CASE REPORT

BLOOD FILLED BLISTERS OF THE MOUTH- ANGINA BULLOSA HEMORRHAGICA- A CASE REPORT

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ABSTRACT

Angina bullosa hemorrhagic (ABH) are oral blood-filled vesicles and bullae, not attributable to any bleeding or clotting factors deficiency, vesiculo-bullous disorders, systemic diseases or any other known causes. The haemorrhagic vesicles cause lot of panic for the patient and remains as an enigma for the physician. This paper reports a case of ABH with the aim to create awareness regarding occurrence of this lesion, thus avoiding any misdiagnosis.

Keywords: *Angina bullosa hemorrhagica, blood blisters, soft palate, trauma*

Angina bullosa hemorrhagica (ABH) is characterized by oral mucosal blood-filled vesicles or blisters.[1] Kirtschig and Happle considered the term ABH ('angina') to be misleading and coined a more appropriate term: 'Stomatopompholyx haemorrhagica.' However, some large blisters may cause a sensation of choking and Gibson justified the term 'angina.' Other terms used include localized oral purpura, benign haemorrhagic bullous stomatitis and recurrent or traumatic oral hemophlyctenosis.[2] Badham, first used the current terminology Angina bullosa hemorrhagica in 1967.[3] This paper reports a case of ABH along with review.

CASE REPORT

A 48-year-old male patient presented with the chief complaint of blister on the check since day one. [Figure1] Medical history revealed he was suffering from depression and hypothyroidism and currently Lorazepam 2mg and clonazepam 0.5mg and eltroxin 75umg. Patient had undergone upper GI tract endoscopy without any contributory findings on intraoral examination, a small vesicle with spilled contents mimicking petechie was present on the left buccal mucosa. The patient gave history of similar blood filled blisters in different sites since past 2 yrs associated with mild pain on rupturing of the blisters. No check biting habit present. On routine blood examination, which included platelet count bleeding time, clotting time, prothrombin time, INR, Hb%, RBC WBC count and random blood sugar were within normal limits thus ruling out blood dyscrasias. On follow up after 7 days a prominent blood filled vesicle was noted on the soft palate measuring about 0.5 cm in diameter. [Figure 2 &3].

The lesion persisted for one day then spontaneously ruptured and healed without scarring. On the basis of

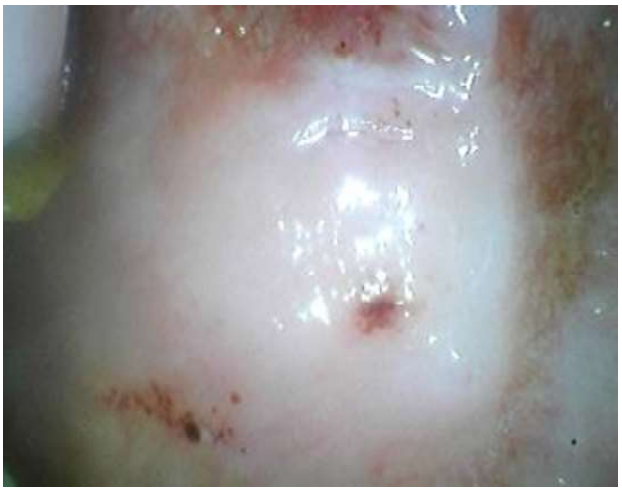

Fig. 1: Ruptured vesicle on buccal mucosa

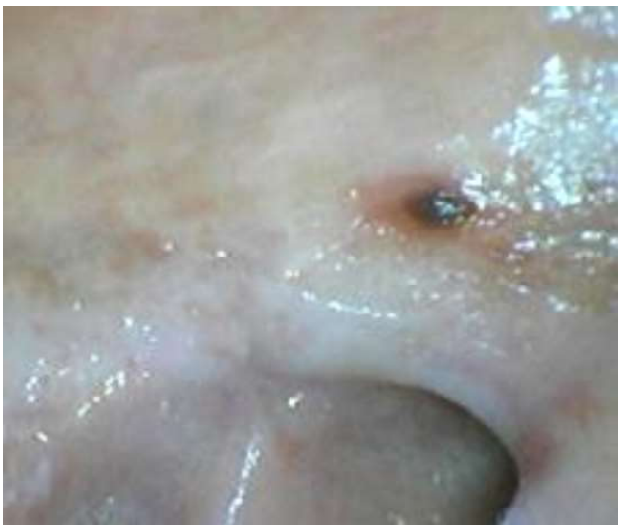

Fig. 2: Vescile on soft palate

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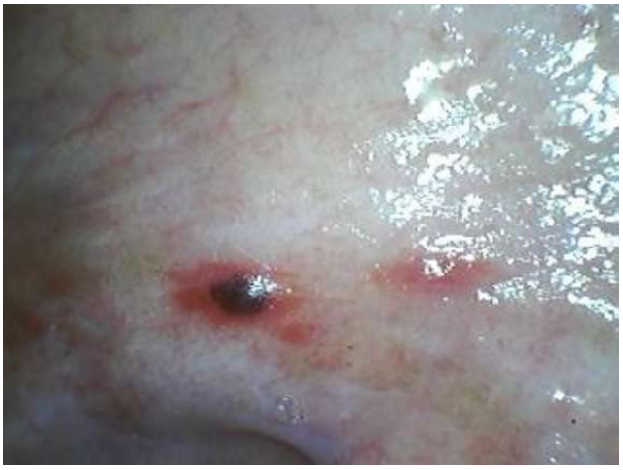

Fig. 3: Vesicle on soft palate

history and clinical examination a diagnosis of ABH was made. Any association between antianxiety drugs, hypothyroidism could not be established with ABH. Lesion of ABH presents as blood filled blister which is painless, raised, round, dark red to purple in colour with ecchymotic halo and measures around 1-3 cm in diameter.[4] The vesicle/ bullae often rupture spilling the blood content in the mouth causing discomfort.[5] ABH may occur either as single or multiple lesions.[3] Most common site of occurrence is soft palate,[3,6] but these lesions can also occur in the anterior pillar of the fauces, epiglottis, arytenoids, pharyngeal wall and esophagus.[3,4] Some authors have reported ABH to have female predilection.[4,5,6] It occurs mostly middle-aged and elderly individuals.[1]

Various causative factors have been attributed for ABH. Trauma, mainly during food ingestion, remains the most likely cause for ABH occurrence. Some authors suggest mild trauma to break the epithelialconnective-tissue junction, causing bleeding of superficial capillaries and resulting in the formation of a subepithelial hemorrhagic bullae.[3,7] Other predisposing factors are as steroid-based inhalers and Diabetes mellitus, periodontal therapy, dental injections of anaesthetics, and chlorhexidine gluconate mouth rinse. Hypertension and ABH shares a temporal relationship both occurring in same age group but to consider it as causative factor is a mere speculative.[8,9] Differential diagnosis of ABH include sub epithelial blisters, such as those observed in epidermolosis bullosa, bullous lichen planus, pemphigus vulgaris, linear IgA disease, and amyloidosis.[6] The constant presence of blood as the blister fluid which is usually not found in other cases, itself is sufficient to rule out above mentioned disorders and arrive to a clinical diagnosis of ABH.[10] The diagnosis of ABH essentially is clinical without the need of a biopsy; however, the cases in which a biopsy has being taken, the microscopic examination reveals a subepithelial bulla filled with blood and an underlying mild and nonspecific mononuclear inflammatory cell infiltrate limited to the region of the lamina propria.[11] No treatment is required for ABH because blisters spontaneously rupture and heal except for very large lesions requiring incision. Use of benzydamine hydrochloride provides symptomatic relief.[3,11] Chlorhexidine gluconate mouthwash should possibly be avoided as it was associated with ABH.[12]

CONCLUSION

ABH has been traditionally thought to be rare 1 however literature review suggests ABH is a fairly common 5 but often remains undiagnosed. Knowing the characteristics of ABH lesions in detail will help in diagnosing these perplexing lesions with ease thus avoiding needless investigations.

SOURCE OF SUPPORT: NIL

CONFLICT OF INTEREST: NIL

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