This presentation involves discussion of off-label use of drugs.

Complex Aphthosis

Orofacial Granulomatosis

Oral Lichen Planus
Complex Aphthosis

Aphthosis is a multifactorial condition

The lesions of aphthosis are a manifestation of a variety of diseases and conditions

Aphthosis may be divided into simple and complex subsets
Recurrent Aphthous Stomatitis

Simple Aphthosis

- Term introduced by Rogers in 1992*
- Describes patient presentation with RAS in the absence of severe or continuous oral ulcerations, and in the absence of Behcet’s disease
- Includes the vast majority of sufferers of RAS
- Includes 20-50% of the population 5-25 years of age

*Postgrad Med 1992;91:141

Complex Aphthosis

- Concept introduced by Jorizzo et al in 1984
- Describes patient presentation of recurrent oral and genital aphthous ulcers or almost constant, multiple oral aphthae, in the absence of Behcet disease
- Complex aphthosis is a small subset of recurrent aphthous stomatitis (RAS)
Vulvar Aphthosis
Complex Aphthosis

Complex aphthosis is an uncommon subset of RAS.

Complex aphthosis is a reactive condition associated with many conditions including Behcet disease.

Complex Aphthosis Associated Diseases

Complex aphthosis
Ulcus vulvae acutum
Reactive non-sexually related acute genital ulcers
Gluten-sensitive enteropathy
Periodic fever, aphthosis, pharyngitis, and adenopathy (PFAPA)

Many patients (up to 2 of 3) with complex aphthosis have recognizable underlying conditions, some of which are amenable to treatment.
Complex Aphthosis

The clinician should seek “correctable causes” and associated conditions in all patients with complex aphthosis.

Complex Aphthosis Management

Exclude associated diseases

Identify “correctable causes”
- Deficiency of iron, folic acid, vitamins B₁, B₂, B₆, and B₁₂
- Menstrual-related aphthosis
- Zinc deficiency
- Gluten sensitivity
- IgA deficiency

Identify and replace deficiencies

Treat primary diseases such as Crohn’s disease or sprue

Modify provocative factors such as drug reactions, trauma

Treat with corticosteroids, NSAIDs such as colchicine and/or dapsone, and other drugs.
Oral Dermatology
Diagnostic & Treatment
Pearls

Seek “correctable causes”
Gain control
Maintain control

Complex Aphthosis
Treatment Results 1998-2007

Lynde CB, Bruce AJ, Rogers RS III.
Successful treatment of complex aphthosis with colchicine and dapsone.

55 patients, 69% female, mean age 41 y/o
Median duration of 13 years
82% oral only, 18% oral and genital aphthosis
Complex Aphthosis

Corticosteroids
Use to provide short term relief
Tapering 3 week course
40-60 / 20-30 / 10-15 mg / week
Does not effect the natural history of the disease

Complex Aphthosis

Treatment Results 1998-2007
Colchicine Treatment
Rx with colchicine successful in 60%
(30/50)
13/50 did not respond & 7/50 did not tolerate colchicine

Complex Aphthosis

Treatment Results 1998-2007
Dapsone Treatment
Rx with dapsone alone or with colchicine was successful in 74% (14/19)
Complex Aphthosis
Treatment Results 1998-2007
Overall, 80% (44/55) achieved success with follow-up of up to 7 years

Lynde CB, Bruce AJ, Rogers RS III

Recurrent Aphthous Stomatitis

References

Complex Aphthosis
Urban Legends
Complex Aphthosis

Orofacial Granulomatosis

Oral Lichen Planus

Orofacial Granulomatosis Practice Gaps

Chronic inflammatory disorder presenting in oral and facial tissues with non-caseating granulomata.

Oral lesions resemble oral Crohn’s disease both clinically and histologically in patients without GI involvement.

One form is recognized as the Melkersson-Rosenthal syndrome, a trisymptom complex of orofacial edema, facial palsy and a fissured tongue.

Therapy to reduce the granulomata and improve the cosmetic deformity is a problem.

Orofacial Granulomatosis Learning Objectives

The learner will be able to describe the 3 components of orofacial granulomatosis (OFG) as exemplified by the Melkersson-Rosenthal syndrome.

The learner will be prepared to evaluate the patient for associated non-caseating granulomatous diseases.

The learner will be able to manage the condition effectively with corticosteroids and non-steroidal anti-inflammatory agents.
Seek “correctable causes”
Gain control
Maintain control

Biopsy of oral lesion
Exclude Crohn disease
Exclude sarcoidosis
Careful dental evaluation
Patch testing (cinnamaldehyde, food coloring)

Sarcoidosis
Atopic diathesis
Food allergies
Tooth root abscess
Inflammatory bowel disease
Orofacial Granulomatosis
Primary Conditions

Melkersson-Rosenthal syndrome
Miescher’s cheilitis granulomatosa
Monosymptomatic MRS
Oligosymptomatic MRS

Melkersson-Rosenthal Syndrome Treatment Modalities

Orofacial swelling
- Intralesional corticosteroids (5-10 mg/ml diluted with lidocaine)
- Systemic corticosteroids
- Dapsone
- Sulfapyridine
- Other antibiotics

- Cheloplasty followed by intralesional corticosteroids and oral antibiotics

- 26/28 recent patients had an excellent response to systemic corticosteroids
- Dapsone is beneficial in maintaining a remission in 80% of patients
- Intralesional corticosteroids are also important in gaining and maintaining a remission
- TNF-alpha inhibitors improve OFG manifestations of patients with Crohn’s disease

- Cheloplasty followed by intralesional corticosteroids and oral antibiotics


Oral Lichen Planus

Oral Lichen Planus is a very common condition... as common as Psoriasis and Alopecia Areata.

Oral Lichen Planus is classified into 2 large groups... #1 raised and #2 atrophic or eroded.

The raised lesions may be relatively asymptomatic.
Oral Lichen Planus
Oral Lichen Planus is a chronic and distressing condition.

Oral Lichen Planus
Oral Lichen Planus has many extraoral manifestations.

Oral Lichen Planus
Oral Lichen Planus often has genital manifestations.
Oral Lichen Planus

Oral Lichen Planus is a treatable condition with topical and systemic medications.

Evaluation
- Record sites and classify oral involvement
- Ask about extraoral lesions
- Assess severity

Consider oral candidiasis
- Clinical vs laboratory evidence

Consider causes
- Drugs, lichenoid contact stomatitis

Oral Lichen Planus Treatment
- Meticulous oral hygiene
- Exclude dental infection
- Control periodontal disease
- Control secondary candidiasis
- Consider contact stomatitis

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Oral Lichen Planus Treatment

Corticosteroids
- topical
- aerosol
- intralesional
- systemic

Retinoids
- topical tretinoin
- isotretinoin
- etretinate

Oral Lichen Planus Topical Treatment

- Lidex (fluocinonide) 0.05% Gel
- Protopic (tacrolimus) Ointment 0.1%
- Nystatin oral suspension or pastilles

Sig: Apply 3-4 times a day after meals and HS by rubbing in with the fingertip
Oral Lichen Planus
Topical Treatment

- Clobetasol 0.05% Ointment, 15 or 60 gm tubes
  Sig: Apply 3-4 times a day after meals and HS by rubbing in with the fingertip

Oral Lichen Planus
Topical Treatment of Candidiasis

- Nystatin oral suspension (100K units per ml) or pastilles (200K units per pastille)
  Sig: one teaspoon rinse and swallow 3-4 times a day or dissolve one pastille 3-4 times a day or one dose at HS as prophylaxis

Oral Lichen Planus
Systemic Treatment

- Hydroxychloroquine
- Metronidazole
- Cyclosporine
- Griseofulvin
Oral Lichen Planus

Systemic Treatment

- CellCept
- Dapsone
- Interferon α-2b
- Corticosteroids

Oral Lichen Planus

Topical Treatment

Gain control with QID applications, maintain control for 4 weeks, taper frequency of applications to the dose necessary to maintain remission

Oral Dermatology

Diagnostic & Treatment Pearls

- Complex Aphthosis
- Orofacial Granulomatosis
- Oral Lichen Planus