ISSN: 2395-6429

INTERNATIONAL JOURNAL OF CURRENT MEDICAL AND PHARMACEUTICAL RESEARCH

IJCMPR

Available Online at http://www.journalcmpr.com

DOI: http://dx.doi.org/10.24327/23956429.ijcmpr20170337

CASE REPORT

MEDIAN RHOMBOID GLOSSITIS WITH PALATAL 'KISSING LESION'-A CASE REPORT OF 12 YEAR OLD CHILD

Mallika S Shetty[1]., Uma MayoorPrabhu[1]., Kevin Fernandez[2]., PrakyathMalli[2]., Faizan Ahmed Khan[3] and Prasanna Kumar Rao[4]

[1,2]Department of Prosthodontics, Yenepoya Dental College, Yenepoya University, Deralakatte, Mangalore

[3]Department of Orthodontics, Yenepoya Dental College, Yenepoya University, Deralakatte, Mangalore

[4]Department of Oral Medicine & Radiology, A.J Institute of Dental Sciences, Kuntikana, Mangalore

ARTICLE INFO

Article History:

Received 8th September, 2017

Received in revised form 20th October, 2017

Accepted 16th November, 2017

Published online 28th December, 2017

Key words:

Median rhomboid glossitis, kissing lesion, tongue, palate.

ABSTRACT

Median rhomboid glossitis (MRG) is characterized by a shiny oval or diamond-shaped depapillated region on the dorsal midline of the tongue situated anterior to the circumvallate papillae at about the junction of the anterior two third and posterior one third of the tongue. Dentists play an important role in the diagnosis and management of oral fungal diseases. Awareness of the signs and symptoms of oral fungal diseases could aid in early diagnosis, and proper treatment. This paper reports a case of kissing lesion in a 12 year old female patient.

INTRODUCTION

Median rhomboid glossitis (MRG) is characterized by a shiny oval or diamond-shaped depapillated region on the dorsal midline of the tongue situated anterior to the circumvallate papillae at about the junction of the anterior two third and posterior one third of the tongue.[1]

The specific location suggests a developmental anomaly related to persistence of an embryonic structure, 'tuberculumimpar'. However, the lesion is now believed to be a localized chronic infection by Candida albicans. Sometimes, MRG occurs in association with candidal commissural leukoplakias and palatine kissing lesions.[2] usually results from direct inoculation that occurs when the dorsal tongue makes contact with the hard palate during deglutition. While most of the cases are asymptomatic, some patients complain of persistent pain, irritation, or pruritus.[3]

There are several pre- disposing factors associated with MRG such as smoking, denture wearing, diabetes mellitus, use of inhaled steroids and broad-spectrum antimicrobial use. It has been shown, as well as candidal infections.[4,5,6] The estimated prevalence of MRG among children in India is reported to be 3.7 %.[7] Because of patient concern and sometimes symptoms, it is always important to be able to assure patients that these conditions are neither precancerous nor contagious.

Case report: A 12 year old female patient was reported to our dental Out Patient Department with a chief complaint of redness in the midline of the dorsum of the tongue.

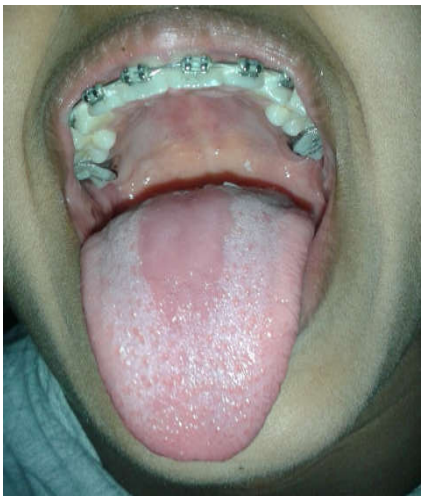

Figure 1 Depapilation on the dorsum of tongue and redness seen on the palate.

Occasionally, there was slight burning sensation when she ate spicy food. On examination the tongue appeared to have a white coating that was thicker in some areas. The filiform papillae appeared denuded in the central portion and the tissue within the central part of the tongue had a smooth, pink appearance as well, with the darker pink areas forming an oval shape. A similar lesion was found in the hard palate so a diagnosis of kissing lesion was given.(Figure 1)

The child was undergoing orthodontic treatment for the past 10 months. Review of her medical history revealed that she was under steroid inhaler for the past four months. Advised Candid lotion (clotrimazole) application daily three times for fifteen days. Patient reported back after fifteen days with complete remission of the lesion.(Figure 2 & 3)

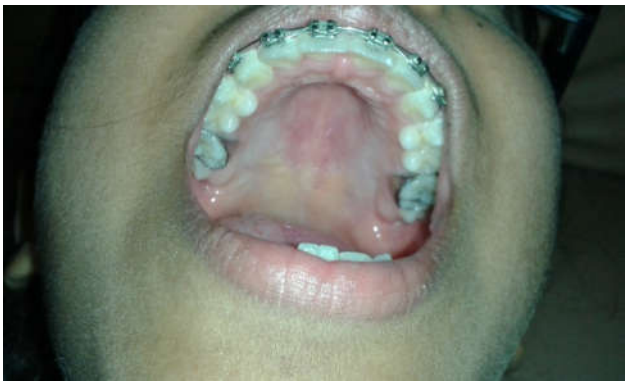

Figure 2 Post Treatment -Healed palatal lesion

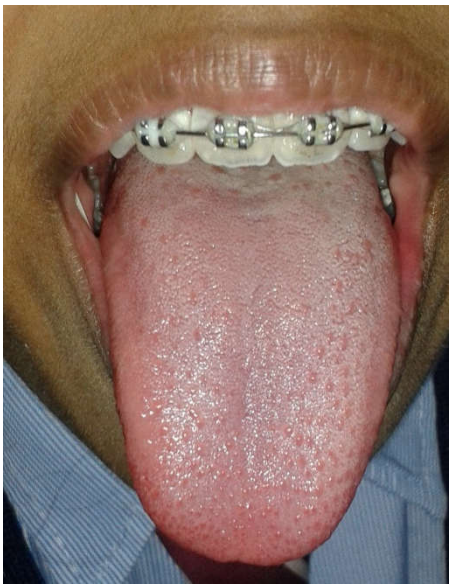

Figure 3 Post Treatment – Healed tongue

DISCUSSION

When MRG is found in association with palatal inflammation corresponding to contact with the involved area on the tongue, it is called kissing lesion; immunosuppression should be suspected in such cases. The Candida species of kissing lesions were the same as those of MRG. Therefore, this finding may suggest that these lesions occur as a result of prolonged contact between the Candida-infected midline dorsum of the tongue and the hard palate.[8]

There are drugs that suppress an individual's resistance to infections by suppressing either the nonspecific inflammatory response or the T-cell-mediated immunity which could in turn predispose individuals to OC. Drugs that come under this category are the corticosteroids used in various inflammatory and immune-mediated diseases. Steroid inhaler medications, intraoral topical steroid preparations.[9]

In this case report the child is under steroid inhaler and it has been shown in several studies that use of inhalational steroids and broad-spectrum antibiotics alter the normal bacterial flora of the mouth cavity and results in overgrowth of Candida spp. By removing competition for growth.[10] The prognosis is good for oral candidiasis with appropriate and effective treatment

CONCLUSION

Dentists play an important role in the diagnosis and management of oral fungal diseases. Awareness of the signs and symptoms of oral fungal diseases could aid in early diagnosis, and proper treatment.

References

1. Dahl PR, *et al*. Jadassohn-Lewandowski syndrome (pachyonychiacongenita). *Semin Dermatol* 1995:14;129
2. Zegarelli DJ. Fungal infections of the oral cavity. *Otolaryngol Clin North Am* 1993: 26; 1069-89
3. Carter LC. Median rhomboid glossitis: Review of a puzzling entity. *Compendium1990*:11;448-51.
4. Van der Wal N, van der Kwast WA, van der Waal I. Median rhomboid glossitis: A follow-up study of 16 patients. *J Oral Med* 1986:41;117-20
5. Soysa NS, Ellepola AN. The impact of cigarette/tobacco smoking on oral candidiasis: an overview. *Oral Dis* 2005:11;268-73.
6. Bhattacharyya S, Satarupa B. Fungal infections of the oral cavity. *Int J Cur Res Rev* 2013:5; 83-8
7. Patil S , Kaswan S, Rahman F, Doni B. Prevalence of tongue lesions in the Indian population. *J ClinExp Dent* 2013:5;128-32.
8. Goregen M, Miloglu O, Buyukkurt MC, Caglayan F, Aktas AE. *European journal of dentistry* 2011:5;367-71
9. Ellepola AN, Samaranayake LP. Inhalational and topical steroids and oral candidosis: A mini review. *Oral Dis* 2001:7;211-6
10. McIntyre GT. Oral Candidosis. *Dent Update* 2001: 28;132-39

****