EFFICACY OF TOPICAL RETIONIC ACID COMPARED WITH TOPICAL CLOBETASOL 17-PROPIONATE IN THE TREATMENT OF ORAL LICHEN PLANUS

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ABSTRACT

Oral lichen planus (OLP) is a common chronic mucocutaneous disease. The prevalence of OLP is 1.9% in the general population. Erosive form usually cause symptoms of pain and discomfort. The most frequently described therapy for OLP has been the administration of topical or systemic corticosteriods.

The purpose of this study was to compare the efficacy of retnoic acid in an orabase 0.05% with clobetasol 17-propionate in an orabase .5% in the treatment of erosive lichen planus.

This study was done on 45 patients with oral lesions, they were divided into 3 groups. Group (A) treated by clobetasol-17 propionate in an orabase. Group (B) treated by mixture of clobetasol and retionic acid in an orabase, and group (C) treated by retionic acid in an orabase. Every patient took a container containing his treatment medication and came every 5 days for 30 days for follow up and recorded his clinical healing stages degree of pain according to the clinical parameters.

The results showed that the best and rapid period of healing was with group (B) (the mixture of clobetasol and retionic acid) and also the treatment with retionic acid showed good results so retionic acid with orabase can be used in cases where corticosteroid is contraindicated so it is better to use the mixture of clobetasol-17 propionate and retionic acid in an orabase within the treatment of oral lichen planus.

INTRODUCTION

Oral lichen planus, is a chronic mucocutaneous disease that is relatively common.[1] The prevalence of OLP is 1.9% in the general population.[2] Although many patient are asymptomatic and require no therapy, those who exhibit atrophic and erosive lesions are of a challenge to treatment.[3] All therapies are palliative and none is universally effective.

Currently employed treatment modalities include corticosteriod administrated topically intralesionally, or systematically.[4] Alternative therapies include topical and systematic retinoids griseofluvin, cyclosporine and surgery.[5,6] Controversy concerning the efficacy of all these treatment suggests that oral lichen planus is a heterogeneous disorder. Eliminatng lichenoid drug eruptions candidiasis, trauma contact mucositis and emotional stress may play a role in the management of these patients.[7]

An immunological base has been suggested for lichen planus, because epithelium in lesional sites has an increased amounts of immune-associated antigens[8,9] while there is a dense band like cellular infiltrate predominantly of activated lymphocytes in the underlying lamina propia.[10] In addition, lichen planus may occasionally be associated with autoimmune disorders and one group of workers has shown that patients with lichen planus have circulating autoantibodies to be a putative LP specific antigen,[11] LP may also be a feature of a graft-versus-host disease.[12]

The most frequently described therapy for OLP has been the administration of topical or systemic corticosteroids. The efficacy of corticosteroids on OLP is mainly attributed to the local anti inflammatory effect and the anti-immunologic properties of suppressing t-cells function.[13] The use of systemic corticosteroids is limited by their toxicity. Therefore potent topical corticosteroids are becoming increasingly useful in the treatment