

Improving Complex Therapy of Lichen Planus of the Oral Mucosa

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Abstract: Lichen planus is a nodular chronic disease that occurs on the skin and visible mucous membranes. The mucous membrane of the oral cavity and the red border of the lips are most often affected. This disease most often affects women aged 35 to 55 years. The etiology of lichen planus is not completely clear. Lichen planus of the oral mucosa was first described by E. Wilson (1898). There are neurogenic, viral, bacterial, and autoimmune theories of this disease.

Keywords: Lichen planus, damage to the oral mucosa, general and local treatment.

Treatment of chronic diseases of the oral mucosa is one of the most complex and pressing problems in practical dentistry. The most clinically difficult to diagnose and treat are dermatoses with manifestations, including those isolated on the mucous membrane - lichen planus. The choice of treatment methods allows you to optimize the overall treatment regimen for the manifestations of this dermatosis on the oral mucosa.

Lichen planus (Lichen ruber planus) is a chronic polyetiological skin disease with manifestations on the oral mucosa. The disease is detected in all age groups. In 62–67% of women over 40 years of age, menopause develops, mainly on the oral mucosa. Damage to the oral mucosa occurs in 75% of patients with skin rashes; morphological manifestations can be papular, exudative-hyperemic, bullous or erosive-ulcerative. Isolated lesions of the oral mucosa with elements of lichen planus range from 25–35%.

Patients complain of significant pain when eating any food, especially irritating food, and a burning sensation. Lichen planus and leukoplakia in the oral cavity can become malignant. Signs of lichen planus are milky-white, rough areas of keratinization and the appearance of fine meshwork, the so-called Wickham mesh. The manifestations of lichen planus on the red border of the lips and tongue acquire a unique clinical picture, especially in patients with reduced immunity while taking certain medications. When examining histological material in such patients, all signs of exudative inflammation are revealed. In fingerprint smears, epithelial cells, normal and degenerated, are revealed against the background of an abundance of red blood cells.

It is recommended to consult an orthopedic doctor to assess the condition of existing structures. The treatment block, relatively speaking, is divided into 2 stages:

Stage 1 - included initial therapy (antiseptic treatment of the oral cavity with a 0.05% solution of chlorhexidine bigluconate; topical anesthesia with 10% Lidoxor gel, supra- and subgingival scaling under the cover of an antiseptic; introduction of the drug "Alvogil" into the periodontal pockets with an exposure of 4–6 hours; prescription of general etiologic and pathogenetic therapy: broad-spectrum antibacterial drug Flexid (levofloxacin) 500 mg once a day for 5 days; non-steroidal anti-inflammatory drug faspik (L-arginine salt of ibuprofen) 200 mg 2 times a day for 5 days, multienzyme drug Wobenzym 2 tablets. 4–5 times a day for 1 month; a diet that excludes spicy, salty, fried foods, as well as foods rich in organic acids: fruits (strawberries, pineapple, cranberries, currants) and vegetables (tomatoes, turnips, radishes).

Stage 2—impact on the LP lesion—included the administration of a drug—a 4-aminoquinoline derivative—plaquenil 200 mg 2 times a day for at least 14 days; complex vitamin preparation Aevit, 2 capsules 3 times a day for 1 month; anti-acidotic agent - dimephosphone solution 15%, 1 tbsp. spoon 3 times a day for 14 days. Local drug therapy consisted of the use of antiseptic drugs (chlorhexidine

bigluconate solution 0.05%), local anti-inflammatory drugs (Tantum Verde in the form of a spray, solution or lozenges), as well as drugs that stimulate regeneration.

Given the complexity of the pathogenesis of lichen planus, the treatment of this pathology is difficult. It is possible to obtain a positive result only in the case of a comprehensive and individualized approach to the patient. The main goals of treatment are the elimination of keratosis, inflammation, normalization of the keratinization process, as well as achieving stable remission. Treatment of all patients necessarily begins with professional oral hygiene, training in rational hygiene, and oral sanitation. Sanitation means the elimination of local irritating factors, grinding off sharp edges of teeth, and eliminating foci of odontogenic infection.

If necessary, patients should be recommended rational prosthetics, replacement of amalgam fillings and fixed bridges made of dissimilar metals. When brushing your teeth, we advised using non-irritating toothpastes, and in the acute period, treating your teeth with a soft toothbrush.

From the diet, patients should exclude foods that cause irritation of the mucous membrane and exacerbation of the disease: alcoholic drinks, canned foods, chocolate, honey, citrus fruits, spices, as well as spicy, salty and hot foods.

General treatment includes the use of sedatives (lemonwort tincture or Novopassit), multivitamins; local - applications of an oil solution of vitamin A (15-20 minutes 3-4 times a day), and for patients with exudative-hyperemic (EHF) - applications of 0.5% prednisolone ointment (2 times a day, 20-30 minutes each). The duration of the course of drug therapy should be 30 days.

Purpose of the study: Optimization of treatment methods for manifestations of lichen planus on the oral mucosa.

Materials and methods of research.

According to a study conducted at the Department of Therapeutic Dentistry of the Belarusian State Medical Institute, the frequency, nature of lesions, and clinical symptoms of the disease were analyzed.

A total of 60 patients were observed, aged from 30 to 65 years, among whom there were 30 men and 30 women. The subjects were divided into 2 groups, depending on the local and general treatment performed.

To confirm the diagnosis and differential diagnosis, all patients were examined by a dermatologist, and also consulted by other specialists (allergist, gastroenterologist, endocrinologist, etc.) depending on the somatic status of the examined patients. As additional laboratory examinations, general and biochemical blood tests, a blood test for parenteral infections and a bacterioscopic examination of scrapings from lesions were prescribed to identify fungal contamination. To treat manifestations of LP on the oral mucosa, all patients underwent traditional pathogenetic therapy with the prescription of general and local drugs.

Results and discussion. The erosion healing processes were monitored on days 7, 14, 21 and 28. It was noted that the effect of local treatment in the first group was significantly lower than in the second. The main disadvantage of local treatment of the first group was that the agents used were easily washed off with saliva and food, so the anti-inflammatory and angioprotective effect did not have a lasting therapeutic effect, and the healing of papules on the mucous membrane did not accelerate.

On the 7th day, the characteristic mesh pattern remained on the oral mucosa in all patients of the first group; epithelialization was noted in 13.2% of formations. On the 14th day, epithelialization of 20.4% of erosions was observed, on the 21st day – 39.5%. On the 28th day, epithelialization of 45.6% of formations was observed. Final healing of erosions by the end of the second month of observation was observed in only 2 patients (12.5%), in 5 patients of this group (31.3%) complete epithelialization of erosions of the oral mucosa occurred within 2 to 3 months after the start of treatment.

In the second group, epithelization processes occurred faster than in the first, including due to the good adhesion of the ointment to the moist mucous membrane of the oral cavity.

Observation of the patients of the second group on the 7th day showed that in all patients epithelization of 41.2% of papules occurred, on the 14th day healing of 51.4% of formations was noted and on the 21st day – 68.3% of papules. In 1 patient (5%) new papules appeared against the background of old ones. On the 28th day, healing of 73.5% of formations was observed. In 7 patients (35%) of this group, complete healing of mucosal papules was noted by the end of the second month of treatment. There were no allergic reactions or complications during treatment.

Conclusions. Thus, the data obtained showed that local treatment carried out in the first group was not effective enough compared to the second. The use of a multicomponent ointment (second group) made it possible to reduce the healing of papular rashes and prevent the development of complications.

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