Oral medicine sheet #9

Last time we talk about liver diseases, metabolism and excretion, storage of vitamins and glycogen, synthesis of growth factors,hormons..

\*patient with chronic liver diseases have 3 main characteristics:

1-impaired drug metabolism

2-bleeding tendency

3-infection transmission

\*GI diseases

They are common ,some of them are important for dental aspect like: gastroesophagial reflux disease ,peptic ulcer, inflammatory bowel disease(crohn's disease+ulcerative colitis),celiac disease and psodomembranous colitis.

#gastroesophageal reflux disease GORD# الارتداد المريئي

Very commom, what happens is apostatizing (ارتداد ) of gastric contents to the esophagus. Mucosa inside the esophagus is columnar ,when it irritated with acid metaplasia happen and cells turn from columnar to squamous,this condition is called "barret'esophagus" which is potentially malignant(patient is at risk of esophageal cancer).

The problem is in gastric sphincter which become loose so gastric content apostatize to the esophagus.

\*risk factors:

Smoking, alcoholism, obesity, stress.

\*signs and symptomps:

#stomach pain is the main one

Others:

-Nausea, dysphagia

-symptoms resembles that of angina like chest pain specially after heavy meal and chronic cough; sometimes all examinations are done to the patient and they found the cause is irritation to the larynx from stomach acid (there is no allergy but the cause is chronic gastro esophageal reflux disease.

\*diagnosis:

-It is easy based on signs and symptoms

-endoscopy is done to the patient to insure that the mucosa is healthy in esophagus.

-PH test to know if patient has helicobacter pylori or not.

\*management:

The most important thing is changing life style of the patient specially obese patient.

Drugs: antacids, proton pump inhibitor and antihistamines

\*dental aspect:

-Erosion at palatal surface of upper anterior teeth or at occlusal surface of lower teeth without the precense of broxism or clenching.

-xserostomia;side effect of drugs used( not from the GORD) like antihistamins, antiacids, proton pump inhibitors.

-palatal erethema; because of irritation of acid.

-there is drug interaction with antifungal; if we want to give the patient systemic antifungal "fluconazol" and the patient is taking cimitidin(antihistamine) then ther is possibility of drug interaction and toxicity from fluconazol.

#peptic ulcer

Common

2types: -either in stomach (gastric ulcer)

-or in deudenum (deudenal ulcer)

\*causes

- in 3/4 of patients H.pylori

-other causes:-stress ,drugs, (steroids)

-hyperparathyroidism

-chronic renal failure;lead to secondary hyperparathyroidism-->Ca++ increase;and Ca++ lead to peptic ulcer.

\*clinical features

-the Classical feature is epigastric pain

-digestion problem

--sometimes no symptoms present but anemia present; chronic heamorrage leads to anemia ..in elderly males and females.

# usually if young female has anemia it is not significant, but if old female or a male of 40years has anemia then the most common cause is GI heamorrage.

\*diagnosis

-Endoscopy, clinical findings

-test H-pylori

-CBC; to insure there is no anemia

same drugs like GORD

\*dental aspect

-xserostomia

-erosion;because peptic ulcer is associated with reflux disease.

-signs of anemia inside oral cavity like: atrophic tongue, burning sensation, angular chelitis, candidal infection.... These signs and symptoms you have to ask your patient about it because he may not tell you!

\*\*NSAIDS -->contraindicated in ptn. With peptic ulcer.

Drug interactions in antibiotics:tetracyclin /erethromycin with antiacids.

\*\*amoxicyline don't have any interaction with peptic ulcer drugs.

#Crohn'sdisease

Chronic granulomatous inflammatory disease/an other name.

Chronic inflammation with formation of granulomas.

Granuloma-->aggregation of multinucleated giant cells (macrophages), present in crohn's disease,TB,sarcoidosis...(all these diseases are granulomatous inflammatory diseases.

\*mostly it affects large intestin mostly illeum and secum..sometimes it is called regional illeuitis.

\*clinical features:

-Abdominal pain, malaise, weakness, fever, diarrhea, vomiting,

-Symptoms associated with malabsorption; important because malabsorption has oral manifestation specially anemia.

\*crohn's disease affect any part of the GI and oral cavity is the first part of the GI so there are specific manifistations and there are patients have crohn's disease limited to the oral cavity, called oral crohn's disease.

\*diagnosis

-Cinical findings which are non specific symptoms; ptn. Has abdiminal pain, vomitting, diarrhia

Malabsorption ;so they have folic acid,iron,B12 defficiency

-endoscopy,biopsy-->chronic inflammation+granuloma+macrophages

\*management

Its important for us, because ptn. Treated with immune suppresant (steroids)..this affect us if we want to extract a tooth or do complex procedure.

-new drugs(immunosuppressant like biological agents).

-nutritiinal support

-surgical removal of the part that has the chronic inflammation.

#so when treating ptn.with crohn's disease we must be attentive about steroids, ptn.is immune compromized and

Need prophylactic antibiotics and because he takes many drugs, he might has secondary hepatotoxicity or liver damage.

\*NSAIDS are contraindicated in these patients.

-and if patient has done resection in bowel he may has bleeding tendency, why?

Because the intestin has bacteria responsible for absorption of vitamin K, and after surgical resection of the bowel the absorption will decrrase and this lead to increase in bleading tendency.

\*note; not all patients have all these manifistationns.

\*oral manifestations

-swelling of lips-->recurrent, without known cause

-mucosal tags

-fissuring to mucosa

#ulcerative colitis

-also it is chronic inflammatory bowel disease (but without granuloma).

-risk of cancer

\*signs and symptoms:

-abdominal pain,vomitting,bleeding

-symptoms related to anemia or malabsorption

\*diagnosis

Same as crohn's disease-->biopsy and endoscopy

And the same mamagement.

\*Differences

Ulcerative colitis occures in colon, there is chronic inflammation without granulomaand less common oral manifestations;include:ophthus like ulcer(as aresult of malabsorption, angular chelitis, candidal infections, glossitis and biostomatitis vigitans (rare).

While in crohn's it affect illeum and secum,its granulomatous infection, more common oral manifestations and more specific.

\*any chronic inflammation is considered a risk factor of cancer if not treated.

\*peptic ulcer if not treated may lead to cancer..the same applied in barriet esophagus.

#coeliac disease "حساسية القمح

common;many people have the disease but not yet diagnosed with the disease they just eat "الخبز الاسمر

Which is made from corns not wheat.

\*cause:

Gluteni ntolerance, patients have sensitivity to one of the components of wheat, this lead to atrophy of the intestine and patient will have malabsorption.

\*\*usuallydiagnosedat childhood; child has signs of malnutrition although he has good nutrition.. after examination, ceoliac disease is found.

-clinical features like other GI diseases are non specific (abdominal pain, malabsorption, nausea, vomiting..)

-some patients have skin rash called “ dermatitis herpetiformis”.

\*diagnosis

-clinical features

-endoscopy

-IGA antibody??( not sure), there is specific antibodies in celiac disease like antiendomesial antibody and others.

\*treatment

There is no treatment for this disease; patient must has gluten free diet and nutritional support.

\*oral manifestations

-ophthus like ulcer

-enamel hypoplasia🡪 malabsorption at young age.

-glossitis

\*dental treatment is not complicated exept if he has anemia.

\*\*intolerance: kind of allergy but limited to specific place, when the patient take wheat he will not has signs of typical allergy( skin rash, itching..) but here atrophy to the mucosa happen.

#psedomembranous colitis

-side effect of antibiotics

-kind of colitis (patient has diarrhea)

-caused by bacteria( clusredium difficle)

-mainly affect elderly and hospitalized but may affect younger ages also.

\* most common cause is using braod spectrum antibiotics.

All braod spectrum antibiotics could may cause psedomembranous colitis but the most popular one is clindamycin although others like amoxicillin and tetracyclin may cause it.

\*\*Q. when does psedomembranous colitis happen; if patient take the drug orally or IV??

It happens in both but in which it occure more?ابحثوا عنها

\*signs and symptoms

-watery diarrhea

-bloody diarrhea

-fever

-abdominal pain

\*if a patient has fever,swelling…and he take broad spectrum antibiotic then after 4 days he come back with diarrhea, bdominal pain… that’s mean he has psedomembranous colitis, you must stop the antibiotic use.

\*sometimes psedomembranous colitis is severspecially in elderly patient who will have dehydration.

\*diagnosis

Mainly clinical; patient has diarrhea after taking antibiotic.

-stool culture to roll out infectious causes.

-sigmoidescopy (تنظير) in chronic cases.

\*treatment

-stop antibiotics

-then management is like the management of any patient with diarrhea;( fluids/ electrolyte replacement)

-in sever cases patient is given metronidazol/ vancomycin

\*vancomycin 🡪 if given orally, will not be absorped by the body so it will work topically (it will kill the clustredium bacteria)

\*note:

Clustredia is present normally in the colon , there is certain measures (quantitative measures) to know if the precense of it is normal or if there is proliferation.. after a limit it will be pathogenic.

\*there is no oral manefistation but candidiosis may happen as aresult of using braod spectrum antibiotic.

* You should know signs and symptoms of the disease so you ease the life of your patient !the treatment will be just stopping the antibiotic.

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