



Oral Tuberculosis Mimicking a Pyostomatitis Vegetans

Mebazaa A¹, Abdelmalek R^{2*}, Azzouz H³, Haouet S³ and Mokni M¹

¹Departments of Dermatology, La Rabta Hospital, Tunisia

²Departments of Infectious Diseases, La Rabta Hospital, Tunisia

³Departments of Histopathology, La Rabta Hospital, Tunisia

Introduction

Tuberculosis is a chronic granulomatous disease mainly affecting lungs [1-3]. Extra-pulmonary tuberculosis is common in Tunisia, accounting for 57% of all tuberculosis cases [3]. Oral tuberculosis is very rare [1-4]; only 0.05 to 5% of all tuberculosis cases may associate oral manifestations [2].

We report a case of a woman with oral tuberculosis that mimicked pyostomatitis vegetans and revealed laryngeal tuberculosis.

Case Presentation

A 27-year-old female was referred for a painful erosive gingivitis that developed within 1 year. She had a dysphonia for 3 years and a weight loss over the past six months. Physical exam noted multiple white friable pustules based on an erythematous and thickened mucosa mainly on the labial and gingival mucosa. Soft and hard palate were vegetant and papillomatous, strewed with erosions and ulcerations (Figure 1) very suggestive of pyostomatitis vegetans. Otherwise, physical examination was normal. An endoscopic Ear, Nose and Throat exam noted an ulcerated palate, a thickened glottis, nasopharynx and vocal cords, as well as a hypertrophied pharynx posterior wall and a cryptic tonsil. Facial CT showed thickening and enhancement of the larynx wall, nasopharynx and oropharynx with liquid abscesses and multiple cervical lymph nodes.

Mucosal biopsy revealed an epithelial hyperplasia and acanthosis with focal ulcerations. The mucosa and larynx lamina propria was very inflammatory with multiple epithelioid and giant cells surrounded by lymphocytes, without caseous necrosis (Figure 2). Tuberculin skin test was strongly positive. Chest radiograph and thoracic CT revealed multiple lung micro nodules due to miliary tuberculosis. Although samples were negative for Koch bacillus, tuberculosis diagnosis was retained. The patient had 2 months of Isoniazid, Rifampicin, Pyrazinamide and Ethambutol followed by Isoniazid and Rifampicin for 4 months. The voice hoarseness disappeared, and the mucosal oral lesions partially regressed. At the end of TB therapy, oral lesions have totally disappeared.

Discussion

Primary tuberculosis infection most commonly affects the lungs. In most cases, host immunity develops, and the infection does not spread. The most reported cases of adult oral tuberculosis are secondary to pulmonary tuberculosis [1-3]. Predisposing factors such as malnutrition, poor oral hygiene, teeth extraction and periodontal diseases may facilitate penetration of Koch bacilli [1,2]. Some authors suggest that oral tuberculosis may occur from hematogenous spread [1,2,4]. In our case, oral lesions have revealed active laryngeal tuberculosis and a miliary pulmonary infection. So, hematogenous route seems to be the most plausible hypothesis.

Rubin [5], in 1927, has reported 72 oral involvements among 5,000 tuberculosis cases. Tongue and palate were the common locations. According to many authors, the most affected sites are tongue, soft and hard palate, tonsils, salivary glands, gingival, uvula, lips and mandibular ridge [2,4]. Typical clinical features are ulcerations with granular base or covered with pseudo-membrane and irregular edges, tumor-like lesions, painful ulcers, indurated soft tissue lesions, nodules, granulomas, chronic inflammation of gingiva or more rarely pustular and vegetant lesions on palate or tongue [2].

Polymorphic clinical presentation often leads to misinterpretation with other infectious or inflammatory diseases such as pyostomatitis vegetans, Crohn's disease, sarcoidosis, tertiary syphilis, deep fungal infection, and foreign body reaction. In our case, clinical features of vegetations and pustules were very suggestive of pyostomatitis vegetans [5,6]. Tuberculosis was then suspected

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*Correspondence:

Rim Abdelmalek, Departments of Infectious Diseases, La Rabta Hospital, Tunis, Tunisia, Tel: +216-98219899; Fax: +216-71578841; E-mail: rimabdelmalek@gmail.com

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Figure 1: Palate lesions. It shows vegetant and papillomatous aspects of soft and hard palate, strewn with erosions.

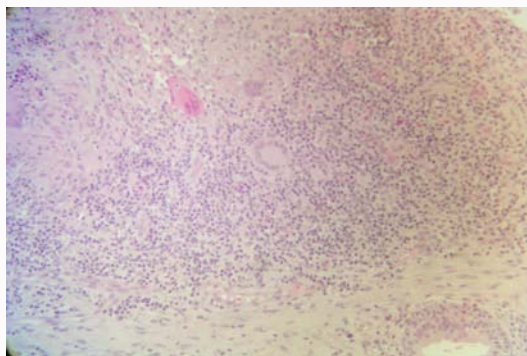


Figure 2: Tuberculosis granulomas. It shows laryngeal biopsy: inflammatory chorion with multiple epithelioid and giant cells forming many tuberculoid granulomas associated with lymphocytic and plasmocytic infiltrates of moderate abundance.

on nasal endoscopy and CT exam. The spectacular improvement of clinical symptoms under TB treatment was additional evidence for diagnosis.

To conclude, oral tuberculosis is exceptional and often misdiagnosed. In case of ulcerated, indurated, non-healing lesions, clinicians should be aware of the possibility of tuberculosis and play a role in the early detection and care of this disease.

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