CLINICOPATHOLOGIC CONFERENCE

Scarring and chronic ulceration of the floor of the mouth

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CASE REPORT

A 63-year-old male patient was first seen for evaluation of chronic intraoral mucosal lesions and ulcerations. His medical history revealed that 30 years earlier, he had experienced Hodgkin lymphoma (HL), which had successfully been treated by chemotherapy. The patient reported that oral lesions apparently developed soon thereafter and had been present periodically. In addition, he had been experiencing itchy cutaneous lesions on the upper trunk and arms for many years, which he claimed had been treated unsuccessfully by corticosteroids. He also had recurrent depressive episodes, which had been treated medically.

Clinical examination disclosed a deep ulcerative lesion measuring 3 cm in diameter on the left anterior floor of the mouth (Figure 1). The carunculae sublinguales could not be identified, and the anterior floor of the mouth demonstrated scarring and induration on palpation. Furthermore, the buccal mucosa showed some bilateral scarring, and an erosive lesion was visible in the left buccal plane (Figure 2). The maxilla was edentulous, and in the mandible, telescopic crowns were fixed on molars bilaterally. The complete maxillary denture and mandibular overdenture were well-adapted. Excoriations, erosions with crusts, and postinflammatory hypopigmentations were found on the skin of the patient's arms, shoulders, thorax, and neck (Figure 3).

DIFFERENTIAL DIAGNOSIS

On the basis of clinical examination and interdisciplinary evaluation, the potential differential diagnoses of the intraoral pathology included mucous membrane pemphigoid (MMP)/cicatricial pemphigoid, aphthous stomatitis with ulcerations of major type, traumatic lesions, recurrent HL, malignant epithelial tumors, and opportunistic or chronic infection.

On the basis of the concomitant presence of chronic, itchy, excoriated lesions on the upper trunk and arms, the patient was first thought to be experiencing MMP, an autoimmune disease causing blisters. It also has been known as cicatricial pemphigoid and is associated with an autoantibody response directed against various components of the epidermal/epithelial basement membrane zone. Typically, in MMP, there are blisters that rapidly rupture and leave erosions or ulcerations with surrounding inflammation.[1] Scarring is a potentially devastating complication, particularly when the ocular mucosae are involved, because the scarring may lead to blindness. Scarring of the oral mucosa, however, is less common.[2] In the present case, the clinical chronic evolution over the course of years, with one unique deep lesion and mucosal scarring, was unusual for MMP. In addition, the Nikolsky sign was not present.

Recurrent aphthous stomatitis is a very common intraoral inflammatory condition characterized by painful ulcerations. Approximately 10% of patients with aphthous stomatitis experience major recurrent aphthous ulcers (MaRAUs), which can be a feature of an underlying systemic disease, such as celiac, Crohn, or Behçet disease.[3-5] MaRAUs have a predilection for the lips, soft palate, and the fauces but can affect any site in the oral cavity. MaRAUs are characterized by ulcers exceeding 1 cm that heal slowly (4-6 weeks) and by scarring.[3,4] The extension of an ulcer to approximately 3 cm—as in the present case—could be an extreme form of MaRAUs, but the floor of the mouth is not a typical site. Dermatologic lesions are not normally correlated with MaRAUs, but papules, pustules, and ulcers of the skin also are clinical features of Behçet disease.[4,5]

Ulcers can be caused by mechanical trauma. Acute or chronic injuries often are seen in association with nonfitting dentures[6] but rarely exceed 1 cm in diameter. The dentures of the present patient were well adapted, and a source of irritation related to the mandibular denture that could cause ulceration in the floor of the mouth could not be found. The depth of the ulceration and the scars also were atypical. Mechanical trauma

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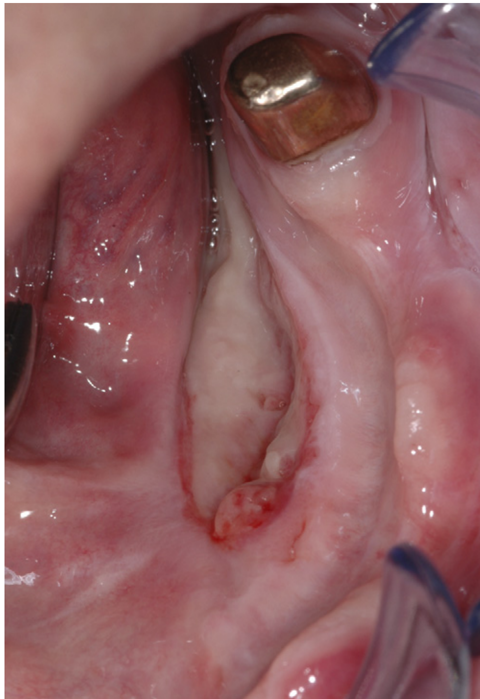

Fig. 1. The patient presented with an expanded ulcerative lesion at the left side of the floor of the mouth. The surrounding mucosa revealed scarring.

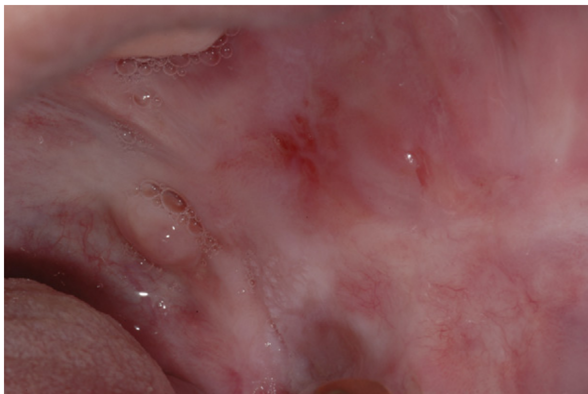

Fig. 2. On the left posterior buccal plane, an erosive red lesion was present at first visit. Scarring in the surrounding mucosa was also noted.

induced by the patient himself also had to be considered for the intraoral and extraoral lesions. Intraoral self-injuries generally are associated with epilepsy,[7] mental retardation,[8] psychiatric diseases like schizophrenia,[9] Lesch–Nyhan Syndrome,[10] or congenital insensitivity to pain with anhidrosis.[11] It has also been reported in combination with emotional disorders,[12,13] such as the recurrent episodes of depression, as reported by the patient.

Because the patient had a history of HL, a localized recurrence of a lymphoproliferative disease had to be considered. HL is primarily a nodal disease, and

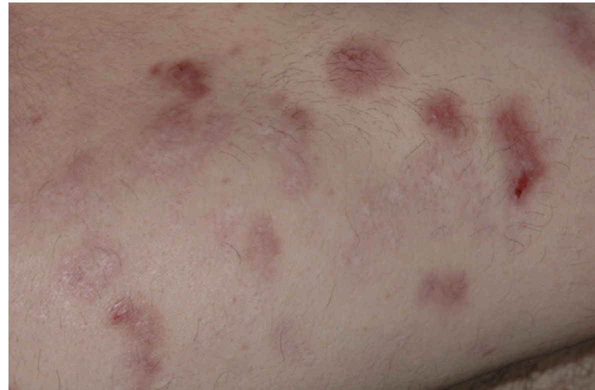

Fig. 3. On the dorsal aspect of the left arm, multiple red patches, erosive lesions, some minor crusting, and scars were present.

when it presents in extranodal tissues, it affects lymphatic tissue of the Waldeyer palatal ring, the palatal tonsil, and the base of the tongue. Extranodal and extralymphatic intraoral manifestations are extremely rare.[14,15] Patients with advanced HL can develop erythematous papules or nodules on the skin. Primary cutaneous lesions in HL have been described but are very rare.[16] Because a bimodal age distribution is known in cases of HL, with the first peak at ages 15 to 35 years and a second peak at approximately 65 years of age,[17] the possibility of a relapse in our patient was conceivable.

More than 90% of malignant neoplasms of the oral cavity are oral squamous cell carcinomas (OSCCs).[18] Our patient did not belong to any of the known risk groups for oral cancer. In Western countries, OSCC is more common in men than women, and the most common locations are the tongue and the floor of the mouth.[18,19] The classic features of OSCCs include ulceration, nodularity, and fixation to the underlying tissues. The ulceration usually has irregular margins that are elevated and hard on palpation. Pain may occur with larger lesions.[19] All these features were seen in the present case. The duration of occurrence, with lack of real progression and the skin lesions were, however, not typical for OSCC.

Severe, nonhealing, or recurrent ulcers can be attributable to chronic viral or bacterial infections. Herpes simplex virus, Epstein–Barr virus, and cytomegalovirus can be associated with ulcerative lesions and may be suggestive of an underlying immunodeficiency. Oral infections by mycobacteria are rare but may present as solitary ulcers.[20] Syphilis, caused by *Treponema pallidum*, is becoming a more frequent occurrence around the world. The ulcus durum (chancre) of primary syphilis is often genital but can also be oral, and it may be deep and have indurated borders. Secondary syphilis gives rise to the typical snail-track ulcers and cutaneous erythema, and in the tertiary stage of the disease ulcers, destroy the underlying tissue as a consequence of gumma formation.[20,21]

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