CASE REPORT

Symptomatic oral squamous papilloma of the uvula – a rare incidental finding

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Abstract

Oral squamous papillomas are benign neoplasms of the oral cavity that occur commonly on the palate. Albeit benign and often asymptomatic, they may still cause concern due to their appearance, which may mimic other malignant oral pathologies. Human papillomavirus (HPV) is usually implicated in papilloma pathogenesis. We present a rare case of symptomatic oral squamous papilloma arising from the uvula and causing tongue and throat irritation. This benign lesion was excised with electrocautery.

Introduction

Oral squamous papillomas (OSPs) are exophytic masses arising in the oral cavity. They are usually benign and asymptomatic. However, they may cause alarm among clinicians, especially primary care providers, due to their clinical appearance. OSPs occur commonly on the palate and tongue. While the pathogenesis is related to the human papillomavirus (HPV), OSPs are essentially non-transmissible innocuous lesions.[1] Nevertheless, early recognition of OSP is important, especially in symptomatic patients, in order to alleviate the symptoms and prevent further complications, such as a malignant transformation to an oral squamous cell carcinoma. Herein, we present a rare case of symptomatic squamous papilloma arising from the uvula.

Case Report

A 21-year-old gentleman presented with long-standing recurrent episodes of sore throat associated with fever and odynophagia. He had been experiencing these episodes nearly every other month for the previous two years. He also complained of irritation on the posterior of the tongue for the past six months. Otherwise, he denied any rhinitis symptoms. His personal, medical, dental and sexual histories were unremarkable. On examination of his oral cavity, his tonsils were observed to be enlarged bilaterally (Grade III), and an incidental finding of an elongated, pedicled uvula was noted (**Figure 1**). The elongated uvula was touching the posterior aspect of his tongue. Flexible nasopharyngolaryngoscopy revealed normal laryngeal findings. He was diagnosed with recurrent tonsillitis and underwent a tonsillectomy, which included a refashioning of his uvula. The pedicled lesion was completely excised with electrocautery. It measured about 1 cm x 1cm. Histopathological examination revealed multiple fibrovascular cores surrounded by benign squamous epithelium consistent with squamous papilloma (**Figure 2**). Post-operatively, the patient remained well with a resolution of the tongue irritation.

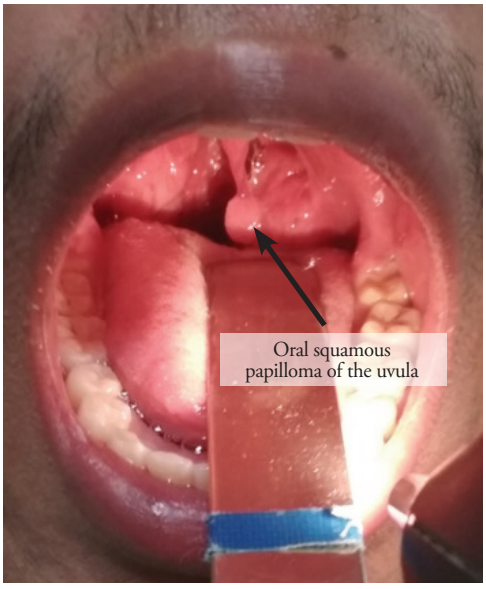

Figure 1: Pedicled lesion arising from the tip of the uvula

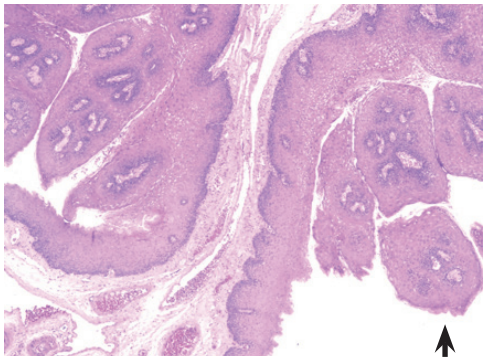

Figure 2: Delicate fibrovascular core covered by benign stratified squamous epithelium (black arrow)

Discussion

OSPs are benign mucosal neoplasms arising in the oral cavity that are commonly associated with HPV, particularly types 6 and 11.[1] OSP occurs predominantly in adult males, with the majority of the cases occurring in the second to fourth decade. OSP is predisposed to develop mostly on the palate and tongue.[2] In contrast, the other type of squamous papilloma found in the head and neck region, namely, recurrent respiratory papilloma, is often found in the pediatric age group and usually is of a multiple, recurring nature involving the laryngotracheobronchial complex.[3] In a case series of 464 oral squamous papillomas, only 4.2% of the cases were located on the uvula. OSP tends to occur as solitary mass and usually grows to a size of 0.5cm.[4] However, in our case, the lesion site on the uvula coupled with large size of about 1cm contribute to the rarity of the presentation.

Macroscopically, OSP usually appears as a pedunculated exophytic mass with cauliflower-like surface projections. OSP is usually white but can occasionally be pink owing to the lack of keratinization. Microscopically, the papilloma typically appears as multiple finger-like projections of squamous epithelium surrounding fibrovascular cores.[5]

OSPs are usually benign and asymptomatic. However, there are reports of symptomatic lesions involving the uvula, and the probability of symptoms increases with the length of the uvula lesion.[6] Note that our patient presented with throat and tongue irritation due to the involvement of the uvula and relatively large lesion.

The differential diagnoses of solitary OSP include verruca vulgaris, condyloma acuminatum, pyogenic granuloma and verrucous carcinoma. While serological tests, such as an enzyme-linked immunosorbent assay (ELISA) and a polymerase chain reaction (PCR), can be performed to detect any virulent origin, these tests are not done routinely. The pathogenesis of OSP is often attributed to HPV; however, recent literature suggests that the presence of HPV may be merely an incidental finding unrelated to the development of a squamous papilloma.[5]

OSPs are less proliferative and rarely associated with malignancy. The malignant transformation of a papilloma is more common in the multiple-recurring type. Nevertheless, there is a small risk of the spontaneous degeneration of OSP into squamous cell carcinoma, particularly in cases involving HPV-16 and HPV-18. The treatment of choice for OSP is surgical or electrocautery excision, laser ablation, cryosurgery or intralesional injections of interferon.[6] The recurrence rate of OSP is very low. In a study by Frigerio comprising 197 patients over a 16-year period, the recurrence rate was found to be about 2%.[7] However, patients infected with human immunodeficiency virus (HIV) may be prone to recurrence.[8] Due to the potential role of HPV in the development of OSP, a vaccine targeted against HPV, particularly types 6, 11, 16 and 18, may prevent its occurrence, albeit such a result has not been proven strongly.[9] In cases of pre-existing OSP, a literature review reveals mixed results in terms of the resolution of disease following the administration of a quadrivalent HPV vaccine.[10] Nevertheless, more randomized controlled trials are warranted to assess the efficacy of the HPV vaccine as a preventive and therapeutic measure for OSP.

Conclusion

OSP is a benign lesion of the oral cavity that is usually asymptomatic. However, in certain instances, it may cause symptoms in the patient, depending on factors such as the site and size of the lesion. Although it is of benign nature, early recognition by clinicians and treatment is pivotal in order to avoid potential complications as well as to alleviate symptomatic presentation.

Funding and Conflicts of Interest

None

How does this paper make a difference to general practice?

- This paper helps to raise awareness among primary care practitioners regarding oral squamous papilloma (OSP).
- This paper highlights OSP, especially cases that arise from the uvula, as a possible differential in patients complaining of persistent throat or tongue irritation.
- It also highlights the small risk of malignant transformation of this type of lesion, although OSP is mostly benign and asymptomatic. Thus, early recognition and referral by general practitioners is warranted for prompt excision of the lesion.

References

1) Flint PW, Haughey BH, Lund VJ, et al. *Cummings otolaryngology—head and neck surgery*. 5th edition. Philadelphia, PA, USA: Elsevier Mosby; 2010.

2) Al-Khateeb TH. Benign oral masses in a Northern Jordanian population-a retrospective study. *Open Dent J*. 2009; 3:147–53.

3) Babaji P, Singh V, Chaurasia VR, Masamatti VS, Sharma AM. Squamous papilloma of the hard palate. *Indian J Dent*. 2014; 5: 211-3.

4) Abbey LM, Page DG, Sawyer DR. The clinical and histopathologic features of a series of 464 oral squamous cell papillomas. *Oral Surg Oral Med Oral Pathol*. 1980;49: 419–28.

5) Jaju PP, Suvarna PV, Desai RS. Squamous papilloma: case report and review of literature. *Int J Oral Sci*. 2010; 2: 222–5.

6) Goodstein LA, Khan A, Pinczewski J, Young VN. Symptomatic squamous papilloma of the uvula: report of a case and review of the literature. *Case Rep Otolaryngol*. 2012; 2012: 329289.

7) Frigerio M, Martinelli-Kläy C, Lombardi T. Clinical, histopathological and immunohistochemical study of oral squamous papillomas. *Acta Odontol Scand*. 2015;73(7): 508-15.

8) Esquivel-Pedraza L, Fernández-Cuevas L, Saeb-Lima M, et al. Recalcitrant oral squamous cell papilloma lesions in two HIV-infected patients successfully treated with topical imiquimod. *J Dermatol Case Rep*. 2015; 9(1):19-22

9) Wadhera, R., Kalra, V., Gulati, S. and Ghai, A. A big solitary oropharyngeal papilloma in a child. *Egyptian Journal of Ear, Nose, Throat and Allied Sciences*. 2012; 13(3):131-2

10) Cyrus N, Blechman A, Leboeuf M, et al. Effect of quadrivalent human papillomavirus vaccination on oral squamous cell papillomas. *JAMA Dermatol*. 2015; 151(12): 1359-63