

Exclusive lingual psoriasis revealed by dermoscopy

Psoríase lingual exclusiva revelada por dermatoscopia

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Abstract

Psoriasis is a chronic immune-mediated disease, in which oral involvement is uncommon and frequently overlooked. We report a 38-year-old man with no personal or family history of psoriasis who presented with chronic, recurrent erythematous depapillation of the left hemi-tongue, and unresponsive to prolonged antifungal therapy. Dermoscopy showed regularly distributed dotted vessels over hypertrophic papillae, contrasting with the normal contralateral mucosa, and guided a targeted punch biopsy. Histology demonstrated psoriasiform epithelial hyperplasia with parakeratosis, elongated rete ridges, and dilated tortuous capillaries within the lamina propria and Munro microabscesses; periodic acid-Schiff staining excluded fungal infection. Extension work-up disclosed no cutaneous, scalp, nail, or joint involvement, supporting exclusive lingual psoriasis. Topical clobetasol propionate produced marked improvement within 4 weeks, with no relapse after 1 year of follow-up. This case illustrates the value of dermoscopy in recognizing atypical oral psoriasis and in avoiding prolonged ineffective antifungal treatment.

Keywords: Oral psoriasis. Tongue. Dermoscopy. Glossitis. differential diagnosis.

Resumo

A psoríase é uma doença crónica imunomediada em que o envolvimento oral é raro e frequentemente negligenciado. Descrevemos um homem de 38 anos, sem antecedentes pessoais ou familiares de psoríase, com despapilação eritematosa crónica e recorrente do hemi-dorso lingual esquerdo, sem resposta a antifúngicos prolongados. A dermatoscopia revelou vasos pontilhados regularmente distribuídos sobre papilas hipertróficas, contrastando com a mucosa contralateral normal, e orientou a biópsia. A histologia mostrou hiperplasia epitelial psoriasiforme, paraqueratose, alongamento das cristas epiteliais, capilares dilatados e tortuosos na lâmina própria e microabscessos de Munro; a coloração pelo ácido periódico de Schiff excluiu infeção fúngica. O estudo de extensão foi negativo, apoiando o diagnóstico de psoríase lingual exclusiva. O clobetasol tópico permitiu melhoria marcada em quatro semanas, sem recidiva após um ano. Este caso ilustra o valor da dermatoscopia no reconhecimento da psoríase oral atípica.

Palavras-chave: Psoríase oral. Língua. Dermatoscopia. Glossite. Diagnóstico diferencial.

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Received: 21-07-2026

Accepted: 27-08-2026

DOI: 10.24875/PJDV.26000094

Available online: 26-10-2026

Port J Dermatol and Venereol. (ahead of print)

www.portuguesejournalofdermatology.com

Introduction

Psoriasis is a common immune-mediated inflammatory disease with an estimated global prevalence of 0.5-4.6%. Although cutaneous involvement is well characterized, oral psoriasis remains rare and controversial, largely because no clinical or histopathological diagnostic criteria have been agreed on.^{1,2} Oral lesions are therefore frequently underrecognized and misdiagnosed, particularly when they occur in the absence of skin disease. Lingual involvement in psoriatic patients is most commonly represented by benign migratory glossitis or fissured tongue,^{3,4} whereas true psoriatic lesions confined to the tongue, without any cutaneous sign, are exceptional. We report a case of isolated lingual psoriasis in a young man with no prior psoriatic history, in which dermoscopy oriented the diagnosis.

Clinical case

A 38-year-old man presented with recurrent inflammatory lesions confined to the left side of the tongue, evolving for more than 1 year. The lesions fluctuated in intensity and were consistently exacerbated by psychological stress. He had received several topical and systemic antifungal regimens without significant improvement. He had no relevant medical history, did not smoke or drink alcohol, took no long-term medication, and reported no family history of psoriasis or autoimmune disease.

Physical examination revealed a well-defined, erythematous, depapillated patch with geographic borders involving the left hemi-tongue, without extension to the buccal mucosa, palate, or gingiva (Fig. 1). Full skin examination, including the scalp, retroauricular folds, umbilicus, intergluteal cleft, and the 20 nails, was normal, and there were no articular symptoms or signs suggestive of psoriatic arthritis.

Dermoscopy of the lesion showed regularly distributed dotted vessels over hypertrophic papillae (Fig. 2A), contrasting sharply with the normal vascular architecture of the contralateral hemi-tongue (Fig. 2B). No pseudomembranous plaque or filamentous white deposit was seen, arguing against candidiasis. A punch biopsy was performed on the area displaying the most typical dermoscopic pattern. Histological examination demonstrated psoriasiform epithelial hyperplasia with parakeratosis, elongation of the rete ridges, dilated tortuous capillaries within the papillae of the lamina propria, and Munro microabscesses (Fig. 3). Periodic acid-Schiff staining was negative for fungal elements.

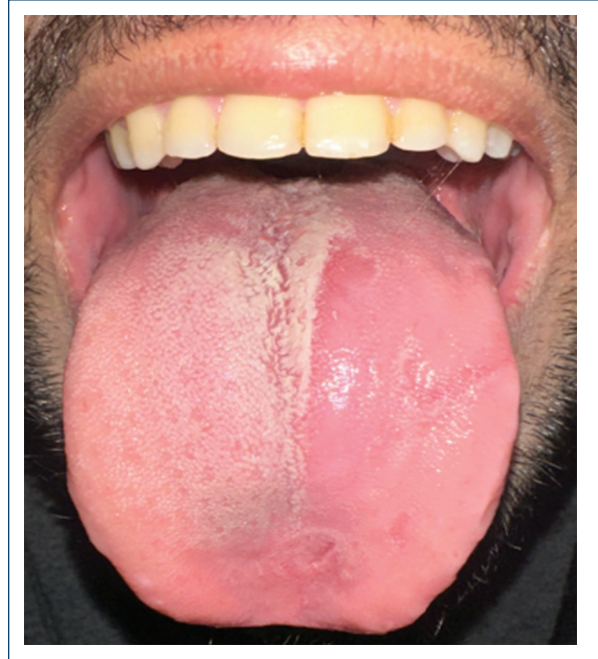


Figure 1. Well-defined erythematous, depapillated patch with geographic borders involving the left hemi-tongue, with a normal contralateral hemi-tongue.

The diagnosis of exclusive lingual psoriasis was retained.

Treatment with topical clobetasol propionate 0.05% applied twice daily for 4 weeks resulted in marked clinical improvement, with re-epithelialization of the depapillated area and disappearance of the dotted vessels on dermoscopic control (Fig. 4). The improvement was sustained and no relapse was observed after 1 year of follow-up.

Discussion

Oral psoriasis is a debated and underreported entity, particularly when it occurs without cutaneous involvement, and the scarcity of well-documented cases makes each report valuable. Oral manifestations most often correspond to benign migratory glossitis or fissured tongue, whereas true psoriatic plaques of the tongue remain a diagnostic challenge.^{2,5,6} The underlying mechanisms are incompletely understood but are thought to involve the same immune dysregulation as cutaneous psoriasis, particularly the interleukin (IL)-17/IL-23 axis.⁷ Stress is a recognized trigger of flares, and our patient's symptoms were clearly stress-dependent.

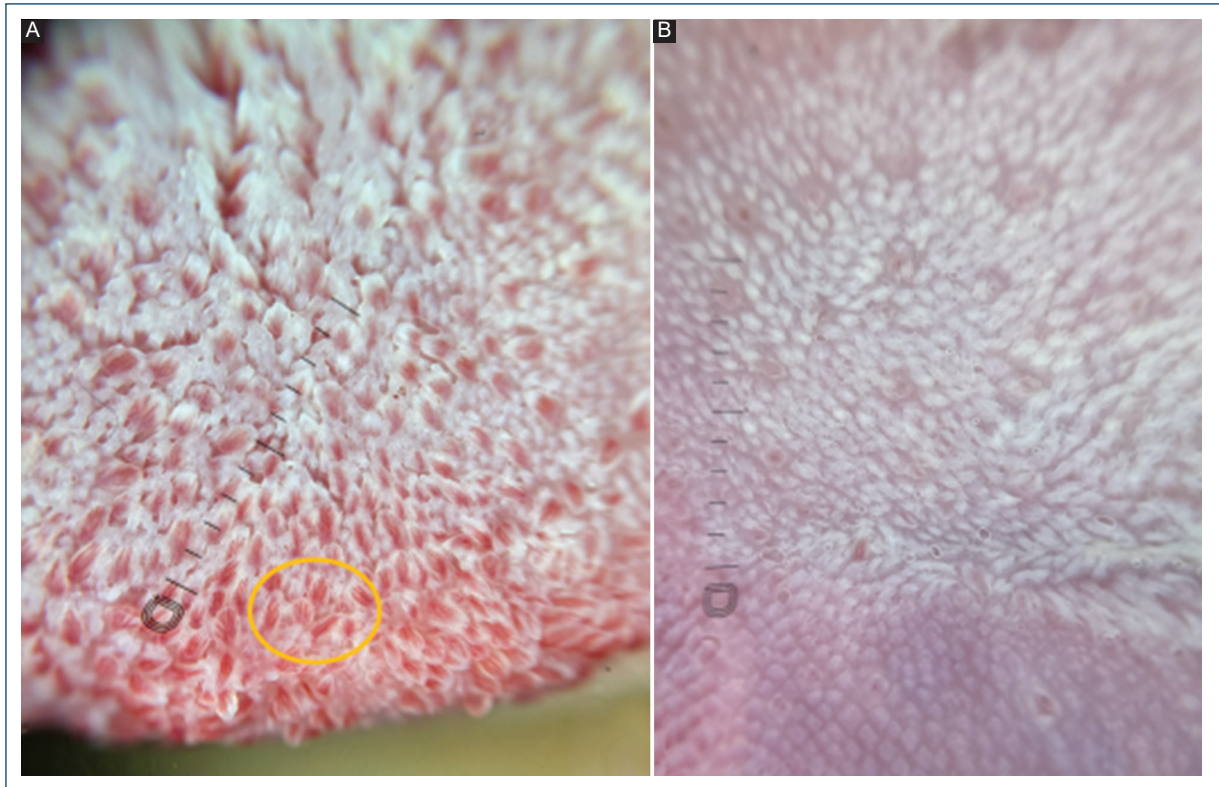


Figure 2. Dermoscopy of the tongue (polarised light, $\times 10$). **A:** left hemi-tongue: regularly distributed dotted vessels over hypertrophic papillae within the depapillated erythematous area (yellow circle). **B:** contralateral right hemi-tongue: normal filiform papillae with a preserved vascular architecture, serving as an internal control.

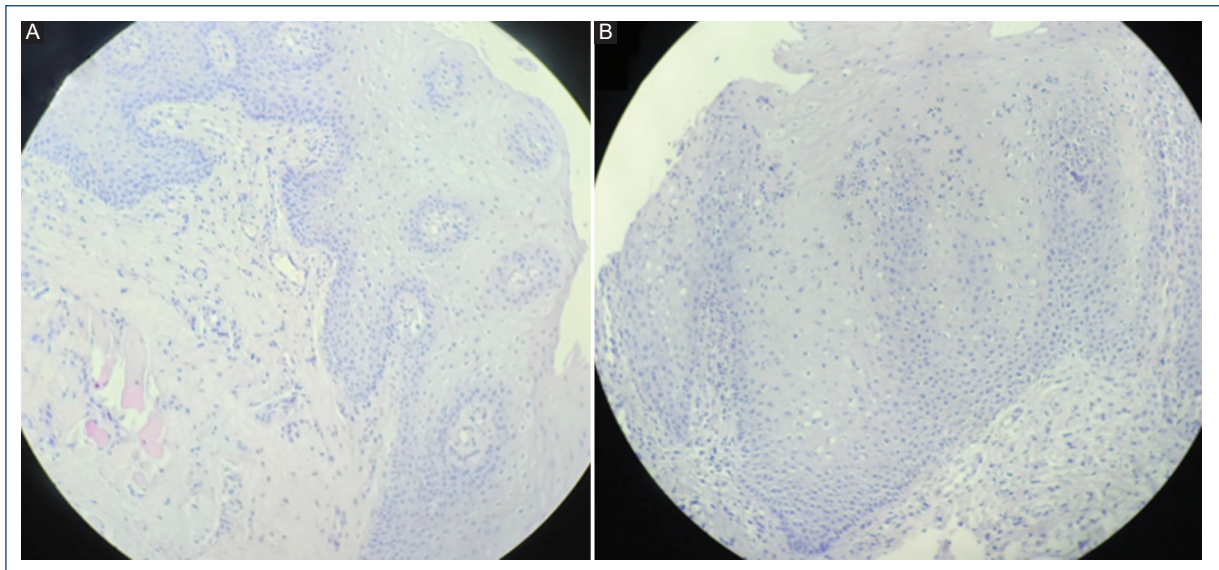


Figure 3. Histopathological examination of the lingual lesion (haematoxylin and eosin, $\times 100$). **A** and **B:** psoriasiform epithelial hyperplasia with parakeratosis, elongation of the rete ridges, dilated tortuous capillaries within the papillae of the lamina propria, and Munro microabscesses.

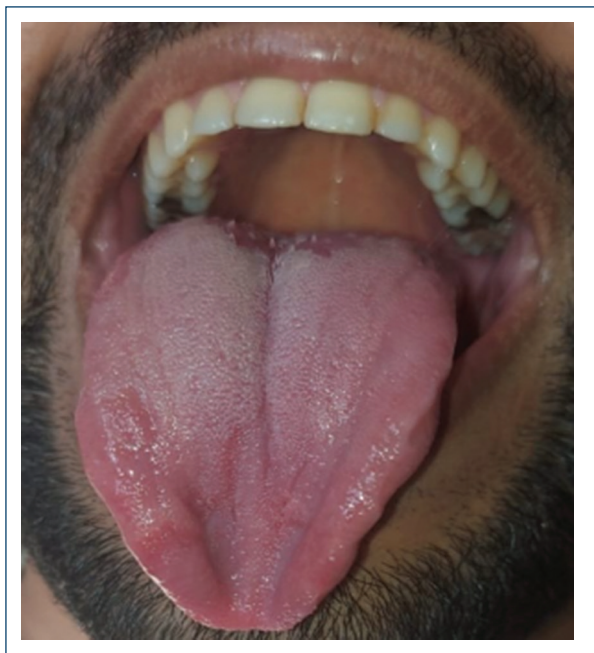


Figure 4. Clinical appearance after 4 weeks of topical clobetasol propionate, showing re-epithelialisation of the depapillated area.

Histopathological findings in oral psoriasis mirror those observed in the skin, including parakeratosis, acanthosis, elongation of the rete ridges, spongiform pustules, and dilated capillaries.^{8,9} Munro microabscesses, a hallmark of the disease, were present in our case and corroborated the clinical suspicion.

Dermoscopy is a non-invasive tool increasingly used in inflammatory dermatoses. In cutaneous psoriasis, it consistently reveals homogeneously distributed dotted vessels on a light red background, a pattern that corresponds histologically to dilated capillaries within elongated papillae.¹⁰ Data on the oral cavity remain limited, but our observations were superimposable: dotted vessels were confined to the depapillated erythematous area and contrasted sharply with the adjacent normal mucosa, directly reflecting the dilated tortuous capillaries seen in the lamina propria. The visualization of hypertrophic papillae and the absence of pseudomembranes or white filaments also helped to rule out candidiasis, the diagnosis most frequently made by default in this setting. Mattsson et al. have emphasized that morphological analysis helps to distinguish psoriasis from other causes of lingual erythema, such as lichen planus, which typically displays Wickham striae, or lupus erythematosus, which shows a different vascular pattern.² Van der Waal and Pindborg had already

described the diversity of clinical patterns of oral psoriasis and stressed the importance of careful morphological assessment.¹¹ Integrating dermoscopy into the evaluation of atypical oral lesions allows a more accurate preliminary diagnosis and, above all, the selection of the most informative biopsy site — a decisive advantage when clinical signs are ambiguous or when the patient is reluctant to undergo an invasive procedure.

Topical corticosteroids remain the first-line treatment and usually provide rapid symptomatic relief and regression of the erythematous plaques.^{4,12} In case of intolerance or insufficient response, Vitamin D analogs such as calcipotriol and topical calcineurin inhibitors are useful alternatives on mucosal surfaces, where they limit corticosteroid-related side effects. Systemic agents extrapolated from cutaneous psoriasis — methotrexate, ciclosporin, acitretin and biologics targeting tumor necrosis factor-alpha, IL-17, or IL-23 — are reserved for exceptionally severe or refractory forms.⁷ Conversely, therapeutic abstention has been advocated in asymptomatic patients, reflecting the often benign and self-limited course of certain oral presentations.¹ Adjunctive measures include avoidance of irritants such as alcohol, spicy food and tobacco, good oral hygiene, and correction of local traumatic factors such as ill-fitting dental appliances. A systematic examination of the skin, nails, and joints remains essential, since lingual involvement may precede or accompany systemic psoriatic disease.⁴

In summary, the dermoscopic hallmark of evenly distributed dotted vessels correlates with psoriatic microangiopathy and, combined with histological confirmation, strengthens the diagnosis of lingual psoriasis. Recognizing such presentations prevents misdiagnosis, guides appropriate management, and spares patients prolonged ineffective therapy. Dermoscopy deserves to be considered a frontline tool in the assessment of chronic, treatment-resistant oral lesions.

Conclusion

Isolated lingual psoriasis should be considered in chronic tongue lesions unresponsive to antifungal therapy. Dermoscopy may help identify suggestive features and guide biopsy, while clinicopathological correlation remains essential for diagnosis and appropriate management.

Funding

The author(s) received no specific funding for this work.

Conflicts of interest

The authors declare no conflicts of interest.

Ethical considerations

Protection of human subjects and animals. The authors declare that no experiments on humans or animals were performed for this research.

Confidentiality, informed consent, and ethical approval. The authors have followed their institution's confidentiality protocols, obtained written informed consent from the patient, and secured approval from the Ethics Committee. Relevant ethical recommendations have been followed.

Declaration on the use of artificial intelligence. The authors declare that Claude was used for traduction, formatting of the manuscript to journal requirements.

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