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Palatal Ulceration of Long Evolution

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Sir,

Cutaneous tuberculosis is a chronic infectious disease of the skin caused by the acid-fast bacillus *Mycobacterium tuberculosis*. Nowadays, it is a rare disease in the developed countries, representing only 1.4% of the total cases of tuberculosis, but its incidence has been on the rise due to immunosuppression associated with HIV and the more frequent use of immunosuppressive treatment.[1]

A 54-year-old man former smoker with a history of hypertension and high blood cholesterol referred to our hospital with a lesion in his palate of 4 months evolution and also associated weakness, odynophagia, cervical adenopathies, and loss of 6 kg in the past months.

Physical exploration revealed an 8-mm ulcerated lesion in his soft palate with a clean background and well-demarcated border and also evidenced a 3 cm infiltrated erythematous plaque on the left scapular region [Figures 1 and 2]. Biopsies of the palate and trunk lesions were performed, samples of the lesions were cultivated for fungi, bacteria, and mycobacteria, and histopathological examination was done.

In the histopathology of the oral lesion, an ulceration was seen in the epidermis with a granulomatous inflammatory infiltrate in the upper dermis. No bacillus was evidenced as Giemsa and Ziehl-Neelsen staining were negative [Figure 3].

Mantoux test was positive (14 mm) as well as the test of interferon-gamma liberation. Thoracic X-rays showed nodular lesions accompanied by fiber-retractable tracts with suprahilar connection and multiple calcified nodules on the apical pleura. Sputum culture, bronchoalveolar lavage, and bacilloscopy came out all negative. Serology for HIV 1 and 2 was also negative.

Biopsy of the cutaneous lesion on the back revealed hyperplasia of the epidermis, superficial, and deep dermis with an inflammatory infiltrate composed of histiocytes, epithelioid cells, lymphocytes, and neutrophils. Furthermore, culture in Löwenstein–Jensen medium was positive.

With the diagnosis of lupus vulgaris (LV) of the oral mucosa, antituberculous treatment was initiated, which included isoniazid, rifampicin, and pyrazinamide daily for 2 months followed by 4 months with isoniazid and rifampicin; this treatment achieved complete resolution of the lesions.

Cutaneous tuberculosis is a consequence of hematogenous dissemination of *M. tuberculosis* or by direct extension from an internal infection or by primary inoculation. The clinical cutaneous variant named LV is the most frequent form, the lesions are normally secondary to a hematogenous or lymphatic dissemination, and much less common can be due to reinoculation. Although it is the most common variant,[2] oral location is rare with a frequency between 0.5% and 3.5% of all cases of lupus vulgaris.[3,4]

LV is a chronic disease which normally appears as a unique lesion characterized by a soft, well-defined, brown-reddish irregular plaque which grows progressively.[5] In these lesions, the bacillus is difficult to find because its usually in a paucibacillary state and only 6% of the cultures are positive.[2]

When located on mucosa, the differential diagnosis should be made with orificial tuberculosis which is a rare variant, produced by autoinoculation, mostly found in immunosuppressed patients and is a multibacillary form of tuberculosis cutis. Eighty percent of cases are found on the head and neck, especially on the nose, cheeks, and earlobes. Tuberculous lymphadenitis is associated in 40% of the cases and 10%–20% coexists with bone or lung tuberculosis.[2]

The multiple manifestations of the disease as well as the many diseases that associate ulcerative lesions in the oral mucosa could be the cause of delay in the diagnosis. The low level of detection and the frequent diagnosis delay, even in typical cases due to lack of familiarity, could be an important problem in the actual reemergent tuberculosis scenario.

Declaration of patient consent

The authors certify that they have obtained all appropriate patient consent forms. In the form the patient(s) has/have given his/her/their consent for his/her/their images and other clinical information to be reported in the journal. The patients understand that their names and initials will not be published and due efforts will be made to conceal their identity, but anonymity cannot be guaranteed.

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Conflicts of interest

There are no conflicts of interest.

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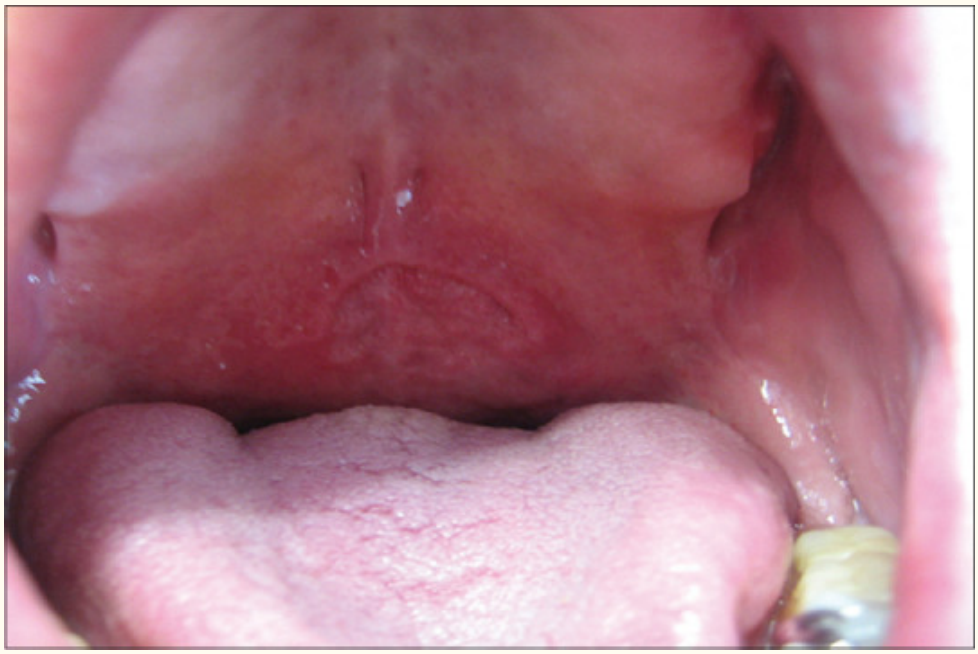
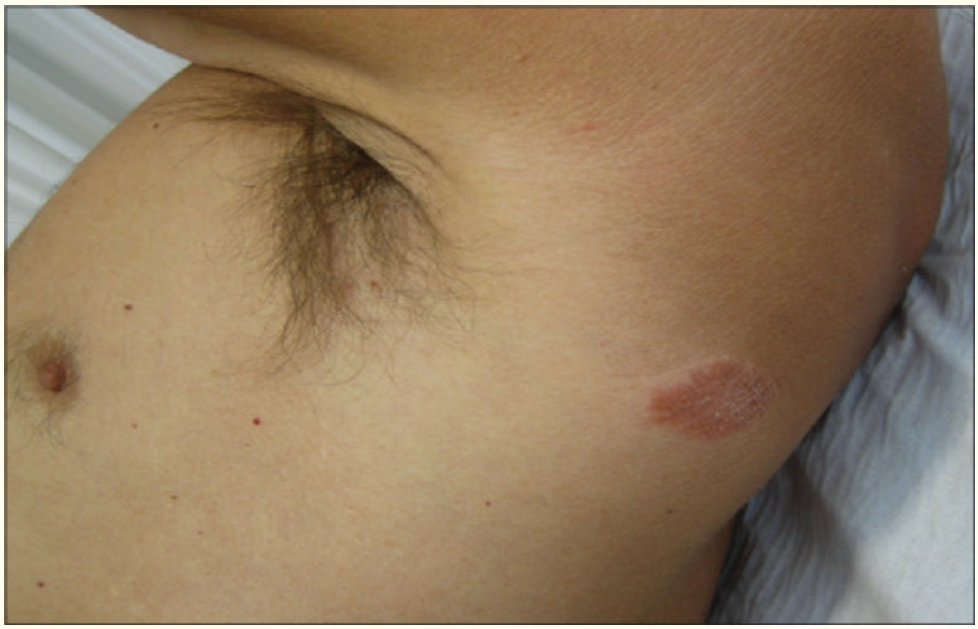
Figures and Tables

Figure 1



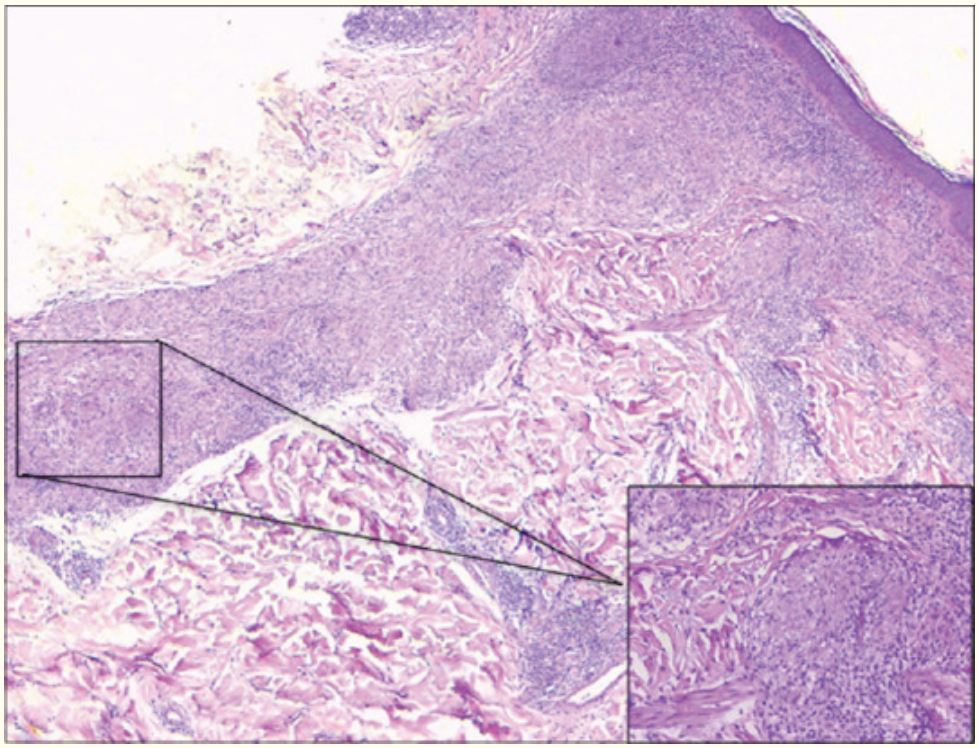
Ulcer on the soft palate with erythematous and raised borders

Figure 2



Elevated and infiltrated erythematous plaque with hyperkeratotic surface

Figure 3



Granulomas with epithelioid cells, lymphocytes, and giant cells of Langhans and foreign body types (H and E, ×40 and ×200)