Oral pathology

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References:
1. Oral Medicine in General Practice Dr Timothy Peter, consultant oral medicine. Feb 2017
2. Burning Mouth Disorders Professor Jane Setchfield webinar Nov 2021
3. Burning Mouth Syndrome: Aetiopathogenesis and principles of management. Professor Jane et al. Pain research and management 2017.
4. UBDA
5. Dr Helen Lindsy dermatology consultant, Southampton NHS, Jan 2021

Burning mouth syndrome

- Unknown aetiology
- Stress aggravates
- 2% resolve over 5y
- 90% have improvement after 5 if you

- Complex syndrome involving dysregulated peripheral and central pain pathways, and psychological factors

Presentation
- Chronic burning sensation of oral mucosa
- Dysgeusia
- Dryness
- Reduced taste intensity
- Metallic/metallic taste

- Metallic/rubber/ash/ash in morning and at meal times.

Investigations
- Impact oral mucosa
- Rule out Sjögren's

Management
- There is no cure.
- Only symptomatic treatments.
- Psychological intervention is important.
- Patients need to be reassured that there are no serious underlying causes. Many are concerned that the cause is cancer, so need to be reassured.
- Continued follow-up is also likely help.

- Medication.
  - Topical
    - Clonazepam wafers
    - Capsaicin
    - Benzydamine
    - Lidocaine
    - Clobetasol
    - Or quin an clonazepam 0.5mg tablet for 2 min and spit out 30 for 2h2 to aid it will walk.
    - Then can pain just PRN 5 bad symptoms.
  - Systemic
    - Amitriptyline
    - Nortriptyline
    - Doxepin
    - Venlafaxine
    - Paroxetine
    - Sertraline
    - Gabapentin
    - Pregabalin
    - Duloxetine
    - Alpha-lipoic acid
    - Melatonin (5-20 mins)
    - Tryptamine (case report)
- Psychological
  - CBT
  - Hypnotherapy
  - Other relaxation techniques e.g. acupuncture

- Chronic burning sensation of oral mucosa
- Dysgeusia
- Dryness
- Reduced taste intensity
- Metallic/rubber/ash/ash in morning and at meal times.

(1) Oral mucosal conditions
(2) Systemic conditions causing oral cavitation cause
(3) Atrophic tongue
(4) Geographic tongue
(5) Geographic tongue
(6) Fissured tongue
(7) Hypertrophic papillomatosis

(1) Parafunctional habits
(2) Cheek sucking
(3) Tongue thrusting

(1) Trauma: mechanical, chemical, thermal

(1) Xerostomia and altered salivary quality
(2) Radiotherapy
(3) Chemotherapy
(4) Oral dryness
(5) Sjögren's syndrome

(1) Systemic factors
(2) Diabetes
(3) Deficiencies/levels of vitamins B1, B2, B12, folate, iron, zinc
(4) Abnormal thyroid function
(5) Allergic reaction to food or dental materials
(6) Gastrointestinal conditions
(7) Autoimmune conditions
(8) Coeliac disease, Crohn's disease
(9) Parkinson disease

(1) Drugs
(2) Parasites
(3) Angiotensin converting enzyme inhibitors

(1) Local nerve damage
(2) Chemotherapy associated neuropathy
(3) Local physical irritation

(1) Various peripheral or central neuropathies

Recurrent ulceration

- Erythema multiforme
  - **Presentation**
    - Target lesions
    - Lips and oral mouth.
    - Origins (partial)
    - Blisters and ulcers.
    - Lasts 2-4/52
    - Herpes can be herpes simplex (cold sores)
  - **Investigations**
    - Herpes serology (antibodies).
    - If active herpes can swab but usually clinical diagnosis (herpetiform) +/ELISA if strong doubt.
    - Mycoplasma sero (IFG spot).
  - **Management**
    - Prednisolone 20mg OD reducing 5mg/wk
    - Prophylaxis acyclovir 400mg BD (TDS if immunocompromised)
    - Acyclovir 200 prevent episodes of herpes simplex in the unremitting cause
- Aphthous ulcers
  - **Presentation**
    - Persistent erythema around white gray ulcers.
  - **Investigations**
    - FBC
    - Ferritin
    - B12
    - Folic acid
    - Coeliac screen
  - **Management**
    - Sodium Lauryl Sulphate free toothpaste
    - Chlorhexidine mouthwash
    - Corticosteroid
    - Lidocaine/amphotari gels.
    - Sucralfate
    - If fails
      - Topical steroids
        - Add betamethasone 500mcg tablet to 10ml of water and swish for 2 min
        - Spit out.
        - Use 4 times a 4 times a day while ulcer present.
        - Note: Can use once a day as prophylaxis.
      - alternatives
        - Can use prednisolone 5mg tablets as above, but more expensive.
        - If spit use mouthwash, can use fluticasone/beclomethasone nose spray or inhaler directly onto the ulcer (if easily reached) 2 puffs 4 times a day (note: Fluticasone inhaler: 50 micrograms)
        - Can use tacrolimus ointment 0.03 (if stable, BD)
        - Or
        - Dexamethasone ointment mixed with Orabase (30-60 minutes). Apply to dried mucosa membrane. Rx tube of each: 30G
        - Or
        - A magnesium ulcer (look like herpes but are not), use Doxycycline 100mg capsule opened and dissolve in 10ml water QDS, once for 1 min and spit out.
      - Systemic medication
        - By 2x care:
        - Colchicine 1500mcg BD although sometimes go to TDS QDS, 2-3 months max.
        - Prednisolone 20mg OD for 1/52, then reduce by 5mg per week).
        - Azathioprine
        - Thalidomide
- Behcet's disease
  - **Presentation**
    - Recurrent ulceration
    - Triad
    - Two of the following:
    - Genital ulceration.
    - Eye lesions.
    - Skin lesions.
    - Uveitis.
    - Arthritis.
    - Arthritis like lesions.
    - Erythema nodosum.
  - **Investigations**
    - HLA-B51
  - **Management**
    - Colchicine
    - Azathioprine
    - Thalidomide

Single episode ulceration

- Necrotic
- Antibiotics
- Antihistamines
- Drug reaction

Solitary persistent ulcer

- Trauma
  - Rubbing against sharp tooth
  - Chewing gum, food
  - Chemical burn from aspirin
  - Necrotic
  - Hot food/drinking burning lands
  - **Investigations**
    - Feel ulcer (make sure soft)
    - Feel for sharp tooth.
  - **Management**
    - Remove any suspected trauma (see above).
    - Antibiotics
    - Diflam.
- Malignancy
  - **Presentation**
    - Persistent ulcer
    - Risk factors
      - Male
      - Smoker
      - Alcohol excess
      - Pre-existing pre/cancerous lesions
      - Immunosuppressed
      - Sun of lesion
      - Papilly growing.
      - Ulcerated
      - Raised rolled border
      - Indurated base
      - Hard
      - Fixed to tissue and lymph
      - Cervical lymphadenopathy
      - Leukoplakia (lowest risk of malignancy).
      - Erythroplakia (highest risk of malignancy).
      - Erythroleukoplakia
      - Immunosuppression.
      - Chronic Hepatitis C/Hepatitis
      - Lichen planus.
      - Discoid lupus.
      - Lichen sclerosus.
      - Chronic hyperplastic candidiasis.
      - Lateral border
      - Lateral tongue
      - Floor of mouth
      - Lips
      - White plaque just inside corner of mouth, usually unilateral.
      - Smoking cessation.
      - Oral pathologist
  - **Investigations**
    - Refer via 2ww.
  - **Management**
    - Remove all trauma
    - Diflam.
- Tb
- Syphilis.

Lichen planus

- **Management**
  - Topical steroids
    - Add betamethasone 500mcg tablet to 10ml of water and swish for 2 min
    - Spit out.
    - Use 4 times 2-3 times a day while ulcer present.
    - Note: Can use once a day as prophylaxis.
    - alternatives
      - Can use prednisolone 5mg tablets as above, but more expensive.
      - If spit use mouthwash, can use fluticasone/beclomethasone nose spray or inhaler directly onto the ulcer (if easily reached) 2 puffs 4 times a day (note: Fluticasone inhaler: 50 micrograms)
      - Tacrolimus ointment mixed with Orabase (30-60 minutes). Apply to dried mucosa membrane. Rx tube of each: 30G
      - Or
      - A magnesium ulcer (look like herpes but are not), use Doxycycline 100mg capsule opened and dissolve in 10ml water QDS, once for 1 min and spit out.
  - Systemic medication
    - By 2x care:
    - Amitriptyline
    - Pentoxifylline
    - Mycophenolate
    - Ciclosporin
    - Methotrexate

Cheilitis

- Actinic (sun damage) cheilitis
  - **Presentation**
    - Older pt.
  - **Investigations**
    - 90 y for 12-15 days.
    - 70% clearance rate.
- Exfoliative cheilitis
  - **Presentation**
    - Lips are peeling, burning, weeping.
  - **Investigations**
    - Lips & nose swab.
    - Patch testing.
    - Hot history.
  - **Management**
    - Treat infection (usually candida and staph). Also treat the mouth of the mouth, so that is where infection is coming from (e.g. if candida then nystatin pastilles).
    - Oral antihistamin mouthwashes.
    - Light foam, as little as possible.
    - Avoid triggers (e.g. toothpaste).
    - Prednisone 0.5% for 5/52. Then once at night. Prednisone 0.1% for 5/52. Maintenance twice a week. Go back to BD if symptoms relapse.
    - Psychological help (40% pt.).

Oral thrush

- **Presentation**
  - In dremps complaint but is a often erythematosus and not the classical white patch.
- **Investigations**
  - FBC
  - Haematinics.
- **Management**
  - Diflam only.

Geographic tongue

- 15% population
- Normal variant
- Worse with stress or has haematinics.

Hand, foot and mouth

- **Presentation**

Primary herpes gingivostomatitis

- **Presentation**
  - Common in children.
  - Flu pains.
  - Fever.
  - Much of oral mucosa affected.
  - Crusted pattern.

Pemphigoid & Pemphigus

- **Management**
  - Topical steroids.
  - Antiseptic mouthwashes.
  - Aim to heal the ulcers.
  - Refer to oral medicine who may start:
  - Dapsone, oral prednisolone, azathioprine etc.

Globus pharyngeus

- **Management**
  - See ENT consultant letter.

Diagnosis: **1. Irritable throat symptoms**

Management: **1. Reassured**
2. General advice on vocal hygiene

I think she has got globus pharyngeus probably related to her depression as well. I have advised her to resist throat clearing and have sips of water, steam inhalation and relaxation would help. If she continues to have symptoms she could be referred on the NHS for throat relaxing therapist by a speech therapist. I have requested her and discharged her from this clinic.

Yours sincerely

Consultant ENT & Head and Neck Surgeon

Excess saliva

- **Management**
  - Atropine 1% eye drops, 1-3 drops NOCTE under tongue