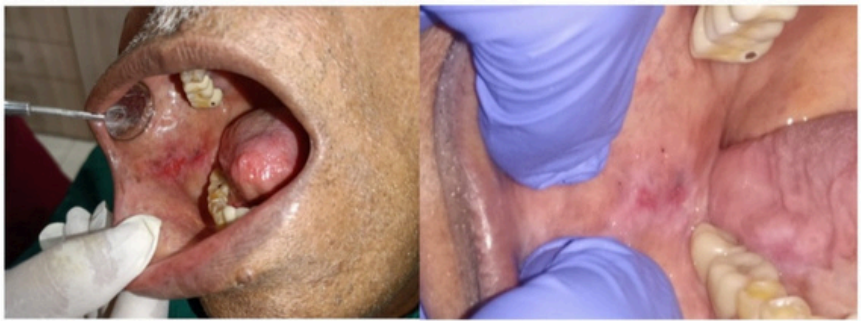
Oral Lichen Planus - An experience in Dental Clinic

Dr. Vinay Hazarey

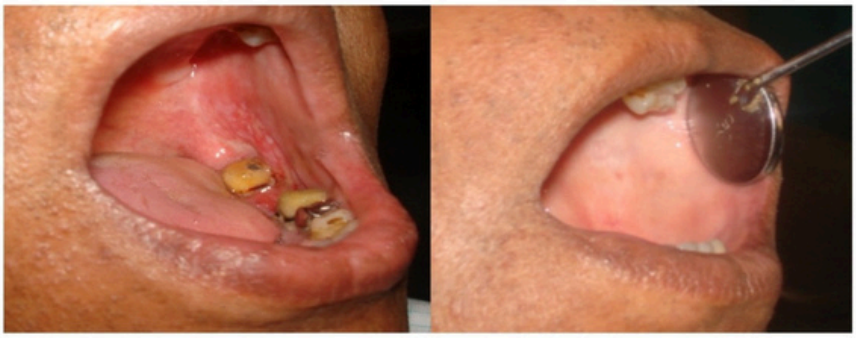
MDS, MFDS-RCPS (Glasgow)
Consultant Oral Pathologist, Nagpur
Adjunct faculty- Dr. D.Y.Patil Dental College and Hospital, Pimpri, Pune

Oral lichen planus (OLP) is a non-infectious, immune-mediated, recurrent, chronic inflammatory, mucocutaneous disease, which is the reason for a high number of dental visits. The WHO recommended definition for OLP is “A chronic inflammatory disorder of unknown aetiology with characteristic relapses and remissions, displaying white reticular lesions, accompanied or not by atrophic, erosive and ulcerative and/or plaque type areas. Lesions are frequently bilaterally symmetrical. Desquamative gingivitis may be a feature”. According to reports, between 0.5% and 4% of people worldwide are impacted. OLP rarely affects children and is typically an adult condition. It is more common among women in their middle years.

Clinically OLP is of six types viz. reticular, atrophic, plaque-like, papular, erosive/ulcerative, and bullous. The most prevalent and well researched type of OLP is reticular and erosive. Reticular type has characteristic erythematous (red) borders and white lacy streak-like appearance Erythematous and atrophic patches encircled by thin, radiating keratotic striae are the hallmark of erosive OLP. The ulcerative subtype shows atrophic lesions with erythema background and superficial white striae at the margins, so it is generally a combination of atrophic-erosive type. Bullous type is most infrequently seen. The exact etiopathogenesis of LP is complicated, intricate, and uncertain.The four main areas implicated in the pathophysiology of LP include immune dysregulation, infections, environmental variables, and genetic factors.According to the information currently available, T-cell (Th1)-mediated targeting of basal keratinocytes is the main cause of LP, however other inflammatory cells may also be involved. Random-effects meta-analysis estimated an OLP malignant transformation rate of 0.2% (95%CI: 0.1-0.3%). The malignant transformation rate of OLP is likely to be lower than previously reported. Other confounding factors like smoking, alcohol abuse, hepatitis C infection and erosive or atrophic subtypes appear to have a greater rate of malignant transformation.

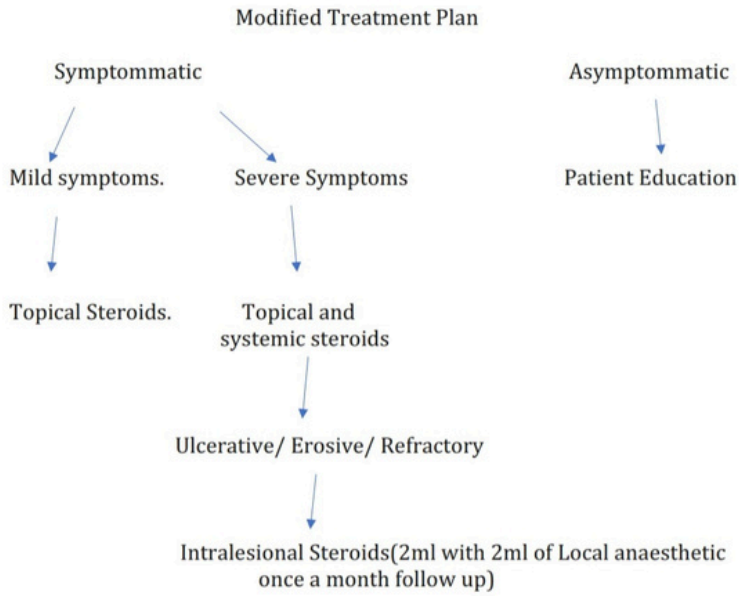


Clinical pictures of OLP pre-treatment



Clinical pictures of OLP post-treatment

Medical management of OLP is symptomatic and involves the suppression of signs and symptoms of the disease. Corticosteroids remains the first line of treatment in most of the cases. Triamcinolone acetonide is a topical corticosteroid most frequently used; Solutions of betamethasone disodium phosphate and clobetasone propionate are successfully used as a therapy for the diffuse form of OLP. Systemic steroids like methylprednisolone and prednisone are prescribed in doses of 1.5–2 mg/kg/day, gradually lowering the dose after clinical improvement. Antioxidants, Immunosuppresents like cyclosporin, tacrolimus, Retinoids, Dapsone, Antimalarial drugs , Interferons, Levamisole are also tried in many cases. Ayurvedic formulations like Glycyrrhizin (licorice), aloevera, curcumin are used along with Photodynamic therapy and PUVA (photochemotherapy) are also tried in refractory cases.



Acknowledgement:
Dr. Supriya Kheur
D.Y.Patil Dental College and Hospital, Pimpri, Pune