# Oral melanoacanthoma of the palate: An unusual presentation of an uncommon entity

Scott M. Peters, DDS,[a] Louis Mandel, DDS,[b] and Michael A. Perrino, DDS, MD[b]
*New York, New York*

***Key words:*** melanoacanthoma; melanocyte; oral pigmented lesion; palate.

## INTRODUCTION

Oral melanoacanthoma (MA), also known as *melanoacanthosis*, is a benign, acquired pigmentation infrequently observed in the oral cavity.[1,2] It represents a distinct entity from the cutaneous MA, which is typically seen on the trunk and is considered to be a variant of seborrheic keratosis.[3] When it occurs in the oral cavity, MA presents as a rapidly expanding, solitary brown macule, most often involving the buccal mucosa. We present a case of MA occurring on the soft palate of a 45-year-old African-American woman, an atypical oral location for this lesion.

*Abbreviation used:*

MA: melanoacanthoma

## CASE REPORT

A 45-year-old African-American woman in excellent health presented to the Columbia University Department of Oral and Maxillofacial Surgery with a chief complaint of "a discoloration on the roof of [her] mouth." Questioning indicated that the discoloration developed suddenly, was painless, and had grown rapidly during the last 2 weeks. No other abnormal body pigmentation was reported by the patient nor were any observed on the exposed body surfaces.

Extraorally, no facial swelling or cervicofacial lymphadenopathy was present. The intraoral examination found a large brown, well-delineated patch involving the posterior palate (Fig 1). The discoloration extended from the molar region to the anterior palatal rugae and covered most of the palatal vault including a torus palatinus (bony exostosis). Palpation indicated that the lesion was painless and flat. No other abnormal intraoral pigmentation was present, and no radiographic changes were noted. An incisional biopsy was performed and sent for histologic analysis, with a request to rule out melanoma.

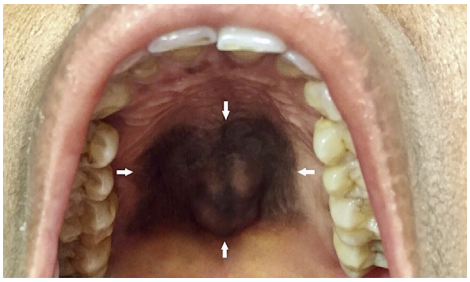

**Fig 1.** Oral melanoacanthoma. Intraoral view of palatal pigmented lesion. Arrows indicate the borders of the lesion.

Numerous dendritic melanocytes, distributed throughout all layers of the surface epithelium, were clearly visible when the specimen was examined microscopically (Fig 2). These histologic findings were consistent with a diagnosis of MA.

## DISCUSSION

The first case of oral MA was reported by Tomich in 1978.[4] Since his initial report, fewer than 100 cases of this entity have been documented. The etiology of oral MA is not fully understood, but it is believed to be a reactive process. A history of trauma has been documented in some cases.[2] Clinically, oral MAs present as well-defined dark-brown to black, smooth, flat, or slightly elevated lesions. They are typically asymptomatic; however, in some cases pruritus, pain,

From the Division of Oral and Maxillofacial Pathology[a] and the Department of Oral and Maxillofacial Surgery,[b] Columbia University Medical Center.

Funding sources: None.
Conflicts of interest: None declared.

Correspondence to: Scott M. Peters, DDS, Columbia University Medical Center, 630 West 168th Street, PH15W-1562, New York, NY 10032. E-mail: smp2140@columbia.edu.

JAAD Case Reports 2018;4:138-9.
2352-5126



https://doi.org/10.1016/j.jdcr.2017.11.023

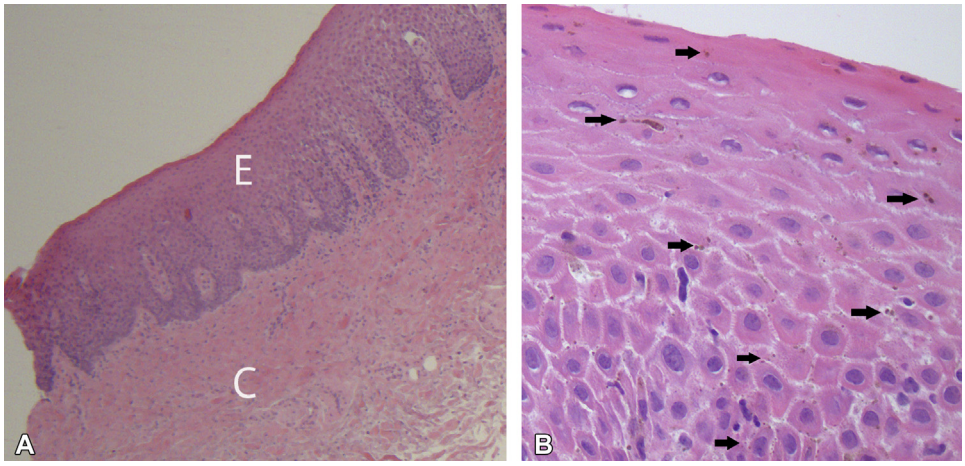


**Fig 2.** Oral melanoacanthoma. **A**, Low-power microscopic appearance of the surface epithelium (E) and underlying connective tissue (C). **B**, The surface epithelium shows numerous dendritic melanocytes (arrows). (**A** and **B**, Hematoxylin-eosin stain; original magnifications: **A**, ×40; **B**, ×400.)

or burning has been reported.[5] MAs rapidly increase in size and can reach a diameter of several centimeters within a few weeks.[6] Because of this alarming presentation, biopsies are often performed to rule out melanoma. On microscopic examination, the melanin-producing dendritic melanocytes, which are normally limited to the basal epithelial layer, are heavily scattered throughout the surface epithelium. It is the dispersal of melanocytes into epithelial layers other than the basal epithelium that causes the discoloration and facilitates diagnosis. Epithelial acanthosis, spongiosis, and increased numbers of basal melanocytes are also important microscopic findings.[2] Once a diagnosis of MA is rendered, no additional treatment is required. MA often regresses spontaneously and has no malignant potential.[5]

Although cutaneous MAs have also been observed, the cutaneous variant is distinctly different from its oral counterpart. Cutaneous MA, first described by Bloch in 1927,[3] is a benign mixed proliferation of keratinocytes and melanocytes and is considered to be a variation of seborrheic keratosis. Most cases of cutaneous MA have been seen in middle-age white adults without a gender predilection. The trunk is the most frequently affected site, and lesions present with a roughened or papillary surface.[7] This appearance is in contrast to that of oral MA, which frequently appears as a rapidly expanding flat or slightly elevated pigmented lesion, usually involving the buccal mucosa. Unlike cutaneous cases, oral MA favors African-American women, with a mean age of presentation in the fourth to fifth decades of life.[3]

The clinical differential diagnosis for oral MA may include other pigmented mucosal lesions such as physiologic pigmentation, medication-induced pigmentation, mucosal (intraoral) nevi, focal melanosis, and most importantly, melanoma.[5] Most of these entities can be excluded with an accurate history, as only oral MA will achieve such a rapid growth in size during a period of only a few weeks. However, in cases in which such a history cannot be ascertained or is unknown, the histologic examination provides the definitive diagnosis.

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