



## EDİTÖRE MEKTUP / LETTER TO THE EDITOR

### Management of oral lichenoid lesion with topical corticosteroid

#### Topikal kortikosteroid ile oral likenoid lezyonun yönetimi

Vagish Kumar L Shanbhag<sup>1</sup>, Abdul Akbar<sup>1</sup>, Laxmikanth Chatra<sup>1</sup>

<sup>1</sup>Yenepoya Dental College and Hospital, Department of Oral Medicine and Radiology, Yenepoya University, Mangalore-Karnataka, India

*Cukurova Medical Journal 2017;42(2):392-393*

Dear Editor,

Oral lichenoid lesions are lesions similar to oral lichen planus and are associated with dental restorations, drugs, graft versus host disease and other factors<sup>1,2</sup>.

A 35 year old female patient came to dental hospital with chief complaint of red patch in the posterior right buccal mucosa since past 4 weeks. Patient also reported burning sensation in that area on intake of spicy food. Patient did not have any associated skin lesions and past medical history was non contributory to any dermatological disorders. Also patient reported that she was not on any medications. On intraoral examination, a diffuse erythematous patch of size 3x3 cm with interspersed white striae in reticular pattern was observed (Figure 1). The left buccal mucosa was normal. Close examination revealed silver amalgam restoration in the mesioclusal portion of maxillary right first molar. Since the lesion was present unilaterally adjacent to silver amalgam restoration and patients medical history was non contributory, a provisional diagnosis of oral lichenoid reaction was made. Cutaneous patch test on the patients hand was positive, confirming the provisional diagnosis. Patient was explained about the need to remove amalgam restoration and re-restore it with glass ionomer cement. However the patient was not ready for the re-restoration procedure. Hence topical corticosteroid, 0.1% triamcinolone acetonide was prescribed for application on the affected area, thrice a day for one week. Patient was recalled after

one week and the lesion was observed to be healed (Figure 2). Patient also reported that burning sensation in the affected area disappeared.

Though oral lichenoid lesions (OLL) and oral lichen planus (OLP) present similar clinical and microscopic features, OLP is idiopathic in nature whereas OLL has identifiable causative factors<sup>1,3</sup>. OLL is prevalent more in females than males with age group of 45-65 years<sup>2</sup>. Oral lichenoid reaction is caused by fixation of antigens on keratinocytes of oral epithelial cells due to drugs, restorative materials, resins and flavouring agents, leading to immune system attack, whereas OLP is an autoimmune disease due to antigenic alterations of keratinocytes<sup>3</sup>. Dental restorative materials containing mercury, tin, copper, nickel, cobalt, gold, potassium dichromate, cadmium, platinum, eugenol, carvone and silver are observed to cause oral lichenoid reaction<sup>4,5</sup>. The restorative materials may react with oral fluids resulting in release of by products which can have toxic effect on oral mucosa of susceptible patients. Also wear and tear or fracture of restorations due to masticatory forces may result in fractured components interacting with oral fluids resulting in OLL<sup>1</sup>. OLL most commonly occurs in the buccal mucosa and lateral borders of the tongue, which usually will be in close contact with the offending tooth restoration<sup>4</sup>. Removal of offending restorative material results in remission of OLP lesions with 1-12 months<sup>5</sup>. Drugs implicated in OLL include anti-hypertensives, oral hypoglycaemic agents, diuretics, gold salts, penicillamine, anti-

Yazışma Adresi/Address for Correspondence: Dr. Vagish Kumar L. Shanbhag, Department of Oral Medicine & Radiology, Yenepoya Dental College and Hospital, Yenepoya Research Centre, Yenepoya University, Mangalore-575018, Karnataka, India. E-mail: vagishkumar\_12@rediffmail.com

Geliş tarihi/Received: 13.09.2016 Kabul tarihi/Accepted: 23.09.2016

malarials and non-steroidal anti-inflammatory drugs<sup>1,4</sup>. Drug induced OLL regresses on discontinuing the offending drug<sup>2</sup>. Development of tertiary lymphoid follicles in OLL is believed to be a reliable marker to differentiate OLL from OLP<sup>1</sup>. Cutaneous patch testing helps to identify the offending restorative material and helps us to arrive at conclusion on which restorative material has to be used while re-restoring the tooth<sup>2</sup>.



Figure 1. Reticular white striae interspersed in erythematous background.

Triamcinolone acetonide has anti-inflammatory and anti-immune actions and hence can help in managing OLL in patients who reject restorative replacement<sup>6</sup>. The topical corticosteroids should be tapered gradually in terms of frequency of application depending upon the healing of the lesions and then stopped. Patients should be on frequent follow up for the lesion to be monitored closely to detect any changes.



Figure 2. Lesions healed after application of 0.1% triamcinolone acetonide for one week.

## REFERENCES

1. Kamath VV, Setlur K, Yerlagudda K. Oral lichenoid lesions-a review and update. *Indian J Dermatol.* 2015;60:102.
2. Pawar RR, Mattigatti SS, Mahaparale RR, Kamble AP. Lichenoid reaction associated with silver amalgam restoration in a Bombay blood group patient: a case report. *J Conserv Dent.* 2016;19:289-92.
3. Do Prado RF, Marocchio LS, Felipini RC. Oral lichen planus versus oral lichenoid reaction: difficulties in the diagnosis. *Indian J Dent Res.* 2009;20:361-4.
4. Dudhia BB, Dudhia SB, Patel PS, Jani YV. Oral lichen planus to oral lichenoid lesions: Evolution or revolution. *J Oral Maxillofac Pathol.* 2015;19:364-70.
5. Sharma R, Handa S, De D, Radotra BD, Rattan V, Kuo RC et al. Role of dental restoration materials in oral mucosal lichenoid lesions. *Indian J Dermatol Venereol Leprol.* 2015;81:478-84.
6. Prompt healing of erosive oral lichen planus lesion after combined corticosteroid treatment with locally injected triamcinolone acetonide plus oral prednisolone. *J Formos Med Assoc.* 2013;112:216-20.