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Head and Neck Lumps and Oral Lesions

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About the speakers



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Abbreviations used in this review

FNA = fine needle aspiration
IV = intravenous
OLP = oral lichen planus
TMJ = temporomandibular joint
US = ultrasound

This publication summarises a session from the virtual 2021 Goodfellow Symposium. Speakers from Allevia Health Head & Neck Service discussed how to assess and manage neck lumps, red flags for head and neck cancers along with diagnosing and managing common presentations of oral lesions in primary care, how to manage first aid dental and maxillofacial problems, and some of the complications that could arise, such as traumatic tooth loss (avulsed tooth), infection and dry socket. The Goodfellow Symposium is a primary care symposium designed for GPs, urgent care physicians, nurses, nurse practitioners and registrars. This Goodfellow session and write up was supported by Allevia Hospitals.

HEAD AND NECK LUMPS: WHAT'S NORMAL AND WHAT'S NOT

Mr Rajan S Patel

What's Normal?

Clinicians are responsible for determining which lumps seen in clinical practice are normal and which lumps are not normal. Furthermore, primary care doctors will need to consider which patients require further investigation via imaging, and most importantly, identify those patients requiring immediate specialist referral without any investigations.

The location of a neck lump can give some clues as to potential diagnoses. Lumps occurring in the midline (from the chin to the supra-sternal notch) are typically limited to thyroglossal duct cysts, thyroid gland pathology and, less commonly, dermoid cysts. Lateral to the midline, lumps can commonly occur in one of the many lymph nodes in the neck along with the submandibular gland, parotid gland or as a branchial cyst.

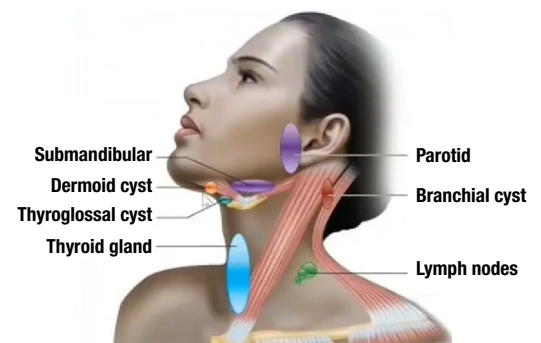


Figure 1: Anatomy of the Neck

Key steps to establishing whether a neck lump needs to be referred involve taking a thorough history including duration of neck lump greater than 2 weeks, smoking, alcohol use, voice change / hoarseness for more than 6 weeks, any problems with swallowing, unilateral nasal symptoms, unexplained ear pain and any experience of unintentional weight loss, night sweats and fatigue. Clinicians should undertake a physical examination of the neck, mouth, ears and surrounding lymph node groups. While physical characteristics of the lump are useful, other features such as change over time, associated symptoms and risk factors provide more useful information towards defining a course of action.

Examination in primary care also needs to consider the drainage pathways of the lymph nodes from the nose, sinus, oral cavity including the hard palate and tongue, nasopharynx, oropharynx and larynx. It is challenging to visualise many of these areas without specialist equipment. Therefore, metastases from a malignancy in these areas should always be considered when evaluating a presenting neck lump.

Midline Neck Lumps

The two most common midline neck lumps that will be encountered in the community include thyroid gland nodules and thyroglossal duct cysts.

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The thyroid gland overlies the trachea and larynx, which are both rigid structures comprising of cartilage. The thyroid gland has to increase in size substantially to compromise the airway. Posterior to the trachea and larynx lie the pharynx and oesophagus. A nodule in the thyroid can cause pressure on the pharynx and oesophagus creating pharyngo-oesophageal compression, which can manifest as pharyngeal irritability producing a non-productive cough and/or dysphagia. Further increase in the nodule size can eventually affect the trachea resulting in stridor. Thyroid function tests are not helpful in differentiating malignant from benign thyroid nodules.

Thyroglossal duct cysts commonly communicate with the back of the tongue hence a common presentation will be a midline neck lump that rises and falls with tongue protrusion. Management options are limited to surgical excision, which is commonly undertaken as these cysts are often viewed as unsightly by the patient and there is a risk of infection and abscess if left untreated.

Lateral Neck Lumps

Normal lymph nodes are frequently self-discovered in young healthy adult patients. These lumps tend to fluctuate in size and are often difficult to locate by both the patient and the doctor. Reactive lymph nodes are a more likely diagnosis when associated with a recent history of infective-type symptoms and initially may be tender to palpation. A trial of antibiotics may be useful with consideration of further assessment if there is no response. Similarly, enlarged lymph nodes occur commonly in children and neck lumps in this age group tend to be infective in nature with or without other associated infective symptoms.

What's Not Normal?

Red flags that indicate that prompt referral is appropriate include:

- Hoarseness for >6 weeks;
- Ulcerations or swellings of the oral/oropharynx mucosa >3 weeks;
- Red and white patches in the oral/oropharynx mucosa;
- Dysphagia (difficulty swallowing or painful swallowing);
- Persistent unilateral nasal discharge especially when accompanied by purulent discharge;
- Neck masses of > 3 weeks duration;
- Cranial nerve involvement; or
- Persistent unilateral otalgia with normal otoscopy.

<https://mcusercontent.com/0a92c50dc3407f9a3df54b1d6/images/03e9c549-d3c9-4fc8-a1c3-c8bfd8c710f.jpg>

If any of the red flags above are present, refer to specialist assessment immediately as waiting for imaging in primary care may delay a potential diagnosis. However, there are two exceptions:

1. In the case of a neck lump accompanied by hoarseness, request a chest x-ray while waiting for a specialist appointment.
2. In a low-risk patient with no red flags where reactive lymph nodes are suspected, refer for an ultrasound (US) as the first-line imaging technique.

A simple rule of thumb applies to neck lumps that are visible. These should definitely be referred for specialist management since their visibility indicates there is significant pathology but not necessarily malignancy.

If public referral is planned, it is important to clearly demonstrate the red flags present within the referral to allow appropriate triage of the case.

On referral to the Allevia Health Neck Lump Clinic, a patient will receive a 45-minute appointment from arrival to diagnosis which includes:

1. US of thyroid and neck with Radiologist - US provides an excellent first tool to assess neck lumps;
2. US-guided fine needle aspiration (FNA), if required;
3. FNA biopsy assessment by in-house Pathologist for immediate diagnosis, if required;
4. Consultation with Surgeon with results of the US and FNA to formulate a treatment plan.

Patients with thyroid nodules are commonly seen in the Allevia Health Neck Lump Clinic. In these patients, our Radiologists are able to provide a risk stratification score, which provides the risk of malignancy for each individual patient evaluated using the American College of Radiology (ACR) Thyroid Imaging Reporting & Data System (TI-RADS) system (**Figure 2**). This collates features identified from the US scan such as composition of the lump, echogenicity, shape, margins and echogenic foci to provide an overall malignancy risk stratification score and ultimately, course of action in terms of the need for FNA. Approximately 40% of patients referred with a thyroid nodule require FNA.

In a similar manner to the radiologist, the pathologist provides a risk of malignancy for the patient based on what is seen in the cytology using the Bethesda system (**Figure 3**). This provides further diagnostic information to the surgeon to aid in treatment planning.

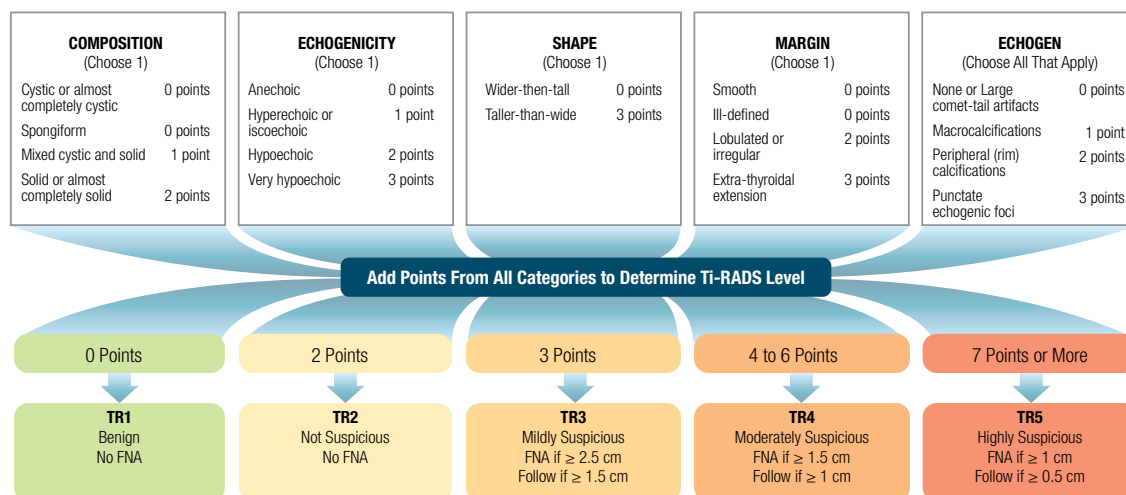
Diagnostic category	Description	Risk of malignancy (%)
I	Non-diagnostic/unsatisfactory	1-4
II	Benign	0-3
III	Atypia or follicular lesion of undetermined significance	5-15
IV	Follicular neoplasm or suspicious for follicular neoplasm	15-30
V	Suspicious for malignancy	60-75
VI	Malignant	97-99

Source: Cibas ES, Ali SZ. The 2017 Bethesda system for reporting thyroid cytopathology. J Am Soc Cytopathol. 2017;6:217-222. <https://doi.org/10.1016/j.jasc.2017.09.002>

Figure 3: Bethesda system for reporting thyroid cytopathology

How not to miss head and neck cancer - red flag symptoms and signs to look out for: <https://tinyurl.com/2s3yk4ut>

ACR Ti-RADS - malignancy risk stratification



Risk of malignancy

- TR1: 0.3%
- TR2: 1.5%
- TR3: 4.8%
- TR4: 9.1%
- TR5: 35%

Figure 2: Stratification or risk of malignancy score provided by Radiologist



CASE STUDIES

1. Female, 43 years, neck lump, 6 months



Patient history:

- Normally well;
- Midline neck lump for 6 months;
- Concerned that people are noticing the lump;
- Nocturnal dry cough;
- Dysphagia to solids requiring more effortful swallow;
- No stridor or respiratory distress.

Examination demonstrates a prominent visible lump in the anterior neck in the region of the thyroid gland to the left of the midline without tracheal deviation. On examination you can't get your fingers underneath it – provides information on whether the lump has spread underneath the sternum.

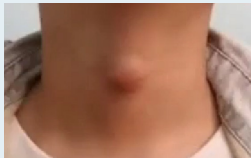
Thyroid Function Tests were normal.

Red flags of dysphagia and a neck mass of > 3 weeks duration are present so referral to a specialist is indicated.

Ultrasound found bulky left thyroid multinodular disease specifically a 4cm TI-RADS 4 nodule which met the ACR TI-RADS criteria for FNA.

FNA demonstrates a benign, Bethesda grade 2 lump with a risk of malignancy of 0-3%. However, the patient was keen to undergo a hemithyroidectomy to treat the cosmetic and compressive symptoms.

2. Male, 23 years, midline neck lump, 2 months



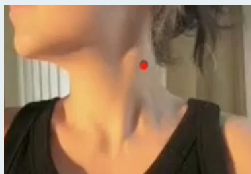
Patient history:

- Midline neck lump;
- Lump rises and falls with tongue protrusion.

Examination of the lump confirms that the lump rises when the patient pokes his tongue out and returns to the resting position when the tongue is retracted. Referral is indicated as one red flag is present: neck mass of > 3 weeks duration.

On referral, a thyroglossal duct cyst is diagnosed and the patient is scheduled for surgery.

3. Female, 20 years, small lateral neck lump, 4 weeks duration



Patient history:

- Small lump of 4 weeks duration;
- Lump has not changed over time;
- No other symptoms;
- Patient has difficulty locating lump.

The lump is difficult to locate because of its small size. However, a small non-tender mobile lump less than 1cm is found behind sternocleidomastoid muscle in posterior triangle. There are no other distinguishing features.

It is reasonable to refer this type of patient directly to US assessment for first line imaging as they meet the exemption for immediate referral in that the patient is considered low risk and has no associated red flags. A reactive lymph node is suspected. However, in this case, the patient was referred to the Neck Lump Clinic where she underwent US and FNA with flow cytology as the ultrasound noted some atypical features.

The FNA confirmed a diagnosis of reactive lymphadenopathy which was reassuring to both the patient and the referrer. It is suitable in such a case to look for a reactive cause such as toxoplasmosis or Epstein-Barr virus etc. Most cases of reactive lymph nodes will resolve spontaneously. In patients with a very slim neck, a small lump may persist indefinitely.

4. Male, 44 years, lateral neck lump, 8 weeks duration



Patient history:

- enlarging neck lump;
- sore throat;
- ipsilateral ear pain;
- no infective symptoms.

Examination reveals a visible prominent non-tender left neck lump measuring several centimetres with normal overlying skin in a systemically well patient. The symptomatic ear has normal otoscopy. Examination of the oral cavity and oropharynx shows a unilateral ipsilateral enlarged tonsil.

Referral is urgently indicated as multiple red flags are present: neck mass of > 3 weeks duration, unilateral otalgia with normal otoscopy, and enlarged ipsilateral tonsil. The patient was referred urgently to the Allevia Health Head and Neck Service, where he underwent FNA biopsy of the neck lumps. The biopsy confirmed p16 positive metastatic squamous cell carcinoma. Further tests demonstrated primary carcinoma originating in the enlarged tonsil. The patient underwent radical surgery followed by radiation therapy with curative intent.

5. Male, 79 years, angle of jaw lump



Patient history:

- enlarging and painful neck lump;
- multiple prior surgeries for skin cancer;
- evidence of skin graft from previous possible skin cancer or melanoma;
- presenting with lump originating in parotid region.

Examination demonstrates widespread actinic change of the skin and evidence of prior skin surgery with skin graft in the right temple region. The lump is located in the right parotid gland and involves the overlying skin with drainage of fluid. Facial nerve function is normal.

US and FNA biopsy confirm metastatic squamous cell carcinoma (likely from previously treated skin squamous cell carcinoma) to the parotid lymph nodes extending to involve the skin. There is no evidence of other metastases elsewhere in the body. While this appears to be advanced disease, it can be treated with surgery – parotidectomy and neck dissection followed by radiotherapy which has a cure rate of >80%. In these cases, facial nerves can be preserved.

6. Female, 31 years, submandibular neck lump



This lump presents in a similar location to the previous case, but in a younger patient with no prior malignancy history. FNA and biopsy confirms cancer of the parotid gland, which was treated with parotid surgery. Pathology confirmed it as a muco-epidermoid carcinoma of the parotid gland and this treatment was undertaken with curative intent.



DIAGNOSING AND MANAGING ORAL LESIONS IN PRIMARY CARE

Dr Muammar Abu-Serriah

Common Dental Presentations and Management

Toothache

There may be many reasons why patients may present with toothache in primary care. Causes can be divided into two categories:

1. Dental pain which may be due to issues affecting the dentin, the dental pulp or the supporting periodontal tissues.
Typical presentations are:
 - Sensitive teeth;
 - Gum disease;
 - Impacted teeth;
 - Inflammation of the tooth pulp (pulpitis);
 - Dental decay;
 - Cracked tooth;
 - Dental abscess.
2. Non-dental causes may originate in the temporomandibular joint (TMJ), tonsils, maxillary sinus (sinus infection or congestion) or can be referred pain, especially in acute myocardial infarction which may refer to the left side of the jaw.

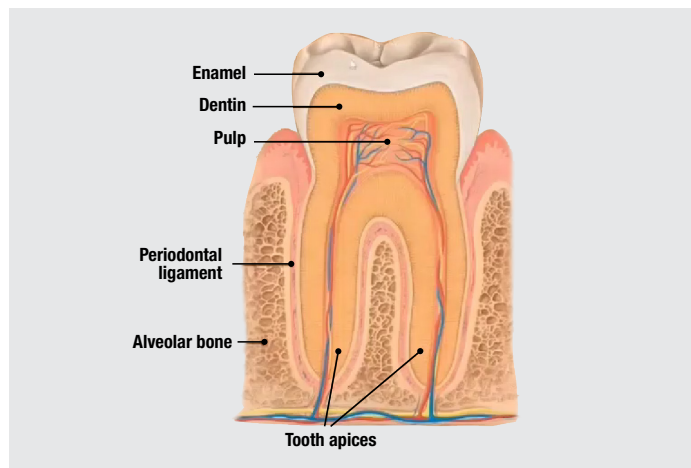


Figure 4: Anatomy of Adult Tooth

Dental decay may manifest as sensitivity to hot and cold. Pulsating severe pain that disturbs sleep is indicative of decay involving the pulp of the tooth. If initially untreated, decay can lead to an abscess in the tooth by which stage the patient would complain of severe pain when biting on the tooth.

On exam it is important to rule out any non-dental origin such as Ischaemic Heart Disease, sinusitis or gastroesophageal reflux disease otherwise refer to the patient's dentist for further management.

Wisdom Teeth

Wisdom teeth do not form in 15-25% of the population. They are the last to erupt and because of that they 'struggle' for space in the jawbone. As a result, they are the commonest teeth to become impacted or unerupted. Partially erupted wisdom teeth may cause pain, gum swelling, tooth crowding and sensations of bad taste along with bad breath or severe neck swelling with airway compromise. Unerupted wisdom teeth, in the other hand, may be associated with cyst formation of odontogenic tumours. Additionally, maleruption may result in decay of adjacent molar. It is important to assess their placement both clinically and radiographically.

Referral to a Oral Maxillofacial Surgeon (OMFS) may be warranted when there is more than one episode of pain or when the teeth are causing crowding, infection, decay or bony lesions. Most private insurers provide coverage for unerupted and/ or impacted wisdom teeth removal.

Dry Socket

Dry sockets can occur after any tooth extraction, not only wisdom teeth. The condition is believed to be due to the lack of clot formation resulting in bone exposure and severe tenderness. A patient will present with severe pain usually 3-5 days post-extraction. It occurs more often in smokers. Examination will reveal empty bone socket with no clot formation, with severe tenderness of the bone to digital pressure with ipsilateral lymph node swelling or lymphadenopathy.

Management should involve referral back to the dentist or treating oral surgeon along with treatment with wound washout/ debridement, antibiotics, analgesia and mouthwash.

Tooth Abscess – It is not only a tooth abscess

Patients with a tooth abscess may present with severe pain, initially localised, but then becoming widespread as infection involves the surrounding tissues. The pain will disturb sleep and may present with swelling. The patient may be feeling generally unwell.

A localised infection corresponding to a specific tooth can be termed a dental abscess. Management of dental cellulitis or 'a non-visible (clinically or on radiographs) tooth abscess' should involve antibiotics and analgesia followed by a referral to a dentist for further management. A localised abscess which is visible and pointing can be incised and drained under local anaesthetic before similar management. A full adult dose of antibiotics should be used to treat the infection right from the start and the combination of amoxycillin plus metronidazole is recommended.

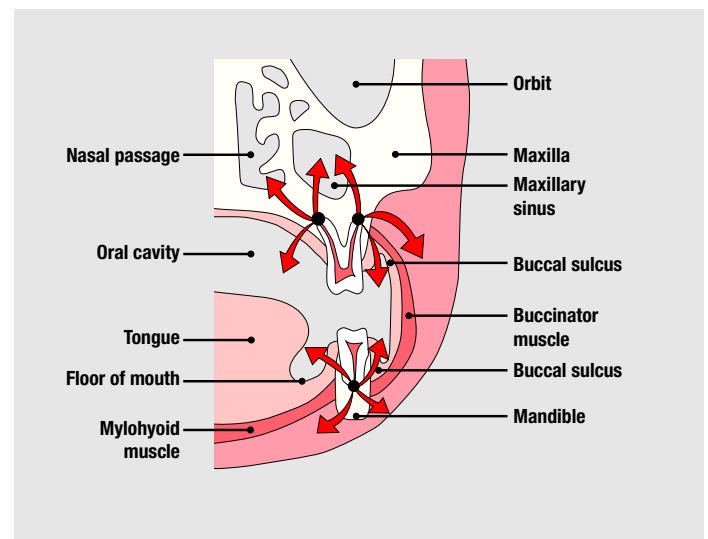


Figure 5: Different pathways through which the infection can spread from a dental abscess

Left unmanaged, a dental abscess may progress to a widespread cervico-fascial space infection. Red flags signs that warrant urgent referral for possible serious odontogenic cervico-fascial infection:

- Rapid progressive swelling of the face and neck;
- Severe worsening trismus;
- Shortness of breath;
- Tachypnoea;
- Change in voice;
- Odynophagia;
- Pyrexia;
- Tachycardia;
- Recent onset of neck stiffness with the above.

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Management of a cervico-fascial space infection with no red flag symptoms present should involve treatment with antibiotics, analgesia, mouthwash and hydration while referring the patient to be seen by an OMFS within 3-5 days.

Where there are red flags for a severe cervico-fascial infection, it is important to keep the patient nil by mouth while initiating treatment with intravenous (IV) antibiotics, analgesia and mouthwash and initiate an urgent referral to an OMFS or Emergency department.

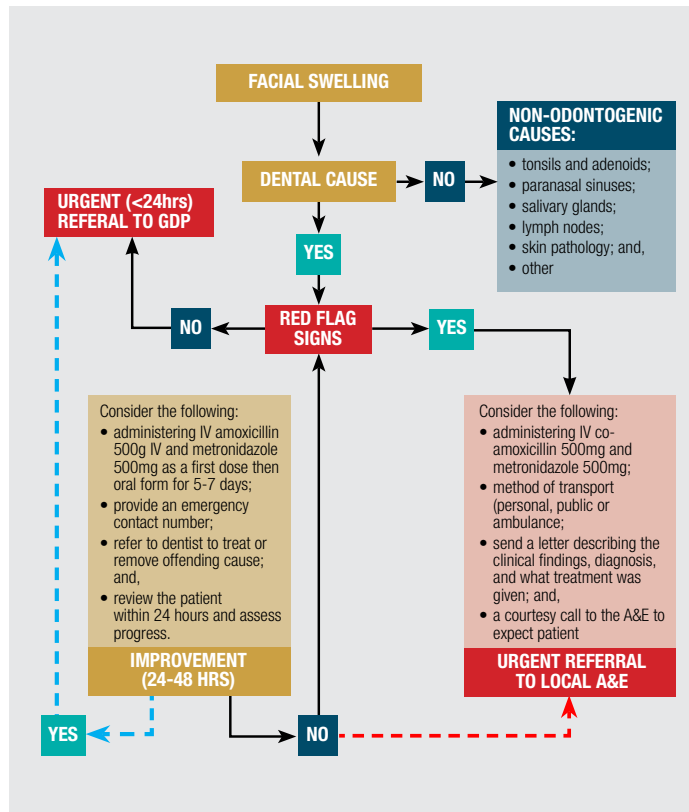


Figure 6: Flowchart on management of facial swelling

Another potential complication of an untreated tooth abscess is an orocutaneous fistula where the infection takes the path of least resistance and forms a sore or fistula through to the skin surface. Cases of orocutaneous fistula have been mistakenly diagnosed as squamous cell or basal cell carcinomas and do not need large areas of excision and reconstruction however addressing the underlying cause of the fistula is essential for cure.

Avulsed Adult Tooth

In the case of an adult tooth being knocked out, after completing a trauma survey and treating other injuries, if the tooth is present attempts can be made to reposition back into corresponding tooth socket and then refer the patient to a dentist. If repositioning is not possible, store the tooth in the mouth or in milk, which can be effective for up to 8-9 hours, and refer to an urgent care dentist for repositioning. If a dentist is not available, then referral to OMFS is appropriate.

In cases where the adult tooth is missing, a chest x-ray is necessary to rule-out inhalation of the tooth and arrange referral to a dentist within 24 hours. For any avulsed baby teeth, repositioning should not be attempted due to the possibility of introducing infection to the developing adult tooth.

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Oral Lesions

Oral Lichen Planus (OLP)

OLP is a relatively common chronic immunologically-mediated mucosal condition occurring more often in women. It usually occurs bilaterally and the commonest type, the reticular lichen planus, presents as a white network of mucosal pigmentation. It can occur as part of other mucocutaneous disease and the patient should be questioned about other skin involvement when taking the patient history. There is a lifetime risk of malignant transformation of 1-3% with the ulcerative and erosive types of lichen planus having the highest risks of malignant transformation. Make sure to rule out any other causes of oral lichen planus such as drugs or hematinic deficiencies.

Management of OLP is largely limited to symptomatic relief and frequency control as there are no curative treatments available at this time. A baseline photograph is helpful and a referral for a biopsy is recommended to rule out dysplastic changes. Asymptomatic patients can be managed in primary care.

For symptomatic patients, treatment with benzydamine 0.15% mouthwash, gel or spray and avoidance of aggravating factors followed by treatment with steroid mouthwash using steroid (e.g. a prednisolone 5mg) tablet crushed in 20mL water and held in the mouth for 5 minutes with no rinsing for 30 minutes. Benefit may also be gained from capsaicin cream. Treatment with systemic immunosuppressants should be limited to symptomatic patients. It is important to highlight that some literature suggests that the risk of malignant transformation may increase when systemic immunosuppressive therapy is used.

Oral Patches (Plakias)

Plakias can appear as white patch (leukoplakia), red patch (erythroplakia) or heterogenous patch (erythrolukoplakia), and are diagnosed by a process of exclusion. Plakias are chronic and painless and, while can be mistaken for oral thrush, a useful rule of thumb is that thrush can be rubbed off while plakias will not rub off. If not resolved within 3 weeks of removing potential cause (such as smoking, sharp tooth, unstable denture, or chewing tobacco) then referral to OMFS is required. There is a risk of malignant transformation of 3-5% therefore biopsy may be needed to rule out dysplastic changes.

Amalgam Tattoo vs Mucous Membrane Melanoma

Amalgam tattoos appear as dark grey non-raised pigmentation of the gingiva. They are painless and commonly occur after a difficult extraction of a heavily amalgam-filled tooth where a small amalgam fragment is left at the extraction site. Amalgam tattoo is due to the uptake of amalgam by macrophages of the gingival the tissue and can persist for several years. Patients can be reassured but if suspicion of a mucous membrane melanoma exists, referral to OMFS is appropriate.



Figure 7: Amalgam tattoo on left versus melanoma of gingiva on right

Malignant melanoma of the oral cavity is rare and often presents with dark pigmented growing lesion which may ulcerate resulting in bleeding and tooth mobility. The 5-year survival is poor at around 4%. The vast proportion are pigmented but a small proportion will be amelanotic melanomas which may look like normal mucous membrane.

Recurrent Aphthous Stomatitis

This may be a common presentation in primary care that affects teens and young adults presenting with recurring bouts of multiple, painful rounded / oval-shaped ulcers of the oral cavity. At this point in time, there is no known cause. It is worth ruling out nutritional deficiencies by completing a full blood count, serum folate, iron and vitamin B12 levels. Symptoms can be managed in similar way to that of OLP.

Temporomandibular Joint Dysfunction

TMJ dysfunctions and locked jaw occurs more often in women and patients with a history of clenching their jaw and/or grinding their teeth. Patients will present with a painful TMJ joint which may be worse in the morning along with outmuscle tenderness, restricted mouth opening and a history of a clicking of TMJ joint.



Useful classification for internal derangement

Wilkes Classification of Internal Derangement

Stage I	Early reducing disk displacement No pain or limitation, early opening click	Reassure and discharge
Stage II	Late reducing disk displacement One or more episodes of pain, mid to late opening click, transient catch & lock	Soft diet, avoidance advice, massage, physio, bite splint. and NSAID
Stage III	Nonreducing disk displacement: acute/subacute Multiple painful episodes, locking, restricted mobility	Arthrocentesis (+/- as stage II)
Stage IV	Nonreducing disk displacement: chronic Increasing functional disturbance	Arthrocentesis, articular disc repositioning, disc removal
Stage V	Nonreducing disk displacement: chronic with osteoarthritis, crepitus, scraping, grating, grinding symptoms: pain, restricted motion, difficult function	Arthroplasty, joint replacement

Figure 8: Classification and treatment options for TMJ dysfunction

For recent onset TMJ dysfunction, a trial of NSAID and paracetamol treatment for 2 weeks is useful along with ice applications, massage and a soft diet. Follow-up with a dentist for a bite splint is recommended. Referral to OMFS may be necessary if the patient has persistent pain and restricted mouth opening.

Is it a Granuloma, Mucocele or Polyp?

Pyogenic granuloma is an overgrowth of the gum that creates an hour-glass shape and will appear leaf-like with a fibrous membrane cover that will bleed easily. The patient may have poor oral health or hormonal changes. Referral to OMFS is necessary for local excision.



Figure 9: Pyogenic granuloma

Patients with mucoceles will present with a saliva-filled blister-like sac which while painless, tends to burst then refill. These are often trauma induced and are a cyst associated with a minor salivary gland. A ranula is a retention salivary cyst which is associated with the sublingual salivary gland. A good rule of thumb is that lumps of the lower lip tend to be mucoceles, while lumps on the upper lip are most likely tumours. Patients with mucoceles' should be referred to OMFS for local excision under magnification as mucoceles lanced within primary care tend to re-occur.



Figure 10: Mucocele

Fibrotic lumps on the edge of the tongue or the cheek are fibroepithelial polyps and are associated with biting of the tongue or cheek respectively and are firm and painless. They can be sessile polyps (with no stalk) or pedunculated (with stalk) polyps. A referral to OMFS is necessary for local excision.



Figure 11: Fibroepithelial polyp

Torus Palatinus, Torus Mandibularis & Differential Diagnoses

Torus palatinus and torus mandibularis will present as a painless, lobular, developmental bony mass that is usually symmetrical and arises in the midline of the palate or the inner aspect of the mandible. No treatment is required unless the presence of the mass interferes with oral health or dental work then local excision may be required.



Figure 12: Torus Palatinus

While similar looking, a palatal dental abscess from an infected tooth will not be lobulated in appearance, will be yellow-looking, cystic, and close to the teeth and may have pus discharge.



Figure 13: Palatal dental abscess

Where an oral lump is unilateral, it is more indicative of an ameloblastoma or carcinoma in comparison to mandibular tori which are bilateral. On CT scan, the tumours are radiolucent while mandibular tori are radiopaque and dense.



Figure 14: Ameloblastoma of the upper mandible

Oral Cancer

In addition to all of the above information that attempts to assist in the diagnosis and management of oral lesions, there are also red flag symptoms that need to be kept in mind when reviewing a patient with oral lesions or ulcers:

- Duration > 3 weeks;
- Painless;
- Change in size (> 5mm);
- Patient history of smoking or heavy drinking;
- Change in sensation or movement;
- Earache;
- Persistent;
- Single lesion or unilateral.

Malignant lesions may also be hard or indurated often associated with contact bleeding (bleeding to gentle palpation with the tip of gloved finger) and may cause teeth loosening (indicating surrounding bone destruction).

A patient can be given analgesia with paracetamol or opiates if in pain but avoid NSAIDs and refer for urgent assessment by OMFS for diagnosis and further management.

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