

The Pharmacologic Management of Common Lesions of the Oral Cavity



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KEYWORDS

- Aphthae • Herpes • Candidas • Lichen planus • Pemphigus • Pemphigoid • Oral • Treatment

KEY POINTS

- Topical therapy is the first line of treatment of aphthous, herpetic, candida, and lichen planus lesions of the oral mucosa.
- Topical medications can be used in the management of oral pemphigus and pemphigoid lesions.
- Intralesional injections allow maximum local benefit with minimal systemic effect.
- Systemic conditions need to be ruled out in patients with recurrent or persistent oral lesions.

INTRODUCTION

The general dentist should be able to identify the presence of soft tissue lesions in the oral cavity. Some of these lesions may be symptomatic, others could be incidental findings. Their cause could be local or systemic. This article provides an overview of the current pharmacologic modalities available to treat aphthous lesions, herpetic lesions, candidiasis, ulcerative lichen planus, mucous membrane pemphigoid, and pemphigus vulgaris. The emphasis is on local pharmacologic therapies, yet systemic conditions that often present with such oral lesions are briefly reviewed along with the appropriate management.

APHTHOUS LESIONS, ALSO KNOWN AS CANKER SORES

Aphthous lesions are perhaps the most common form of oral ulcerations, the prevalence in the US population being approximately 20%.¹ These lesions can occur as an isolated event or may reoccur at intervals as often as a few days in isolated or multiple foci.² In such cases, the condition is known as recurrent aphthous ulcers or

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recurrent aphthous stomatitis (RAS) and it seems to be more frequent in women, patients younger than 40 years, white persons, nonsmokers, and those of high socioeconomic status.³ No precise cause has been identified; the cause is thought to be of genetic predisposition, immune mechanisms, anemia, possible nutritional deficiencies, or stress.¹

The typical features of aphthous ulcers are their predilection for nonkeratinized mucosa (Figs. 1 and 2) and the associated pain. Lesions less than 1 cm usually heal within 1 to 2 weeks and larger lesions may take more than 6 weeks, yet scarring is uncommon.⁴ If the patient is immunocompromised, the lesion can become secondarily infected with bacteria or fungi.

The treatment of aphthous ulcers is palliative, the goal being to reduce the duration, size, and recurrence of lesions. First-line treatment options comprise antiseptics, such as chlorhexidine, anti-inflammatory drugs, and analgesics for as long as the lesions persist⁵ (Table 1).

Topical steroids can decrease the symptoms and improve healing time, but do not affect recurrence rate. If multiple lesions are present, an aqueous solution is preferred. A dexamethasone rinse can be considered.⁶ In the case of isolated lesions, a high-potency topical steroid (kenalog, clobetasol, or fluocinonide^{6,7}) in an adherent carrier, such as orabase or denture adhesive paste, can be applied in small amount to the specific area.⁸ Steroids should not be used for more than 2 weeks and the patient should be monitored for yeast superinfection. Also, topical steroids should not be placed on viral lesions, which could aggravate the lesion.

Minocycline, an antibiotic with immunomodulatory effect suppressing neutrophils, T lymphocytes, and collagenase activity,⁴ can also be used. A blind crossover study shows significant reduction in duration and severity of pain compared with placebo.⁴

Intralesional treatment with triamcinolone (0.1–0.5 mL per lesion) can be considered for a painful single aphtha.⁹ In case of severe lesions resistant to topical or local treatment, a systemic steroid, such as prednisone, is recommended. It is started at 1 mg/kg/day as a single dose in patients with severe lesions and tapered after 1 to 2 weeks.¹⁰ The recommendation is to use less than 50 mg per day, preferably in the morning, for 5 days.⁶

Severe cases of RAS can be treated with colchicine,¹¹ pentoxifylline,¹² dapsone,¹³ or infliximab¹⁴ but these modalities should be reserved to oral medicine specialists because of the multiple side effects.



Fig. 1. Single aphthous ulceration of upper lip. (From Neville BW, Damm DD, Allen CM, et al. Oral and maxillofacial pathology. 3rd edition. Philadelphia: Saunders/Elsevier; 2016; with permission.)

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