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A burning sensation in the mouth

FIGURE 1. White reticular striated lesion on the left buccal mucosa.

Corticosteroids, oral or topical, are the mainstay of treatment

A 38-year-old man presented with a burning sensation in the mouth for the previous 2 months. He was currently a smoker. He had no history of any dental procedure or new drug intake.

On examination, his oral hygiene was poor, and a whitish, striated lesion 3-by-3 cm was noted on the left buccal mucosa (**Figure 1**). Based on the appearance and pattern of the lesion, a clinical diagnosis of reticular-type oral lichen planus was made. The patient was advised to stop smoking. A thorough scaling of the teeth was done, and he was started on topical triamcinolone acetonide ointment for 2 weeks. At a 4-month follow-up visit, the symptoms had resolved.

ORAL LICHEN PLANUS

Oral lichen planus is a chronic inflammatory disease that affects the mucous membrane of the oral cavity. It is a T-cell mediated autoimmune disease in which the cytotoxic CD8+ T cells trigger apoptosis of the basal cells of the oral epithelium.[1] No risk factors have been identified, but the condition has been associated with smoking, chewing tobacco, dental materials such as amalgam, celiac disease, ulcerative colitis, stress, diabetes, and use of systemic drugs such as nonsteroidal anti-inflammatory drugs and beta-blockers.[1,2] Women are affected more than men in a ratio of 1.4:1, frequently in the fourth decade.

The clinical forms are reticular, papular, plaque-like, erosive, atrophic, and bullous types.

Clinical presentation

The lesions are usually asymptomatic. Symptoms such as a burning sensation are associated mainly with the erosive and atrophic types,[1–3] although in rare cases it occurs with the reticular form, as in our patient. Erosive and atrophic types carry a 1% to 2% risk of malignant transformation and require close follow-up.[3]

Oral mucosal lesions present alone or, in up to 15% to 20% of cases, with concomitant skin lesions.[1,2] The most common oral sites are the buccal mucosa, tongue, and gingiva. Skin lesions present as violaceous flat-topped papules on the ankles, wrists, and genitalia.

DIAGNOSIS AND TREATMENT

The differential diagnosis of oral lichen planus includes cheek-frictional keratosis, lichenoid reaction, leukoplakia, pemphigus, oral candidiasis, and chronic ulcerative stomatitis.[1,2]

The diagnosis is clinical, but biopsy is indicated in the erosive or atrophic type and when a malignant lesion is suspected, especially in patients with a history of smoking and tobacco chewing. Oral lichen planus may be associated with oral candidiasis, especially in patients

doi:10.3949/ccjm.84a.16005

with poor oral hygiene and smoking, and this needs to be addressed before a diagnosis of oral lichen planus can be made.

The mainstay of management is oral or topical corticosteroids.[4] Calcineurin inhibitors, retinoids, dapsone, hydroxychloroquine, mycophenolate mofetil, and enoxaparin have also been shown to be effective and are used when corticosteroids alone are ineffective or contraindicated.[4]

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