



Oral lichen planus: The intra oral web – Two case report

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Abstract

The widespread chronic immunological inflammatory mucocutaneous illness known as oral lichen planus (OLP) can have a variety of appearances, including reticular or plaque-like keratotic, erythematous, and ulcerative. A mixture of erythematous and ulcerated regions surrounded by finely radiating tissue characterizes the erosive phase of OLP. Treatment should be focused on reaching particular objectives after taking the severity of clinical engagement, Asymptomatic reticular lesions usually don't need treatment.

Keywords: oral lichen planus, immunological inflammatory, clinical engagement

Introduction

Lichen planus (LP) is a chronic immune-mediated inflammatory disease that affects the skin and mucous membranes. OLP is the mucosal counterpart of cutaneous lichen planus and it was first described in 1866 as white papular eruptions in the oral cavity [1]. Most cases of this illness have been documented in middle-aged patients ranging from 30–60 years old, with a female to male ratio 1.4:1 [2]. Three different forms of lichen planus have been described in the literature: reticular lesions, such as plaques, papules, and white lines; atrophic or reddish-colored lesions; and erosive lesions, such as blistering lesions and ulcers. But reticular forms are mostly asymptomatic and occasionally found during a clinical examination of the mouth, the erythematous types are unpleasant, resulting in the patient's suffering [3, 5]. Clinically, the distribution is symmetrical, often involving the tongue and buccal mucosa, with clearly defined white striations on a somewhat erythematous backdrop [4]. Under a microscope, the lesion has a strong inflammatory infiltrate that is primarily lymphocytic, directly beneath the epithelium, and arranged into a thick pattern resembling bands. An acanthotic epithelium could exist and the basement layer's cells might exhibit hydropic degradation and discontinuity [3]. The five main histological characteristics of the classical lichen planus are hydropic degeneration of the epidermal basal layer, thick band-like lymphocytic infiltrate in the upper dermis, acanthosis, hyperkeratosis, and hypergranulosis [1]. Lichen planus has potential for malignant transformation [5]. In this, we discuss a case presentation of lichen planus (OLP) of the right and left buccal mucosa.

Case report

Case 1: A 17years old male patient reported to the department of oral medicine and radiology complaining of brown pigmentation and burning sensation in his mouth for past 2 weeks. His history of presenting illness revealed pain

and burning sensation in his right and left buccal mucosa (FIGURE: 1 and 2), It was intermittent in nature and had gradually progressed to the present state for past one week.

Soft tissue examination: On inspection, presence of fine, radiant, white striae with central plaque, interspread with erosive areas surrounded by brown pigmentation seen on left buccal mucosa of size approximately 3*2, extending anteriorly 1cm from the commissure of lip, posteriorly 3cm from the hamular notch, superiorly 1cm from the left buccal vestibule, inferiorly 3mm below the occlusal plane and another linear lesion of approximately 3*1cm seen on the 3mm above the left lower vestibule in relation to 43 to 46 region. On palpation, all inspectory findings were confirmed with respect to size, site, and extent. it is tender, smooth, and non-scrapable with no evident of bleeding and pus discharge.

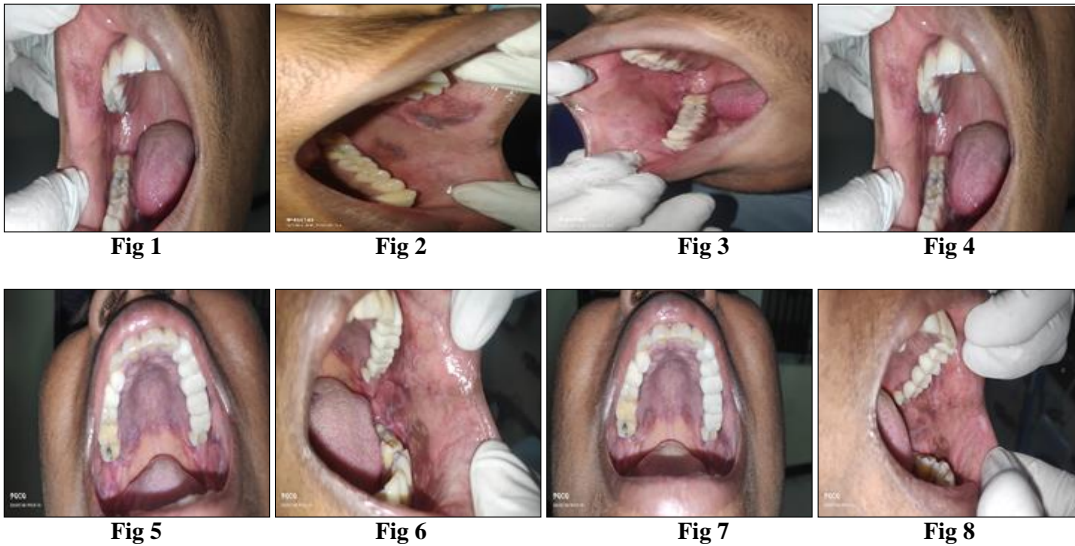
Case 2: A 49 Years old female patient reported to the department of oral medicine and radiology complaining of burning sensation in her mouth for past 6 month (FIGURE 5 and 6). Her history of presenting illness was apparently normal before 6months than she developed the burning sensation which is intermittent in nature, aggravates on taking spicy foods and relieved by itself. On Intra oral examination; On palate: Presence of 2 well defined erythematous surface with interlacing white radiating keratotic lines seen on the hard palate in relation to 17, 25, 26, 27 region. On Buccal mucosa: presence of single erythematous area of size 0.5 * 0.5 cm seen on left buccal mucosa, opposite to 26 regions. presence of linear keratotic line along the occlusal plane, extending 1 cm away from commissure of lip, upto pterygomandibular raphae.

Based on history and clinical examination a provisional diagnosis Reticular lichen planus on right and left buccal mucosa for case 1 and he was advised a regimen of anti - oxidant and topical corticosteroids [0.1% kenocart cream]

take it in equal proportion of both creams, mix well and apply on the affected side for 3 to 5 minutes, and gargle with plenty of water. No per oral for half an hour. Advice to report after 20 days. The prognosis was good and after a period of two months the lesion had regressed completely and patient's oral mucosa was back to normal. Patient was further recalled after 6 months (FIGURE :3 and 4); no incidence of recurrence was seen.

Based on history and clinical examination a provisional diagnosis erosive lichen planus on hard palate for case 2,

right and left buccal mucosa and she was advised a regimen of anti - oxidant and topical corticosteroids [0.1% kenocort cream] take it in equal proportion of both creams, mix well and apply on the affected side for 3 to 4 minutes, and gargle with plenty of water. no per oral for half an hour. Advice to report after 20 days. The prognosis was good and after a period of two months the lesion had regressed completely and patient's oral mucosa was back to normal. patient was further recalled after six months (Figure: 7 and 8); no incidence of recurrence was seen.



Discussion

Lichen planus is a mucocutaneous illness characterized by vacuolating basal epithelial layer degeneration, acidophilic particles that may represent apoptotic epithelial cells, and a cellular inflammatory infiltrate enriched in CD4+cells [2]. OLP has been linked to immune-mediated disorders such as diabetes, hepatitis C virus, hypertension (Grinspan syndrome), and celiac disease. such as Dermatomyositis, Myasthenia gravis, and Alopecia areata. OLP is more common in females in their middle years. 28 percent of Skin lesions with SIX "P" presentations are present in OLP. Platonic, Papules & Plaques, Polygonal, Purple, Pruritic [6]. The spread of oral lichen planus is often bilateral and affects the buccal mucosa, dorsum, and ventral regions of the tongue and/or gingiva. It frequently manifests as gingivitis that is desquamative. Involvement of the palate and labial is uncommon [7]. OLP can be of several forms, including papular, reticular, plaque, atrophic, and bullous. The common kind of OLP is reticular OLP. With erosive OLP, there is variable degrees of core ulceration. Lesions often have delicate, white margins surrounding them. Wickham's Striae are radiating lines. Participation of gingiva Desquamative gingivitis is produced in EOLP; it is always accompanied by scorching and discomfort in the affected

area locale [8]. The characteristic histopathologic hallmarks of OLP include discrete areas of hyperkeratinization, a dense band-like lymphocytic infiltrate at the interface between the epithelium and the connective tissue, and liquefactive degeneration of the basal cell accompanied by apoptosis of the keratinocytes. epithelium (which produce the clinically noticeable Wickham's striae) and sporadic regions of atrophic epithelium where the pointed, shorter rete pegs may be present (a feature referred to as saw rete pegs for teeth.

Civatte bodies, or eosinophilic colloid bodies, are a symbol for deteriorating Keratinocytes are frequently seen in the surface epithelium's lower half [9]. Using topical or systemic corticosteroids to modify the patient's immune response is the most used treatment for OLP lesions. When treating lesions with mild to severe symptoms, topical corticosteroids are the go-to medication. 0.05% clobetasol propionate gel, 0.1% or 0.05% triamcinolone acetonide ointment, 0.05% fluocinonide gel, 0.05% clobetasol butyrate ointment or cream, and 0.1% betamethasone valerate gel are among the options (given in terms of decreasing potency [10]. The following flow chart illustrates a simple systematic protocol which will aid in effective treatment (Figure: 9)

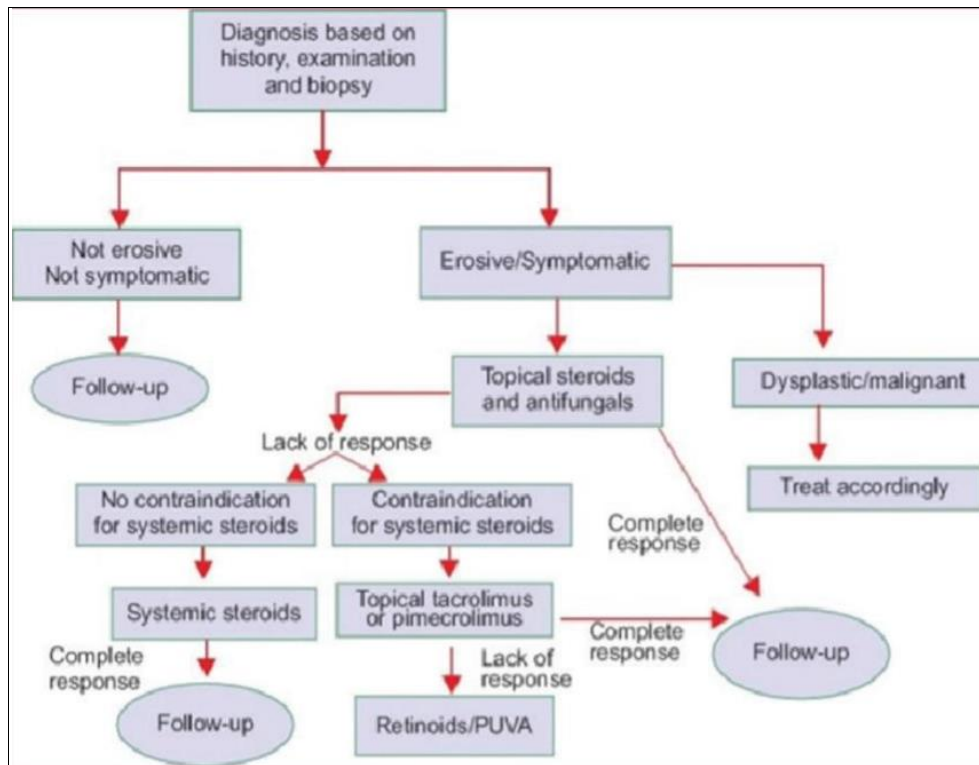


Fig 9: A simple systemic flow chart protocol for effective treatment planning

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