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Atypical Lesion on Soft Palate: A Curious Case

Lesión Atípica en el Paladar Blando: Relato de Caso

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ABSTRACT: The aim of this work is to present a case of a 39-years-old man with a 2cm sized purple pedunculated tissue on the soft palate, next to upper right retromolar area, asymptomatic, with one day time evolution and vascular appearance. There was no trauma history or systemic diseases. Based on the clinical findings our previous diagnosis was traumatic granuloma, hemangioma or blood coagulum formation after local trauma. After one week, intraoral examination revealed absence of the lesion, which disappeared completely. This case illustrates that the absence of trauma history and atypical clinical characteristics can be a diagnostic defiance in the clinical routine.

KEY WORDS: injuries; mouth mucosa; oral hemorrhage.

INTRODUCTION

Traumatic lesions of the oral mucosa occur frequently in clinical practice. Most of them represent acute or chronic injuries of soft tissues arising from incorrect hygienic procedures. Only sometimes do they become artefactual problems, burns and posttraumatic mucosal lesions. However, their origin, location and clinical signs may considerably differ. They can appear atypically and sometimes may present bizarre characteristics (Curran & Rives, 2000). The purpose of this article was to report a curious case of an uncommon lesion on soft palate, with fast evolution and uncertain etiology, but probably due a local trauma.

CASE REPORT

A 39-years-old man sought our Institution complaining of "a lesion in his mouth, which looks like a liver's peace". He reported no trauma, infection or surgical treatment in the mouth. There was no history of dental manipulation or immunossupression and he had no systemic complaints. He had all teeth in mouth, include the third molars.

Intraoral examination revealed a 2 cm sized dark purple pedunculated tissue on soft palate, next to upper right retromolar area, asymptomatic, with one day time evolution and vascular appearance (Fig. 1). Presence of ischemic areas in the lesion was noted. The manipulation of the lesion showed a very tenuous pedunculated area, and there was no bleeding under manipulation (Fig. 2).

Even there was no history of local trauma, based on the clinical findings and the hemorrhagic and necrotic appearance of the lesion, our previous diagnosis was traumatic granuloma, hemangioma or blood coagulum formation after local trauma.

We planned for this case excisional biopsy with electric bistoury, to prevent hemorrhage. After one week, at the moment of the surgery, routine hematological, biochemical and serological investigations were normal. However, intraoral examination revealed absence of the lesion, which disappeared completely. According to the patient, he would have swallowed the lesion, but without perceiving. There were no signs of bleeding or recurrence of the lesion.

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Follow-up examinations were carried out at 1 week, 1 month, 6 months and 1 year. No complaints and clinical signs of recurrence have been observed. This case illustrates a difficult diagnosis because of the absence of trauma history or systemic diseases and impossibility of making a biopsy. We believe that the lesion was a blood coagulum caused by an unknown trauma, based only on the clinical characteristics and case evolution.

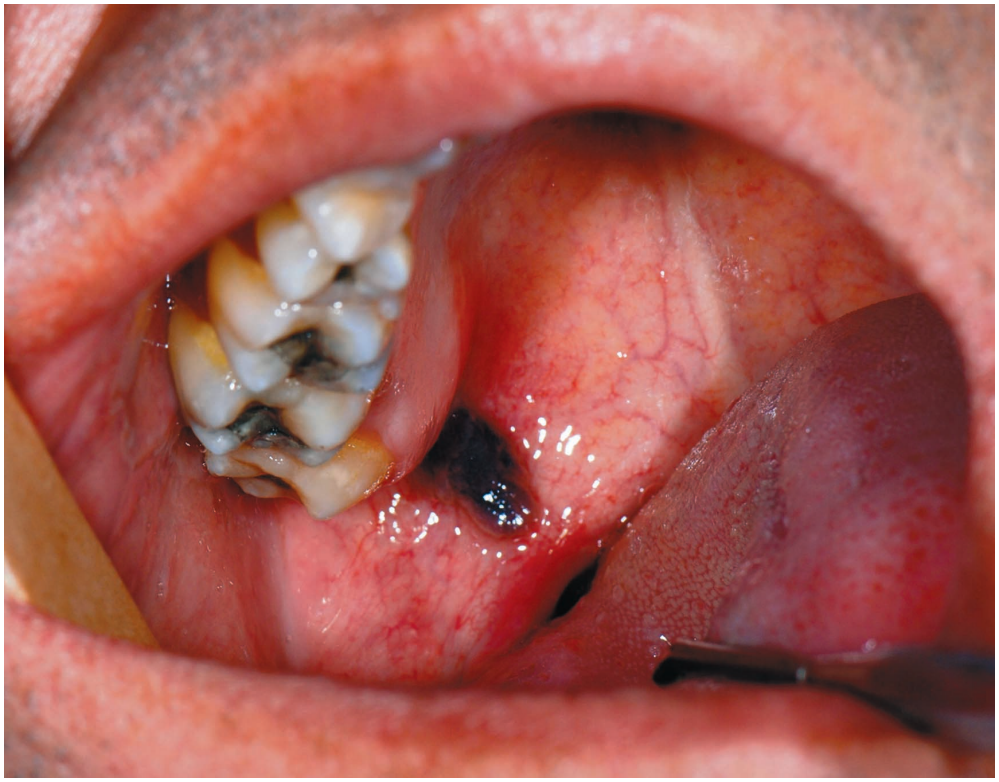

Fig. 1. Clinical aspect of the lesion.

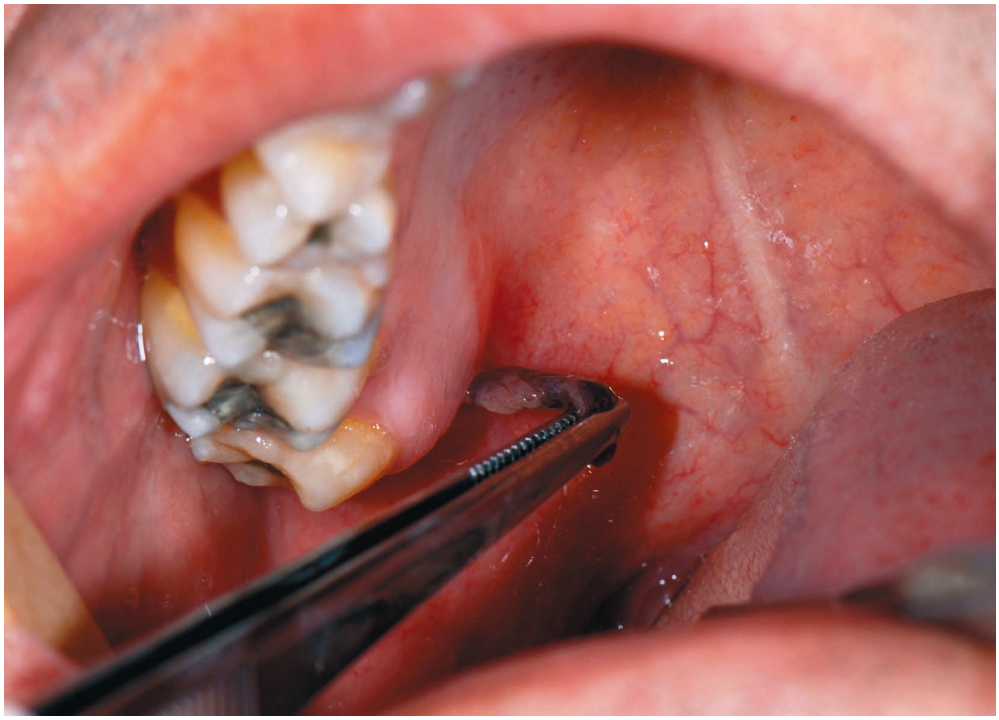

Fig. 2. Aspect of the lesion under manipulation.

DISCUSSION

Usually, traumatic oral mucosal lesions share relatively typical clinical signs: (i) sudden origin during eating and/or drinking; (ii) involvement of typical areas of the oral mucosa covered by non-keratinized epithelium (soft palate, lateral border of the tongue and floor of the mouth); (iii) temporary presence (minutes) of the asymptomatic hemorrhagic bulla in the oral cavity; (iv) short profuse bleeding from the burst bulla into the oral cavity and/or oropharynx; (v) a resulting shallow but very painful ulceration of the oral mucosa; (vi) protracted healing without scarring over 2 – 4 weeks; (vii) negative clinical findings in other oral mucosal compartments and skin; (viii) negative anamnestic data related to possible hemorrhagic disorders; (ix) negative laboratory findings, (x) absence of recurrence in most patients, (xi) typical age distribution mostly in the sixth and seventh decades with (xii) slight predominance of females (Curran & Rives). Considering these characteristics, our case corroborate the following data: the lesion appeared suddenly, involved soft palate, had an asymptomatic and short duration, negative clinical findings in other skin or oral mucosal compartments, no anamnestic data related to possible hemorrhagic disorders, no laboratory findings and absence of recurrence.

It may be assumed that mechanical and/or thermal injury of the areas covered by non-keratinized oral epithelium can lead to the rupture of a small mucosal blood vessel associated with the bleeding into the mucosa with the formation of a subepithelial hemorrhagic bulla, but some authors believe that the cause remains uncertain in most patients (Giuliani *et al.*, 2002; Ferguson *et al.*, 2005). In the present case, there was no bulla formation, but a pedunculated tissue, which has become the case more defying.

The most frequent location of traumatic hemorrhagic lesions is the soft palate, corroborating the findings of this case, leading to specific subjective complaints associated with its functional movements during swallowing and speech, which becomes very painful. It is presumed that the movement of the soft palate is also the cause of the protracted healing. Our patient had complaints about functional movements, but there was no pain.

Traumatic lesions can mimic a bout of various serious hemorrhagic, vesicobullous, ulcerative and systemic diseases affecting predominantly oral cavity and rarely also pharyngeal and esophageal mucosa (Kloudová *et al.*, 2004). All these suspected lesions do require biopsy including immuno-fluorescent microscopy to verify the clinical diagnosis of the autoimmune disease (Plemons *et al.,* 1999; Pahl *et al.*, 2004; Salavec, 2004). Biopsy of the oral mucosa is recommended for the diagnosis in uncertain cases of oral amyloidosis (Ferguson *et al.*; Stoolper *et al.*, 2003; Slezák, 2005), bullous autoimmune dermatoses such as pemphigoid group or pemphigus vulgaris or persistent varicella-zoster virus infection (Plemons *et al.*). In the present case, the absence of trauma history and systemic diseases led us to consider other diagnosis hypothesis, like hemangioma or granuloma. After one week, when the patient returned to be submitted to biopsy, there was no sign of lesion anymore, reinforcing the traumatic etiology of the lesion.

Therapeutic possibilities for these cases are restricted (Giuliani *et al.*). The use of topically applied anesthetics prior to eating may be useful. Antiseptics (e. g. chlorhexidine) could be used to eliminate secondary microbial infection. Benzydamine application should be recommended due to its anesthetic and analgesic properties. The reassurance of the patient about the benign nature of the lesion is necessary. In the present case, in the one week following-up, the patient did not showed the lesion, which was probably swallowed. Also, there was no sign of recurrence or hemorrhage. Thence, any kind of therapy was performed.

Intraoral traumatic hemorrhagic lesions do not seem to be rare diseases. Regardless of their typical clinical signs and course, they probably often remain undiagnosed. All mucosal bullae and ulcers located in the soft palate area require exact clinical examination of the patient to establish a univocal diagnosis. Detailed anamnestic data gathering represents an inseparable part of the examination. It helps to avoid abundant diagnostic and therapeutic procedures, which may unnecessarily strain the patients. The absence of history data and typical clinical characteristics can be a diagnostic defiance.

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RESUMEN: El objetivo de este trabajo es presentar un caso de un hombre de 39 años de edad, con un tejido de 2 cm pediculado color púrpura en el paladar blando, junto al área retromolar superior derecha, asintomático, con un día de evolución y de aspecto vascular. No había historia de trauma o enfermedades sistémicas. Con base en los hallazgos clínicos nuestro diagnóstico previo fue granuloma traumático, hemangioma o la formación de coágulos sanguíneos, después de un traumatismo local. Luego de una semana, el examen intraoral reveló ausencia de la lesión, la que desapareció por completo. Este caso ilustra que la ausencia de historia de trauma y las características clínicas atípicas, puede ser un desafío diagnóstico en la rutina clínica.

PALABRAS CLAVE: lesiones, mucosa bucal, hemorragia oral.

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