

Primary Manifestation of Sarcoidosis Involving the Gingivae

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ABSTRACT

Sarcoidosis of the gingiva is rarely the primary manifestation of the disease. The following case presentation highlights clinical signs and symptoms that are not uncommon or unusual except for the anatomical location of the initial expression. Appropriate treatment must be based on a definitive diagnosis which, in turn, requires a biopsy for histologic analysis.

Keywords: Sarcoidosis, Gingivae, Oral cavity.

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INTRODUCTION

Sarcoidosis is a granulomatous disorder that is characterized by noncaseating granulomas that may affect any organ.^{1,2} Frequently, bilateral hilar lymphadenopathy, pulmonary infiltration and cutaneous and ocular lesions are common manifestations.^{1,2} This disease may have a multisystem presentation with 90% of cases having pulmonary manifestations.³ Symptoms of pulmonary involvement are likely to include dyspnea, nonproductive cough, chest pain, wheezing and nasal congestion and hemoptysis.⁴ Though the pulmonary system is the most commonly targeted organ system, only 43% of patients with this involvement have minimal symptoms and near normal results in lung function tests.⁴ Multiple organs and progressive pulmonary involvement indicate a poor prognosis with a mortality rate of approximately 5% in such cases.⁵

Cutaneous involvement of sarcoidosis is common and has a reported incidence of 9 to 37%.⁶ In the United States, African-Americans have a higher incidence and females are more likely to develop cutaneous sarcoidosis in comparison to males.⁷ The peak onset of the disease is most often observed in adults between the ages of 20 and 29.⁸ Skin lesions that contain sarcoid granulomas are histologically classified as specific lesions and often present in association with the chronic course of this disease. Nonspecific lesions may not present with the typical noncaseating granulomas, but are commonly noted with acute presentation of sarcoidosis.^{9,10} Clinical presentations may be alopecia, erythroderma, subcutaneous nodules, erythema nodosum, macules, papules and plaques and lupus pernio.⁶

Involvement of the oral mucous membranes is unusual and distinctly rare: Tongue (23%), buccal mucosa and vestibule (23%), lip (23%), hard and soft palate (17%) and gingiva (14%) indicating that oral sarcoidosis affects any site of the oral mucosa excluding the floor of the mouth.^{11,12} Sarcoidosis of the gingivae as the primary or initial clinical lesion must be considered highly unusual as there are relatively few reports of gingival sarcoidosis. Gingival sarcoidosis often appears as drug-induced gingivitis.¹³ Oral mucosal involvement in sarcoidosis usually manifests after systemic symptoms develop.¹² Oral manifestations of sarcoidosis have been described and include multiple, nodular, painless, indistinct ulcerations of the gingiva, buccal mucosa, labial mucosae and palate. Biopsy of oral sarcoidosis lesions reveal noncaseating granulomas with associated multinucleate giant cells and a lymphocytic infiltrate.^{1,3}

Other granulomatous diseases must be considered in the differential diagnosis, such as Wegener granulomatosis, Crohns disease or tuberculosis.^{1,3,14} Treatment often involves the use of systemic corticosteroids when given early in the course of the acute disease.⁵ Exact use of indications, dosing, duration of therapy and effect on the natural history of the disease remain unclear.⁵ Other drug choices, such as antimalarial, immunosuppressive and anti-inflammatory drugs have been used with some success in improving symptoms and suppressing inflammation.¹⁵ Treatment of sarcoidosis typically depends on the pulmonary function and severity of the symptoms. Patients with the acute disease may experience spontaneous resolution of the disease, undergo remission, or may not have symptoms significant enough to warrant treatment.⁵ Thus, treatment of sarcoidosis is individualized based on severity of disease and symptoms. Accurate diagnosis of sarcoidosis can be a challenge to clinicians. This disease is a 'disease of uncertainty' in terms of its cause, presentation and clinical course.⁸ Referred to as the 'great imitator', cutaneous sarcoidosis may mimic a wide array of dermatological conditions that may hinder the initial diagnosis by clinicians.⁸ Diagnosis of sarcoidosis is established based upon history, pulmonary function tests, chest radiograph, hematology, biochemical investigations and histologic studies.¹ Thus, awareness of this condition is essential for practitioners as an alternative diagnosis.

CASE REPORT

In 2010, a 28-year-old Caucasian female was referred to the UMKC School of Dentistry, Graduate Department of Periodontics from the Oral Pathology Department concerning the patients' labial gingiva. This patient's chief complaint involved red, swollen gums located on the lower arch that were esthetically displeasing to her. Hypertrophic tissue, isolated to the labial gingiva on the lower arch was noted. This particular area had been excised before, as stated by the patient, but the tissue had regrown to the current state. No health history concerns or allergies were listed by this patient and hereditary factors did not contribute to the case. Evaluation of the area revealed that the patient had localized moderate periodontitis with isolated class III mobility on tooth number 24 (Fig. 1).

Past history revealed that a biopsy in this particular area had been taken in 2006. Erythematous hypertrophy of the gingiva had been present throughout the entire mouth for many years before this initial biopsy. It consisted of a $1.0 \times 0.7 \times 0.3$ cm piece of tan, soft tissue from the buccal anterior

mandible. The tissue exhibited a robust lymphoplasmacytic infiltrate and numerous giant cell foreign body granulomas. This was suggestive of foreign body gingivitis.

Presenting with a similar condition as in 2006, a second biopsy was obtained in 2010 on the labial mucosa/gingiva on teeth 21 to 28. The tissue presented with a more strawberry-like texture. Sections of the gingival mucosa exhibited a brisk lymphoplasmacytic infiltrate punctuated by numerous epithelioid granulomas. Birefringent foreign materials were identified in a few of the granulomas, but most were noncaseating and free of foreign body. Granulomatous gingivitis was the diagnosis with sarcoidosis being considered as a differential diagnosis.

Presenting with further reddened, hyperplastic tissue with a granular surface texture and bone loss in 2011, a third and final biopsy was obtained (Figs 2 and 3). Within this specimen, the superficial lamina propria revealed numerous noncaseating, sarcoid-like granulomas with epithelioid cells and multinucleated giant cells in a background of a lymphoplasmacytic infiltrate (Figs 4 and 5).



Fig. 1: Intraoral photograph of patients' mandibular anterior sextant taken in 2010



Fig. 3: Intraoral photograph of patients' lower anterior region from 2011



Fig. 2: Full mouth series of radiographs from 2009

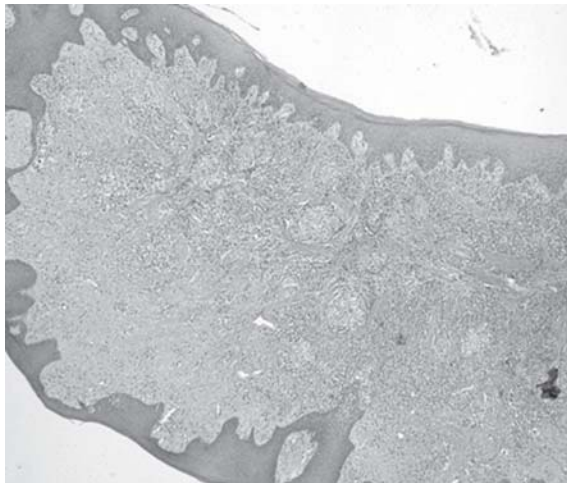


Fig. 4: Low power view of a section of gingival tissue from 2011. The specimen is surfaced by mildly hyperplastic epithelium. Within the lamina propria, several noncaseating granulomas can be seen interspersed between bands of dense collagen and a florid chronic inflammatory cell infiltrate. Hematoxylin and eosin stained (original magnification: $\times 50$)

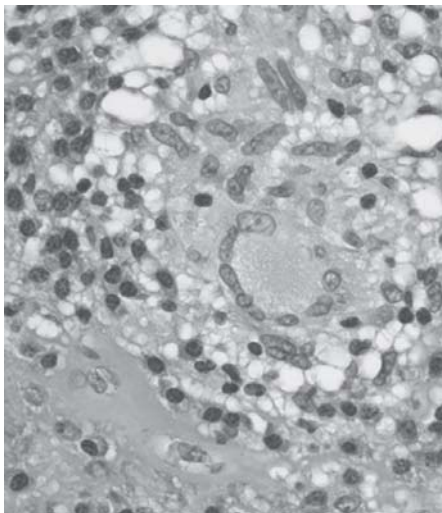


Fig. 5: High power view of a section of gingival tissue from 2011. This high power view shows the detail of one of the noncaseating granulomas. It is comprised of epithelioid histiocytes and a lymphoplasmacytic infiltrate. A prominent multinucleated giant cell can be seen on the center-right of the field. Hematoxylin and eosin stained (original magnification: $\times 1,000$ oil)

Clinical information revealed hilar lymphadenopathy and the patient was referred to her physician for a computed tomographic (CT) examination of the chest. This revealed a nonspecific ground-glass opacity of the upper left lobe measuring 15 mm in dimension, noncalcified pulmonary nodules and a 7 mm nodular density of the left breast. The interpretation of the imaging, in conjunction with the clinical information, and the histopathology, confirmed the diagnosis of sarcoidosis. This patient was placed on a systemic corticosteroid regimen until further recommendations by the overseeing physician were given.

CONCLUSION

Sarcoidosis is a disease of exclusion that mimics multiple alternative diseases. Though presentation of sarcoidosis in the oral cavity is rare, clinicians should be versed and aware of this condition as a possibility for diagnosis.

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