



BANE OF PAINFUL ORAL ULCERS- A CASE REPORT

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ARTICLE INFO

Article History:

Received 17th September, 2017

Received in revised form 12th

October, 2017

Accepted 04th November, 2017

Published online 28th December, 2017

Key words:

Major aphthous ulcers; Topical treatment;
Steroids; Mouthwash.

ABSTRACT

Recurrent aphthous stomatitis (RAS) is inflammation of the mucosa with painful ulcerations in the oral cavity. It is one of the most common disorder seen in primary care, affecting upto 25% of the general population and 3-month recurrence rates are high as 50%. Female predominance is seen. Approximately 2 per cent of patients with RAS present with severe, persistent form of the disease. Although less number of people are affected, the suffering is great. Such patients usually present with history of continual referral between various specialties of the healing profession, with no improvement. This paper deals with such a 20-year old male patient who presented a 4-year history of episodes of multiple recurrent ulcers on the oral mucosa accompanied with severe pain.

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INTRODUCTION

Recurrent aphthous stomatitis (RAS) is an inflammatory ulcerative condition of the oral mucosa characterized by painful and recurrent ulcers, whose exact pathophysiology remains unclear, factors contributing to this clinical entity include local trauma, smoking, stress, hormonal status, genetics, hematinic deficiencies (iron, folic acid, vitamins B2, B3, B6, B12, and C), immunological factors, microorganisms and systemic diseases.^[1] RAS is classified according to clinical features as minor, major, and herpetiform. The most common presentation is minor RAS with round, clearly defined, small, painful ulcers that heal in 10 to 14 days without scarring. In major RAS (Sutton's disease) the lesions are larger (>1.0 cm), can last for six weeks, and frequently scar. The third variety of RAS is the herpetiform, which presents as multiple clusters of pinpoint lesions that coalesce to form large irregular ulcers and last seven to ten days.^[1,2] Similar-appearing lesions may arise in some systemic disorders like behcet's disease, sweet's syndrome, cyclic neutropenia, benign familial neutropenia, MAGIC syndrome, and various nutritional deficiencies with or without underlying gastrointestinal disorders.^[3]

Case report

A 20 year old male patient presented with multiple ulcers all over the oral mucosa since 14 days. Patient suffered severe pain and difficulty while eating and during speech.

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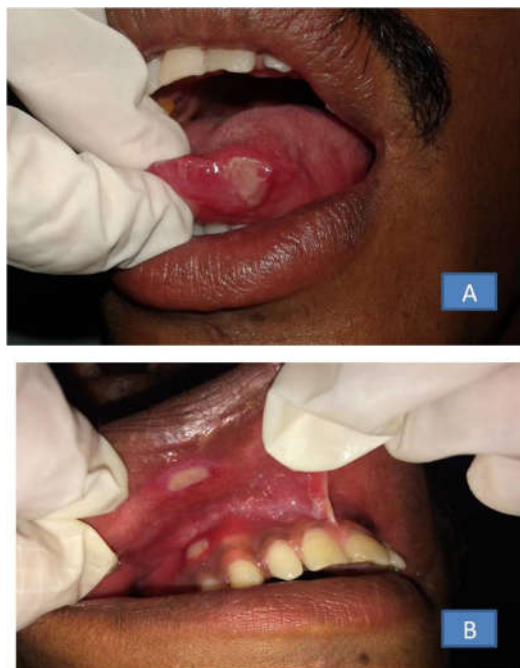
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His history revealed that similar ulcers appear at different sites of the oral mucosa every month, and heals in a span of one month, since 4 years. Patient had previously visited many clinicians for the treatment, who prescribed oral gels and vitamin B capsules for several months. But there was no improvement. Clinical examination revealed multiple symptomatic ulcers with a perilesional erythematous halo covered with a pseudomembrane, on the upper labial mucosa, alveolar mucosa and tip of the tongue. [Figure A&B] The size of ulcers were more or less 10 mm in diameter. The ulcers were not associated with any type of discharge and were tender on palpation. The medical history and the family history were non-contributory. A clinical diagnosis of recurrent aphthous ulcers was made on the basis of the history and the clinical examinations. Laboratory tests including a hemogram were ordered to determine folic acid, iron, ferritin, vitamins B2, B6, and B12 levels, serum hemoglobin, and medium corpuscular volume (MCV). All the findings were under normal limits.

The patient was initially subjected to a therapeutic regimen consisting of daily topical application of Amlexanox oral paste, topical lignocaine and systemic vitamin B-complex. Patient was advised to apply the topical lignocaine 4 times a day, half an hour before meal and amlexanox oral paste half an hour after meal on the affected area. Patient was also advised to take vitamin B-complex once in a day. These medicines were advised for 7 days. Diet modification was also done. Patient was advised to take green vegetables and non-spicy food. Patient was recalled after 7 days for follow-up. At follow up there was no much reduction in pain and discomfort. Hence

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patient was asked to discontinue with Amlexanox and instead use chlorhexidine oral rinse and Triamcinolone acetonide 0.1%, to be applied half an hour after meal on the affected area, four times daily for one week. On follow up the ulcers had healed without scar formation. No side effects were recorded.



A Recurrent Aphthous Ulcer seen on the tip of the tongue.
B Similar ulcers seen in the upper labial mucosa and alveolar mucosa.

DISCUSSION

RAS is characterized by recurrent, multiple, small, round, or ovoid ulcers, with circumscribed margins having yellow or gray floors.^[4] Because of its uncertain etiology and various clinical presentations, aphthous stomatitis remains a challenge for the oral health care professionals.^[3]

Treatment of aphthous ulcers is fundamentally symptomatic: it is aimed to reduce the severity and duration of the pain and decrease the frequency of the relapse. The lack of an efficacious and definitive prophylactic protocol has led to the development of several treatments that use different drugs, antibacterial agents (eg, minocycline, tetracycline, cephalexin), anti-acidic agents (eg, sucralfate) and antineoplastics (eg, thalidomide). Anti-inflammatory and immunomodulatory agents such as clofazimine, thalidomide, pentoxifylline, colchicine, levamisole, azathioprine, and amlexanox have been administered with varying clinical benefits.^[5,6] Mouthrinses like Chlorhexidine gluconate, Benzylamine hydrochloride, Betadine. And topical corticosteroids like Hydrocortisone hemisuccinate, Triamcinolone acetonide, Flucinonide, Betamethasone valerate, Betamethasone-17- benzoate, Flumethasone pivalate, Beclomethasone dipropionate are also used with different success rates. Other treatments that can be taken into consideration are systemic zinc sulphate, Sodium cromoglycate, Deglycyrrhizinated licorice, Low-energy laser.^[3]

Topical treatment offers numerous advantages related to the scarcity of side effects, a more tolerability and its easy use in the delimited area to treat.^[7] Hence they are the first choice of

treatment for RAS.^[3] The Anti-microbial mouthwash used in RAS is intended to control microbial contamination and secondary infection. Chlorhexidine can reduce the number of ulcer days and increase ulcer-free days and the interval between bouts of ulceration, but cannot prevent the recurrence of ulcers. Chlorhexidine is generally used as a 0.2% w/w mouthrinse, but the 0.10% w/w mouthwash or 1% gel can also be beneficial.^[7] Tetracycline, an antibiotic mouthwash reduces ulcer size, duration and pain because of its ability to reduce not only secondary infection but also to inhibit collagenase activity.^[8] Topical medications are easily washed away from the target area. This problem can be addressed by using different kinds of adhesive vehicles^[9] in combination with the drug. For example, strong topical corticosteroids when compounded with mucosal adherents are effective despite limited contact time. Topical glucocorticoids that have demonstrated efficacy for RAS are fluocinonide, triamcinolone and clobetasol.^[10] In our case, the patient responded well to topical application of triamcinolone along with chlorhexidine oral rinse.

Differentiation between RAS and other forms of oral ulcers seldom pose a major clinical or diagnostic problem, although similar-appearing lesions may arise in systemic disorders.^[11] Oral lesions of herpes simplex virus, shingles, herpangina, erythema multiforme, pemphigus vulgaris, and hand-foot-mouth disease could be considered under differential diagnosis of RAS.^[12]

CONCLUSION

RAS can be a very frustrating condition for both patients and clinicians. There is no complete cure for RAS and, while there are indications of what may cause certain cases, We are far from knowing the exact etiology. RAS can also occur due to a number of systemic conditions. Before proceeding with the treatment, a definitive diagnosis must be made and biopsy of the site may be required at times. A patient with RAS should be initially treated with palliative therapy along with topical anesthetics. The proper treatment of RAS can make a significant difference in maintaining a patient's quality of life.

References

1. Garcia BG, Cardoso MFP, Faria O, Gomez RS, Mesquita RA. A Case Report of Pernicious Anemia and Recurrent Aphthous Stomatitis. *J Contemp Dent Pract* 2009; (10)2:083-089.
2. Ship JA. Recurrent aphthous stomatitis. An update. *Oral Sug Oral Med Oral Pathol Oral Radio Endod.* 1996;81(2):141-7.
3. Iqbal MA, Anwar N, Khan M, Gupta CP, Rayeen HS, Shrivastava D. Recurrent aphthous stomatitis: A case report. *The Pharma Innovation Journal* 2017;6(7): 908-910.
4. Son CG. Case Report for a Refractory Recurrent Aphthous Stomatitis Treated with Jibaekpalmi-hwon. *The Journal of Korean Oriental Medicine* 2012;33(2): 73-77.
5. Nardi GM, Grassi FR, Lauritano D, Petruzzi M. An Alternative Approach for the Treatment of Major Aphthosis: Case Report. *J Interdiscipl Med Dent Sci* 2014; 2(5):1-3.
6. Karavana SY, Gökçe EH, Rençber S, Özbal S, Pekçetin C, et al. A new approach to the treatment of recurrent

- aphthous stomatitis with bioadhesive gels containing cyclosporine A solid lipid nanoparticles: in vivo/in vitro examinations. *Int J Nanomedicine* 2012;7: 5693-704.
7. Hapa A, Aksoy B, Polat M, Aslan U, Atakan N. Does recurrent aphthous stomatitis affect quality of life? A prospective study with 128 patients evaluating different treatment modalities. *J Dermatolog Treat* 2011;22:215-20.
 8. Ship Ja, Ahwvej Em, Doerr Pa, Henson Bs, Sarmadi M. Recurrent aphthous stomatitis. *Quintessence Int* 2002;31:95-112.
 9. Ylikontiola L, Sorsa T, Hayrinenimkonen R, Salo T. Doxymycinecyanoacrylate treatment of recurrent aphthous ulcers. *Oral Surg Oral Med Oral Pathol Oral Radiol Endod.* 1997; 83:329-333.
 10. Vincent SD, Lilly GE. Clinical, historic, and therapeutic features of aphthous stomatitis. *Oral Surg Oral Med Oral Pathol Oral Radiol Endod.* 1992; 74:79-86.
 11. Porter SR, Scully C. RECURRENT APHTHOUS STOMATITIS. *Crit Rev Oral Biol Med* 1999;33: 330066-2211
 12. Ship JA, Chavez EM, Doerr PA, Henson BS, et al. Recurrent aphthous stomatitis. *Quintessence Int.* 2000:95-112.

How to cite this article:

Reshma Suvama *et al* (2017) 'Bane of Painful Oral Ulcers- A Case Report', *International Journal of Current Advanced Research*, 06(12), pp. 8581-8583. DOI: <http://dx.doi.org/10.24327/ijcar.2017.8583.1389>
