

Dermatology Digest

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FIGURE 1
Cluster of vesicles
on lower lip mucosa

Painful sores in a young boy's mouth

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›CASE

The patient was a 7-year-old boy who presented with painful sores in his mouth. Three days before presentation, the patient complained to his mother that his mouth felt extremely painful. He said the pain was worse when he ate or drank. On examination, his mother noticed multiple small ulcers all over the inside of the boy's mouth. She administered an OTC oral anesthetic spray, but this did not relieve the pain. The patient had no associated fever, chills, headache, rash, sore throat, nasal congestion, or cough. He had not been exposed to any sick contacts. No other family members had similar oral lesions. The patient had been healthy before the onset of the ulcers. He was up to date on his childhood vaccinations and had no medication allergies.

Physical examination Multiple clusters of vesicles and ulcers were seen on the child's buccal mucosa, palate, and along the upper and lower lip mucosa (see Figure 1). Mildly tender anterior cervical adenopathy was noted. No pharyngeal erythema or tonsillar enlargement was seen. The vesicles were limited to his oral mucosa. No associated rash was found on the hands or feet, and the remainder of the examination was normal.

›WHAT IS YOUR DIAGNOSIS?

- *Aphthous ulcers*
- *Herpetic stomatitis*
- *Hand-foot-and-mouth disease*

›DISCUSSION

The ulcers were clinically diagnosed as herpetic stomatitis. The ulcers had ruptured, so no cultures were obtained. Generally, herpetic stomatitis in children is caused by the herpes simplex 1 virus and is not associated with a genital disease.¹ Transmission occurs via airborne droplets and/or direct contact. The outbreak of lesions is typically sudden, starting as small vesicles that slowly enlarge to form punched-out

ulcers.² A foul-smelling odor may be noted when the vesicles rupture. Diagnosis is usually made by clinical presentation and history.

Comment Symptomatic treatment is the mainstay of therapy, but if started early, antiviral agents may be useful. Oral anti-inflammatory drugs can help reduce mucosal discomfort. Viscous lidocaine should be avoided or used very sparingly in pediatric patients because of reports of lidocaine toxicity-induced seizures in children.² The lesions can persist for 5 days to 2 weeks.

Hand-foot-and-mouth disease is caused by a coxsackievirus and is highly contagious. Symptoms begin with a prodrome of malaise, lymphadenopathy, sore throat, and low-grade fever, followed by small, painful oral vesicles. Subsequent or concomitant multiple maculopapular lesions appear on the palms and soles of the feet. The absence of the rash on the patient's hands and feet ruled out this diagnosis.

Aphthous ulcers or *canker sores* are one of the most common oral pathologies seen across all age groups. The ulcers can start as an itching or stinging sensation. An erythematous macule forms in the area and turns into an ulcer that eventually heals. Aphthous ulcers are not as widespread as herpetic stomatitis, making this diagnosis unlikely in our patient.

Treatment The patient was treated with a rinse of diphenhydramine (Benadryl) and aluminum hydroxide/magnesium hydroxide (Mylanta) suspension, 225 to 200 mg/5 mL solution, to soothe the ulcers. Ten days later, the patient had complete resolution of all lesions. **JAAPA**

Joe R. Monroe, PA-C, MPAS, department editor

REFERENCES

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