International Journal of Enhanced Research in Medicines & Dental Care (IJERMDC),
ISSN: 2349-1590, Vol. 4 Issue 6, June-2017, Impact Factor: 1.102

Median Rhomboid Glossitis: A Report of two cases.

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ABSTRACT

The median rhomboidal Glossitis is asymptomatic lesion of tongue whose etiology and pathogenesis have subject of controversial discussion for a long time. Although it has traditionally been attributed to an embryologic fault, but no case of this disorder has been reported in a young child. In the recent time, the possible role of candida albicans has been stressed. It appears much more likely that the lesion is of an inflammatory, infectious or degenerative nature. It is suggested that it represents a clinical rather than a pathologic entity.

Key words: Median Rhomboid Glossitis, HIV, Kissing lesion, Candida.

INTRODUCTION

Median rhomboid Glossitis (MRG) is defined as central papillary atrophy of the tongue affecting 0.01% - 1% of the population.[3] The lesion appears clinically as an erythematous patch, which may be roughly ovoid or rhomboid in shape. It is typically located around the midline of the dorsal surface of the tongue just anterior to the cicumvallate papillae. This area is usually smooth and devoid of filliform papillae. It is asymptomatic lesion until infected by Candida. Despite its relative frequency, little is known about its etiology. There are lots of predisposing factors associated with MRG like smoking, denture wearing, diabetes mellitus and candidal infections. No treatment is required unless the lesion is symptomatic. The lesions are generally regarded as having no malignant potential.

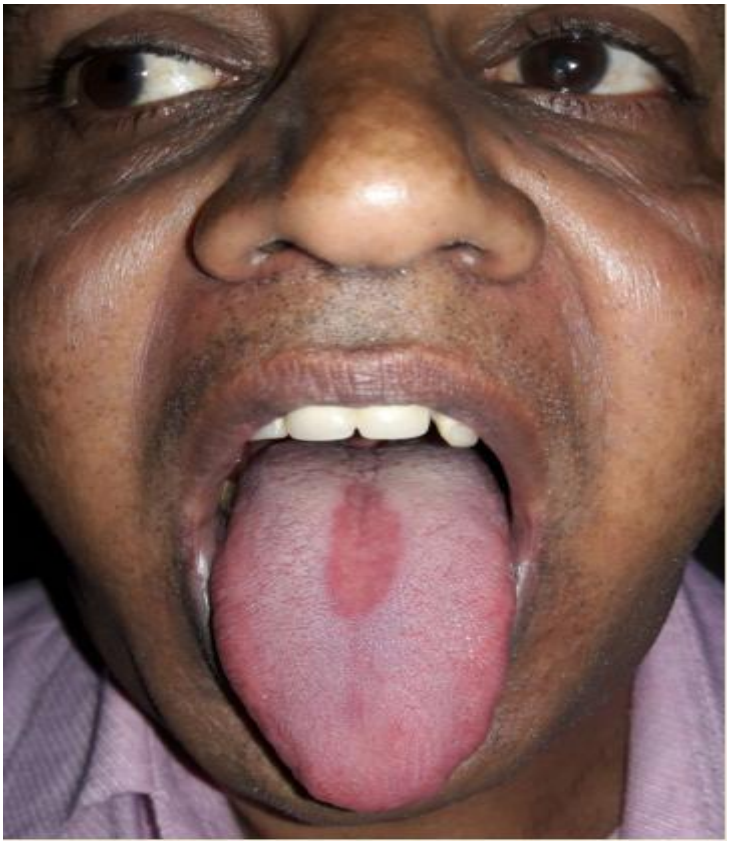
CASE REPORTS

A male patient of 46 year old came to the centre for the concern of smooth surface over the tongue without any symptoms. No treatment was given. Patient was told to keep good oral hygiene and regular tongue cleaning.
Second patient also came for the same concern. Both the patients were asymptomatic.

DISCUSSION

MRG is also known as central papillary atrophy of the tongue. It was once thought to be a developmental defect of the tongue, occurring in 0.01% to 1% of the adults. It was supposed to have resulted from failure of the embryologic tuberculum impar to be covered by the lateral processes of the tongue. Roger and Bruce stated that men are affected 3 times more often than women. However, Wright showed a 4:1 female predominance.

It occurs as a well-demarcated, symmetric, depapillated area arising anterior to the circumvallate papillae (Figure 1 and 2). The lesion is typically less than 2cm in greatest dimension[10]. However, it sometimes appears in the paramedical location[5]. The surface of the lesion can be smooth or lobulated.[3] When these lesions become more nodular, the condition is referred to as hyperplastic median rhomboid Glossitis. While most of the cases are asymptomatic, some patients complain of persistent pain, irritation, or pruritis.[3, 4]



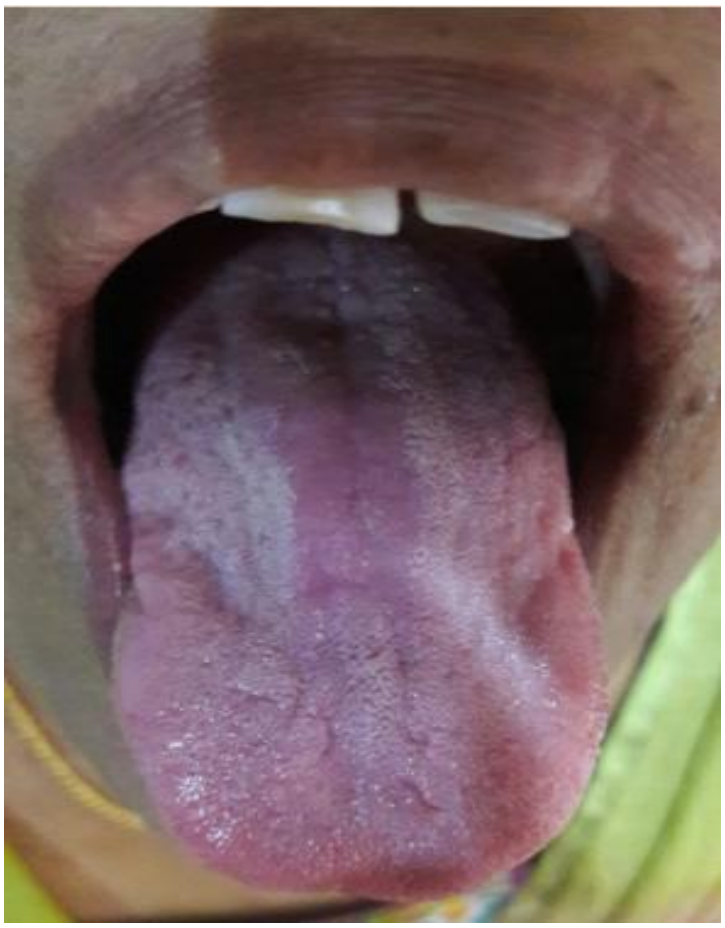


Figure 1 and 2. Two patients with long standing atrophic area in the midline of the tongue. This was diagnosed as median rhomboid Glossitis.

MRG is susceptible to recurring or chronic atrophic candidiasis resulting in a recent shift towards use of posterior midline atrophic candidiasis as a more appropriate diagnostic term. These lesions with atrophic candidiasis are usually more erythematous. In case of infected tongue, there may occur soft palate erythema due to rest of the dorsal part of the tongue to that part of the palate which is commonly referred to as kissing lesion because of the intimate proximity of the involved area. This has been considered a marker of AIDS .[1,6]

Histologically, it shows as smooth or nodulated surface covered by atrophic stratified squamous epithelium overlying a moderately fibrous stroma. Fungi form and filliform papilla are not seen.

The MRG should be differentially diagnosed from gumma of tertiary syphilis, the granuloma of the deep fungal infection, lingual thyroid and granular cell tumor.

Usually no treatment is required for the median rhomboid Glossitis. Infected cases due to candida are best treated by antifungal therapy to reduce clinical erythema and inflammation. Some lesion will disappear entirely with antifungal therapy such as nystatin suspension or clotrimazole troches. These can be given for 2weeks. Oral fluconazole for 2 weeks period can be tried. Nodular cases often required removal and biopsy. Wall [7] have stated that there is no clear relationship between MRG and cancer, there have 3 previous reports of malignant transformation [8,9].

CONCLUSION

MRG is a form of oral candidiasis that still gives rise to questions concerning its importance and etiology. These lesions were originally thought to be developmental in nature but are now considered to be a manifestation of chronic candidiasis. It requires no treatment until infected. Only the patients with kissing lesions on the hard palate may be the cause for the concern about HIV and hence, should be screened for the same.

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