AAOM 2017 - Case Report Award Presentations
OTDO Session: Friday, 04/07/2017, 11:00-12:00

= Presentation Number, *Presenter

To conserve space, we list only the institution and the country submitted as 1st organization.

#1: 11:00

GLYCOGENIC ACANTHOSIS IN THE ORAL MUCOSA: REPORT OF TWO CASES

*Erika Akahori, Yoshinori Jinbu, aoi Sakuyama, Yumi Aoyama, Yoshiyuki Mori, Jichi Medical Univercity Hospital, Japan

Background: Glycogenic acanthosis (GA) is a benign lesion characterized by small, white, raised plaques commonly detected in the esophagus. Very few reports have been described GA in the oral mucosa. We report two cases of GA in the oral mucosa.

Case summary: Case 1 involved a 40-year-old woman was referred to our hospital with white lesions on the buccal mucosa bilaterally. She had a history of smoking for more than ten years. Diffuse white lesions with smooth surfaces were observed on the buccal mucosa. Clinically, leukoplakia was suspected and biopsy was performed. Histopathological examination revealed thickened squamous epithelium with clear, enlarged keratinocytes. The cells showed positive staining with periodic acid-Schiff (PAS) that was removed by predigestion with diastase. The histological diagnosis was GA. Case 2 involved a 72-year-old woman who visited our hospital complaining of white lesions on the floor of the mouth. She had first noticed the lesions 10 days earlier. The lesions appeared as plaque-like thickenings on the left side of the floor of the mouth. The clinical diagnosis was leukoplakia, and the lesion was histologically examined. Histopathologically, thickened squamous epithelium with clear, enlarged keratinocytes was observed. These cells showed positive staining with PAS that was removed by predigestion with diastase. The histological diagnosis was GA.

Conclusions: GA has not been widely recognized in the field of dentistry, but must be included among the differential diagnoses of white lesions in the oral cavity.

#2: 11:12

NEUROSENSORY ABNORMALITIES AND PAIN: POST-SURGICAL NEUROPATHY OR MARKER OF RECURRENT CARCINOMA?

*Rashmi Malhotra, Mark T Drangsholt, Edmond L Truelove, University of Washington, USA

Background: Squamous cell carcinoma (SCC) is the most common type of cancer seen in the oropharynx. Early diagnosis & management is of utmost importance in these cancers because the spread of unrecognized disease is often fatal. Symptoms after oropharyngeal cancer treatment can lead to delayed or misdiagnosis. Analysis of a recent oropharyngeal cancer case with symptoms that mimicked other orofacial pain conditions leading to diagnostic delay, is presented to help prevent poor outcomes and delays in similar cases.

Case Summary: This report describes the case of a 66-year-old man with the history of SCC of right lateral tongue T1N1M0R0 and p16 negative treated with partial glossectomy and neck dissection without adjuvant therapy. He did well initially but began to develop paroxysmal right facial pain and right tongue burning 2 months post-surgery. The radiologist and surgeon's review of his postsurgical orofacial MRI was within normal limits. RCT of #3 & #31 followed by extraction of #31 resulted in no reduction of orofacial pain. Inferior alveolar nerve block transiently reduced pain leading to a diagnoses of postsurgical trigeminal neuropathic pain. He was referred to UW Oral Medicine Service for further evaluation. A firm submucosal area posterior to the area of resection was detected at the base of tongue suggesting a recurrence.

Review of prior imaging demonstrated a mass and a new CT scan confirmed it at the base of right tongue suggesting recurrence or a metastatic nodule. Biopsy was positive for poorly differentiated squamous cell carcinoma within stroma involving right base of tongue/neck T4aN2bM0.

Conclusions: In patients with a recent history of head and neck cancer, recurrence or metastatic disease should be considered in the presence of orofacial pain complaints. Careful clinical assessment and repetitive review of imaging is important to avoid misinterpretation and diagnostic delays leading to reduced survival.

#3: 11:24

UNUSUAL PRESENTATION OF DISSEMINATED HISTOPLASMOSIS

*Janaina Braga Medina, Nathália Tuany Duarte, Marília Trierveiler Martins, Paulo Henrique Braz-Silva, Cristiane Teixeira Leite, Karem L. Ortega, School of Dentistry, University of São Paulo, Brazil

Background: Immunosuppressant patients can have opportunistic infections which, due to their intrinsic systemic disease, easily develop into more aggressive and less common clinical pictures.

Case summary: A 42-year-old female presented with small lesions in nasal and oral mucosa followed by purulent nasal discharge, haemoptoic catarrh, vespertine fever episodes, odynophagy and dysphagia for three months. Rapid loss of weight (15kg in two months) associated with intense pain, fever and coughing culminated in hospitalisation and confirmation of HIV-seropositivity (CD4 < 100 cells/mm^3). Before being referred for diagnosis of lesions in skin and mucosa the patient was medicated with ciprofloxacin, azithromycin and fluconazole and antiretroviral therapy was started with zidovudine, lamivudine and efavirenz. On physical examination, the patient exhibited extensive crust-like lesion covering the whole nasal apex with partial destruction of the nose wing. Small crust-like lesions, malar erythema and macrocheilia were also observed in the face, in addition to similar lesions in the upper limbs. On intra-oral examination, shallow ulceration with irregular borders was observed in the middle portion of the hard palate, extending into the soft palate and being painful on palpation. Biopsy was performed and Grocott-stained sections showed great amount of yeast-like fungus. The patient was submitted to other complementary examinations which then confirmed that pulmonary and hepatic functions were compromised, with final diagnosis of disseminated histoplasmosis. Therapy with amphotericin B (35 mg in 500 ml of 5% glycoside serum) was initiated with slow infusion for 4 hours. The patient was completely recovered from oral lesions on the 14^{th} day and from skin lesions after 4 months. The patient was followed up for 4 years and submitted to cosmetic surgery for repair of the nose wing.

Conclusions: In view of the severe immunosuppression, deep fungal infections increase morbidity and their unusual clinical characteristics may make clinical diagnosis difficult.

#4 11:36

SYNOVIAL OSTEO-CHONDRAMATOSIS OF THE TEMPOROMANDIBULAR JOINT: A CASE REPORT.

*Vandana Singh, Noura Alsufyani, School of Dentistry, University of Alberta, Canada

Background: Synovial osteo-chondramatosis is a benign condition of the joints which is characterized by the proliferation of mesenchymal remnants of synovial membrane. The condition is rarely seen in temporomandibular joints. The synovial lining undergoes proliferation and

fragments may break off. The fragments can grow in size and calcify and present as loose bodies in the joint space or surrounding areas.

Case Summary: A 48-year-old female presents to TMD/Orofacial pain clinic for evaluation of bilateral jaw pain and clicking that started a few years ago following a motor vehicle accident. She reported constant pain ,limited mouth opening of 35mm and frequent clicking noises. MRI, showed bilateral anterior disc displacement without reduction. A cone beam CT scan revealed multiple, well defined, round/oval radiopacities in the left TMJ space of varying sizes. Majority of the radiopacities were similar to cancellous bone in density defined by a cortex similar to cortical bone in density. The interpretation in left TMJ was consistent with synovial osteo-chondramatosis with bilateral secondary degenerative joint disease. She was referred to an Oral and maxillofacial surgeon for removal of the lesions. She was explained the risks of nerve injury, chronic pain and would require intense physical therapy after her surgery. The lesions were removed by open joint arthroplasty, debridement and removal of loose calcified bodies. The pathology results confirmed synovial osteo-chondramatosis. Her post-operative mouth opening was 45mm with no discomfort.

Conclusions: A rare case of synovial osteo- chondramatosis is described with successful open jaw debridement and removal of the intra-articular lesions. This case emphasizes the importance of imaging along with clinical examination while managing the temporomandibular joint disorders.

#5: 11:48

LYMPHOMATOID PAPULOSIS OF THE ORAL CAVITY

*Maryam Jessri, Sook-Bin Woo, Brigham and Women's Hospital, USA

Background: Lymphomatoid papulosis (LyP) is a chronic relapsing-recurrent papulonecrotic or papulonodular CD30+ cutaneous T-cell lymphoproliferative disorder. This is a case of LyP involving the oral cavity and its management.

Case Summary: A 63-year-old female, never-smoker presented with a slightly sensitive ulcer of the left buccal mucosa noted for 3 weeks. She did not recall any history of trauma to the area and did not have a history of oral ulcers. Her medical history was significant for ALK-, CD30+ LyP (diagnosed via a skin biopsy two years prior) with no current systemic symptoms or current skin lesions. She also had a history of osteoporosis, eczema, angle-closure glaucoma and hearing impairment. Her medications included alendronate, cholecalciferol, clobetasol ointment, mometasone cream and olopatadine. Extraoral examination revealed two 0.5-0.7 cm areas of atrophic, hypopigmented skin on the right chest and midline of the lumbar area, and an ulcerated papule on the skin of the right lower leg consistent with healed LyP. Intraoral examination revealed 2.0 x 2.0 cm ulcer on the left buccal mucosa with slightly raised, firm borders and moderate marginal erythema. Biopsy of the ulcer revealed intermediate to large atypical lymphoid cells with round to irregular to occasionally multilobated nuclei, dispersed to vesicular chromatin, prominent nucleoli, and moderate amounts of cytoplasm. Lesional T-cells were CD3+ and CD30+ consistent with oral involvement by LyP. The lesion was injected with 34 mg triamcinolone acetonide and the patient was prescribed clobetasol 0.05% gel to be applied to the ulcer for 20 minutes BID. At one-month follow-up, the patient reported no pain and the mucosa had completely healed.

Conclusions: LyP is a low-grade cutaneous T-cell lymphoproliferative disorder that rarely involves the oral mucosa, and exhibits atypical CD30+ lymphocytes, a relapsing-recurring course, and good response to topical steroids.