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Palatal ulceration

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Abstract Palatal ulcers are a common presentation and can be conveniently divided into developmental and acquired causes, the latter of which is subdivided into acute and chronic causes. Most commonly seen dermatologic causes have associated skin manifestations. Acute and multiple ulcers are usually infectious or drug induced in origin. Recurrent ulcers are largely dominated by aphthosis, while chronic ulcers are seen in immunocompromised patients and can occasionally be malignant. It is essential to involve the oral and maxillofacial surgeons early in the therapeutic management to tackle the inevitable complications that may ensue in the chronic cases.

Palatal ulceration

Palatal ulceration is a clinical problem, which is a diagnostic issue, especially in cases without cutaneous involvement (Figure 1) and in cases with a chronic ulcer. Palatal ulcers are consequent to a loss of tissue (both the epithelium and the underlying connective tissue), and may involve both the keratinized or nonkeratinized oral mucosa.[1,2] The causes are diverse, ranging from developmental causes to a variety of inflammatory (Figure 2), infectious (Figures 3, 4, and 5), immune-mediated (Figure 6), iatrogenic (Figure 5), and neoplastic causes.[3,4] The ulceration may either be limited to the palate or represent a part of a generalized pathologic process involving the entire oral mucosa. The latter is more common and diagnosis is relatively easy compared with when the lesions are limited solely to the palate. A battery of investigations is often required to delineate the etiology, and the period between onset and institution of therapy can range from months to years. The present review discusses the etiology, pathogenesis, classification, diagnosis, and management of palatal ulcers.

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Classification

The causative factors can broadly be divided into developmental and acquired causes. Among the developmental causes, cleft palate is the most common, while in the acquired, recurrent aphthous stomatitis is probably the most common cause.[1,5] A comprehensive list is enumerated in Table 1 with a special emphasis on common and rare causes. There are two approaches to diagnose these disorders. The first is based on the site of involvement (Figure 1), the second is based on the onset, number of ulcers, and the course of the disease (Figures 7 and 8). A judicious use of this (Figures 1, 7, and 8) can help to narrow down the common cause and probable diagnosis.

Brief description of common entities

Aphthous stomatitis

This is perhaps one of the most common cause of oral ulceration.[1] Although various factors including genetic, autoimmune, hormonal changes, hypersensitivity to certain foods, drugs, blood deficiency, zinc deficit, and stress, etc have been implicated in the etiology, none of them can be solely held responsible for a particular episode, and hence the therapy is primarily directed at suppressing the inflammation

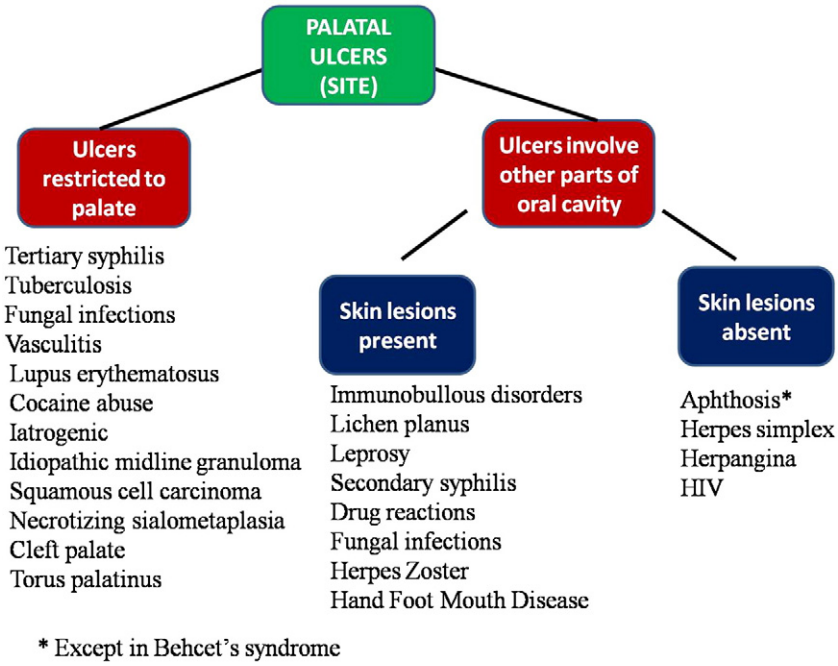

Fig. 1 Site dependent classification of palatal ulcers.

and pain associated with lesions.[6] Three types have been identified: minor, major, and herpetiform ulcers.[7] Only the major and herpetiform variants are seen on the palate.

Major aphthae (also known as periadenitis mucosa necrotica recurrens or Sutton's disease) are generally >10 mm in size and painful (Figure 2). They can occur as single or multiple ulcers, and persist for more than 6 weeks and heal with scars.[8] Herpetiform aphthae are characterized by multiple (50-100), small (2-3 mm) and painful ulcers that tend to coalesce and form ulcers of a larger size. They usually heal within 7 to 10 days without leaving any sequela. Apart from palate, the major and herpetiform variants may also involve the lips, cheeks, tongue, floor of the mouth, and pharynx.[6] Because the nonkeratinized mucosa is more commonly involved, the lesions are seen on the soft palate, an important point that differentiates it from herpetic stomatitis, which involves chiefly the keratinized part of the mucosa.[9]

Various systemic disorders have been associated with recurrent aphthous stomatitis including behcet's syndrome, sweet's syndrome, agranulocytosis, cyclic neutropenia, and periodic fever syndrome.[6,10] Behcet's syndrome is the most well-recognized and should be considered in case the patient has coexisting genital ulcers, visual complaints, joint pains, and neurologic symptoms.

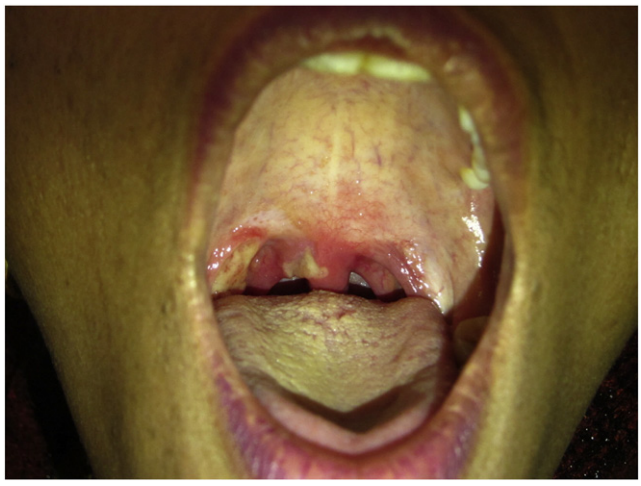

Fig. 2 Deep, painful ulcers on the soft palate and faucets of a patient with major aphthous ulcers. The patient responded to a short 7-day course of oral steroids and doxycycline 100 g BD for 10 days.

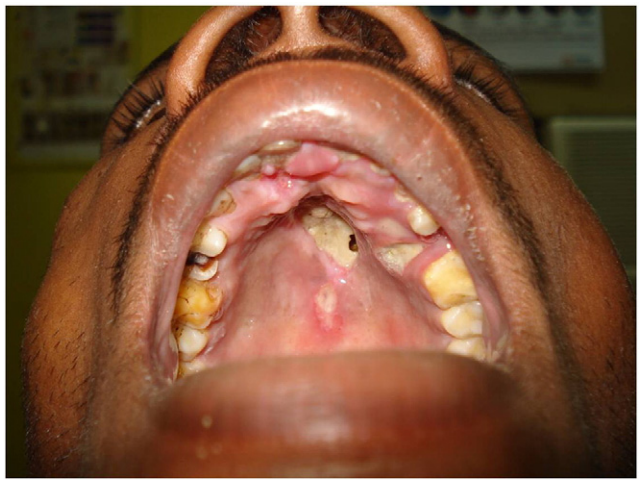

Fig. 3 Deep necrotic ulcer with palatal involvement in a case of Mucormycosis in a diabetic patient.