Painful Oral Lesions

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KEYWORDS

• Vesiculoerosive • Vesiculobullous • Aphthous ulcer • Herpes labialis

KEY POINTS

- Oral lesions generally fall into the category of either being neoplastic, inflammatory, reactive, or developmental.
- Painful oral vesiculoerosive diseases (OVD) discussed here are reactions to an autoimmune or a viral pathosis with a secondary inflammatory component.
- First-line treatment of autoimmune-related OVD are topical or systemic corticosteroids. Extraoral lesions need referral to an appropriate physician.
- For optimal treatment of herpetic oral lesions, antiviral medications should be instituted as soon as possible within the first day or 2.

Pain is a powerful motivator to seek medical or dental care. When that pain is combined with a visible, physical lesion or abnormality, health care providers should expect these patients to present with a great deal of concern and anxiety about their condition. Dental practitioners should be well-versed in pain conditions that occur outside of the dentition and periodontium. Oral health care providers are key to the identification and management of the more common painful oral lesions that patients may present with. In addition to the pain and anxiety concerning oral lesions, there is further concern that these ailments would interfere with mastication, nutritional intake and speech.

In general, lesions can be classified via the NIRD acronym: neoplastic, inflammatory, reactive, and developmental. Even if the clinical diagnosis is elusive, by way of history and clinical examination, the clinician may be able to at least classify the lesion into one of the above categories. For example, there is an erythematous lesion in the soft tissues adjacent to tooth no. 30. History includes placement of a large amalgam restoration adjacent to the lesion a short time before the lesion was noticed. Cognitively, the clinician should at least consider that the lesion may represent a reactive process.

The following additional information can help further subdivide an oral lesion into a clinical differential diagnosis:

- Location: Where inside the oral cavity is the lesion? Besides the presence of oral lesion(s), are there any lesions present at other body locations? If yes, the disease entity can be part of a wider systemic or dermatologic condition.

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- How many? Is the oral lesion single or multiple? The chancre associated with primary syphilis is a single lesion at the site of viral inoculation. Lesions of condyloma acuminatum associated with human papilloma virus are multiple.
- How long has the lesion(s) been there? This will help determine if the lesion is an acute process or a chronic state.
- Has this ever happened before? This will help determine if it is a primary event or part of a condition whereby recurrence is known to happen.
- Color: White, red, mixed, purple, or pigmented. For example, hemangiomas are purple or red in color and not white.

The above data also make for useful information to include in the patient record.

ORAL VESICULOEROSIVE DISEASES

Oral vesiculoerosive diseases (OVD) are a group of conditions that effect mucocutaneous tissues to include the oral cavity. They present with smaller vesicles or larger bullae (ie, blisters) that can rupture to leave painful denuded mucosa or ulcers. The most relevant of the OVD are those that have a proposed autoimmune or allergen-related cause to their pathophysiology. Several relatively common OVDs are presented followed by their collective treatment, because their management is often similar. Treatments unique to a given condition are addressed within their respective sections.

Lichen Planus

Lichen planus (LP) is a chronic disease affecting the skin and/or mucous membranes. Dermal LP is often self-limiting. The skin lesions associated with LP present as the 4 P's: pruritic, polygonal, purple papules. Oral lichen planus (OLP) may be symptomatic or asymptomatic. Symptomatic OLP may be quite painful if not outright debilitating. In the worst cases, speech and nutrition are often difficult secondary to the pain. Most commonly, OLP is unaccompanied by LP at other sites.

Relative to the other OVD, OLP is rather common. A review of population studies puts the overall prevalence at 1.27% (0.96% in men, 1.57% in women).[1] Two-thirds of cases are found in women with the average age at diagnosis in the late 50s, with an age range of 11 to 94.[1–4] OLP affects individuals of all races, but reports are more frequent from India.[1]

Clinical features of OLP are that of a flat, erythematous base that is interlaced with raised white lines (Wickham striae) or patches. Lesions are often symmetric and diffuse. By far the most affected oral site is the buccal mucosa with other common sites being the tongue, gingiva, and vestibule.[2,3,5] When OLP affects the gingiva, in those cases it is often the only site. When the gingiva becomes involved, it may present with erythema, ulceration, and bleeding. The outer layer of the gingiva may separate and slough off, leaving behind a raw, red, painful surface. The sloughing process is referred to as a desquamative gingivitis. However, other OVDs such as pemphigus vulgaris (PV) and mucous membrane pemphigoid (MMP) may also present as such and should be differentiated from OLP.

Although most cases of OLP are asymptomatic, when symptoms are present, pain is the most common feature (reported 27%–43%) but can also be accompanied by reports of xerostomia, mucosal roughness, and dysgeusia.[2,3] Symptoms tend to wax and wane over time. Quiescent periods may be interrupted by acute exacerbations of pain. Clinical subtypes of OLP are based on appearance and can include the common reticular form of OLP (**Fig. 1**) and also the more painful form called erosive lichen planus (ELP).[6] Less common are the plaque, bullous, and papular subtypes.[7] The clinical subtype can progress from a less symptomatic variety (reticular OLP) to a more painful variety (ELP) and vice versa. Over time, 65% of the cases have the

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