A 76-year-old woman presented with a 1-month history of a rapidly expanding painful ulcerated nodule on her tongue following tooth extraction. Triamcinolone acetonide ointment was applied twice daily for 1 month without any benefit. The histopathology of the excision specimen was consistent with an eosinophilic ulcer of the oral mucosa. There has been no recurrence 12 months later.

**Key words:** oral mucosa, traumatic ulcerative granuloma with stromal eosinophilia.

**CASE REPORT**

A 76-year-old woman presented with a 1-month history of a rapidly expanding ulcerated nodule on the right lateral border of her tongue. The patient had severe pain that disturbed her eating. A tooth had been extracted under local anaesthesia 2 days prior to the onset of the ulcer. The patient stated that her tongue had been quite traumatized during the extraction. Topical antiseptic mouthwashes and oral analgesics had been given during the dental extraction. She denied any other physical or chemical injuries. The patient was taking no other medications. Her past medical history was unremarkable. She did not have a history of aphthous ulceration or stomatitis, vasculitis, autoimmune connective tissue diseases, or sensory or autonomic dysfunction. On dermatologic examination, a regularly shaped nodule 1 cm in diameter with central punched-out ulceration and rolled edges was observed (Fig. 1). The lesion was hard on palpation. She was in good general health otherwise, and no lymphadenopathy was noted. Results of a full blood count were normal. Results of VDRL and anti-HIV antibody were negative.

The ulcerated nodule persisted despite a 1-month course of triamcinolone acetonide ointment (0.1% b.d.) application. We performed a total excision of the lesion for histopathologic examination with the differential diagnoses of eosinophilic ulcer of the tongue, squamous cell carcinoma and extranodal non-Hodgkin lymphoma. Histopathological examination showed an ulcerated surface and mixed inflammatory infiltrate consisting predominantly of eosinophils extending into the mucosa, submucosa and the layers of the striated muscle fibres. No cellular atypia was observed (Fig. 2). The diagnosis was eosinophilic ulcer of the tongue. At 1-year follow-up there was no recurrence.

**DISCUSSION**

Eosinophilic ulcer of the oral mucosa, also known as traumatic ulcerative granuloma with stromal eosinophilia, is a rare benign entity. It occurs as an ulcerated nodule in the oral mucosa with an acute onset. The lesion is mostly solitary and located on the tongue. Pain or tenderness may be present in approximately one-third of cases. Multiple lesions may be observed.

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Eosinophilic inflammation is one of the reactions to tissue trauma.\(^5\) T lymphocytes in the infiltrate suggest that cell-mediated immunity may play an important role in the pathogenesis.\(^1\) Whether eosinophils and mast cells play a major pathogenic role or are present as a result of T lymphocyte recruitment is not yet clear.

The histogenesis of eosinophilic ulcer of the oral mucosa remains controversial. Immunophenotypic studies have shown that the large atypical cells in the infiltrate have a myofibroblastic\(^4\) or histiocytic origin.\(^6\) These findings suggested a relationship with other disorders reported in the oral mucosa with similar clinical and histopathological features such as atypical histiocytic granuloma, angiolymphoid hyperplasia with eosinophilia, and Kimura’s disease. Alternatively, infiltrating T lymphocytes recently have been shown to express the CD30 antigen,\(^7\) suggesting that some of the cases previously reported might be the oral counterpart of CD30\(^+\) primary cutaneous lymphoproliferative disorders.\(^8\) Eosinophilic ulcer of the oral mucosa therefore seems to be an umbrella term covering a spectrum of disorders with diverse cells of origin.\(^8\)

The clinical features of eosinophilic ulcer of the oral mucosa lead to wide differential diagnoses (Table 1).\(^2\) Spontaneous healing usually occurs within 1 month, but may rarely take as long as 8 months.\(^1\) An incisional biopsy is often required for definitive diagnosis when no evidence of spontaneous healing is observed at 1-month follow up. Recurrence has been reported rarely.\(^2\)

Surgical excision is the most commonly cited treatment procedure among the different therapies used (Table 2).\(^2\) In our case, the patient had severe pain, and the lesion persisted for 2 months despite topical corticosteroid treatment, thus an excisional biopsy was the most appropriate diagnostic and therapeutic choice. However, once the possibility of a malignancy can be ruled out and the diagnosis can be confirmed with incisional biopsy, eosinophilic ulcer of the oral mucosa is better left to a wait-and-see approach.
REFERENCES


