ULCERS

TRAUMATIC ULCER

- History from the patient
- Important to differentiate from squamous cell carcinoma
- Observe and follow up for healing within 1-2 weeks
- Consider Biopsy

CONSIDER

- Cancer
- Deep fungal infections in immuno compromised patients
- HIV
- Myelosuppressive Cancer chemotherapy
- Immunosuppressive drug therapy
- Syphilis in primary and tertiary stage
- **Deep fungal infections**
- Histoplasmosis
- Blastomycosis
- Mucormycosis
- Aspergillosis
- Cryptococcosis
- Coccidiomycosis

CAUSES OF TRAUMATIC ULCER

Physical/ Mechanical

- Acute bite injuries (numb mucosa after LA)
- Malocclusion

- Ill fitting prosthesis
- Overzealous tooth brushing and flossing
- Self injurious habits

Thermal/Electrical burns

- Accidental chewing of electrical wire
- Hot pizza/ Coffee burn on palate
- Microwave oven related – differential heating (Cheese and pastry fillings)
- Iatrogenic –heated dental instrument (especially in anesthetised mucosa)

Chemical

- Aspirin, Oral bisphosphonates
- Mouthwashes and products with high alcohol content, hydrogen peroxide, phenol (especially undiluted form/ too frequent , prolonged contact)
- Drug induced – Medications used to treat apthous ulcers which contain high concentration of silver nitrate, phenols or sulphuric acid
- Denture cleansers; Metha acrylate monomers
- Vasoconstrictors used in LA; Chemicals used in endodontics

CLINICAL FEATURES

- Ulcer
- Necrosis of bone
- Site – especially lips (EXTENSIVE) – electrical burns – initial lesions are charred and appear dry and sloughed out ; associated with excessive bleeding and underlying vital structures are exposed.
- Site – palate, lips (LOCALISED) – hot food burns – area of tenderness and erythema – ulceration within hours with delayed healing.

- Possibility of secondary infections – candida , HSV
- Investigate: Culture, Biopsy, Periapical films in endodontic scenario.

Management

- Topical anaesthetics and steroids in self healing smaller lesions related to thermal/chemical injury.
- To avoid re injury
- To be careful and avoid iatrogenic injuries.
- Antibiotics to prevent secondary infection if healing is delayed.
- Microstomia may be a sequelae of electrical burns due to scarring and contractures (Microstomia prevention devices, surgical correction)

TRAUMATIC ULCERATIVE GRANULOMA/ EOSINOPHILIC ULCER OF TONGUE

- 50% - trauma history
- Anterior part of the tongue – Dorsal , ventral part; posterior and lateral aspects
- Riga fede disease – newly erupted primary incisors (ventral surface of tongue)
- Familial dysautonomia , Reiley day syndrome, Lesch Nyhan syndrome - (Congenital incapacity to sense pain)

CLINICAL FEATURES

- Punched out with surrounding erythema and some degree of whiteness
- Persists for weeks/ months
- Small to large lesions
- Indurated surrounding tissue
- May be occasionally multifocal
- Recurrence – common

- Rarely – ulcerated, mushroom shaped, polypoid mass.

Management

- Preventive use of night guard
- Wound debridement
- Intra lesional steroid
- Excision

DEEP FUNGAL INFECTIONS

HISTOPLASMOSIS

- Inhalation of dust contaminated with infected bird/bat droppings.
- Most common systemic fungal infection
- Histoplasma capsulatum
- Histoplasma duboissi (African form)
- Agricultural workers and laborers exposed to the predisposing factor.

CLINICAL FEATURES

- Pulmonary disease similar to tuberculosis
- Disseminated form – AIDS

Oral presentation

- Erythema – papule – granulomatous tender ulcer with indurated form with lymphadenopathy

Management

- Intravenous - Amphothericin B
- Itraconozole / Ketoconazole

BLASTOMYCOSIS

- Pulmonary infection acquired by Inhalation
- Common in agricultural workers and construction workers.
- Blastomyces dermatitidis – normal inhabitant of soil.
- Acute self limiting form

CLINICAL FEATURES

- Mild cough, malaise, low grade fever
- Shortness of breath, weight loss, blood tinged sputum
- Spread through lymphatic system
- Involvement of skin, bone , mucosa
- Subcutaneous nodules – well circumscribed indurated ulcers
- Oral lesions – rare site
- Mild pulmonary symptoms that may be overlooked by the physician.
- Non specific painless verrucous ulcer with indurated borders.
- Pseudoepitheliomatous hyperplasia with malignant changes.
- Hard nodules and radiolucent jaw lesions

Management

- Amphothericin B
- Flucanazole
- Ketoconazole
- Itraconazole

MUCORMYCOSIS (PHYCOMYCOSIS)

- Fungus occurs in soil, mold on decaying food.
- Immunocompromised patients with poorly controlled Diabetes mellitus, hematologic malignancies, Cancer chemotherapy, immunosuppressive drug therapy.
- Pulmonary, gastrointestinal, disseminated , rhino cerebral form.
- Rhino maxillary form – subdivision of rhino cerebral form.
- Proptosis
- Loss of vision
- Nasal discharge
- Sinusitis
- Palatal necrosis

CLINICAL FEATURES

- Palatal necrosis
- Dental pain or bacterial maxillary sinusistis

Management

- Surgical debridement of the infected area with systemic administration of amphotericin B
- Proper management of underlying disorder
- Renal toxicity assessment (measurement of blood urea nitrogen and creatinine) in patients with amphotericin B
- Posoconazole – a new drug in patients who are unable to tolerate the toxicity of amphotericin B