COMMENT

Letters to the editor

Send your letters to the Editor, *British Dental Journal,* 64 Wimpole Street, London, W1G 8YS. Email bdj@bda.org.
Priority will be given to letters less than 500 words long. Authors must sign the letter, which may be edited for reasons of space.

CASE REPORT LETTERS

Oral cancer

B-cell lymphoma

Sir, we write to inform you of a recent case of interest. A 54-year-old gentleman was referred to the oral and maxillofacial surgery clinic by his general dentist with a lower second molar tooth becoming mobile and intraoral radiographs revealing resorption of the roots. The tooth had been becoming increasingly loose over a six-week period with no associated discharge, swelling or paraesthesia in the region. The patient reported no unexplained weight loss, loss of appetite, voice changes, increasing malaise or family history of cancer or haematological malignancy.

He was normally fit and well, taking no regular medications, drinking five units of alcohol per week and had never smoked.

On examination, the patient had no cervical lymphadenopathy, axillary lymphadenopathy or hepatosplenomegaly and cardio-respiratory examination was also unremarkable (Fig. 1).

The mobile tooth was removed and curettage content of the extraction socket was sent for histopathology, given the atypical presentation of what was thought to be a dental-related pathology. A possible differential diagnosis was primary intraosseous carcinoma. The initial pathology report showed features of a dense lymphoid infiltrate highly suspicious of B-cell lymphoma. Wider excision by means of an alveolectomy provided adequate tissue that confirmed diffuse large B-cell lymphoma (stage 1E).

The patient experienced no 'B symptoms' such as night sweats, fever, persistent skin itching, persistent cough or breathlessness. Blood tests taken as part of the diagnostic work-up were normal and the PET CT scan showed the disease was confined to the left mandible only (Fig. 2).

The patient received chemotherapy with rituximab, cyclophosphamide, doxorubicin, vincristine and prednisolone, known as R-CHOP. Lymphomas represent 3.5% of all intra-oral malignancies in the head and neck, lymphoma being the second most common neoplasm after squamous cell carcinoma. We note stage 1 median survival time for stage 1E non-Hogkin's lymphoma (NHL) is ten years.[1] After six cycles of R-CHOP chemotherapy with adjuvant involved field radiotherapy completed, the patient is in remission and was last reviewed on clinic in March 2017.

More than 12,000 people are diagnosed with non-Hodgkin's lymphoma in the UK every year, with the average age of diagnosis being 50–55 years.[2] NHL usually presents with a painless swelling in a lymph node in the neck, armpit or groin,[2] although 24% of cases affect extra-nodal locations.[3] Diffuse large B-Cell lymphoma is the most common subtype of non-Hodgkin's lymphoma in the head and neck. The commonest site of NHL in the oro-facial region is Waldeyer's lymphatic ring.[4]

There are few other case reports documenting the mandibular presentation of B-Cell lymphoma. A. Bugshan *et al.* (2015)[1]

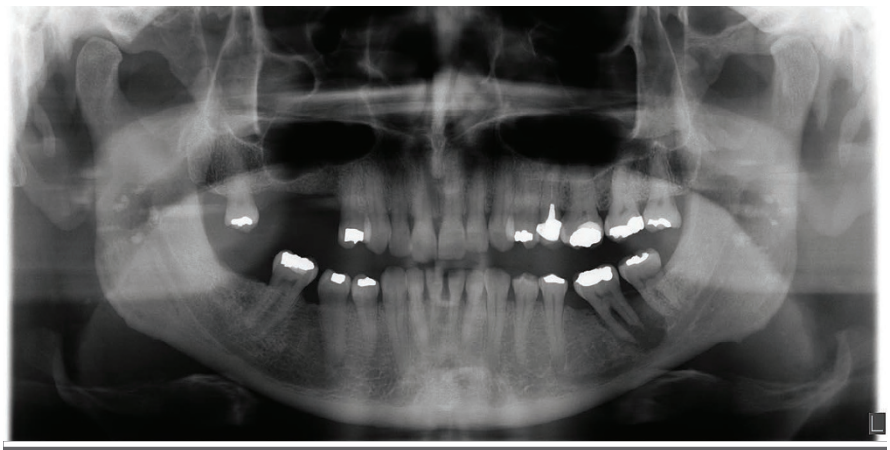

Fig. 1 Orthopantomogram radiograph showing the left mandibular second molar and associated well-defined periradicular radiolucency extending to the superior border of the inferior dental canal. Note: bilateral tonsilloliths giving the appearance of multifocal radiopaque punctate areas

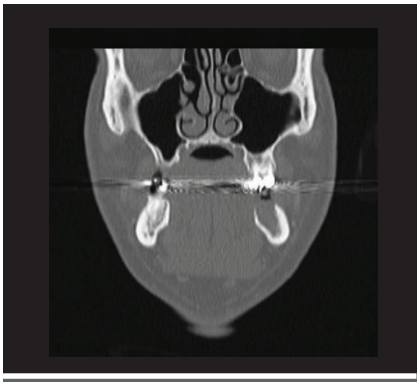

Fig. 2 Coronal view from the CT scan showing tumour invasion of the cancellous bone in the left body of mandible

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described a patient presenting with swelling of the cheek and unilateral numbness of the lower lip. R. Kini *et al.*[3] (2009) talk of a firm, insidious swelling of the right mandible without any loss of sensation.

The learning point from this case is the unusual presentation of the disease and without the appropriate index of suspicion in a case which could have been easily dismissed as periodontal disease, there was a real risk of misdiagnosis and adverse sequelae. It is a rare, uncommon case with only 0.6% of isolated malignant non-Hodgkin's affecting the mandible[5,6] but we feel that this rare presentation should be considered as a reminder that haematological malignancies such as lymphoma can present in the extranodal areas of the head and neck. The most common presenting symptoms in the head and neck region are painless swellings (most commonly in the maxilla), unexplained tooth mobility or bone pain and discomfort. Radiographs may reveal tooth root resorption and a unilocular radiolucency mimicking dental pathology.

J. Kelly, M. Ho, I. Suida, by email

1. Bugshan A, Kassolis J, Basile J. Primary diffuse large B-Cell lymphoma of the mandible: case report and review of the literature. *Case Rep Oncol* 2015; **8:** 451–455.
2. NICE. Lymphoma Guidelines. Available at: https://www.evidence.nhs.uk/Search?ps=20&q=Lymphoma+Guidelines (accessed 1 February 2017).
3. Kini R, Saha A, Naik V. Diffuse large B-cell lymphoma of mandible: a case report. *Med Oral Patol Oral Cir Bucal* 2009; **14:** e421–424.
4. Adouani A, Bouguila J, Jeblaoui Y *et al.* B-cell lymphoma of the mandible: a case report. *Clin Med Oncol* 2008: **2:** 445–450.
5. Parrington S J, Punnia-Moorthy A. Primary non-Hodgkin's Lymphoma of the mandible presenting following tooth extraction. *Br Dent J* 1999; **187:** 468–470.
6. Helmberger H, Baumeister M, Fellbaum C, Dietzfelbinger H, Bautz W. Primary non-Hodgkin's lymphoma of the mandible: a rare differential diagnosis. *Rontgenpraxis* 1995; **48:** 202–205.

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Sub-mucosal swelling

Sir, a patient presented for a check-up with no complaints other than for an occasionally sensitive upper left first molar. The patient is a 52-year-old male who has attended regularly for check-ups and supportive hygiene therapy for almost 20 years. There is no medical history of note. He is a non-smoker and an occasional social drinker. Having completed the dental part of the check-up, the soft tissues were assessed working methodically around the lips, tongue, palate and soft tissues including the floor of the mouth.

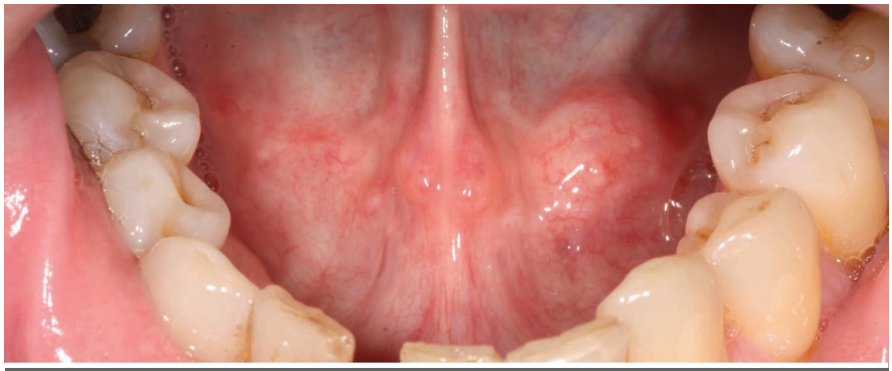

Fig. 1 Sub-mucosal swelling clearly visible in left floor of the mouth

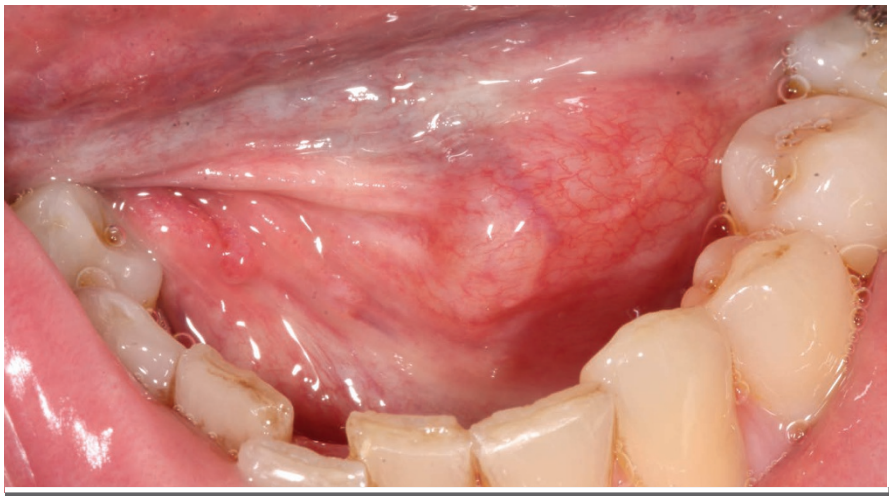

Fig. 2 Swelling remains in left floor of the mouth when extending tongue to the right

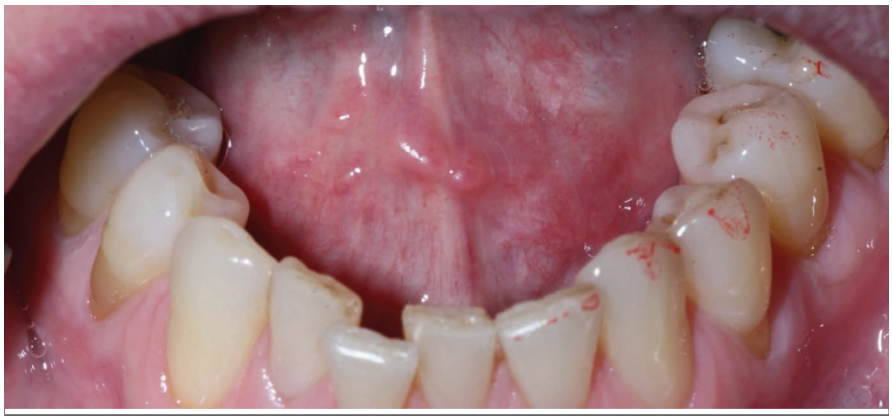

Fig. 3 Lifting tongue – three months after surgical removal

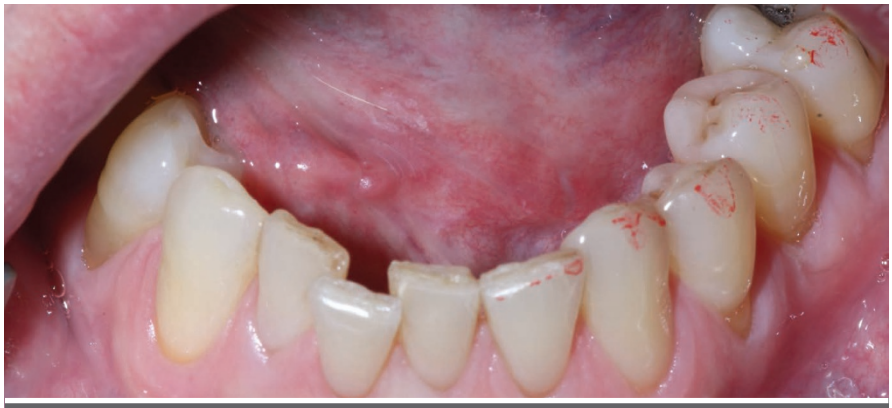

Fig. 4 Moving tongue to the right – three months after surgical removal

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