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Case Report

Self-inflicted oral mucosa lesion in non syndemic, non-psychiatric patient: Management with Pharmacological and Multicomponent Behavioural Intervention - A Case Report

Abstract

Oral Mucosal white lesions have been commonly found in the oral cavity as white coloured patches. Although most of these lesions appear similar to each other, their identification requires an integrated approach which includes a detailed history, clinical examination and appropriate investigations. Clinically the term, “morsicatio mucosae oris,” “morsicatio buccarum,” or “morsicatio labiarum,” has been used to describe white lesions caused due to self-inflicted behaviours in the oral cavity. The clinical appearance of such lesions depends on the severity of the habit. “Morus” means bite, buccarum or labiarum termed based on their location [1]. Constant chewing of the oral mucosa causes acute mucosal injury which further leads to an oral traumatic ulcer or chronic oral mucosal tissue injury. The lesions undergo morphological changes that appear as macerated or shredded greyish white patch caused due to repetitive habitual chewing, biting, or “nibbling” of the teeth over the mucosa. Such injuries have been clinically termed as “Morcicatio” [1].

Morsicatio labiarum, a self-mutilated white lesion, has been observed in adults as well as children and can be an associated feature of syndromes and psychiatric disorders [2,3].

Cheek biting habit or chewing of the oral mucosa can be performed while the individual is awake or seen as a nocturnal habit. This article presents a case report of self-inflicted morcicatio lesion diagnosed in a well oriented patient with no underlying psychiatric disorder. The treatment was directed towards multicomponent behavioural intervention habit reversal HRT along with tablet alprazolam 0.5mg to be taken every night for three months with regular periodic observation.

Introduction

White lesions of the oral cavity can be commonly seen on the oral mucosa during routine examinations. This nonspecific terminology has been used to describe any abnormal area of the oral mucosa which clinically appears whiter than the surrounding tissues and usually seen as a slightly raised, rough or otherwise different texture than the adjacent normal mucosa [4]. White lesions can be benign or an alarming sign to the clinician that manifests as a marker of the underlying local or systemic pathology. Self-mutilated white lesions have been caused due to behavioural disturbances where the individual deliberately inflicts harm to one’s own body tissues [5]. Although the exact prevalence of such lesions are uncertain, it has been observed to affect people regardless of their age, sex or ethnicity. Previous studies have found that most patients were in fifth and sixth decade with highest incidence in second decade. The lesion appears most commonly on the buccal mucosa. Some cases involving the lateral border of the tongue and labial mucosa have also been reported [6]. Self-mutilated injuries occur due to Organic and Functional disturbances. Organic self-mutilation injuries are seen in comatose patients, syndromic patients such as Lesch-Nyhan syndrome, De Lange syndrome, Tourette syndrome, Leigh syndrome, autistic and patients with familial dysautonomia. Functional self-mutilation refers to intentional self-injuring associated with physically healthy patients without detectable genetic disorders [7], patients with poorly constructed prosthetic teeth.

with teeth placed too far buccally and or labially outside the neutral zone have been reported of being involved in Chronic self-induced chewing of oral mucosa [3]. Study conducted by, Doval N [7], Kang SH [8], Park KC [9], Sook-Bin Wo [1], have reported cases of moricicatio lesion associated with habitual sucking where the lesion was located on the lateral borders of the tongue and buccal mucosa.

Clinically these lesions are characterized with diffuse, poorly demarcated, peeled, thready or shredded oral mucosa and are asymptomatic. Diagnosis and management of self-mutilation injuries are based on a thorough medical history, physical examinations, mental status evaluation and psychiatric consultation. It has been reported that patients affected visit the dental office for treatment than to psychiatrists. Thus, there has been fewer reports on psychiatric management of such patients [10]. An association between the chewing of the oral mucosa and stress has been reported, where patients perform the act during the prodromal period of tension to feel a release of tension [8]. Hence the psychological assessment of a patient is mandatory and multidisciplinary approach helps to carry out the overall management of the affected individual. As this oral lesion has no malignant potential, but must be excluded from other lesions like leukoplakia, candidiasis and oral potentially malignant lesions, carcinoma in situ, squamous cell carcinoma with appropriate investigation [11]. Clinical implication of moricicatio lesions has been of mere interest as the lesions are asymptomatic and has no pathological correlation. However these lesions are secondary to existing local, systemic or psychological factor which needs to be addressed. Therefore, this article is a case report of a patient with self-inflicted oral mucosal lesion due to lack of sleep at night.

**Case Report**

A 39-year-old male patient reported to the clinic with a chief complaint of diffuse white patches in the oral cavity. On eliciting the history patient revealed that he has the habit of chewing his oral mucosa for the past 2 years. Initially the patient started chewing his oral mucosa due to lack of sleep at night and later it developed into a habit that involved vigorous chewing of his mucosa throughout the day. Further examination of the patient revealed that he was conscious, oriented in time, place and person with normal vitals. There were no significant findings on general physical and central nervous system examination. Mental status examination revealed normal psychomotor activity, speech was normal and no abnormality in perception and other higher mental functions was observed. Intraoral examination revealed diffuse white shredded plaques involving the labial mucosa, bilateral buccal mucosa and bilateral exaggerated Linea Alba (Figures 1–3). Upon palpation the white plaques were scrapable and non-tender. Based on the above history and clinical findings, a provisional diagnosis of moricicatio mucosa oris was given with a differential diagnosis of oral candidiasis. The patient was subjected to KOH and PAS examinations to rule out candida and the results were negative. Patient was also referred to a psychiatrist to rule out stress related disorder, and the psychiatrist’s report revealed normal. The patient was advised to administer tablet alprazolam 0.5mg only at night for three months, and also follow and practice the five phases of habit reversal therapy. The five phases include (a) awareness training: patient was reminded to keep himself informed that he is actively performing the existing oral habit this self-reminder was to keep himself reminded to reduce the frequency and intensity of the existing habit. (b) Relaxation training: to help relieving any underlying stress (c) competing response training: patient was advised to engage himself in the other most liked activities whenever he was tempted to perform the habit (d) Motivation procedures: patient was advised to keep reminders for himself to be informed about the control of habit like phone reminders and also to inform his close family members to keep him informed about the habit (e) Generalization training: patient was informed to keep himself aware of the triggering situation. In this case it was lack of sleep hence the patient was advised to regularize his sleep pattern by administering tablet alparzolem 0.5mg every night and has been kept under observation. Thorough diagnosis of self-mutilated injuries are essential for successful management of the condition and multidisciplinary approach is required.

**Discussion**

Previous literature reports that buccal mucosa, teeth and periodontium were the most affected sites for self-inflicted injuries in sleep deprived patients [12]. The patient’s history, clinical appearance of the existing oral soft and hard tissue finding aid in the diagnosis of the lesions [12]. Clinically oral mucosal lesions characteristically appear with bilateral thick white lesions. In this case the patient reported that he had lack of sleep and the clinical features examined on the oral mucosal soft
tissue were comparable to the features stated in the literature but with no findings observed on teeth and periodontium. It has been reported that occurrence of such self-inflicted habitual oral mucosa lesions were related to personal problems and mental stress [13]. However in the present case medical history was non-contributory and personal history revealed that he failed to sleep at night which was related to his underlying stress. Management for such lesions requires a multidisciplinary approach which involves identification of precipitating factors, reassurance, counselling, relaxation techniques, anxiolytics and different types of prosthetic shields and HRT [14]. Successful treatment relies on patient compliance. For the present case, management was directed towards habit reversal training (HRT). This was according to Azrin and Nunn HRT, a multicomponent behavioural intervention designed to reduce the manifestations of habit-based disorder and along with administration of an anxiolytic drug. The patient was prescribed alprazolam which has anxiolytic, sedative, hypnotic, skeletal muscle relaxant and antidepressant properties. This treatment plan was found to be beneficial for the present case. Since the patient was reluctant towards wearing of intra oral occlusal splints, the treatment modality was restricted to HRT and pharmacological agent.

Conclusion

Management of self-perpetuated habitual mucosal lesion requires identifying the precipitating factor by evaluating thorough history, examination, mental health status assessment. The treatment of such lesions include pharmacological approach, reversal of habit, patient reassurance and compliance.

References


2. Morsicatio buccarum. Link: https://goo.gl/r9bnMi


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