



Case report

An aggressive, solitary non-healing ulcer: Not always cancerous

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Any “single persistent oral ulcer showing no sign of healing ten to fourteen days after any putative trauma is removed, then it must be considered as malignant, unless proven otherwise” [1].

A 63 year old farmer, a known smoker and beetle nut chewer for over thirty five years, presented to our hospital with three month old complaints: (i) pain in the left side of the mouth, which was aggravated whenever he opened his mouth to talk and chew food. Pain was secondary to an ulcerative lesion present in the left buccal mucosa, which gradually increased in size to involve the left angle of the mouth; (ii) progressive trismus for over a month; (iii) productive cough with scanty, white, mucoid, non-foul smelling, non-blood stained sputum; (iv) fever was intermittent, low-grade not associated with chills, rigors, or night sweats. He had no significant past, family or allergy history. He denied losing weight and having reduced appetite. The differentials considered were: (I) malignancy (II) infection.

On examination, he was found to be moderately built, poorly nourished, pale, with digital clubbing, and a fever of 101 °F associated with night sweats. His respiratory system examination revealed bilateral scattered crepitations on auscultation. He was immunocompetent.

Local examination revealed: a solitary, non-healing ulcer in the left oral cavity, irregularly shaped, measuring 2.5 cm × 3 cm. From its location in the left buccal mucosa, it extended anteriorly to involve the left commissure, left mucocutaneous junction of both lower and upper lip. Its posterior extent was 3 cm from the commissure. Medially extending to the left labial mucosa and

laterally extending to the left commissure. Yellowish slough was present over the ulcer's floor. Palpation elicited firmness in the middle, due to fibrosis, with tenderness and bleeding spots in the left commissure and left lower lip region.

Oral examination revealed: teeth numbers 14, 16, 23, 24, 28; 34 to 38; 43 to 46, 48 were periodontally involved with local factors like calculus, stains, gingival recession, furcation involvement, mobility, with dental attrition. He was partially edentulous in relation to the other teeth. Physiological melanin pigmentation was observed in the residual alveolar ridges, buccal and labial mucosa. The tongue was coated and fissured. The remaining quadrants too showed poor dental hygiene as described above. No other ulceration, fissure, growth or swelling was seen in oral cavity.

Routine investigations were normal except for his chest x-ray, which showed bilateral patchy opacities with scarring. (a) Punch biopsy of the buccal ulcer showed caseating granuloma surrounded by epithelioid cells, giant cells with acid-fast bacilli. (b) Wedge biopsy of the ulcer involving the left angle of the mouth showed chronic inflammation. His (c) sputum was positive for acid-fast bacilli. He was immunocompetent. Diagnosis made was intraoral tuberculosis involving the left buccal mucosa, commissure, lower

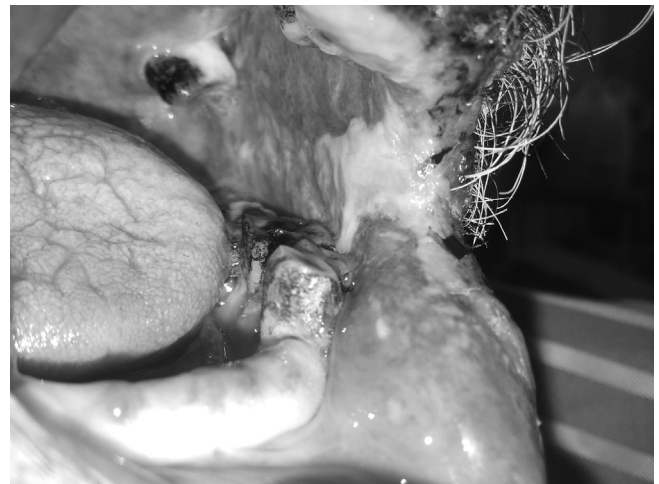


Fig. 1. Ulcer involving the left buccal mucosa, commissure, upper and lower lip, on admission.

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Fig. 2. Healed ulcer of the left buccal mucosa, commissure, upper and lower lip, at 3rd & 6th month follow-up.

and upper lips secondary to pulmonary tuberculosis. He was treated with antitubercular therapy under RNTCP DOTS Category-I intermittent regimen [2H₃R₃Z₃E₃ & 4H₃R₃] (see Figs. 1 and 2).

Follow-up examination of his oral cavity, after three months of treatment, revealed a completely healed ulcer with profound fibrosis of the left buccal mucosa with persistence of trismus, while his chest x-ray and labs were within normal limits. His findings remained unchanged when he followed up after completing the entire six month course.

This cancerous looking lesion was neither malignant nor benign. Instead, it proved to be an atypical presentation of a common infectious process of *Mycobacterium tuberculosis*.

Intraoral tuberculosis is rare, accounting for 0.05–5.0% of all tuberculosis cases [2] with the tongue most commonly affected [3]. Primary oral tuberculous lesions are extremely rare, usually observed in young adults with cervical lymphadenopathy. Secondary oral tuberculosis, cited here, comprises 0.05–1.5% of all tuberculosis cases [4] and affects older patients.

With the rising frequency of co-morbidities and immunocompromised states globally, this case highlights the benefits that accrue from a multidisciplinary approach to patient evaluation and management.

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