PREVALENCE OF APHTHOUS ULCERS AMONG THE PATIENTS PRESENTING IN OUTDOOR DEPARTMENT

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ABSTRACT:
Aphthous stomatitis is a common condition characterized by the repeated formation of benign and non-contagious mouth ulcers (aphthae) in otherwise healthy individuals. The informal term canker sores is also used, mainly in North America, although this may also refer to any mouth ulcers. This cross-sectional study was conducted among the patients presenting in the outdoor department of different hospitals. Name, age, gender and history and duration of aphthous ulcers were noted on a predefined proforma. All the data was entered and analyzed with SPSS Ver. 23.0. A total of 90 patients presenting in outdoor were included in this study i.e., 45 males (50%) and 45 females (50%). The mean age of the patients was 30.12±4.27 years. Out of 90 patients, thirteen patients presented with the disease and that they were taking treatment for that.

Keyword: Aphthous Ulcers
INTRODUCTION:
Aphthous stomatitis is a common condition characterized by the repeated formation of benign and non-contagious mouth ulcers (aphthae) in otherwise healthy individuals. The informal term canker sores is also used, mainly in North America, although this may also refer to any mouth ulcers. The cause is not completely understood but involves a T cell-mediated immune response triggered by a variety of factors which may include nutritional deficiencies, local trauma, stress, hormonal influences, allergies, genetic predisposition, certain foods, dehydration or some food additives. These ulcers occur periodically and heal completely between attacks. In the majority of cases, the individual ulcers last about 7–10 days, and ulceration episodes occur 3–6 times per year. Most appear on the non-keratinizing epithelial surfaces in the mouth – i.e. anywhere except the attached gingiva, the hard palate and the dorsum of the tongue – although the more severe forms, which are less common, may also involve keratinizing epithelial surfaces. Symptoms range from a minor nuisance to interfering with eating and drinking. The severe forms may be debilitating, even causing weight loss due to malnutrition.

The condition is very common, affecting about 20% of the general population to some degree. The onset is often during childhood or adolescence, and the condition usually lasts for several years before gradually disappearing. There is no cure, and treatments such as corticosteroids aim to manage pain, reduce healing time and reduce the frequency of episodes of ulceration. Persons with aphthous stomatitis have no detectable systemic symptoms or signs (i.e., outside the mouth). Generally, symptoms may include prodromal sensations such as burning, itching, or stinging, which may precede the appearance of any lesion by some hours; and pain, which is often out of proportion to the extent of the ulceration and is worsened by physical contact, especially with certain foods and drinks (e.g., if they are acidic or abrasive). Pain is worst in the days immediately following the initial formation of the ulcer, and then recedes as healing progresses. If there are lesions on the tongue, speaking and chewing can be uncomfortable, and ulcers on the soft palate, back of the
throat, or esophagus can cause painful swallowing. Signs are limited to the lesions themselves. Ulceration episodes usually occur about 3–6 times per year. However, severe disease is characterized by virtually constant ulceration (new lesions developing before old ones have healed) and may cause debilitating chronic pain and interfere with comfortable eating. In severe cases, this prevents adequate nutrient intake leading to malnutrition and weight loss.

Aphthous ulcers typically begin as erythematous macules (reddened, flat area of mucosa) which develop into ulcers that are covered with a yellow-grey fibrinous membrane that can be scraped away. A reddish "halo" surrounds the ulcer. The size, number, location, healing time, and periodicity between episodes of ulcer formation are all dependent upon the subtype of aphthous stomatitis (1-3).

**MATERIAL AND METHODS:**
This cross-sectional study was conducted among the patients presenting in the outdoor department of different hospitals. Name, age, gender and history and duration of aphthous ulcers were noted on a predefined proforma. All the data was entered and analyzed with SPSS Ver. 23.0. The quantitative variables were presented as mean and standard deviation. The qualitative variables were presented as frequency and percentages.

**RESULTS:**
A total of 90 patients presenting in outdoor were included in this study i.e., 45 males (50%) and 45 females (50%). The mean age of the patients was 30.12±4.27 years. Out of 90 patients, thirteen patients presented with the disease and that they were taking treatment for that.

**DISCUSSION:**
The cause is not entirely clear but is thought to be multifactorial. It has been suggested that aphthous stomatitis is not a single entity but rather a group
of conditions with different causes. Multiple research studies have attempted to identify a causative organism, but aphthous stomatitis appears to be non-contagious, non-infectious, and not sexually transmissible. The mucosal destruction is thought to be the result of a T cell (T lymphocyte) mediated immune response which involves the generation of interleukins and tumor necrosis factor alpha (TNF-α). Mast cells and macrophages are also involved, secreting TNF-α along with the T cells. When early aphthous ulcers are biopsied, the histologic appearance shows a dense inflammatory infiltrate, 80% of which is made up of T cells. Persons with aphthous stomatitis also have circulating lymphocytes which react with peptides 91–105 of heat shock protein 65–60, and the ratio of CD4+ T cells to CD8+ T cells in the peripheral blood of individuals with aphthous stomatitis is decreased.

Aphthous stomatitis has been associated with other autoimmune diseases, namely systemic lupus erythematosus, Behçet’s disease and inflammatory bowel diseases. However, common autoantibodies are not detected in most patients, and the condition tends to resolve spontaneously with advancing age rather than worsen. Evidence for the T cell-mediated mechanism of mucosal destruction is strong, but the exact triggers for this process are unknown and are thought to be multiple and varied from one person to the next. This suggests that there are a number of possible triggers, each of which is capable of producing the disease in different subgroups. In other words, different subgroups appear to have different causes for the condition. These can be considered in three general groups, namely primary immuno-dysregulation, decrease of the mucosal barrier and states of heightened antigenic sensitivity (see below). Risk factors in aphthous stomatitis are also sometimes considered as either host-related or environmental (4-6).

REFERENCES: