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Clinical Challenges Q&A 11. Ulcers

A 42-year-old secretary, currently not employed, complained of recurrent oral ulceration. She suffered from ulcers occasionally as a child and teenager, ameliorated whilst she smoked from age 18–37, but which became much worse when she stopped at that age. The ulcers were typically 2–4 mm in diameter and rarely affected the palate or gingivae, but involved most other areas, especially the vestibules. They occurred in crops of 3–4 and lasted up to 3 weeks. She had had remissions for only very few days. She had had a couple of episodes of genital ulceration 5 years previously. There were no cutaneous, gastro-intestinal, ocular or joint problems and cardiorespiratory or bleeding problems.

The medical history included epilepsy since age 18 years, for which she used phenytoin. The patient had no known allergies or history of fever. She had been multiply investigated, including HIV exclusion. She had tried *Corsodyl*, *Corlan*, *Adcortyl*, *Bonjela*, *Ambesol*, *Frador* and *Canker*.

Her father suffered from Behçet's disease and died from brain



Figure 1. (a) Tongue ulceration. **(b)** Drug-induced gingival swelling.

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thrombosis. Her sister also suffered from mouth ulcers. Her social history included no current tobacco use but alcohol consumption at almost half a bottle of wine daily.

Extra-oral examination revealed no significant abnormalities apart from Campbell de Morgan spots, and specifically no cervical lymph node enlargement, or cranial nerve, salivary or temporomandibular joint abnormalities and pyrexia were recorded.

Oral examination revealed a 1cm ovoid ulcer on the left lateral border of the tongue (Figure 1a) with an inflammatory halo and no induration, and evidence of scarring in several sites, especially the lateral borders of the tongue and the lower labial mucosa. The non-vital protrusive left maxillary central incisor (damaged during an epileptic seizure) had been subject to an attempt at repair and there was also clinical evidence of phenytoin drug-induced gingival swelling (DIGO) (Figure 1b).

Q1. What is the likely cause of the ulceration?

- (a) Traumatic ulcer;
- (b) Carcinoma;
- (c) Aphthous stomatitis (simple aphtha or part of Behçet's syndrome);
- (d) Syphilitic chancre.

A1. The answer to what is the likely cause of the ulceration?

(c) *Aphthous stomatitis*: (simple or part of Behçet's syndrome). Aphtha present as a single or multiple ulcers, with inflammatory halo lasting 3–4 weeks, in the movable oral mucosa. The size of the ulcer (1 cm), its location and the number of co-existed lesions suggests major aphtha. Aphthous ulcers can also be aggravated

by smoking cessation – and phenytoin and alcohol can cause folate deficiency which could also aggravate the ulcers.

The genital lesions and a positive family history raise the possibility of Behçet's syndrome. However, neither cutaneous, ocular joints nor thrombotic issues, which are commonly found in Behçet's syndrome, were identified. HLA typing for B5101 may help. The history and clinical findings are thus most consistent with a diagnosis of aphthous-like ulceration, but Behçet's syndrome, or a variant, or an auto-inflammatory (periodic) syndrome, should be excluded.

(a) *Traumatic ulceration* is characterized as a single irregular ulcer, with a white rim and a positive history of trauma. Obviously, people who suffer from

seizures can traumatize and ulcerate their tongues. As the ulcers started since the patient's childhood and phenytoin was used only from the age of 18 years, the ulceration is unlikely to be an adverse effect of phenytoin. However, phenytoin and alcohol can reduce blood folic acid level, thus causing an aggravation of ulcers.

(b) *Carcinoma* often presents as a single indurated persistent ulcer with irregular margins without an inflammatory halo but often associated with cervical lymph node enlargement.

(d) *Syphilitic ulcer or chancre* is usually a single lesion persistent for some weeks, and is always associated with local lymphadenopathy, not seen in our patient.

Errata

Osteochondroma of the Mandibular Condyle: an Unusual Case of Dentofacial Asymmetry. *Dent Update* 2015; **42**: 372. Figure 6 appeared upside down. See corrected Figure 6 below.



A Clinical Guide to Needle Desensitization for the Paediatric Patient. *Dent Update* 2015; **42**: 378. Missing text from article please go to our website for corrected version of article. <http://www.dental-update.co.uk/articleMatchList.asp?sqs=A+Clinical+Guide+to+Needle+Desensitization+for+the+Paediatric+Patient>

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