

Recurrent Aphthous Stomatitis (RAS) Treatment & Outcome in Kashmiri Population.

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Abstract-

Objectives: To assess difference in treatment of aphthous ulcer in patients treated with local steroids, local analgesics multivitamin tablets and oral hygiene maintenance versus those treated with multivitamin tablets and maintenance of oral hygiene. Main objective of this study was whether to treat aphthous ulcer or not. **Materials and methods:** 46 consenting adults aged between 15 and 45 years, 18 males and 28 females with aphthous ulcers were included in study, a hospital based study conducted in shri maharaja harisingh hospital srinagar kashmir for a period of 8 months from feb 2014 to october 2015. Patients were followed on day 3, day 7, 3 weeks and 2 months & were divided into 2 groups, group 1 included patients treated with local steroids, local analgesics multivitamin tablets and oral hygiene maintenance and group 2 included those treated with multivitamin tablets and maintenance of oral hygiene only. Patients were divided in two groups. However only few patients agreed for no treatment and were included in group two. **Results:** In total of 46 patients, 5 patients had recurrent oral ulceration. In group one [1]; 3 out of 38 patients i.e, 7.894 % had recurrent ulceration whereas in group two[2]; out of 8 patients 2 patients i.e, 25% developed recurrent oral ulceration. **Conclusion:** While aphthous ulcers healed in both groups over a period of about 3 weeks however time taken in group 1 was less as compared to group 2 and also recurrence was less in group 1 as compared to group 2 patients.

Keywords : recurrent aphthous stomatitis , kashmir, steroid.

INTRODUCTION:

Aphthous stomatitis also called as “recurrent aphthous stomatitis” or “recurrent oral aphthae” is a common condition characterized by formation of repeated benign, non contagious mouth ulcers in otherwise healthy adults. These present clinically as

multiple, small, round or ovoid ulcers, with circumscribed margins, covered by yellowish or gray white fibrous exudate and surrounded by erythematous halo¹. These ulcers occur in attacks and heal completely between attacks without any scar formation usually within a period of 7 to 14 days and ulcers occur 3 to 4 times a year usually. Cause for aphthous ulceration is not known exactly , but is thought be a T cell mediated immune response triggered by variety of factors such as nutritional deficiencies, local trauma, smoking, dental caries, stress, hormonal influences, allergies, genetic predisposition among others. Persons with aphthous stomatitis have no systemic signs and symptoms, symptoms include prodromal sensation of burning, itching, and stinging; and pain which is out of proportion to size of lesion and is worsened by physical contact especially with irritant foods and drinks. If lesion is present on tip of tongue speaking and chewing can be uncomfortable, ulcers on soft palate, oropharynx, or esophagus cause odynophagia^{1,2}. Signs are limited to lesions themselves. Females are affected more frequently than males, as females are more prone to stress and emotional situations which can affect their immune response. Hormonal changes during pregnancy and menstruation also affect immune response.

There are three clinical types of aphthous ulcers: **Aphthous ulcer minor:** also known as mickuliczs ulcers, account for about 80% of all aphthous ulcers, size of lesion is less than 10mm, heals without scar formation and commonly seen on non keratinized mucosal surfaces. **Aphthous ulcer major:** also known as suttons disease, affects 10 to 15 % of cases of aphthous ulcers, are larger than minor lesions usually larger than 10mm, may involve keratinized oral mucosa such as hard palate, lips etc, may take more than 3 weeks to heal and may heal with scar formation. **Herpiform ulceration:** characterized by recurrent crops of numerous, small ulcerations, named so because of resemblance with herpes simplex lesions, may

affect keratinized mucosal surfaces in addition to non keratinized, occurs in slightly older age group³.

Diagnosis of aphthous ulcer is usually clinical, made on the basis of history, clinical examination. investigations like CBC, ESR, serum folate and B12 levels, serum ferritin, rheumatoid factor etc can be done to rule out various cause of oral ulceration^{3,4,5}.

MATERIALS AND METHODS: 46 consenting adults aged between 15 and 45 years, 18 males and 28 females with aphthous ulcers were included in study, a hospital based study conducted in Shri Maharaja Harisingh Hospital Srinagar Kashmir for a period of 12 months from October 2014 to October 2015. Diagnosis of aphthous ulcer was made on the basis of history, clinical examination. investigations like CBC, ESR, serum folate and B12 levels, serum ferritin rheumatoid factor etc. Swabs were taken from lesions and normal tissues and organisms found were similar in lesion sites and healthy sites. Patients were classified into minor major and herpiform groups. Suspected malignant ulcers were excluded from study. patients were divided into 2 groups, group 1 included patients treated with local steroids, local analgesics multivitamin tablets and oral hygiene maintenance and group 2 included those treated with multivitamin tablets and maintenance of oral hygiene only. Patients were followed on day 3, day 7, 3 weeks and 3months.

RESULTS: In total of 46 patients, 5 patients had recurrent oral ulceration. In group 1; 3 out of 38 patients i.e, 7.894 % had recurrent ulceration whereas in group 2 out of 8 patients 2 patients i.e, 25% developed recurrent oral ulceration, and also time taken by lesions to heal was less in group 1 as compared to group .

FIGURE 1 Distribution On Basis Of Recurrence Rates:

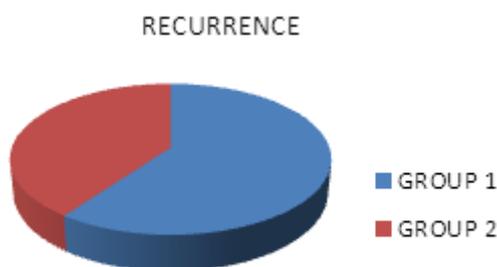


TABLE 1: DISTRIBUTION ON BASIS OF SITE OF LESION:

Site	Number of lesions
Buccal mucosa	16
Lip	8
Tongue	6
Uvula and posterior pharyngeal wall	2
Multiple sites	14

DISCUSSION:

Patients visit OPD frequently with complaints of oral ulceration which cause a lot of suffering and agony to patient. While most of these ulcerations have some local cause like trauma, burns or drug induced or due to systemic causes, autoimmune diseases etc, however large subset of patients do not have a definite cause for these oral ulcerations. These are included in group of aphthous ulcers. In our study we present information relating to effectiveness of various interventions like use of topical steroids, topical analgesics on outcome of management of aphthous ulcers^{4,5}. A significant difference was seen between outcome of those who were treated with topical steroids, topical analgesics, multivitamin tablets and oral hygiene maintenance; and those who were treated with multivitamin tablets and maintenance of oral hygiene only. And also recurrence rates were less among those who received topical steroids and topical analgesics as compared to those who did not receive topical steroids and analgesics. Majority of patients were of low socioeconomic status this could be attributed to poor oral hygiene, more nutritional deficiencies and thus poor immune response among this group of population. Therefore, based upon the inherent difficulties associated with treatment of aphthous ulcers, the clinician should individualize treatment to each patient by considering a number of relevant factors, including the potential psychological benefits of treatment, the degree of patient discomfort experienced, the probability of patient compliance with required application procedures and trade-offs between the enhanced rate of recovery and the economic burden of purchasing the treatment⁶.

CONCLUSION:

Although aphthous ulcers heal over a period of 10 to 14 days, time taken for healing of lesions is reduced significantly if these are treated with

topical steroids, topical analgesics multivitamin tablets and maintenance of oral hygiene. Thus it is better to use topical steroids and analgesics along with multivitamin tablets and oral hygiene maintenance.

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