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Case Report

A Case Report of Oral Ulceroproliferative Growth

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ABSTRACT:
Ulceroproliferative growth in the mouth is a symptom of oral squamous cell carcinoma; a type of cancer that can appear as an ulcerative lesion in the oral mucosa. It can occur anywhere from the lips to the oropharynx, but is most common on the gingivobuccal sulcus of the mandible, tongue and floor of mouth. Despite advancements in diagnostics and treatment, oral ulceroproliferative growth poses challenges due to their diverse aetiology, overlapping clinical features, and potential for misdiagnosis. Early identification and timely intervention remain pivotal to improving patient outcomes.
Keywords: Ulceroproliferative Growth, Lesion, Oral Squamous Cell Carcinoma, Oral Cancer, Malignant Lesions

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INTRODUCTION

An ulceroproliferative growth in the oral cavity represents a lesion that combines persistent ulceration with abnormal tissue overgrowth. These lesions are characterized by a combination of non-healing ulceration and abnormal tissue proliferation frequently raising suspicion for oral squamous cell carcinoma (OSCC). The oral cavity is a dynamic region, constantly exposed to mechanical trauma, chemical irritants and pathogens. This makes it susceptible to a wide variety of ulcerative and proliferative condition. Oral cancer accounts for the eleventh most typical cancer worldwide. Oral squamous cell carcinoma is the most common oral cancer with diverse clinical presentations. It accounts for more than 90% of all malignant lesions in the oral cavity. The non healing nature of these lesions associated with pain, bleeding and swelling often prompts clinical investigation. The clinical presentation of OSCC varies from a white plaque to an ulcerated lesion. Malignant lesions within the gingiva may resemble oftenly seen inflammatory lesions of the gingiva. Oral cancers can usually be misdiagnosed as other inflammatory lesions in the oral cavity leading to delay of treatment.

CASE REPORT

A 53-year-old male patient came to the department of Oral Medicine and radiology with a chief complaint of pain and growth in left lower vestibule region since 4 months. Patient gave history of hypertension and diabetes since 5 years and is under medication. Patient gave history of gutka chewing for 15 years and quit the habit 6 years ago. Patient also gave history of smoking since 10 years. On extraoral examination no abnormality is seen. On intraoral examination blanching is seen involving oral mucosa. 2 fibrous bands palpable on left buccal mucosa and 1 fibrous band is palpable on right buccal mucosa. Mouth opening is reduced which is 28 mm. On bilateral examination of lymph nodes left submandibular lymph nodes are palpable. A growth of size approximately 2x3 cm seen involving lower left buccal vestibule extending antero-posteriorly from 32 to 37 region. A greyish white plaque seen involving right buccal mucosa extending antero-posteriorly 1 cm from right corner of mouth to retromolar area. Considering all the clinical examination diagnosis is given as grade II oral submucous fibrosis, ulcero-proliferative growth involving lower left buccal

vestibule and homogenous leukoplakia involving right buccal mucosa. Biopsy is done involving the ulceroproliferative growth and report revealed moderately differentiated squamous cell carcinoma. Patient is referred to cancer hospital for further treatment.

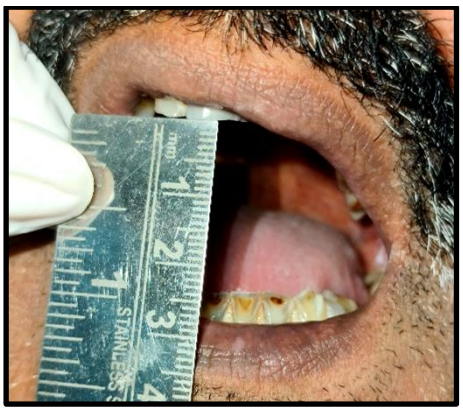

Figure 1: Reduced Mouth Opening 28 mm

Figure 2: Ulcero-Proliferative Growth Involving Lower Left Buccal Vestibule

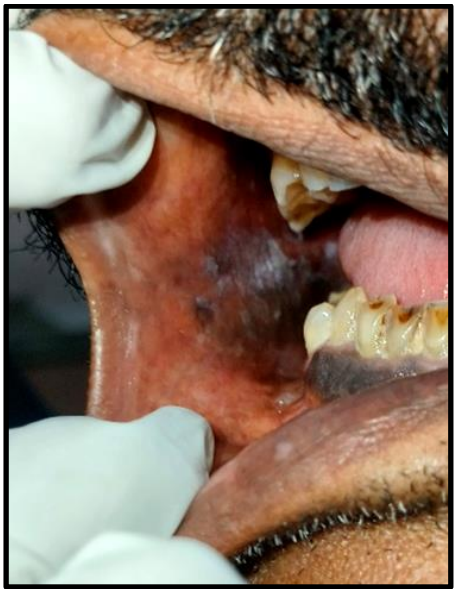

Figure 3: Greyish White Plaque Seen Involving Right Buccal Mucosa

MACROSCOPIC FEATURES:

Received single bit of soft tissue measuring 0.5x08x0.3cm, irregular in shape, brownishblack in color, soft in consistency with irregular borders.

HISTOPATHOLOGIC FEATURES:

The given H&E stained section shows parakeratotic startified squamous epithelium with long and thin retepeg formation. Epithelium shows dysplastic features like cellular and nuclear pleomorphism, increased nuclear & cytoplasmic ratio and hyperchromatic nuclei extending upto middle 3rd. There is a breach in the basement membrane with epithelial islands extending into underlying connective tissue. The connective tissue is fibrocellular having fibroblasts, dysplastic epithelial islands, moderate chronic inflammatory infiltrate and blood vessels filled with RBCs. These features are suggestive of moderately differentiated Oral squamous cell carcinoma.

HISTOPATHOLOGICAL DIAGNOSIS: MODERATELY DIFFERENTIATED ORAL SQUAMOUS CELL CARCINOMA.

Figure 4: Histopathological Features

DISCUSSION

The term "ulceroproliferative" combines two characteristics. Ulcerative component: Represents tissue breakdown, typically with a non-healing surface and often associated with pain. Proliferative component: Indicates abnormal tissue growth, which may range from reactive hyperplasia to malignant transformation. The prevalence of ulceroproliferative growth in India is notable; particularly in the context of oral & other cancers. A 5-year study conducted in Visakhapatnam, Andhra Pradesh analysed 936 cases and found that 42% of lesion are ulceroproliferative in nature; categorized as benign (33%) premalignant (19%) and malignant (48%) Predominantly seen in males, malignancies most common in older individuals aged 61-70 years. tongue & buccal mucosa were the most affected sites for malignant cases. 1) Etiology & presentation: causes of this lesion are diverse and can be broadly categorized: Infective causes: Chronic infection like tuberculosis or syphilis may present as non-healing ulcers with raised margin. Inflammatory or autoimmune causes: condition such as erosive lichen planus or pemphigus vulgaris may mimic malignancy. Malignancies: oral squamous cell carcinoma is the most concerning differential diagnosis, particularly in individuals with risk factor like tobacco or alcohol use.

Clinically, there lesion often present as: irregularly shaped ulcers with indurated, rolled or everted edges (A tendency to bleed on touch). Pain or discomfort; worsening over time. Regional lymphadenopathy in advanced cases. Dysphagia- bleeding or paveitueria. A high index of suspicion is essential, particularly for lesion persisting beyond two weeks despite conventional treatment. Diagnostic Approach includes Detailed history and clinical Examination, Biopsy and histopathology: The gold standard procedure to confirm or rule out malignancy, Imaging: Radiographs; CT or MRI are useful for assessing bone involvement or deeper tissue invasion in suspected malignancy.

Treatment for ulcero-proliferative Growth: Treatment varies with the underlying Causes

1. Infectious aetiologies: antimicrobial therapy tailored to the infection for resolution post-treatment.
2. Inflammatory/Auto Immune Lesion: Corticosteroids or Immunosuppresants, Symptomatic care and elimination of triggers.
3. Malignant Lesion: (eg: Oral Squamous Cell Carcinoma) (a) Surgery: wide local excision with tumour-free margin. (b) Adjuvant therapy: Radiotherapy and/or chemotherapy for advanced stages or recurrence. (c) Rehabilitation: Proituetic & functional restoration post- treatment.

Advanced Treatment modalities:

1. Surgical Innovation: (a) Robotic surgery (b) sentinel Lymph Node Biopsy (SLNB) (c) Microvascular Free Flap Reconstruction
2. Radiotherapy: (a) Intensity–Modulated Radiotherapy (IMRT) (b) Sterotactic Body Radiotherapy (SBRT) (c) Protou Beam Therapy
3. Systemic Therapy: Targeted Therapy: EGFR Inhibitors: Eg: drugs like cetuximab Antiangiogenic agents like Bevacizumab. Immuno Therapy- Immune check-point inhibitors: With drugs likes pembrolizumab and nivolumab. Cancer Vaccines:
4. Photodynamic Therapy (PDT)
5. Molecular & Genetic Approaches- Gene Therapy - Liquid Biopsy
6. Adjunctive Therapies: a) Hyperthermia Therapy, b) Nanotechnology
7. Reliabilitation and supportive care

CONCLUSION

The most prevalent malignant epithelial tumor with a variety of oral manifestations is oral squamous cell

carcinoma. Consequently, the oral pathologist or dentist should be aware of the characteristics of the illness. Distant metastasis is the most deadly consequence as the illness worsens. Because the clinical presentation of oral squamous cell carcinoma might mimic that of inflammatory gingival lesions, prompt and accurate diagnosis is crucial, and there is a greater likelihood of misdiagnosis.

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