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What is your diagnosis?

Tanınız nedir?

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A 58-years-old woman was admitted to our outpatient clinic with the complatint of painful red lesios on her tongue for 6 months. Her medical history revealed that she had undergone thyroidectomia for goiter 2 years ago and had been using levothyroxine sodium since then. She had also been using valsartan and hydrochlorothiazide for hypertension. Dermatological examination revealed 2-3 mm sized purplish papules on the lateral and ventral of the tongue (Figure 1).The routine labaratory tests and thyroid function tests of the patient were within normal limits. The histopathology of the punch biopsy taken from the lesion revealed dilatated, congestioned vessels beneath the stratified squamous epithelium (Figure 2). Magnetical resonance imaging of the neck did not reveal any pathological finding.

What is your diagnosis?

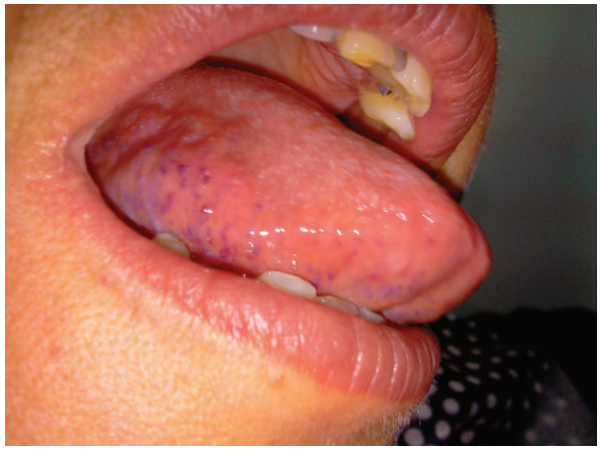
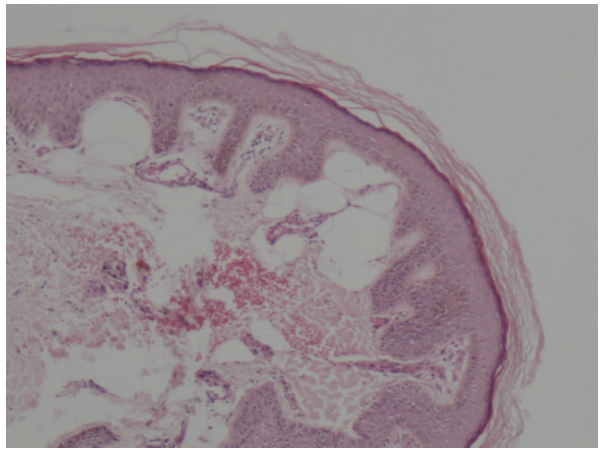


Figure 1. Purplish papules on the lateral sides of the tongue



Figıure 2. Dilatated, congestioned vessels beneath the stratified squamous epithelium (H&E, x40)

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What is your diagnosis?

Tanınız nedir?

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A seventy-five-year male patient presented to our outpatient clinic complaining about firm and swelling in his lips. The patient stated that the lesion had been there for 2 months, growing slightly over time. In his dermatologic examination, we saw a well-demarcated, skin-colored and moderately stiff nodular lesion 7x4 mm in size, which was localized in the right half of his upper lip neighboring the lip commissure (Figure 1). It did not cause any subjective complaints other than occasional itching. The patient was on dialysis due to chronic renal failure. There were not any additional peculiarities in the patient's family history. His hemogram and routine biochemical values were normal with the exception of creatine. A punch biopsy was taken from the lesion. Its histopathological examination showed presence of compact hyperkeratosis, acanthosis, and dense infiltrates consisting of mature plasma cells, lymphocytes and a small amount of neutrophils in the dermis (Figure 2a, 2b). On the basis of these clinical and histopathological findings, what is your diagnosis?

What is your diagnosis?

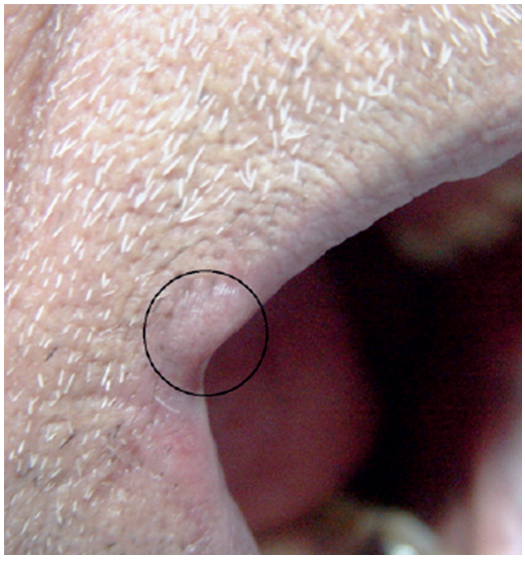

Figure 1. Well-demarcated, skin-colored and moderately firm nodular lesion

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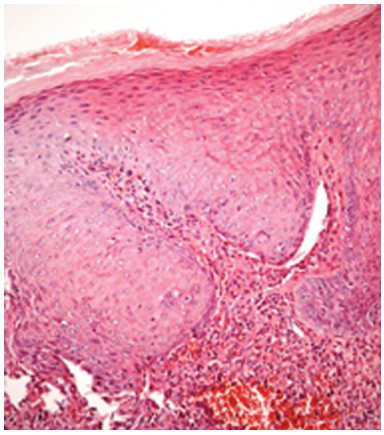

Figure 2a. Compact hyperkeratosis, acanthosis, and dense infiltrates consisting of mature plasma cells, lymphocytes and a small amount of neutrophils in the dermis (H&E x40)

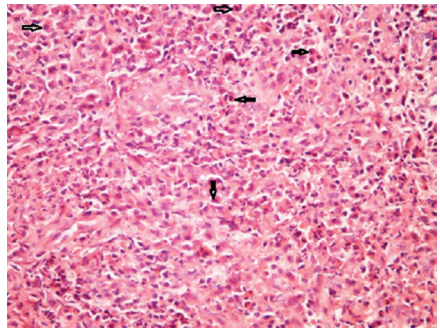

Figure 2b. Mature plasma cells, lymphocytes and a small amount of neutrophils in the dermis (plasma cells marked with arrows) (H&E x100)

Diagnones of the case

Diagnosis: Plasma cell cheilitis

Plasma cell cheilitis is a rare, benign, idiopathic, inflammatory disease that may present with erythema, erosion, ulcers, and sometimes nodular lesions in the lips. Besides lips, such lesions may appear in the penis, vulva, buccal mucosa, palate, tongue, epiglottis, and larynx[1,2]. White et al.[1] suggested using the term 'plasma cell orificial mucositis' to define this common condition that occurs in various parts of the body.

The etiology of the disease is not fully known, but it is thought to be a nonspecific inflammatory response to unidentified exogenous agents such as subclinical infections, poor hygiene, traumas, humidity, Candida, and frictions[3].

Allergic and irritant contact dermatitis, candidiasis, syphilis, actinic cheilitis, cheilitis granulomatosis, and mucosal lichen planus should also be considered when making a differential diagnosis for plasma cell cheilitis. Our case was differentiated histopathologically from contact dermatitis due to lack of spongiosis and eosinophil, from actinic cheilitis due to lack of solar elastosis and keratinocyte atypia, from cheilitis granulomatosis due to lack of granulomatous infiltrates, and from lichen planus due to lack of lichenoid interface dermatitis. The specific and nonspecific screen tests required for syphilis and the direct fungal examination of the lesion were negative.

The treatment of the disease is annoying. Surgical excision, cryotherapy, electrocauterization, CO_2 laser, radiation therapy, topical fucidic acid, intralesionary and topical steroids, systemic griseofulvins, and topical immunomodilators have all been used with varying success rates[2,4,5]. There was an apparent accompanying acanthosis in the histopathology of our patient. Since we thought that this thick epidermal barrier zone can be block the absorption of topical drugs, we did not attempt to prescribe any topical treatment. A surgical excision wasn't suggested ruled out as the patient refused it. Cryotherapy was started for the patient. The lesion recovered nearly total after three sessions of cryotherapy.

Ethics

Informed Consent: Consent form was filled out by all participants.

Authorship Contributions

Surgical and Medical Practices: Hakan Turan, Murat Oktay, Esma Uslu, Cihangir Aliağaoğlu, Concept: Hakan Turan, Murat Oktay, Esma Uslu, Cihangir Aliağaoğlu, Design: Hakan Turan, Murat Oktay, Esma Uslu, Cihangir Aliağaoğlu, Data Collection or Processing: Hakan Turan, Murat Oktay, Esma Uslu, Cihangir Aliağaoğlu, Analysis or Interpretation: Hakan Turan, Murat Oktay, Esma Uslu, Cihangir Aliağaoğlu, Literature Search: Hakan Turan, Murat Oktay, Esma Uslu, Cihangir Aliağaoğlu, Writing: Hakan Turan, Murat Oktay, Esma Uslu, Cihangir Aliağaoğlu.
Conflict of Interest: No conflict of interest was declared by the authors.
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