Clinician Reviews®

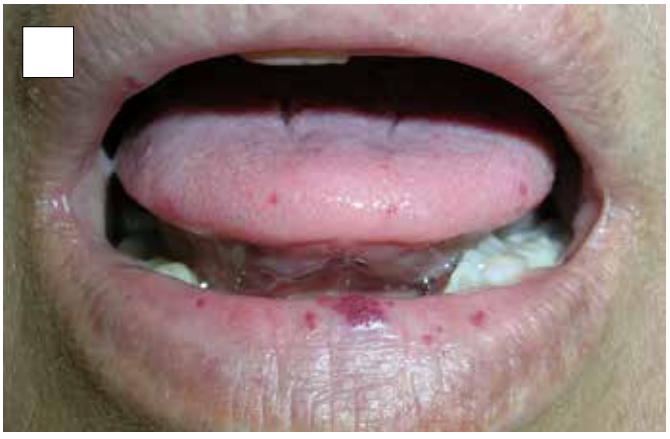
Say Ahh … Part 3

Spots and dots on the tongue—sometimes they're benign, sometimes not. Can you tell which is which?

Match the diagnosis to the photo by letter

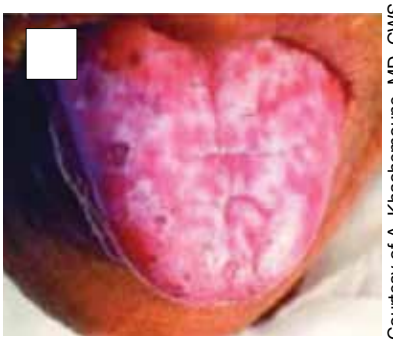
a. Chronic hyperplastic candidiasis
b. Oral lichen planus
c. Hereditary hemorrhagic telangiectasias
d. Herpetic glossitis

1. A 56-year-old woman sought care for a nosebleed that was difficult to stop. She reported recurrent nosebleeds since childhood. The clinician noted red spots on the patient's lips and tongue. The patient indicated that her mother also had recurrent epistaxis and red spots on her lips and tongue.



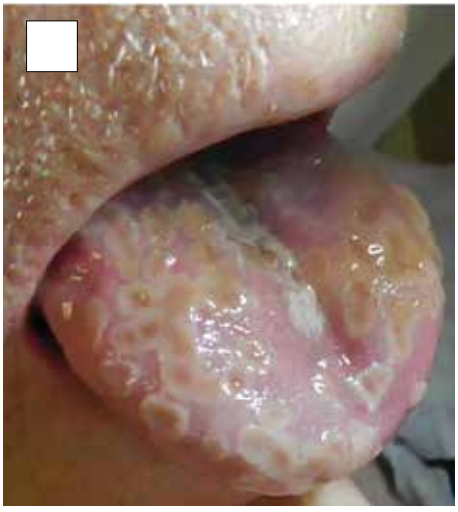
Courtesy of Richard P. Usatine, MD

2. A 40-year-old woman presented with a 1-year history of painful red lesions with white striations on her tongue. She experienced burning after eating spicy food and increased sensitivity to mouthwash. She reported a slow, progressive onset and worsening of her condition, with intensifying symptoms during periods of emotional stress. Physical exam revealed an erythematous and cream-colored reticulated patch with a few small focal areas of erosion covering the dorsal tongue.



Courtesy of A. Khachemoune, MD, CWS

3. A 77-year-old man with a history of chronic obstructive pulmonary disease and recent pneumonia was treated with oral prednisone 40 mg/d, antibiotics, and a fluticasone-salmeterol inhaler. One week into treatment, the patient developed painful lesions limited to the oral cavity. Physical exam revealed many fixed, umbilicated, white-tan plaques on the lower lips, tongue, and posterior aspect of the oropharynx. Lesions failed to respond to nystatin oral suspension.



4. An 82-year-old woman with atrial fibrillation and chronic obstructive pulmonary disease presented with a 10-year history of pruritic and painful lesions on the tongue. She had not been treated with corticosteroids during the course of the pulmonary disease. Physical exam shows several fleshy and well-defined erythematous papules speckled with whitish areas on the dorsal aspect and anterior border of the tongue. Superficial whitish areas could not be removed by scraping.

ANSWERS

Diagnosis: Undiagnosed **hereditary hemorrhagic telangiectasias** (HHT), also known as *Osler-Weber-Rendu syndrome*, was suspected. This autosomal dominant vascular disease—with an estimated prevalence of 1 in 10,000—causes arterioles to become dilated and connect directly with venules without a capillary in between. Although manifestations are not present at birth, telangiectasias later develop on the skin, mucus membranes, and gastrointestinal tract; in addition, arteriovenous malformations often develop in the hepatic, pulmonary, and cerebral circulations.

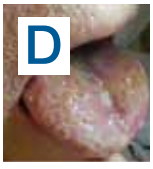
HHT is diagnosable when 3 of the following 4 criteria are met: recurrent spontaneous nosebleeds (occurs in > 90% of patients); mucocutaneous telangiectasia; visceral involvement (lungs, brain, liver, colon); and an affected first-degree relative. Patients with HHT should be checked for iron-deficiency anemia due to recurrent nosebleeds and/or gastrointestinal bleeding. HHT has no cure; it is often best to do as little intervention as possible (and preferably with input from specialists) as complications and recurrence are frequently encountered.

Originally published in *The Journal of Family Practice* (2012;61[3]). For more information, see https://bit.ly/2WTEobJ.

Diagnosis: Compared with the more self-limited nature of its cutaneous counterpart, **oral lichen planus** (OLP) causes chronic inflammatory lesions, resulting in increased morbidity and a greater therapeutic challenge for clinicians. Affecting approximately 1% to 4% of the population, OLP is seen most commonly in older women and has a predilection for bilateral involvement of the buccal mucosa but can affect (in descending order of frequency) the tongue, gingiva, lips, floor of the mouth, and palate.

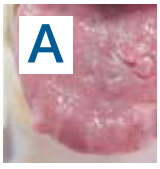
OLP has 3 basic clinical morphologies: reticular, erythematous, and erosive. The erosive form tends to be more symptomatic and prompts patients to seek treatment. The relatively asymptomatic reticular form is the most easily recognizable variant and may cause increased symptoms when the tongue is involved.

Originally published in *The Journal of Family Practice* (2005;54[1]:33-36). For more information, see https://bit.ly/2WRP8Hz.



Diagnosis: This patient developed oral reactivation of herpes simplex virus (HSV) following recent immunosuppression, resulting in **herpetic glossitis.** Clinical presentation varies from deep and/or broad ulceration or nodular lesions to linear, crosshatched, or sharply angled branching lesions with painful fissuring. When recurrent HSV involves intraoral lesions, they are typically confined to the gingiva and palate. Tongue involvement is exceedingly rare, and the pathogenesis remains elusive, although one hypothesis proposes a protective role of salivary-specific immunoglobulin A and lysozyme.

Originally published in *Cutis* (2016;97[4]:E4-E5). For more information, see https://bit.ly/36IGAaw.



Diagnosis: This patient exhibited the typical clinical presentation of the nodular type of **chronic hyperplastic candidiasis** (CHC), a rare form of oropharyngeal candidiasis. CHC is histologically characterized by parakeratosis and a hyperplastic epithelium invaded by *Candida hyphae*—a species commensal in up to 50% of the healthy population—and thus superficial colonization of tissues is not enough to indicate notable disease. Biopsy is usually required to confirm the diagnosis.

First-line treatment options include topical or systemic antifungal agents, as well as elimination of predisposing factors (eg, dentures, smoking, immunosuppression). Untreated or persistent lesions may evolve into carcinoma, necessitating follow-up to verify complete resolution after treatment. In this case, the lesions resolved after 15 days of oral fluconazole treatment. **CR**

Originally published in *Cutis* (2016;98[6]:E3-E4). For more information, see https://bit.ly/33sKuSN.

Text for case 1 courtesy of Richard P. Usatine, MD. This case was adapted from Hitzeman N. Hereditary vascular lesions in adults. In: Usatine R, Smith M, Mayeaux EJ, et al, eds. *The Color Atlas of Family Medicine.* New York, NY: McGraw-Hill; 2009:865-868.
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Text for case 2 courtesy of Amor Khachemoune, MD, CWS.