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Letter to Editor

Dentistry Section

Proliferative Verrucous Leukoplakia - A Perpetuating Ambiguity

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Dear Editor,

Proliferative Verrucous Leukoplakia (PVL) has innumerable confusions in relation to its terminology, stages and mode of diagnosis. It has been defined variably as a progressive model beginning like a simple, solitary patch tending to recur and proliferate over a protracted course and ultimately resulting into an exophytic lesion [1].

Terminology Ambiguity: The term PVL appears to describe a type of leukoplakia spreading out from a smaller, almost flat primary lesion into a diffuse one with verrucal extensions. It fails to describe the enigmatic etiopathogenesis of multiple lesions of PVL which recur. Looking at the components of the term PVL; firstly the word "Verrucous" appears questionable as the initial lesions are generally not warty and the verrucous projections appear only later [2]. Secondly, calling it a PVL does not appear justifiable since 'verrucous Leukoplakia (VL)' is a clinical term without any established histopathology. Thirdly, considering it a type of 'Leukoplakia' when it is not similar to leukoplakia in many aspects seems incorrect.

Classification of PVL as a Subtype of Leukoplakia: It is inappropriate to consider PVL as a type of leukoplakia as it is different from conventional leukoplakia in its unknown etiology with questionable viral role, frequent involvement of keratinized mucosa, presence of widespread and multi-focal lesions, recurrent nature, resistance to therapy and high rate of field cancerization [3].

PVL: Potentially malignant or malignant?: Hansen's grading describes PVL as a ten stage histopathological continuum with homogenous leukoplakia at one end and a malignancy at the other [1]. The World Health Organization has further described PVL as a distinctive high-risk (with high potential for malignant transformation) leukoplakia [4]. Term 'Potentially malignant' only carries a potential to change into a cancer, whereas the spectrum of PVL includes malignancy. Hence, calling it as a potentially malignant leukoplakia and a malignancy at same time is inappropriate.

Discrepancies in Staging: The Hansen's staging with the differences being forwarded by Batsakis et al., perplex the situation [1,5]. These inconsistencies have occurred firstly, because PVL is a multi-stage disease and the lesions in different evolutionary stages can be present at one point of time. Secondly, individual perception of the clinical lesions; leukoplakia, VL, Verrucous Hyperplasia (VH), Verrucous Carcinoma (VC) and carcinoma could refrain from compatible data. Thirdly, there are histological inconsistencies in the literature regarding the presence or absence of dysplasia, diagnosing it as VH or VC and inclusion of papillary squamous cell carcinoma as a component of PVL or not [1,5].

Diagnostic Dilemma: The bewildering stages of PVL and their clinical appearances bring along diagnostic difficulties. For example, PVL has not been well defined and entities like "VH" and "VC" may be clinically identical. Histological identification is made difficult often due to small specimen size, poor orientation, and failure to sample margins. Further, multiple biopsies including adjacent normal tissue for appropriate interpretation becomes necessary.

Retrospective clinical diagnosis, multiple biopsies over several years, late detection, enigmatic etiology, no successful treatment as yet and recurrence after treatment adds hay to fire. With so many uncertainties encompassing PVL, the authors feel a pronounced need for exploration in its present concepts.

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