

# Oral Lesions, Ulcers and Infections

[Disclaimer](#)

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## Red Flags

Any lesion persisting for > 2 weeks, with no discernible benign cause or local reversible causative factor

## Background

### About oral lesions, ulcers and infections

- Potentially malignant lesions may arise from the lining of the oral cavity, including the tongue.
- These lesions may be white, white and red, or ulcerated.
- As it is often difficult to predict which lesions are malignant or will become malignant, biopsy is recommended.
- Early diagnosis is essential as oral cancers are often diagnosed late, after they have metastasised.

## Assessment

### Aboriginal and Torres Strait Islander care.

1. **Ask** and record if the patient identifies as being of Aboriginal or Torres Strait Islander origin. Consider the **specific cultural and spiritual needs** of each patient.

➤ If a patient or their family want to know why you are asking this question, you may reply with:

- We ask this question of everyone.
- It enables us to help you access extra services that are funded for Aboriginal and Torres Strait Islander peoples, such as support to buy medications and extra funded visits with some health care providers.
- This information helps our practice and the health care providers we refer you to, to provide culturally safe care.

For more information, see the RACGP's [Five steps towards excellent Aboriginal and Torres Strait Islander healthcare](#).

- **Advice for communicating with Aboriginal and Torres Strait Islander people**

- Encourage patients to book a longer consultation, to allow sufficient time for discussion and building trust.
- Only use traditional terminology such as "Aunty" and "Uncle" if invited to do so.
- Consider the role of factors such as gender, kinship, family ties, language barriers and socio-economic issues.
- Offer the patient:
  - the option of seeing a health professional of the same gender or if this is not possible, referral to another [service](#).
  - the option to have support person present, such as a family member, a community member, or an Elder.
  - access to funding assistance to overcome any identified or potential financial barriers e.g., ITC Funding. See [SEMPHN Aboriginal and Torres Strait Islander health](#)

➤ Acknowledge and respect how cultural, spiritual and historical beliefs and experiences impact on **decision-making**.

**Respecting Aboriginal and Torres Strait Islander people's decision-making processes**

- Aboriginal and Torres Strait Islander knowledge, values, beliefs, cultural needs, and health history may strongly inform decision-making processes about treatment and ongoing care.
- If possible and if requested by the patient, support the inclusion of cultural practices e.g., involvement of a traditional healer, or performing ceremonies.

➤ Be aware the term "survivor" may have negative connotations for historical reasons.

- Proactively explore and monitor symptoms of **pain**.  
**Considerations for assessing and managing pain in Aboriginal and Torres Strait Islander people**  
 Aboriginal and Torres Strait Islander patients may not actively report pain or other needs.
  - Offer patients the option to discuss their needs with a health professional of the same gender.
  - If available, use a pain tool that is culturally appropriate for the local community.
  - Allow sufficient time to discuss and explain the options, usage, and side-effects of pain relief in full.
  - Be aware of:
    - significant cultural practices regarding which family members can assist with providing pain relief, and how pain medication is administered.
    - fears that pain relief medicines may accelerate the passing of the patient.
  
- Understand how the concept of **family** is different for Aboriginal and Torres Strait Islander people.  
**Considerations when discussing family with Aboriginal and Torres Strait Islander people**  
 For Aboriginal and Torres Strait Islander people:
  - the concept of family is broader than being genetically related.
  - be sensitive when taking a family history, as discussing members of the stolen generation may be distressing
  - Be sensitive when referring to people who have died – check and ask permission. There may be cultural taboos in discussing Sorry Business (referring to people who have died).
  
- Be supportive and understanding if **appointments** are missed, and facilitate follow-up or rebooking.  
**Appointments for Aboriginal and Torres Strait Islander people**
  - Patients who identify as Aboriginal and Torres Strait Islander people may have complex factors e.g., family and community responsibilities, or previous experiences with mainstream medical services, that make it difficult for them to attend appointments.
  - The following supports may facilitate this process:
    - Recall and reminders
    - ITC funding
    - Referral to an Aboriginal Liaison officer, support, or health worker.
  
- Aboriginal and Torres Strait Islander people are more likely to have multiple co-morbidities that can impact treatment outcomes.
- Ensure contact details are up to date.
- If available, use **assessment tools and resources** designed specifically for Aboriginal and Torres Strait Islander people.  
**Aboriginal and Torres Strait Islander assessment tools and resources**
  - See [SCNAT-IP](#) – online tool that assesses the supportive care needs of Aboriginal and Torres Strait Islander cancer patients and their families.

## 2. Take a history and perform examination:

- Determine whether lesion or ulcer is in a high-risk oral cancer site.
  - **High-risk oral cancer sites**
    - Floor of the mouth
    - Lateral margin of the tongue
    - Tonsillar fossa and retro molar region
    - Lower lip (from sun damage)

- Examine for local adenopathy in the neck.
- If oral ulcer persistent for > 2 weeks, look carefully for **features of carcinoma** and check for **high-risk patient factors**.
  - **Features of carcinoma**
    - Ulcer or mass with raised heaped up margins, firm to palpate, with puckering or tethering to adjacent tissue
    - Fiery red lesion (erythroplasia) or red white lesion (leukoerythroplakia) has a higher transformation risk into squamous cell carcinoma (SCC) than simple leukoplakia (white patch).
    - Unexplained loose tooth or non-healing extraction socket
    - Neck mass
  - **High-risk patient factors**
    - Male aged 50 to 60 years
    - Smoker, alcohol, or betel nut exposure
    - Poor oral hygiene
    - Human papilloma virus (HPV) infection (associated with tonsil fossa and/or tongue base SCC's in non-smokers, often aged late 40 to 60 years)
    - Lower socio-economic group
    - History of prior oral SCC – 3 to 7% incidence per annum of second primary carcinoma
    - Immunocompromised
    - UV skin exposure

3. Determine the most likely cause:

- **Local trauma** – physical, chemical or thermal
  - Sharp tooth, ill-fitting denture, habitual biting, thermal burns.
  - Traumatic lesions of this type usually present as:
    - a shallow single ulcer in an otherwise well patient.
    - a white calloused lesion, if more chronic.
    - The cause should be readily apparent on history or examination.
- **Oral cancer**
  - Squamous cell carcinoma (SCC) may present as non-healing ulcer, plaques, erosions, or exophytic mass, that is present for > 2 weeks, firm to palpate with raised rolled edges, and granular floor.
  - Cervical lymphadenopathy may be present.



Oral Cancer  
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➤ **Leukoplakia**

- Oral leukoplakia is a precancerous lesion that presents as white patches or plaques on the mucous membranes that cannot be rubbed off.
- 1 to 20% of lesions will progress to carcinoma in 10 years.



White plaque is a high risk zone

Source: dozenist –

[Leukoplakia](#) CC-BY-SA-3

➤ **Drug-induced lesions**, many drugs can cause mouth ulceration:

- Cytotoxic agents e.g., methotrexate (usually non-specific and painful lesions).
- Lichenoid reactions e.g., antihypertensives, antidiabetics, NSAIDs, antimalarials.
- Local chemical burns e.g., aspirin (solitary local lesion)
- Erythema multiforme e.g., sulphonamides, barbiturates (blood encrusted lips and swelling).



Drug-induced Lesions

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➤ **Recurrent aphthous stomatitis (RAS)**

- Affects 20% of the population, typically starting in childhood and generally improving with age. Usually ovoid, yellowish floor with a red inflammatory halo.
- Clinically, three types:
  - Minor or Mikulicz – small < 4 mm diameter and last up to 2 weeks, heals without scarring. May be associated with [coeliac disease](#).
  - Major or Sutton – large > 1 cm on any site and last much longer (> 1 month), and heals with scarring.
  - Herpetiform ulcers – multiple 2 mm diameter ulcers that coalesce to form larger ones with ragged edges. May appear like herpes.



*Palatal ulceration*

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➤ **Infections**

- Oral candidiasis:
- White plaques on the palatal and buccal mucosa, with associated pain or discomfort, typically occurring in immunocompromised, elderly patients, and users of inhaled corticosteroids.
- The lesions can be brushed off.
  - Herpes simplex virus
  - Varicella Zoster virus
  - Coxsackie virus
  - HIV infection

➤ **Systemic disease**

- Leukaemia
- Lymphoma
- Gastrointestinal causes – [coeliac disease](#),
- orofacial granulomatosis,
- [inflammatory bowel disease](#)
- [Secondary syphilis](#)
- Dermatological disorders, e.g.:
  - epidermolysis bullosa
  - lichen planus
  - lupus erythematosus
  - pemphigoid
  - other vesiculobullous disorders resembling pemphigoid clinically (pemphigus, dermatitis herpetiformis, linear IgA, erythema multiforme).

## Management

1. If local cause such as burn or trauma:
  - treat with 0.2% chlorhexidine mouthwash or **warm salt water mouthwash**.
    - **Warm salt water mouthwash**
      - One-quarter teaspoon of salt in 1 cup of warm water.
      - Rinse mouth well and spit out.
      - Use full cup of mouthwash at least four times a day
  - remove the cause e.g., ill-fitting denture, then review to ensure improvement.
2. If oral ulcer persistent for > 2 weeks, and suspicious features of [carcinoma](#) or [high-risk patient factors](#), contact the relevant services to arrange an appointment within 2 weeks for either an [urgent ENT assessment](#) or [urgent oral and maxillofacial surgical assessment](#) for biopsy.
3. If caused by drugs, consider stopping or changing the drug and treating with 0.2% chlorhexidine mouthwash, or combined anaesthetic and antiseptic mouthwash.
4. If recurrent aphthous stomatitis (RAS), consider and treat any **underlying causes**. Treat with:
  - Kenalog in Orabase applied with cotton tip.
  - 0.2% chlorhexidine mouthwash, or if topical analgesia required, consider topical anaesthetic mouthwash e.g., Cepacaine.
  - **Underlying causes**
    - Stress
    - Menstruation
    - Food allergy e.g., chocolate, cinnamon
    - Nutritional deficiencies e.g., vitamin B, iron, and folic acid
    - [Coeliac Disease](#)
    - [Inflammatory Bowel Disease](#)
    - [Behcet's disease](#)
    - Immunodeficiencies e.g., HIV and cyclic neutropenia
5. If candidiasis is suspected, take a swab and commence amphotericin lozenges for 7 days, or nystatin drops, and ensure dentures are being washed and sterilised at night.
6. If systemic disease suspected:
  - consider medical investigation and/or refer to relevant specialty.
  - treat symptomatically e.g., 0.2 % chlorhexidine mouthwash and/or Cepacaine mouthwash.
7. If patient identifies as Aboriginal or Torres Strait Islander, understand their **specific cultural and spiritual needs** when discussing and delivering treatment options.
  - Offer referral to culturally appropriate social and emotional wellbeing [services](#).
  - Consider including an [expert](#) in the multidisciplinary team, to provide culturally appropriate care to Aboriginal and Torres Strait Islander people.
  - Provide culturally appropriate information or resources about the signs and symptoms of recurrent disease, secondary prevention, and healthy living.

## Referral

- If oral ulcer persistent for > 2 weeks, and suspicious features of [carcinoma](#) or [high-risk patient factors](#), contact the relevant services to arrange an appointment within 2 weeks for either an [urgent ENT assessment](#) or [urgent oral and maxillofacial surgical assessment](#) for biopsy.
- If a traumatic ulcer fails to respond to conservative measures, arrange [urgent](#) or routine dental referral.
- If systemic disease suspected and specialist help is required, refer to relevant specialty.
- If Aboriginal or Torres Strait Islander patient, offer referral to [specific Indigenous services](#). For all referrals, to both mainstream and Indigenous services, ensure Indigenous status is clearly marked on the referral.
  - For hospital referrals, consider engaging support from the [Aboriginal Hospital Liaison Officers](#).
  - For community referrals, consider referral to an Aboriginal Community Controlled Health [service](#).
  - For care coordination, support and advocacy throughout treatment, consider referral to [Care Coordination and Supplementary Services \(CCSS\)](#).

## Information

### For health professionals

BMJ Learning – [Mouth Ulcers: A Guide to Diagnosis and Management](#) (registration required)

Cancer Council:

- [Optimal Care Pathway for People with Head and Neck Cancers: Quick Reference Guide](#)
- [Optimal Care Pathway for Aboriginal and Torres Strait Islander People with Cancer: Quick Reference Guide](#)

### For patients

- Better Health channel – [Mouth Ulcers](#)
- Cancer Council:
  - [Checking for Cancer: What to Expect](#)
  - [Head and Neck Cancer](#)
- Cancer Council Victoria – [Aboriginal Communities: Information](#)
- DermNet NZ – [Aphthous Ulcer](#)
- HealthInfo – [Reducing Your Risk of Mouth and Throat Cancer](#)
- National Indigenous Cancer Network – [About Cancer](#)

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