

Nursing Management of patient with disorders of digestive system



Disorders of oral cavity



CHEILITIS

- Cheilitis is a medical condition that results in an inflammation of the lips marked by one or more of these symptoms: redness, swelling, dryness, and cracks. Commonly known as simply chapped lips, cheilitis can be a side-effect of certain medications, including phenone lithium, and chemotherapy. High doses of vitamin A can also be a cause. This is a medical condition involving inflammation of the lip. It is associated with many conditions including megaloblastic anemia from vitamin B deficiency, iron deficiency anemia and oral candidiasis. It can also be a symptom of allergies, such as allergy to Balsam of Peru. Cheilitis can also be caused by taking the (retinoid) drug Isotretinoin (brand name Accutane). It may also be a pre-malignant lesion for squamous cell carcinoma.
- 1 CHEILITIS EXFOLIATIVA
- Cheilitis exfoliativa is an inflammatory condition of the lips, in which they may be covered with crusts. Exfoliative cheilitis presents with continuous peeling of the vermilion (outer) part of the lips. It may affect just one lip, usually the lower. The lip may look normal or red before the formation of the thickened surface layer. The peeling appears to be cyclical and proceeds at different rates in different sites, so there is always some part of the lip peeling at any time. There may be associated bleeding resulting in formation of a haemorrhagic crust. When both lips are involved, the lower lip is usually more affected than the upper.
- CLINICAL FEATURES OF EXFOLIATIVE CHEILITIS
- The condition may be painful, causing difficulty in eating and speaking. Other symptoms include sensations of tingling, itch and dryness. Ulceration or fissuring may occur.



*Depression and personality disorders have been reported commonly in association with exfoliative cheilitis. However the cheilitis (bent can be of such unpleasant appearance that the patient avoids social situations, contributing to mood disturbance. The typical of exfoliative cheilitis is chronic over years. It may fluctuate, worsening with further stress. Spontaneous improvement has been reported, but it often recurs

*DIAGNOSIS OF EXFOLIATIVE CHEILITIS

*As exfoliative cheilitis can look similar to other conditions, tests are required to exclude these other conditions. Swabs for infections including candida and a biopsy should be done. Exfoliative cheilitis is a diagnosis of exclusion and there is no specific diagnostic test for it. A careful psychiatric assessment can be especially helpful as treatment of an associated mood or anxiety disorder has been reported to also improve the cheilitis

*TREATMENT OF EXFOLIATIVE CHEILITIS

*Unless a predisposing or associated condition can be identified and treated, exfoliative cheilitis is typically resistant to treatment. Unsuccessful use of keratolytic lip balms, sunscreen, antifungal creams, topical steroids, systemic steroids, antibiotics, and cryotherapy have been described. There has been one report each of the successful use of topical tacrolimus and Calendula officinalis (marigold) ointment.

*In the setting of immunosuppression such as AIDS, antifungal treatment can be helpful if Candida species are identified on swabs from the lip. Treatment of an associated mood or anxiety disorder has been reported to improve the cheilitis. Obsessive-compulsive disorders respond best to selective-serotonin reuptake inhibitors, compared to factitious conditions. Anti-depressants have been reported to help but not clear the cheilitis

*2. ALLERGIC CONTACT CHEILITIS

*Allergic contact cheilitis is a condition of the lips characterized by a dryness, fissuring

*edema, and crusting. Allergic contact cheilitis is allergic contact dermatitis affecting the

*lips). It is due to a type IV hypersensitivity reaction following contact with an allergen and

*usually presents as an eczema-like inflammation of the outer lip or vermilion margin

*CAUSES AND RISK FACTORS

*Allergic contact cheilitis is a common cause of lip inflammation and is more common than contact stomatitis, despite considerable overlap in allergen sources. Approximately one quarter of cases of chronic eczematous cheilitis is due to allergic contact.

*Allergic contact cheilitis is more common in women than men. It can affect all age groups, but adults are more commonly affected than children. However the allergens involved vary in different age groups. These differences reflect the usage patterns of the different age groups and sexes. Lip cosmetics are the most common allergen source in women, and toothpastes in men. Medications are an important source of allergic contact cheilitis reactions in the elderly. Dental materials and oral hygiene products cause cheilitis in all age groups. Reactions to food mainly affect children. Patients are often also atopic.

*Major sources of allergens causing contact cheilitis include

*Lipsticks and other lip cosmetics including sunscreens. Toothpaste and other dental care products (mouthwash, denture cleaner, dental floss,



*toothpicks)

*Metals dental restorations, orthodontic devices, musical instruments, metal casings of lip cosmetics, habitual sucking of metal objects

*Food

*Medications Nail varnishes

*- Rubber/latex gloves

*Common allergen groups that cause contact cheilitis include: -Metals such as nickel

*Fragrance/Flavourings

*• Preservatives

*CLINICAL MANIFESTATIONS

*Allergic contact cheilitis usually presents as eczema-like changes on the vermilion margin or skin around the mouth. One or both lips may be red with dryness, scaling and cracking. The changes may be quite localised or affect the whole lip. Involvement of the angles of the mouth may also be seen (angular-cheilitis). The pattern of the reaction may give some clue as to the cause, for example allergy to a musical instrument will develop changes only in that part of the lip in contact with the instrument. Allergic contact cheilitis rarely affects the inner mucosal aspect of the lip..

*The patient may report associated itch, burning or pain of the lips. Pigmented allergic contact cheilitis is an uncommon variant and presents with pigmentation of the lip which persists after resolution of the eczema. Clinical examination should include, in addition to the lips, the inside of the mouth and general skin. Atopic dermatitis is commonly associated with contact cheilitis

*DIAGNOSTIC EVALUATIONS

*Patch testing is the key to this diagnosis. Testing should include the standard series of patch test allergens as well as cosmetic and toothpaste series, and others suggested by the history. It is most important to also test the patient's own products and musical instruments if possibly relevant. Cosmetics are often applied 'as is', but sawdust from wooden instruments should be applied diluted to 10% in petrolatum. A significant number of patients react only to their own products. The relevance of positive results must be assessed, based on careful history taking and clinical examination. Multiple positive reactions are common.

*Repeated open application test (ROAT) or start-restart testing may be required for a patient's own products due to irritation under occlusion in patch testing, such as with toothpastes. Photopatch testing may also be useful when investigating cheilitis when routine patch testing is negative. Should contact urticaria of the lip be suspected then prick/scratch testing is required. It is common for patients with allergic contact dermatitis to have a second diagnosis

*such as atopic cheilitis or irritant contact cheilitis.

*TREATMENT OF ALLERGIC CONTACT CHEILITIS Avoidance of the allergen in all of its possible sources is the treatment. The reaction then



*usually settles quickly. Avoid the allergen is the best idea. Use organic makeup for lips and Use a petroleum jelly to keep the area moisturized. Corticosteroid ointments may be used. Sometimes, antihistamines are also prescribed to bring relief from the tender, swollen and itchy lips

*3. ACTINIC CHEILITIS

*Actinic cheilitis, sometimes known as "farmer's lip" or "sailor's lip," is a precancerous condition related to cumulative lifetime sun exposure. In actinic cheilitis, there is thickening which discoloration of the lip at the border of the lip and skin. The lower lip is most often affected Individuals with actinic cheilitis often complain of persistent dryness and cracking of the lips. They will frequently exhibit other effects of sun-damaged skin, such as precancerous lesions on the skin called actinic keratoses and extensive wrinkling.

*CAUSES AND RISK FACTORS

*Actinic cheilitis is significantly more common in men, the elderly and fair skinned individuals Normally the individuals who get actinic cheilitis are those individuals who are above the age of 50 and individuals who are fair skinned. This ailment is normally due to chronic and excessive exposure to ultra-violet radiations. This is the main reason why fair skinned individuals are most susceptible to this condition, as these individuals have lesser melanin. It is also most commonly seen in older fair-skinned men

*The use of tobacco is one cause as well as irritation of the lips because of chemical or physical factors such as using lip balm containing allergen. Other causes can include poor oral hygiene as well as ill-fitting dentures and prostheses seem to be responsible for further aggravating this problem. A major risk of actinic cheilitis is that it is a precancerous condition. Actinic cheilitis has a 10% chance of turning to squamous cell carcinoma or cancer of the lip. Because it has not been identified as which kind of actinic cheilitis will develop into cancer, the standard of care is to treat all lesions properly.

*CLINICAL MANIFESTATIONS

*Actinic cheilitis is located on the lips, most often the lower lip. Persistent redness, scaliness, and chapping are among the symptoms noted. Erosions and cracks (fissures) may be present

*as well

*TREATMENT OF ACTINIC CHEILITIS

*Treatment of actinic cheilitis includes the use of chemotherapeutic agent (5-fluorouracil) or a topical immunomodulator (imiquimod) may be prescribed. This medication is helpful for minor actinic cheilitis. This medication works by blocking DNA synthesis. Treatment with this medication normally takes up to a month to yield any type of results which are visible. Initially with treatment there will be inflammation with redness, erosion and burning of lesions. Approximately 50% of individuals do respond well to this management and are reported to have gone into total remission.

*In severe cases without evidence of malignancy, a lip shave procedure (vermilionectomy) may be performed. In less extreme cases, physician may recommend destruction (ablation) of the damaged cells with a carbon dioxide (CO) laser. Alternative treatments include the use of electric current to destroy the precancerous cells (electrodesiccation) and a facial sanding technique (dermabrasion).



*Cheilitis glandularis is a conditions characterized by swelling and eversion of the lower lip. It is an uncommon skin condition which affects the lips, and sometimes the face. It consists of a lumpy-feeling swelling of the lips, and in some cases other areas of the face. Cheilitis glandularis is an acquired disorder, of unknown aetiology, characterized by swelling, ulceration, crusting, mucous gland hyperplasia, abscesses, and sinus tracts.

*CAUSES AND RISK FACTORS

*Granulomatous cheilitis occurs in conjunction with other conditions, such as allergies, Crohn disease, and Sarcoidosis. In rare cases, it can occur with genetic disorders, cancers, and infections. Overall, the condition is rare and may affect any gender, age or ethnic group, and generally appears during early adulthood.

*CLINICAL MANIFESTATIONS

*Swelling begins in the upper lip, which may resolve quickly. Affected areas will feel nodular and be soft or firm to the touch. In some cases, both lips may swell, and rarely, the forehead, eyelids or even the scalp may experience swelling. Granulomatous cheilitis may be accompanied by fever, headache, lymph node enlargement, Fissured tongue, and weakness of the facial muscles

*DIAGNOSTIC EVALUATIONS

*Initial diagnosis based on skin appearance. Granulomatous cheilitis is initially diagnosed based on the appearance of the affected area. Health care professionals will then perform a Biopsy of the affected area to confirm the diagnosis and rule out the presence of other, similar appearing conditions..

*TREATMENT

*Treatment of granulomatous cheilitis is often predicated on the treatment of the associated condition. In granulomatous cheilitis caused by an allergy, it is recommended that the allergen be avoided. Additionally, treatment of other associated conditions may reduce symptoms. Several therapies have been shown to have varying effects, including topical corticosteroids, long-term antibiotic/anti-inflammatory drug courses, corticosteroid injections to the affected area, mast cell stabilizers, sulfasalazine, Clofazimine, and even

*surgical reduction of the affected area. 5. ANGULAR CHEILITIS (PERLÈCHE)

*Angular cheilitis is an inflammatory lesion at the labial commissure, or corner of the mouth, and often occurs bilaterally. The condition manifests as deep cracks or splits. In severe cases, the splits can bleed when the mouth is opened and shallow ulcers or a crust may form.

*CAUSES AND RISK FACTORS

*Usually associated with a fungal (Candidal) or bacterial (Staphylococcal) infection, those affected may also have thrush (oral candidiasis). The areas are generally slightly painful. The condition can last from days to months, depending upon whether or not the affected person seeks treatment. Angular cheilitis may affect people of all ages. Chronic pooling of saliva encourages



*fungal and bacterial growth, and patients who are immunocompromised, have undergone head and neck radiation, or have diabetes mellitus are also

prone to this condition. Patients who are predisposed to this condition also may have problems with: Iron deficiency, vitamin B12 deficiency, folate deficiency and drooping of the corners of the mouth caused by dentures that do not adequately support the facial musculature.

*CLINICAL MANIFESTATIONS Angular cheilitis can be found in the corners of the mouth. A patient with angular cheilitis may notice: Cracking and fissuring of the corners of the mouth, with redness, ulceration, drainage of pus and tissue softness and tenderness

*TREATMENT

*Treatment of angular cheilitis varies depending on the cause. For minor cases caused by bacterial infection, applying a topical antibiotic to the area for several days is sufficient to treat the infection and heal the lesions. Treatment of angular cheilitis is usually undertaken with topical antifungals such as nystatin, clotrimazole, or econazole. Combinations of a topical antifungal and a topical steroid-such as Mycostatin and triamcinolone or iodoquinol and hydrocortisone - may also be prescribed. In persistent cases, oral antifungals may be used to treat the condition.

*Certain cases are caused by malabsorption syndrome. This is ameliorated by B-12 shots, or especially by the entire B complex shots. The amount given and the frequency of shots is determined by the severity of the lesions and the history of the response once healing is achieved.

*6. PLASMA CELL CHEILITIS

*Plasma cell cheilitis is a condition characterized by a sharply outlined, infiltrated, dark red plaque with a lacquer-like glazing of the surface of the involved oral area. It is histologically

characterized by plasma cell infiltrates into the mucosa.

*Plasma cell cheilitis is sometimes resistant to conventional topical corticosteroid therapy.

*Other choices include oral griseofulvin, topical cyclosporine, and intralesional corticosteroid

injection, all of which occasionally fail to produce satisfactory result.



Gingivitis

- Gingivitis is inflammation of the gums (gingiva). Gingivitis is the mildest form of periodontal disease. Periodontal disease: involves inflammation and infection that destroys the tissues that support the teeth, including the gums, the periodontal ligaments, and the tooth sockets (alveolar bone). It causes the gums to become red, swollen, and bleed easily. There is usually little or no discomfort at this stage
Gingivitis is often caused by inadequate oral hygiene.
- CAUSES AND RISK FACTORS
- Gingivitis is due to the long-term effects of plaque deposits. Plaque is a sticky material made of bacteria, mucus, and food debris that develops on the exposed parts of the teeth. It is a major cause of tooth decay If you do not remove plaque, it turns into a hard deposit called tartar that becomes trapped at the base of the tooth. Plaque and tartar irritate and inflame the gums. Bacteria and the
- toxins they produce cause the gums to become infected, swollen, and tender. Injury to the gums from any cause, including overly vigorous brushing or flossing of the teeth, can cause gingivitis. The following raise risk for developing gingivitis:
General illness,
- poor dental hygiene, pregnancy (hormonal changes increase the sensitivity of the gums),



*smoking and uncontrolled diabetes. Misaligned teeth, rough edges of fillings, and ill-fitting or unclean mouth appliances (such as braces, dentures, bridges, and crowns) can irritate the gums and increase the risk of gingivitis. Medications such as phenytoin, calcium channel blockers and birth control pills, and heavy metals such as lead and bismuth are also associated with gingivitis. Family history of dental disease can be a contributing factor for the development of gingivitis.

*TYPES OF GINGIVITIS

*1. Chronic Gingivitis: Chronic gingivitis is the more common type of gingivitis and is closely linked to inadequate oral hygiene. In most cases, a person is unaware that they have chronic gingivitis and do not seek medical treatment until the symptoms become pronounced. Slight bleeding and mild swelling of the gums are the first signs and symptoms. If attended to in the early stages, gingivitis may be totally reversible with simple measures such as brushing, flossing and

*cleaning.

*2. Acute Necrotizing Ulcerative

*Gingivitis (ANUG): The other

*form of gingivitis is known as

*acute necrotizing ulcerative

*gingivitis (ANUG), Vincent's stomatitis, or trench mouth. It is rarely seen these days. ANUG is more likely to develop in a person with an impaired immune system or in those with severe malnutrition. This is a more acute and invasive form of gingivitis which may cause foul smelling breath (halitosis), fever and painful gums in addition to other symptoms. ANUG may develop in people with a history of gingivitis who experience a stressful event and is more common in smokers than in non-smokers.

*PATHOPHYSIOLOGY

*The most common type of gingivitis involves the marginal gingiva and is brought on by the accumulation of microbial plaques in persons with inadequate oral hygiene. Gingivitis proceeds through an initial stage to produce early lesions, which then progress to advanced disease.

*The initial stage of an acute exudative inflammatory response begins within 4 or 5 days of plaque accumulation. Both gingival fluid and transmigration of neutrophils increase. Deposition of fibrin and destruction of collagen can be noted in the initial stage. At approximately 1 week, transition to early lesions is marked by the change to predominately lymphocytic infiltrates. Monocytes and plasma cells also may be present. With time, lesions become chronic and are characterized by the presence of plasma cells and B lymphocytes. As chronic local inflammation progresses, pockets develop where the gingiva separates



*from the tooth. These pockets deepen and may bleed during tooth brushing, flossing, and even normal chewing. As this persistent inflammation continues, periodontal ligaments break down and destruction of the local alveolar bone occurs. Teeth loosen and eventually fall out.

*CLINICAL MANIFESTATIONS

*Gum disease may progress painlessly, producing few obvious signs, even in the late stages

*of the disease. Although the symptoms of periodontal disease often are subtle, the condition

*is not entirely without warning signs. The symptoms of gum disease include Bleeding gums (blood on toothbrush even with gentle brushing of the teeth)

*Bright red or red-purple appearance to gums Gums that are tender when touched, but otherwise painless

*Mouth sores

*Swollen gums and shiny appearance to gums

* Fever Halitosis (Bad breath)

*Marked gingival edema

*Ulceration

*DIAGNOSTIC EVALUATIONS

*The dentist will examine mouth and teeth and look for soft, swollen, red-purple gums. Deposits of plaque and tartar may be seen at the base of the teeth. The gums are usually painless or mildly tender. No further testing is usually necessary, although dental x-rays and dental bone measurements may be done to determine whether the inflammation has spread to the supporting structures of the teeth.

*TREATMENT

*Prompt treatment can usually reverse symptoms of gingivitis and prevent its progression to more serious gum disease and tooth loss. Effective treatment requires professional care followed by stepped up oral hygiene at home. The goal is to reduce inflammation. The teeth are cleaned thoroughly by the dentist or dental hygienist. This may involve various instruments or devices to loosen and remove deposits from the teeth.

*Careful oral hygiene is necessary after professional tooth cleaning. In chronic gingivitis, brushing with a fluoride dentifrice will slow disease progression and may help resolution. Most electric toothbrushes have additional benefit over manual brushing. Daily flossing in addition to brushing will reduce plaque and bacterial counts. A saline solution can be gargled with once a day to improve mouth's health. The saline solution is simply warm water mixed with a bit of salt. Saling rinses can help to speed resolution, and oral rinses with a hydrogen peroxide 3% solution also may be of benefit.

*Medical treatment involves antibiotics, NSAIDs, and topical Xylocaine for pain relief. Antibacterial mouth rinses or other aids may be recommended in addition to frequent, careful, tooth brushing and flossing. Repair of misaligned teeth or replacement of dental and orthodontic appliances may be recommended. Any other related illnesses or conditions should be treated.



•PREVENTION

- Good oral hygiene is the best prevention against, gingivitis because it removes the plaque that causes the disorder. The teeth should be brushed at least twice daily and flossed gently at least once per day. For people who are prone to gingivitis, brushing and flossing may be recommended after every meal and at bedtime. Consult the dentist or dental hygienist for Instructions on proper brushing and flossing techniques.
- Special appliances or tools may be recommended by the dentist for use by people who are particularly prone to plaque deposits. The use of supplements does not replace thorough brushing and flossing. Appliances and tools may include special toothpicks, toothbrushes, water irrigation, or other devices. Antiplaque or antitartar toothpastes or mouth rinses may be recommended by the dentist or dental hygienist. Regular professional tooth cleaning is important to remove plaque that may develop even with careful brushing and flossing. Many dentists recommend having the teeth professionally cleaned at least every 6 months.
- Proper nutrition helps immune system fight infection. Eating foods with antioxidant properties, for example, those containing vitamin E or vitamin C (vitamin E-containing foods include vegetable oils, nuts, green leafy vegetables; vitamin C-containing foods include citrus fruits, broccoli and potatoes) can help your body repair damaged tissue. Avoid clenching and grinding teeth. These actions may put excess force on the supporting tissues of the teeth and could increase the rate at which these tissues are destroyed.



SIALADENITIS

- Sialadenitis or salivary glands infection, which commonly affects the parotid glands and the submandibular glands, is due to hyposecretion or obstruction of the ducts but may also develop without any obvious cause. Most of the times, it is caused by a bacteria or virus (mumps) Individuals in their 50's to 60's, with Sjögren's syndrome, chronically ill individuals having xerostomia, teenagers, those with anorexia, poor oral hygiene and those who have undergone radiation of the mouth are the ones commonly affected. Bacterial sialadenitis is usually brought on by *Staphylococcus aureus* but may also be caused by other microorganisms including coliforms, streptococci or several anaerobic bacteria.



*TYPES OF SIALADENITIS

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*There are chronic and acute forms. Acute sialadenitis is uncommon and usually affects the parotid glands

*A. Chronic Sialadenitis: Chronic sialadenitis is a recurrent salivary glands inflammation. Reduction of the salivary flow involving stasis is the key factor to this type of sialadenitis. The obstruction of the ducts is most often caused by salivary calculi (salivary duct stone). The condition may also occur following a previous episode of acute sialadenitis especially if it had suppurative inflammation that led to glandular destruction. Recurrent parotitis may also be another possible causative factor for this condition. The chronic inflammatory process causes the alteration of the saliva's chemistry which leads to sialectasis, acinar atrophy and ductal ectasia with lymphocyte infiltrates.)

*B. Submandibular Sialadenitis: Submandibular sialadenitis (submandibular gland swelling) is the inflammation of the glands that produces saliva located underneath the mouth's floor. It comes in acute and chronic forms. Acute infection is mostly due to bacterial infection while chronic forms are related to formation of calculi and diminished saliva related to several causes. To assess this gland, the doctor's primary diagnostic tool is the ultrasound since it is safe, economical and accurate.

*C. Parotid Gland Infection: This condition is also known as parotid sialadenitis and is usually manifested with intermittent yet painful swelling of the parotids. Acute conditions are usually caused by an infiltration of the *Staphylococcus aureus*. They may also be due to microorganisms that cause tuberculosis and would lead to suppurative parotitis. Sometimes other medical conditions may also cause swelling of the parotids (parotitis) and these would include diabetes, eating disorders such as bulimia and anorexia, AIDS and alcoholism. Chronic parotid gland infection may be due to Sjogren's syndrome, an autoimmune disease, characterized by parchedness of mouth, dry eyes, nose and face.

*CLINICAL MANIFESTATIONS

*Common manifestations of this disease condition include chills, fever, unilateral inflammation and pain (below the ear or jaw). Affected gland is diffusely tender and firm and erythematic, its overlying skin may exhibit edema. Focal enlargement may be a sign of abscess and pus should be squeezed out from the salivary duct and cultured to determine causative organism. Other not so common symptoms would include inflammation of the oral cavity, difficulty in swallowing, neck and mouth pain, nausea, vomiting and dental pain.

*TREATMENT

*Initial treatment would be the use of antibiotics against the causative microorganism. If the inflammation is caused by *Staphylococcus aureus*, dicloxacillin 250mg (first generation cephalosporin) four times a day or clindamycin may be taken but this can be modified based on the results of the culture and sensitivity test results. However, with an increasing incident of Staphylococcus aureus resistant bacteria especially with the elderly in nursing homes, the need for vancomycin may be necessary. Local measures such as hydration, warm compress, sialagogues (substances that generate production and flow of saliva like lemon juice and hard candy), gland massage and the maintenance of good oral hygiene should be done also. If abscesses are present, then it is important to drain them. Relapsing and chronic sialadenitis may need superficial removal of the parotid glands or excision of the submandibular gland.



Thank you 



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