CASE REPORT

Malignant Transformation of a Potentially Low Risk Lichenoid Reaction
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ABSTRACT
Lichenoid reaction represents a family of oral lesions identical, both clinically and histologically to oral lichen planus. The triggering factor for this lesion varies from medicines to dental materials, usually demonstrating a cause-effect relationship unlike lichen planus. We present a typical case of lichenoid reaction on the buccal mucosa that appeared in response to betel quid which progressed to carcinoma during a follow-up period of 6 months. Lichenoid reactions occurring in response to known carcinogens and that occurring in risk group population has to be observed more cautiously.

Key words: Lichenoid reaction. Oral lichen planus. Malignant transformation.

INTRODUCTION
Lesions of the oral mucosa that resemble lichen planus clinically, with a distinct etiology and less characteristic morphology are referred to as oral lichenoid reactions or oral lichenoid lesions (OLLs). The malignant transformation of the OLLs is calculated as 0.71% per year.1 A case report of a 50 years old male patient diagnosed clinically and histologically as lichenoid lesion that turned into malignancy within a short span of time is presented hereby.

CASE REPORT
A 50 years old male patient presented with a complaint of burning sensation on left buccal mucosa on taking hot and spicy food for one month. Patient had the habit of chewing betel leaf mixed with tobacco, areca nut and slaked lime 4-5 times a day for 2 years. On intraoral examination, fine grayish white radiating lines interspersed with erythematous areas measuring 2 cm in longest dimension were noticed in relation to left posterior buccal mucosa. The lesion was non-tender and non-scrapable. After clinical evaluation and histopathological confirmation a diagnosis of lichenoid lesion was arrived at. Patient was put on antioxidants and topical Triamcinolone acetonide after giving proper habit counselling. He was kept under regular observation. However, after 3 months, lesions were noticed to be more whitish in appearance and more plaque like compared to the previous radiating striae (Figure 1). Vital staining with toluidine blue was followed, which was readily taken up by the lesion (Figure 2). An incisional biopsy was carried out and subjected to histopathological analysis which revealed stratified squamous keratinised epithelium exhibiting disruption of basement membrane with infiltration of dysplastic epithelial islands suggestive of severe dysplasia changing into SCC (Figure 3). Surgical excision of the lesion was done followed by placement of graft.

DISCUSSION
Four types of oral lichenoid lesions (OLLs) can be distinguished. These include amalgam restoration associated lesions; drug related lichenoid lesions; lichenoid lesions in chronic graft versus host disease (cGVHD) and OLL, unclassified which include lesions that have a lichen planus like aspect, but that lack one or more characteristic clinical aspect such as bilateral presentation.2 OLP-like lesion has been observed in Indian betel-tobacco chewers during an epidemiologic study of oral cancer and pre-cancerous lesions of Indian population in Kerala, India.3 This OLP-like lesion consisted of white, linear, wavy, parallel, non-elevated streaks which could not be scraped off. In some instances the lesions radiated from a central erythematous area. The fine white lines however, did not overlap or criss-cross as in classical OLP. The lesion generally presented at the site of placement of the betel quid. The term ‘betel-quid lichenoid lesion’ is used to describe this OLP-like lesion.4 The case presented over here was similar to this. It was also been shown that increased numbers of granulated mast cells in areas of basement membrane degeneration, increased vascularity and increased PAS-positive basement membrane thickness is seen in OLP when compared with oral lichenoid lesions.5

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The malignant transformation of the OLL group has been estimated to be 0.71% per year. The patients with OLL have an increased risk of development of oral cancer. So OLL patients have to be monitored twice a year for early detection of possible malignant transformation. As in OLP the question arises whether one or all types of OLL are to be considered a potentially malignant disorder. This case was monitored regularly and on noticing the unusual change, vital staining followed by an excisional biopsy was done, which was later histopathologically diagnosed as squamous cell carcinoma. Regular follow-up and subsequent intervention was crucial in determining and treating this potentially low risk lichenoid reaction which in a short span had turned into a malignancy.

The malignant transformation rate in individual types of lichenoid lesions is not well documented in the literature. It is suggested hereby that lichenoid reactions occurring in response to known carcinogens and in risk group population have to be observed regularly at short intervals as rapid malignant transformation is quite a possibility and an early diagnosis leads to better prognosis.

REFERENCES


