



RED LICHEN PLANUS OF THE ORAL MUCOSA IN THE PRACTICE OF A DENTIST-SURGEON

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Abstract: Currently, in the clinical practice of a dental surgeon, patients with various diseases, anomalies and deformities in the oral cavity are often found. Lichen planus erythematosus (KPL) is no exception. This paper examines the main features of the course of the disease in the oral cavity and possible approaches to therapeutic tactics during surgery. Thus, patients with CPL have edema, hyperemia, multiple or single nodular rashes on the oral mucosa (SOPR), enlarged and painful lymph nodes, and discoloration of the gums. Among the main complaints, pain and bleeding in the area of the changed EPR are identified, which aggravates the process of surgical intervention and creates certain difficulties for a dental surgeon. Due to the spread of this disease among people from 30 to 60 years old, who often require dental care, clinicians need and need to have knowledge about this pathology.

Key words: clinic, lichen planus, surgical intervention, pathology, approach, oral mucosa.

In dental practice, there are cases when orthopedic, orthodontic, therapeutic and surgical care is sought by patients with chronic pathologies of the COPD. At the same time, inflammatory disorders often progress. One of these diseases is lichen planus, which is a chronic progressive inflammatory disease of the skin and mucous membranes, typical elements of which are lichenoid papules. Lichen planus was first described by Ferdinand von



Gebra in 1860 as lichen ruber and in 1869 by W. E. Wilson as lichen planus [1]. The disease reaches its greatest prevalence among people aged from 30 to 60 years, mainly in women. The lichenoid tissue reaction in the occurrence and development of lichen planus (KPL) is based on changes on the part of the immune system in the form of delayed hypersensitivity.

There are several clinical forms of CPL: 1. Typical – small bluish-mother-of-pearl papules form on the unchanged CPR, which can merge to form a characteristic network in the form of various patterns. Most often, lesions are localized in the distal part of the cheeks along the line of closure. Papules are painless and have a rough surface. 2. Exudative hyperemic – edema and hyperemia appear in the papules, the formation of small erosions or extensive eroded surfaces that are covered with fibrous plaque is possible. Due to the increase in the inflammatory process, the corresponding symptoms develop: itching, burning, bleeding, pain in the areas of the SOPR, there may be slurred speech and bad breath. 3. Erosive and ulcerative – accompanied by pronounced edema and hyperemia, the development of erosions leads to the formation of ulcerative surfaces, around which papules or traces of a CPL grid are located. The affected areas give a strong painful reaction. The regional lymph nodes are enlarged and painful. 4. Bullous – characterized by the formation of subepithelial blisters that can burst and as a result, bright red erosions remain. The gum acquires a meat-red color, has soreness and increased bleeding. 5. Hyperkeratotic – white hyperkeratosis plaques appear along with papules. 6. Atrophic – plaques form on the back of the tongue and atrophy of the filamentous papillae occurs. 7. Atypical – develops on the gum in the area of the frontal group of teeth on the upper jaw and the mucous membrane of the upper lip in the form of hyperemia with clear boundaries [3]. Lichen planus is diagnosed on the basis of a characteristic clinical picture: swelling, burning, itching, bleeding of the mucous membrane, bad breath, enlarged and painful lymph nodes, pain when talking and eating, the presence of the main element of the lesion – papules. Luminescent diagnostics gives a bluish glow to the foci of the lesion of the SOPR. Additionally, scraping from areas of erosion and plaques,



biopsy, and cytological analyses are performed. Histological diagnosis reveals hypergranulosis, acanthosis, parakeratosis, hyperkeratosis, inflammatory infiltration and dilated capillaries in connective tissue. Skin tests are performed – IFAS, RTMA, RBT, GDTKW [4]. The treatment of the disease consists of several directions: 1. General therapy – elimination of keratosis, inflammation and normalization of the process of keratinization of the epithelium, elimination of intra- and para-focal complications, normalization of redox processes, treatment of carcinophobia and concomitant diseases. Vitamin therapy (A, D2, D3, PP, E), physiotherapy procedures (galvanic collar or electrophoresis with Shcherbakov bromine), sedatives, immunodifiers (T-active preparations of human interferon, synthetic glycolipoids) are used for this purpose. 2. Local treatment – sanitation of the oral cavity (removal of dental deposits, sharp edges of teeth, filling of carious cavities, correction of fillings and dentures, therapy of periodontal diseases), treatment of keratosis foci (vitamins A, E, keratolytic agents), hygienic rinsing with antiseptic solutions (0.05% solution of chlorhexidine bigluconate, aquin), restoration mucosal functions (NSAIDs and SPVS), removal of necrotic plaque (proteolytic enzymes) [1, 4].

The purpose of the work. To determine the main features of surgical treatment of patients with lichen planus of the oral mucosa.

Research methodology. A clinical case is presented. As planned, patient N., 59, a resident of Samarkand, was diagnosed with lichen planus in the surgical department for the purpose of tooth extraction.

The results of the study and their discussion. Lichen planus was identified from the anamnesis, the diagnosis was first made 2 years ago, when the first clinical manifestations in the oral cavity (edema and hyperemia in the area of pathological foci, the presence of papules and a reticular pattern) were revealed at an appointment with a dentist-therapist, while there is no genetic predisposition, possible factors may be emotional stress, toxic-allergic and viral effects. Among the patient's complaints, soreness was detected when eating, especially hot, spicy and salty food, itching and burning of the mucous membrane, bleeding, and bad breath.



There is a dryness of the red border of the lips and the mucous membrane of the oral cavity, which led to the development of angular cheilitis (congestion in the corners of the mouth). Against the background of edematous and hyperemic mucous membrane, a characteristic mesh pattern is revealed, formed by the fusion of small papules. There is also the appearance of erosions and erosive surfaces covered with plaque – an erosive and ulcerative form of the disease.

Due to the localization of foci on the tongue and bottom of the oral cavity, speech is slightly complicated. Sialorrhea is pronounced, which is characterized by an increase in the amount of saliva and its discharge from the oral cavity mainly at night (a symptom of a "wet pillow"). Oral hygiene is difficult, and as a result, plaque deposition and the appearance of an unpleasant odor are observed. An examination was carried out, during which the features of the facial skeleton were studied. The chin is pushed forward and pointed. Senile progenia is observed. From the moment of diagnosis, the restoration of oxidative-basic processes, symptomatic therapy, vitamin therapy were carried out; no deterioration in the general condition was observed. After preliminary therapeutic preparation – sanitation of the oral cavity (removal of dental deposits, filling of carious cavities, removal of sharp edges of teeth), together with the patient, a treatment plan was chosen: removal of a bridge prosthesis and supporting teeth in the area of 1.5, 1.6, 1.7 teeth. The treatment was carried out jointly with a dentist, a therapist and a periodontist against the background of taking medications with optimal dosage and local treatment of pathological foci. The surgical intervention was performed during the period of the greatest abatement of the process in the oral cavity with the least injury to the SOPR. After the removal of the structure and teeth, curettage of the holes 1.5 and 1.7 teeth was performed, and a collagen hemostatic sponge was laid. The healing period of the wound proceeded without complications, with secondary tension. Then the patient continued the course of treatment with a periodontist. Timely diagnosis and treatment neutralize the progression of the disease and contribute to a favorable prognosis. The clinician should remember that for patients with concomitant systemic pathology, a



differentiated approach to dental treatment and surgical intervention in the oral cavity is advisable, taking into account the severity of the clinical manifestations of the underlying disease.

Conclusion. The high prevalence of somatic pathologies, the peculiarities of manifestations in the oral cavity, the severity of clinical manifestations depending on the severity of the inflammatory process justify the need for a differentiated approach to surgical treatment. At the same time, it is necessary to observe consistency, complexity and individuality at each stage and timely adjust dental treatment.

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