A Periodontal-Oral Medicine Approach to the Gingival Oral Lichen Planus

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Received: 28-Sep-2022, Manuscript No. OHDM-22-18680; **Editor assigned:** 30-Sep-2022, Pre QC No. OHDM-22-18680 (PQ); **Reviewed:** 14-Oct-2022, QC No. OHDM-22-18680; **Revised:** 21-Oct-2022, Manuscript No. OHDM-22-18680 (R); **Published:** 28-Oct-2022, DOI: 10.35248/2247-2452.22.21.1024.

Description

Skin and mucous membranes are both impacted by the chronic immune-mediated inflammatory illness known as lichen planus. White papular eruptions in the oral cavity were first recognized as Oral Lichen Planus (OLP), the mucosal analogue of cutaneous lichen planus. OLP is categorized as a nonplaque-induced gingival lesion by the American Academy of Periodontology. OLP typically affects the buccal mucosa and tongue, showing up as an approximately symmetrical distribution of distinct white patterns on a backdrop of mild erythema. Atrophic, erosive, papular, plaque-like, and lesions of the bullous type are some of the more clinical patterns that have been documented in the literature. An oral pathologist should obtain crucial histological characteristics from biopsy specimens to allow clinicopathological linkage and rule out oral epithelial dysplasia in order to ensure a correct diagnosis of OLP. Cytotoxic CD8+ T cells migrate to the epithelium throughout the disease's progression, causing basal keratinocytes to undergo apoptosis.

Numerous etiological causes for OLP have been proposed, including medicines, dental materials, pathogenic agents, stress, and local and systemic inducers of cell-mediated hypersensitivity. Patient education and awareness are crucial since OLP therapy aims to reduce related symptoms and regulate active inflammation. Successful management outcomes also depend on maintaining good dental hygiene, being free of oral candidiasis, having healthy gums, and having functioning salivary glands. The treatment of OLP with topical, intralesional, and systemic corticosteroids, immunosuppressive drugs, retinoids, and immunomodulators is discussed. Due to variability in patient responses, these therapy regimens may be applied in succession until satisfactory symptomatic management is achieved. It's important to remember that the literature reports that OLP has a 1% overall malignant transformation potential. This is because patients with OLP exhibit an absence of epithelial dysplasia in oral cancer cases. OLP has been classified as an oral, possibly malignant condition as a result.

It should be emphasized that oral lichenoid reactions cause OLP clinical manifestations that are similar to those of OLP; nevertheless, it is not always easy to tell the two illnesses apart clinically and histopathologically. Having stated that, the majority of oral lichenoid lesions are seen next to direct restorative materials like amalgam and composite. A long-term management strategy for OLP cases can be implemented with the help of more knowledge and clinical expertise. OLP must exhibit both distinctive histological findings and clinical manifestations in order to be diagnosed. Successful management outcomes are influenced by maintaining optimal periodontal health and practicing good dental hygiene. From a therapeutic perspective, the suggested periodontal treatment approach included patient education about the pathophysiology, management, and prevention of periodontitis. The use of an electric ultrasoft toothbrush, spongy dental floss, and soft interdental brushes is advised in the detailed oral hygiene guidelines. In order to preserve periodontal stability, the patient was urged to practice excellent oral hygiene and keep scheduled appointments for periodontal reviews.

The patient underwent two nonsurgical periodontal therapy sessions in the same month, and then the state of the periodontal tissues was assessed again 12 weeks after the debridement procedure was finished. After that, supportive periodontal therapy was administered. Overall, the patient's nonsurgical periodontal therapy with good dental hygiene had a great outcome. Additional care is needed in the case's overall management given the implicated OLP. OLP is typically asymptomatic or merely brought on by slight discomfort. This is particularly true for lesions of the papular, reticular, and plaque kinds that frequently go unreported by patients and general dentists. In contrast, atrophic and ulcerative lesions can cause excruciating discomfort, especially when people eat certain foods or practice aggressive oral hygiene. To be more precise, betamethasone valerate 0.05% was applied topically to the afflicted areas. During the review appointment, if it was found that the active gingival inflammation and background erythema had successfully resolved, then left buccal mucosa and other oral cavity-related areas have considerably improved.

Conclusion

From a periodontal standpoint, the treatment of periodontal disease (conservative nonsurgical approach) and atraumatic oral hygiene in terms of gentle tooth brushing and flossing with spongy type floss are the most crucial components of the therapeutic regimen. This assertion is supported by the research when it comes to individualized plaque control for OLP gingival symptoms. This will in turn result in significant improvements for a huge number of patients. It is necessary to establish effective plaque clearance without harming the gingival tissues. If the lesion contains candida species, antifungal treatment may be required in cases of prolonged pain that is often related to ulcerative and atrophic forms. Topical corticosteroids are regarded as the first-line drugs to reduce patients' symptoms in cases of chronic and symptomatic OLP because the above treatment regimens typically have poor results. However, recurrence is highly prevalent in these situations, and prolonged periods of intermittent treatment may be necessary. However, it's crucial to take into account the negative consequences of repeated use of topical corticosteroids in the oral cavity. For a decided management approach in such circumstances, it is crucial that knowledge and comprehension of gingival pathology be at the core.

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