

LETTER TO THE EDITOR

**ORAL SQUAMOUS CELL CARCINOMA: ARE GENERAL PRACTITIONERS
TRAINED TO DIAGNOSE IT PROPERLY?**

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Dear Editor,

Oral cancer is a major health problem worldwide, especially in developing countries. Brazil's National Cancer Institute (INCA) estimates 11,140 new cases of oral cancer in males and 4,350 in females¹ in 2016. The oral cavity is the fifth most prevalent site for the occurrence of cancer in Brazilian males, outstripping the esophagus (6th), bladder (7th) and larynx (8th). Although these epidemiological data show that oral cancer is a prevalent disease, the formation provided by Brazilian medical schools in terms of the diagnosis of this malignancy is deficient. Consequently, Brazilian physicians are generally not sufficiently trained to diagnose oral cavity cancer. The following case report could confirm this assertion.

A brown-skinned, 63-year-old, male, farmer, complaining of a non healing lesion on the tongue, was referred to the Oral Medicine Center at the Municipal Health Service of Palmas, Tocantins, Brazil. The patient was first seen by a primary care physician who diagnosed his tongue ulcer as a Mucocutaneous Leishmaniasis (MCL) after a positive intradermic test for *Leishmania* sp. (Montenegro Test). The physician prescribed 30 N-methyl-glucamine-antimoniate injections which yielded no therapeutic response. As well as a 3-month-old ulcer on the lateral part of the tongue, the patient also reported increased salivation, eating difficulties and dysphagia. He also admitted to having been a chronic cornhusk cigarette smoker and drinker of a distilled alcoholic beverage since his adolescent years.

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An intraoral examination revealed a large ulcerated lesion, measuring approximately 3cm in diameter, located on the lateral left tongue, presenting with raised edges and base covered by white slough (Figure 1).



Figure 1. Large ulcer on the left lateral border of the tongue extending to floor of mouth and presenting with raised edges and base covered in white slough.

Infiltration and induration of the surrounding tissue were detected by palpation. The first diagnostic impression was of a Squamous Cell Carcinoma (SCC), so an incisional biopsy was immediately undertaken. Microscopic analysis showed mucosa with irregular masses consisting of atypical keratinocytes, with large hyperchromatic and pleomorphic nuclei, individual dyskeratotic cells and atypical mitotic figures, and invasion of the corium which presented with mild lymphocytic infiltrate (Figure 2).

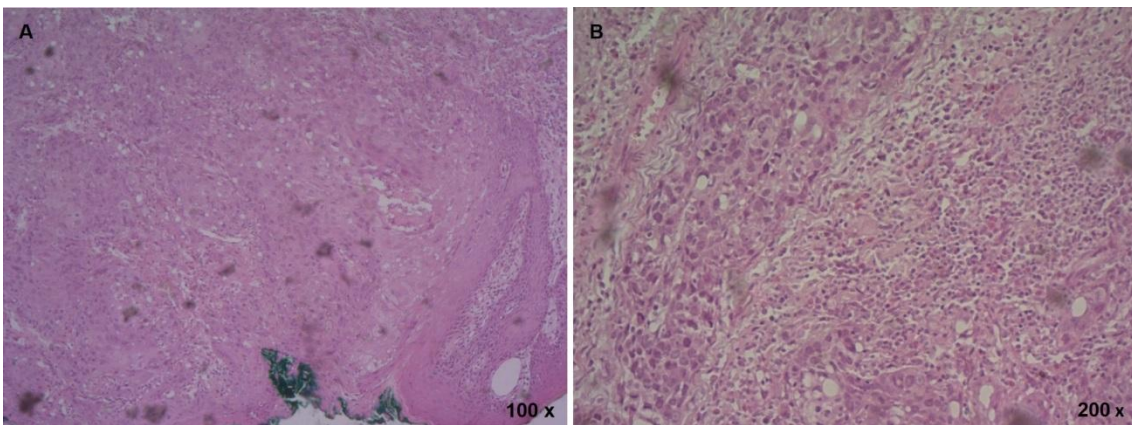


Figure 2. H-E stained photomicrographs exhibiting characteristic features of oral SCC. Mucosa with irregular masses consisting of atypical keratinocytes, with large hyperchromatic and pleomorphic nuclei, individual dyskeratotic cells and atypical mitotic figures (A-B), and invasion of the corium which presented with mild lymphocytic infiltrate (B).

These microscopic findings established a final diagnosis of well-differentiated SCC. The patient was referred to the Head and Neck Cancer Surgery Service for appropriate treatment and did not return for subsequent follow-ups.

This case presents a typical oral squamous cell carcinoma in a male in his sixties, an inveterate drinker and smoker, presenting with a non-healing ulcer on the lateral part of the tongue. However, despite the typical characteristics of the SCC, the primary care physician committed a basic error by diagnosing and treating the tongue lesion as MCL. This condition usually progresses in two stages: a primary cutaneous lesion which, after a varying period of latency, can reach the mucous membranes either by metastases or local spread. It is most commonly found in the nasal mucosa and may extend by contiguity to the nasopharynx, oropharynx or palate². Indeed, the occurrence of MCL as a single ulcer on the tongue is extremely rare³. In addition, the choice of supplementary tests is considered inappropriate. As the clinical picture had strongly suggested SCC, an incisional biopsy was mandatory, and not the Montenegro test. Although such a test is highly sensitive, it is not species-specific and could have yielded a false positive result in this particular case⁴. It is worth stressing that diagnostic errors always lead to inadequate therapy and delayed treatment. In oral cancer patients, this diagnostic delay can be very damaging or even fatal.

In conclusion, it is crucial that medical schools provide their undergraduate students with regular and consistent information on oral cancer, especially SCC, the most common type. Oral cancer must be considered a serious, lethal, crippling disease and should be seen as a major public health problem in Brazil. As the SCC usually settles on the oral mucosa, there is a great potential for early detection at primary care level, without needing expensive specialized resources. Early diagnosis can be promptly made through comprehensive anamnesis and a careful physical examination of the head and neck region, including palpation of the cervical lymphnodes and examination of the oral cavity. In addition to this clinical evaluation, a biopsy is essential.

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