THE DENTAL SOCIETY OF GREATER ORLANDO

Journal

SPRING 2025

DENTISTS' DAY ON THE HILL

UPDATE email on FL Water Fluoridation

Specialist Corner

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A MEANINGFUL AND MEMORABLE JOURNEY

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- UCF WAX WORKSHOP

The 2025 Florida Mission of Mercy (FLA-MOM) took place in Daytona Beach on March 21-22!

With your help, the Florida Dental Association (FDA) Foundation was able to have a positive impact by relieving pain and restoring smiles for patients in Volusia County.

SUCCESSES:

- *$1.9 million in donated dental care*
- *1,511 patients treated*
- *10,264 procedures*
- *Over 20,000 volunteer hours provided by 2,070 volunteers*

fda foundation
FLORIDA DENTAL ASSOCIATION
PRESENTS
FLA MOM
MISSION OF MERCY
A HIGHER STANDARD ... A HIGHER CALLING

2026 Florida Mission of Mercy Volunteer Pre-registration

Thank you for your interest in volunteering at the

2026 Florida Mission of Mercy

May 15 - 16, 2026

Jacksonville, FL

Prime Osborne Convention Center

What's Inside

A Meaningful *and Memorable Journey*

Dearest Members of The DSGO,

As my term as President comes to a close, I want to take a moment to express my deepest gratitude to each of you for the privilege of serving this organization. It has grown to be among the greatest honors of my professional life.

Over the past year, I have grown tremendously — not only as a leader but also as a colleague and friend. This role has offered me invaluable opportunities to listen, to learn, and to lead alongside a talented and dedicated group of professionals in our dental community. Your support, collaboration, and shared commitment to excellence have made this journey both meaningful and memorable.

I am immensely proud of what we have accomplished together: from strengthening our membership meetings, to expanding our means of communication and fostering deeper connections among members. None of these achievements would have been possible without the collective efforts of our board of directors, and committed volunteers. Thank you for your trust, your encouragement, and for inspiring me daily.

Though my term as President is ending, I look forward to continuing to support the mission of The DSGO mission and cheering on the remarkable leaders who will guide us forward. The future of our organization is bright, and I am excited to see all that we will continue to achieve together.

Warm Regards,

ArNelle Wright, DMD, MS

Dr. ArNelle Wright
DSGO PRESIDENT
2024-2025
863-514-7607

IMPORTANT REMINDER
FOR MEMBERSHIP MEETINGS

We truly value your participation in the Dental Society of Greater Orlando's membership meetings and events. To help us plan effectively and ensure we provide the best possible experience, we kindly ask that all members who RSVP for meetings make an effort to attend. If you are unable to join us, please notify us in advance so we can adjust our arrangements accordingly. Your cooperation helps us maintain a high standard of organization and ensures we can offer meaningful and productive events for all.

Thank you for your continued commitment and engagement!

Dr. Sara Shah
STB DSGO President of 2025-2026

IN MEMORIUM

Curtis F. Johnson
11/3/41-3/18/25

Dr. Ross T. Enfinger
8/9/77-5/4/25

PADO Wellness: Bringing Whole-Body Healing to Dental Professionals and Patients

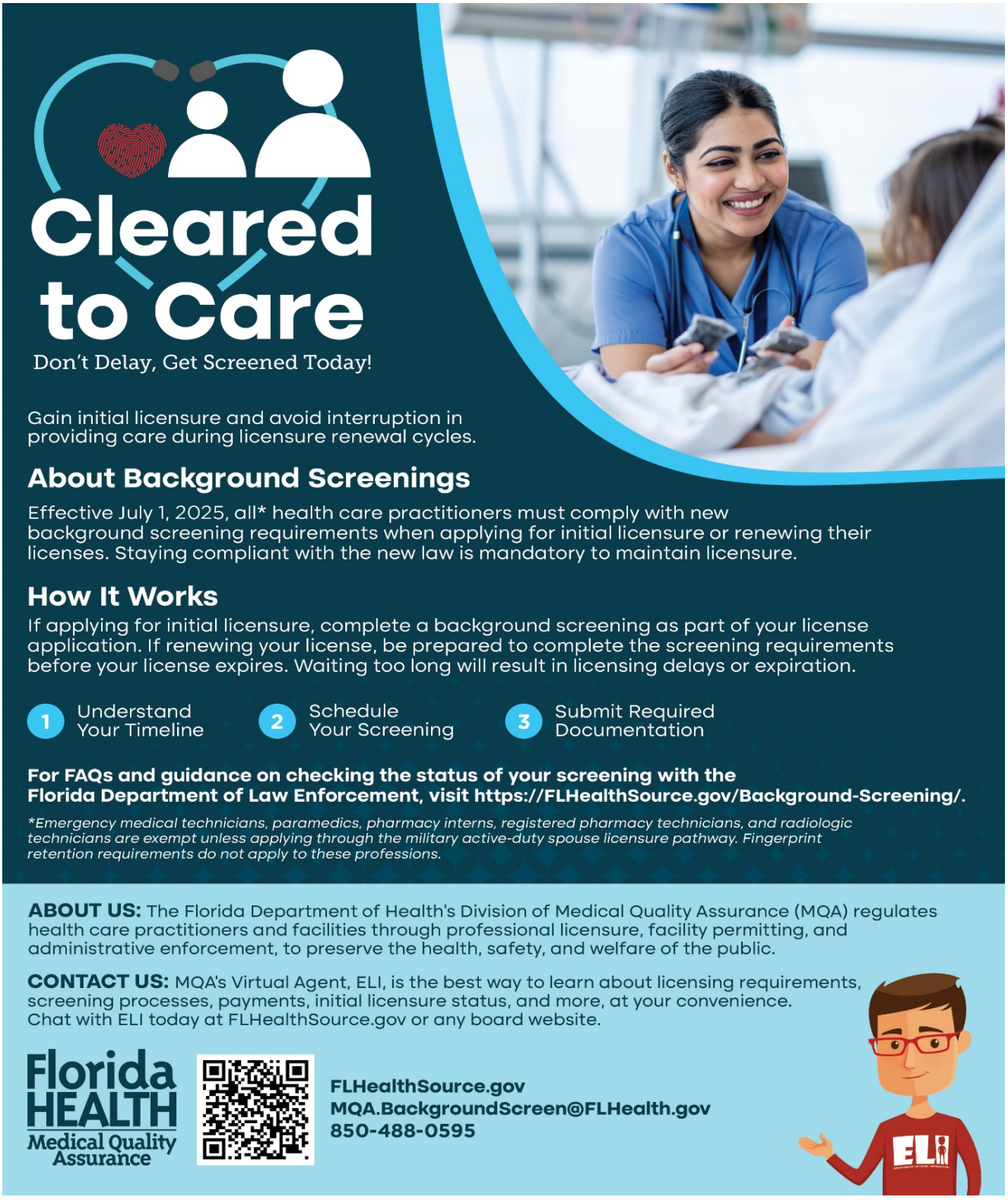
PADO WELLNESS CENTER

We're excited to share that **PADO Wellness Center**, located next to Advanced Endodontics in Lake Mary, is now offering **Physical Therapy** services for dental professionals and patients experiencing neck, shoulder, and back pain — common issues for those of us in dentistry. Our licensed physical therapists are trained to address musculoskeletal strain caused by long hours of clinical work or postural challenges.

Additionally, **Red Light Therapy** is now available to help **reduce pain, stimulate salivary flow**, and assist in the **healing of oral mucositis**. This non-invasive treatment is ideal for patients undergoing radiation therapy, individuals with xerostomia, or anyone looking to support tissue regeneration and comfort.

PADO Wellness is proud to support comprehensive health — because when our bodies feel better, we perform better.

For referrals or to learn more, contact us at 407-229-7236.



NEW! Fingerprinting at FDC2025

All Florida **licensed dentists and hygienists** renewing their license by February 28,2026, **must undergo a fingerprint-based Level 2 background check, including state and national criminal records checks**, and are required to comply with the background screening requirements established in section 456.0135, F.S.

Click here to add an appointment to your FDC registation. Our Livescan vendor will take digital fingerprints and your photograph and then submit them to the Florida Department of Law Enforcement to conduct the Level 2 background check. The total time to take prints/photo will be approximately 5 minutes.

2025-2026 DSGO BOARD OF DIRECTORS

Swearing in of the 2025-2026 DSGO Board of Directors at the May 2025 Membership Meeting.

Are We Doing Too Many *Crowns?*

By John Gammichia, DMD, FAGD

This happens all the time in our offices. 45 year old comes in with an MOD amalgam/composite filling on tooth #19 and the lingual cusp broken off. And it's in bad shape and you tell this patient they need a build-up and an onlay/crown.

Then the patient asked how much is all that. And at my office it is in the $2,000-$2,100. And this father of 3 kids under 11 years old has a painful look and asked, "How much to take it out?"

My name is Dr. John Gammichia; I work in the NW part of Orlando in Apopka. It's is blue collar town with real life going on. Not everyone can afford "ideal" dentistry. In this scenario, are there other options?

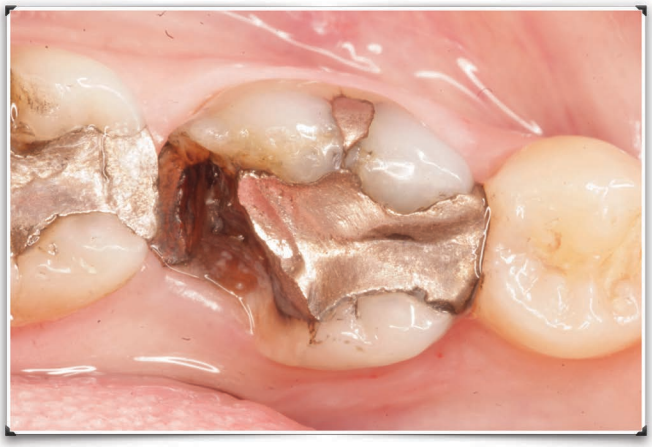
What happened to the large, complex composite restoration? I am old enough to learn in dental school the minum pin amalgams. And I am still impressed when I see the 30 year old 2 cusp amalgam restoration done by the military.

Why do we not entertain just restoring it? In my office we utilize this option all the time. In fact, this has become my treatment of choice. The "ideal" treatment has become the more conservative approach.

I used to tell the patient, "This is a very big filling and I just don't know if this is going to last" But then I would see this restoration on recall and it would look great. Then I did this treatment again and again and I would continue to monitor them … and much to my surprise, they looked great.

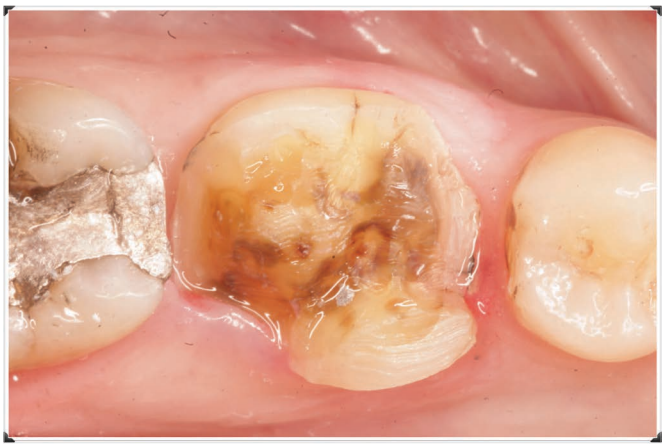
But now, through experience, I really believe in this. I do a complex composite restoration every time. I find it is a great treatment. I find that it is very profitable. I find almost every patient is thrilled (raving fans) and I find that they last.

Okay, now I am going to back up everything I just said with another real life story. This time with photos. One of my hygienists has a woman who cleans her house. This "cleaning lady" (we will call her Betty) knew that she worked for a dentist. Betty came to my hygienist upset. See Betty had broken a tooth and she was told she needed a build-up and crown. Betty was upset because she just didn't have the money to fix her tooth. My hygienist suggested to Betty that she see me.



This is what the tooth looked like when I first saw her. I was thinking to myself, "this is no big deal. I pride myself on doing exquisite composite, I can do this no problem." We talked about the price and how long it would take and she was on board.

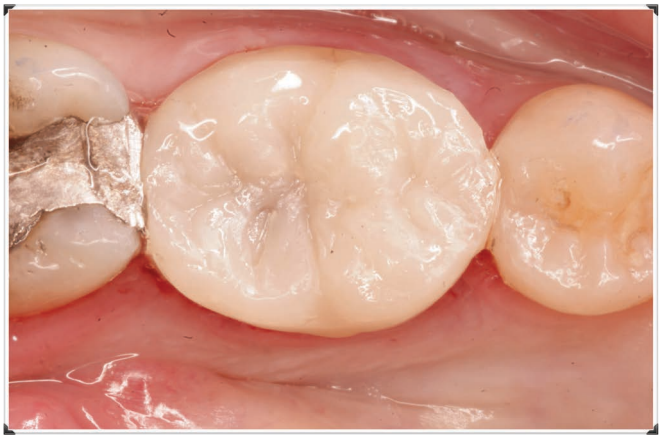
I began by taking the old amalgam out and then the most unexpected thing happened. The buccal cusps broke off. It became very apparent that the amalgam was holding these cusps in place and when I took the amalgam out, there went the cusps. Now, I have one cusp left on this tooth (oh snap) and I know she doesn't have the money for an onlay.



This is what the tooth looked like after removing the old amalgam and the decay. There wasn't a lot of tooth left but I have done big fillings before, this one was just going to be bigger.

I electrosurged the Distal-Lingual tissue away then wrapped my tofflemire (Dixieland) matrix around this tooth and held it down with my finger. I use a bonding system that I really trust (SE Protect) and then started building up this tooth with composite.

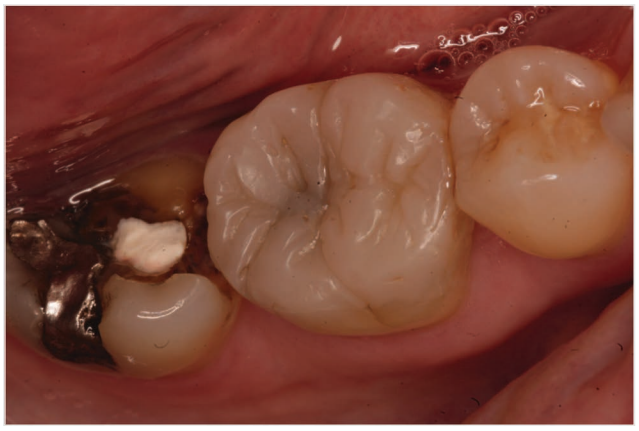
It comes out of the matrix pretty raw but you just start forming this composite to look like a tooth. And after all the forming and putting in anatomy, I was pretty happy with the results.



Ok. So never see her again. And I start thinking about this tooth after some time. I then ask my hygienist if she still sees Betty. She told me sadly Betty no longer cleans her house.

I then went to the computer system and found Betty's phone number. What do I have to lose, so I text her. Turns out it is still her number and I call her. I introduce myself and ask her how our tooth is doing. She said, "You are not going to believe this but the tooth has recently broken." I was happy and sad at the same time. See it has been over 9 years and I am happy it lasted for all that time but I really wanted it to last decades. I asked if she could take a photo of it so I can see how this restoration broke and maybe I could learn from the photo.

She sent me two really bad photos that I couldn't see anything, so I just asked her if she could come in so I could take a photo of this tooth. She agreed and the photo below is the photo I took EIGHT AND A HALF YEARS AFTER THE COMPLETION OF THIS FILLING!!



See as it turns out, the restoration was still looking pretty darn good and the tooth that actually broke was #31.

Now, I know you are thinking this is a one off. But actually this is more of the rule than the exception at my office. I do large restorations all the time and I fully expect them to last for at least one decade. In fact, I had two different patients break the lingual cusps off of their lower first molar yesterday. I removed the old restoration, and restored this tooth with a beautiful composite restoration in less than 30 minutes. Everyone wins.

I am not telling you to change the way you practice. But what I am telling you is that you can get creative when someone is not interested in "ideal" dentistry. The complex composite restoration is fun to do, it lasts a very long time, it can be a very profitable procedure and I assure you, you will make raving fans of your patients.

PRIMROSE LANES EVENT

DENTAL SOCIETY OF
GREATER ORLANDO
AN AFFILIATE OF THE CENTRAL FLORIDA DISTRICT, AMERICAN & FLORIDA DENTAL ASSOCIATIONS

The Board of Directors for the Dental Society of Greater Orlando planned a reclamation, retention, and recruitment event at Primrose Lanes, in Winter Park, Florida. The event was held on April 10, 2025 from 6-8 PM, and although members of The DSGO were invited to attend, our primary focus was to connect with non-members in an effort to display value for membership.

Dentists' Day on the Hill 2025

Daniel J. Crofton, D.D.S., M.D.

On Tuesday, March 25, 2025, approximately 95 dentists from all over Florida met in Tallahassee for our annual Florida Dental Association's (FDA) Dentists' Day on the Hill (DDOH). The weather was beautiful and the skies were blue as dentists headed up Capitol hill. The legislative session convened on March 4th and will adjourn on May 2nd. The Dental Society of Greater Orlando (DSGO) was represented this year by Steve Hochfelder, Bernie Kahn, Brenna Kever, Katie Miller, Don Thomas, Tony Wong and myself.

This year's event was well-organized by our FDA Governmental Affairs Office (GAO) led by Joe Anne Hart, Jamie Graves, Brandon Edmonson and Jerilyn Bird of the Alliance of the FDA. On Monday night, March 24th, the staff of the GAO kicked-off the event with a legislative briefing at the Hotel Duval which was followed by a complimentary buffet dinner. Our FDA director of governmental affairs, Joe Anne Hart, hosted the briefing. Joe Anne, Jamie and Brandon did a terrific job reviewing the issues of interest. Numerous legislative guests arrived at the briefing and welcomed the participants. Our dental colleague, Michael Friend, DMD was introduced and mentioned that he is running for the Florida House of Representatives for the 2026 election to represent District 102 in south Florida.

Joe Ann and Brandon presented the FDA's position on each issue. Brandon noted that the FDA supports community water fluoridation at 0.7 parts per million. Legislation has been filed to prohibit community water fluoridation. Senate Bill 700 (SB 700) sections 31 and 32 and House Bill 651 (HB 651) sections 31 and 32 would preempt local governments' authority to determine if their communities should be fluoridated. **The FDA does not support these two sections of these bills and feels that this decision should remain at the local level.**

Dental therapy legislation returned again this year. Dental therapists are educated for as little as three years after high school and would be authorized to administer local anesthesia and to perform irreversible procedures like extractions and partial root canals.

Proponents of dental therapists claim that this would be a solution to address an access to care problem in underserved areas. **The FDA is opposed to dental therapists practicing in Florida because this is not a proven or effective solution.**

The FDA supports legislation to ensure that all dentists licensed in Florida are graduates of dental schools accredited by the Commission of Dental Education (CODA).

Legislation passed last year allows for licensure by endorsement for all health care professions licensed under chapter 456. This legislation known as the Mobile Opportunity by Interstate Licensure Endorsement or MOBILE Act allows for a dentist to come to Florida, but

not to be held to the same standard as a graduate of a CODA-accredited dental school. SB 286 and HB 509 or so-called glitch bills would ensure that no matter what pathway is used to obtain a Florida dental license, that everyone would be subject to the same standards for their dental educations.

The FDA supports funding for the Veterans Dental Care Grant Program administered through the Florida Department of Veterans Affairs (DVA). Currently, unless a veteran is 100% disabled or has a direct service-connected injury impacting their oral health, they do not qualify for dental care once they leave active duty. The FDA is making a budget request for $1 million in non-recurring funds to implement this grant program.

The Florida Mission of Mercy (FLA-MOM) is a two-day dental clinic that rotates to a different part of Florida annually and helps thousands of Florida citizens who are suffering from dental pain or who require routine dental care. This year the FLA-MOM clinic was held in Daytona Beach and provided approximately $1.8 million worth of dental care. **This year the FDA is requesting $500,000 for the 2026 FLA-MOM, event to be held in Jacksonville**.

The FDA supports increasing funding for dental services in the Medicaid program which includes increasing dental reimbursement rates. Last year the Legislature allocated $35 million to dental services, however, Florida still ranks at the bottom of all states for Medicaid dental reimbursement rates.

During the remainder of this legislative session, the Legislature will be grappling with the Florida state budget of $116.5 billion. The Senate and the House are both working on their own budgets and a conference committee will be required to negotiate their differences. This year the budget was negatively impacted by the severity of hurricanes that struck the state. Hopefully, sufficient funds will be allocated to FDA supported programs.

During DDOH, your DSGO members met

with 14 of our local legislators or legislative aides. We met with Sen. Tom Wright (R-Port Orange), Rep. Jon Albert (R-Winter Haven), Rep. Webster Barnaby (R-Deland), Rep. Lavon Bracy Davis (D-Orlando), Rep. Anna Eskamani (D-Maitland), Rep. Rita Harris (D-Orlando), Rep. David Smith (R-Winter Springs), Rep. Leonard Spencer (D-Orlando), Rep. Paula Stark (R-St. Cloud) and Rep. Chase Tramont (R-Port Orange). We met with the legislative aides of Sen. Kristen Arrington (D-Kissimmee), Sen. Jason Brodeur (R-Lake Mary), Sen. Keith Truenow (R-Tavares) and Rep. Bruce Antone (D-Orlando).

On a sad note, one of our local politicians and pillars of our community, Sen. Geraldine Thompson (R-Orlando) passed away on February 13, 2025. Sen. Thompson graciously met with local FDA members during DDOH for years. The DSGO members fondly recalled our meetings with Sen. Thompson and all agreed that her soft-spoken advice will be missed both in Tallahassee and in central Florida.

Legislators met with all of the dentists in attendance. The goal of the dentists was to make sure that our issues were heard and understood and that the way we practice dentistry will be preserved so Floridians can continue to receive the highest level of care. DSGO members can rest assured that dentists have an excellent reputation among the legislators and that our issues will continue to be given serious consideration.

The legislators complemented the job that our GAO staff is doing by informing the legislators and their staffs about our issues and guiding our bills through the legislative process. This year's DDOH was again well organized, well staffed and well attended.

I would also like to acknowledge other members of our FDA team who assisted the dentists this year. Our FDA Executive Director Drew Eason supervised the gathering. FDA chief financial officer Greg Gruber was in attendance and FDA President Dr. Jeff Ottley welcomed the dentists to the Monday night briefing.

A lunch buffet was provided to all of the attendees by the Alliance of the FDA. Lunch was served in the TCC Center for Innovation. Lunch was a welcome break after a busy morning visiting with legislators.

Our DSGO legislative team Bernie Kahn, Brenna Kever and I will be following all of the above legislators and issues and continue to inform you about important events taking place. Advocacy remains one of the most valuable benefits that organized dentistry provides to members. For more information on these topics I encourage you to check out the FDA website at www.floridadental.org. The Capital Report can be found on the FDA website and the report is a very informative publication.

If anyone is interested in attending DDOH 2026, then please contact our DSGO executive director Sharon Hamilton for more information. If you have never been to DDOH, then please consider attending with us at least once. This is a fun and interesting meeting with our colleagues that only takes you away from the office for a day and a half. Important issues that influence the way we practice dentistry are being addressed in Tallahassee and it is important that we pay attention to what is happening there or else there may be consequences for our profession. I encourage any and all DSGO members to be attentive to these issues, to support candidates who support our Tooth Party and to plan on attending DDOH 2026 next January. Please try to attend next year because there is strength in numbers!

UPDATE email on FL Water Fluoridation

Florida Dental Association
From: fda@floridadental.org
To: a.belknap@aol.com

We need your help! Contact the governor today!

May 2, 2025

Dear Dr. Belknap,

During the 2025 Legislative Session, the Legislature passed **SB 700**, the legislative priority for Commissioner Wilton Simpson, head of the Florida Department of Agriculture and Consumer Services. **SB 700**, which was know as the "Farm Bill," contained several different provisions, including a provision to prohibit local governments from adding fluoride to their water supply. The Florida Dental Association (FDA) opposed SB 700, sections 31 and 32, which established the language to prohibit fluoridation.

As **SB 700** moved through the legislative process, it was apparent that facts and scientific evidence showing that fluoridation is safe and effective at the optimal level of 0.7 parts per million was not significant enough to stop the bill or amend the language out of the bill.

Misinformation and distorted reports that referenced higher levels of fluoride in other countries were justification enough to move forward with language taking away citizens and local governments' rights to decide what is best for their communities.

SB 700 now heads to Gov. Ron DeSantis for final action. The governor can sign the bill into law, veto the bill or allow the bill to become law without his signature.

We need you to contact the governor and urge him to veto SB 700.

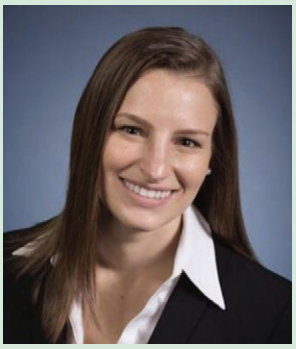
You can click on the alert below to send a message (which can be personalized) or you can send a message through the **governor's web portal**.

In case you missed it, click **here** to view FDA President Dr. **Jeff Ottley's** message about fluoridation.

Additional information on fluordation can be found at:

- **FDA Fluoridation**
- **ADA Fluoridation**
- **ADA Key Messages on Fluoridation**
- **American Fluoridation Society**
- **Fluoridation for the Patient: JADA June 2024**
- **Fluoride: Fact Sheet for Health Professionals**
- **AAP's Campaign for Dental Health: Court Case**
- **AAP's Campaign for Dental Health: NTP Report**

"TRIPLE B" BELKNAP BIOPSY BRIEFING



By Dr. Austin N. Belknap

This column will be published quarterly to The Dental Society of Greater Orlando Journal as a contribution from Dr. Austin N. Belknap, the clinical oral pathologist and newest provider at **Orofacial and Dental Implant Surgery**. The article will provide readers one case that was referred to Dr. Belknap who clinically investigates, identifies, and manages diseases affecting the oral and maxillofacial region. Dr. Belknap's case presentation is to provide awareness and insight on important and challenging oral diseases. Clinicians are invited to submit referrals from their practices and the cases may be featured in "Triple B" with credit given to the submitter. Questions, comments, and referrals can be submitted to Dr. Belknap at: abelknap@ofdis.com. Also check OFDIS website for CE opportunities with lunch and learns! No reported conflict of Interest to disclose.

CASE PRESENTATION:
This case is of a 49-year-old female who was kindly referred to our practice from **Coast Dental**. The patient's chief complaint encompassed a lesion of the left ventral tongue that has been present for approximately a year and a half and has continually increased in size. The patient described the lesion as bothersome and uncomfortable, which has caused some difficulty eating, especially within the last couple of months. The patient reported to the referring office and was prescribed Nystatin rinse and triamcinolone dental paste to apply to the lesion. Upon returning to the referring dental office in 2 weeks' time, the medications did not resolve the lesion or the symptoms. The patient's medical history was reported as: epilepsy with grand-mal seizure that occurred last year, acid reflux, hypertension, anxiety, depression, and arthritis — all which are controlled with medications. Her social history was non-contributing and no family history of cancer was reported. Upon clinical examination and as seen in **figure 1**, the lesion can be described as a large convex ovoid ulceration with fibrotic rolling border, and fibrinopurulent exudative membrane center of the left ventral tongue, measuring approximately 2x1.5cm. A month regimen of the anti-fungal therapy Clotrimazole troches was attempted, while the medical clearance was obtained by the patient's neurologist, with no reduction in size of the lesion but mild resolution of the symptoms. An excisional biopsy was completed, which resolved the lesion with no recurrence as of the one-year follow-up.

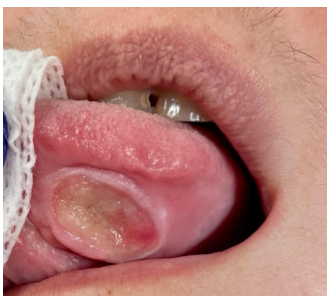


Figure 1: Large convex ovoid ulceration with a fibrotic border and fibro-purulent exudate center of the left ventral tongue, measuring approximately 2x1.5cm.

QUESTION: Which of the following is the most likely diagnosis given the clinical scenario and clinical features illustrated in the image below?

A. Squamous cell carcinoma (SCCa)
B. Aphthous ulcer
C. Necrotizing sialometaplasia
D. Traumatic Ulcerative Granuloma with Stromal Eosinophilia (TUGSE)

A. Squamous cell carcinoma (SCCa)
Incorrect- Due to the high-risk location, I am confident this differential diagnosis crossed your mind. To begin with, the tongue location accounts for greater than 50% of intra-oral cancers in the US. Of these cases, the more common lingual location with two-third of the SCCa cases appearing as painless, indurated masses or ulcers of the posterior lateral border and 20% occurring on the anterior lateral or ventral surfaces of the tongue. Most importantly, the lesion completely mimics clinical features of an endophytic SCCa as central, depressed ulceration with a surrounding indurated rolled border. One final comparison of SCCa to our ulcerative lesion is the amount of time that the lesion has been present. Moreover, oral cancers tend to be slow growing in most cases and require time to create such a large ulceration with destruction of tissue as a common but late finding in most cases. Always remember that SCCa are notorious for their ability to mimic benign conditions and *should always* be considered in the differential diagnosis for oral ulcerations.

B. Aphthous Ulcer
Incorrect- clinical similarities, but symptoms, location, and history does not match. Aphthous ulcers are one of the most common oral mucosal pathoses with 20% occurrence in the general population. These ulcerations have the hallmark symptom of pain which is usually inconsistent to the size of

the lesion(s). Unlike our case, our patient reported the ulcer as bothersome and uncomfortable, but pain was not used to describe her symptoms. As for location, the most common affected oral areas are the buccal and labial mucosa, followed by the soft palate, floor of the mouth, ventral tongue, and tonsillar fauces. Of the two types of aphthous ulcers, our case most likely mimics a major aphthous ulceration. Major aphthous ulcers are larger-1-3cms, deeper, and demonstrate a longer duration of 2-6 weeks. As for the clinical features of major aphthous ulcers the ulceration is usually flat with an irregular shaped erythematous border and deep central fibropurulent exudate. The last important point of distinction from the actual diagnosis, is the fact major aphthous ulcers will only last up to 6 weeks and progressively remain painful throughout the time the lesion is present.

C. Necrotizing Sialometaplasia

Incorrect- Necrotizing Sialometaplasia is a fairly uncommon, locally destructive, benign, inflammatory lesion that most commonly affects the minor salivary glands. The main clinical difference of this diagnosis in regards to our case is the location, with more than 75% of all cases occurring on the posterior palate. Other minor sites of involvement include soft palate, lip, retromolar area, tongue, mucobuccal fold, tonsillar fossa and larynx. Initially lesions typically present as a non-ulcerated swelling, often associated with pain or paresthesia. Within 2-3 weeks, necrotic tissue sloughs out, leaving a crater-like ulcer that can reach more than 5cm in diameter. However, clinical features can vary from swelling to crater-like lesions, which may exhibit no symptoms.

Research has shown that the lesion results due to ischemia of the salivary tissue, which leads to local infarction. The result of the ischemia being a crater like deficit (as seen in **Figure 2**). The most presumable etiology has been linked to local trauma induced by dental treatment, such as local anesthesia followed by dental infections, heavy smoking, alcoholic abuse, traumatic injury, upper respiratory infection, and allergies. Self-healing occurs in within 5-6 weeks, with no need for any additional treatment. Regardless, due to the worrisome clinical presentation, these lesions are usually biopsied to reach a conclusive diagnosis.

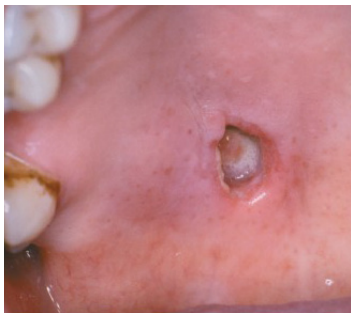


Figure 2: From the Neville et al. Oral Pathology textbook (pg.439)[5] – Later-stage necrotizing sialometaplasia showing craterlike defect of the posterior palate.

Traumatic Ulcerative Granuloma with Stromal Eosinophilia (TUGSE)

Correct!- As I mentioned above, SCCa should always be a top differential diagnosis for a large ulceration of a high risk location, luckily this case was diagnosed as a TUGSE. It is rudimentary knowledge that the oral cavity is prone to acute and chronic traumatic injuries, which results in surface ulcerations. Usually, these surface ulcers heal within days, but TUSGE are a histopathologically unique type of chronic traumatic ulceration that clinically appear extremely worrisome. What makes these ulcerations unique and causes the slow resolution is that they exhibit a deep pseudoinvasive inflammatory reaction as a granuloma flooded with eosinophils. In the majority of cases, including our case, there is an adjacent source of irritation. As seen in **figure 3** (on next page), the lingual tilt of tooth #20 was the source of irritation.

As for the clinical features, these ulcerations form on the sites commonly injured by the dentition- tongue, lips and buccal mucosa. Similar to our case, the individual ulcerations

appear as ovoid in shape with a centralized yellow fibrino-purulent exudate membrane, with rare cases growing in an exophytic manner. The more chronic cases will have a rolled border with an indurated growth clinically mimicking SCCa. Multiple sources states that these ulcerations may last up to a year. As for treatment for these lesions, the source of irritation requires resolution and due to the clinically mimicry of SCCa, an excisional biopsy rules out the possibility of malignancy. Rapid healing after a biopsy is a typical event for large lesions with recurrences not expected. This is an excellent case to stress the importance of properly diagnosing an ulcerative lesion of a high-risk location and to reiterate that this lesion can mimic a malignant process, both clinically and microscopically.

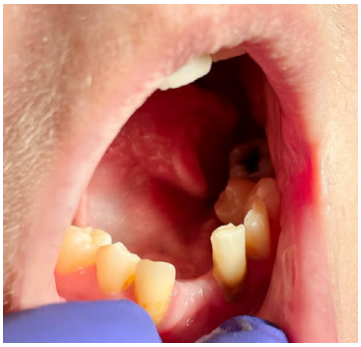


Figure 3: Lingually tilted tooth #20, later extracted, which was identified as the source of irritation of the TUGSE

REFERENCES

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