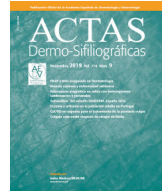




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Challenging Cases

A Spot on the Palate

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10 Clinical history

Q2 A 43-year-old woman with no relevant medical history presented with a 2-week history of asthenia, myalgias, and generalized arthralgias accompanied by skin lesions.

14 Physical examination

15 Physical examination revealed erythematous-violaceous papules over the metacarpophalangeal and proximal and distal interphalangeal joints of both hands (Fig. 1), as well as on the elbows and knees. Dilated capillaries and periungual erythema were also observed, together with an ill-defined hyperpigmented plaque on the upper chest. Examination of the oral cavity showed an oval erythematous macule with well-demarcated whitish areas located on the midline of the hard palate (Fig. 2).

23 Histopathology

24 Skin biopsy of one of the hand lesions showed vacuolar interface dermatitis with interstitial mucin deposition.

26 Other additional tests

27 Blood analysis included a polymyositis immunoblot, which was positive for anti-Mi-2b antibodies. Tumor marker analysis showed a mild elevation of CA 15-3 (32.6 U/mL) and squamous cell carcinoma antigen (SCC, 2.4 ng/mL). Thoracoabdominopelvic computed tomography, mammography, and abdominal ultrasound were performed and showed no abnormalities.



Fig. 1.

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Fig. 2.

33 What is your diagnosis?

34 Diagnosis

35 Dermatomyositis with anti-Mi-2b antibodies.

36 Course of the disease and treatment

37 Treatment with high-dose corticosteroids and methotrexate 15mg weekly produced progressive clinical improvement. After 6 months of follow-up, no underlying malignancy was detected.

41 Comment

42 The palatal ovoid patch is a very uncommon sign of dermatomyositis that appears as a well-demarcated, nonulcerative erythematous macule on the posterior hard palate.¹ This mucosal lesion was first described in 2016 by Bernet et al., who reported its presence in 18 of 45 patients (40%) and found that it was significantly associated with anti-TIF1 γ antibodies and strongly associated with internal malignancy.² Since then, three additional articles addressing this finding have been published in the literature, summarized below.

Reference	No. of cases	Sex (n)	Age (median)	Antibody subtype (n)	Underlying neoplasm (n)	Type of neoplasm
Bernet et al. (2016) ²	18	Female (17), Male (1)	59	Anti-TIF1 γ (15), no antibody (3)	Yes (7), No (11)	Not specified
Bhat-ta-char-gee et al. (2020) ³	1	Female	48	Not performed	Not studied	-
Fran-ciosi et al. (2020) ⁴	1	Female	80	Anti-TIF1 γ	Not studied	-
Liu et al. (2023) ⁵	1	Female	58	Anti-TIF1 γ	Yes	Ovary
Present case	1	Female	43	Anti-Mi-2b	No	-

53 In contrast with previous reports, in our case the presence of a palatal ovoid patch was not associated with malignancy or with the TIF1 γ immunophenotype but rather with another antibody, anti-Mi-2b, an association not previously described to our knowledge in the literature. This antibody is associated with a classic dermatomyositis phenotype, a good response to treatment, and a low association with malignancy or interstitial lung disease.⁶

54 Because no underlying malignancy was detected in our case and the patient was positive for anti-Mi-2b antibodies, malignancy surveillance recommended for dermatomyositis will be continued. This is particularly relevant given that previously reported cases with palatal patches – both those associated with anti-TIF1 γ antibodies and those not tested – appear to show a higher frequency of associated tumors.

67 Conclusions

68 In conclusion, we emphasize the importance of oral examination in patients with suspected dermatomyositis because, despite the case presented here, the ovoid palatal patch does not appear to be an exclusive finding in patients with anti-TIF1 γ antibodies.

72 Conflict of interest

The authors declare no conflict of interest. Q3

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