

Kobkan Thongprasom¹, Somchai Sessririsombat², Kanjana Singkharotai², Achara Vathanasanti³, Keskanya Subbalek²

Topikalni steroidi i CO₂-laser u terapiji refraktorne lihenoidne reakcije na lijekove i lihenoidne kontaktne lezije: prikaz slučaja

Topical Steroids and CO₂ Laser in the Treatment of Refractory Oral Lichenoid Drug Reaction and Lichenoid Contact Lesion: a Case Report

¹ Odjel za oralnu medicinu Stomatološkog fakulteta Sveučilišta Chulalongkorn, Bangkok, Tajland

Oral Medicine Department, Faculty of Dentistry, Chulalongkorn University, Bangkok 10330, Thailand

² Odjel za oralnu maksilofacijalnu kirurgiju Stomatološkog fakulteta Sveučilišta Chulalongkorn, Bangkok, Tajland

Oral and Maxillofacial Surgery Department, Faculty of Dentistry, Chulalongkorn University

³ Odjel za farmakologiju Stomatološkog fakulteta Sveučilišta Chulalongkorn, Bangkok, Tajland

Pharmacology Department, Faculty of Dentistry, Chulalongkorn University

Sažetak

Pacijentica u dobi od 54 godine bila je primljena s jakim bolovima u gingivi i obraznim sluznicama. Oralnim pregledom uočene su plamenocrvene desni i ulcerirane lezije s bijelim strijama prekrivene pseudomembranama na objema obraznim sluznicama. Bolovala je od hipertenzije, dislipidemije, subkliničkog hipotiroidizma i artritisa. Bila je pod terapijom atorvastatina, hidroklorotijazida, valsartana, levotiroksina i nesteroidnih protuupalnih lijekova (NSAID). Oralne lezije pacijentice blago su se smanjile nakon terapije kremom s *pimekrolimusom*, 0,1-postotnim triamkinolon-acetonidom u orabazi i injekcijama. Nakon što je Diclofenac zamijenjen Tenoxicamom i oralne lezije tretirane različitim steroidima, stanje se znatno poboljšalo. Na temelju biopsije bukalne sluznice dijagnosticiran je lihen planus. Patch-test pokazao je pozitivnu reakciju na živu, zlatni natrijev tiosulfat i platinu. Nakon godinu dana na lijevoj obraznoj sluznici pojavila se crvena, okrugla papilomatozna lezija. Patohistološkim nalazom potvrđeno je da je riječ o nespecifičnom ulkusu s kroničnom upalom. Lezije su buknule nakon zamjene amalgamskih ispuna u zubima krunama. Nakon terapije ugljično-dioksidnim laserom, lezije su se donekle smanjile. Direktna i indirektna imunofluorescencija lezija bila je negativna. Ovaj prvi prikaz slučaja pokazuje da tijekom palijativne terapije refraktorne oralne lihenoidne lezije snažnim topikalnim steroidima sedam godina nije bilo nuspojava. U ovom slučaju CO₂-laser može biti alternativna terapija.

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Adresa za dopisivanje

Kobkan Thongprasom
Chulalongkorn University
Faculty of Dentistry
Oral Medicine Department
Bangkok 10330, Thailand
tel: +66-2-2188942
faks: +66-2-2188941
kobkan.t@chula.ac.th

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Uvod

Oralne lihenoidne reakcije na lijekove (OLDR) karakteriziraju bijele strije i eritematozna i ulcerirana područja koja nastaju nakon primjene lijekova poput *angiotensin-converting* enzima (ACE) inhibitora, nesteroidnih protuupalnih lijekova (NSAID), hipoglikemičnih lijekova, penicilina itd. (1). Oralna lezija (OLDR) slična je i klinički i patohistološki oralnom lihen planusu (OLP) (2). Teškoće u razlikovanju tih dviju bolesti uzrokuju probleme u primjeni terapije i kontroli. Dijagnozu OLDR-a može potvrditi i to što oralne lezije nastaju zbog primjene lijekova, a nestaju kad se prestanu primjenjivati.

Oralne lihenoidne kontaktne lezije (OLCL) neposredno su u doticaju s uzročnim sredstvom, a to je amalgam ili metalni restorativni materijali. Ako se oni uklone, lezije se postupno smiruju. Zamjena restorativnih materijala ipak je i dalje kontroverzna (3). Naime, ne mogu se uspješno liječi-

Introduction

Oral lichenoid drug reactions (OLDR) characterized by white striae and erythematous or ulcerative area that erupts after administration of drugs such as angiotensin-converting enzyme (ACE) inhibitors, non-steroidal anti-inflammatory drugs (NSAIDs), hypoglycemic drugs, penicillamine, etc.(1). The oral lesion of OLDR is similar to OLP both clinically and histopathologically (2). Difficulties in distinguishing between these two diseases resulted in difficulties in treatment and management of the lesions. However, the diagnosis of OLDR is rendered when oral lesions erupt after administration of the drugs and the lesions can be resolved after withdrawal of suspected drugs. Oral lichenoid contact lesions (OLCL) are in direct contact with offending agents such as amalgam or metal restorative materials. When the amalgam restoration or metal restorative materials are removed, the lesions are gradually resolved. However, replace-

ti svi slučajevi, posebice ako se uzima više lijekova ili ako se OLDR pojavljuje istodobno s OLCL-om. Prikazani slučaj bio je izazov jer je istodobno bio OLDR i OLCL. Različiti topikalni steroidi i dalje ostaju lijekovi izbora za smirivanje bolova i upale te kao medicinska konzultacija. Za refraktorne slučajeve OLDR-a i OCCL-a nema posebne terapije, ali prestane li se primjenjivati sumnjivi lijek to svakako koristi jer se može poboljšati cijeljenje lezija (4). Dugoročno praćenje potrebno je radi poboljšanja kvalitete života pacijenata i ranog otkrivanja lezija u slučaju da nastane maligna transformacija. Prema našim spoznajama, ovo je prvi prikaz slučaja koji je predstavio sedmogodišnju palijativnu terapiju refraktorne oralne lezije s pomoću snažnih topikalnih steroida bez nuspojava.

Prikaz slučaja

Pacijentica u dobi od 54 godine upućena je 2006. godine na Odjel oralne medicine Stomatološkog fakulteta Sveučilišta Chulalongkorn u glavnome tajlandskom gradu Bangkok, zbog već pet godina bolne gingive te lijeve i desne obrazne sluznice. Bolove je osjetila pri konzumiranju vruće i začinjene hrane. Specijalist otorinolaringolog liječio ju je 1-postotnom kremom s pimecrolimusom (Elidel), usnim gelom protiv ulkusa, 0,1-postotnim triamkinolon-acetonidom u orabazi te Kamistadom. Kamistad je oralni terapijski gel koji sadržava ekstrakt cvijeta kamilice i lidokain HCl i indiciran je za terapiju bolnih i upalnih procesa oralne sluznice, no lezije su se samo blago smanjile. U leziju je četiri puta injiciran i triamkinolon-acetonid (Kenacort) od 10 mg/ml, ali poboljšanja nije bilo. Obiteljski liječnik zatražio je patohistološki nalaz oralnoga lihen planusa iz uzorka bukalne sluznice zbog mogućih malignih promjena. Obavljena je bila i biopsija kože te je dobiven nalaz pigmentiranog purpurnog dermatitisa (PPD). Svi patch-testovi bili su na početku negativni, no nakon četiri godine jedan je pokazao pozitivnu reakciju na živu i paladij. Anti-HB bio je pozitivan s 138 mIU/mL, a anti-HCV bio je negativan. Nalazi serologije za autoimune bolesti bili su negativni i to za LE-stanice, antinuklearni faktor i anti-DNK. Od sistemskih bolesti pacijentica je bolovala od hipertenzije, dislipidemije, subkliničkog hipotiroidizma i artritisa. Od lijekova je uzimala Atorvastatin calcium – ½ tablete po., Hydrochlorothiazide 50 mg – ¼ tablete po., Valsartan – ½ tablete po., Eltroxin (levothyroxine) 0,1mg – 1 tableta po. Diffiam lozeng 3 mg – 1 tableta tid pc. i Diclofenac potassium – 1 tableta po. Pri kliničkom oralnom pregledu tijekom prvog posjeta Odjelu oralne medicine Stomatološkog fakulteta Sveučilišta Chulalongkorn, pronađene su ulcerirane eritematozne lezije s bijelim strijama i prekrivene pseudomembranama na objema obraznim sluznicama (slika 1. a, b.). Slobodna i pričvrsta gingiva bila je uglavnom plamenocrvene boje. Struganjem površine lezije i korištenjem 10-postotnog kalijeva hidroksida dobiven je pozitivan nalaz na hife i gljivičnu formu *Candida*. Početna dijagnoza bila je oralna lihenoidna reakcija na lijekove (OLDR) s kandidijazom. Budući da je lezija oralnoga lihen planusa

ment of restorative materials in OLCL is still controversial (3). Moreover, not all cases can be treated successfully, particularly in cases with multiple drugs administration or OLDR being concurrent with OLCL. This presented case was one of both OLDR and OLCL that was a challenge to manage. Various topical steroids still remain the first line of therapy to reduce pain and inflammation in this case as well as medical consultation. There is no specific treatment in refractory cases of OLDR and OCCL. However, the withdrawal of a suspected drug is useful during the treatment of refractory cases and can enhance healing of the lesions (4). A long-term follow-up is needed to improve the quality of life of the patient and to detect early lesions, should malignant transformation occur. To our knowledge, this was the first case report that showed the palliative treatment of refractory oral lesions with potent topical steroids for 7 years without side-effects.

A case report

A 54-year-old female was referred to the Oral Medicine clinic at the Faculty of Dentistry, Chulalongkorn University, Bangkok, Thailand in 2006 with a chief complaint of pain on the gingiva, the right and the left buccal mucosa for 5 years. She experienced pain when eating hot and spicy food. The otorhinolaryngologist treated her with pimecrolimus (Elidel) cream 1%, sore mouth gel, triamcinolone acetonide 0.1% orabase and Kamistad gel. Kamistad gel is an oral therapeutic gel with ingredients of Chamomile flower extract and Lidocaine HCl which is indicated for the treatment of painful and inflammatory processes of the oral mucous membrane was also treated, but the oral lesions showed only slight improvement. Triamcinolone acetonide injection (Kenacort) 10 mg/ml was also injected into the lesion 4 times, but no improvement. Her physician referred this patient with the histopathological report of oral lichen planus with no malignancy change from the biopsy specimen from the buccal mucosa. The skin biopsy from her leg was also done by her physician and it was pigmented purpuric dermatitis (PPD). All patch tests were negative at first. Surprisingly, 4 years later, the patch test showed positivity to mercury and palladium. Anti-HBs was positive with 138 mIU/mL, whereas anti-HCV was negative. Investigations of serology for autoimmune disease showed all negative for LE cells, antinuclear factor and anti DNA.

Regarding systemic diseases, she had a history of hypertension, dyslipidemia, subclinical hypothyroidism and arthritis. Her medications were Atorvastatin calcium ½ tab OD, Hydrochlorothiazide 50 mg, ¼ tab OD, Valsartan ½ OD, Eltroxin (levothyroxine) 0.1mg, 1 tab OD, Diffiam lozeng 3 mg 1 tab tid pc and Diclofenac potassium 1 tab OD.

Oral findings in this case at the first visit to the Oral Medicine clinic, Faculty of Dentistry, Chulalongkorn University revealed ulcerative, erythematous lesions with white striae covered with pseudomembranes on the right and the left buccal mucosa (Figure 1 a, b). Her gingiva showed generalized fiery red on marginal and attached gingiva. Scraping from the surface of the lesions and using potassium hydroxide 10% was positive for both hyphal and yeast forms



Slika 1. a, b Prvi posjet: ulcerativna i eritematozna lezija s bijelim strijama prekrivena pseudomembranom na desnoj i lijevoj obraznoj sluznici
Figure 1 a, b First visit, ulcerative and erythematous lesions with white striae covered with pseudomembranes on the right and the left buccal mucosa,

Slika 2. a, b Desna obrazna sluznica u boljem je stanju; na lijevoj obraznoj sluznici nalaze se okrugle crvene papilomatozne lezije veličine 0,5 x 0,5 cm i 0,3 x 0,3 cm
Figure 2 a, b The right buccal mucosa showed improvement. The left buccal mucosa showed round papillomatous-like lesions, size 0.5x0.5 cm. and 0.3x0.3 cm. with red color

Slika 3. Rezovi pokazuju meko tkivo s ogoljelim epitelom i fibrozim pokrovnim eksudatom i veliku količinu površinske infiltracije polimorfonuklearnih leukocita; u području su vidljive i mnogobrojne nove krvne žile u formiranju, plazma-stanice i limfociti
Figure 3 The sections reveal soft tissue with denuded epithelium showing fibrinous exudate coverage. Large amount of superficial polymorphonuclear leukocyte infiltration is seen. Numbers of new forming blood vessels, plasma cells as well as lymphocytes are seen at the area.

Slika 4. a, b, c Upaljena je cijela gingiva i sluznica na desnom i lijevom obrazu; pojedine lezije prekrivene su pseudomembranama; gingiva pacijentice upaljena je i vatreno crvena
Figure 4 a, b, c All gingiva, the right and the left buccal mucosa flared up particularly pseudomembrane covered on the surface of the lesions. Her gingiva was generalized fiery red with inflammation

Slika 5. a, b, c Nakon CO₂-laserke terapije lezija se povlači
Figure 5 a, b, c After the CO₂ laser treatment, the lesions showed improvement

nusa nastala nakon primjene navedenih lijekova, postavljena je dijagnoza OLDR-a. Obiteljskom liječniku predloženo je da promijeni lijekove i tretira oralnu leziju fluokinolonima s 0,1-postotnim klotrimazolnim gelom, sodom bikarbonom (vodica za usta) te folnom kiselinom 5 mg, 1 BID tableta. Njezin liječnik Diclofenac je mjesec dana poslije zamijenio

of *Candida*. The diagnosis at the initial visit was oral lichenoid drug reaction (OLDR) with candidiasis. Because the oral lichen planus-like lesions erupted after using medications mentioned above the diagnosis of OLDR was established. We suggested to her physician to change the medications and treated her oral lesions with fluocinolone with clotrimazole

Tenoxicamom. Kako su simptomi ostali isti, umjesto fluokinolona s 0,1-postotnim klotrimazolnim gelom primijenjen je fluokinolon-acetonid 0,1 posto u otopini. Nakon dva mjeseca simptomi su se smanjili za 50 posto, ali oralne su sluznice s obje strane do retromolarnog područja bile prekrivene ulkusima okruženima bijelim strijama sa žućkastom pseudomembranom. Kao terapija propisana je vodica za ispiranje usta Dexamethasone 0,05 posto. Preporučeno je također bilo zamijeniti antihipertenzivni lijek (Hydrochlorothiazid). Četiri mjeseca poslije zamjene Valsartanom, lezija se počela smanjivati. Za liječenje oralnih lezija odabrani su snažni topikalni steroidi poput klobetasol propionata 0,05 posto i fluokinolon-acetonida 0,1 posto u orabazi.

U kolovozu 2007. pacijentica je dočekala djelomično poboljšanje – gingiva i sluznica na desnom obrazu bile su u znatno boljem stanju, ali na lijevoj obraznoj sluznici pojavile su se okrugle crvene papilomatozne lezije veličine 0,5 x 0,5 cm. i 0,3 x 0,3 cm (slika 2. a, b). Biopsički materijal iz tog područja poslan je na patohistologiju i nalaz je pokazao da je riječ o nespecifičnom ulkusu s kroničnom upalom. Na rezovima se vidjelo meko tkivo s ogoljelim epitelom prekrivenim fibrinoznim eksudatom. Pri površini bila je opsežna infiltracija polimorfonuklearnim. Uočen je i početak formiranja novih krvnih žila, plazma-stanica i limfocita (slika 3.).

U svibnju 2009. pacijentica je liječena Valsartanom, Levothyroxine sodiumom i Simvastatinom. Njezin liječnik dentalne medicine zamijenio je amalgamski ispun na lijevom drugom mandibularnom kutnjaku punom keramičkom krunicom. Gingiva se razbuktala plameno crveno, a površinu lezija pokrivale su pseudomembrane (slika 4. a, b, c). Za liječenje lezija korišteni su vodice za ispiranje usta Triamcinolone acetoniid 0,1 posto i Dexamethasone 0,05 posto i Clobetasol propionate 0,05 posto u orabazi. Pacijentica je upućena na Odjel oralne i maksilofacijalne kirurgije na terapiju ugljično-dioksidnim (CO₂) laserom. Nakon tretmana dva puta po dvije minute (5W snage), oralne lezije su pokazale poboljšanje (slika 5. a, b, c).

U studenome 2013. njezin je stomatolog izvadio drugi lijevi mandibularni kutnjak, no lezije su i dalje perzistirale i aktivirale se. Test direktne i indirektne imunofluorescence korišten je za isključivanje oralnoga pemfigusa ili mukozno-membranoznog pemfigoida jer je lezija na gingivi i obraznoj sluznici bila slična toj vrsti. Uzet je uzorak s desne obrazne sluznice i test indirektne imunofluorescence bio je negativan na cirkulirajuća IgG antitijela u zoni bazalne membrane. Direktna imunofluorescencija bila je negativna na IgG, IgA, IgM, C3 i fibrin.

Rasprava

Pacijenti s mnogo sistemskih bolesti i mnogobrojnim lijekovima mogu imati teške oblike OLDR-a. Hidroklorotiazid, levotiroksin i NSAID-i mogu uzrokovati teške i kronične oblike OLDR-a (1). Dijagnostički kriterij za OLDR jest nastanak oralnih lezija nakon uzimanja sumnjivog lijeka. U

gel 0.1%, sodium bicarbonate mouthwash and folic acid 5 mg, 1 tab bid. After that, her physician changed diclofenac to tenoxicam one month later. However, her symptoms remained the same so the fluocinolone acetoniid 0.1% in solution was used instead fluocinolone with clotrimazole gel 0.1%. Two months later, her symptoms showed approximately 50% improvement, but the right and left buccal mucosa to retromolar areas showed ulcers covered by yellowish pseudomembrane and surrounded with white striae. Dexamethasone mouthwash 0.05% was used for the treatment. Antihypertensive drug (Hydrochlorothiazide) was recommended to be replaced by others. After the replacement, hydrochlorothiazide with valsartan for 4 months, the lesions showed improvement. The potent topical steroids such as clobetasol propionate 0.05%, fluocinolone acetoniid 0.1% orabase were used to treat the oral lesions.

In August 2007, her gingival and the right buccal mucosa showed marked improvement, but the left buccal mucosa showed round papillomatous-like lesions, size 0.5x0.5 cm. and 0.3x0.3 cm. with red color (Figure 2 a, b). Biopsy specimen was taken from this area and the histopathological report was non-specific ulcer with chronic inflammation. The sections revealed soft tissue with denuded epithelium showing fibrinous exudate coverage. Large amounts of superficial polymorphonuclear leukocyte infiltration were seen. A number of new forming blood vessels, plasma cells as well as lymphocytes were seen in the area (Figure 3).

In May 2009, the patient was treated with valsartan, levothyroxine sodium, and simvastatin. Her dentist replaced the amalgam restoration on the left mandibular second molar with a full porcelain crown. Generalized fiery red gingiva, the right and left buccal mucosa flared up with pseudomembrane covering the surface of the lesions (Figure 4 a, b, c). Triamcinolone acetoniid 0.1%, mouthwash, clobetasol propionate 0.05% orabase, dexamethasone 0.05% mouthwash were used to treat the lesions. The patient was referred to the Oral and Maxillofacial Surgery department for CO₂ laser. After the treatment with CO₂ laser 5 watt for 2 minutes twice, the oral lesions showed improvement (Figure 5 a, b, c).

In November, 2013, the left mandibular second molar was extracted by her dentist but the lesions still persisted and flared up. Direct and indirect immunofluorescence tests were assessed to exclude the lesions from oral pemphigus or mucous membrane pemphigoid because the oral lesions on the gingiva and buccal mucosa were similar to those lesions. The specimen was taken from the right buccal mucosa and indirect immunofluorescence report was negative to circulating IgG anti-basement membrane zone antibody. Direct immunofluorescence study showed negative findings to IgG, IgA, IgM, C3 and fibrin.

Discussion

Patients with many systemic diseases and taking multiple medications can have severe OLDR.

Hydrochlorothiazide, levothyroxine, NSAIDs can induce severe and chronic OLDR (1). The diagnosis criterion for OLDR is the eruption of oral lesions after taking suspect-

opisanom slučaju pacijentica je uzimala više lijekova, uključujući hidroklorotijazide, levotiroksin i NSAID, za koje se zna da mogu potaknuti teške i kronične oblike OLDR-a (1). Dijagnoza OLCL-a postavljena je nakon što se pojavila lezija poslije neposrednog doticaja s amalgamskom zubnom restauracijom ili metalnom krunicom. Uklanjanjem i zamjenom sumnjivih materijala, većina takvih slučajeva OLCL-a nestaje za nekoliko mjeseci (1). Anatomija obrazne sluznice bez pre-giba u tom slučaju može utjecati na uspješnu terapiju. Ako su zubi blizu obrazne sluznice, neposredna apsorpcija topikalnih steroida ponekad ne zadovoljava.

U dugoročnoj terapiji oralnih lihenoidnih lezija tek se treba razmotriti primjena topikalnih steroida. Dugotrajna uporaba snažnih topikalnih steroida pokazala se korisnom u liječenju teških oralnih lezija kod pacijenata s mnogo sistemskih bolesti. U opisanom slučaju nije bilo ozbiljnih nuspojava nakon duge upotrebe topikalnih steroida zbog liječenja oralne lihenoidne lezije. Osim toga i CO₂-laser može biti alternativna terapija u liječenju refraktornih slučajeva poput opisanoga. U kontrolnom razdoblju pozornost treba posvetiti oralnoj higijeni.

U slučaju ovakvih perzistirajućih oralnih lezija trebala bi se razmatrati etička načela liječnika dentalne medicine jer bi se možda mogle zaliječiti zamjenom amalgamskih ispuna kompozitima (5). I postupak brušenja za krunicu, ako se u radu ozlijede okolna tkiva, može uzrokovati nastanak lezije. Zamjene amalgamskih ispuna ili metalnih kruna nisu uvijek uspješne, ali liječnici dentalne medicine trebali bi razmatrati i tu mogućnost tijekom liječenja pacijenata s OLCL-om. Zato bi pacijente trebalo upozoriti na obje mogućnosti prije zamjene ispuna ili postavljanja krunica. Pozitivan nalaz patch-testa bio je nedosljedan i slab prediktor poboljšanja nakon uklanjanja amalgama (6). Suradnja specijalista oralne medicine ostalih specijalnosti važna je pri tretiranju teških oralnih lezija. Potrebne su dugoročne kontrole kako bi se poboljšala kvaliteta života pacijenata s refraktornim oralnim bolestima.

Zaključak

OLDR i OLCL već su dugo poznati u oralnoj medicini, a potpuno izlječenje lezija jako je teško postići. Terapijski protokoli, poput ordiniranja snažnih topikalnih steroida i zamjene lijekova, standardi su u liječenju OLDR-a. Ovdje smo opisali doista izazovan slučaj OLDR-a i OLCL-a kad je riječ o liječenju. Unatoč neprekidnom liječenju refraktornih oralnih lezija snažnim topikalnim steroidima i CO₂-laserom, tijekom dugogodišnjih kontrola nisu se pojavile teže pojave. Ovo je prvi put da je predstavljena sedmogodišnja palijativna terapija oralne lezije snažnim topikalnim steroidima bez ikakvih nuspojava. Nalazi iz ovog prikaza mogli bi poboljšati kvalitetu života pacijentima s mnogo sistemskih bolesti.

ed medications. The patient described here had been taking multiple medications including hydrochlorothiazide, levothyroxine and NSAIDs which have been reported for inducing severe and chronic OLDR (1).

The diagnosis of OLCL was made when the lesion appeared after direct contact to dental restoration such as amalgam or metal crown. With the removal and replacement of the suspected causative material, the majority of such OLCLs resolved within several months (1). The anatomy of the buccal mucosa with no mucobuccal fold might affect the successful treatment in this case. The direct absorption of topical steroid when the buccal mucosa is close to the teeth might not occur properly. Topical steroids application in long-term treatment of oral lichenoid lesions should be considered. However, continued use of potent topical steroids has been found to be useful in the management of severe oral lesions in these patients with many systemic diseases. No serious side-effects from treatment with topical steroids for oral lichenoid lesions in this case. Moreover, carbon dioxide laser can be used as an alternative treatment in this refractory case. However, maintaining good oral hygiene should be considered during follow-up.

Ethical considerations for dentists during management of recalcitrant oral lesions should be taken into account. The lesion may resolve if amalgam filling is replaced by composite resin (5). The procedure of crown preparation for full porcelain might be affecting the surrounding tissues and could trigger the lesions. However, replacing amalgam fillings or changing a metal crown is not always successful but the dentists should consider it during management of such patients with OLCL. Therefore, patients should be informed of the possibilities of positive or negative outcomes before replacement of the restoration or the crown. Positivity to patch testing was an inconsistent and generally weak predictor of improvement following amalgam removal (6). The cooperation of oral medicine specialists, other specialties and physicians is important during management of severe oral lesions. A long-term follow-up is needed to improve the quality-of-life in the patient with refractory oral lesions.

Conclusion

OLDR and OLCL have been known for a very long time in oral medicine and a complete cure of the lesions is very difficult to achieve. Treatment modalities such as potent topical steroids and drug replacement are standard of care in OLDR cases. We presented a refractory case with OLDR and OLCL who was indeed a challenging one to treat and manage. Continuous treatment of refractory oral lesions with potent topical steroids and CO₂ laser showed no serious side-effects during the long-term follow-up. This was the first case report that showed the palliative treatment of oral lesions with potent topical steroids for 7 years without side-effects. Therefore, the treatment modalities in this case report could improve the quality-of-life in patients with many systemic diseases.

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Abstract

A 54-year-old female presented with severe pain on the gingiva and buccal mucosa. Oral findings revealed generalized fiery red gingiva, ulcerative with white striae covered by pseudo-membranes on both buccal mucosae. She had hypertension, dyslipidemia, subclinical hypothyroidism and arthritis. She was treated with atorvastatin, hydrochlorothiazide, valsartan, levothyroxine and non-steroidal anti-inflammatory drug (NSAIDs). Her oral lesions were a slight improvement from a previous treatment with pimecrolimus cream, triamcinolone acetonide 0.1% orabase and injection. After diclofenac was replaced with tenoxicam and oral lesions were treated with various topical steroids, the lesions showed marked improvement. The biopsy from the buccal mucosa revealed oral lichen planus. Patch test showed positivity to mercury, gold sodium thiosulfate and palladium. One year later the left buccal mucosa showed red, round papillomatous-like lesions. The histopathological report showed a non-specific ulcer with chronic inflammation. The lesions flared up after replacing amalgam with crowns. After CO₂ laser treatment, the lesions showed some improvement. Direct and indirect immunofluorescence of the lesions proved to be negative. This first case report showed that the palliative treatment of refractory oral lichenoid lesions with potent topical steroids for 7 years had no side-effects. CO₂ laser can be an alternative treatment of refractory lesion in this case.

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Address for correspondence

Kobkan Thongprasom
Chulalongkorn University
Faculty of Dentistry
Oral Medicine Department
Bangkok 10330, Thailand
Tel: +66-2-2188942
Fax: +66-2-2188941
kobkan.t@chula.ac.th

Key words

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