Reverse Koebnerization in a linear oral lichenoid lesion: A case report

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Abstract

The spectacle of Koebner’s phenomenon (KP) is interesting in that trauma precipitates a subset of pathologically distinct conditions, indicating the subtle interplay between sensitization and dermato-mucosal integrity. KP is interesting because, if factors initiating it are controlled, then it may be possible to prevent these debilitating conditions through induction of reverse Koebnerization. Herein, we present a report of a patient with an erosive lesion, localized to the occlusal plane on buccal and lingual mucosa, that interestingly subsided following 1 week after a dental scaling procedure. This report analytically describes the role of dental calculus and cuspal trauma as important triggers surrounding the genesis of oral lichenoid lesion and oral lichen planus. An engaging discussion on these closely related enigmatic entities forms the central theme of this report.

Introduction

Koebner’s phenomenon (KP) was first identified by Heinrich Koebner in 1877. It can be defined as mechanical irritation precipitating a skin or mucosal eruption in a patient without pre-existing dermatosis.1 KP is often associated with lichen planus, psoriasis, and vitiligo,1 and can be triggered through simple irritation from ECG electrode placement,2 trauma caused from tattoos and acupuncture procedures,3 and surgical procedures like biopsy. Subtle sources of irritation in oral lichen planus (OLP) and oral lichenoid lesion (OLL) include: dental plaque and calculus,4,5 and low-grade trauma caused by dental cusps.6,7 In a review focused on oral lichenoid lesions, dental calculus/tarter was classified as other factor besides restorations, drug and medication use, and graft versus host reaction.8 From available literature, both OLP and OLL have dental calculus and cuspal trauma as triggers in the disease process.

Mechanical trauma caused by dental cusps, explains the bilateral, mirror image pattern of lesions in OLP, that preferably involve the buccal mucosa and lateral border of tongue. Furthermore, gingival involvement in OLP is common, and noticed in patients with poor oral hygiene.4,5 Although KP is a well-known in OLP and OLL, the development of linear, unilateral lesions along the occlusal plane is a unique and rare finding.6,7 Our report highlights one such presentation, which showed rapid regression (<1 week) following a dental scaling procedure.

Case Report

A 42-year-old female patient reported to the Oral Medicine Clinic (Department of Oral Medicine and Radiology, MNR Dental College and Hospital, Sangareddy, Telangana, India) with a 6-month history of burning sensation and occasional oral bleeding on the right side of mouth. On intraoral examination halitosis was notable, dental calculus was significant, and diffuse erosive areas were seen in relation to the right buccal mucosa (Figure 1) and lateral border of tongue along the line-of-occlusion (Figure 2). Surrounding the lingual eruptions, slender white lines were present, indicative of Wickham’s striae (WS) (Figure 2). The gingiva and labial mucosa were also involved predominantly on the right side, in close proximity with dental calculus (Figure 3). Patient was not under any systemic medication or oral ointment, is not a tobacco/betel-quit chewer, did not change toothpaste recently, and had no dental restorations or prosthesis in the oral cavity. Furthermore, she was in good general health, and displayed no signs-of-anxiety during examination. She denied other sources of life stress such as loss-of-job, loss-of-loved ones or close family members in the recent past, excluding likelihood of psychosomatic origins. Also, all other dermato-mucosal sites like skin, nails, esophagus, genitals, and ocular tissues were completely spared. These clinical findings are compatible for the diagnosis of oral lichenoid lesion. All blood investigations were within normal limits except for low hemoglobin (8.3 mg/dL). The close proximity between dental calculus and oral lesion distribution compelled us to advise dental scaling, and no topical corticosteroids were recommended during that visit. She was recalled a week later for review and a significant regression of lesions was noticed (Figures 4 and 5). She is under follow-up, and has not developed any symptoms during the last 6 months.

Discussion

Many local factors have been implicated in the potential development of OLL and OLP. They range from mechanical trauma caused by restorative materials,8 prolonged...
denture wear, chronic cheek and lip biting, and contact sensitization from dental calculus. Herein, we add additional insight into cuspal trauma and dental calculus as potential triggering factors.

Interestingly, a number of immunemediated, oral mucosal disorders (e.g., pemphigus) occur first along the buccal mucosa and tongue, indicating the possible role of persistent, low-grade trauma caused by dental cusps, during rest and chewing process. These, disorders thus serve as an in-direct proof pointing at the subtle workings of low-grade mucosal trauma. Low-grade trauma/irritation can at times trigger and/or exacerbate a number of OLP and OLL presentations, and deserve due consideration by clinicians.

OLL occurs chiefly due to galvanic phenomenon associated with metallic restorations, contact sensitization to resin based restorations and prosthesis, systemic drugs, and tobacco and betel-quid use. OLL are often noticed in the vicinity of these local factors. However, in the present case, the trigger is dental calculus. In both OLP and OLL, a reticular mesh like pattern (WS) is notable, that is distinct from the diverging sunray/brush border pattern in oral discoid lupus, a differential for OLL. Leukoplakia is a flat keratotic plaque, that frequently involves the buccal mucosa, at the site of tobacco placement. Erythroleukoplakia is a fitting differential for some erosive OLLs, but can be easily excluded in the absence of tobacco habit. Another important differential for unilateral oral erosive lesions is erythomatous candidiasis. Additionally, some candida sps are also associated with OLP, and it is recommended to institute anti-myocytic therapy before advising treatment for doubtful OLP cases. Frictional keratosis is another common condition caused by direct mechanical trauma. It is a relatively small, focal lesion, seen on the buccal mucosa coinciding with sharp dental cusps or edges of molar teeth.

In the present case, all dermatomucosal mucosal sites were completely spared. In one of the largest studies on OLP, skin lesions occurred in 93 (16%) of 584 cases, and genital lesions occurred in 77 (19%) of 399 female patients. The absence of systemic involvement in our patient, was highly suggestive of a local reactive process like OLL. Also, there is some literature available on unilateral OLP, which compels a brief discussion. Oliveira Alves et al. reported unilateral OLP in 7 of 90 reticular OLP of cheek mucosa, and 2 of 46 erosive OLP of cheek mucosa. In another large study by Eisen et al. on 723 biopsy proven OLP patients, unilateral lesions were noted in 9 patients (1.2%) on buccal mucosa, in 4 (0.6%) on dorsal tongue, and in 62 (8.6%) on gingiva. Unilateral lesions were reported by Andreasen in 6 of 115 OLP cases. The linear OLL restricted to the buccal and lingual mucosa, reported in the present report closely mimics the unilateral OLP report of Hartl et al. However, some authors emphasize that unilateral OLP were in fact OLL misdiagnosed as OLP. We favor this argument and unilateral presentations must be generally considered for an OLL diagnosis, especially when a local trigger is discernible. In several studies, plaque control resulted in regression of OLP and OLL. So far, there has been only little emphasis about the role of calculus in the genesis of OLL. Detailed case reports such as this provide direct-proof for the subtle interaction between calculus and disease inception and progression. From this standpoint, it is essential that all patients with OLL and OLP are motivated...
and counseled to maintain good oral hygiene, and patients with severe calculus must be offered a scaling procedure before providing any further treatment. Furthermore, the frequent involvement of gingiva in OLP, indicates the role of periodontal pathogens in accumulated plaque and calculus, causing long-term contact sensitization. OLL are interesting and have been noticed in the region of calculus deposition similar to OLP. In a study by Katsoulas et al. on 24 lichenoid lesions of lower lip, calculus deposition was noticed in 16 cases, and 6 cases presented with resin/composite restorations. Backman et al. reported that of the 22 patients with lichenoid lesions, 18 (80%) achieved improvement and complete relief with chlorhexidine, suggesting a microbial component in OLL. Literature is pointing at the role of microbial irritation in the development of both OLP and OLL, emphasizing their nearness. Important precipitating factors like poor oral hygiene/heavy calculus can cause low-grade irritation precipitating and/or exacerbating OLL and OLP.

Furthermore, OLP is a chronic condition, and has little tendency for rapid regression following brief treatment. In the study by Stone et al. at 20-week follow-up, 89% of intervention group showed improvement from baseline, and in control group only 53% patients showed improvement. Similarly, the study by Holmstrup et al. showed regression after 12 months.

Some studies were also focused on healing/regression of OLLs. In a study on 44 white lesions, removal of dental fillings caused regression only in OLL, and no regression occurred in OLP. In another study on 24 OLL cases, 63% healing was noticed within 3 months. These references are pointing at the superior healing potential of OLL over OLP, following elimination of triggering factor. However, in the present case, the trigger was calculus and regression time was extremely short (<1 week), suggesting the diagnosis of a local reactive process like OLL. Based on direct topographic relationship between clinical lesions and calculus, rapid regression following removal of calculus, unilateral presentation, and complete lack of systemic involvement, the reported case bends towards OLL over (unilateral) OLP.

OLL and OLP are known to undergo reverse Koebnerization. Deeper understanding of this process can serve potential benefits, as these stimuli if controlled, might serve as a therapy for numerous patients with these conditions and a range of other mucocutaneous conditions. One such therapy is the use of low-grade electric stimulation which recently showed desirable effect in the management of OLP. It is therefore important that investigators design potential therapies that can evoke cutaneous involvement, and complete lack of systemic lesions and calculus, rapid regression following removal of calculus, unilateral presentation, and complete lack of systemic involvement, the reported case bends towards OLL over (unilateral) OLP.

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Conclusions

Based on the findings of present case, it is highly recommended to thoroughly screen OLL and OLP for underestimated sources of irritation like dental calculus, sharp cusps/incisal edges, and pointed edges of restorations/prosthesis. Recommending dental scaling procedure might solely trigger reverse Koebnerization, and subsidize severity of lesions, as occurred in the present case. If dental restorations are associated with OLL, they should be exchanged with other compatible restorative materials, and followed-up for management. KP and reverse Koebnerization are subtle biological events that highlight dermal and mucosal sensitization as an important factor governing overall dermato-mucosal health and integrity.

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