Oral Mucosal Lesions in Children

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Abstract

Soft tissue lesions of the oral cavity are common in children, have various clinical presentations as colored lesions, mucosal ulceration or Nodular lesions and so. Some are a symptomatic and some are symptomatic or even disturb the daily activities of the child. When evaluating soft tissue lesions, it is important to distinguish between findings that are normal and those that are indicative a pathological condition, and normal anatomical variations. Most of adult oral soft tissue lesions may present in child oral cavity with predilection for some lesions. The literatures regarding oral mucosal lesions in children are relatively few. The most common oral disease, found was caries in priority and cancer therapy-related mucosal disorders.

Keywords: Oral lesions; Children; Soft tissue Nodules; Color changes

Introduction

As a result of usage of various diagnostic criteria, limited oral lesions included in the survey and absence of standardization, the prevalence of oral mucosal lesions in children is controversial. A cross-sectional retrospective study was done by Alessandra Majorana et al. [1] to evaluate the prevalence of oral mucosal lesions in 10,128 children aged 0-12 years in Italy. Oral mucosal lesions were detected in 2,918 (28.9%) children. The most common lesions were oral candidiasis (28.4%), followed by traumatic lesions (17.8%), least common was erythema multiforme (0.9%).

Children with systemic diseases were significantly had frequent oral mucosal lesions in comparison with healthy children. Traumatic oral soft tissue lesion is usually due to habits that cause injuries as food burns, lip and cheek biting, orthodontic devices, Sharp ends of wires in space maintainer or habit breaker, and any traumatic events. Andres Pinto et al in 2014, in his article (Pediatric Soft Tissue Oral Lesions) he divided the lesions into several categorists according to lesions types as follows. Anatomic Variations in Gingiva, Frenum.

a) Developmental Lesions: Geographic tongue, Fissured tongue, Retro cuspid papillae, Gingival overgrowth.


c) Brown-Black Lesions: Physiologic Pigmentation, Amalgam Tattoo/Graphite, Melanotic Nevus.


e) Benign Tumors: Hemangiom a, Lymphatic malformations, Fibroma, Benign neoplasms

Squamous papilloma.

f) Cysts: Eruption cyst

g) Ulcerations: Traumatic ulcers, Aphthous ulcers.

h) Infections: Herpes simplex virus, Coxsackievirus, Herpangina, Hand, foot, mouth, Candida albicans, HIV infection [2].

In regards to Martha A [3] oral soft tissue lesions in children were classified according to their location as followings: Lesions Of The Gums that include, Eruption cyst or hematoma, Pigmentation, Retrocuspid papillae, Parulis (“gum boil”), Gingival overgrowth,
Gingival recession, HIV gingivitis, Other lesions. Lesions Of The Tongue include, Ankyloglossia ("tongue-tie"), Congenital lingual melanotic macules, Geographic tongue, Fissured tongue, Mucoceles, Other lesions. Lesions of the Lips involves, Herpes labialis, Angular cheilitis, Freckling, Abnormalities of the labial frena, Mucoceles and ranulas, Other lesions. Lesions Of The Palate which are, Herpangina and Other lesions. Lesions of the Buccal Mucosa. Lesions That Occur at Multiple Sites as Benign tumors (Hemangiomas, Lymphangiomas)

Traumatic overgrowth (Irritation fibromas, Peripheral ossifying fibromas, Pyogenic granulomas, Peripheral giant cell granulomas, Ulcerations, Traumatic ulcers, Aphthous ulcers and Infections. Most of the oral lesions were diagnosed bases on clinical findings [4,5]. Some of the oral lesions are common as infection especially Herpes simples viral infection were found in 6.9% of children, regardless of the systemic health status, the primary attach is with severe oral and systemic clinical presentation usually [6]. In addition, acute pseudo membranous candidiasis is more likely to occur in children with systemic diseases, owing to local and systemic predisposing factors (immune-deficiencies, diabetes, endocrine disturbances, antibiotic therapies, corticosteroids therapies, malignancy, asthma, xerostomia and poor oral hygiene). Angular Cheilitis which is chronic atrophic erythematous kind of fungal infection at commissures [7,8]. Traumatic lesions as traumatic ulcers are mostly located in the tongue as it is the most motile organ in the oral cavity. Mucoceles may occur any were in the oral mucosa on lips, buccal mucosa, tongue and palate. In children were commonly located on the lower lip [9]. Histopathologic examination of the mucoceles revealed that almost all of them were of the extravasation type [10].

Localized reactive hyperplastic lesions such as, peripheral giant cell granuloma, focal fibrous hyperplasia, peripheral ossifying fibroma and pyogenic granuloma, all are result from chronic low grade irritation. Although it is of commonly observed in the second decade of life but it can occur in childhood the gingiva frequently affected site with a higher maxillary prevalence. Most of these lesions were symptomatic, nodular with bleeding with low recurrence rate [11]. Others rare lesions as in gingival fibromatosis is a rare, slowly-growing fibrous genetic and clinical heterogeneity, it could be drug induced or as a part of a syndrome. When gingival fibromatosis is a clinical manifestation of a syndrome is usually associated with generalized hypertrichosis, mental retardation, or epilepsy for such oral lesion with any systemic relation should be taken in consideration for the patient treatment planning and management [12]. Absence of the inferior labial and lingual frenulum was found to be associated with Ehlers-Danlos syndrome, the classical and hypermobility types [13]. On the other hand Ankyloglossia which short, tight, lingual frenulum that cause impaired tongue function due to limitation in its movement. It is a congenital uncommon oral anomaly [14]. The oral cavity congenital malformations could involve any part of oral cavity, lips, floor of mouth, jaws, the hard palate, tongue and floor of mouth, as single or as more than single defect [15]. Few reports found regarding fissured tongue, Benign Migratory Glossitis (geographic tongue) in children. A transient harmless benign oral condition with low prevalence in paediatric population and of uncertain aetiology. The condition could be symptomatic in infected or asymptomatic [16].

Pigmented lesions as white lesion may present in children as in adults Linea alba, Leukokeratoma, White sponge nevus in which all are asymptomatic [17] while red purpur lesions could be due to local or systemic reason resulting in Petechiae, Purpura, Ecchymosis. Median Rhomboid Glossitis, a symptomatic in most patients, however, in some cases it is painful especially on irritation, revealed that although Mustafa Goregen et al. [18] found a significant association between Candida and diabetes mellitus and Median Rhomboid Glossitis, and that some risk factor were encounter [19]. Melanotic nevi present as localized brown, blue, gray, black, or colorless macule papule. The color variation depending on the location or depth, quantity of the pigmentation, the superficial appear brown the deeper looks blue or black that makes the diagnosis of the pigmented oral lesions challenging and crucial for the exclusion of potential risk of malignancies [20,21].

References


