I. INTRODUCTION

Amyloidosis refers to a heterogeneous group of disorders characterised by the extracellular deposition of fibrillar Congo red positive proteins in various tissues of the body\(^1\). Amyloidosis can be localized or generalized, which is very important in the prognosis and treatment of the patient\(^2,3\). Localized amyloidosis in the head and neck is a rare and benign disease. Although the larynx is the most common site of involvement, the oral cavity may also be involved in localized amyloidosis of the head and neck\(^4\).

Amyloidosis affecting the oral cavity tends to involve the tongue, buccal mucosa and gingiva\(^2,4\). Involvement of the palate is rare, with only six cases in the literature\(^4-6,8-10\). We have described an additional case of primary localized amyloidosis of the palate with review of literatures.

II. CASE REPORT

A 49-year-old woman presented with a chief complaint of an asymptomatic swelling of the palate. The patient had noted discomfort for approximately 2 months prior. Her medical and family history was not remarkable. Physical examination revealed a 4×3 cm, soft, nodular tumor mass on the left palate (Fig. 1a). The patient had no paresthesia or limitation of mouth opening. Neither mucosal ulcerations nor cer-
vical lymphadenopathy was detected, CT scan demonstrated an expansile mass with slight peripheral enhancement without evidence of bony invasion (Fig. 1b). Based on clinical and radiographic findings, a presumptive diagnosis of pleomorphic adenoma was made. The lesion was biopsied and subsequently treated by total excision. The postoperative course was uneventful, and there was no sign of recurrence during 3 years of follow-up.

Cut surface of the lesion was relatively homogeneous pink to gray–yellowish. Microscopic examination revealed extensive stromal deposition of pale eosinophilic amorphous hyaline material in the lamina propria and submucosa, which often involved the walls of small blood vessels and occasionally surrounded the residual salivary parenchyma (Fig. 2a). Apple green birefringence was seen when histologic sections stained with Congo red were viewed with polarized light, thus identifying amyloid (Fig. 2b). There was no evidence of plasma cell aggregates in the lesion. A histopathological diagnosis of an amyloidosis was made. The patient underwent extensive workup including a skeletal survey, chest radiograph, electrocardiogram, urinalysis, serum creatinine, liver function tests and serum electrophoresis. There was no evidence of systemic involvement.

III. DISCUSSION

There is a wide differential diagnosis that should be considered in patients presenting with nodular palatal lesion such as in our patient, various soft tissue tumors, adenomatoid hyperplasia, lymphoproliferative disease, and salivary gland tumours would be among the differential. When the diagnosis of oral amyloidosis is made, further investigations are mandatory for the evaluation of systemic involvement or associated diseases. Our case presented with a nodular lesion of the palate. A pleomorphic adenoma was suspected. However, a diagnosis of localized amyloidosis was made after the incisional biopsy revealed characteristic staining on Congo red, and an extensive workup for systemic involvement was negative.

There is no consensus as to the management of localized amyloidosis of the palate. In the absence of systemic disease, localized amyloidosis may be treated conservatively. In this case, surgical excision was done and there was no sign of recurrence during 3 years of follow-up. Because localized amyloidosis is a disease of great rarity and slow progression for which spontaneous regression is known to occur, it is difficult to predict the outcome. Additionally, no documentation exists to suggest that localized amyloidosis can progress to systemic amy—
Nevertheless, all patients with localized amyloidosis should be followed up for any evidence of systemic amyloidosis or recurrence. Amyloidosis has a variety of presentations in the oral region and may be the sole manifestation of the disease process. Localized amyloidosis of the palate usually appears as painless soft nodule like our case, which may resemble benign tumors. It is not often considered in the differential diagnosis of palatal lesions. Localized amyloidosis of the palate should be considered in the differential diagnosis of palatal nodular lesions, as it may be clinically indistinguishable. Alternatively the lesion resembles ulcerative or red papule/plaque lesions.

IV. REFERENCES
