Oral lesions of tuberculosis are rare and when present they are usually secondary to pulmonary tuberculosis. Persistent painful oral ulcer may be the only symptom for which the patient seeks advice. In the absence of clinical features of any systemic disease, these lesions may be misdiagnosed. Histopathological examination in such cases must be performed so as not to miss some rare conditions.

Key Words
Tuberculosis, oral ulcer

INTRODUCTION

Tuberculosis can affect any part of the body but the involvement of oral cavity is rather rare. The intact oral mucosa is believed to be resistant to tubercular infection due to cleansing action of saliva, presence of saprophytes, antagonism of the striated musculature to bacterial invasion and the thickness of a protective epithelial covering. Predisposing factors include poor oral hygiene, trauma, irritation, dental extraction, pyogenic foci and leukoplakia. The incidence of oral lesions ranges from 0.4% to 1.5% in patients with pulmonary tuberculosis (Rauch 1978).

REPORT OF CASE

A 45 years old farmer presented with slowly progressing painful ulcer on left lateral border of tongue. Patient also experienced difficulty in eating and talking and excessive salivation. There was no history of trauma, toothache, change in voice, difficulty in swallowing or breathing, cough, fever, blood mixed sputum or night sweats. Patient was chronic tobacco chewer and a bidi smoker for past 20 years. He did not give history of any major illness, surgery or hospitalisation in past though he complained of gradual loss of weight and general weakness. General physical examination was normal, oral examination revealed poor oral hygiene, some of the teeth were missing, rest were irregularly placed and tobacco stained. Teeth adjacent to the ulcer area were particularly sharp and peg like.

The examination of oral cavity showed a coated tongue with an ovoid ulcer 2.2 cm over left lateral border of tongue at junction of anterior one third and posterior two thirds. Margins of the ulcer appeared to be undermined and base was covered with pale slough (Fig. 1). On palpation, the ulcer was tender to touch and margins were indurated. Movement of tongue was painful and hence restricted. Examination of neck revealed a palpable left middle deep cervical lymph node 2.1 cm in size, firm, mobile and nontender. Overlying skin was free. Considering the patient's age of presentation, six month duration of history, habit of tobacco chewing and smoking, palpable middle cervical lymph node and an apparent absence of any other systemic disease; a provisional diagnosis of malignant ulcer was made and an incisional biopsy of ulcer was taken. Surprisingly, histopathological examination revealed features of granulomatous inflammation in the form of epitheloid cells, giant cells of Langans type and lymphocytic infiltration suggestive of tuberculosis.

The biopsy report being tuberculosis; the patient was further investigated on this line. Routine hematologic investigations showed a raised ESR (53mm/1st hr, wintrobe). Mantoux test was
strongly positive, chest x-ray showed extensive fibrosis secondary to pulmonary Koch's (Fig.2). Three consecutive stainings of sputum for acid fast bacilli were negative.

On the basis of these clinical features and investigations a diagnosis of tubercular ulcer of tongue with pulmonary Koch's was made and patient was put on antitubercular therapy. There was regression the size of ulcer after 6 weeks of antitubercular treatment.

**DISCUSSION**

Tuberculosis, a chronic granulomatus disease has world spread and causes multisystemic involvement. Tuberculosis now affects more than a third of the world population (Sudre et al, 1992). The rising incidence is due to a number of factors. The emergence of mycobacterial strains with multiple drug resistance and rising population of young adults (who form a large group infected by TB) have also fuelled the epidemic such that tuberculosis is now world's leading cause of death from single infective agent (Godlee, 1993). The resurgence of tuberculosis world wide and its association with HIV infection means greater likelihood of otolaryngologists encountering the disease in one form or another (William et al, 1995).

Tongue is the most common organ of oral cavity infected by tuberculosis. Other sites are floor of mouth, soft palate, gingiva, lips and hard palate. The oral lesion of tuberculosis are more commonly seen in middle aged or older men. These oral tubercular lesions generally develop secondary to pulmonary tuberculosis; but occasionally primary infection is seen in cases with poor orodental hygiene or with other causes of mucosal damage including dental extraction (Prabhu, 1978). Oral tuberculosis lesions may occur in various forms as ulcers, nodule, fissures,