Diagnosis and Treatment of Xerostomia and Related Oral Mucosal Diseases

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Xerostomia or dry mouth, is a common, but sometimes overlooked, condition that is typically associated with salivary gland hypofunction. Reduced salivary flow can cause difficulties in tasting, chewing, swallowing, and speaking; it can also increase the chance of developing dental decay, demineralization of teeth, tooth sensitivity, and/or oral infections.

There are a variety of potential causes of xerostomia, including adverse effects of medication, toxicity of chemotherapy and/or radiation therapy of the head and neck, autoimmune disease, other chronic disease, and nerve damage.

he goals of treating xerostomia include identifying the possible cause(s), relieving discomfort, and preventing complications (e.g., dental caries and periodontal infections).

Xerostomia may be alleviated by use of saliva substitutes and other palliative measures; lifestyle tips and other dental/oral health specific recommendations may help provide relief from or prevent adverse sequelae of dry mouth.

Oral candidiasis is an opportunistic infection caused by Candida albicans, and is classified into proliferative, pseudomembranous, and atrophic types. Conditions associated with the development of oral candidiasis include altered resistance to infection, impaired immune system function, and general patient weakness. Oral candidiasis can be treated well by taking appropriate antifungal drugs, but denture management is also very important for users of removable dentures.

Oral ulcers are characterized by a loss of the mucosal layer within the mouth. This loss may be acute or chronic, localized or diffuse. This is one of the most common oral problems presenting in primary care and can arise as a result of a number of disorders. Some of these relate to problems around the oropharynx but there is a wide variety of systemic disorders that can also give rise to these lesions. Oral ulceration is a common condition. These lesions can arise as a result of a vast number of disorders. The most common causes are local trauma and recurrent aphthous ulceration.

Management of RAS should be based on identification and control of the possible predisposing factors, with the exclusion of possible underlying systemic causes, and the use of a detailed clinical history along with complementary procedures such as laboratory tests, where required. Only in the case of continuous outbreaks and symptoms should drug treatment be prescribed, with the initial application of local treatments in all cases.

Profile

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