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CASE REPORT

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What is the cause of palate lesions? A case report

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Oliveira SC, Slot DE, Van der Weijden GA. What is the cause of palate lesions? *A case report*.

Abstract: *Objectives:* Trauma to the oral tissues can be caused by fellatio. Few cases are reported in the literature. *Methods:* A case of oral palate lesions is presented and discussed. *Results:* The patient developed a large band of petechial haemorrhage extending across the soft palate following the practice of fellatio. The diagnosis was made through an interview with the patient, which disclosed a probable case for fellatio as the cause of the palatal spots. At the follow-up visit 14 days later, the lesions disappeared. *Conclusions:* Oral sex activity has increased over the last decades. The dental care professional should be aware that lesions of the palate may result from sexual behaviour. With this possibility in mind, those working in the area of head and neck medicine should consider fellatio as an addition to the differential aetiology of intraoral petechiae.

Key words: fellatio; oral sex; palate lesions; trauma

Introduction

When fellatio is practised, the phallus strikes the palate with varying degrees of force. Due to the shape of the palate, the point of contact will be towards its posterior aspect, and expecting some trauma at the point of contact seems reasonable, depending on the zestfulness of the act (1). Oral manifestations of fellatio typically occur at the junction of the hard and soft palates and are characterized as erythematous, petechial, ecchymotic macules, patches or as purpura. This entity has been referred to as 'palatitis', 'palatal erythema and ecchymoses' and 'petechial haemorrhage of the soft palate'. They may appear bilaterally or as single lesions extending across the midline. The lesions do not blanch with pressure and are asymptomatic and non-ulcerated. The uvula and structures of the oropharynx are typically spared (2). Although trauma as a result of a violent sexual assault is easy to imagine, normal sexual behaviour and relations between consenting adults can also lead to such situations (3).

Traumatic lesions caused by sexual activity are not commonly documented, perhaps because they are often only mildly symptomatic and resolve spontaneously (4, 5). However, the reluctance on the part of the patient to give an accurate history and also failure by the dental care professional (DCP) to include sexual activity in the differential diagnosis may be responsible for this lack (6). The prevalence of orogenital sexual practices dictates that fellatio should be considered in the diagnosis of all intraoral lesions (4).

Oral sex activity has increased throughout the years (7). In a study conducted by Grunseit *et al.* (8), between 1990 and 1997, the practice of fellatio has risen 17% among young women in a sample of students in Australia. In a similar sample, Rissel *et al.* (9) reported that 67% of the

women older than 16 years of age had experienced oral sex, and the number is even higher at 82% in subjects younger than 16 years of age.

Because most of the relevant case reports were published some time ago, the objective of this case report is to bring lesions following fellatio under renewed attention to ensure that the DCP should consider fellatio as part of the differential diagnosis.

Case description

A 20-year-old female student, participating in a research project of the Department of Periodontology at the Academic Centre for Dentistry Amsterdam (ACTA), showed up for a routine oral examination. During this early morning visit, she presented asymptomatic palate lesions. The haemorrhagic region was distinct and limited to the soft palate, and she was not aware of it herself. It did not involve the pharyngeal walls, uvula or other posterior oral structures. The student had no relevant medical or dental problems. She reported to have not eaten or drunk anything different from what she usually does. After examination, photographs were taken (Fig. 1).

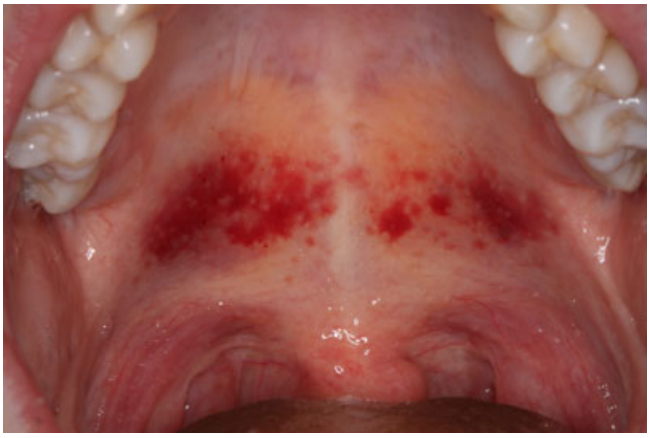

Fig. 1. Haemorrhagic lesions in the soft palate.

Diagnosis

The student was interviewed by the study coordinator about aspects such as allergies, vomiting behaviour, toothbrushing trauma and sexual activity. She was asked whether she had a boyfriend. Upon her affirmative response, she confirmed engaging in oral intercourse with him. The student recognized the possibility that the lesions could have resulted from the fellatio practices the night before. The photographs were shared with an oral–maxillofacial surgeon to discuss the possible diagnosis.

Follow-up

After 14 days, the participant returned for a re-examination. No lesions could be detected in the soft palate (see Fig. 2). She reported, based on self-monitoring, that the lesions had disappeared within 3 days after the previous visit. Upon questioning, the participant admitted that she continued practising oral intercourse between the day she found out the lesions disappeared and this follow-up visit but without any clinical signs upon oral inspection.

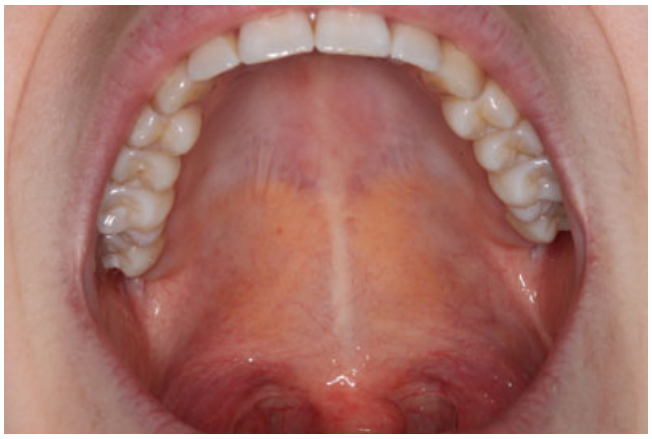

Fig. 2. After 2 weeks, the lesions disappeared in the soft palate.

Discussion

The first narrative of a case with trauma in the palate area due to oral sex was published in the French literature. It is a colourful report of palatal lesions in a professional fellatrix, and it was quoted in Ronchese's monograph, 'Occupational Marks'. The second case appeared in the English literature in 1949. This case described and opens as follows:

> *A new clinical experience is always stimulating and as such should be shared with one's colleagues. It is in that spirit that I record the following case. For quite some time I had been observing a comely young woman for soreness of the roof of the mouth.*

Rattner (10) further described this case in which a female patient developed a 3-cm erythematous patch of the hard palate that contained punctuate haemorrhages and cycled with her menstrual periods. After an exhaustive search for a cause, the patient questioned if it might be due to fellatio which she practised only during the menstrual periods. For final proof, the patient allowed the lesion to heal and then reproduced the lesion according to her hypothesis. Later on, Schlesinger *et al.* (5) reported a case of trauma due to fellatio in a 25-year-old woman. The patient presented petechial haemorrhages limited to the soft palate and not involving other posterior oral structures. The authors described the lesions as a result of repetitive negative pressure in the oral cavity combined with the action of the tensor veli and levator veli palatini muscles. Forceful thrusting against the highly vascular palatine aponeurosis also may contribute to the characteristics findings.

Two variations of mucosal alterations secondary to fellatio have been described (5):

1 Erythema, petechiae, purpura or ecchymosis of the soft palate can be found at the junction of the hard and soft palates,

sparing the uvula and not involving the post-pharyngeal wall. Histologically, these lesions show widespread haemorrhaging in the lamina propria, formation of subepithelial haemorrhagic vesicles and migration of red and white cells into the epithelium (2).

2 Instead of a submucosal haemorrhage, the clinical appearance may also present itself as mucositis. In patients with palatal mucositis, fellatio can be considered, but oral candidiasis (*Candida albicans* infection) should definitely be ruled out as an alternative causative factor in these cases (5).

A long list is available for the differential diagnosis, which includes the following: 'paroxysmal coughing, sneezing, vomiting, oropharyngeal infection, nasopharyngeal tumours, blood dyscrasias and capillary fragility, antithrombotic or anticoagulant drug therapy, piercing and penetrating trauma, playing a wind instrument, infectious mononucleosis, a recent history of intubation or nasogastric feeding as a result of hospitalization or general anaesthesia, thermal or chemical ingestion and pressure on or abrasion of the tissue overlying an elongated pterygoid process' (2, 6, 11).

A history of fellatio, within a specific time period before the onset of the lesion, confirms the diagnosis and spares the patient from further examinations, as postulated by Bellizzi *et al.* (6), Damm *et al.* (5) and Terezhalmy *et al.* (2). In the underlying case, the patient reported being engaged in oral intercourse with her boyfriend the night before the examination. For the examiner, confronting a patient with respect to their sexual activity can understandably be a diagnostic challenge, and the patient may also be reluctant to admit the aetiology. Therefore, taking a history that includes fellatio when trauma to the soft palate is suspected is difficult at best. It may well embarrass young patients accompanied by their parents or male patients who are suspected of homosexual activities. In the case of teenagers and young adults, fear of such an admission in their parent's presence could result in a complete denial of the act. The parents may also take personal offence at such a suggestion and might even bring the issue to court. Therefore, private disclosure between the patient and the examiner should be considered, and confidentiality thereby assured (6). Gender or marital status should not deter the DCP from obtaining a more personal patient history in the search for aetiologic factors of palatal erythemas (5). Common sense, tact and discretion can thus lead to an accurate diagnosis while sparing the patient personal embarrassment or social ostracism.

The presence of lesions arising from fellatio may be an incidental finding in those actively engaged, as described in this case, but may also be present in children suffering from sexual abuse (2). In such cases, evidence of the crime may be observed physically in the oral cavity of the child (12), and the DCP can play a role in the diagnosis of child abuse by observing these lesions in the mouth. DCPs are not often thought of as having knowledge in the area of domestic violence physical injuries. The recognition of child maltreatment is filled with frustration for most healthcare professionals. The problem with recognition is the initial, awful realization that parents and caregivers do harmful things to defenceless, vulnerable children. All DCPs need to understand the seriousness of child maltreatment and realize that children do not just get hurt in abuse and neglect but often die as a direct result of their maltreatment. Dentistry can do its part to help stop the pain, suffering and deaths that result from child maltreatment (13). The average age of a physically abused child is 3 years old. With the initial dental examination now being advocated to occur at age 1, potentially abused children can be recognized and assisted through the efforts of DCPs and physicians before the child can voice their situation and pain (12).

The practice of oral sex is enjoying greater legitimacy and acceptability in recent times among young people (8), regardless of whether they have previously been engaged in penetrative intercourse (14). For example, in the United States, 57% of college students had practised fellatio (15). The driving forces behind this change in the experience of oral intercourse are open to speculation. There appears to have been a repositioning of oral sex as a mainstream sexual practice, such that it makes an appearance earlier in people's sexual careers. This change may be a function of a general move towards sexual liberalism or perhaps as a response to the hazards of the transmission of HIV through penetrative sexual practices. Thus, soft tissue trauma that is the direct result of fellatio may be more commonly observed in practice than reported in the dental literature.

In conclusion, because oral sexual activity has increased over the last decades, the DCP should be aware that lesions of the palate may result from sexual behaviour. With this possibility in mind, fellatio should also be considered as an addition to the differential aetiology of intraoral petechiae.

Clinical relevance

Scientific rationale

The trauma of oral tissues can be caused by oral sexual activities.

Principal findings

Case report: palate haemorrhagic lesion resulting from fellatio.

Practical directions

1 Dental care professionals should be aware that palate lesions may be the result of oral sexual intercourse.

2 Diagnosing the possibility of a causal relationship between oral lesions and sexual behaviour is challenging due to privacy issues. To create an atmosphere of confidentiality, interviewing should preferably be performed in a room without the presence of personnel or family.

3 Palatal lesions can result from sexual behaviour performed out of pleasure but may also be the result of violent sex abuse. The latter should be kept in mind when oral trauma lesions are observed.

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