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Lichenoid Lesion of the Unilateral Buccal Mucosa

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A B S T R A C T

Oral lichenoid lesion (OLL) is a response that occurs on the oral mucosa to some sort of reaction. It includes allergic responses to the dental materials, drugs or graft versus host disease (GVHD). OLL can be seen related to various dental materials including amalgam or composites when it comes in direct contact or close proximity to the mucosa in sensitized individuals. Nowadays, we have a lot of people living with diabetes mellitus and hypertension. Medications that produce OLL are oral hypoglycemic agents, anti-hypertensives, and non-steroidal anti-inflammatory agents (NSAIDs). Very often oral lichen planus (OLP) and OLL are misdiagnosed. The clinical and histopathological features of OLL are similar to OLP. However, the presence of a potential putative drug or a filling material can make it easier to differentiate between the two. Both of these, if left untreated can undergo dysplastic changes at times and to malignancy in the presence of a provoking agent. Erythematous lesions therefore, must be observed frequently and biopsies performed if needed.

Keywords: Oral lichenoid lesion; Man; Buccal mucosa; Bhutan

1. Introduction

Oral Lichenoid Lesion (OLL) is a response that occurs on the oral mucosa to some sort of reaction. Oral lichenoid lesion (OLL) is a term usually used to describe a lesion in the oral cavity having a potential putative etiology (1-3). In the literature, different terms are used to refer these lesions (3). OLLs sometimes have been described as contact allergies, oral lichenoid lesions, contact lesions or oral lichenoid reaction (3, 4). OLLs have been postulated as a condition in response to a wide variety of triggering factors. There are various classifications for OLL based on their etiologies (5). As per Al-Hashimi et al., OLL lesions are grouped as follows: A) OLL related to contact (OLLC) as a result of allergic contact stomatitis (immune retarded hypersensitivity mediated by cells) - this reaction is most often attributed to dental restorative materials(commonly amalgam) (3, 4) B) OLL related to drugs (OLLD) in which oral and/or skin lesions appear in temporal association with the intake of drugs; C) oral lichenoid lesion(s) of graft-versus-host disease (OLL-GVHD) (3, 4) which is a common complication of allogeneic hematopoietic stem-cell transplantation (4). OLL and OLP are similar clinically as well as histologically (3). However, the former has a distinct identifiable putative etiology, while the later still is of unknown etiology (6). Removal or withdrawal of this agent often regresses and heals the oral lesion (6, 7). In most cases after removal of the etiology a topical steroid is used to reduce inflammation and for early regression of the lesion (1, 6).

2. Case Report

We discuss a case of oral lichenoid lesion in a 47 year old man. This man visited our clinic without any complain of pain or burning sensation but he thought he had developed mouth cancer when coincidently he saw the white patch in the mouth. He observed the lesion some one year ago. The lesion did

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not improve but grew in size over the full one year period. He was an occasional drinker. The only medical problem he revealed was dyslipidemia, for which, he took regular medication. His vitals were all within normal range.

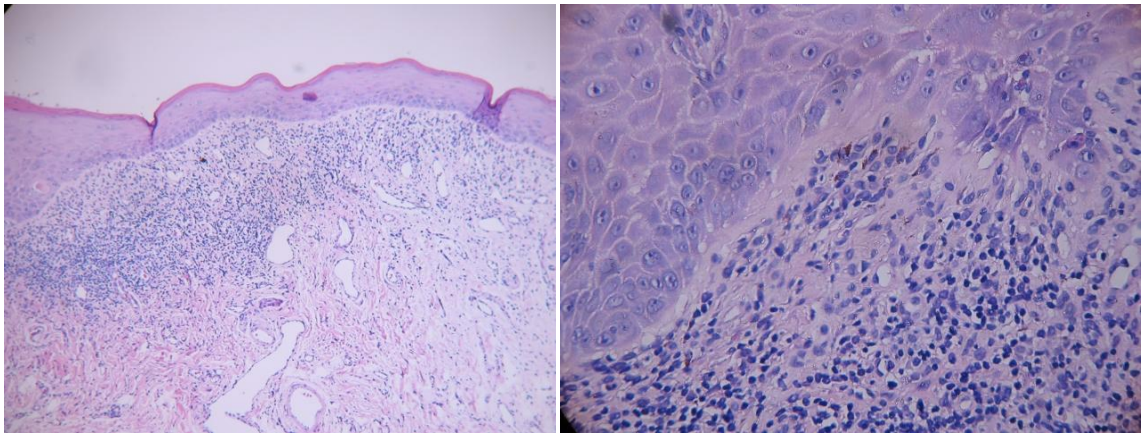
On extra-oral examinations, there were no swellings, ulcers or skin lesions. His Temporo-mandibular joints were normal and there was no facial asymmetry.

On intra-oral examinations, there was mild erythema with white striations/ plaque on the left buccal mucosa adjacent to teeth 35, 36 and 37. The tooth (36) was also seen with amalgam restoration. All other structures of the mouth were normal with no lesions. This was the only lesion present in this patient. The lesion as seen in Figure 1(a) below:

1 (a)-Lichenoid lesion on the buccal mucosa (Left side)

The lesion typically and clinically looked like a lichenoid lesion. However, an incisional biopsy was done and sent for histopathological examination (HPE) and direct immune-fluorescent (DIF) study. Both the HPE and DIF reports were consistent with oral lichen planus. But, in this patient we treated as oral lichenoid lesion because of two reasons:

1. The lesion was adjacent to amalgam restoration and
2. The patient was taking anti-dyslipidemic drugs..



2 (a)-Low power field 2(b)-High power field

Since the lesion was adjacent to the amalgam restoration which was the most potential putative agent for OLL, the restoration was removed and replaced by Glass Ionomer restoration. Topical corticosteroid (Triamcinolone Acetonide in orabase 0.1%) was used for treatment of the lesion. The patient was followed up at 2 weeks, 4 weeks, monthly till 3 months and then 3 monthly. During the patient's 3 monthly visit, the lesion had completely healed. We continued the topical corticosteroid once a day for a longer duration so as to prevent irritation to the erythematous area and for patient comfort. The picture after treatment as seen in Figure 2(a) below:

3(a)-After Treatment

3. Discussion

The most important thing we need to know in OLL and OLP is that in both, the clinical and histological features are similar (3). If potential putative agent is present the diagnosis most likely would be the former. OLL is often encountered mucosal pathology by dental practitioners and oral pathologist but it is misdiagnosed many a times. It is important to make correct diagnosis of the lesions and initiate proper and timely treatment. The aims of the treatment are to alleviate painful symptoms, to heal the ulcerative and/or atrophic lesions, reduce the risk of malignant transformation (1, 8). Histopathological examination is done to confirm the clinical diagnosis and also to exclude lesions with dysplastic or malignant changes (9). Lichenoid drug reaction is termed as a condition of the oral cavity having an identifiable etiology, which is clinically and histologically similar to oral lichen planus (9). A number of drugs have been described as a causative factor of those reactive lesions (6). The most preferable treatment is withdrawal of the drugs and administering a topical steroid regimen (1, 6, 7).

REFERENCES

Crispian scully; oral & maxillofacial medicine tbodatte. R.A C. Oral Pathology and Oral Medicine. Book. 2008.

Grossmann SMC OC, Souto GR, Góes C, Mesquita RA. Oral lichenoid lesion: A review of the literature. World J Stomatol 2015; 4(2): 103-107.

Al-Hashimi I, Schifter M, Lockhart PB, Wray D, Brennan M, Migliorati CA, et al. Oral lichen planus and oral lichenoid lesions: diagnostic and therapeutic considerations. Oral surgery, oral medicine, oral pathology, oral radiology, and endodontics. 2007;103 Suppl:S25.e1-12.

Scully C, Felix DH. Oral medicine [mdash] Update for the dental practitioner Aphthous and other common ulcers. British dental journal. 2005;199(5):259-64.

Rotaru D, Chisnoiu, R., Picos, A.M., Picos, A., & Chisnoiu, A. (2020). Treatment trends in oral lichen planus and oral lichenoid lesions (Review). Experimental and Therapeutic Medicine, 20, 198. https://doi.org/10.3892/etm.2020.9328.

Usatine RP, Tinitigan M. Diagnosis and treatment of lichen planus. Am Fam Physician. 2011;84(1):53-60.

Cosgarea R, Pollmann R, Sharif J, Schmidt T, Stein R, Bodea A, et al. Photodynamic therapy in oral lichen planus: A prospective case-controlled pilot study. Scientific Reports. 2020;10(1):1667.

Müller S. Oral lichenoid lesions: distinguishing the benign from the deadly. Modern Pathology. 2017;30(1):S54-S67.