We here present five cases of congenital melanotic lingual macules seen in our hospital. All the patients were healthy and normally thriving. A close follow-up showed that lesions were non-evolutive and allowed us to exclude malignancies. Pigmented oral lesions may show great variability in presentation, hue, number, size, and location in the oral cavity. Congenital, stable lesions generally raise less concern than acquired and/or rapidly evolving spots. As for tongue lesions, an accurate patient history and thorough head-to-toe physical examination in search for other lesions or stigmata of known syndromes is -in most cases- sufficient to exclude malignancies. Lesion excision should therefore not represent the first choice if a close clinical follow up can be established.

Key words: Lingual macules; Pediatrics; Dermatology

CASE SERIES

Patient 1
A male Italian newborn was referred to us at day of life 11 for four congenital pigmented spots on the upper left side of the tongue. A whitish patch was present all around the pigmented lesions, and contralaterally (Figure 1A), where no melanotic spots were present. The baby was asymptomatic and fed well.

Patient 2
A male Bengalese newborn presented with a pigmented brown streak along the median line of the tongue. The lesion was present all around the pigmented lesions, and contralaterally (Figure 1A), where no melanotic spots were present. The baby was asymptomatic and fed well.

Patient 3
A 2-month Italian toddler exhibited since birth several black macules on the upper side of the tongue. Surrounding white discoloration was interpreted as a possible mycosis and therefore treated with one week of topical antifungal therapy associated with daily rubbing of lingual surface, without any change in the pigmented spots (Figure 1C).
Congenital lingual macules

Figure 1 A, congenital pigmented tongue spots in a 11-day male Italian newborn; B, congenital pigmented brown streak along the median line of the tongue in a 4-week male Bengalese newborn; C, black macules on the upper side of the tongue of a 2-month Italian toddler, unchanged after one week of topical antifungal therapy; D, brown spots along the median line of the tongue of a 1-year-old Bengalese boy, reported as present since birth without any growth or modification; E, pigmented macules of the tongue, unchanged from birth, in a 10-week female Italian newborn.

Figure 2 Two possible differential diagnoses of congenital melanotic lingual macules. A, microcystic lymphangioma (usually presenting as vesicular, transparent “frog eggs-like” lesions, sometimes blackened due to traumatic hemorrhage); B, lingua nigra villosa or black hairy tongue, an acquired condition usually occurring after prolonged antibiotic therapy.

emergency. Incidentally, asymptomatic brown spots along the median line of the tongue were detected (Figure 1D). Parents reported that those lesions were present since birth, and never grew nor modified. The boy was otherwise healthy and thriving.

Patient 5
Pigmented macules of the tongue (Figure 1E) were noticed since birth in a 10-week female Italian newborn. She received two weeks of topical antimycotics with no change in the lesions. The baby was asymptomatic and normally thriving.

DISCUSSION
Multiple conditions may be accountable for focal hyperpigmentation of the oral mucosa: among others, exposure to drugs/toxics; post-traumatic submucosal hemorrhages; small hemangiomas or microcystic lymphangioma (usually presenting as vesicular, transparent “frog eggs-like” lesions, sometimes blackened due to traumatic hemorrhage, as in the patient of Figure 2A); post-radiotherapy pigmentation[1]; pigmented fungiform papillae; lingua nigra villosa or black hairy tongue (an acquired condition usually
Pigmented oral lesions may show great variability in presentation, hue, number, size, and location in the oral cavity. Congenital, stable lesions generally raise less concern than acquired and/or rapidly evolving spots. As for tongue lesions, an accurate patient history and thorough head-to-toe physical examination in search for other lesions or stigmata of known syndromes is sufficient to exclude malignancies. Lesion excision should therefore not represent the first choice if a close clinical follow up can be established.

CONCLUSIONS AND FINAL REMARKS

Pigmented oral lesions may show great variability in presentation, hue, number, size, and location in the oral cavity. Congenital, stable lesions generally raise less concern than acquired and/or rapidly evolving spots. As for tongue lesions, an accurate patient history and thorough head-to-toe physical examination in search for other lesions or stigmata of known syndromes is sufficient to exclude malignancies. Lesion excision should therefore not represent the first choice if a close clinical follow up can be established.

REFERENCES

