

## CASE REPORT

## STITCH IN TIME SAVES NINE: REPORT OF ORAL LESIONS

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## ABSTRACT

*This article discusses various oral lesions reported at Clove Dental clinic and the importance of early diagnosis in satisfactory clinical outcome is emphasized. In addition, current concepts in management of these lesions that can aid practitioners are also discussed.*

**Keywords:** Premalignant, Aphthous, Enlargements.

## INTRODUCTION

“Stitch in time Saves nine” here, stresses at clinical diagnosis as the first successful therapeutic management of a patient with oral mucosal disease or oral lesion. Without the information provided by the history and physical examination, the diagnostic process and treatment outcome is reduced to hazardous speculation.<sup>1</sup> The purpose of this article aims at gathering relevant clinical findings for primary diagnosis of oral lesions reported and their treatment staying abreast of current concepts of management.

## CASE REPORT 1 - APHTHOUS STOMATITIS

(Canker sores, recurrent aphthous stomatitis, RAS): A 19 year old female patient reported with recurring painful symptoms during the ingestion of food since 3 months and that these symptoms had been previously treated with different topical medicines, however, the lesion did not regress. There was no history of any trauma, swelling pus discharge, blood discharge, fever, paresthesia, anorexia and weight loss. On extraoral examination, no abnormality was detected. Clinical examination revealed ulcers with perilesional erythematous halos that were covered with a pseudo membrane and located in the labial mucosa and on the left side border of the tongue, exceeding 1cm in diameter. A clinical diagnosis of RAU was made on the basis of the history and the clinical examinations. The other aspects of the patient’s medical history and family

medical history were insignificant. Laboratory tests including a blood count analysis were performed to determine the levels of folic acid, iron, ferritin, as well as vitamins B2, B6, and B12, all of which showed normal results. Recurrent aphthous ulcerations (RAU) are common oral lesions that affect approximately 10% to 20% of the population. The disease is characterized by recurrent and painful ulcerations of the oral non-keratinized mucosa, which measure from 3 to 10 mm in diameter and heal without scarring in 7 to 14 days.<sup>1,2</sup> Current concepts in management of RAS primarily aims at bringing relief from pain, reduction in ulcer duration, and the restoration of normal oral function.

Secondary goals include a reduction in the frequency and severity of recurrences and the maintenance of remission. In present report, the patient was subjected to following local therapy) oral rinses with benzidamine hydrochloride and 0.2% chlorhexidine in rinses or gel, three times a day without swallowing. b) The administration offixed-dose doxycycline in mucoadhesive gel format RAS. C) Ointment Amlexanox (antiinflammatory and antiallergic) 5%, applied 2-4 times a day. To reduce the frequency of ulceration, levamisole hydrochloride (150 mg) for 3 consecutive days/week for three consecutive weeks. The therapeutic method used in this case provided significant relief from symptoms and no recurrence in follow ups till date.

## CASE REPORT 2- DRUG INDUCED GINGIVAL ENLARGEMENT:

A 42 -year-old male patient reported with a chief complaint of generalized swollen gums which bled on slight provocation for the last 2 years. His medical history revealed epilepsy since the age of 20, controlled with medication (phenytoin 100 mg BID) for the last 7 years. On inspection generalized mulberry shaped gingival overgrowth which was bright pink in color, was seen involving the interdental papillae, marginal and attached gingiva on the facial and lingual aspects of maxillary and mandibular teeth. The extent of the gingival overgrowth was such that it extends coronally upto the middle of the crown portions of the maxillary and mandibular teeth. Overlying mucosa was lobulated. On palpation it was non tender, firm in consistency with no bleeding or any discharge. On probing generalized deep

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periodontal pockets were present. Anthropantomograph of the patient revealed bone loss in the lower posterior regions. Complete hemogram results were under normal limits. A diagnosis of generalized drug-induced gingival enlargement superimposed with periodontitis was made.

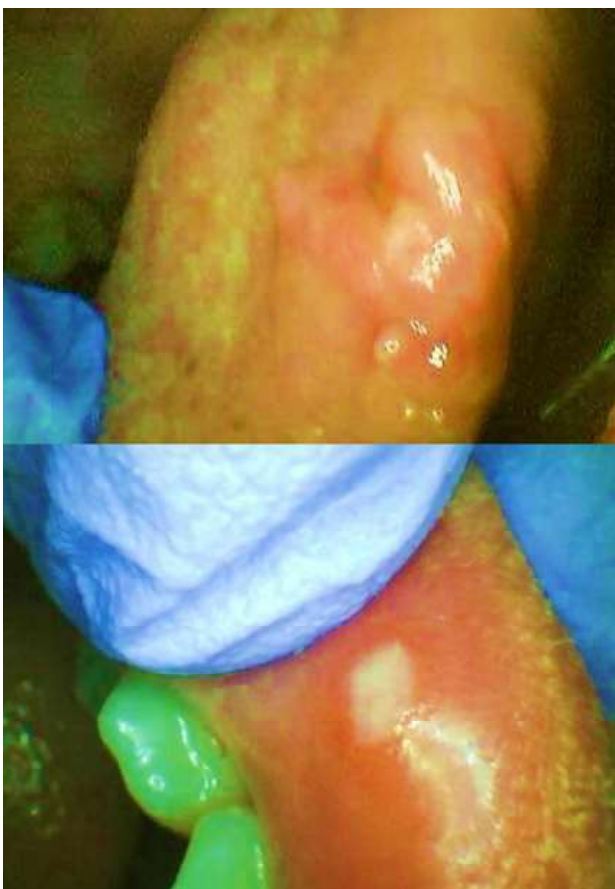
Current concepts in management of drug induced gingival enlargement aims initially at drug substitution followed by advocating diligent plaque control measures. Surgical therapy is planned if gingival enlargement does not regress after drug substitution and nonsurgical periodontal therapy. United States Food and Drug Administration (FDA) in 2000 has approved the incorporation of a systemically delivered collagenase inhibitor consisting of a 20-mg capsule of doxycycline hyclate as an adjunct to scaling and root planning for the treatment. Benefits included a statistically significant reduction in probing depths, a gain in clinical attachment levels and a reduction in the incidence of disease progression.<sup>6</sup>

Patient in present report was advised to consult his physician for the replacement of phenytoin by some other anticonvulsant and he was also advised to undergo thorough oral prophylaxis. With the consent of the patient and his physician, complete professional oral prophylaxis

was performed, along with a prescription of a 0.2% chlorhexidine mouthwash. Cap. The recommended dosage is 100 mg bid the first day, and then 100 mg OD was prescribed for 14 days. After 1 week, the gingival condition improved and the patient was asked to maintain oral hygiene with a soft, gentle toothbrush and warm saline gargles (Fig... With the physician's consent, phenytoin was substituted with gabapentin (300 mg TID after titration of the dose). Substantial regression in gingival enlargement was observed. Patient was recalled for supportive periodontal therapy.

**CASE REPORT 3 - ORAL SUBMUCOUS FIBROSIS:**

A 52 years old male patient visited with the chief complaint of decreased mouth opening noticed since 10 years. He also gave history of burning sensation to salty and spicy foods and even in the absence of stimuli. Personal history revealed that he used to consume areca nut regularly for a period of 8 years in the past but has stopped consuming now. On the right buccal mucosa, generalized erythema was seen which was mixed with whitish areas. On palpation vertical fibrous bands were palpable and they were tender. Pliability of the mucosa was lost. On the left buccal mucosa whitish appearance



**Fig. 1**



**Fig. 2**

was seen mixed with erythema, less of the red component. Mucosa of the lower lip and buccal mucosa was fibrosed and stiff. Tongue was depapillated and shrunken affecting its protrusion. Uvula was shrunken. Mouth opening recorded as 22 mm. A clinical diagnosis of OSMF stage 2 was made on the basis of the history, clinical examinations and investigations. Oral submucous fibrosis (OSMF) is a chronic, progressive, disabling, scarring, precancerous condition of the oral mucosa which is irreversible either remain stationary or become severe with high risk of oral cancer development due to denuded or atrophic oral mucosa vulnerable to carcinogens. OSMF has malignant transformation rate of 7–30%. Its poorly understood etiopathogenesis leads to difficulty in management.<sup>8</sup> Currently, after progressive understanding of its pathogenesis, concepts of therapy being followed are tabulated in table 2<sup>9,10</sup>. Counselling was done regarding the discontinuing of the use of areca nut for the patient in present report. He was advised to take bland diet, diet rich in high proteins and was prescribed a Benzylamine HCl mouthwash to be used before meals.<sup>5</sup> times daily physiotherapy by

interpositioning tongue spatulas between teeth and adding a new spatula every 5–10 days for 4 months was recommended. Intralesional injection therapy of dexamethasone mixed with hyaluronidase biweekly was started for 12 weeks. Cap Lycosuf to be taken once daily. Gradual increase in the mouth opening and decrease in stiffness of mucosa was observed in 2 months period. Burning sensation and pain was decreased in intensity.

#### CASE REPORT 4- ORAL LICHEN PLANUS

A 53 years old male patient visited with chief complaint of burning sensation on taking hot and spicy food since 7 months. History of presenting illness revealed that ulcerations were noticed by the patient since 7 months back for which he was treated outside the Clove Dental with different topical medicines, however, the lesion did not regress. History of presenting illness revealed that burning sensation was continuous and aggravated on eating spicy food. No history of any type of eruptions on any other body part. Intraoral examination revealed. An erythematous area with white striae at periphery, approximately 3-4 cms in maximum diameter was present on left and right buccal mucosa starting from pterygomandibular region anteriorly upto labial sulcus. On palpation lesion was tender, and rough in ulcerated area and mucosa was pliable. On the basis of history, clinical examination and biopsy report, diagnosis of Erosive lichen planus was made.

Oral lichen planus (OLP) is a common chronic autoimmune disease associated with cell-mediated immunological dysfunction. Erosive lichen planus (ELP) affecting mucosal surfaces is often more painful and debilitating than the non-erosive types of lichen planus. OLP lesions are consistently more persistent than the dermal lesions and have been reported to carry a risk of malignant transformation to oral squamous cell carcinoma (OSCC) of 1-2%.<sup>1</sup> Due to the recurring periods of exacerbation and remission and longer duration of disease progression, and seldom non responsiveness and exuberation of lesions after conventional therapeutic modalities, such lesions poses a treatment challenge to the dentists and thereby its efficient management. The patient was advised T. Wysolone 10mg [Prednisone] QID x 1 week which was tapered in 4 weeks duration & was instructed the local application of Kenacort ointment [triamcinolone acetonide 0.1%] 3-4 times daily in due time. The patient was reevaluated after 20 days during which the bilateral erosive areas were healed. During the subsequent follow up in 1 month, 2 months and 3 months, it was noticed that there was complete resolution.



Fig. 3

## CONCLUSION

An attempt is made to report few oral lesions with emphasis on role of diagnosis and its subsequent management thus reducing the rate of morbidity and mortality. The dental practitioner bears the responsibility for the recognition of oral disease at an early stage and spread awareness among how serious lesions can turn if ignored and timely treatment is essential to prevent severe consequences that can arise otherwise.

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