Oral Mucosal Lesions 101: Recognition, Risk Assessment, and Referral

March 27, 2025

CareQuest Institute for Oral Health®

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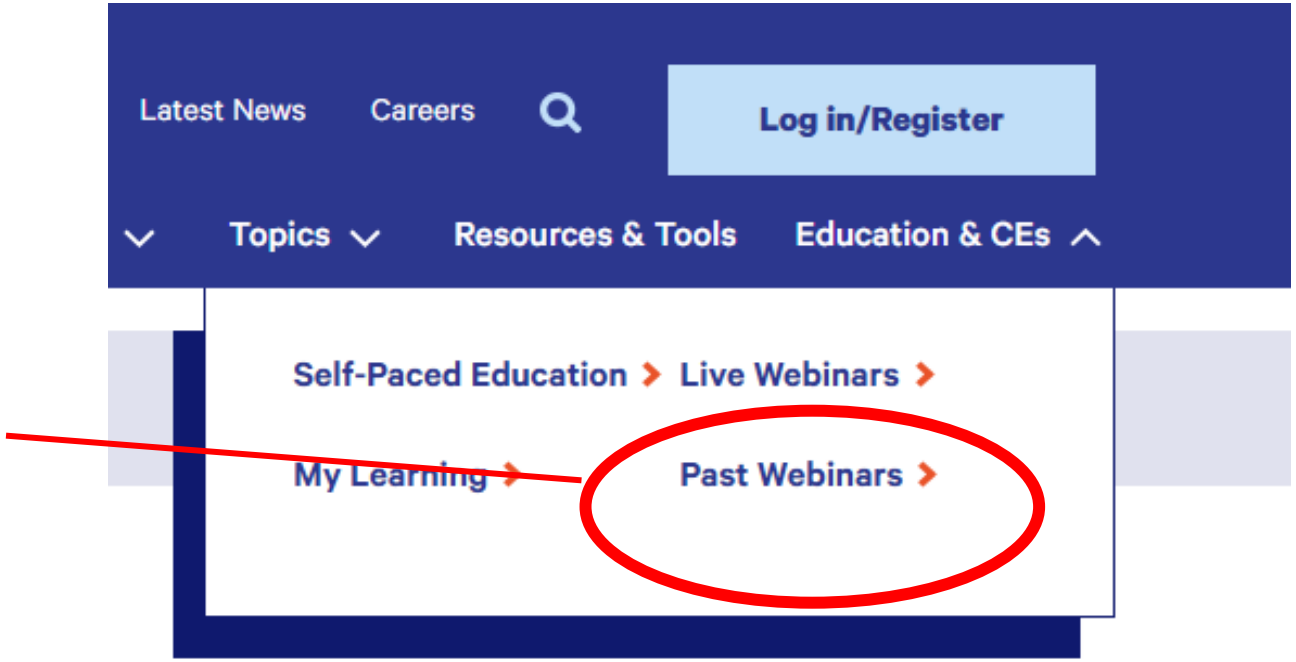

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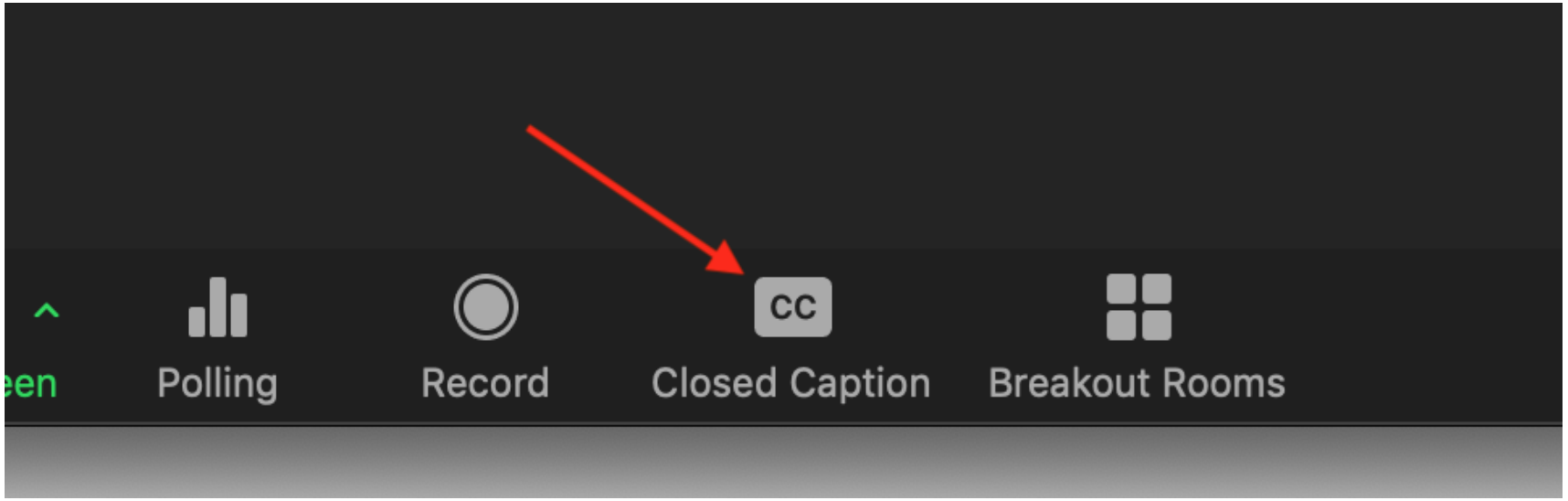

CareQuest Institute for Oral Health

Thank You

CareQuest Institute for Oral Health

CareQuest Institute for Oral Health

AAOM The American Academy of Oral Medicine

Webinar

Oral Mucosal Lesions 101:

Recognition, Risk Assessment, and Referral

Thursday, March 27, 2025
7-8 p.m. ET

ADA CERP Credits: 1

Moderator and Presenter

Kentaro Ikeda, DDS, MPH
President,
The American Academy of Oral Medicine;
Associate Surgeon in the Division of Oral Medicine and Dentistry, Brigham and Women's Hospital

Presenter

Herve Y. Sroussi, DMD, PhD
Assistant Secretary,
The American Academy of Oral Medicine;
Associate Surgeon and Director for Research in the Division of Oral Medicine and Dentistry, Brigham and Women's Hospital

Learning Objectives

- **Identify** common and high-risk oral mucosal lesions by recognizing their clinical presentation, etiology, and associated risk factors through case-based examples.

- **Apply** evidence-based assessment techniques to evaluate oral mucosal lesions and support informed treatment decisions.

- **Evaluate** appropriate case management strategies for suspected malignant lesions, including when to make referrals and consider treatment options.

Poll Questions

1. **How often do you conduct an oral soft tissue exam?**
   a) Every appointment
   b) Periodically (i.e. every 3 months, annually etc.)
   c) When requested
   d) Never

2. **How confident are you in identifying oral mucosal lesions in patients?**
   a) Very confident
   b) Somewhat confident
   c) Slightly confident
   d) Not confident at all

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Oral Mucosal Lesions 101: Recognition, Risk Assessment, and Referral

Herve Sroussi DMD, PhD

Associate Professor, Department of Oral Medicine, Infection and Immunity

Harvard School of Dental Medicine

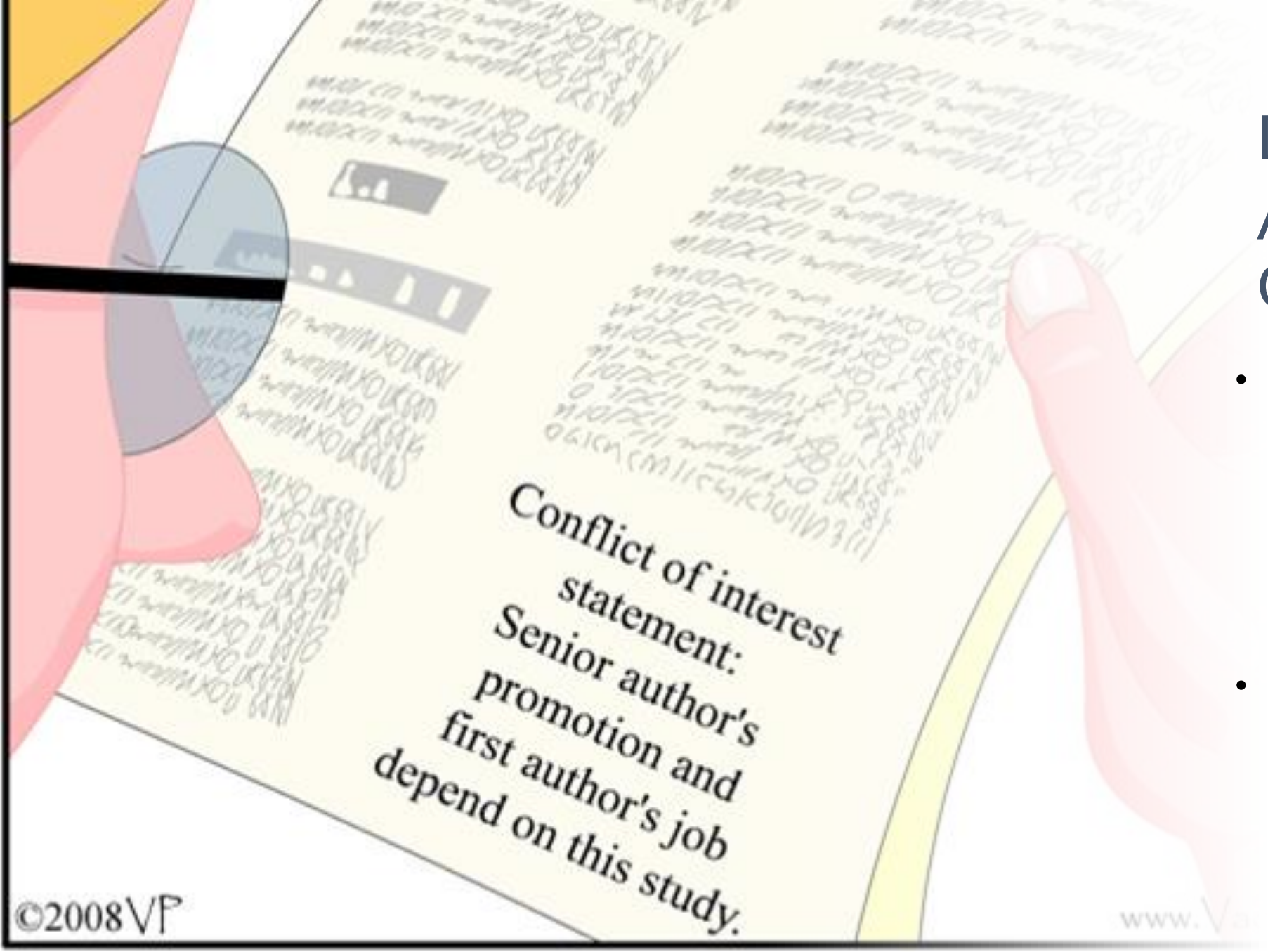
The American Academy of Oral Medicine
INTEGRATING MEDICINE AND DENTISTRY

BRIGHAM HEALTH
BRIGHAM AND WOMEN'S HOSPITAL

CareQuest Institute for Oral Health

HARVARD MEDICAL SCHOOL TEACHING HOSPITAL

MAGNET RECOGNIZED

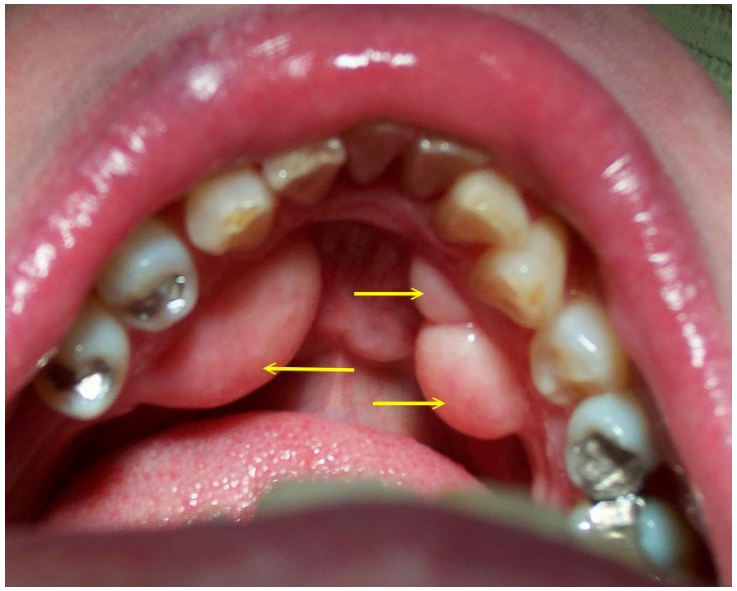


DISCLOSURES AND CONFLICTS OF INTEREST

- Disclosures: Dara Biosciences (consulting), Janssen (consulting), Lipella (consulting/research funds), Meira(research funds), and Naveris (research funds)
- Includes off-label use of FDA-approved agents

Content

What is normal? And what is not?



Evaluate appropriate case management strategies ***for suspected malignant lesions,*** *including when to make referrals and consider treatment options*

- Presentation (what you see)
- Persistence (what you hear)
- Location (where you see it)
- Symptoms? (what your patient tells you)

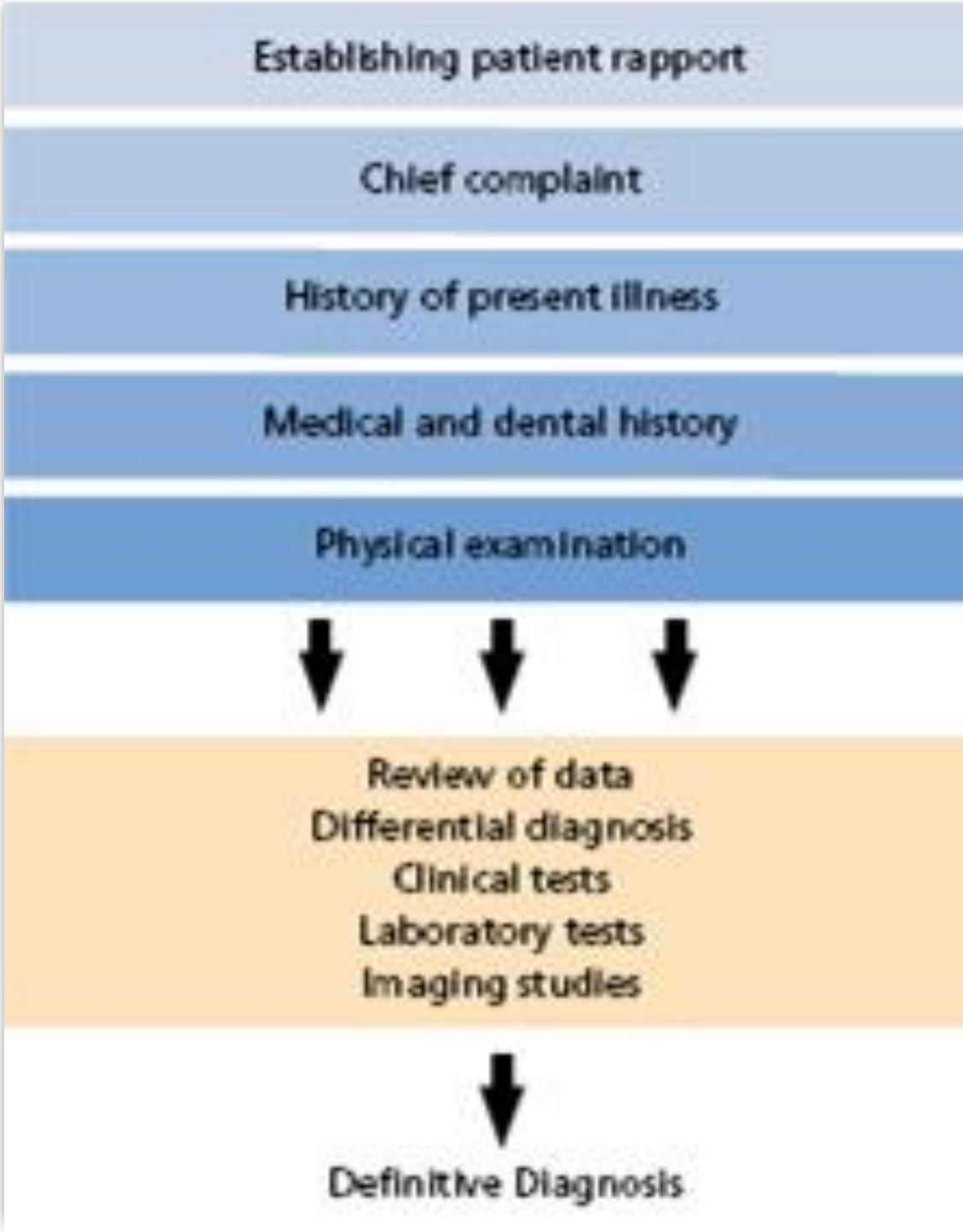
Two-Week Rule

Successful Management: Recognition, Diagnosis, and Planning

- History taking
- Examination
- Appropriate test selection (if needed)

- Recognition
- Accurate Diagnosis

- Referral as indicated (training, experience)
- Selection of appropriate therapy



Essentials of Oral Medicine
Book by Edmond L. Truelove, Lewis R Eversole, and Silverman Jr Sol

Geographic Tongue

Geographic Tongue

- Prevalence was **3%** (Confidence interval [CI]: 0.4%-5.5%, n = 9813).
- The greatest prevalence occurs in the age group of 20 to 29 years of age at about **39.4%**.
- Women **>** men.
- Approximately **one in 30 adults** has a geographic tongue.
- More prevalent in first-degree relatives than in the control group (**14.4% vs. 4%**).
- Etiology is **unknown.**

Pereira, R. d. P., de Oliveira, J. M. D., Pauletto, P., Munhoz, E. d. A., Silva Guerra, E. N., Massignan, C., & De Luca Canto, G. (2022). Worldwide prevalence of geographic tongue in adults: A systematic review and meta-analysis. *Oral Diseases*, 00, 1–10. https://doi.org/10.1111/odi.14397

Picciani B, Santos VC, Teixeira-Souza T, Izahias LM, Curty Á, Avelleira JC, Azulay D, Pinto J, Carneiro S, DiasE. Investigation of the clinical features of geographic tongue: unveiling its relationship with oral psoriasis. Int JDermatol. 2017 Apr;56(4):421-427.

Geographic Tongue

Geographic Tongue: Differential Diagnosis

- Lichen planus
- Candidiasis
- Erythroplakia/Leukoplakia
- Contact stomatitis
- Trauma

.Picciani B, Santos VC, Teixeira-Souza T, Izahias LM, Curty Á, Avelleira JC, Azulay D, Pinto J, Carneiro S, Dias E. Investigation of the clinical features of geographic tongue: unveiling its relationship with oral psoriasis. Int J Dermatol. 2017 Apr;56(4):421-427.

Stoopler ET, France K, Ojeda D, Sollecito TP. Benign Migratory Glossitis. J Emerg Med. 2018 Jan;54(1):e9-e10.

Geographic Tongue: Management

- **Antihistamines**
- **Topical corticosteroids**
- Cyclosporine
- Zinc
- Vitamin A
- Acetaminophen
- Topical tacrolimus

.Picciani B, Santos VC, Teixeira-Souza T, Izahias LM, Curty Á, Avelleira JC, Azulay D, Pinto J, Carneiro S, Dias E. Investigation of the clinical features of geographic tongue: unveiling its relationship with oral psoriasis. Int J Dermatol. 2017 Apr;56(4):421-427.

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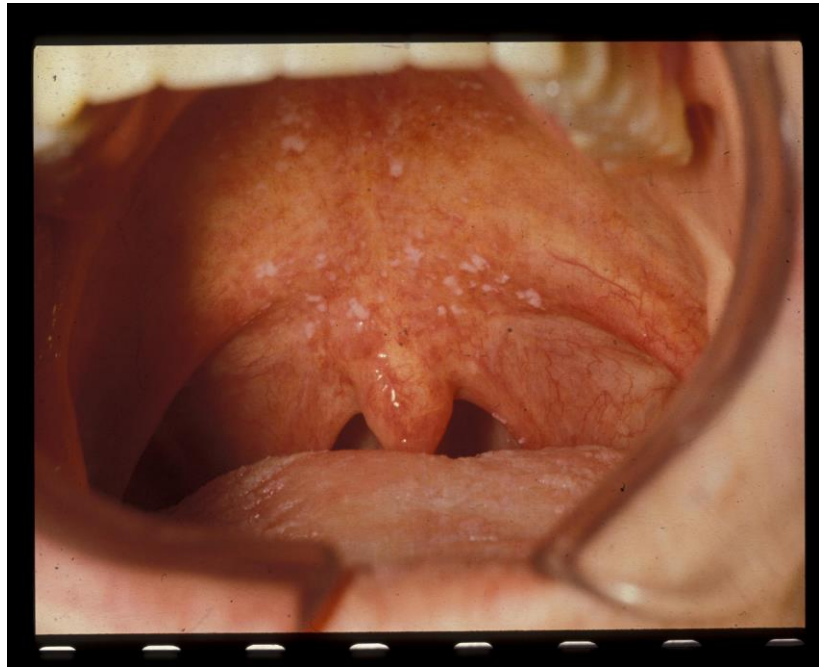
Oral Candidiasis

- Pseudomembranous candidiasis
- Erythematous candidiasis (also denture stomatitis, median rhomboid glossitis)
- Angular cheilitis
- Hyperplastic candidiasis

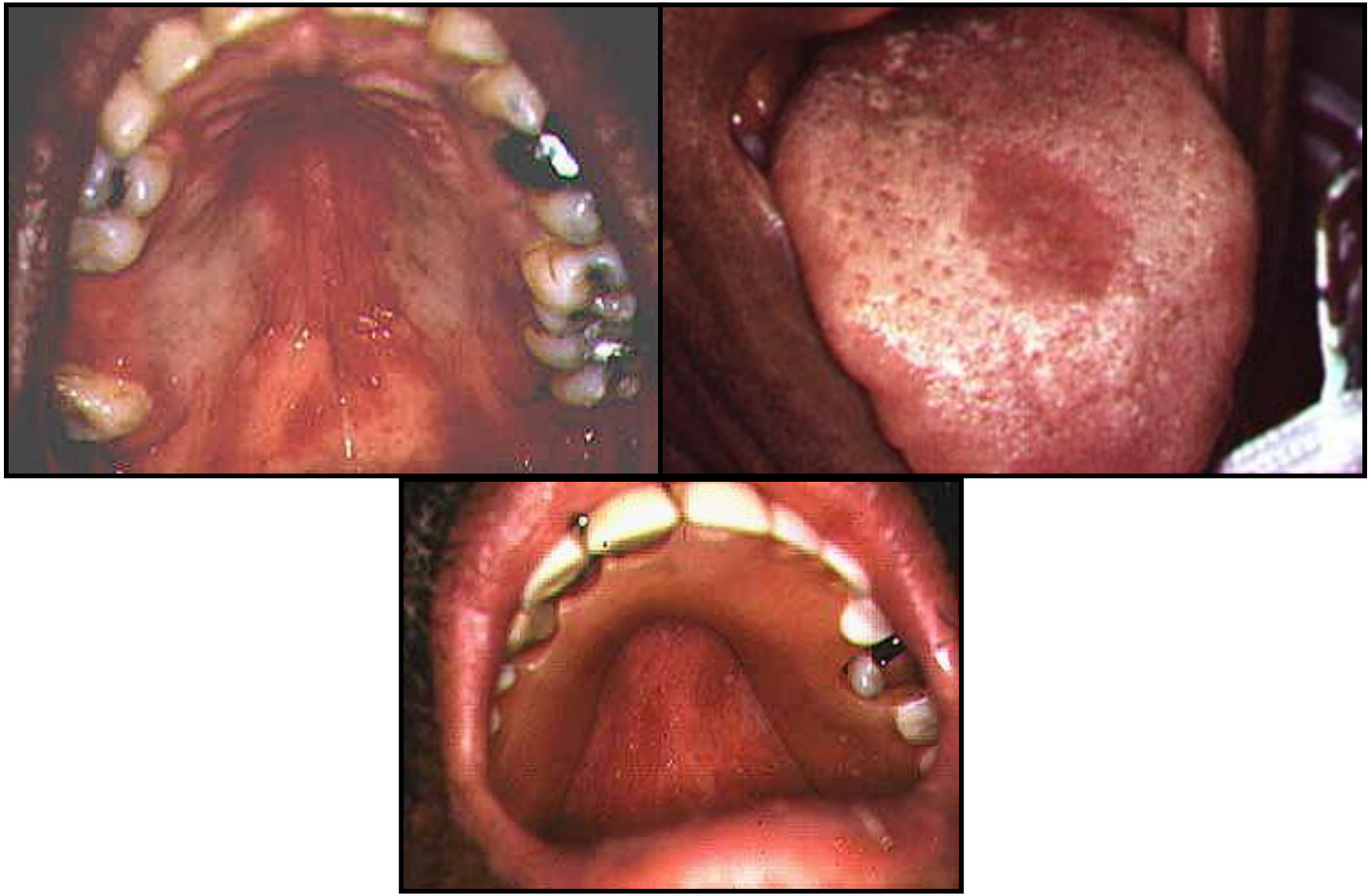
Oral Candidiasis

Pseudomembranous Candidiasis

- ✓ Multiple white to yellow soft plaques
- ✓ Plaques easily removed by gauze
- ✓ Areas may bleed when plaque removed
- ✓ Taste alterations (bitter, metallic)
- ✓ Xerostomia



Erythematous Candidiasis



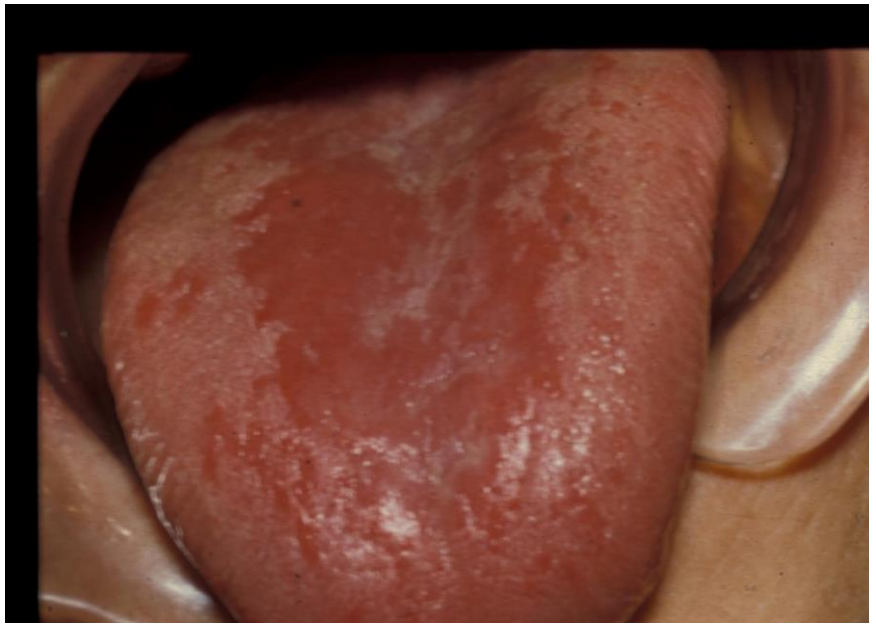
Oral Candidiasis

Erythematous Candidiasis

✓ Spotty appearance

✓ May look like pizza burn/depapillation of tongue

✓Often missed/underdiagnosed



Treatment

- Antifungal medications

Oral Candidiasis

Angular Chelittis

- ✓ Cracking and fissuring
- ✓ Inflammation/irritation
- ✓ Pain upon opening the mouth
- ✓ Bleeding

Oral Candidiasis

Hyperplastic Candidiasis

✓Similar to pseudomembranous but does not rub-off
✓Could be mistaken for leukoplakia
✓Diagnosed through biopsy or diagnostic treatment (KOH)

Treatment For Oral Candidiasis

Rx:
Clotrimazole troches, 10 mg
Disp: 70 troches
Sig: Let 1 troche dissolve in mouth 5 times per day for 14 days. Do not chew. NPO 1/2 hour.

Rx:
Fluconazole tablets, 100 mg
Disp: 15 tablets
Sig: Take 2 tablets stat, then 1 tablet q.d. for 14 days

Rx:
Nystatin Oral Suspension
Disp: 280 ml
Sig: Swish with 5 ml for 5 minutes and spit QID for 2 weeks.

Don’t forget the dentures!

Treatment For Angular Cheilitis

Ketoconazole cream 2%
or

Clotrimazole cream 1%
or

Miconazole cream 2%

Disp: One tube (15 gm)

Sig: Apply to affected areas q.i.d. (after meals, and at bedtime) for 14 days.

Recurrent Aphthous Stomatitis (RAS)

- Most common ulcerative disease of the mouth
- Painful round shallow ulcers with well-defined erythematous
- RAS has a characteristic prodromal that lasts from 2 to 48 hours before an ulcer appears.
- It occurs in otherwise healthy individuals and is typically located on the buccal and labial mucosa and tongue.
- Less likely in keratinized mucosa of the palate and gingiva

Dent Clin North Am. 2014 April ; 58(2): 281–297.
doi:10.1016/j.cden.2013.12.002.

Recurrent Aphthous Stomatitis (RAS)

1. Minor RAS:

- **8 to 10 mm** in size
- Most common variant (**80% of RAS**)
- Heal within **10–14 days** without scarring

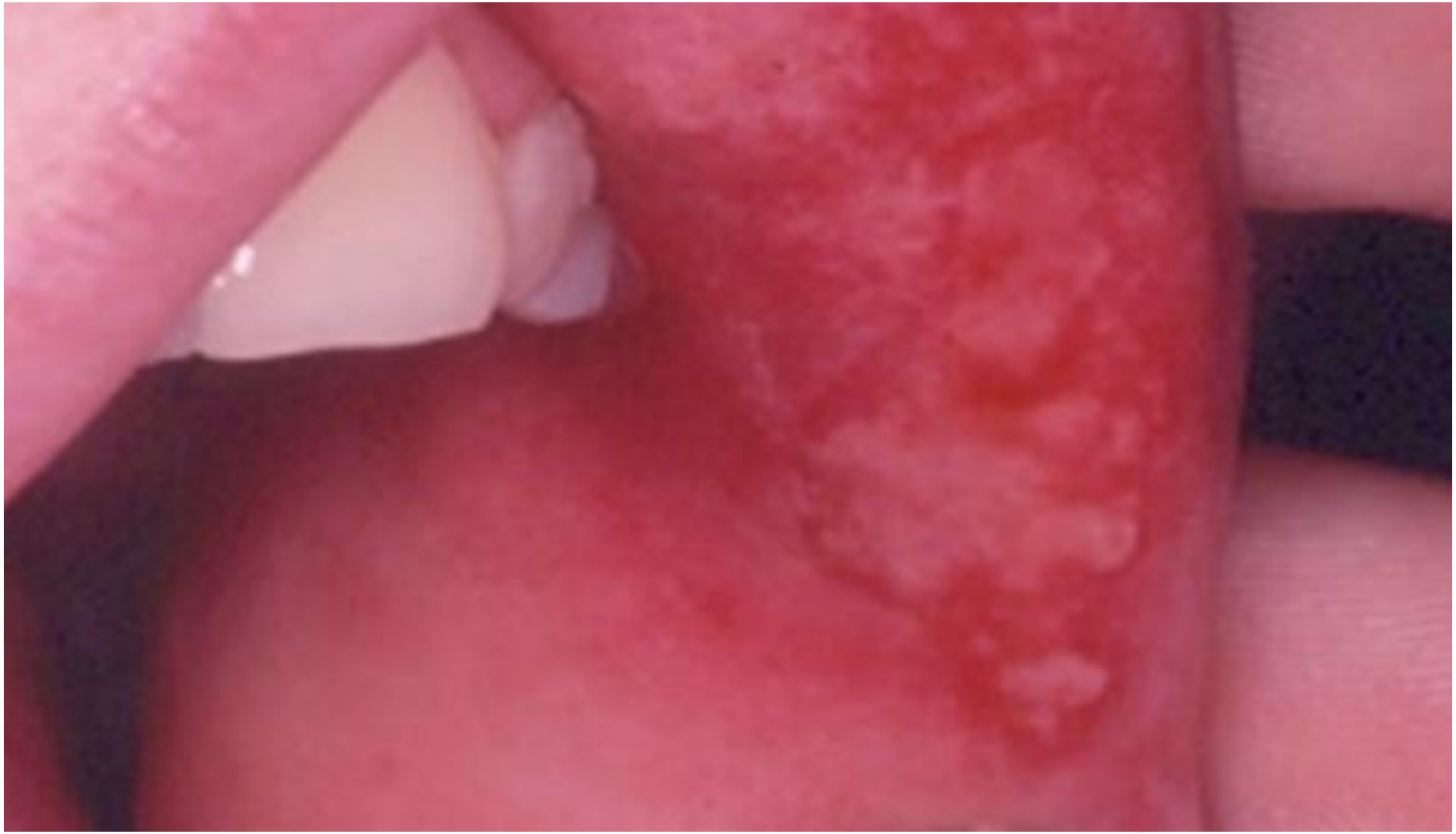
2. Major RAS

- **> 1 cm** in diameter
- **10–15%** of patients.
- Persist for up to **6 weeks** and often heal with scarring.
- **Most common sites** are lips, soft palate

3. Herpetiform RAS

- **2–3 mm** in diameter. May coalesce to form large irregular ulcers
- Lasts for about **10–14 days**
- Unlike herpetic ulcers, these are not preceded by vesicles
- **More common** in women and have a later age of onset than other clinical variants of RAS

J Oral Maxillofac Pathol 2011;15:252-6.



Recurrent Aphthous Stomatitis (RAS)

Table 1: Systemic diseases with recurrent oral ulceration (modified from reference 1)

Disease	Presentation
Behcet's syndrome	Recurrent aphthous ulceration (RAU); ocular: Uveitis, conjunctivitis, retinitis; genital: Scrotal or penile ulcers, vaginal or vulval ulcers, perianal ulcers, epididymo-orchitis; Dermatological: Papules, pustules, erythema nodosum-like skin lesions, cutaneous pathergy response; Artharalgias, Neural: Headaches, meningo-encephalitis
Magic syndrome	Variant of Behcet's syndrome—major apthae and inflamed cartilage
PFAPA	Periodic fever, apthae, pharyngitis, and cervical adenitis. Seen in young children
Sweet's syndrome/acute febrile neutrophilic dermatosis	Fever, increase in PMN in peripheral blood, skin lesions: Erythematous plaques, nodules, vesicles, pustules, dense dermal neutrophilic infiltrate
Cyclic neutropenia	Cyclic reduction in circulating neutrophils. Oral ulceration, cutaneous abscess, upper respiratory infections, lymphadenopathy.
HIV	Apthous-like ulceration

J Oral Maxillofac Pathol 2011;15:252-6.

Recurrent Aphthous Stomatitis (RAS): Management

High potency steroids only (class I or II) (Lidex, Temovate etc)

The main potential side effect is candidiasis

Applications 2-4 times a day

Classification of topical steroid preparations by potency

LOW POTENCY

Alclometasone dipropionate 0.05%
Aclovate (crm, oint)

Fluocinolone acetonide 0.01%
Synalar (soln)

Hydrocortisone base or acetate 0.5%
Cortisporin* (crm)

Hydrocortisone base or acetate 1%
Cortisporin* (oint)
Hytone (crm, oint)
U-cort (crm)
Vytone* (crm)

Hydrocortisone base or acetate 2.5%
Anusol-HC (crm)
Hytone (crm, oint)

Triamcinolone acetonide 0.025%
Aristocort A (crm)
Kenalog (crm, lotion, oint)

INTERMEDIATE POTENCY

Betamethasone valerate 0.12%
Luxiq (foam)

Clocortolone pivalate 0.1%
Cloderm (crm)

Desonide 0.05%
Desonate (gel)
DesOwen (crm, lotion, oint)
Verdeso (foam)

Desoximetasone 0.05%
Topicort-LP (emollient crm)

Fluocinolone acetonide 0.01%
Derma-Smoothe/FS (oil)
Capex (shampoo)

Fluocinolone acetonide 0.025%
Synalar (crm, oint)

Flurandrenolide 0.025%
Cordran-SP (crm)
Cordran (oint)

Flurandrenolide 0.05%
Cordran-SP (crm)
Cordran (lotion, oint)

Fluticasone propionate 0.005%
Cutivate (oint)

Fluticasone propionate 0.05%
Cutivate (crm, lotion)

Hydrocortisone probutate 0.1%
Pandel (crm)

Hydrocortisone butyrate 0.1%
Locoid (crm, oint, soln)
Locoid Lipocream (crm)

Hydrocortisone valerate 0.2%
Westcort (crm, oint)

Mometasone furoate 0.1%
Elocon (crm, lotion, oint)

Prednicarbate 0.1%
Dermatop (emollient crm, oint)

Triamcinolone acetonide 0.1%
Aristocort A (crm, oint)
Kenalog (crm, lotion)

Triamcinolone acetonide 0.2%
Kenalog (aerosol)

HIGH POTENCY

Amcinonide 0.1%
Cyclocort (crm, lotion, oint)

Betamethasone dipropionate, augmented 0.05%
Diprolene AF (emollient crm)
Diprolene (lotion)

Desoximetasone 0.05%
Topicort (gel)

Desoximetasone 0.25%
Topicort (emollient crm, oint)

Diflorasone diacetate 0.05%
Psorcon e (emollient crm, emollient oint)

Fluocinonide 0.05%
Lidex (crm, gel, oint, soln)
Lidex-E (emollient crm)

Halcinonide 0.1%
Halog (crm, oint, soln)

Triamcinolone acetonide 0.5%
Aristocort A (crm)
Kenalog (crm)

SUPER HIGH POTENCY

Betamethasone dipropionate, augmented 0.05%
Diprolene (oint, gel)

Clobetasol propionate 0.05%
Clobex (lotion, shampoo, spray)
Cormax (oint, scalp application)
Olux (foam)
Olux-E (foam)
Temovate (crm, gel, oint, scalp application)
Temovate-E (emollient crm)

Fluocinonide 0.1%
Vanos (crm)

Flurandrenolide 4mcg/sq cm
Cordran (tape)

Halobetasol propionate 0.05%
Ultravate (crm, oint)

*Indicates that the product has more than one active ingredient.

The classification is based on vasoconstrictor assays and clinical studies. Potency varies according to the corticosteroid, its concentration, and the vehicle. In general, corticosteroids in lotions, creams, gels, and ointments are increasingly more potent due to increased absorption from these vehicles.

Absorption is increased by prolonged therapy, large areas of skin damage, and the use of occlusive dressings which may cause an increase in the incidence of side effects. (Rev. 6/2007)

World Health Organization. WHO Model Prescribing Information: Drugs Used in Skin Diseases. Geneva, Switzerland: World Health Organization; 1997.

Recurrent Aphthous Stomatitis (RAS): Management

Topical Medications:

- Tetracycline
- Chlorhexidine gluconate
- Diluted hydrogen peroxide
- Anesthetics such as topical lidocaine (2% viscous solution, gel, or spray) or benzocaine azathioprine
- Topical Cyclosporine
- Isotretinoin gel

Systemic Management:

- Prednisone ± steroid--sparing immunosuppressants
- Cyclosporine, systemic isotretinoin, colchicine, pentoxifylline, dapsone, doxycycline, thalidomide, pidotimod, Aprimelast

Low Laser Therapy

Manfredini M, et al.. Recurrent Aphthous Stomatitis: Treatment and Management. Dermatol Pract Concept. 2021 Sep 1;11(4)

Evaluate appropriate case management strategies ***for suspected malignant lesions,*** *including when to make referrals and consider treatment options*

- Presentation (what you see)
- Persistence (what you hear)
- Location (where you see it)
- Symptoms? (what your patient tells you)

Two-Week Rule

Herve Y. Sroussi, DMD, PhD
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Oral Mucosal Lesions 101: Recognition, Risk Assessment, and Referral

Ken Ikeda, DDS, MPH, FDS RCSEd

Statement Disclosure

I have no actual or potential conflict of interest in relation to this presentation

Contents

- Oral Lichen Planus
- Leukoplakia/Erythroplakia
- Screening for Oral Cancer/Oral Potentially Malignant Diseases (OPMD)
- Confusing cases

Oral Lichen Planus

- Chronic inflammatory condition affects oral mucosa
- Unknown etiology
- Prevalence: 1%
- It can be asymptomatic
- Symptoms varies – mild irritation to severe pain that prevents patients from eating

Oral Lichen Planus

- Intra-oral: Reticular, erosion/ulceration, bullous forms, desquamative, plaque-like

- Extra-oral: PPPP: purple, polygonal, pruritic papules- Flexural surfaces, nails, genitals

Oral Lichen Planus

- Lichenoid reactions (drugs, amalgam, gold) can look identical to LP lesions
- Distinguish from oral lichenoid reaction is not easy – based on history, proximity to fillings, etc.
- Management/treatment is for mainly symptomatic relief
- Management: Topical steroids stay as mainstream
- Premalignant? Recent meta-analysis: 1.1-1.4%

Oral Lichen Planus

- Managements:
  - Avoid/remove irritants
    - Remove the irritants as much as possible
    - Advise to avoid acidic/salty/spicy food
  - Protective agents
  - Topical anesthetics
  - Topical steroids

Oral Lichen Planus

- Managements:
  - Protective agents/topical anesthetics
    - Benzocaine
    - Lidocaine gel
    - Viscous lidocaine
    - Liquid Diphenhydramine
    - Aluminum-Magnesium Hydroxide

Oral Lichen Planus

- Management
  - Topical steroids
    - Dexamethasone 0.5mg/5ml, 5 ml, swish and hold for 5 minutes and spit 2-3 times a day
    - Fluocinonide or clobetasol gel 0.05%
    - Triamcinolone 0.05% paste

Leukoplakia/Erythroplakia

- Clinical diagnosis
- White patch or plaque that cannot be wiped off: process of exclusion
- Histologically: hyperkeratosis, hyperplasia, mild/moderate dysplasia, severe dysplasia, carcinoma in-situ
- Thin leukoplakia: seldom malignant change
- Thick leukoplakia: **1-7% malignant change**
- Granular or verruciform: **4-15% malignant change**
- Erythroleukoplakia: **28% malignant change**

Leukoplakia/Erythroplakia

- Considered as Oral Potentially Malignant Disorders (OPMD)

- Management
  - Biopsy
  - Monitoring vs. excision vs. abrasion

- Screening?

Oral Cancer

- H&N Cancer
  - Account for 5% of all cancer
  - About 50% of H&N cancers occur intraorally
  - Approximately 54,000 new cases of oral cancer are diagnosed each year in the U.S.

Oral Cancer

- The 5-year survival rate;
  - Localized oral – 83%
  - Spread to other area – 32%

Oral Cancer and OPMD Screening

- The US Preventive Services Task Force
  - Concluded that the available evidence was insufficient to assess the balance of benefits and harms of screening for oral cancer in asymptomatic adults
  - The recommendation was intended for primary medical care providers

Oral Cancer and OPMD Screening

- American Cancer Society
  - Recommends that adults aged 20 y or older who have periodic health examinations should have the oral cavity examined as part of a cancer-related checkup

Oral Cancer and OPMD Screening

- American Dental Association
  - Recommends that clinicians perform a visual oral examination in all adult patients during initial, routine, or emergency visits

Oral Cancer and OPMD Screening

- Things to concern:
  - White/red/mixed lesion
  - Surface smoothness/roughness
  - Surface thickness
  - Raised
  - Induration
  - Ulceration
  - Symptoms

Case 1

Case 1

- 52yo M, referred by ENT for eval of white lesions on tongue and gingiva

Case 1 Cont.

- **HPI:**
  - History of white lesion on the tongue for more than 10 years
  - History of **Verrucous Carcinoma on the tongue - excision (19 month ago)**
  - White lesion on the same area was **biopsied/removed (5 month ago):** mild dysplasia with lichenoid features, but no malignancy
  - **About 1 month ago,** he developed white lesions and pain on gingiva as well as FOM/ventral tongue
  - **Aggravating factors:** Eating, anything touching the area
  - **No** known alleviating factors
  - He did not start any new medication or oral product within several months prior to the oral symptoms or the white lesion
  - **Past management:** Some kind of OTC mouth rinse after development of gingival pain - no relief.

Case 1 Cont.

- **PMH:**
  - HTN, Asthma
- **Meds:**
  - Metoprolol, Amlodipine, Irbesartan, Alprazolam, Zolpidem, Proair, Atorvastatin
- **ALL:**
  - NKDA
- **SHx:**
  - Denies use of any tobacco products or recreational drug, ETOH: 7-14 drinks a week
  - Stress level: Medium high - can’t tell if stress is related to symptom of mouth


Kentaro Ikeda,
DDS, MPH , FDS RCSEd


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Case 1 Cont.

- Appearance of tongue was concerning
- Oral lichen planus features
- Treated for oral lichen planus


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Diagnosis: Site: Left ventral tongue **ORAL TISSUE** DOS: 8/9/17

EPITHELIAL DYSPLASIA, MODERATE, LEFT VENTRAL TONGUE MUCOSA.

SEE COMMENT

Comments:

This tissue sample shows a process that is largely moderate epithelial dysplasia. There is one focal area where the dysplasia is bordering on severe. There is moderate dysplasia at the lateral inked excision margins. Additional therapy is recommended.

We appreciate the opportunity to review this case.
/kw

Clinical History:

A lesion of over ten years duration presented affecting the tongue . The patient has had multiple biopsies which showed mild to moderate dysplasia. The current lesion (s) occurred two months ago. The patient has had a history of verrucous carcinoma on the tongue.

Clinical Impression:

A presumptive diagnosis of plaque type oral lichen planus versus dysplasia is submitted.

Gross Description:

Received in formalin is a 0.5x0.3x0.2 cm white soft tissue ellipse labeled with the patient's name and biopsy site. Margins inked in green. Bisected and submitted in toto in one cassette.

Microscopic Description(s):

Sections demonstrate a mucosal ellipse. The ellipse is covered by keratinizing squamous epithelium. The epithelium demonstrates a dysplastic atypia including loss of cellular polarity, basal layer hyperplasia, basal layer budding and dyskeratosis. There is evidence of moderate epithelial dysplasia at the lateral inked excision margins of the specimen. The supporting collagen is chronically inflamed.


Kentaro Ikeda,
DDS, MPH , FDS RCSEd

Diagnosis: Site: Right floor of mouth ORAL TISSUE DOS: 6/2/16

LICHENOID MUCOSITIS, CONSISTENT WITH CLINICAL FINDINGS OF LICHEN PLANUS, RIGHT FLOOR OF MOUTH.

SEE COMMENT

Comments:

This tissue sample does show some mild maturational change in the form of basal layer hyperplasia. It does not meet the criteria for lichenoid dysplasia, but given the fact that the lesion is a plaque-like lesion as opposed to a reticular lesion, affecting the floor of the mouth, close long term follow-up is recommended since 2% of lichen planus cases can undergo malignant transformation.

We appreciate the opportunity to review this case.
/kw

Clinical History:

A lesion presented in a patient with biopsy proven oral lichen planus. The current lesion involves right floor of the mouth.

Clinical Impression:

A presumptive diagnosis of rule out dysplasia/malignancy is submitted.

Gross Description:

Received in formalin is a 0.5x1.0x0.4 cm firm, tan-brown, tissue fragment labeled with the patient's name and biopsy site. Trisected and submitted in toto in one cassette.

Microscopic Description(s):

Sections demonstrate a mucosal ellipse that is covered by keratinizing squamous epithelium. The epithelium shows some evidence of liquefaction degeneration of the basal layer. Colloid bodies are seen in the spinous layer. There is a linear infiltrate of chronic inflammatory cells seen in the superficial collagen. The epithelium does demonstrate some mild maturational change in the form of basal layer hyperplasia. There is no evidence of a malignant infiltrate.


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Case 2

Case 2

- 54yo, M, referred by internist for eval of erosive lesions on right buccal mucosa

Case 2 Cont.

- **HPI:**
  - **White lesion on the tongue -** biopsied 8 month ago **reported** lichen planus with mild dysplasia
  - Right side of the tongue is very sensitive
  - Aggravating factors: Spicy food, OTC mouth rinse (anything containing alcohol), hot temperature, acidic food, crunchy food
  - Alleviating factors: None
  - Past management: Some kind of OTC mouth rinse that did not help. Mouth rinse prescribed by oral surgeon (he cannot remember the name) that did not help - he reports that the mouth rinse was numbing his mouth but it did not alleviate the pain/sensation much. Therefore, he did not use it regularly.

Case 2 Cont.

- **PMH:**
  - DM, HTN, high cholesterol
- **Meds:**
  - Simvastatin, Insulin, metformin, HTN med (he does not recall the name)
- **ALL:**
  - PCN - skin rash

Case 2 Cont.

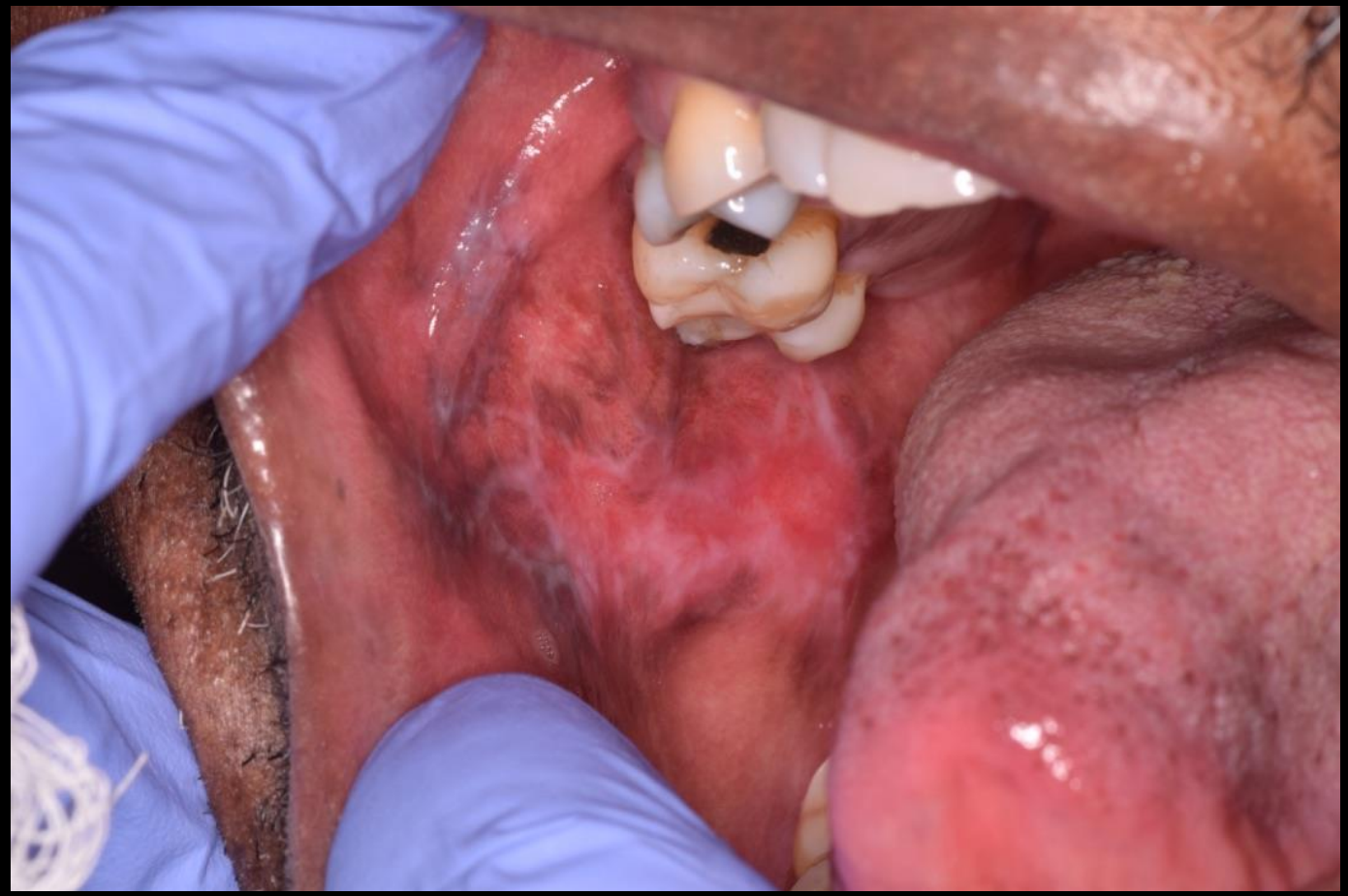
- **SHx:**
  - Pt denies use of any tobacco product or recreational drug
  - Occasional use of ETOH

- **Stress level:**
  - Medium, stress does not seem to worsen his oral lesions/sores

- **Oral products:**
  - No change in oral products before the onset of symptoms

Case 2 Cont.

Case 2 Cont.



Case 2 Cont.

Case 2 Cont.

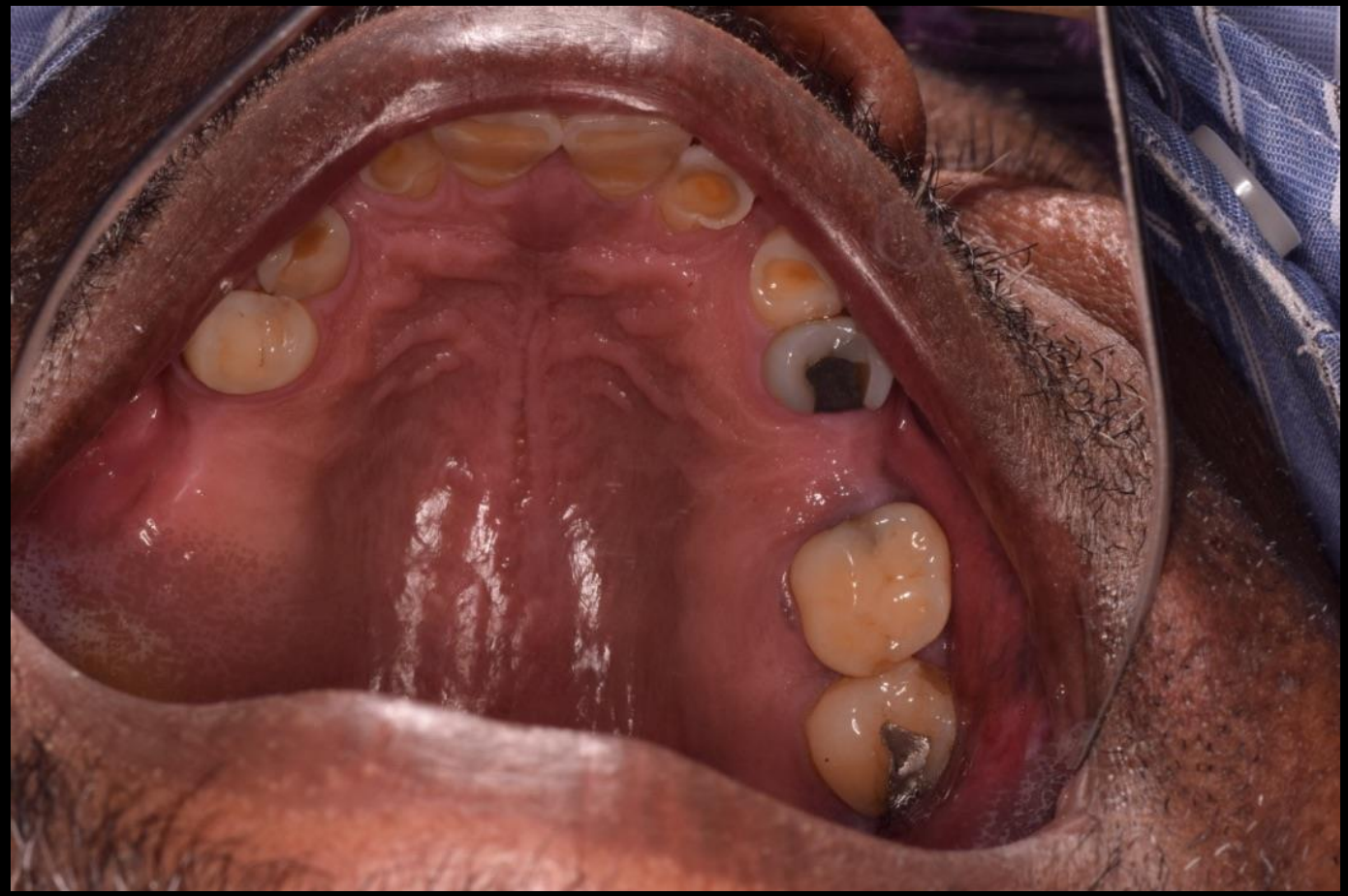
Case 2 Cont.

- A/P:
  - OLP on one side?
  - Differences between right and left in his mouth

Case 2 Cont.

Case 2 Cont.

Case 2 Cont.



Case 2 Cont.

Received from UniPath Laboratories are four H & E stained slides labelled T17-035, T17-306 A & B, along with one KI67 stained slide, one P63 stained slide, a PAS stained slide, and appropriate controls.

Microscopic findings: Tissue sample A demonstrates a mucosal ellipse. The ellipse is covered by keratinizing acanthotic squamous epithelium. The epithelium demonstrates mild maturational atypia in the form of basal layer hyperplasia and basal layer budding. There is lichenoid change along the basement membrane zone with focal liquefaction degeneration of the basal epithelial layer. A chronic inflammatory infiltrate is seen in the superficial collagen. There is evidence of mild basal layer hyperplasia at the lateral excision margins of the specimen. The opposite excision margin of the specimen also demonstrates basal layer hyperplasia.

Tissue sample B: Sections demonstrate a mucosal ellipse. The ellipse is covered by squamous epithelium. The epithelium demonstrates basal layer hyperplasia and mild loss of cellular polarity. There is focal ulceration at one tissue margin. The ulcer is supported by a base of granulation tissue and chronic inflammatory cells. There is basal layer hyperplasia at the inked excision margins of the specimen.

Diagnosis: Lichenoid mucositis with mild dysplastic atypia, right tongue mucosa, (A). Lichenoid mucositis with mild dysplastic atypia, right tongue mucosa, (B).

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- Canadian Academy of Oral and Maxillofacial Pathology and Oral Medicine (CAOMPOM)
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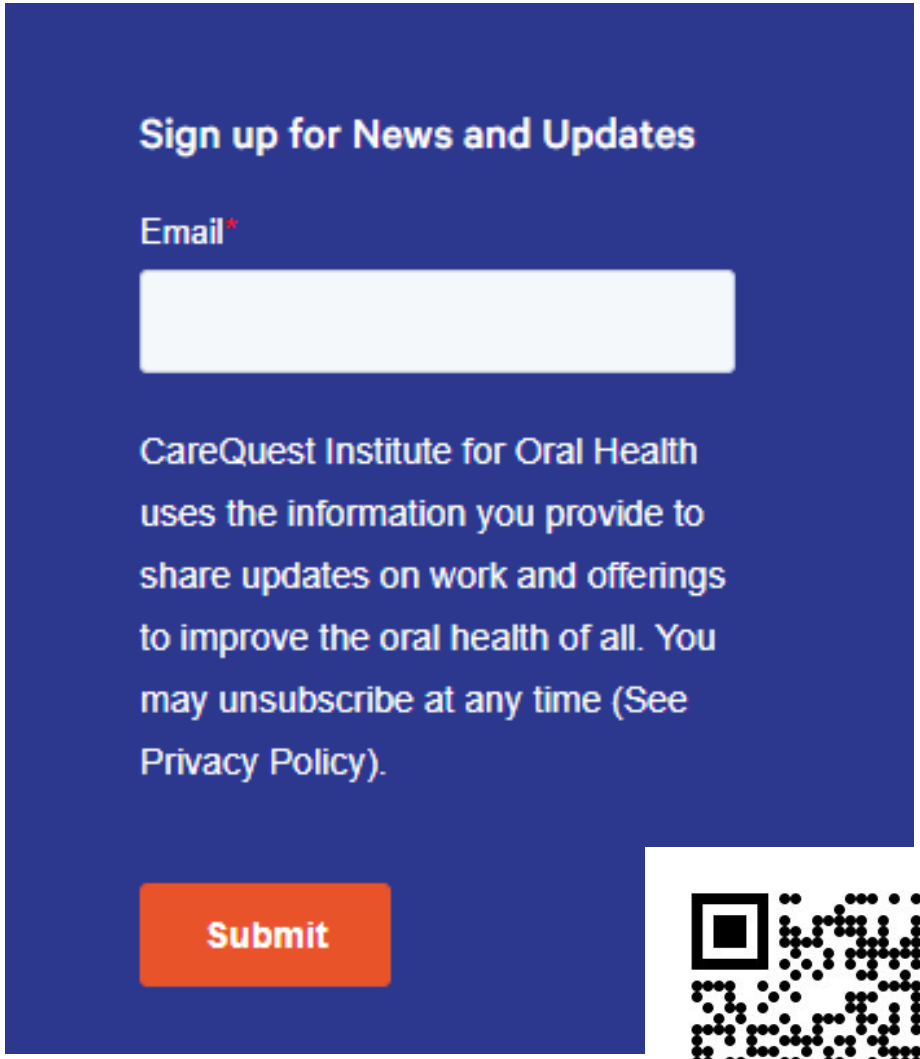

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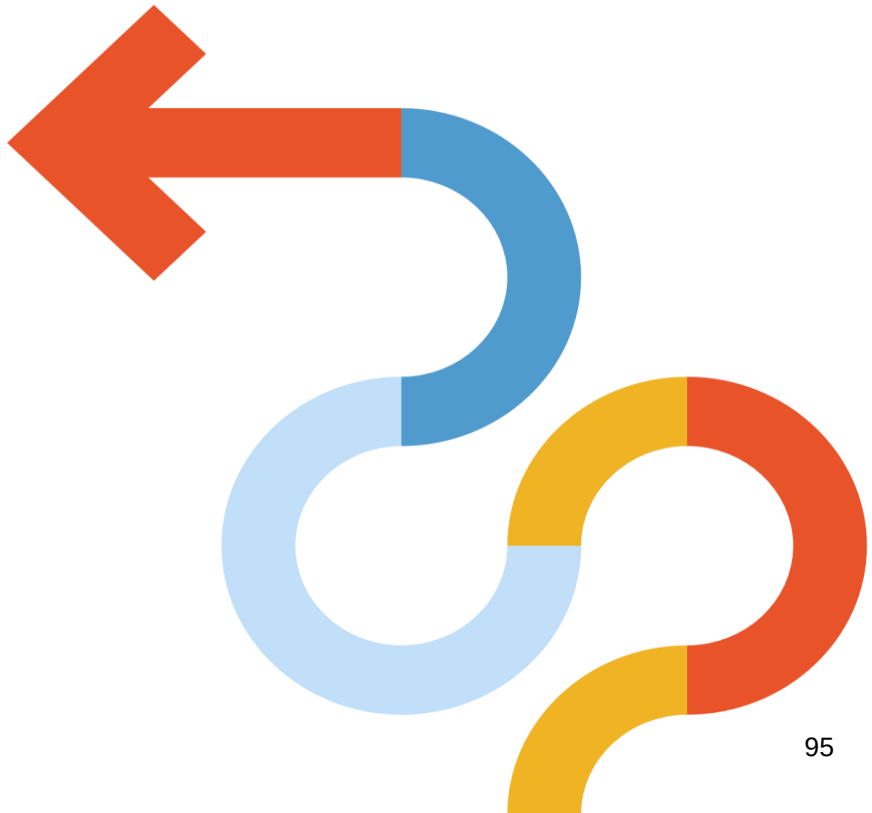

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