Papilloma in lower lip: A case report and review

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ABSTRACT

Oral squamous papilloma (OSP) is a benign proliferation of the stratified squamous epithelium, which results in a papillary or Verrucous exophytic mass. These lesions rarely cause symptoms. It is a common lesion of the oral mucosa with a predilection for the mucosa of the hard and soft palate. As an oral lesion, it raises concern because of its clinical appearance, which may mimic exophytic carcinoma, verrucous carcinoma or condyloma acuminatum. Its pathogenesis is related to human pappiloma virus but there is controversy regarding its viral origin. Here we present the case of a squamous papilloma in lower lip region near the commisure of mouth.

Introduction

Oral squamous papilloma (OSP) is a benign proliferation of the stratified squamous epithelium, which results in a papillary or Verrucous exophytic mass. Papillomas appear as pedunculated or sessile, white or normal colored cauliflower like projections that arise from the mucosal surface.[1,2] The most common site is the palate uvula (34%) area followed by tongue and lips. Of all sites, the soft palate is the most common and accounted for 20% of the lesions. Although its exact etiology is still unknown, it is believed that the origin of papillomas is related to traumatisms or to human papillomavirus, especially HPV-6, 11, 16, which have already been identified in these lesions.[3] The theory that associates papillomas to the HPV advocates that this virus is capable of invading the nuclei of the cells in the spinous layer, inducing a series of proliferative alterations that result in tumoral growth.[2,4]

SP can be further divided into several types: isolated, solitary and multiple-recurring.[5]

HPV infection can occur in three ways: transitory infection in 50% of cases; spontaneous regress lesions in 30% of cases; and persistent infections, with constant relapses. Clinically the lesions normally have a verrucous aspect that may be not detected by visual inspection, but through magnification techniques such as colposcopy. Different laboratory techniques for diagnosis should read as cytology, biopsy, immunohistochemistry and molecular techniques.[2,3]

Conservative surgical excision is the treatment of choice with rare recurrence. The patient should be monitored for 6 (six) months after treatment of lesions, which is a critical period for recurrence.[2,3] There is no evidence that papillomas are premalignant.

Here we are reporting a case of Squamous papilloma in lower lip of male patient.

Case report

A 58 year old male patient reported to the Department of Oral Medicine and Radiology with a complaint of over growth of mass in the inner aspect of lower lip near the corner of mouth since two years.

It was single, pedunculated, and sessile with cauliflower like appearance. It was white in colour with finger like projections of size 1.5x2cm (Figure 1). It was asymptomatic and was increasing in size gradually.

Figure:1. Exophytic growth at the lower lip

Blood investigation was normal. Surgical excision was done and the biopsy specimen was sent for Histopathological

examination which revealed proliferation of the spinous layer cells, following a digitiform pattern with a delicate core of fibrous connective tissue constituting the supporting stroma suggestive of Squamous papilloma (Figure. 2).

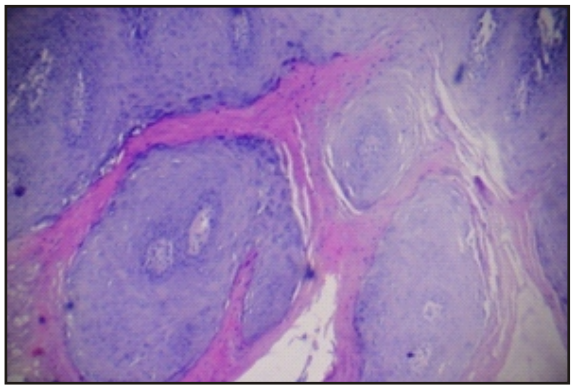

Figure.2. H & E staining showing features of squamous papilloma

Discussion

The oral SP is a benign entity presented as an exophytic lesion, with a rugose red or white surface, sessile or pediculed.[1-3,6] It can be granular, fingerlike and may be asymptomatic.[5] Its average size is less than 1.0 cm, only 8% were larger than 2.0 cm. Many are only 3 or 4 millimeters. The mean age of patients with papilloma is 36.4 years with a range from 2 to 91 years. There is no sex preference. The most common site is the palate uvula area followed by tongue and lips.[1] The durations ranged from weeks to 10 years but 50% of the papillomas present between 2 to 11 months.

In presented case papilloma was present in 58 year old male patient at lower left inner surface of lip of size 1.5 x 2 cm in diameter since 2 year. It appeared as pedunculated exophytic mass.

The etiology remains unknown. Viral origin has always been suspect but studies are still inconclusive. As for its differential diagnosis, the literature shows that other diseases may be an oral challenge to diagnose as condyloma acuminatum, verruca vulgaris, focal epithelial hyperplasia (Heck disease), papillary hyperplasia and verruciformis, because they are among a clinically and/or histopathological the injuries that present similarities although the feature distinct.[7] Large papillomas may resemble early verrucous carcinoma.

Generally, the clinical appearance of oral papillomas is hardly distinguishable from that of common warts (verrucae vulgaris). For an accurate differential diagnosis, it is necessary that any HPV that is normally found in skin lesions also be identified in the intraoral lesion.

A logical association for clinical diagnosis would be to establish a connection between the presence of common warts in the child's hands and fingers, habits such as thumb or finger-sucking and onychophagia, and the oral papilloma lesion.[8]

The histological examination of these lesions reveals the proliferation of the spinous layer cells, following a digitiform pattern with a delicate core of fibrous connective tissue constituting the supporting stroma.[3,8] Variable degrees of inflammatory reaction can be observed in this stroma, depending on the existence of epithelial ulcerations.[9]

Surgical removal is the treatment of choice by either routine excision or laser ablation. Other treatment modalities include electrocautery, cryosurgery, and intralesional injections of interferon. Recurrence is uncommon, except for lesions in patients infected with human immunodeficiency virus(HIV).[5,10].

A report showed that the prevalence of HPV in HIV-infected adults is greater (36.4%) than in HIV-negative patients (6.1%).[7] However, a study in children, showed a prevalence of 3.6% in HIV+ patients against 12.3% of those not infected.[8] The specimen should be sent for histopathologic examination to confirm the clinical diagnosis of papilloma and to assure that the surgical intervention and treatment management of the pathology were adequately performed.

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