

ORAL LESIONS SEEN IN 58 PATIENTS DURING CLINICAL EXAM IN THE ORAL SURGERY AND STOMATOLOGY DEPARTMENT OF UNINGA: A GENERAL APPROACH TO DIAGNOSIS

THAILA MARIANI DA SILVA¹, WASHINGTON RODRIGUES CAMARGO^{2*}

1. Undergraduate Student in Dentistry, UNINGÁ; 2. Dentist, Doctor by the Faculty of Dentistry, FOB-USP, Professor of Dentistry at the UNINGÁ.

* Morangueira Av., 6.104, Maringá, Paraná, Brazil. ZIP CODE: 87035-510. prof.washingtoncamargo@uninga.edu.br

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ABSTRACT

We conducted a qualitative analysis of 58 clinical cases reported in Clinical Surgery and Stomatology of the UNINGÁ Dentistry Course. Gathered up information of these cases and forward the probable diagnosis, we proceeded to a general approach on lesions. Lesions were candidiasis, paracoccidioidomycosis, pemphigoid, Mucocele, proliferative tissue growth non-neoplastic, Torus, Aphthous stomatitis, hemangioma, Macula melanocytic, Glossitis Rhomboidal Average, Ankyloglossia, Squamous cell carcinoma, dysplasia Cemento Bone Florida, lichen plan, Macroglossia and Glossitis Migration.

KEYWORDS: Epidemiology, oral lesions, clinical examination, diagnosis.

1. INTRODUCTION

Dentistry has dedicated studies and presented programs of oral health prevention in recent years, generating academic efforts of the Dentistry Courses and political efforts of Municipal Health Secretariats. When analyzing the numerous epidemiological data published on oral health in Brazil, it was found that representative results have not yet appeared in the population^{1,2}.

In a microenvironment of the Dentistry Surgery and Stomatology Clinic, oral lesions were found in 16 of the 58 patients evaluated, representing 27.58%. The lesions were candidosis, paracoccidioidomycosis, pemphigoid, mucocele, non-neoplastic proliferative tissue growth, torus, hemangioma, melanocytic macula, rhomboid medium glossus, ankyloglossia, squamous cell carcinoma, flowering bone cement dysplasia, lichen planus, macroglossia and migratory glossitis.

This study, based on epidemiological data collected and with partial review of the literature, presents a general approach on what represents each of the lesions found, as well as the clinical aspects and form (s) of treatment (s).

2. MATERIAL AND METHODS

Fifty-eight patients were examined at the Clinic of Surgery and Stomatology of Uningá, Maringá, Paraná, Brazil. The clinical files containing oral lesions were separated. From these data, it was collected in classic books and journals of pathology, which represented each of the pathological processes.

3. LITERATURE REVIEW

Candidosis is a fungal infection caused by *Candida albicans*, a fungus that resides in the oral microbiota of healthy people. It grows in an acid environment, changing its yeast form to a pathogenic form in hyphae. Among the predisposing factors are: xerostomia, poor oral hygiene, poor sanitized prosthesis, diabetes, anemia, abusive use of corticosteroids and antibiotics and other immunosuppressive drugs. Clinically it is characterized by exfoliative masses, erosive, pseudomembranous lesion in the form of plaque, reddish white in the tissue plane and tiny circular lesions at the tissue level. The drug of choice for topical use is nystatin and systemically the use of fluconazole³.

Paracoccidioidomycosis is an infection caused by the fungus *Paracoccidioides brasiliensis*. It presents a predilection for middle-aged male patients and rural workers, especially residents in Central and South America. Paracoccidioidomycosis cases initially present with a pulmonary infection, and can be disseminated through the lymphatic or hematogenic route⁴. Clinically, they may involve oropharynx, jugal mucosa, tongue and lips, but it is more common in the gingiva, palate and alveolar mucosa, presenting as moriform ulcers. Treatment depends on the severity of the disease. For mild and moderate cases, sulfonamides are the medicine of choice, for more severe cases it is indicated intravenous amphotericin B. Oral Itraconazole is the best option in cases where there is no risk of death and treatment is necessary for several months.

Although the side effects are greater, ketoconazole can also be used⁵.

The pemphigoid, a term used because of its similarity to pemphigus, differing only in prognosis and microscopic aspects. It is a chronic, autoimmune, vesiculobullous disease in which autoantibodies of the IgG type (IgG1 and IgG4) specific to the epithelium are produced against glycoproteins desmogleins 1 and 3 of the epidermal cell desmosomes of the skin⁶. The pemphigoid is capable of affecting the ocular mucosa in addition to the buccal mucosa and may sometimes manifest in the larynx, nasolarynx, esophagus, trachea, rectal mucosa and genitals. The Nikolsky maneuver is an important tool used to diagnose the pemphigoid⁷. Clinically the lesions start as vesicles or blisters that rupture, resulting in superficial ulceration, usually symptomatic, and may remain weeks to months, if not treated⁵. Usually affect adults and elderly, being the female gender more affected than the masculine⁷. Systemic immunosuppressants such as prednisone or azathioprine are used as treatment, or tetracycline and niacinamide are used in less severe cases⁵.

The mucocele originates from minor salivary glands or their ducts. They can be of two types: extravasation, related to nibbling and trauma, with a higher incidence between the second and third decade of life or retention mucocele related to partial duct obstruction, with greater involvement in elderly patients. They are clinically presented as painless, floating, spherical and single massiform vesicles, which may vary in size, exhibit equal coloration to the adjacent mucosa, or bluish and translucent. Treatment consists of cryosurgery or surgical excision³.

Non-neoplastic proliferative tissue growth consists of a nonspecific proliferative inflammatory reaction and a tissue response to constant traumas. For this reason, the gingival mucosa has a high rate of recurrence. The female gender is the most prevalent, but there are large variations in race and age. The term hyperplasia should be condemned, because histologically the increase in the number of fibroblasts is not well demonstrated⁸. Treatment consists of elimination of the cause (trauma), improvement of oral hygiene and / or surgical removal⁹.

Palatine torus represents common exostosis that occurs in the midline of the hard palate. It has its origin in genetics, being attributed to the developmental disorder. They are usually asymptomatic. Clinically it presents as a bone mass located in the median line of the hard palate and/ or the lingual of the mandible. They usually do not exceed 2 cm in diameter, increasing during the patient's growth phase. They occur more frequently in young female patients, especially in the feoderma race. They exhibit high variety among ethnic groups, although Asian and Eskimo are more prevalent. Surgical removal may be necessary in cases of edentulous patients (for better adaptation of the prosthesis), in cases where it interferes with

oral function or when recurrent ulceration^{10, 11}.

The ulcer is characterized by tissue loss in the buccal mucosa, which can occur in single or multiple form, one common condition of the oral cavity. Its etiology is related to erosions that appear by trauma in the buccal mucosa¹². Clinically it is characterized by ulceration covered with whitish fibrin and surrounded by an erythematous halo¹³. Demonstrates a hereditary and autoimmune tendency, they are classified into canker sores of Mickulicz (smaller), or of Sutton (larger or herpetiformes). Most patients with cold sore are not treated, although they may use various therapies with topical corticosteroids such as betamethasone, fluticasone, clobetasol, thiaminolone, among others. In more severe cases systemic corticosteroids are used as dapsone or azathioprine¹⁴.

Hemangioma is an injury where there is moderate or intense proliferation of blood vessels characterizing itself as a benign neoplasm¹⁵. It is considered that in this pathological process the endothelium retains its original shape and also does not assume a biological role of unbridled growth¹⁶. It may be typically red, reddish-purple and reddish-blue¹⁷. It has a higher incidence in females¹⁸. Variably, it can be a lesion at the tissue level, as well as in the form of tissue growth assuming a net collection¹⁶. Both manifestations may have irregular boundaries and variable extensions¹⁷, and be localized in any part of the body; And may also be associated with lymphatic vessels, where a lympho-hemangioma¹⁹.

Melanocyte macula is a pigmentary, flat, brown or bluish, round or oval, solitary or multiple⁵ lesion that involves gingiva, soft palate and hard palate, buccal mucosa and lips. Its onset is due to the local increase in melanin deposition. In most cases, the lesion is unique and can vary up to 7 mm in diameter²⁰. Its etiology is attributed to factors such as deposition of exogenous materials, increase in the number of melanocytes or local increase of melanin production in the buccal mucosa²¹. This lesion can affect any age, although the fourth decade of life is more affected; There is also no predilection for gender, although the female gender has a greater involvement. Usually does not require treatment, except for aesthetic reasons⁵. Biopsy is necessary because of its differential diagnosis of melanoma¹⁸.

Median rhomboid glossitis has unknown etiology, suspected chronic focal candidiasis or a developmental change due to persistent tuberculosis. It is characterized by a depapillated area in the dorsal region, middle and posterior of the tongue, of a rhomboidal or angular shape with a reddish-red or whitish color. Its surface can vary between lobulated and smooth and usually the lesion is symmetrical. It is often asymptomatic, however, it can cause a burning sensation in some cases. It affects adults between 40 and 45 years of age in situations favorable to the onset of *Candida* spp. Its incidence is higher in individuals with regular treatment based on corticosteroids,

antibiotics, antidepressants, many of them being anticholinergic (resulting in salivary reduction) and / or carriers of fixed or removable prostheses. The treatment is in the case of candidiasis, with itraconazole and oral fluconazole, precisely because of the clinical picture of both being similar^{22,23,24}.

Ankyloglossia, also known in its popular form as "prey tongue", constitutes a developmental disorder characterized by changes in the reduced tongue's bracing or its insertion near the tip of the tongue²⁵, resulting in limitations of the movements of this structure, Swallowing and phonation²⁶. It may present clinical signs ranging from mild cases with little clinical significance to severe cases where the tongue is fully fused to the oral floor. The incidence of ankyloglossia is in newborn male patients, although it is not uncommon in adults. It does not need treatment, since it causes little or no clinical problem, however, when there are functional interferences in the tongue, it indicates the frenotomy or frenectomy⁵.

Spinocellular cell carcinoma (SCC) is found mainly in the upper mucosa of the aerodigestive tract, the base of the tongue, pyriform sinus and larynx. Alcohol and smoking are major risk factors for the development of such an injury. Clinically it can be characterized by loss or also tissue growth, and may present painful symptomatology and/ or interference in swallowing. Its incidence varies according to age, gender, occupation, habits, geographic location and ethnic groups. However, CPB is the cancer that affects the age group between 50 and 70 years, preferably the male patients. Surgical treatment is recommended, followed by radiotherapy and/ or adjuvant chemotherapy⁵.

Flow-cementum-bony dysplasia (FCBD) is characterized by a benign growth of fibrous connective tissue associated with cementum-bony tissue. It is usually asymptomatic, but there may be complaints of weak and intermittent pain in the affected bone when the lesion becomes secondarily infected. Biopsy or surgical intervention is contraindicated, as they may result in the establishment of an infectious process, since it is a poorly vascularized and poorly cellularized region. The jaw is the most common location of the maxilla²⁷. Clinically, it can occur in dentate or edentulous areas, presenting radiographically as a radiolucent halo with a clear tendency for bilateral symmetrical localization²⁸. The FCBD shows a predilection for female patients, with a mean age of 42 years and prevalence of melanodermal patients^{27,28}. These lesions are maintained in follow-up through periodic controls, mainly in edentulous patients. Treatment with antibiotics is indicated in cases of surgical intervention in which there may be presence of secondary infection²⁷.

Lichen planus clinically presents as white, homogeneous and dense plaques, which may reach the back of the tongue or buccal mucosa. They may have indistinct mar-

gin or "cotton" or even stripe-like²⁹. They are asymptomatic or may exhibit mild discomfort. This lesion does not present a predilection for ethnicities, but there is a predilection for the female gender, between 30 and 60 years. The treatment consists of injectable, topical or intralésional use of corticosteroids when they present erosive form. Asymptomatic lesions do not require therapy³.

Macroglossia is a condition caused by a wide variety of etiologies, including: inflammatory, traumatic, metabolic, congenital or neoplastic (benign or malignant in nature), relatively uncommon. It can be classified as relative (when the oral cavity is not large enough to harbor the tongue) or true (when an enlargement of the tongue occurs). This pathological process can be acquired or congenital (the result of a developmental disorder). Macroglossia causes disorders such as difficulty in chewing, swallowing, speech, as well as obstruction of the airways. Above all, the protrusion of the tongue predisposes to dryness of the buccal mucosa, lingual trauma, in addition to repetitive infections of the upper airways. Clinically it is observed the increase of the volume of the tongue, being able to lead to the open bite, prognathism, among others. Treatment depends on cause and severity. The occurrence is higher in pediatric patients³⁰. In mild cases, in which only the phonetic function is affected, speech therapy is indicated as treatment, and there is no need for surgical intervention. However, in symptomatic patients, there may be a need for surgical intervention for tongue reduction (glossectomy)⁵.

Migratory glossing, also called geographic language, is characterized clinically by the presence of furrows and fissures in large quantity, ranging from 2 to 6 mm deep on the dorsal surface of the tongue. Although its etiology is uncertain, there is a correlation with developmental disorder. It is usually asymptomatic, but there may be reports of mild pain or burning. It occurs more frequently in adults and children, and the male gender is more affected. No treatment is indicated, because it is a benign condition, there is only the need for proper hygiene to remove food debris⁵.

4. CONCLUSION

It was found that approximately one-third of the patients attended presented some oral pathological process. The lesions were framed in developmental disorder, autoimmune, fungal, trauma, pigmentary, tumoral, benign and malignant neoplasia. It is necessary to value the clinical examination also from the viewpoint of stomatology. Many cases can pass hidden to the dentist if he or she is focused on another treatment, whether restorative or rehabilitative. If this negligence occurs, serious problems can result to the patient. Because of this, studies should be performed and periodic should be read by the health professional.

Considering that an individual (not having a painful

sensation, does not realize any disease that may occur in the mouth) recommendations and instructions should be part of all dental care, as well as dental campaigns with the perspective of prevention of oral lesions.

REFERENCES

- [1] Nascimento GJP, Paraiso DP, Goes PSA, Sobral APV. Estudo Epidemiológico de 2147 Casos de Lesões Bucocomacilo-Faciais. *Revista Brasileira de Patologia Oral* 2005; 4(2).
- [2] Narvai PC, Frazão P. Saúde bucal no Brasil: muito além do céu da boca. Rio de Janeiro: Fiocruz, 2008.
- [3] Laskarias G. Atlas Colorido de doenças da boca. 3ª ed. Porto alegre: Artmed, 2004.
- [4] Tolentino ES, Barbosa BA, Taveira LAA, Chinellato LEM. Manifestações bucais da paracoccidioidomicose- considerações gerais e relato de caso RFO 2010; 15(1):71-76.
- [5] Neville B, Damm D, Allen CM, Bouquot JE. *Patologia Oral e Maxilofacial*. 3ª ed. Rio de Janeiro: Elsevier, 2009.
- [6] Amormino SAF, Barbosa AAM. Pênfigo Vulgar: revisão de literatura e relato de caso clínico. *R. Periodontia- Junho* 2010; 20(02).
- [7] Lins SA, Castro AL, Miyahara GI, Júnior EGJ, Lins, SA. Penfigóide benigno de mucosa. *Salusvita* 2009; 28(2):205-211.
- [8] Picciani BLS, Santos BM, Moleri AB, Teixeira HGC, Silva DG, Tinoco EMMB et al. Lesões proliferativas não neoplásicas no periodonto: estudo epidemiológico. *R. Periodontia* 2008; 18(3).
- [9] Lopes RM, Bastos TR, Guimarães JP, D'Addazio PSS. Fibromatose gengival anômica: caso clínico. *Arquivos em Odontologia* 2008; 44(1).
- [10] Ponzoni D, Guarino JM, Perez AP, Souza RM, Paro RF. Remoção cirúrgica de toro palatino para confecção de prótese total convencional: indicações de diferentes incisões. *RFO* 2008 maio-ago.13(2):66-70.
- [11] Pereira ARNR, Vale DS, Pereira MKC. Utilização de placa de silicone após tratamento cirúrgico de torus palatini: relato de caso. *Rev Cir Traumatol Buco- Maxilo- Fac* 2014 jan.-mar.; 14(1):09-14.
- [12] Costa GBF, Castro JFL. Etiologia e tratamento da estomatite aftosa recorrente – revisão de literatura. *Medicina (Ribeirão Preto)* 2013;46(1).
- [13] Reichart PA, Philipsen HP. Atlas coloridos de Odontologia patologia bucal. Porto Alegre: Artmed, 2000.
- [14] Consolaro A, Consolaro MF. Aftas após instalação de aparelhos ortodônticos: porque isso ocorre e protocolo de orientações e condutas. *R. Dental Press Ortodon Ortop Facial* 2009; 14(1):18-24.
- [15] Neville BW, Damm DD, Allen CM, Bouquot JE. Tumores dos tecidos moles. In: *Patologia oral e maxilofacial*. 3ª ed. Rio de Janeiro: Guanabara Koogan, 2002; 419-47.
- [16] Robins SL, Cotran RS. *Patologia – Bases Patológicas das Doenças*. 2ª ed. Rio de Janeiro, 2010.
- [17] Regezi JA, Sciubba JJ. Leões vermelho azuis. In: *Patologia bucal: correlações clínico patológicas*. 3ª ed. Rio de Janeiro: Guanabara Koogan, 2000.
- [18] Rubin E, Gorstein F, Rubin R, Schwarting R, Strayer D. *Patologia, bases clínico patológicas da medicina*. Rio de Janeiro: Guanabara Koogan, 4ª ed. 2006.
- [19] Regezi JA, Sciubba JJ, Porgrel MA. Atlas de patologia oral e maxilofacial. Rio de Janeiro: Guanabara Koogan, 1ª ed. 2002.
- [20] Egg NSO, Castro CLS, Rodrigues FN, Cury VF. Melanose racial e outras lesões pigmentadas da cavidade bucal- revisão de literatura. *R Periodontia* 2009; 19(3).
- [21] Lutz M, Silva DA, Gomes APN. Lesões pigmentadas da mucosa bucal- um estudo retrospectivo. *RFO* 2012; 17(2):145-149.
- [22] Silva MR, Fernandes NC. Afecções das mucosas e semi-mucosas. *Jornal Brasileiro de Medicina* 2001; 80(3):50-66.
- [23] Simões RJ, Fonseca P, Figueiral MH. Infecções por Candida spp na Cavidade Oral. *Odontol Clín Cient* 2013; 12(1):19-22.
- [24] Leite RMS, Leite AAC, Friedman H, Friedman I. Glossite romboide mediana associada a candidíase esofagiana: uma possível relação etiológica com a Candida albicans. *An bras Dermatol* 2002; 77(5):579-583.
- [25] Oliveira DV, Albuquerque GC, Martins VB, Gonçalves FC, Arantes PH, Anquiloglossia, tratamento cirúrgico: relato de caso clínico. *Revista de Ciências da Saúde da Amazônia*.
- [26] Melo NSF, Lima AAS, Fernandes A, Silva RPGVC. Anquiloglossia: relato de caso. *RSBO* 2011; 8(1):102-7.
- [27] Freitas DQ, Paza AO, Passeri LA, Montebello Filho A. Displasia cemento-óssea florida com história familiar. *Robrac* 2003; 12(33).
- [28] Quirino MRS. Displasia cemento-óssea florida: relato de um caso. *Rev Biociênc* 2000; 6(1):11-14.
- [29] Cawson AR. Atlas colorido de enfermidades da boca. 2.ed. Porto Alegre: Arte Médicas, 1997.
- [30] Cymrot M, Teixeira FAA, Sales FCD, Muniz Neto FJ. Glossectomia subtotal pela técnica de ressecção lingual em orifício de fechadura modificada como tratamento de macroglossia verdadeira. *Ver Bras Cir Plást* 2012; 27(1):165-9.