

# Link between Serum Antigen and Direct Fluorescence Examination in Senior Individuals with Red and White Oral Lesions

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Our study, "Correlation of serum ANA and direct immunofluorescence studies in elderly Thai patients with red and white oral lesions," was published recently. The oral lesions in the elderly Thai patients were identified as Oral Lichen Planus (OLP) based on a histological examination and clinical evaluation [1]. Nonetheless, there are several ways to interpret their Direct Immunofluorescence (DIF) data: as OLP/Lupus Erythematosus (LE), an immune complex-mediated illness, lesions resembling Chronic Ulcerative Stomatitis (CUS), or negative results.

Our findings showed that the oral presentations of OLP and LE were clinically similar, and that it was challenging to distinguish between the two at first, especially in middle-aged or older patients who were on medication. This occurred because the patients were unable to recall the duration of their drug regimen or whether their oral lesions had appeared before to or following medication administration [2]. Consequently, the original diagnosis for such lesions was drug-induced lupus erythematosus, often known as OLP, or oral lichenoid drug reaction (OLDR). When a clinical evaluation does not yield a firm diagnosis of the lesion, serum antinuclear antibody (ANA) and DIF studies are necessary. Nonetheless, these patients who tested positive for serum ANA at the initial assessment usually had modest titers (1:80). Furthermore, in order to confirm the right diagnosis in

these cases, long-term follow-up is necessary. One patient in our oral medicine clinic had been taking the hypertension medication Atenolol for more than ten years. After five years of follow-up, her titer had considerably increased from 1:320 to 1:1,280. Her blood ANA was positive with a speckled pattern. Her serum ANA, however, continued to test positive with a cytoplasmic pattern and the same prior titer of 1:80.

Three patients that had white radiating striae surrounding the lesions on the gingival palatal mucosa and buccal mucosa, and oral symptoms resembling ulcerative/atrophic OLP, were recently found to be ANA positive with high titers (1: 1,280). These three cases—two with speckled patterns and one with centromere patterns—were compatible with OLP based on their clinical and histological diagnoses. Nevertheless, two instances had non-specific results according to the DIF interpretation of the specimens, and one case was OLP (lupus erythematosus could not be ruled out, though).

According to our oral medicine clinic's clinical experiences, the oral lesions in those recalcitrant instances frequently did not respond to any medication, even strong topical steroids or systemic steroids. Fluocinolone Acetonide (FA) 0.1% is a strong topical steroid that has been found to be useful in treating a variety of symptomatic oral mucosal illnesses. However, FA 0.1% did not demonstrate efficacy in treating oral lesions that were ANA positive and had high titers.

Consequently, it is important to closely monitor red and white oral lesions in middle-aged or older patients who have oral symptoms similar to OLP lesions and whose histological findings are comparable with OLP. This is especially important when DIF staining has a granular pattern at the basement membrane zone. This is because Systemic Lupus Erythematosus (SLE), which can impact various organs in the body, may be the origin of these lesions. Importantly, for early, accurate diagnosis and to avoid the devastating consequences of an autoimmune disease like SLE, lesion biopsy, serum ANA assessment, and DIF

evaluation should be performed annually in instances without a conclusive diagnosis. References

### References

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