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Review Article

Oral Involvement in Patients With Primary Sjögren's Syndrome. Multidisciplinary Care by Dentists and Rheumatologists☆

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ABSTRACT

Primary Sjögren's syndrome is a chronic systemic autoimmune disease that causes destruction of lacrimal and salivary glands. The most common and earliest symptoms are oral and ocular dryness. Dry mouth makes talking difficult, tasting and chewing properly, impairing quality of life of these patients. The most common oral signs and symptoms are hyposialia with or without xerostomia, tooth decay, fungal infections, traumatic oral lesions, dysphagia, dysgeusia, and inflammation of salivary glands. There are different therapeutic strategies, depending on the severity of each case, and the increase in the amount of saliva, to reduce the number of cavities and oral infections. It is particularly important to establish a close relationship between the dentist and the rheumatologist in order to make an early and correct diagnosis, promoting appropriate dietary and hygiene measures, as well as to treat and prevent potential oral complications.

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Afectación oral en el paciente con síndrome de Sjögren primario. Manejo multidisciplinar entre odontólogos y reumatólogos

Palabras clave:
Síndrome de Sjögren
Sequedad oral
Xerostomía
Caries
Flujo salival
Candidiasis oral

RESUMEN

El síndrome de Sjögren primario (SSp) es una enfermedad autoinmune sistémica crónica, que cursa con destrucción del tejido glandular lagrimal y salival. Sus síntomas más frecuentes y tempranos son la sequedad oral y ocular. La sequedad oral dificulta que el paciente hable, deguste y mastique correctamente, lo que disminuye la calidad de vida del enfermo. Los signos y síntomas orales más frecuentes son la hiposialia con o sin xerostomía, la caries dental, las infecciones fúngicas, las lesiones orales traumáticas, la disfagia, la disgeusia y la inflamación de las glándulas salivales. Existen distintas estrategias terapéuticas en función de la gravedad de cada caso que aumentan la cantidad de saliva y disminuyen el número de caries e infecciones orales. Por ello, es de especial importancia establecer una relación cercana entre el dentista y el reumatólogo que permita hacer un diagnóstico temprano y correcto, fomentar las medidas dietéticas e higiénicas adecuadas, tratar y prevenir las posibles complicaciones orales.

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Introduction

Primary Sjögren's syndrome (pSS) is a chronic, systemic, autoimmune, rheumatologic disease characterized by the presence of a lymphocytic inflammatory infiltrate in the salivary and lacrimal glands, which results in the destruction of the gland tissue. The most common and earliest symptoms of this disease are dry eyes and mouth, although extraglandular manifestations involving musculoskeletal, pulmonary, gastrointestinal, hematological, cutaneous, renal and neurological systems can also develop.[1,2]

Primary Sjögren's syndrome was described for the first time by the Swedish physician, Henrik Sjögren, who reported the cases of 19 women presenting with ocular dryness, the great majority of whom had rheumatoid arthritis.[3] There are 2 types of Sjögren's

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syndrome, pSS, which occurs as an isolated disease, and secondary (sSS), which is associated with other autoimmune diseases, such as rheumatoid arthritis and systemic lupus erythematosus.[2,4] The pathogenesis of pSS has been related to immunological, inflammatory, genetic, epigenetic, environmental, hormonal and infectious factors.[5]

The prevalence of pSS ranges from 0.5% to 4% of the general adult population. It is diagnosed more frequently in women than in men, in a proportion of 9:1, and it usually presents between the fourth and sixth decade of life, although it can appear at any age.[2,4,6,7] It is widely reported throughout the world, although it is most prevalent among Caucasians. As there are few symptoms, especially in the early stages, the disease is underreported, and there can be a considerable delay in the diagnosis, with a mean interval between symptom onset and definitive diagnosis of 3.5 years.[7]

The classification criteria for pSS include clinical signs and objective tests to detect dry eye and mouth, characteristic serological abnormalities (presence of anti-Ro/SSA and/or anti-La/SSB), and compatible histopathological findings in minor salivary glands (focal lymphocytic sialadenitis, with a focus score ≥1; a focus is defined as an aggregate of at least 50 lymphocytes and the score, as the number of such foci in a surface area of 4 mm^2 of salivary gland tissue).[8] At the present time, the classification criteria most widely employed are those proposed by the American-European Consensus Group in 2002 (Table 1).[9] The American College of Rheumatology and the *Sjögren's International Collaborative Clinical Alliance* have recently drawn up new classification criteria (Table 2).[1,10]

Presenting Symptoms

The majority of the patients with pSS first note dryness in the mouth and/or eyes. Mouth dryness makes it difficult to speak correctly and to taste and chew food properly. Dry mouth is frequently the first complaint of these patients, who constantly need to chew gum or suck on hard candy to stimulate the production of saliva, and who wake up several times a night to drink large amounts of water.[2,11] Thus, dry mouth has an important impact on the quality of life of patients with pSS.[12–14]

Individuals with dry mouth usually consult first with their primary care physicians, who, in many cases, do not have the means to determine whether the dryness reported by the patient is real (hyposalivation) or subjective (xerostomia). It is essential to establish this difference because many individuals of advanced age, mostly women, have burning mouth syndrome (BMS), a complex condition that produces, among other symptoms, a subjective sensation of dry mouth that cannot be detected in supplemental tests. Burning mouth syndrome is characterized by the presence of a burning sensation in the oral mucosa, despite normal analytical findings and no decrease in salivary flow. It is encountered most often in women from the age of 40 years on. Its prevalence ranges between 0.7% and 7%, and is higher among postmenopausal women, in whom the prevalences is as high as 12%–18%. This syndrome frequently affects the tip and lateral edges of the tongue, lips, and hard and soft palate. Patients with BMS also experience pain, loss of taste sensitivity and xerostomia.[15–17]

It is also necessary to rule out other possible causes of dry mouth, such as alterations in afferent stimuli, central nervous system disorders, dysfunction of the afferent pathways of the autonomic nervous system, chronic salivary gland inflammation (of immunological and nonimmunological origin), use of drugs associated with xerostomy[18] (Table 3), psychological disorders, use of tobacco and other drugs, systemic diseases, treatment with head and neck radiotherapy and dehydration.[4] If the primary care physician findings no modifiable cause associated with xerostomia, the patient should be referred to a dental professional for a complete checkup; if there is any datum in the patient's history or finding in the physical examination that suggests Sjögren's syndrome, the patient should also be referred to a rheumatologist.

Table 1
Diagnostic Criteria for Primary Sjögren's Syndrome Proposed by the American-European Consensus Group.

Ocular symptoms: a positive response to at least one of the following questions:
Have you had daily, persistent, troublesome dry eyes for at least 3 months?
Do you have a recurrent sensation of sand or gravel in the eyes?
Do you use artificial tears more than 3 times a day?
Oral symptoms: a positive response to at least one of the following questions:
Have you had a daily feeling of dry mouth for at least 3 months?
Do you had recurrent or persistent swelling of the salivary glands?
Do you frequently drink liquids to aid in swallowing dry food?
Ocular signs, that is, objective evidence of ocular involvement defined as a positive result for at least one of the following tests:
Schirmer's I test, performed without anesthesia (<5 mm in 5 min)
Rose bengal score or other ocular dye score (>4 according to van Bijsterveld's scoring system)
Histopathology of minor salivary glands (obtained using apparently healthy mucosa): focal lymphocytic sialoadenitis, with a focus score ≥ 1; a focus is defined as an aggregate of at least 50 lymphocytes and the score, as the number of such foci in a surface area of 4 mm^2 of minor salivary gland
Salivary gland involvement, objective evidence of salivary gland involvement defined by a positive result for at least one of the following diagnostic tests:
Unstimulated whole salivary flow (<1.5 ml in 15 min)
Parotid sialography showing the presence of diffuse sialectasias (punctate, cavitary or destructive pattern), with no evidence of obstruction in the major ducts, according to the scoring system of Rubin and Holt
Salivary scintigraphy showing a reduced concentration or delayed excretion of the tracer, according to the method proposed by Schall et al.
Autoantibodies: presence in serum of the following autoantibodies:
Antibodies to Ro(SSA) or La(SSB) antigens, or both
Revised guidelines for the classification of primary Sjögren's syndrome: in patients with no potentially associated disease, primary Sjögren's syndrome should be defined as follows:
The presence of any 4 of the above 6 items indicating primary Sjögren's syndrome, as long as item 4 (histopathology) and 6 (serology) are positive
The presence of any 3 of the 4 objective criteria (for example, items 3, 4, 5 and 6)
The classification tree procedure represents a valid alternative method for classification, although it should be properly used in clinical-epidemiological studies

Table 2
Diagnostic Criteria for Primary Sjögren's Syndrome Proposed by the American College of Rheumatology and Sjögren's International Collaborative Clinical Alliance.

According to this group, patients with Sjögren's syndrome should meet 2 of the following 3 conditions:
Presence of anti-Ro/SSA and/or anti-La/SSB or presence of rheumatoid factor and ANA ≥ 1:320
Keratoconjunctivitis sicca with ocular staining score of 3 or higher (provided the individual is not currently using eye drops for glaucoma and has not had corneal surgery or cosmetic eyelid surgery during the preceding 5 years)
Minor salivary gland biopsy revealing focal lymphocytic sialadenitis with a focus score greater than 1 per 4 mm^2 of gland tissue

Table 3
Drugs Associated With the Presence of Xerostomia.

Anorexic agents
Anxiolytics
Anticonvulsants
Tricyclic antidepressants
Antiemetics
Antihistaminics
Antiparkinsonian drugs
Antipsychotics
Bronchodilators
Decongestants
Diuretics
Muscle relaxants
Narcotic analgesics
Sedatives
Antihypertensive drugs
Antiarthritic agents

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