A guide to oral ulceration for the medical physician

Sir,

Goel et al's guide to oral ulceration for the medical physician (vol 76(6), 2015, p. 337) was a comprehensive review of this key clinical sign. We would also like to highlight other important infectious causes. Atypical mycobacteria such as *Mycobacterium avium complex* may cause oral ulceration in patients with advanced HIV (Robinson et al, 1996).

In south-east Asia, penicilliosis is an AIDS-defining disease caused by the dimorphic fungus *Penicillium marneffei*, which may cause oral lesions including papules, erosions or shallow ulcers covered by yellow necrotic slough (Deepa et al, 2014). Paracoccidioidomycosis is a chronic mycosis caused by *Paracoccidioides brasiliensis*, usually seen in adult men with a history of agricultural work. The primary presentation is with pulmonary disease, but oral manifestations are characterized by painful punctate moriform stomatitis and ulceration with a granular appearance (Webber et al, 2014). Although the disease is endemic to Latin America, the long period of latency of the fungus can result in clinical presentation many years after migration to non-endemic countries. Mucosal leishmaniasis is a known risk from *Leishmania* species of the viannia subgenus, typically found in the Americas. This parasitic disease is a sequelae of cutaneous infection, which results from dissemination of parasites from the skin to the naso-oropharyngeal mucosa, causing oral ulceration (Mignogna et al, 2015).

With increasing travel and migration, tropical infections are no longer limited by borders. It is thus important for clinicians to recognize the broad spectrum of infectious diseases that may cause oral lesions when considering the differential diagnosis for oral ulceration.

Padmasayee Papineni
Clinical Research Fellow
Department of Medicine
Yong Loo Lin School of Medicine
119228 Singapore
(padmasayee@yahoo.co.uk)

Arathi Papineni McIntosh
Specialty Doctor in Oral Surgery
Queen Mary's Hospital
Sidcup
Kent

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Sir,

We read with great interest the symposium on systemic manifestations of disease, and the article by Goel et al on the topic of oral ulceration. We wish to highlight that systemic lupus erythematosus warrants inclusion in the list of systemic conditions mentioned in the article.

In 1997, the American College of Rheumatology updated the eleven criteria that encompass a diagnosis of systemic lupus erythematosus, which includes oral ulceration (Hochberg, 1997). Indeed, the estimated prevalence of systemic lupus erythematosus is 28 cases per 100 000 people in the UK (Johnson et al, 1995). This is more common than Behçet's disease, which the authors mentioned in the article and has an estimated prevalence of 0.64 cases per 100 000 people in the UK (Mendes et al, 2009). Thus physicians are likely to come across several patients with systemic lupus erythematosus during the course of their careers and should be aware that it is a relatively common cause of oral ulceration.

Shawn DP Ellis
FY1
School of Medicine
University College London
London WC1E 6BT
Elliott R Carthy
FY1
School of Medicine
Imperial College London
London
(shawn.ellis@doctors.org.uk)

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Sir,

Regarding the letter from Papineni and Papineni McIntosh, the causes of oral ulceration are legion and doctors must be aware of infectious causes. Our article focussed primarily on oral lesions that general physicians or hospital doctors might encounter. Although foreign travel is increasingly common, we would argue that many of the diseases mentioned rarely present in the UK.

We agree with Ellis and Carthy that systemic lupus erythematosus can present with oral ulceration with a frequency which appears to be greater than Behçet's disease. Although Behçet's disease is rare, oral ulceration is a classical clinical feature for diagnosis, and we agree that physicians should be aware of both important conditions.

Systemic lupus erythematosus which presents with oral ulceration can be difficult to distinguish from lichen planus or a lichenoid reaction. We consider a diagnosis of systemic lupus erythematosus if there is an atypical lichenoid reaction.

Rishi M Goel
Clinical Research Fellow and Specialist Registrar in Gastroenterology
Departments of Gastroenterology and Oral Medicine
(rgoel1@nhs.net)
Martyn Ormond/Shalini Nayee/ Esther A Hullah
Specialty Dentist/Core Dental Trainee in Oral Medicine/Specialist Registrar in Oral Medicine
Oral Medicine Unit
Jeremy D Sanderson
Reader and Consultant
Department of Gastroenterology
Michael Escudier
Reader in Oral Medicine
King's College London Dental Institute
Honorary Consultant in Oral Medicine
Oral Medicine Unit
Guy's, King's & St Thomas' Hospitals
London SE1 7EH