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ORAL ULCERATION

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Abstract

Oral Ulceration is a common complaint of patients attending out-patient clinic. The aim of this review is to provide oral surgeons with a differential diagnosis of oral ulceration, a practical guide for the management of recurrent apthous stomatitis.
Key words :- Ulceration, diognosis, apthous, Stomatitis

1. Brief description of condition

Lesions in the oral cavity or on the lips that are usually, but not always, painful. Ulcers are caused by a number of conditions, most of which are benign (e.g. recurrent aphthous stomatitis, herpes viruses, hand foot and mouth disease). Other causes include adverse reactions to drugs, nutritional deficiencies, some gastrointestinal diseases and, more seriously, oral cancer. For other abnormal appearance in the mouth.

2. Key signs and symptoms

- Pain (lips and/or oral cavity)
- Inflammation
- Ulceration
- Abnormal appearance
- If the ulceration is severe, some patients (e.g., children, elderly, infirm) may in addition be:
- Listless or agitated
- Dehydrated

3. Initial management

- If a patient presenting with oral ulceration is severely dehydrated; advise the parent/corer to seek emergency medical care.
- If there are signs of dehydration (dizziness/lightheaded, tiredness, dry mouth, lips, eyes) advise the patient or parent/carer to seek urgent medical care.

- Do not examine with ungloved hands because of potential infection risk with viral ulcers.
- Determine how long the ulceration has been present.

If ulceration has been present 3 weeks or more, refer the patient for urgent care via the local rapid access pathway (oral surgery) to investigate potential dysplasia or malignancy.

4. When ulceration has been present for less than 3 weeks:

- If ulceration is recurrent and self-limiting, advise the patient to use 0.2% chlorhexidine mouthwash* and to seek non-urgent dental care. For children, recommend optimal analgesia, soft diet and advise that ulcers are likely to resolve within 1 -2 weeks.
- If the patient is receiving drug treatment or has an underlying medical condition that might be the cause of the ulcer(s), advise them to seek urgent medical care.
- If there are multiple ulcers present, advise the patient to seek non-urgent dental care. However, if the patient is

also systemically unwell, advise them to seek urgent medical care.

- If ulceration is due to ill-fitting dentures, advise the patient to use 0.2% chlorhexidine mouthwash*, to keep dentures out where possible and to seek non-urgent dental core.
- If there has been trauma from an adjacent tooth or orthodontic appliance, advise the patient to seek non- urgent dental care.
- If ulceration is likely to be due to trauma to anaesthetised tissue following recent treatment using local anaesthesia, advise the patient to avoid smoking, drinking hot liquids and biting the cheek or lip, and to see a dentist only if symptoms persist or worsen.
- If a single ulcer appears not to have been caused by trauma, advise the patient to use 0:2% chlorhexidine mouthwash* until symptoms resolve or if the ulcer fails to heal within a week, to see a dentist within 7 days.
- Do not prescribe antibiotics unless there are signs of spreading infection, systemic infection, or for an immunocompromised patient.
- In all of the above cases, recommend optimal analgesia, including prescription of topical analgesics (e.g. benzydamine oromucosal spray).

**Chlorhexidine mouthwash is not suitable for children under 7 years old.*

5. Underlying medical conditions that may cause oral ulceration

Viral infections	Herpetic stomatitis	Chicken pox
		Herpangina
	Hand, foot and mouth disease	
	HIV	
Bacterialinfections	Syphilis	Tuberculosis
Mucocutaneous diseases	Lichen planus	Erythema multiforme
	Behcet's syndrome	Pemphigoid and variants
	Pemphigus vulgaris	Chronic Ulcerative Stomatitis
Haematological diseases	Anaemia	Haematinic deficiencies
	Leukaemia	Neutropenia
Gastrointestinal disease	Coeliac disease	Crohn's disease
	Ulcerative colitis	

6. Subsequent care

Consider:

- Fixing ill-fitting dentures if appropriate.
- Prescribing a topical steroid.
- Referring to the local rapid access pathway to investigate potential dysplasia or malignancy if symptoms persist.
- Referral to a dermatologist or an oral medicine specialist if vesiculobullous disorder is suspected.

In cases of primary herpetic gingivostomatitis or herpes zoster infection, if the symptoms are severe or the patient is immunocompromised, consider prescribing antiviral agents (aciclovir or penciclovir), ideally in the early stages.

Refer to a general medical practitioner if the patient has an underlying medical condition and is receiving a drug that may be the cause of ulceration.

7. Conclusion

All patients with recurrent or persistent oral ulceration should be fully investigated to establish a definitive

diagnosis and eliminate the possibility of an underlying systemic disorder or oral malignancy. The diagnosis of RAS is based on the patient's history and clinical appearance of the ulcers. The majority of RAS cases

respond to topical corticosteroid and/or topical antimicrobial therapy, but a few will require systemic

immunomodulators. Patients with RAS may proceed to develop Behc¸et's disease, which is diagnosed solely on the basis of clinical criteria. In spite of recent advances in systemic therapy for Behc¸et's disease the functional prognosis of patients will remain poor until the underlying pathogenesis of the disease is elucidated. Clinical trials are currently being conducted to investigate the efficacy of anti-TNFa. agents for Behcet's disease. Patients with undiagnosed oral ulceration should be referred to an oral physician/surgeon for further investigations, including biopsy if appropriate.

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