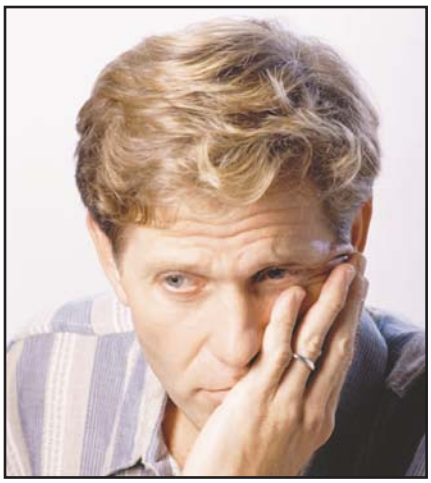
*Case in Point is a series of interesting cases and diagnoses, so general practitioners can sharpen their skills. Submissions and feedback can be sent to **diagnosis@sta.ca**.*

Case in Point

What are these sores in my mouth?

By Mitchell B. Rubin, MD



A 32-year-old patient presented to me in January 2000, with a one-week history of painful lesions on his tongue, uvula, mouth floor, and buccal mucosa. He told me he had a small cold sore on his outer lip initially. He had seen his dentist, who felt his diagnosis was that of an oral herpes simplex virus infection (HSV). A viral swab was taken, and was negative.

The patient returned again in January, with a worsening condition, including more vesicles and ulcers on his palate and inner and outer lips. Acyclovir and clindamycin were prescribed, and he was referred to see an otolaryngologist. The otolaryngologist felt the patient had a resolving severe herpes stomatitis and full blood work and immunologic tests were undertaken. All results, including an HIV test, were negative. By mid-February (six weeks later), the patient's symptoms and lesions had resolved.

He returned again the following November, with recurrent mouth ulcers. He was given famciclovir 500 mg for seven days, and percocet for the pain. The episode again lasted over six weeks. He lost over 10 lbs and was unable to eat or brush his teeth. A dermatology referral did not lead to a diagnosis, and he was given 2% tetracycline in kaopectate and benadryl suspension to take as needed. Further blood work and a complete physical exam were all normal. A viral swab was again negative. There was no evidence of malignancy.

In March 2001, he developed a cold sore on his lip followed by a 1.5 cm ulcer on his buccal mucosa. He also developed a painful sore on his outer urethra. He saw his dermatologist again and was given prednisione 40 mg orally, to taper the outbreak quickly. The patient quit smoking marijuana and avoided alcohol. His stress level was high, and he continued on his venlafaxine hydrochloride for chronic dysthymia.

He had a further six-week outbreak in August 2001, and his dermatologist was considering a diagnosis of erosive lichen planus or pemphigus vulgaris. The patient was referred to another dermatologist in September, with a significantly eroded and scarred mouth. The dermatologist had another theory about his diagnosis and biopsied the active mouth.

What happened?

What is the diagnosis?

The second dermatologist felt the patient was experiencing recurrent erythema multiform (EM) eruptions following an initial labial HSV infection. The biopsy results were compatible with healing EM, immunoflorescence was negative, and the pathology didn't show acantholysis. The patient was advised to decrease the stress in his life, and use valacyclovir hydrochloride 500 mg once

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daily prophylactically, to prevent further HSV outbreaks and secondary EM eruptions.

Erythema multiform is most common in individuals under 30 years old. It is more frequent in males. More than 50% of cases are idiopathic, but it can follow myplasma or herpes infections, and can occur secondary to the use of drugs such as sulphonamides, phenytoins or penicillin. Lesions usually develop over 10 days or more, and are often iris or target shaped with a 1 cm to 2 cm macule and a central vesicle or bullae. They are usually localised to the dorsa of the hands, palms, soles, elbows and knees. They can also occur on mucous membranes of the mouth, lips and eyes and can occur around the penis, vulva and in the lungs. Severely ill patients may respond to systemic corticosteroids such as oral prednisone. Remission occurs spontaneously over several weeks. Many will suffer recurrent episodes. Dx

Dr. Rubin is a family physician at Mount Seymour Clinic in North Vancouver, British Columbia.