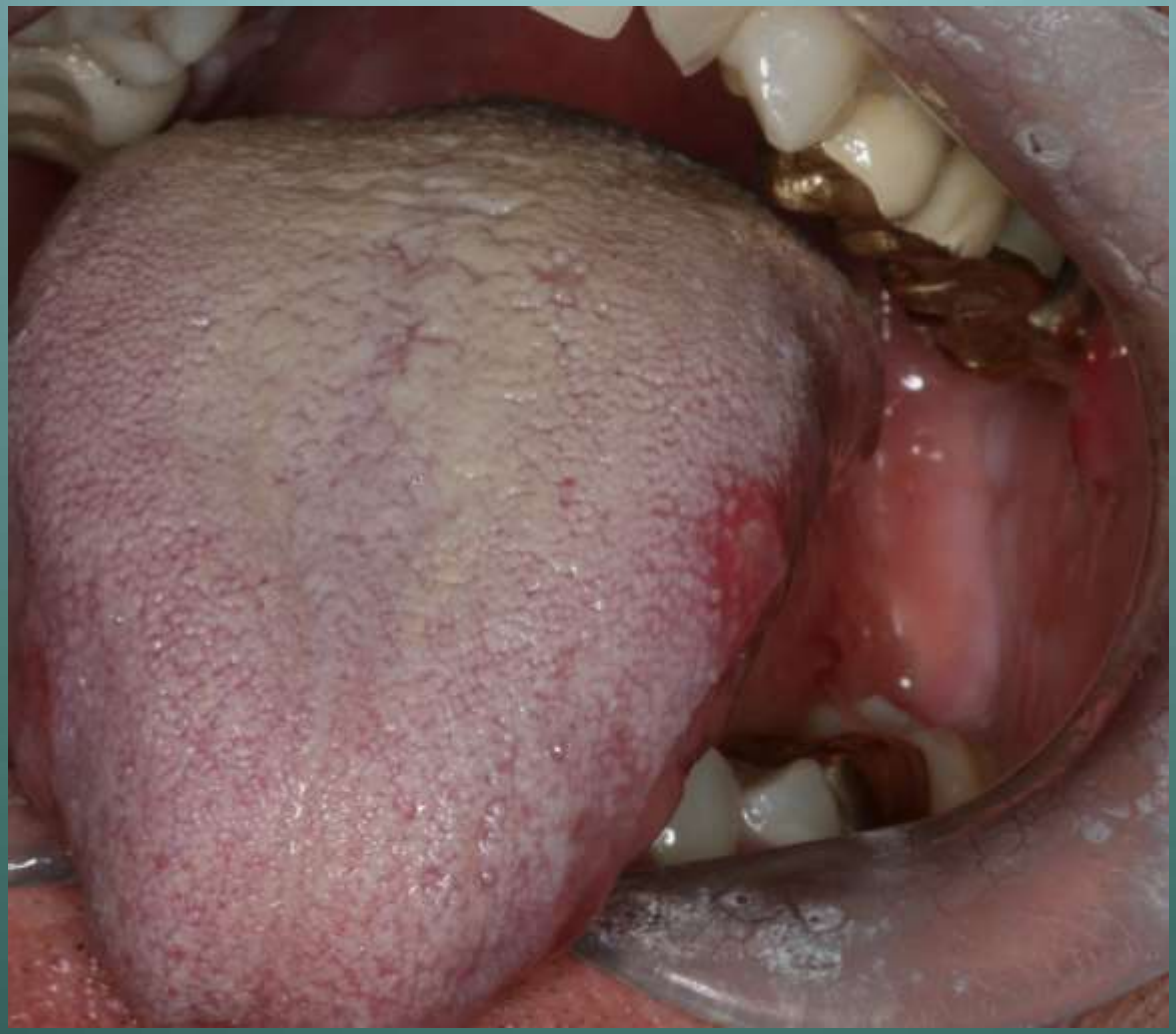
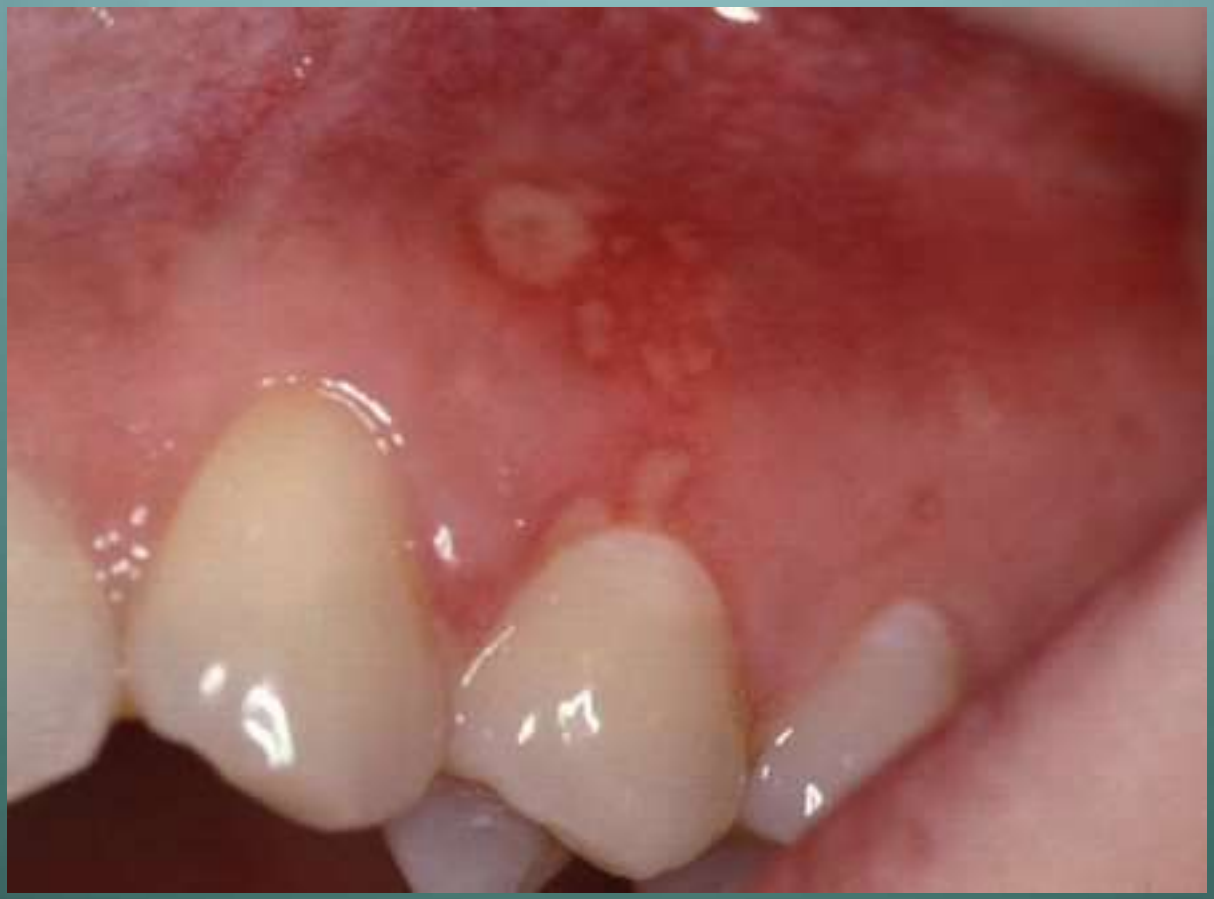


Recurrent Intraoral Herpes

- Relatively uncommon
- Usually few symptoms
- Cluster of shallow ulcers
  - intact vesicles rare
- Mucosa bound to periosteum
  - Hard palate and attached gingiva
- Heal within one week

Recurrent Intraoral Herpes



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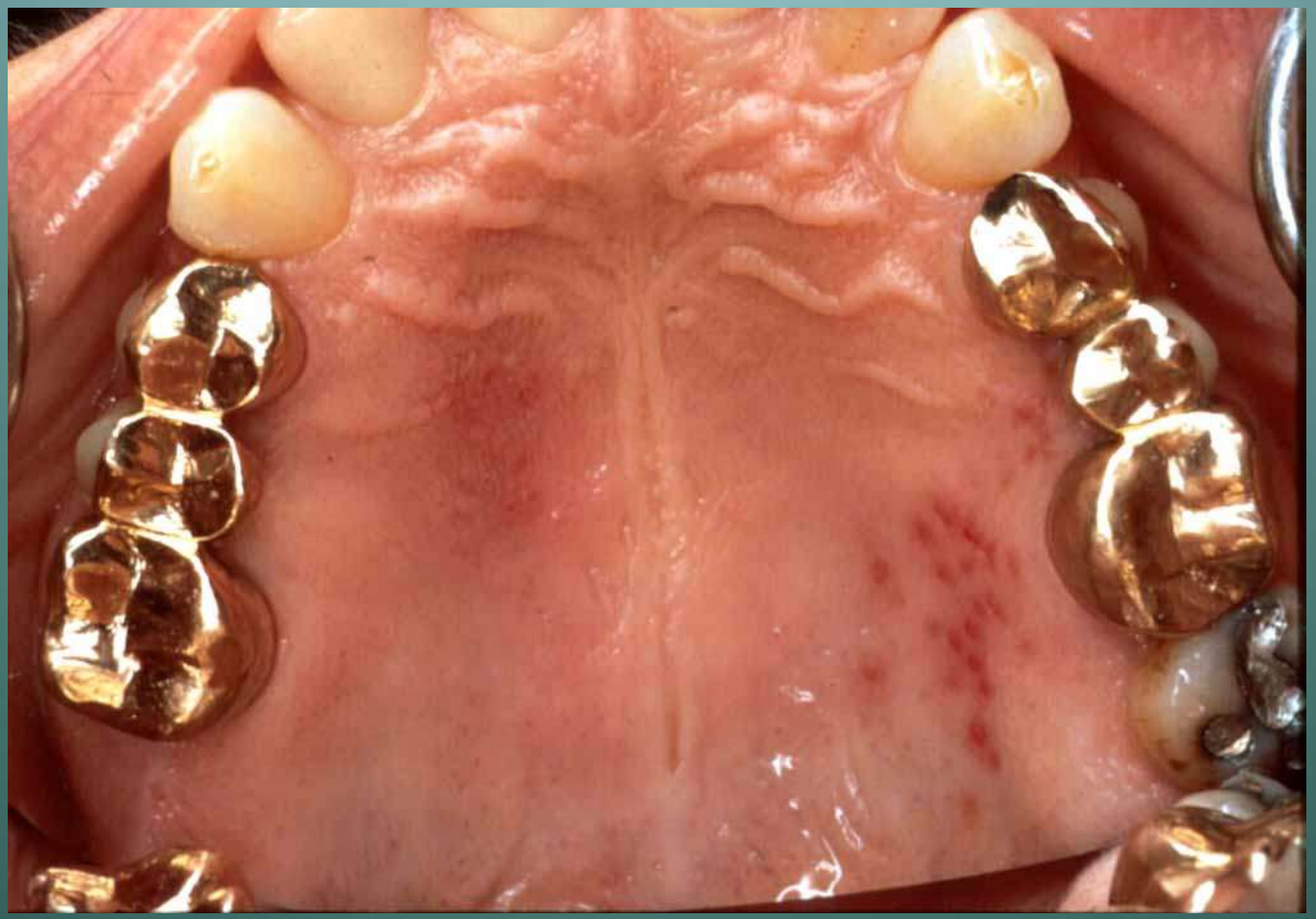


Primary Herpes-Treatment

- Restrict contact with lesions
- Topical anesthetics
  - Dyclonine HCL or viscous lidocaine
- Ibuprofen or other NSAID's
- Soft diet with fluids
- Antiviral medications of recognized early (1st 72 hours)

Recurrent Aphthous Stomatitis

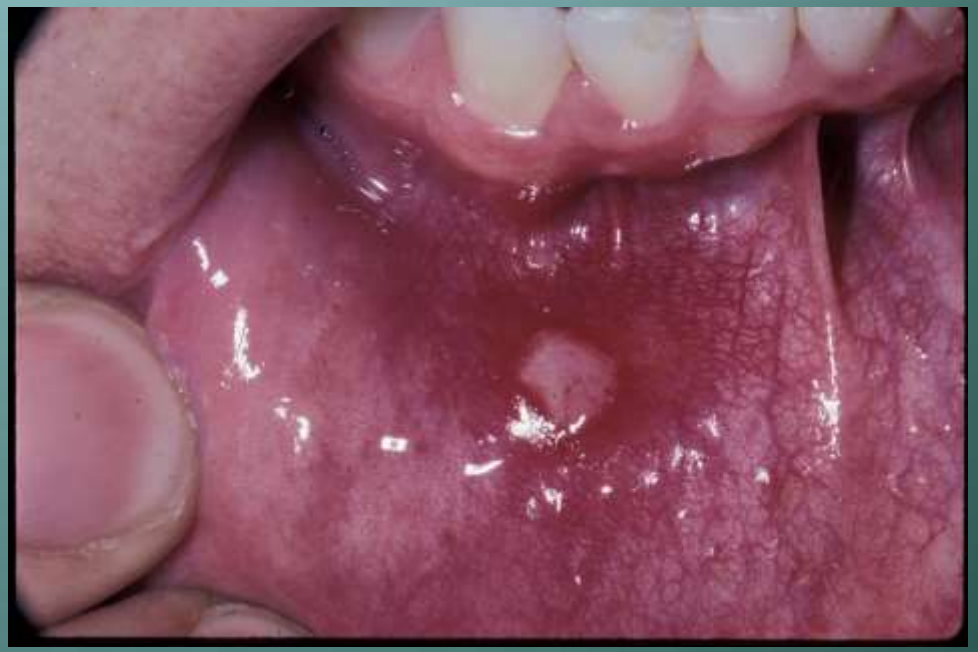
- Very common condition of unknown etiology and pathogenesis
- Likely an immunologically mediated condition
- Numerous potential contributing factors
  - HLA types
  - Trauma
  - Foods
  - Stress
  - HIV

Recurrent Aphthous Stomatitis – Clinical Features

- Three major forms
  - Minor
  - Major
  - Herpetiform

Recurrent Aphthous Stomatitis – Clinical Features

- Minor aphthae
  - 3-mm ulcer with yellow-white membrane and erythematous halo
  - Unattached mucosa



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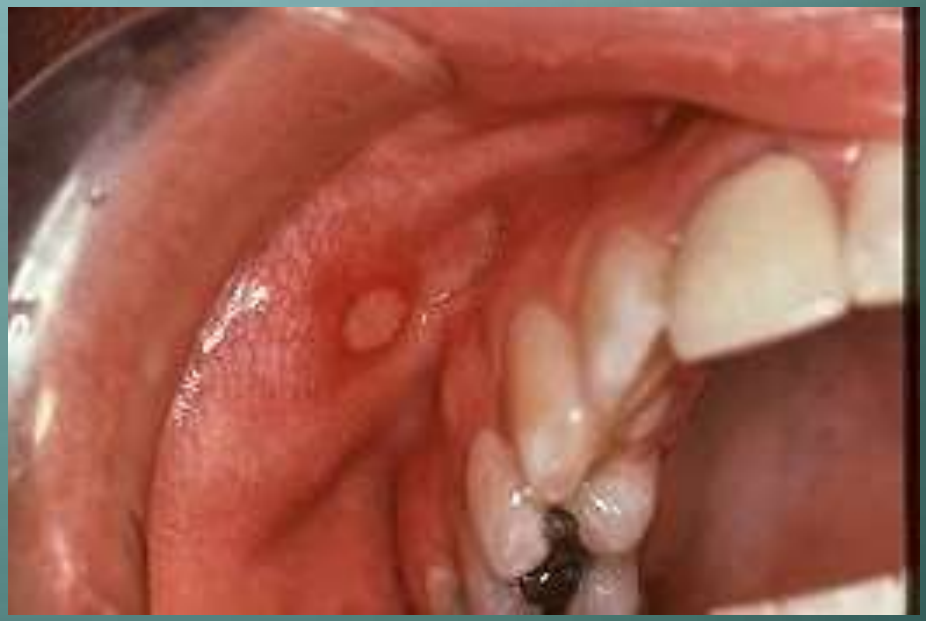

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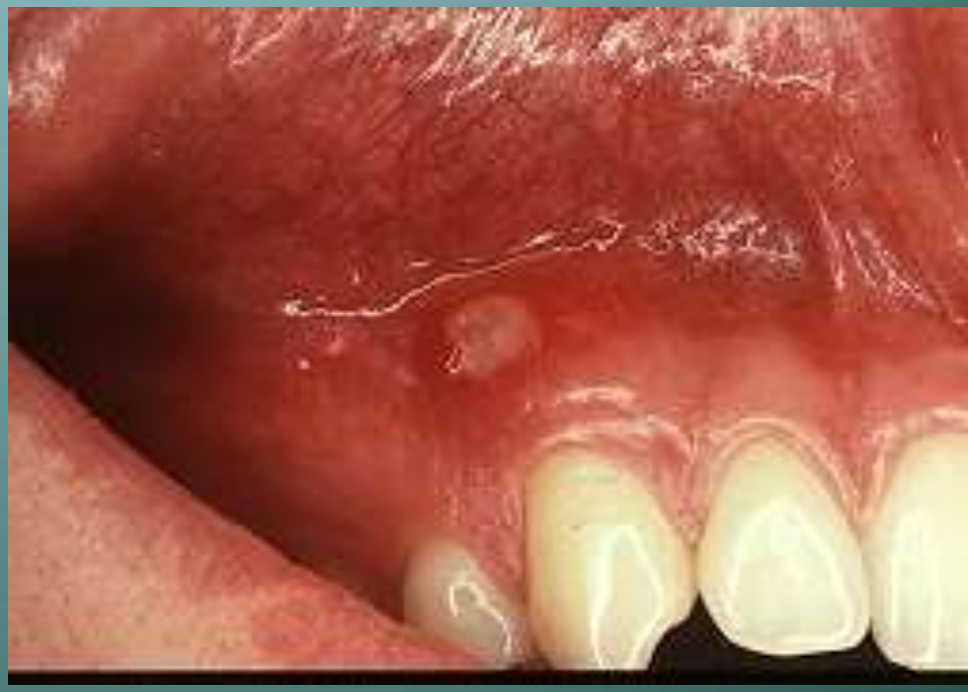

Recurrent Aphthous Stomatitis – Clinical Features

- Major aphthae
  - Larger (up to 3cm) and longer duration (2-6 weeks)
  - May heal with scar
  - HIV

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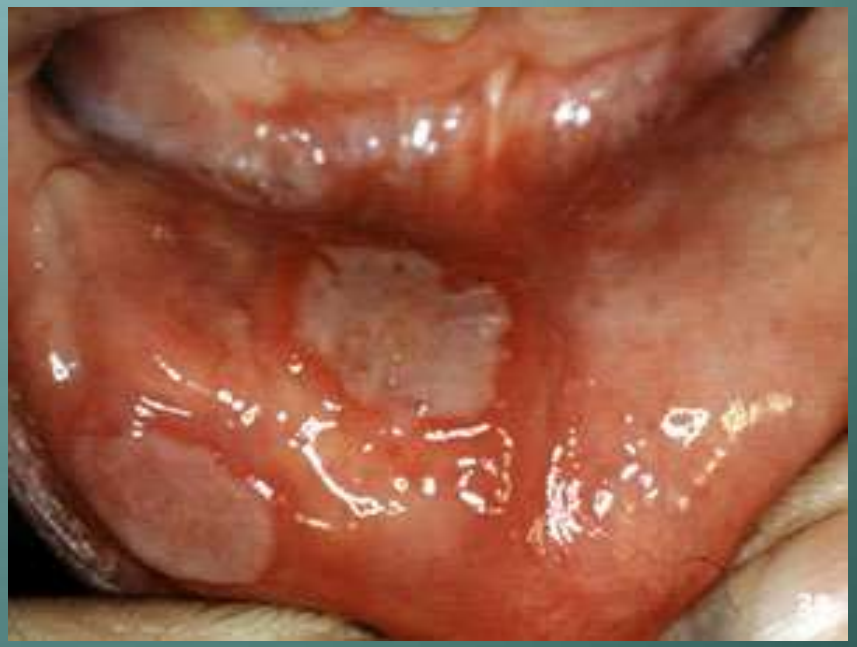

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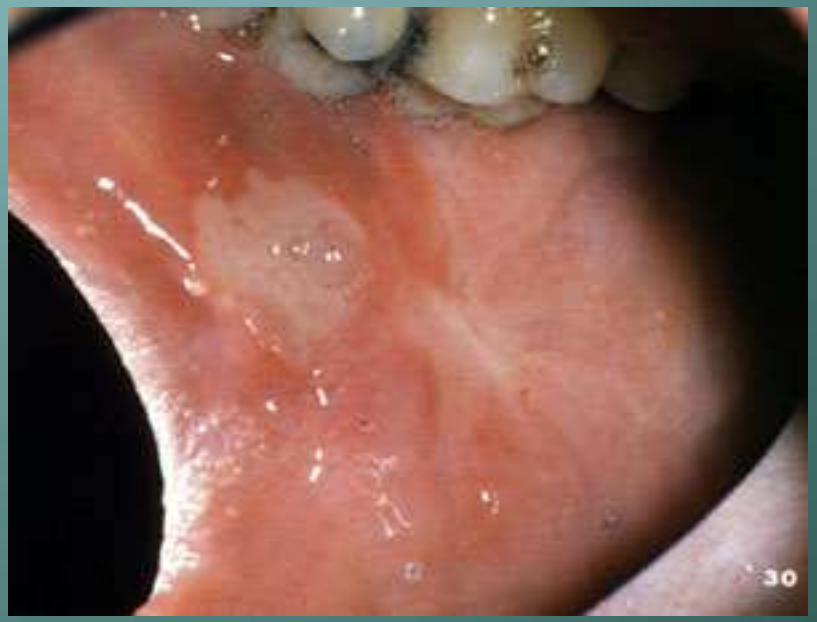

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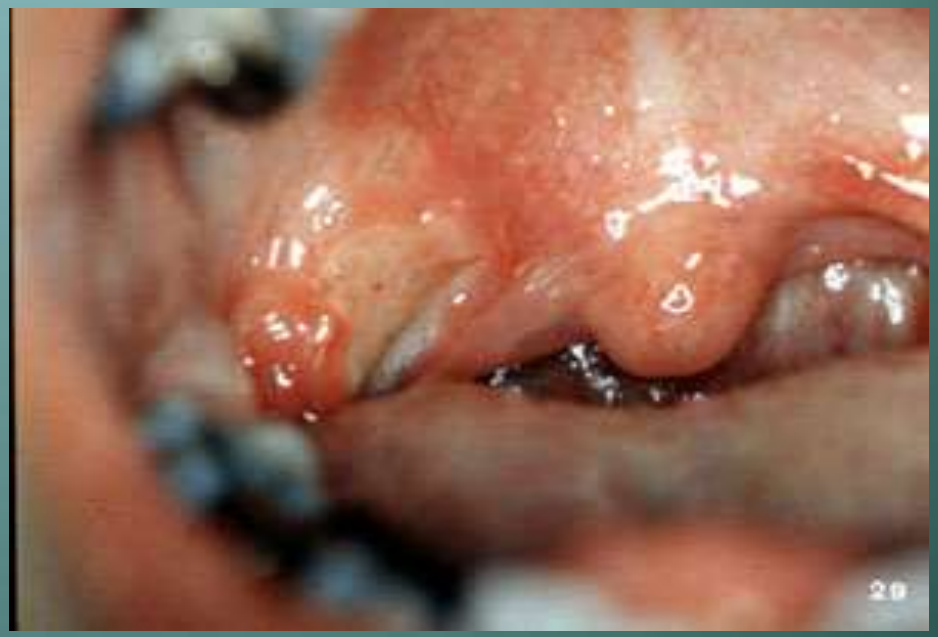


Recurrent Aphthous Stomatitis - Treatment

- Topical corticosteroids
  - Betamethasone 0.05%
  - Clobetasol propionate 0.05% (Temovate gel)

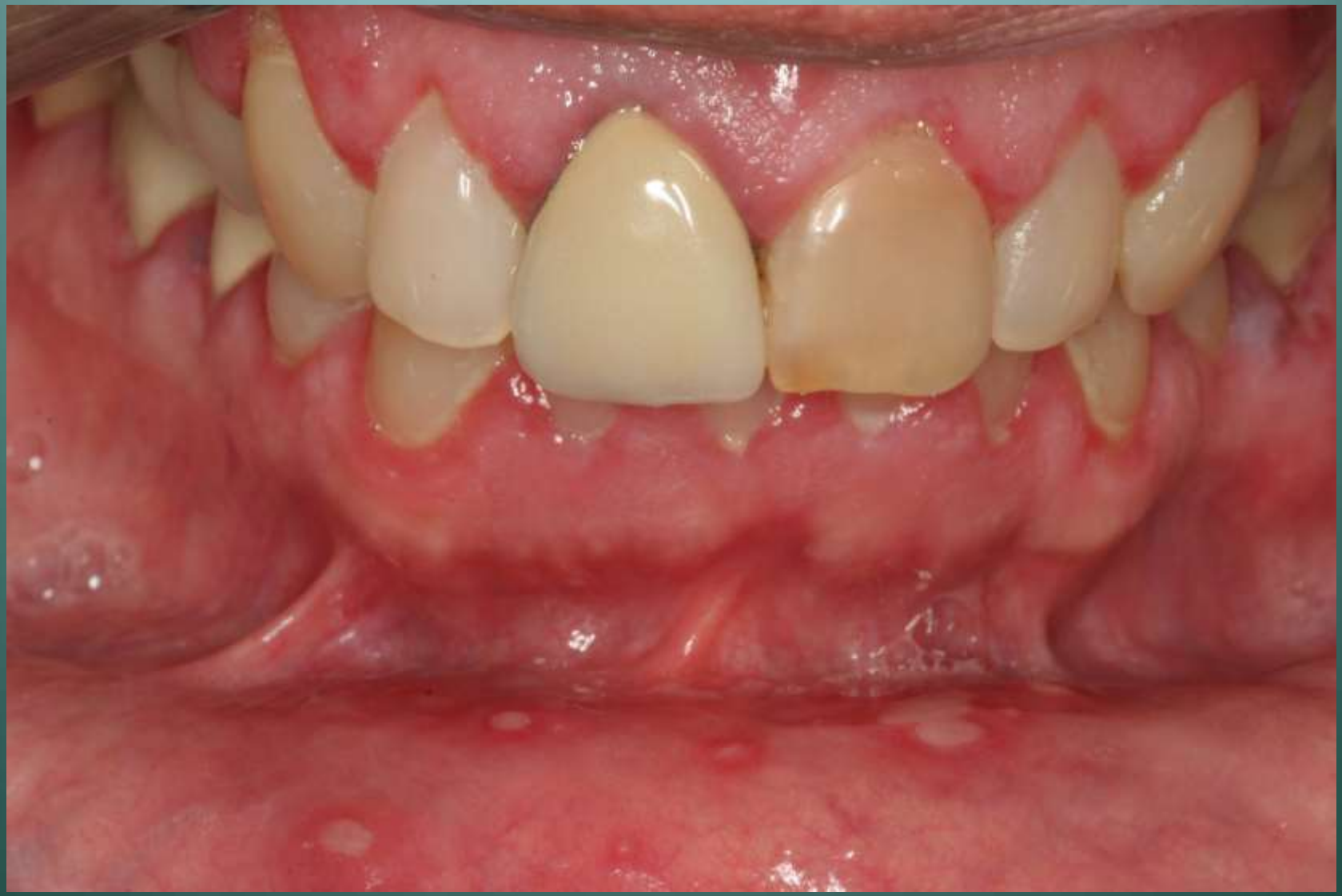
- Elixirs or syrup preparations for numerous and/or ulcerations in inaccessible areas

- If unresponsive, investigate possible underlying cause

Case #7 – Differential Diagnosis

- Herpes Simplex Type 1
- Recurrent Aphthous Stomatitis
- Erythema multiforme

Diagnosis Case #5 – Primary Herpetic Gingivostomatitis



White, Red and Malignant Lesions

Smokeless Tobacco Use/Tobacco Pouch Keratosis

- Mucosal lesion secondary to the presence of chronic irritation from smokeless tobacco
- These products are currently used by approximately 4.5% of US males
- Also associated with gingival/periodontal destruction and tooth decay

Tobacco Pouch Keratosis – Clinical Features

- Gray or gray-white plaque in the area of placement
- Diffuse borders
- Corrugated surface texture

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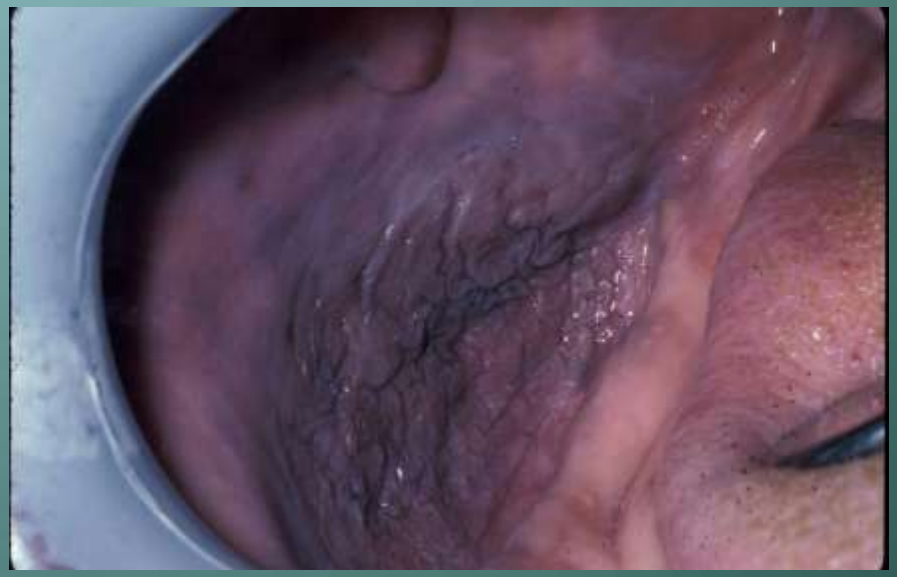
- Corrugated surface texture



Tobacco Pouch Keratosis – Clinical Features

- Gray or gray-white plaque in the area of placement
- Diffuse borders
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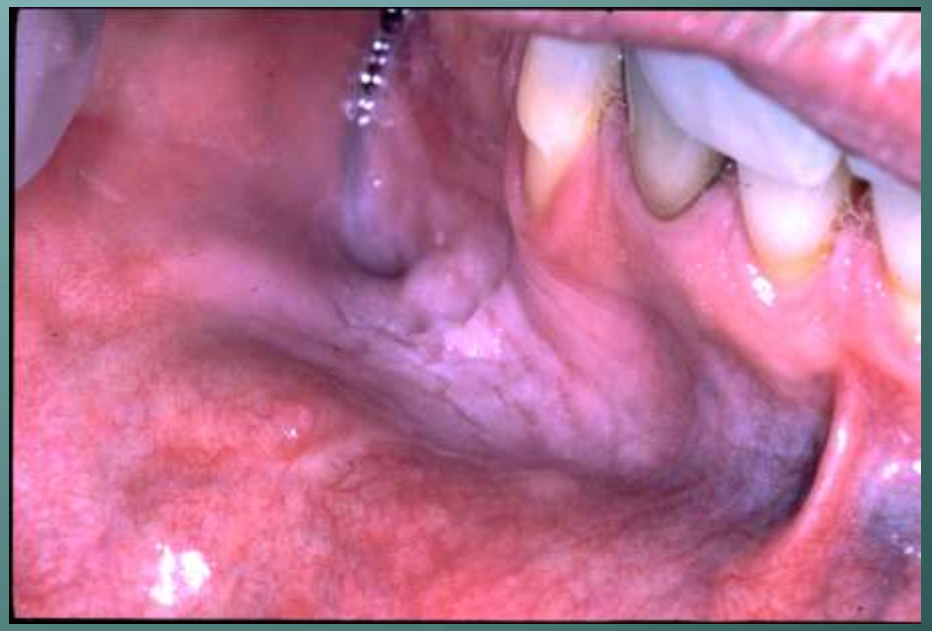

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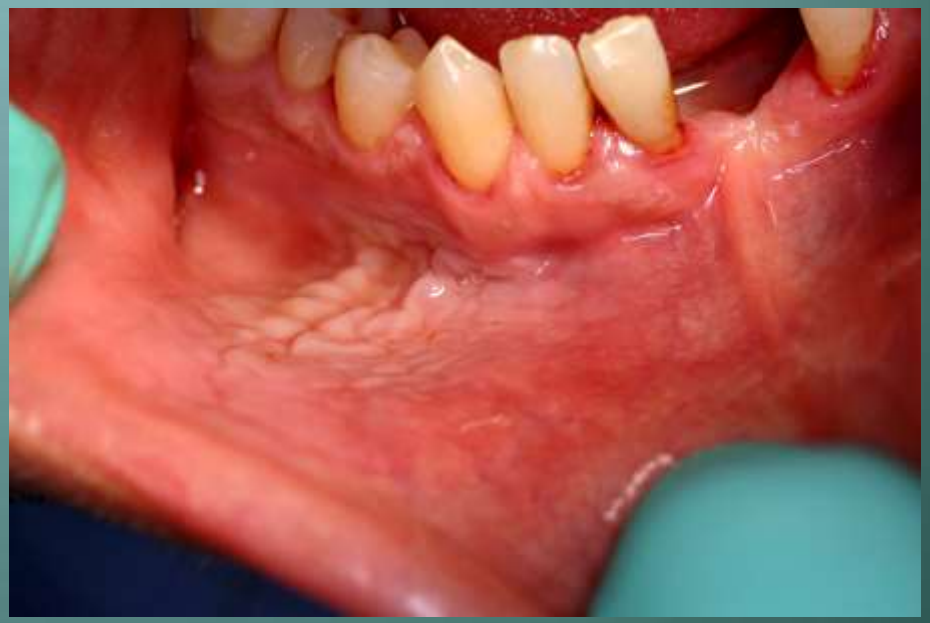

Tobacco Pouch Keratosis – Treatment and Prognosis

- Have patient stop or move the tobacco to another location to observe for resolution (2-4 weeks)
- If the lesion persists (after 6 weeks), biopsy for histologic diagnosis
- Controversy over true carcinogenicity of smokeless tobacco

Nicotine Stomatitis

- Benign hyperkeratotic change to the palatal mucosa secondary to tobacco smoking
- Most common in pipe and cigar smokers
- Similar changes may be induced by drinking hot beverages

Nicotine Stomatitis – Clinical Features

- M>F,
- >45 years
- Grey-white mucosa, multiple papules with erythematous center

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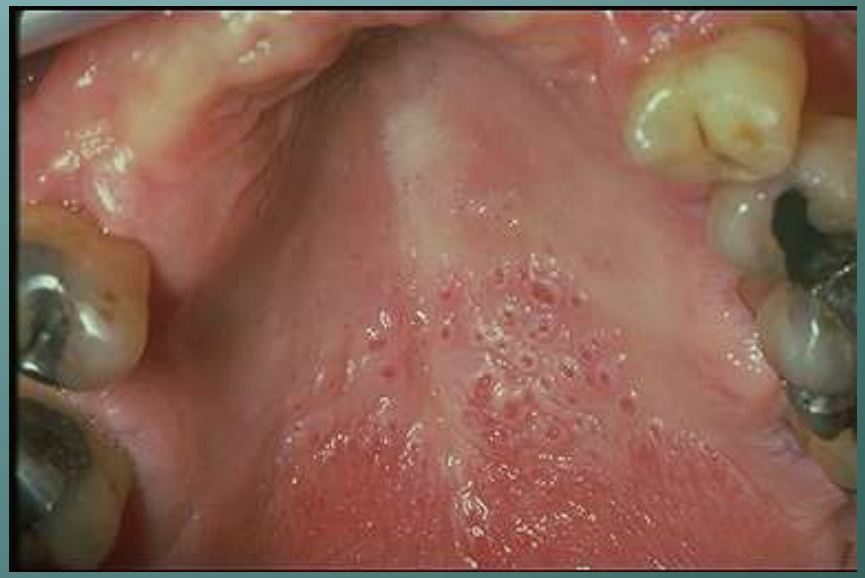

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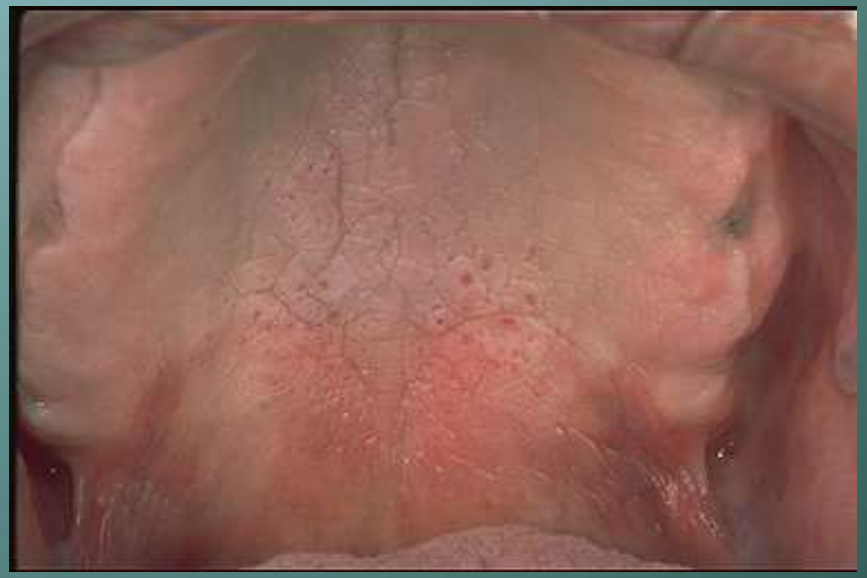

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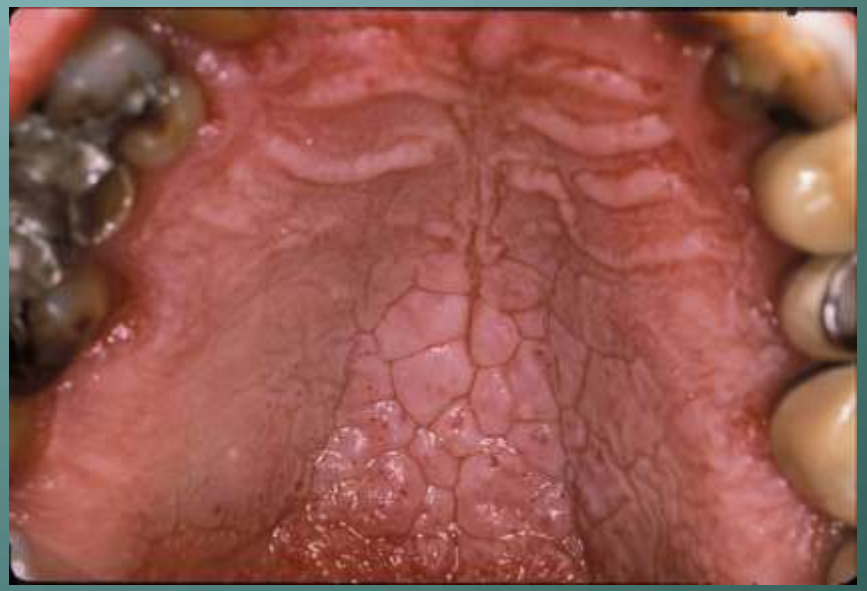

Nicotine Stomatitis – Clinical Features

- M>F
- >45 years
- Grey-white mucosa, multiple papules with erythematous center

Nicotine Stomatitis – Treatment

- None
- If patient quits, changes will normally resolve within 1-2 weeks
- Persistent changes should be biopsied

Leukoplakia

- Definition (WHO)-A white patch or plaque which cannot be characterized clinically or pathologically as any other disease

- Considered premalignant
  - Most common precancerous oral lesion

Leukoplakia

- Etiology-Technically unknown
  - Tobacco smoking
  - Alcohol is not necessarily associated with leukoplakia
- Lesions that are not leukoplakia
  - Nicotine stomatitis
  - Frictional keratosis
  - Lichen planus
  - Amalgam reactions

(NOT) Leukoplakia

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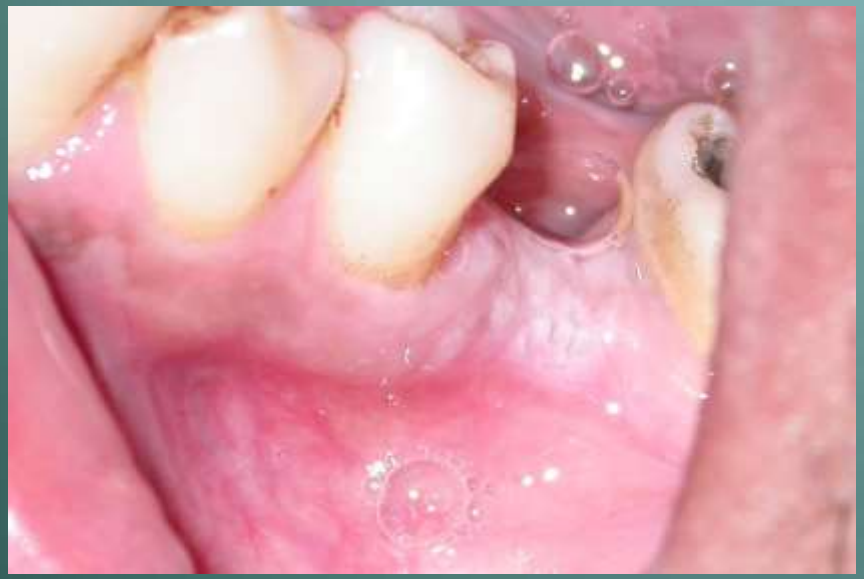

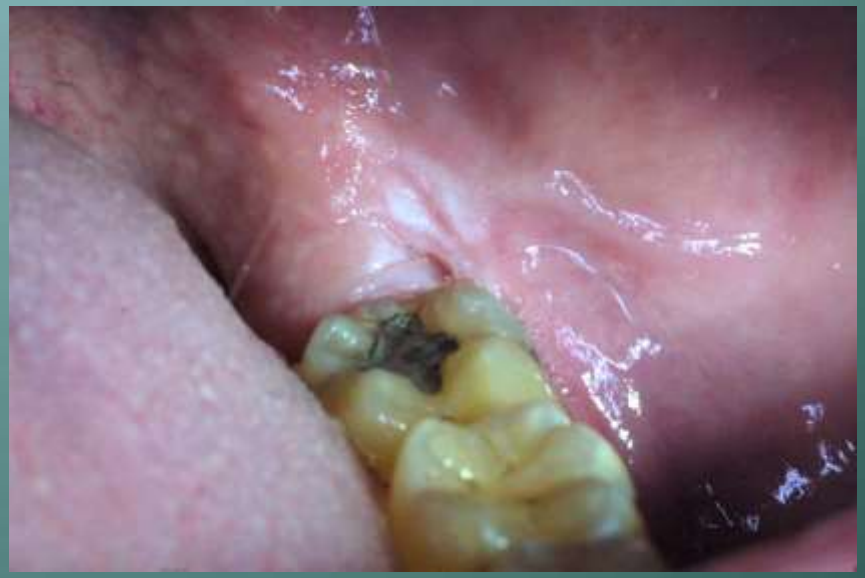

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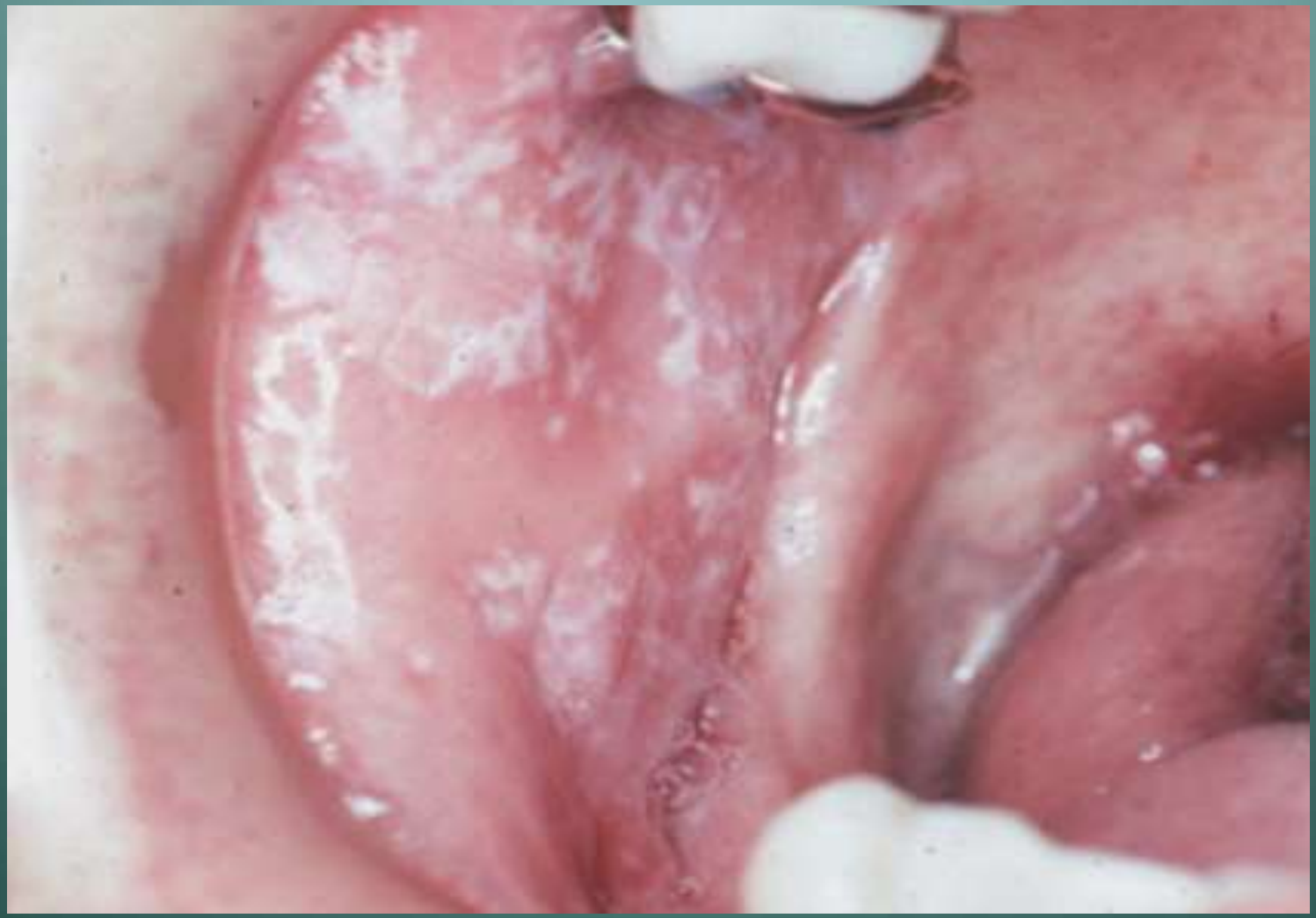

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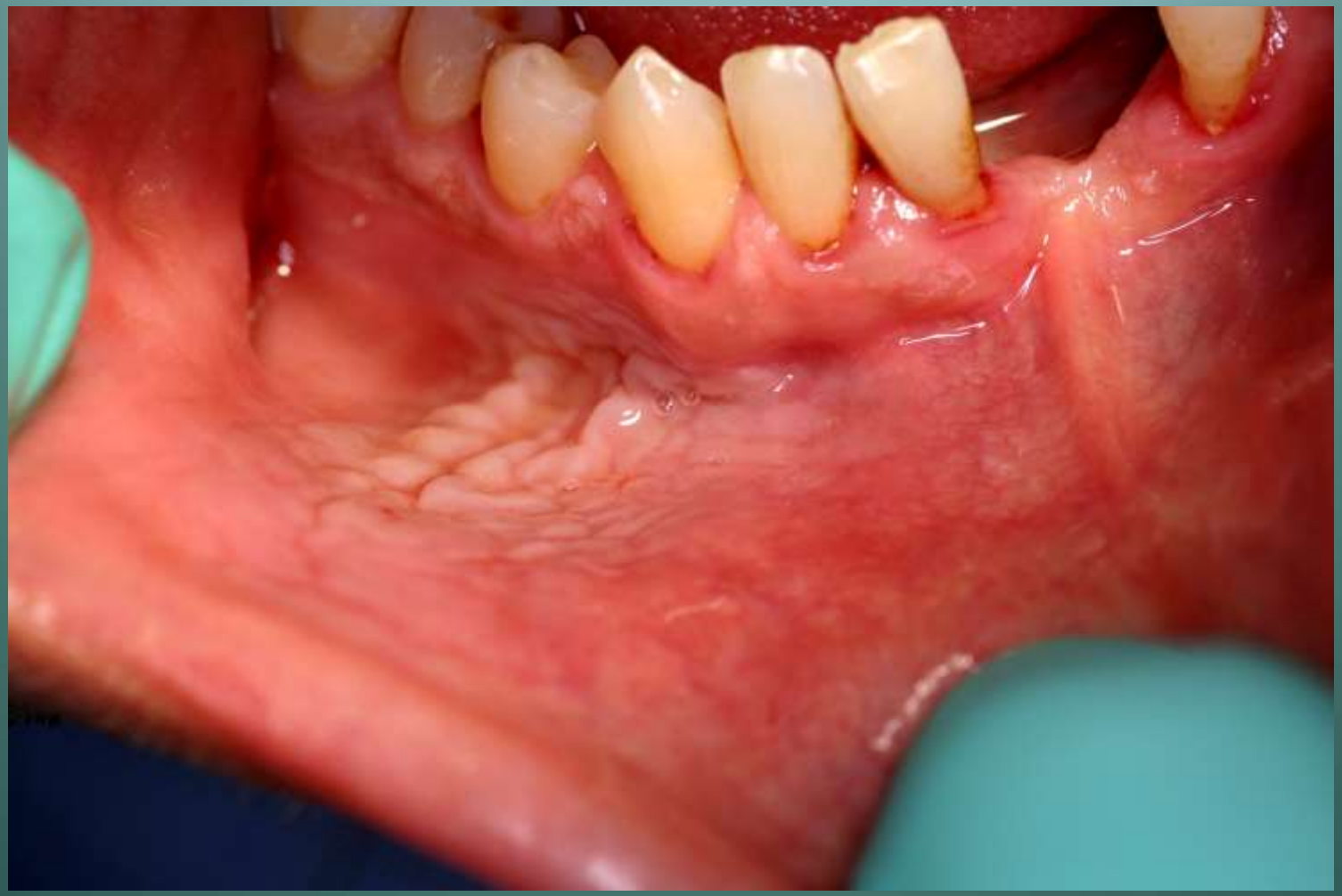

Leukoplakia – Clinical Features

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- Homogenous, speckled
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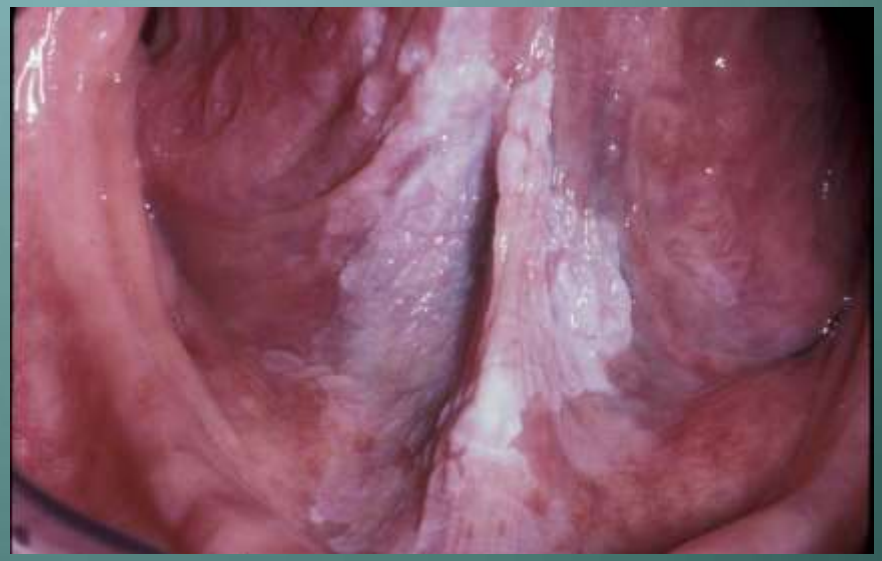

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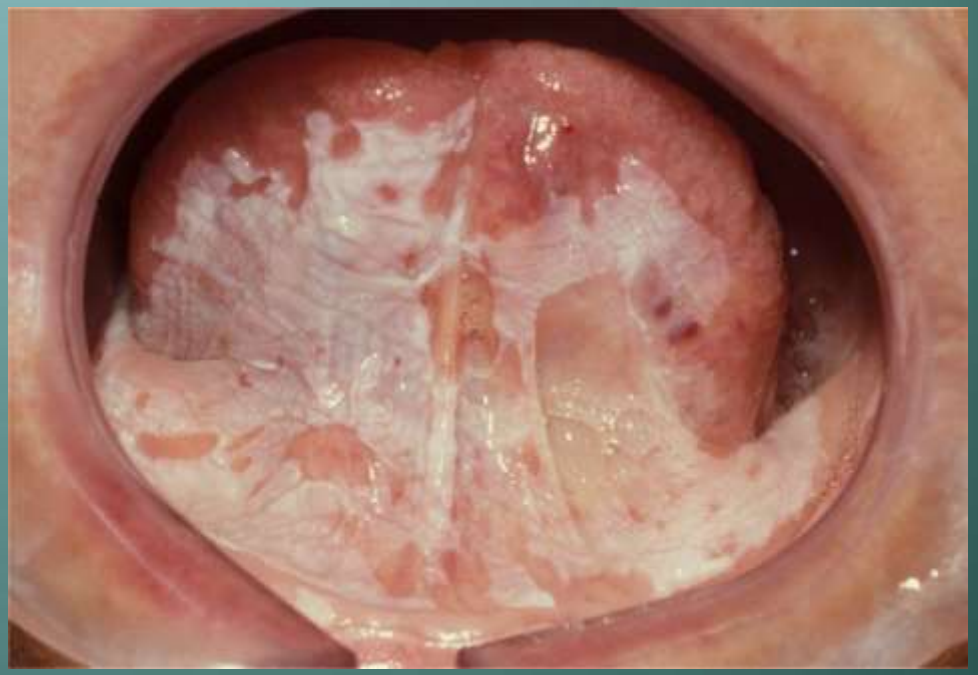

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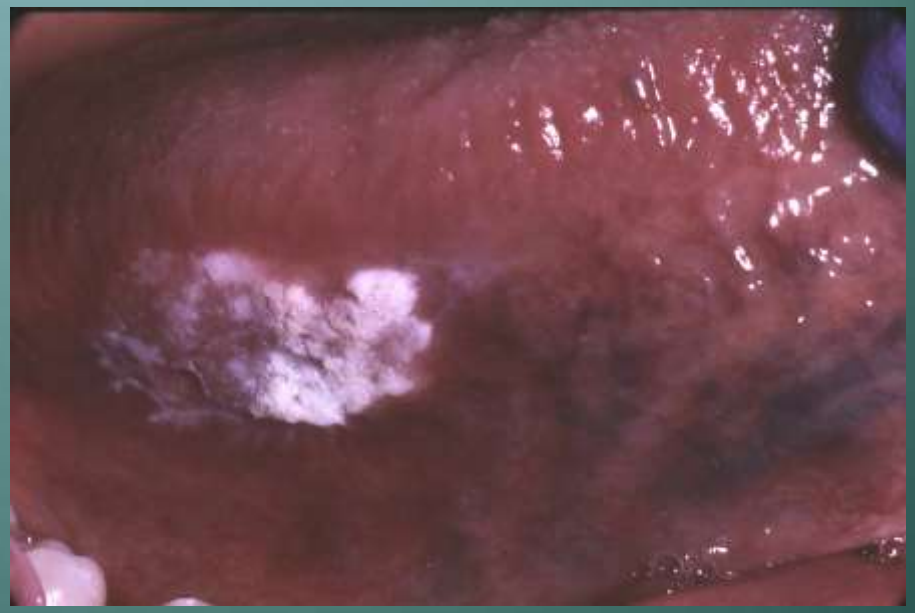

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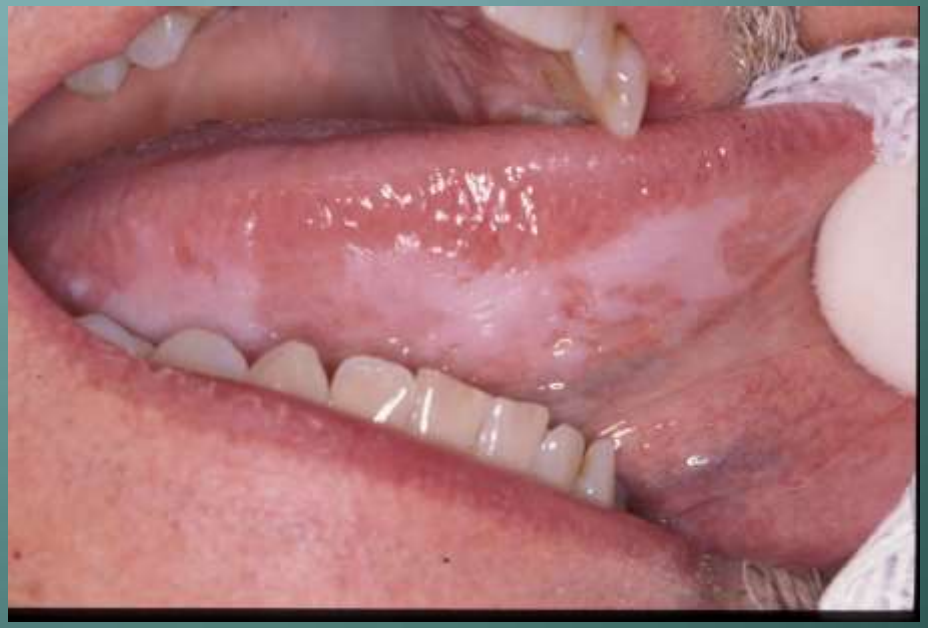

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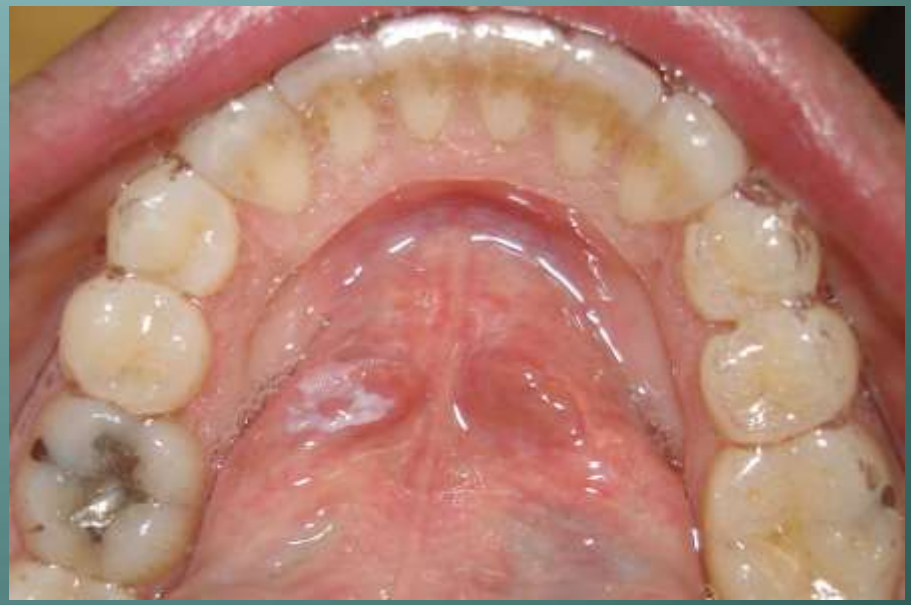

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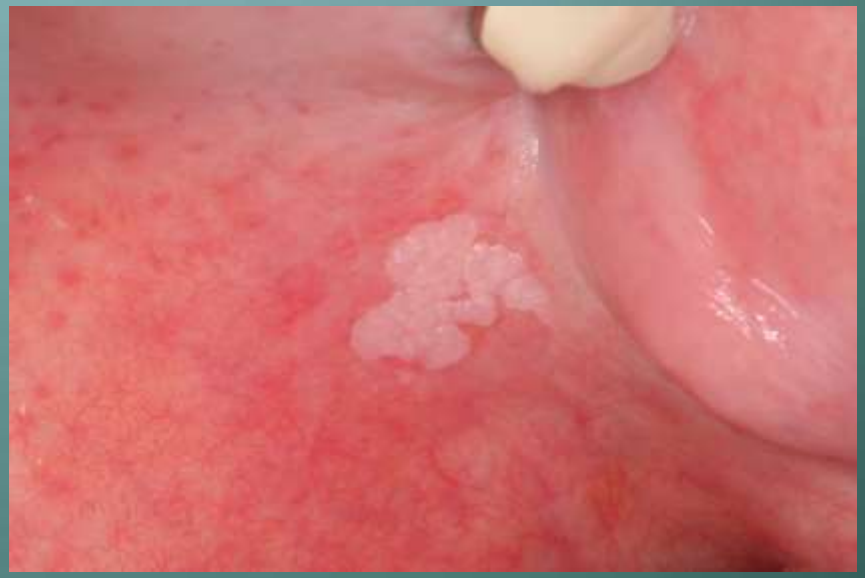

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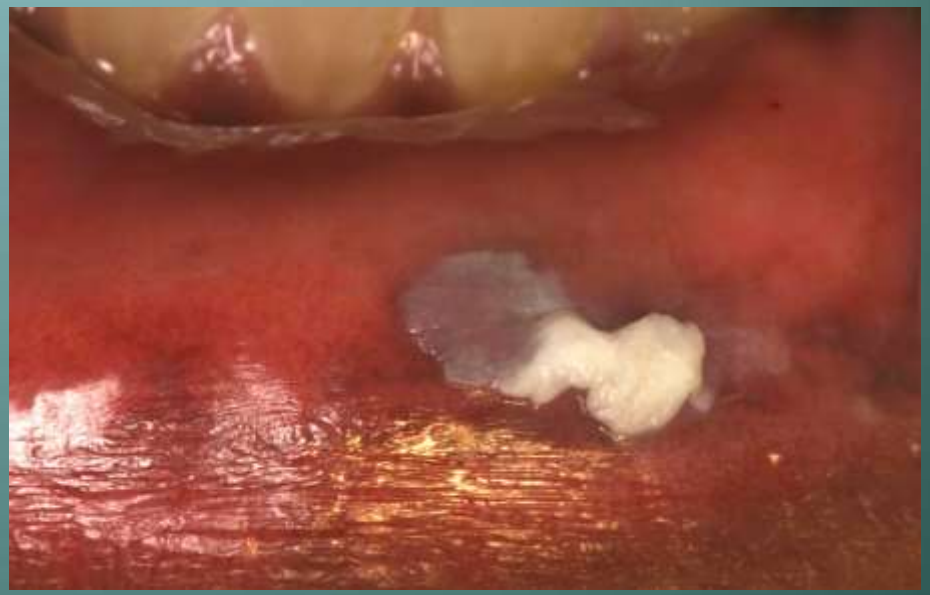

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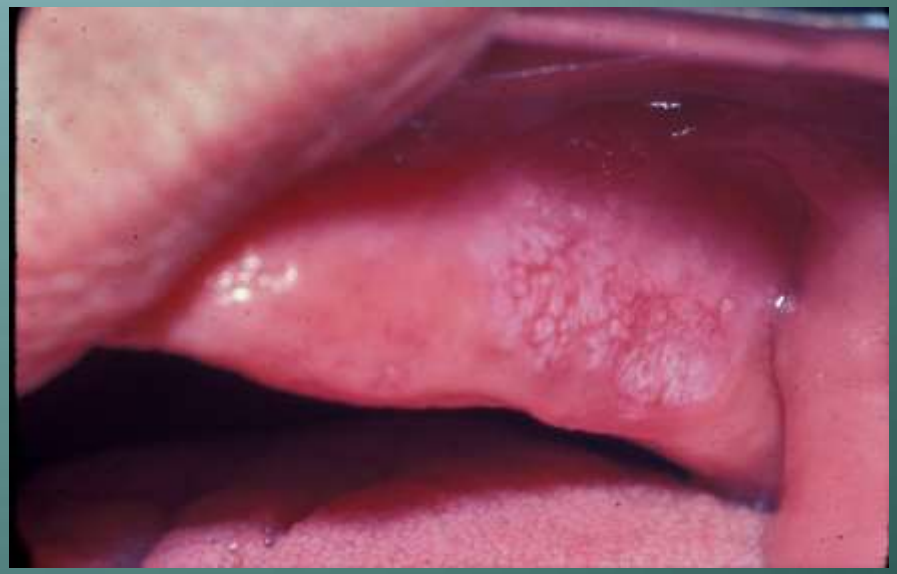

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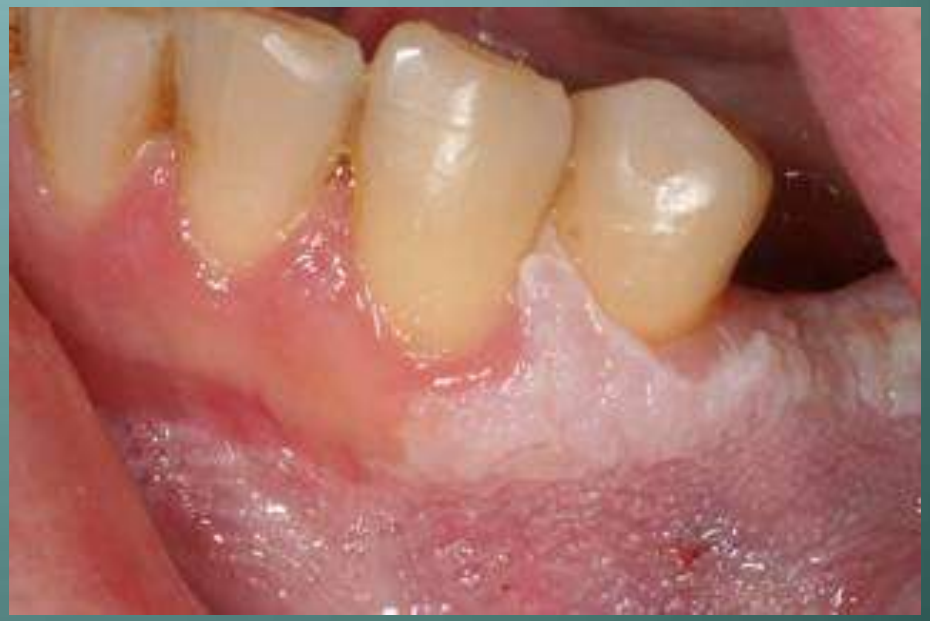

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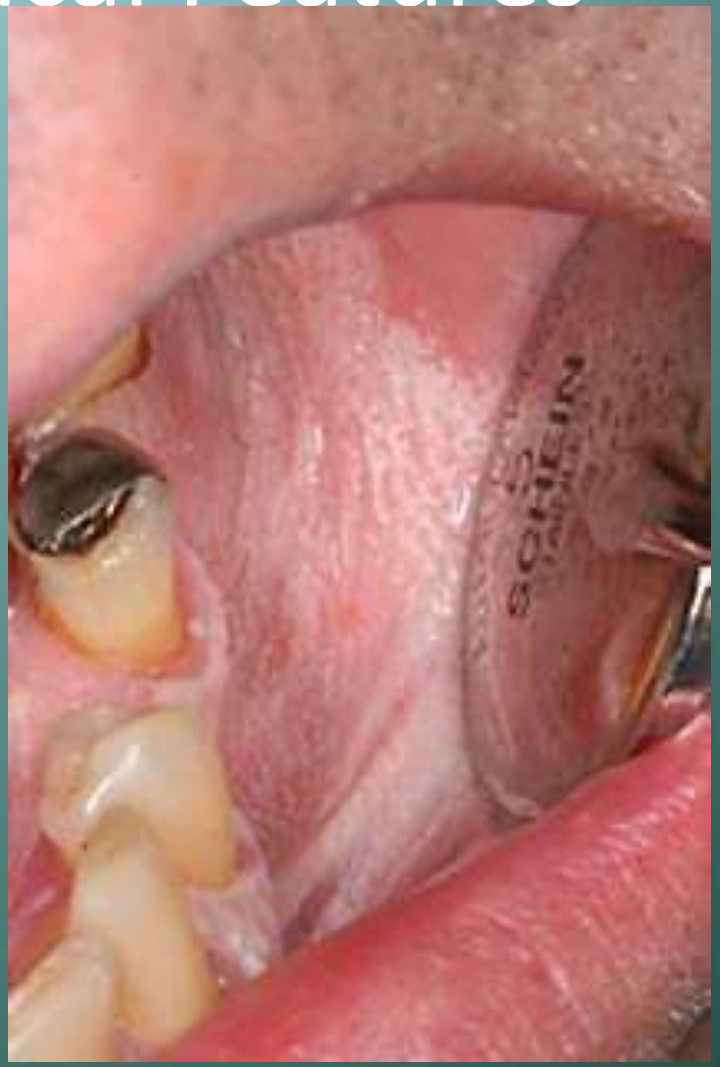

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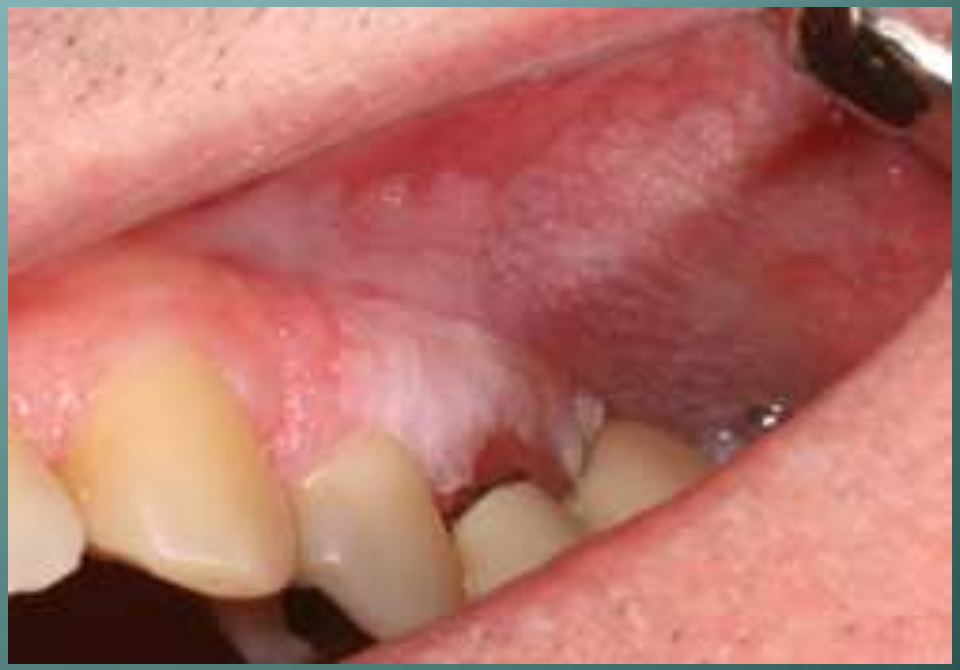

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Leukoplakia – Treatment and Prognosis

- Biopsy is mandatory
- Treatment will then depend upon the histologic findings
- 4% risk of transformation to SCC
- With or without removal, follow-up is essential
- Recurrences are common (about 1/3)

Erythroplakia

- Red patch that cannot be clinically or pathologically diagnosed as any other condition
- Greater presence of dysplasia than leukoplakia
- Same etiology as SCC (tobacco, alcohol)

Erythroplakia – Clinical Features

- Older males
- Floor of mouth, tongue, soft palate
- Well-demarcated velvety, red plaque
- May be adjacent to areas of leukoplakia

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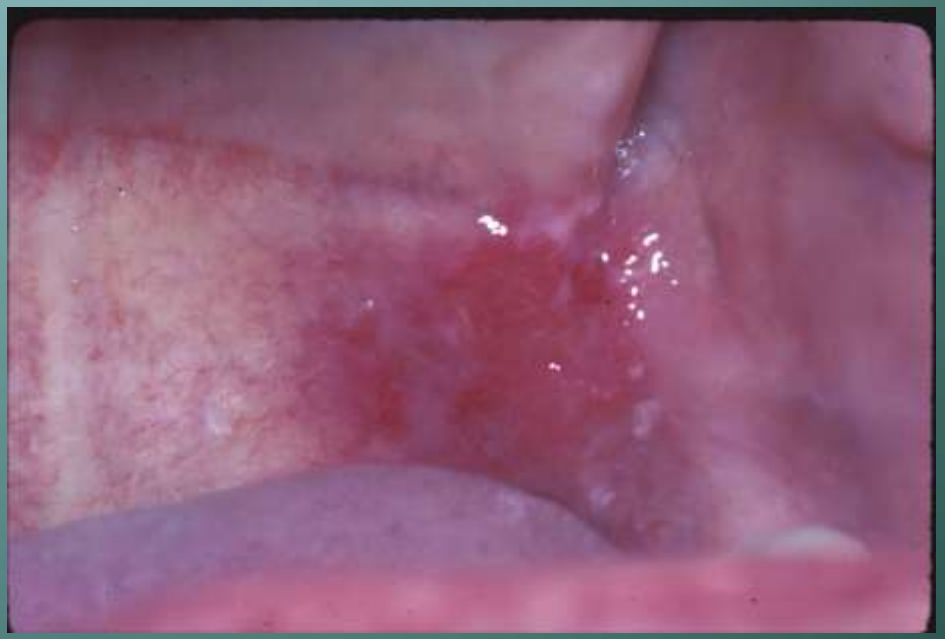

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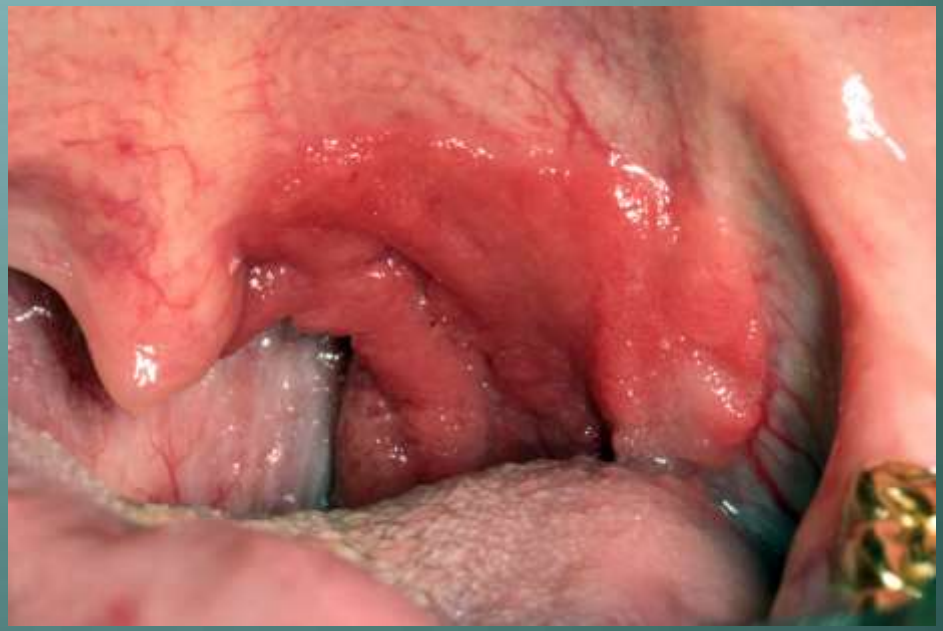

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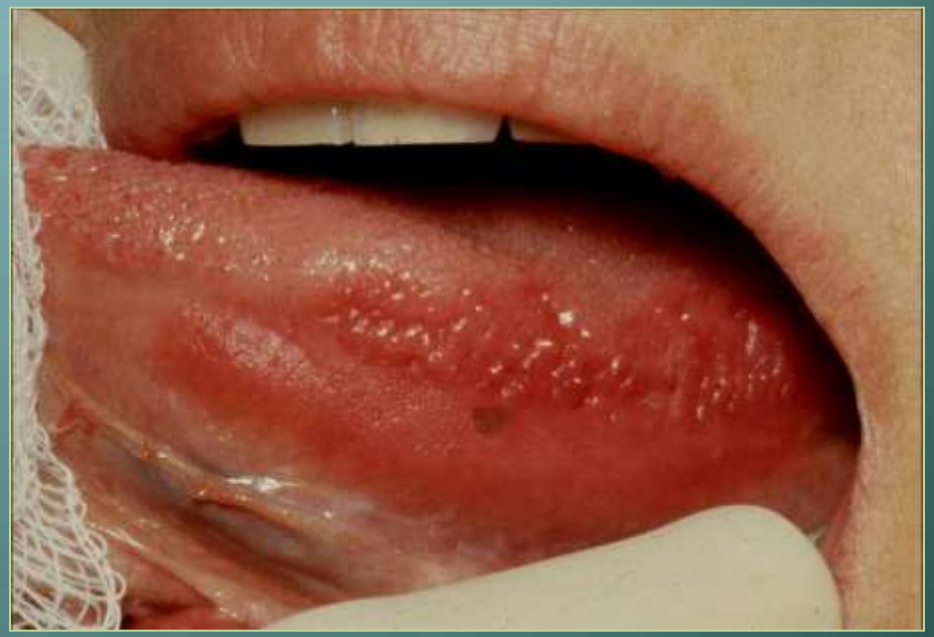

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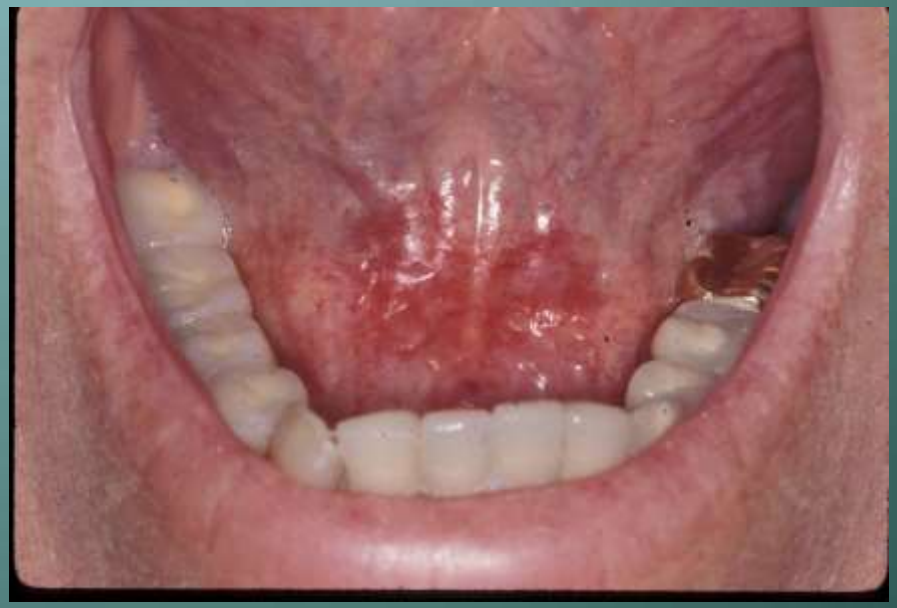

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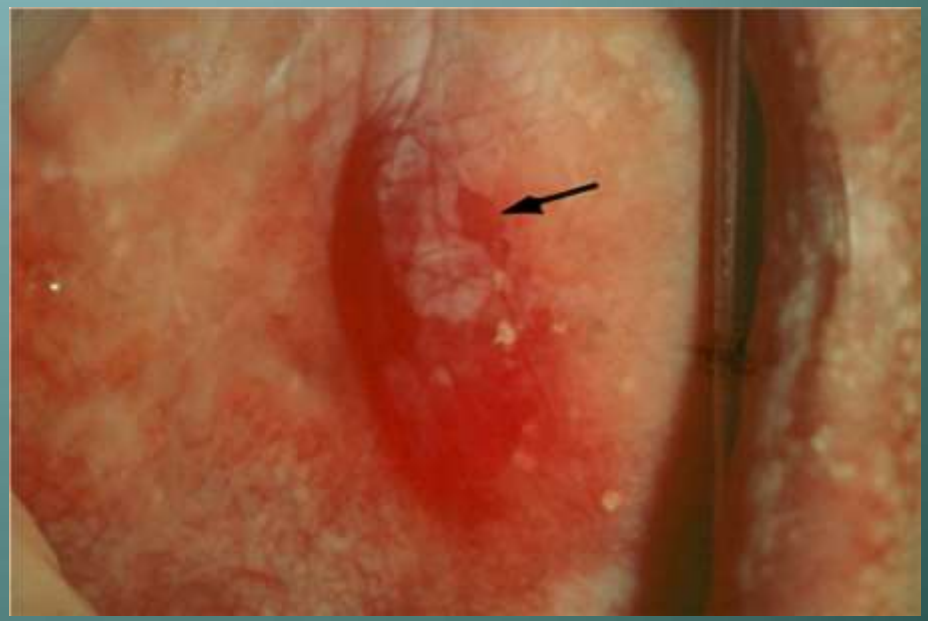

Erythroplakia - Histology

- 90% will show severe dysplasia or CIS
- Epithelial atrophy with lack of keratin production
- Chronic inflammation

Erythroplakia – Treatment and Prognosis

- Biopsy is mandatory, with treatment dependant upon the degree of dysplasia
- Close follow-up is necessary, since recurrence and the development of separate lesions are common

Oral Squamous Cell Carcinoma

- 22,000 cases per year, with about 1 in four dying of the disease
- Males-8th most common cancer (Females-15th)
- M>F
- Blacks>Whites
- Carcinoma of the lip should be considered in a different context

Oral Squamous Cell Carcinoma - Etiology

- Tobacco (especially combustible)
- Alcohol (works synergistically with tobacco)
- Radiation
- Plummer-Vinson syndrome (iron deficiency anemia, glossitis, dysphagia)
- Viruses (HPV)
- Immunosuppression

Oral Squamous Cell Carcinoma – Clinical Features

- Varied
  - Exophytic
  - Endophytic
  - Ulcerated
  - Erythroplakic
  - Leukoplakic

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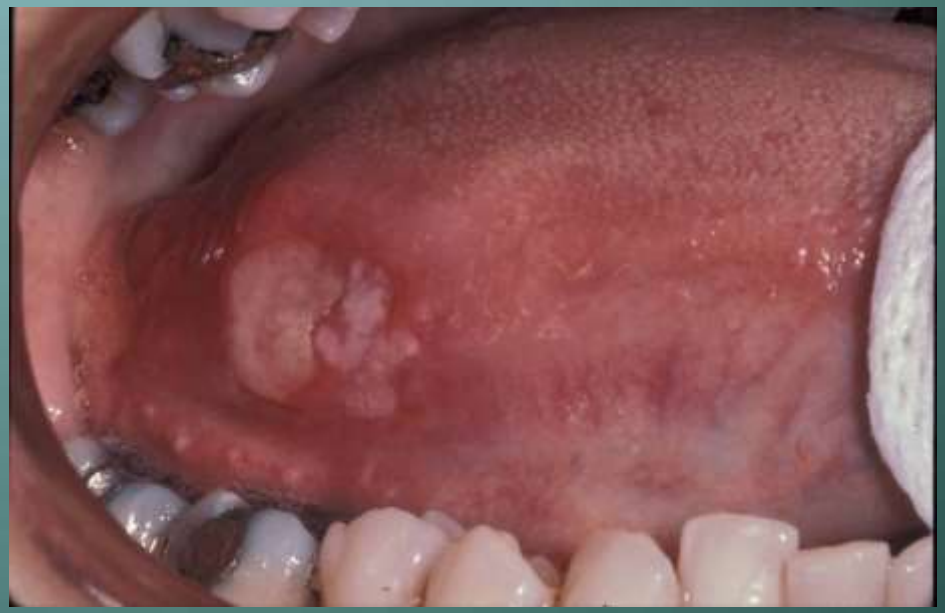

Oral Squamous Cell Carcinoma – Clinical Features

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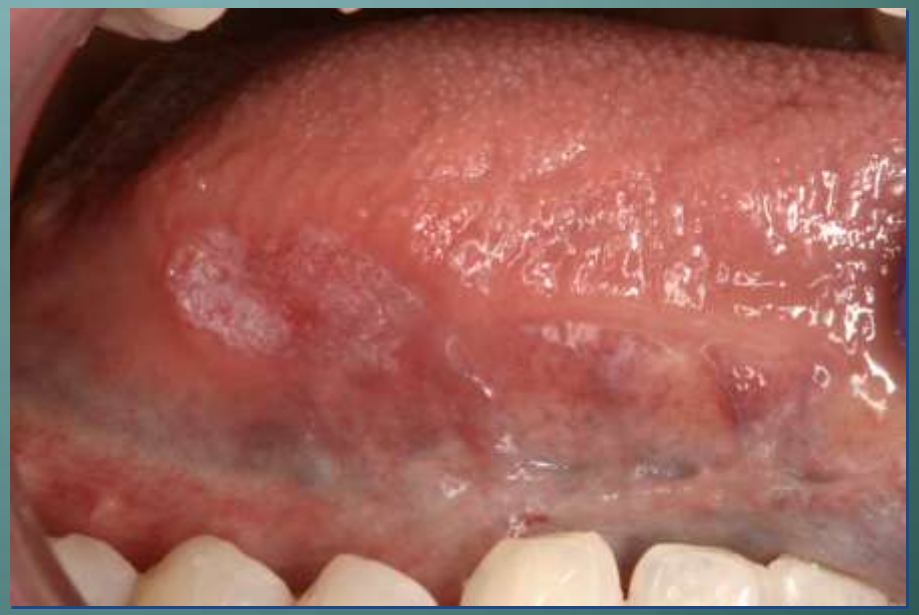
- Usually minimal pain
- Underlying bone may be altered



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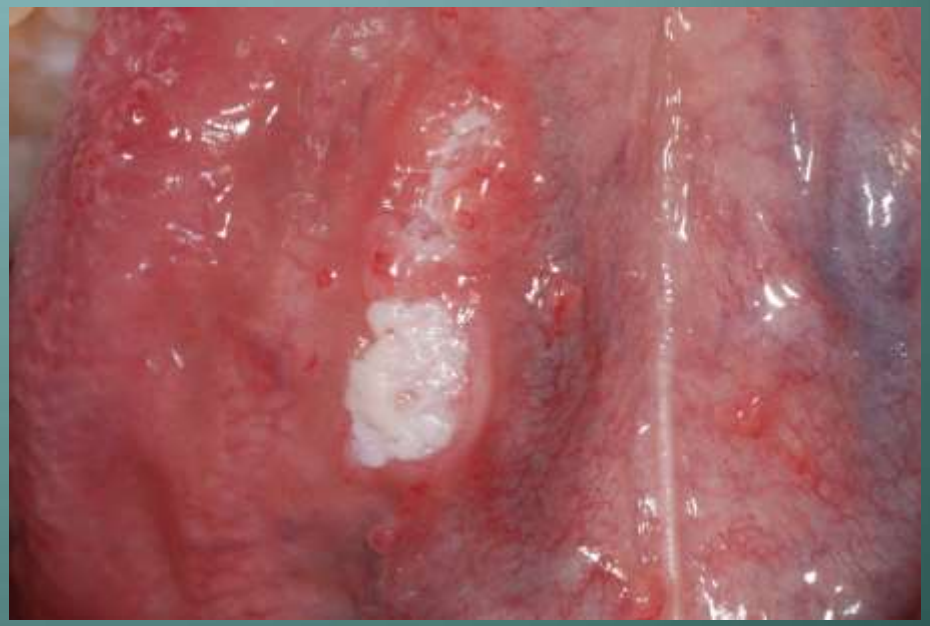

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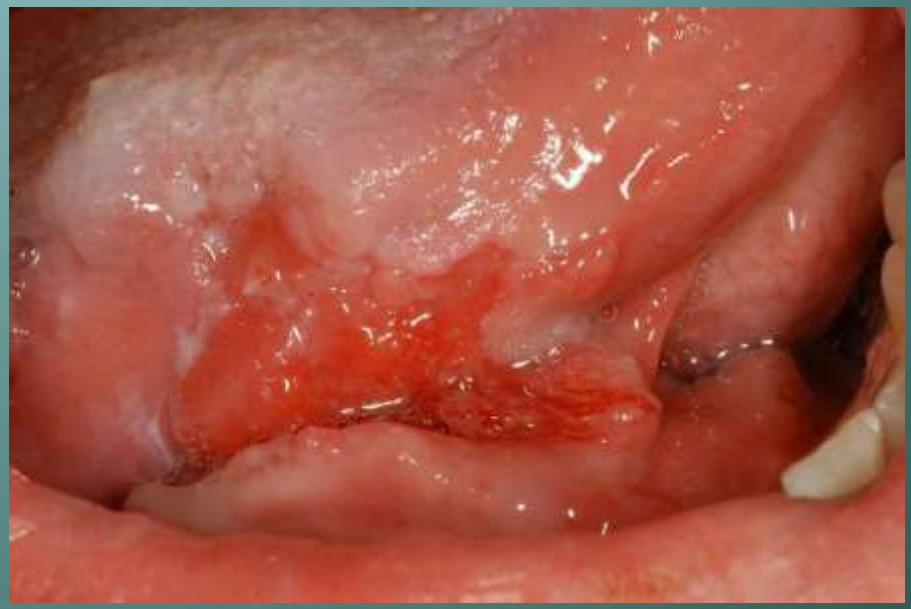

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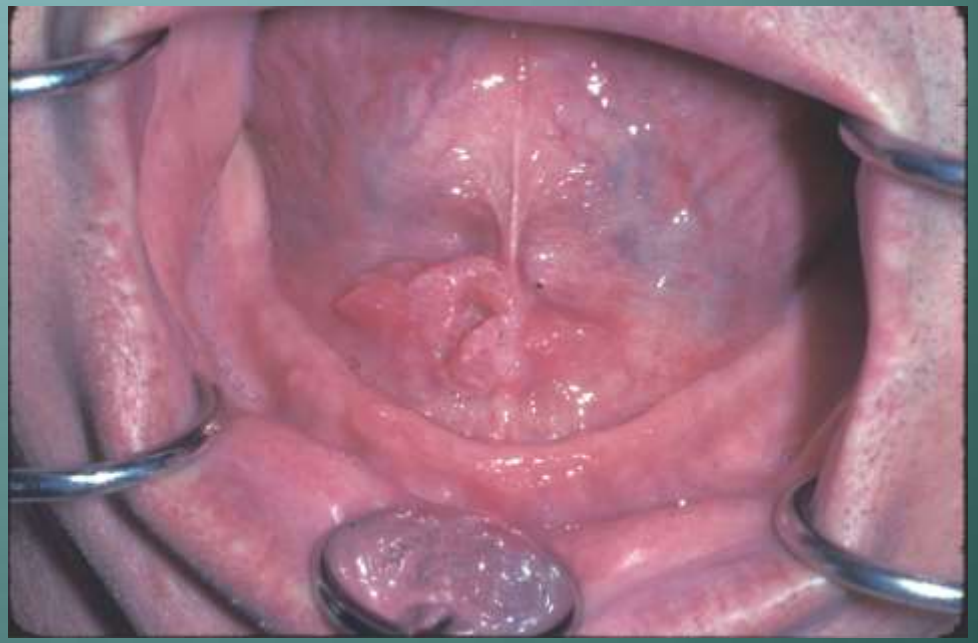

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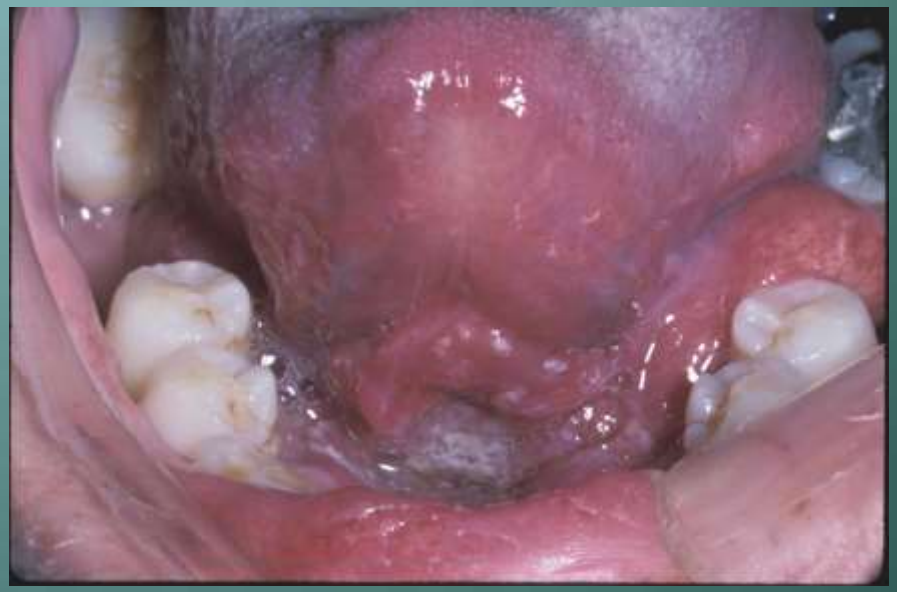

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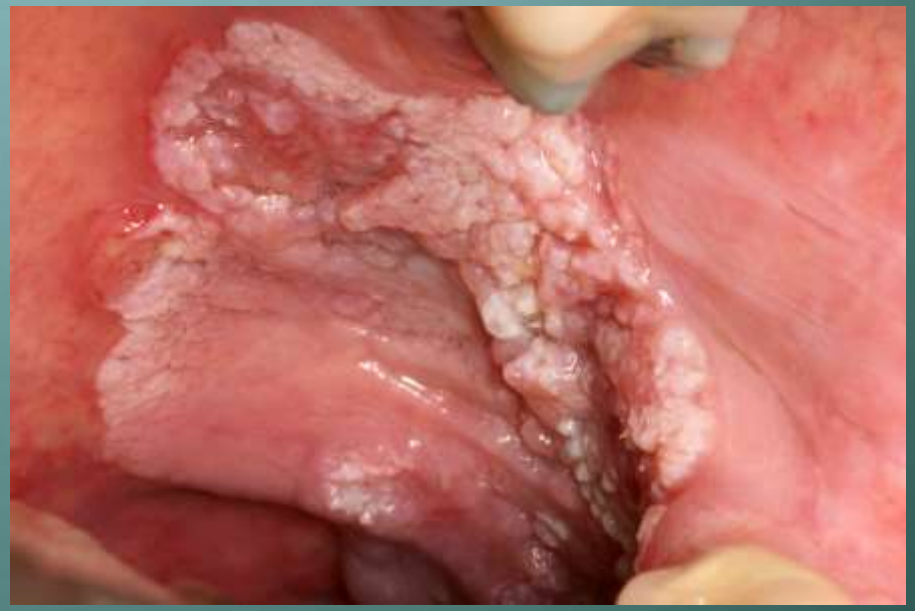

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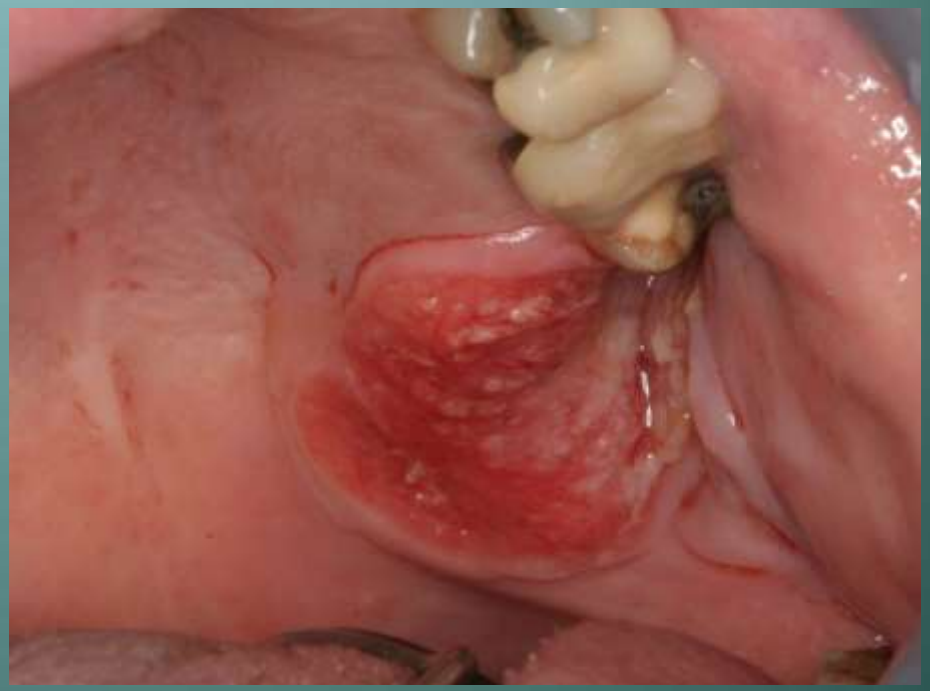

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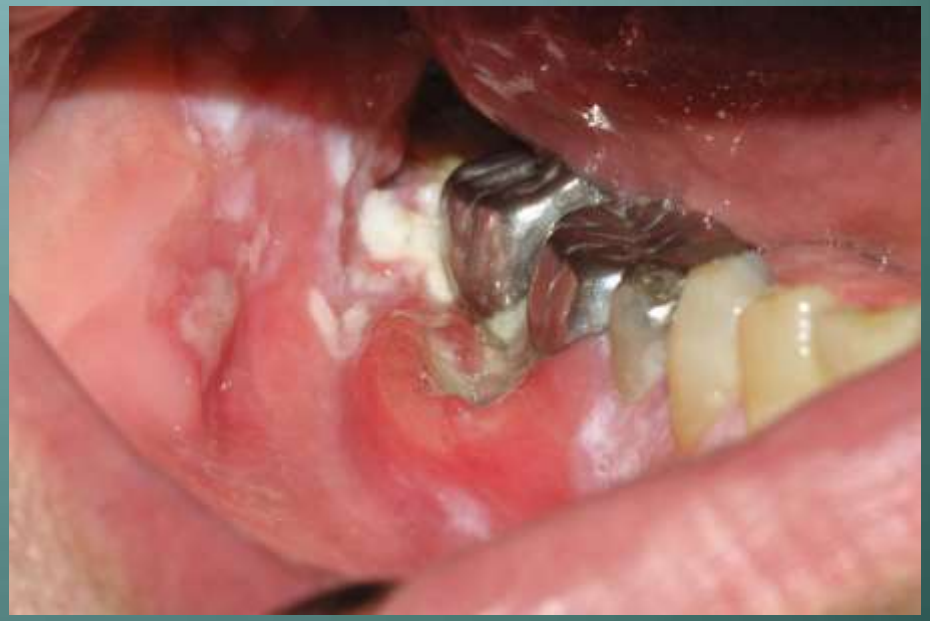

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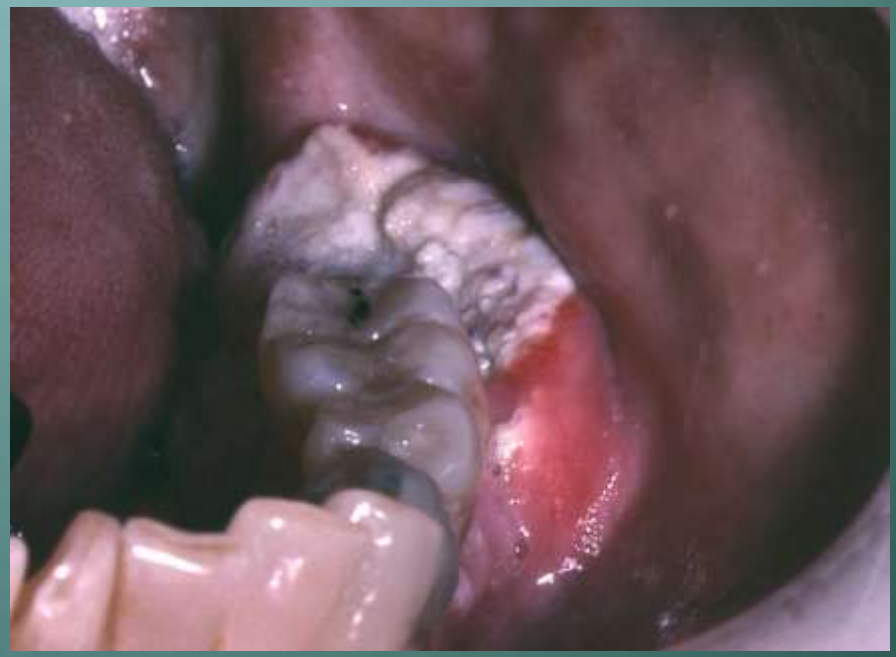

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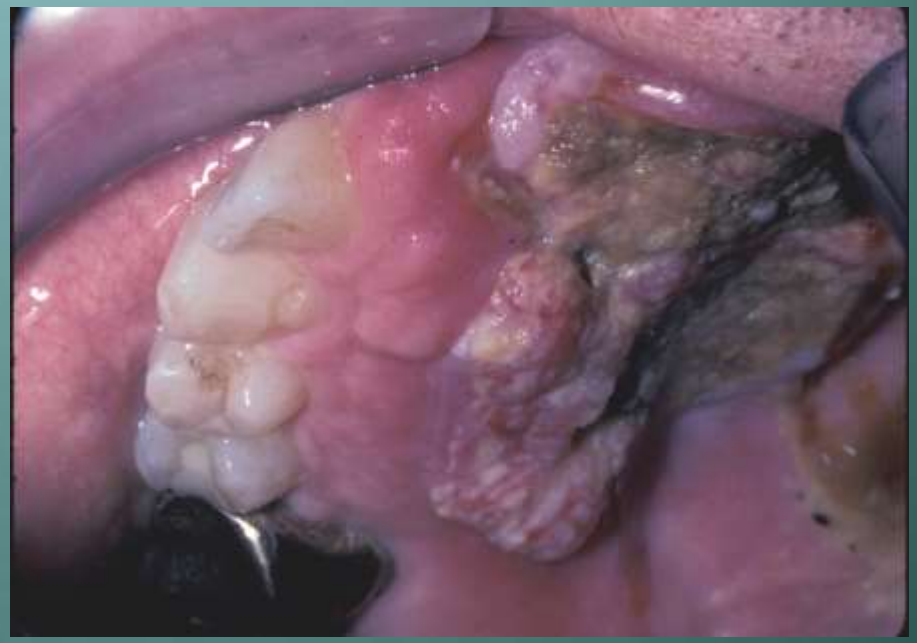

Oral Squamous Cell Carcinoma – Clinical Features

- Tongue (ventral and lateral), floor of mouth, soft palate are the most common sites
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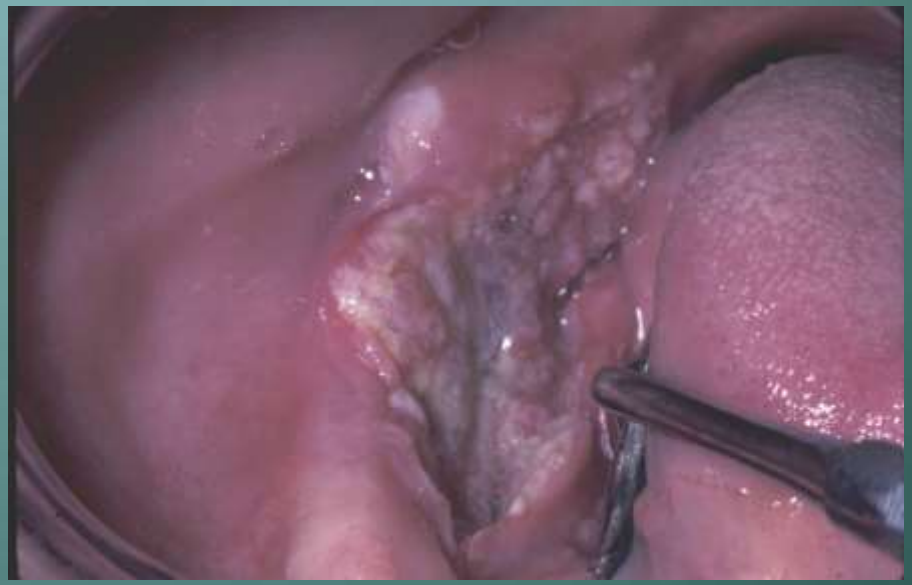

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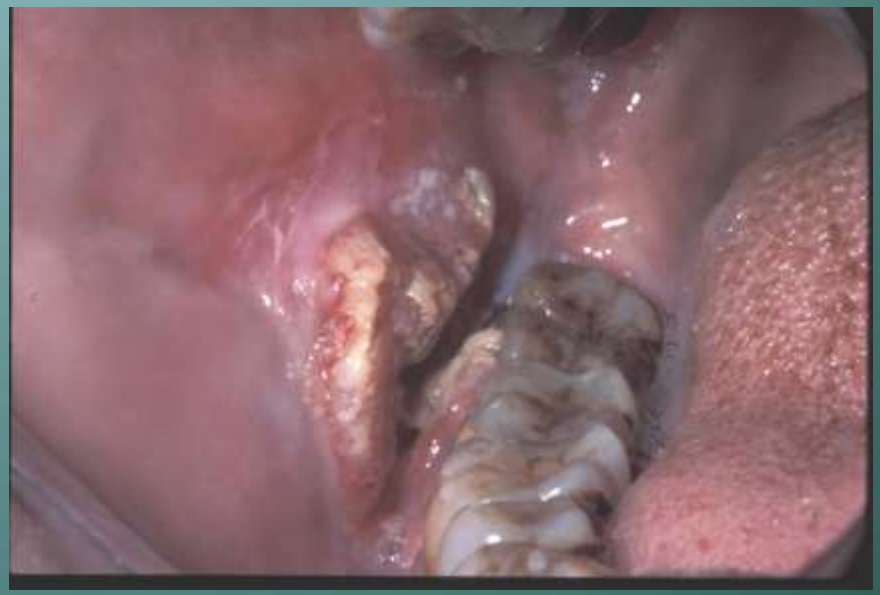

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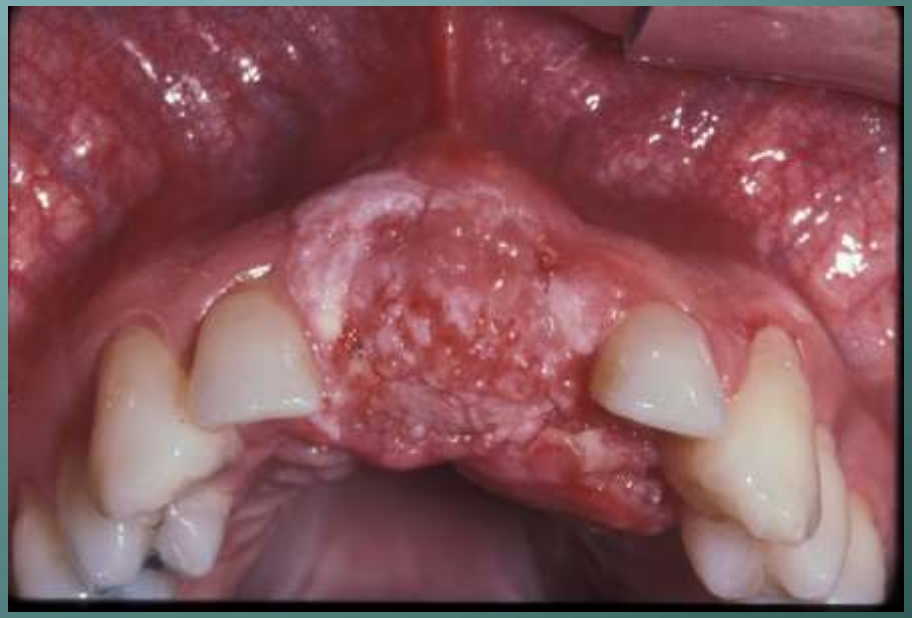
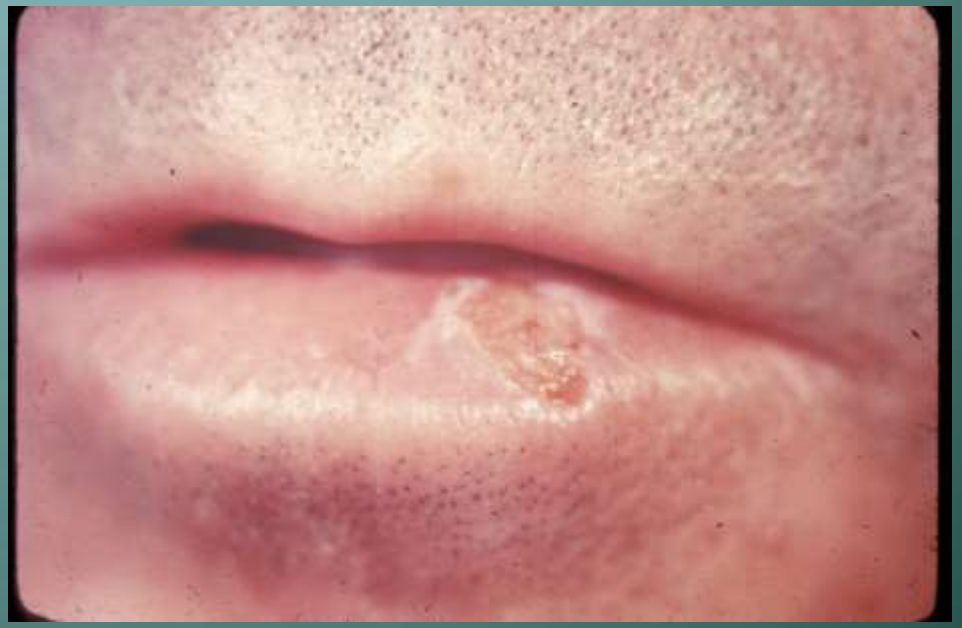


Squamous Cell Carcinoma of the Lip – Clinical Features

- Etiology-Chronic sun exposure
- Males, typically with outdoor occupations
- Slowly growing indurated ulceration



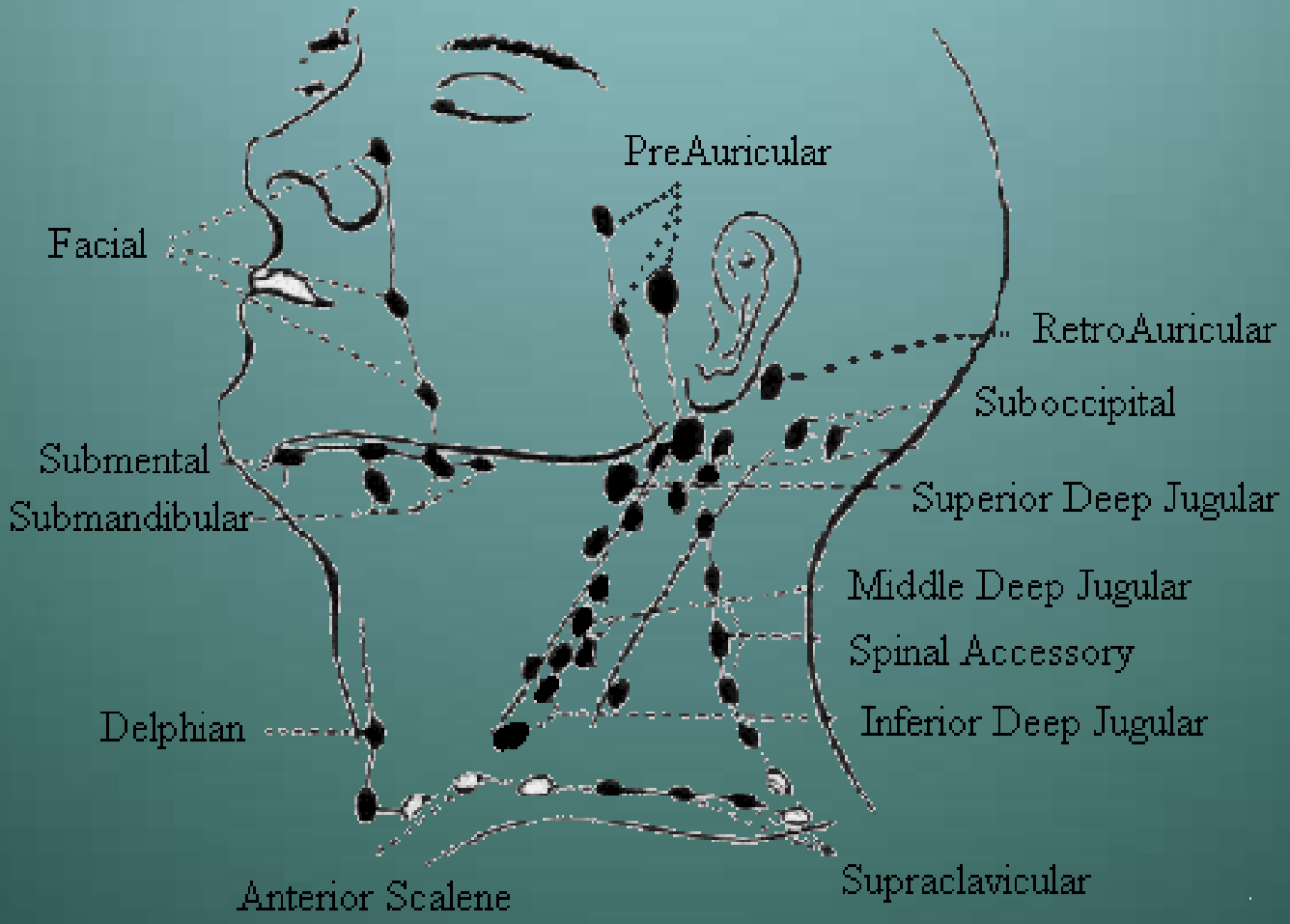
Squamous Cell Carcinoma - Metastasis

- Spread through lymphatics
- Firm nodes
- Movable or fixed
- Distant spread to lungs, liver, bones
- TNM staging
  - Stage at diagnosis is the most important prognostic indicator

Squamous Cell Carcinoma - Metastasis

- TNM staging system
  - T-Tumor size
  - N-Local node involvement
  - M-Distant metastasis

Squamous Cell Carcinoma - Metastasis



Squamous Cell Carcinoma – Treatment and Prognosis

- Surgical excision/resection
- Radiation
- Chemotherapy – Squamous cell carcinoma rarely responds well

- Stage I – 85% 5 year survival
- Stage II – 66%
- Stage III – 41%
- Stage IV – 9%

Squamous Cell Carcinoma – Treatment and Prognosis

- National Comprehensive Cancer Network
- http://www.nccn.org/professionals/physician_gls/f_guidelines.asp

Squamous Cell Carcinoma – Treatment and Prognosis

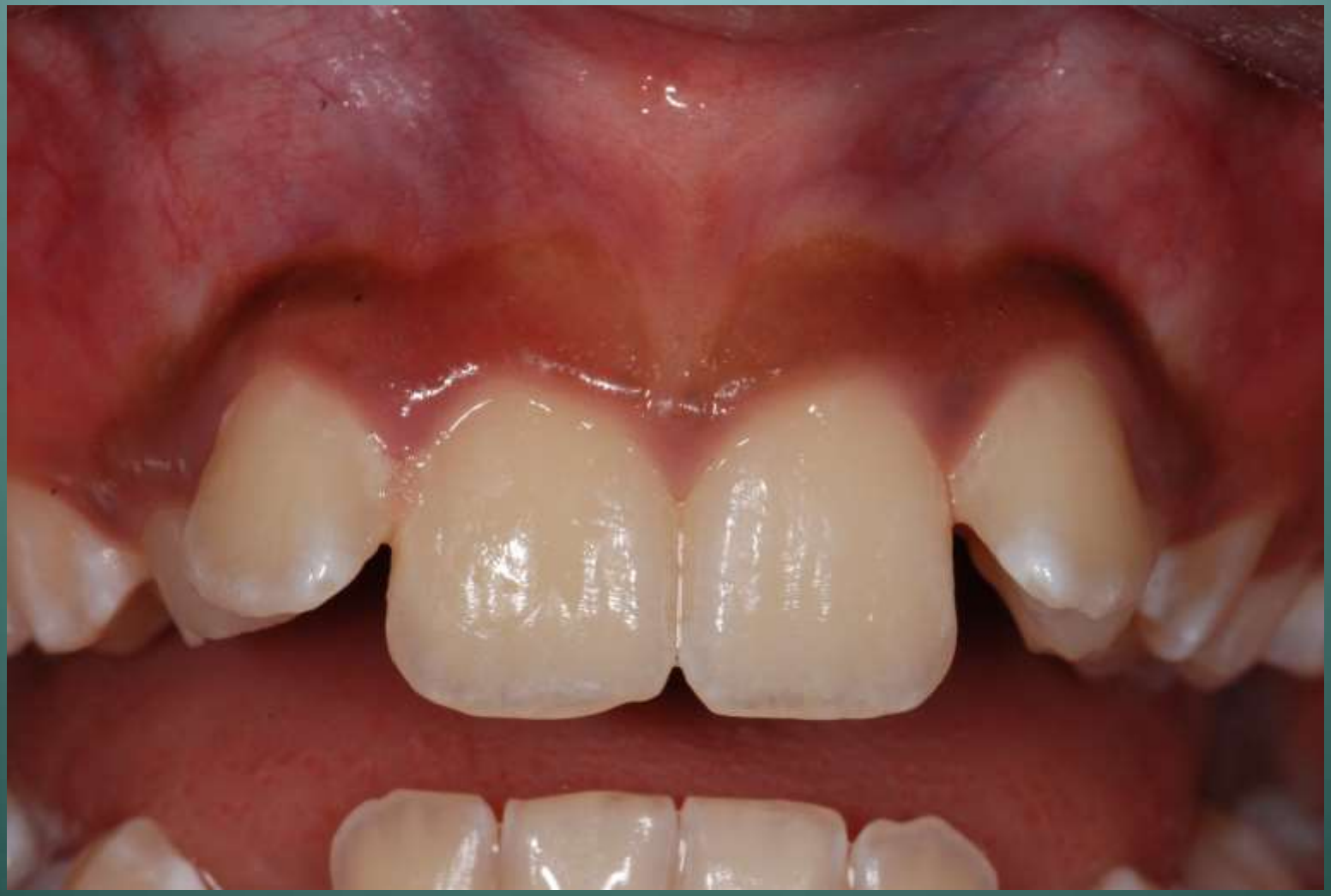
- Carcinoma of the lip carries a much better prognosis
- Prognosis is better for Whites than Blacks
- "Field cancerization" – Persons with one carcinoma are at increased risk of developing a second mucosal tumor

Odds and Ends

Case #6

- This patient presented with recent onset of the pigmentation seen here

Case #6



Case #5 – Differential Diagnosis

- Normal Physiologic Pigmentation
- Smoker's Melanosis
- Medication-Associated
- Addison's Disease

Smoker's Melanosis

- Rather common melanocytic response found in heavy smokers
- Probably a protective response to the harmful aspects (polycyclic aromatic hydrocarbons) of tobacco smoke

Smoker's Melanosis – Clinical Features

- F>M
- Frequently on anterior facial gingiva
- "Reverse smokers" show involvement of the palate

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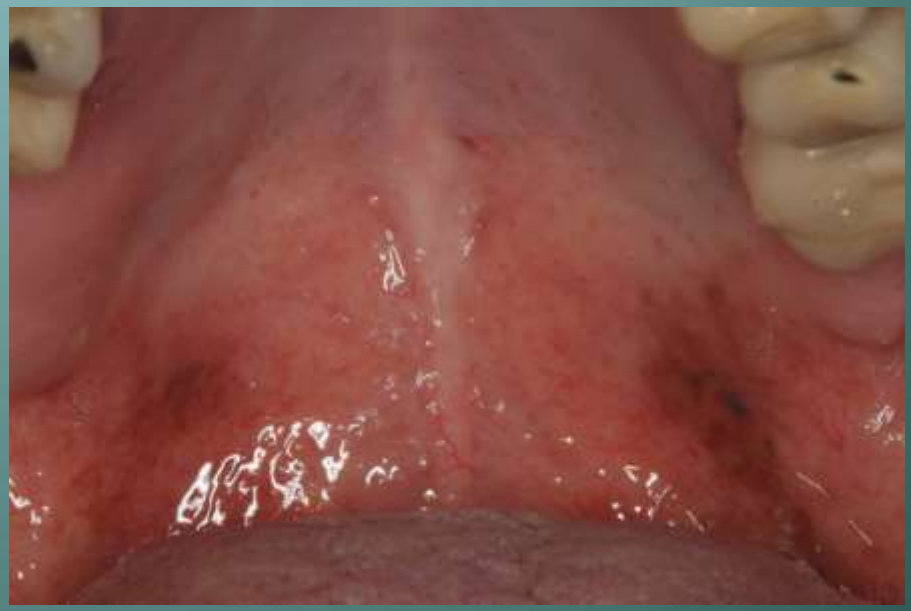

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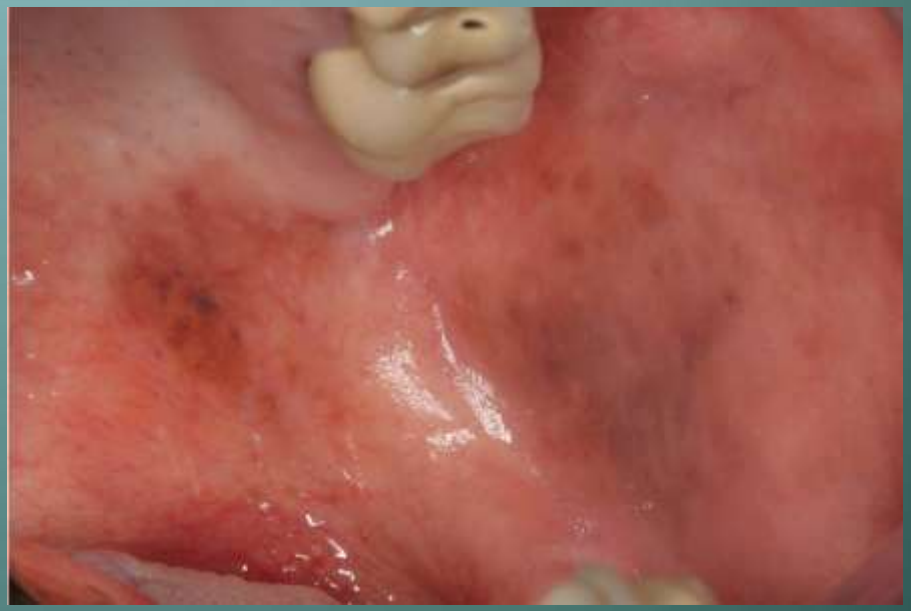

Smoker's Melanosis – Diagnosis and Treatment

- Clinical, tobacco, and medical history
- May need to rule out systemic cause
- Cessation of smoking will result in gradual resolution

Drug-Related Discolorations of the Oral Mucosa

- Discoloration secondary to melanocytic stimulation or direct deposition into tissue
- Antimalarial meds, minocycline, estrogen, chemotherapeutic agents, AIDS medications

Clinical Features

- F>M
- Diffuse discoloration of skin and mucosa
- Minocycline-Discoloration of underlying bone

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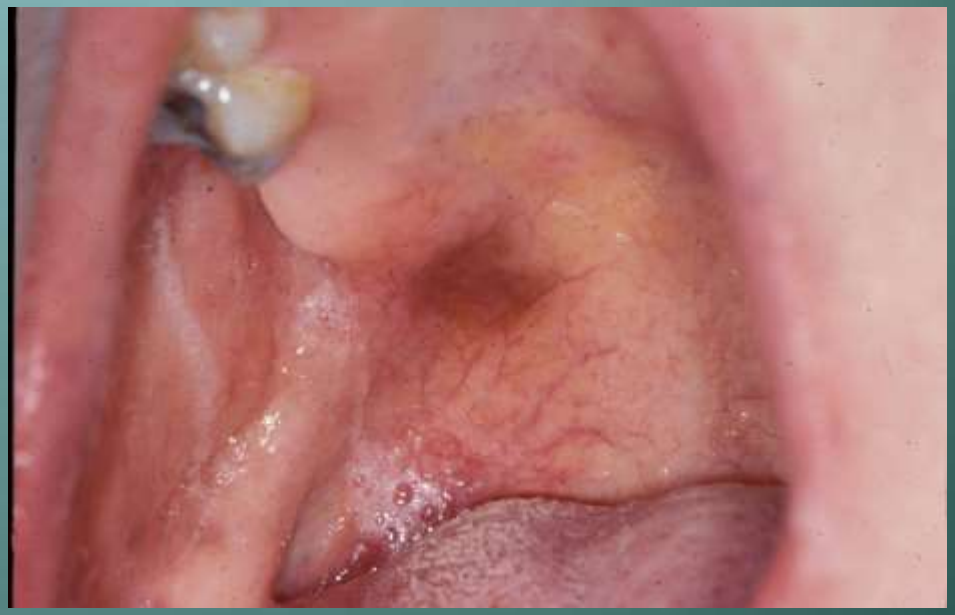

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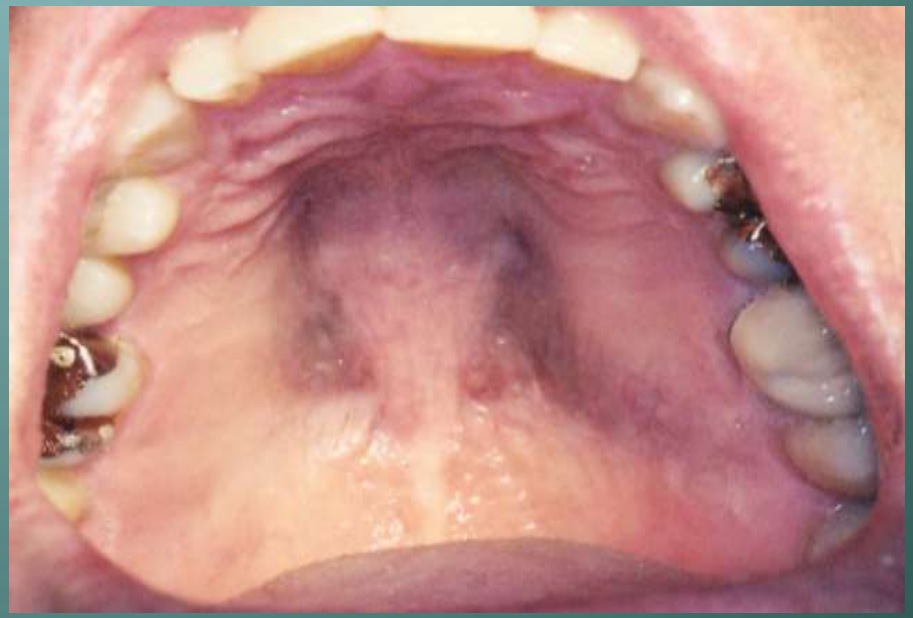

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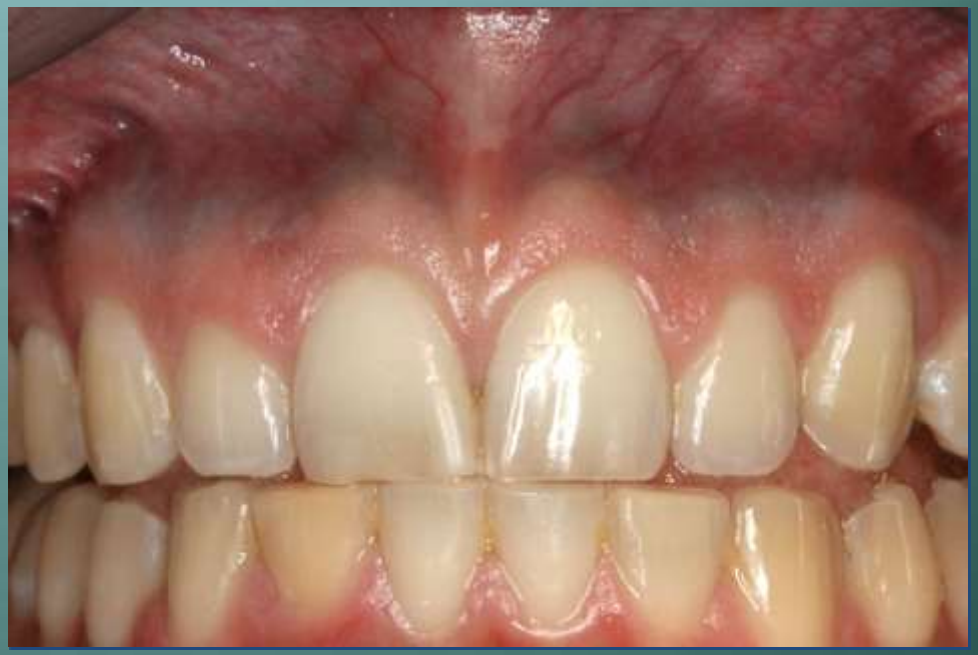

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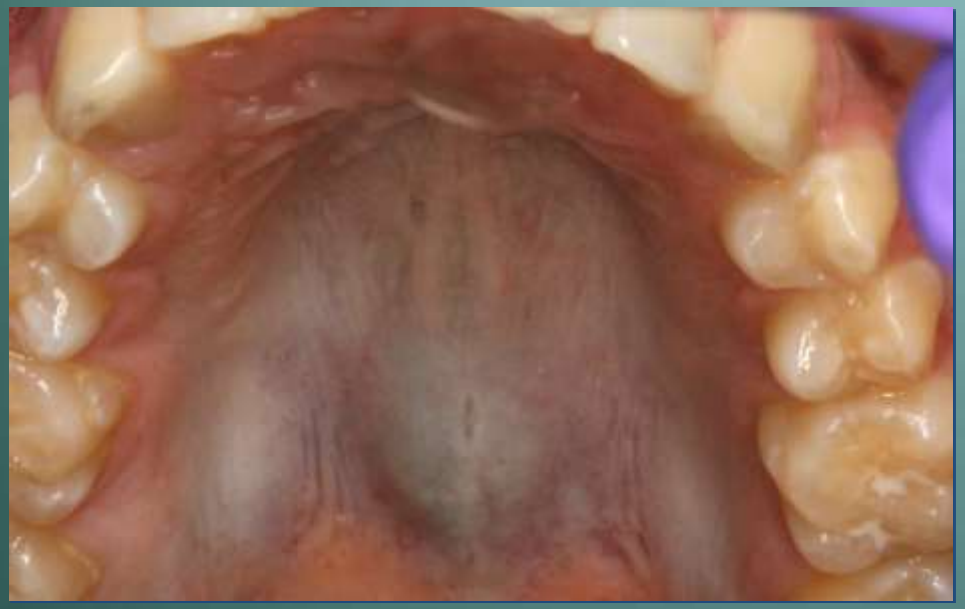

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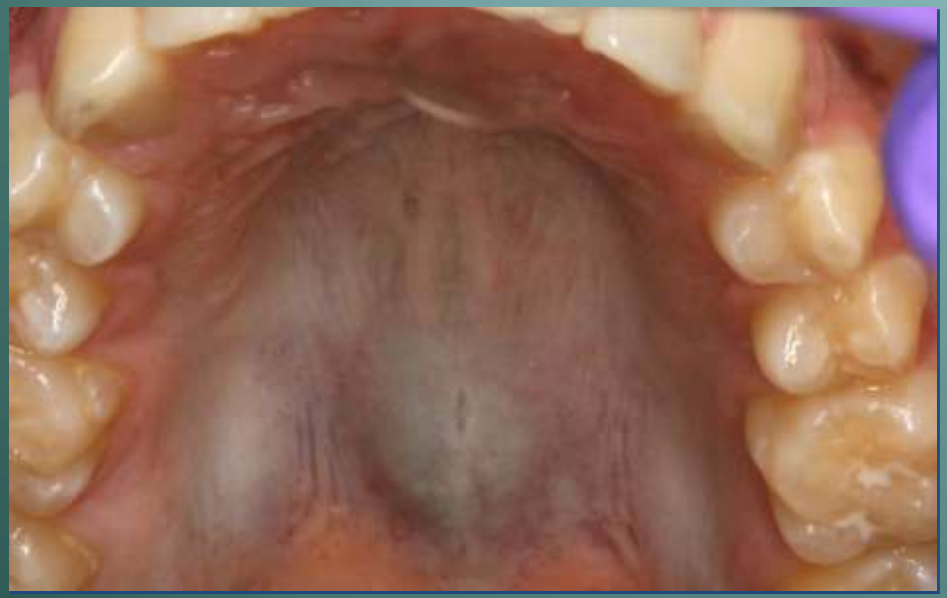
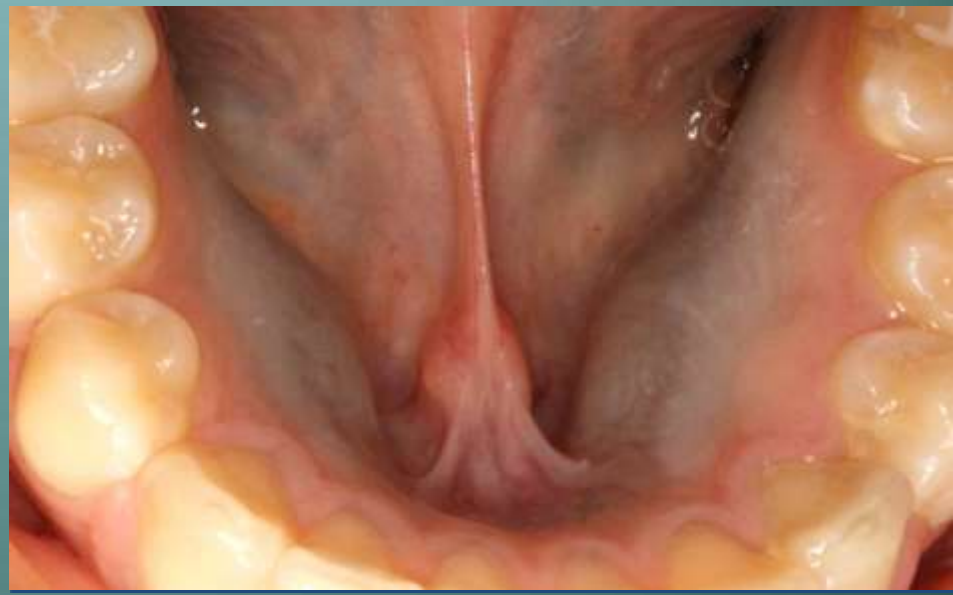




Treatment

- Gradual resolution upon discontinuation of medication
- Strictly and esthetic issue
- No long term complications

Addison's Disease (Hypoadrenocorticism)

- Insufficient production of adrenal corticosteroid hormones
- Primary – Secondary to adrenal destruction
- Secondary – Due to malfunctioning pituitary gland

Addison's Disease – Clinical Features

- Fatigue, irritability, depression, weakness, and hypotension
- Hyperpigmentation (may be seen intraorally)
- GI symptoms, salt-craving

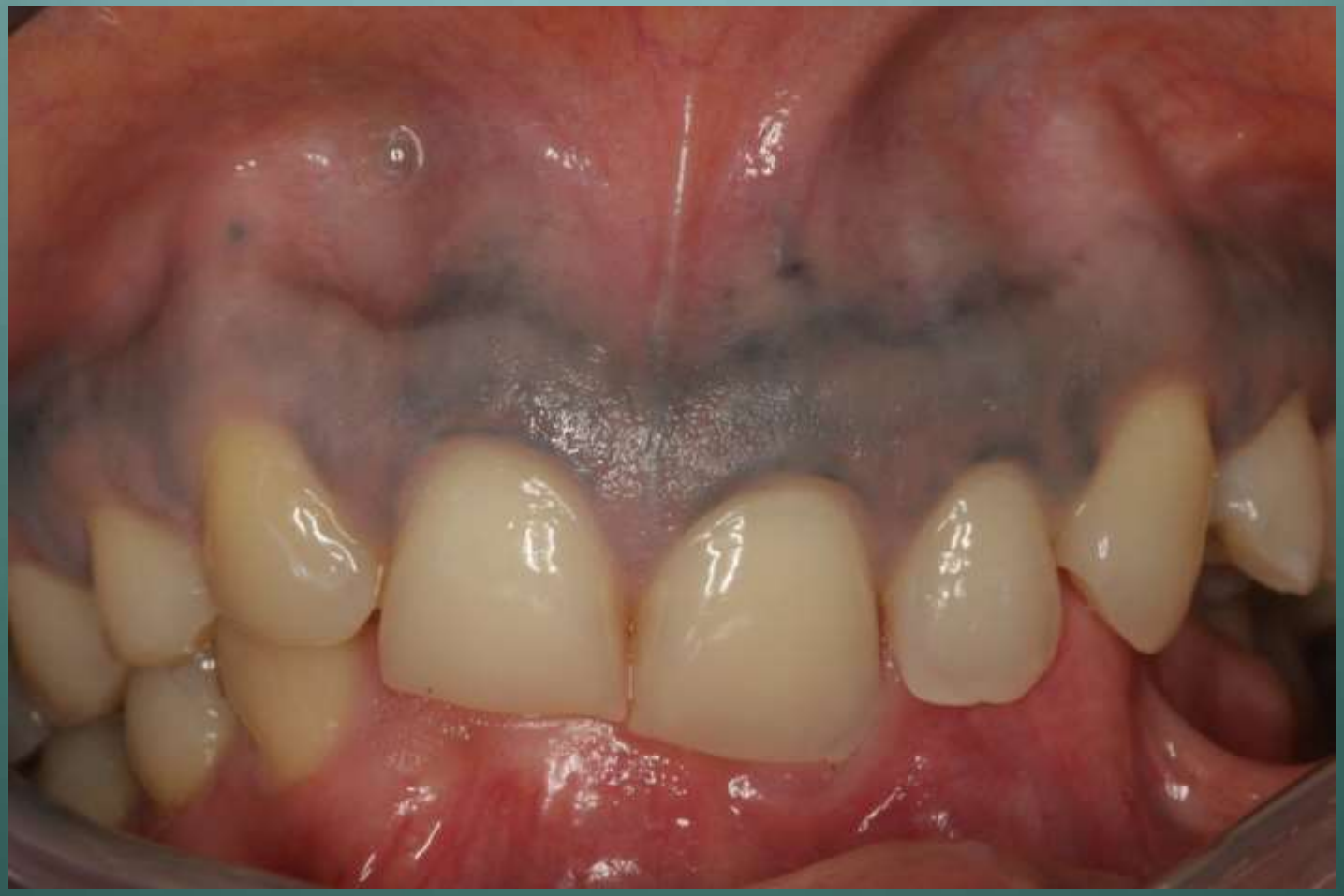
Addison's Disease – Lab Findings

- Primary – High plasma ACTH
- Secondary – Low plasma ACTH

Addison's Disease - Treatment

- Corticosteroid replacement therapy
- Preplan dental and oral surgical procedures
- Good prognosis, with patients typically living a normal life span

Additional Consideration – Intentional Tattooing



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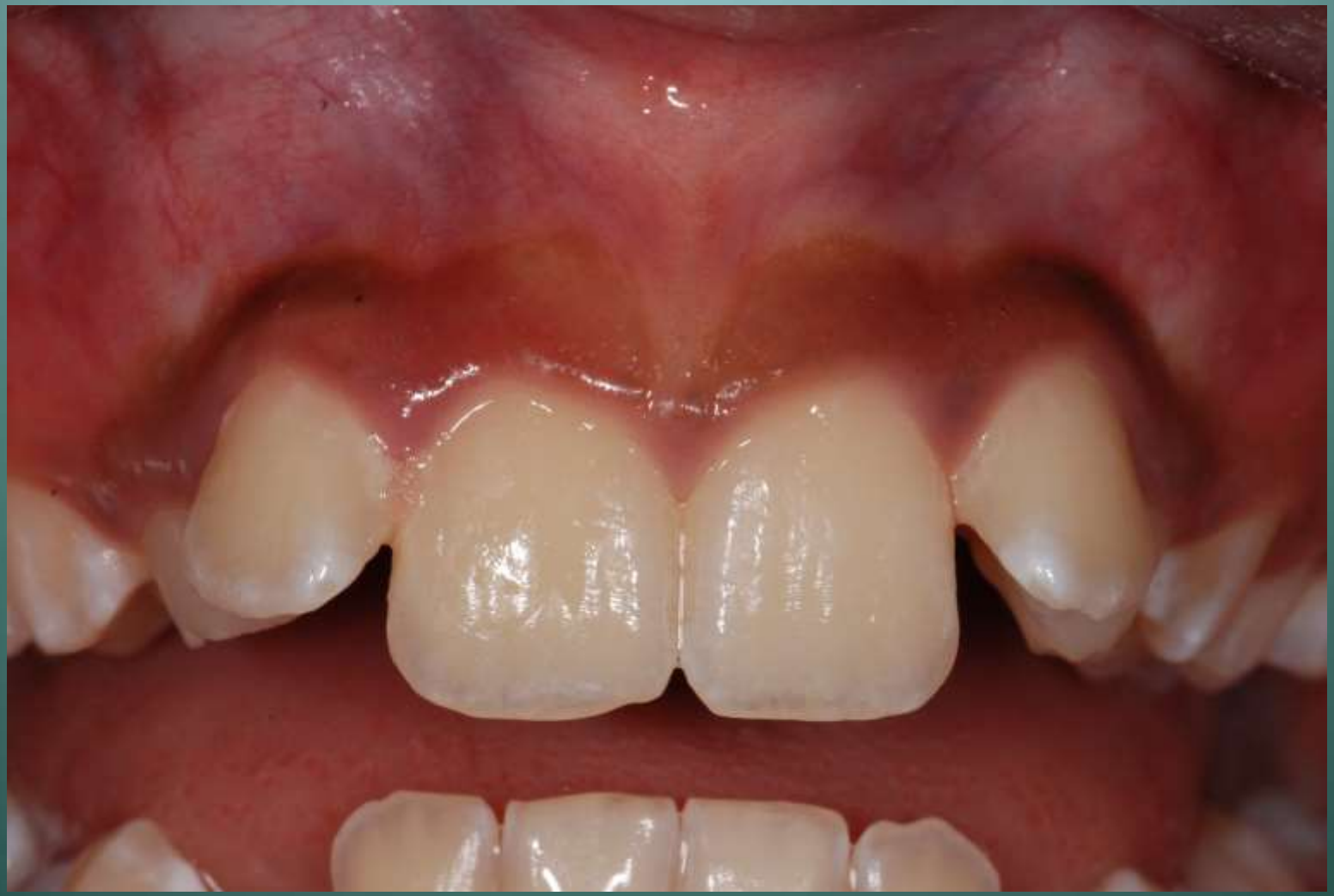
Diagnosis Case #6 – Addison's Disease



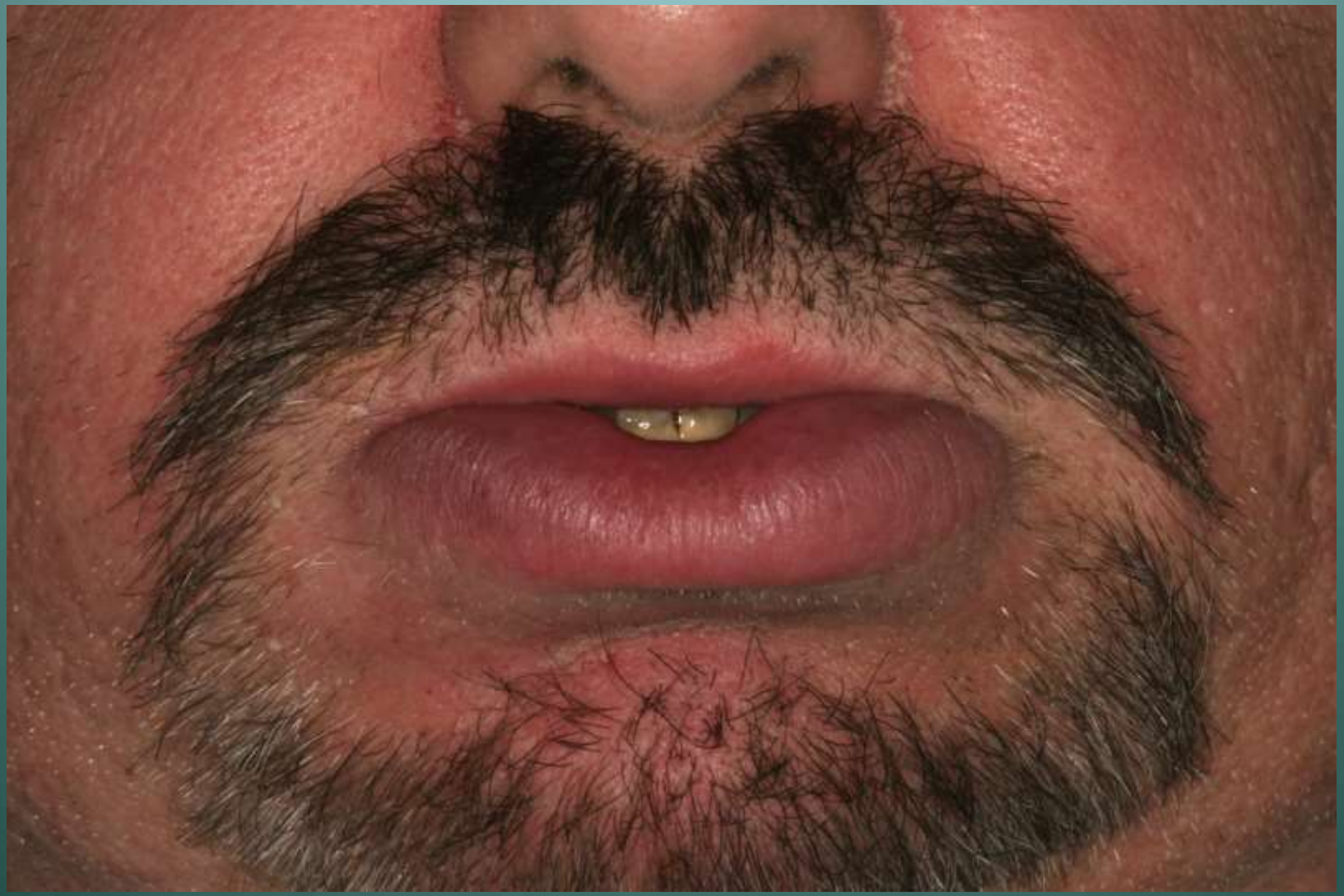
Diagnosis Case #6 – Addison's Disease

- Further questioning revealed a one month history of nausea, vomiting and intermittent weakness

Case #7

- This patient presents with the abnormality seen

Case #7



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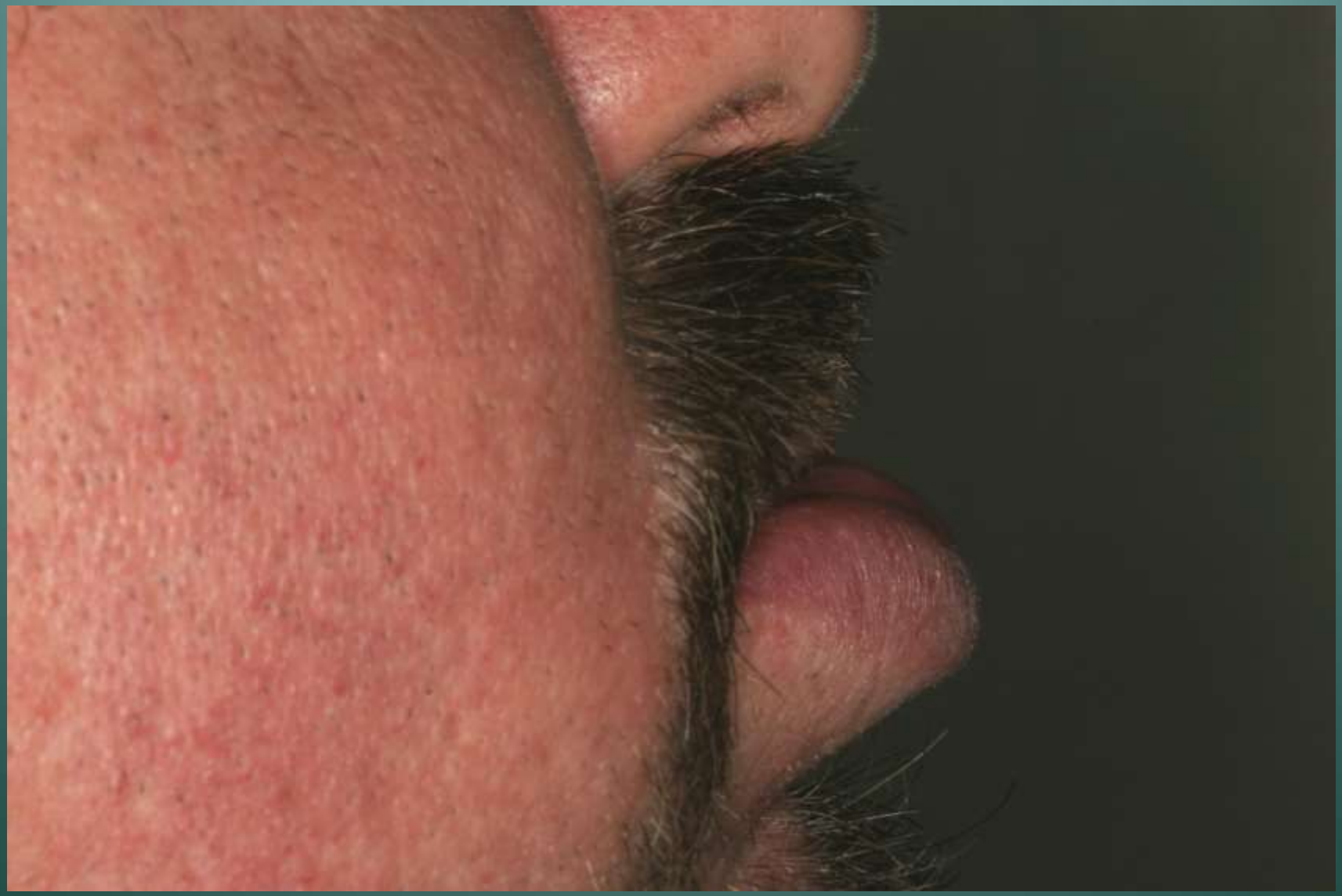

Case #7 – Differential Diagnosis

- Angioedema
- Cheilitis Granulomatosis (Orofacial Granulomatosis)

Angioedema (Quincke's Disease)

- Diffuse, often intermittent swelling of the soft tissue
- Three primary mechanisms-
  - Hypersensitivity reaction due to IgE mediated mast cell degranulation
  - Associated with ACE inhibitor antihypertensives, secondary to increased bradykinin levels
  - Lack of or inactive C1 esterase inhibitor (inherited or acquired)

Angioedema – Clinical Features

- Enlargement of relatively rapid onset
- Pruritis, erythema
- Respiratory involvement may be life threatening

Angioedema – Diagnosis

- Allergic - Clinical presentation in association with suspected antigen
- Inciting cause often not determined
- Evaluate functional C1-INH

Angioedema - Treatment

- Antihistamines for allergic form
- IM epinephrine
- ACE inhibitor-related and C1-INH deficient do not respond to antihistamines
  - C1-INH concentrate administration or esterase inhibiting drugs

Cheilitis Granulomatosis (Orofacial Granulomatosis)

- Granulomatous inflammation of unknown etiology or the orofacial presentation of Crohn's, sarcoidosis, TB, or any other granulomatous process

Orofacial Granulomatosis – Clinical Features

- Highly variable presentation
- Involvement of lips- cheilitis granulomatosa

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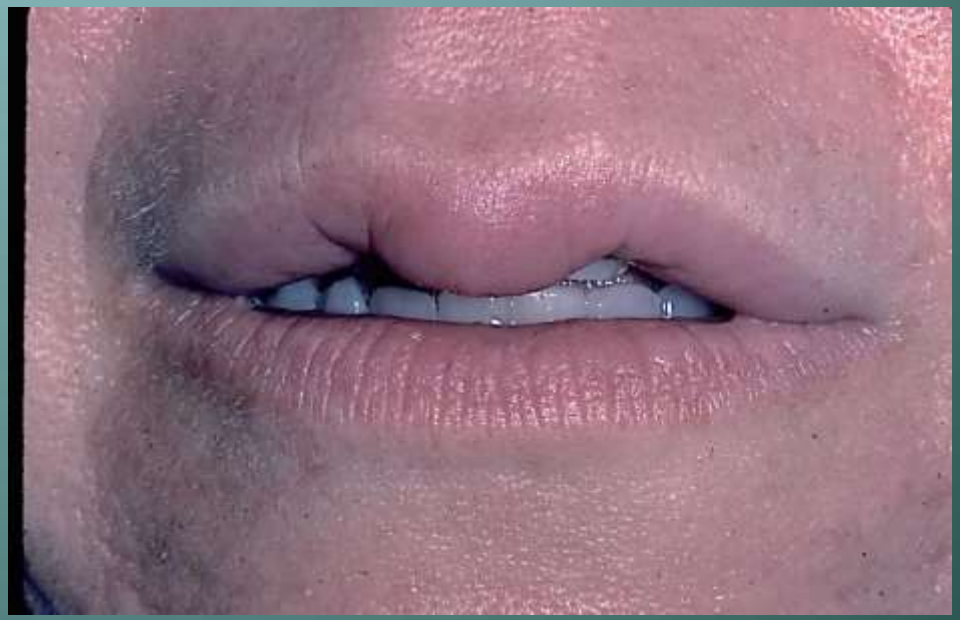

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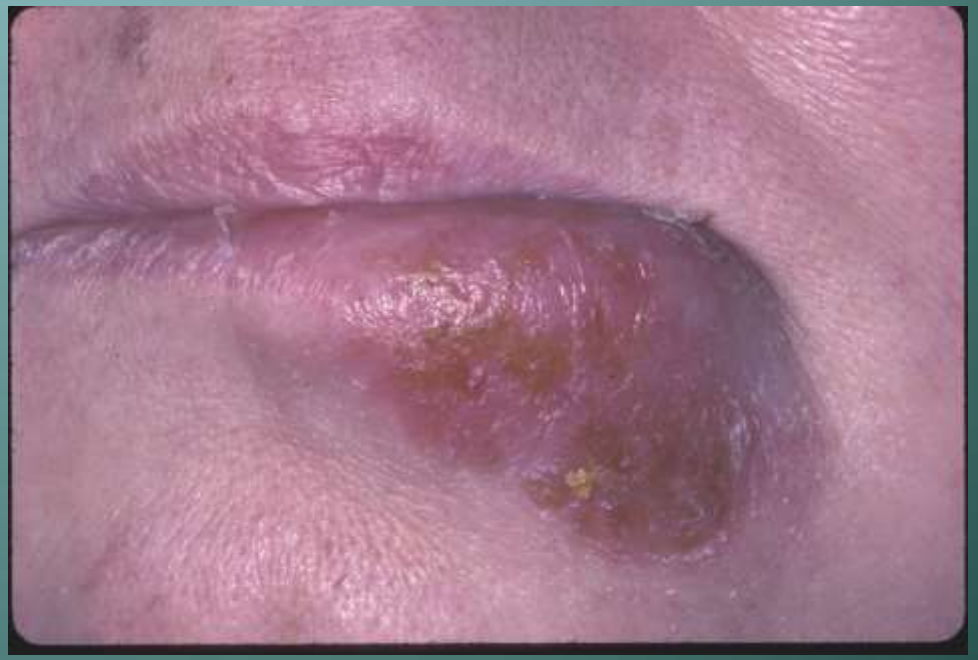

Treatment and Prognosis

- Intralesional corticosteroids
- Multiple treatments
- Good prognosis; requires thorough work-up
- Primarily a cosmetic problem

Case #7 – Differential Diagnosis

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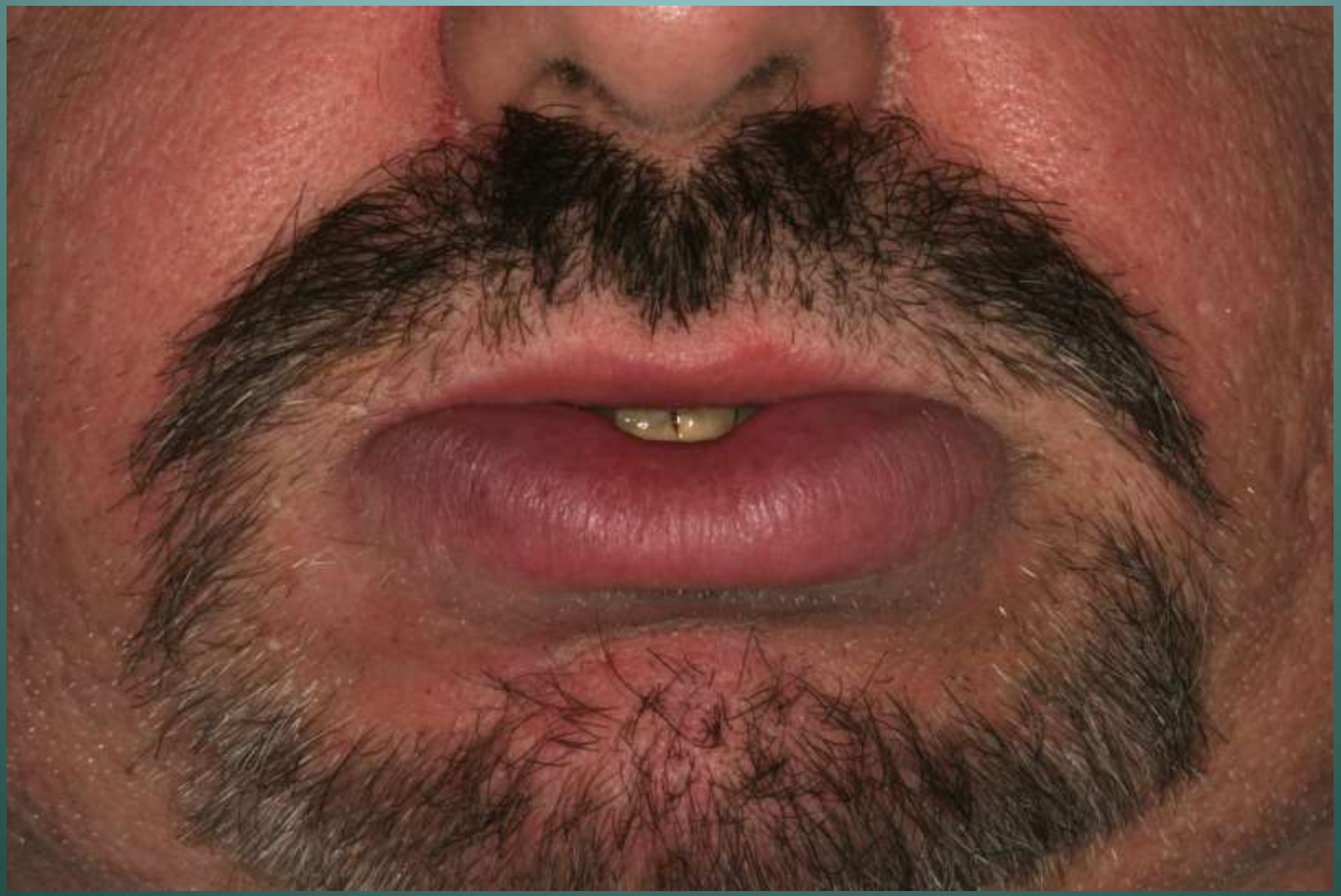
Diagnosis Case #7 – Cheilitis Granulomatosis



Thank You

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