

Oral Medicine 2 — Salivary Glands, White & Red Lesions, Oral Ulceration

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EXAM-DAY SUMMARY

everything on this page → detail in §§ overleaf

SG ANATOMY & OUTPUT → §1

- 3 pairs major + 800–1000 minor (esp. palate)
- Output: submandibular 70% · parotid 25% · sublingual 3–4%
- Parotid serous; all others mainly mucous
- 1000–1500 ml/day, peak at meals

DISORDER CLASSES → §2

- 1 Developmental: aplasia = gland · atresia = duct · aberrancy = ectopic
- 2 Enlargement: inflammatory / non-inflammatory
- 3 Cysts · 4 Tumours · 5 Dysfunction

MUCOCELE VS RANULA → §2

- Mucocele: lower lip, trauma, pools of mucous present
- Ranula: floor of mouth, partial duct obstruction, no pools

ENLARGED GLAND → §3

- Mumps: paramyxovirus, ~6 y, self-limiting; gonadal spread → infertility
- Bacterial: painful, red skin, purulent discharge → amoxicillin 500 mg 5–7 days, milk gland, sialogogues
- Allergic: iodine sialography; self-limiting
- Sialosis: painless, unknown cause, exclusion — alcohol · anorexia · iodine drugs

BENIGN TUMOURS → §4

- PA: most common benign, up to 90%; parotid → palate/lip; females; encapsulated, mobile, no ulceration
- Rule of 80: parotid tumours benign / are PA; PAs in parotid / superficial lobe; untreated stay benign
- Warthin's = papillary cystadenoma lymphomatosum; males; parotid tail

MALIGNANT TUMOURS → §4

- Signs: rapid growth · pain · fixation · ulceration · nerve · LNs · younger age · bone perforation
- Mucoepidermoid: low/intermediate/high grade · adenocarcinoma: palate, recurrence ~14%
- ACC: perineural invasion → facial palsy; radioresistant — no radiotherapy

XEROSTOMIA → §5

- Sialometry normal 1–3 ml/min; true xerostomia < 1 ml/min
- False = dryness/bad taste/burning, normal flow
- Causes: secretory tissue loss · innervation · systemic · radiotherapy · cognitive · aging
- Manage: preventive → symptomatic (artificial saliva) → stimulatory (pilocarpine HCl)

SJÖGREN'S → §6

- Autoimmune, exocrine glands; F : M = 9 : 1; parotid, bilateral
- Primary = dry eyes + dry mouth only; secondary adds joints (arthritis > 50%) + systemic
- Dx: dry eyes/mouth > 3 months · snowstorm sialography · Schirmer's · sialometry · focal lymphocytic sialadenitis
- Complications: sialadenitis · B-cell lymphoma · LN cancer

STONES & DROOLING → §7

- Sialolithiasis = meal-time syndrome; 80–90% submandibular — against gravity, tortuous duct, mucous
- Swells on eating → subsides; occlusal film x-ray; surgical removal
- Sialorrhoea abnormal after age 4; MS · cerebral palsy · Parkinson's

LEUKOPLAKIA → §8

- White patch, premalignant, cannot be rubbed off, diagnosis by exclusion
- Homogenous (commonest) · speckled · verrucous (rare); rougher = more dangerous
- Incisional biopsy mandatory; mild → review 6-monthly + re-biopsy; moderate/severe → excise
- Hairy: HIV, bilateral lateral tongue, corrugated vertical, no malignant potential

CANDIDIASIS → §8

- Candida albicans; can be rubbed off
- Predisposing: poor OH · xerostomia · anaemia · dentures · DM
- Miconazole X with warfarin/statin → use nystatin; systemic if immunocompromised

OTHER WHITE/RED → §8

- Geographic tongue: benign migratory glossitis, reassure only
- Fordyce's: ectopic sebaceous glands, upper lip vermillion
- MRG: midline, anterior to circumvallate papillae
- LE: butterfly rash; oral lesions discoid 15–25% · systemic 30–45%

ORAL ULCERATION → §9

- Causes: systemic (TB, syphilis) · malignant (SCC) · traumatic · RAU
- RAU affects 10–30% of population; flares on smoking cessation
- Minor 3–6 mm, ≤ 6, heals 7–10 days · Major 1–2 cm, 3–6 weeks · Herpetiform 1–2 mm crops
- Herpetiform X HSV; treat with mouthwash + topical steroids

§1 Salivary glands — structure, secretion, output

KEY POINTS

Three pairs of major glands + 800–1000 minor glands · parotid = serous, everything else mainly mucous · submandibular contributes 70% of output, parotid 25%, sublingual 3–4% · 1000–1500 ml saliva/day, peak at meal time.

- **Major salivary glands (SGs):** paired — parotid · submandibular · sublingual
 - lecture slide reads "2 pairs of" then lists three glands → slide typo, **three pairs** is correct
- **Minor SGs:** ★800–1000 glands, scattered through the oral cavity → esp. **palate**
- **Secretion types:** mucous · serous · mixed
- **Functions of saliva:** lubrication for speech + swallowing · assists taste sensation · antibacterial · digestive · cleaning
- **Volume:** ★1000–1500 ml/day → highest rate during meal time

Table 1 — The salivary glands: secretion and share of output

Gland	Secretion	Share of daily output
Parotid	Mainly serous	25%
Submandibular	Mixed, mainly mucous	70%
Sublingual	Mixed, mainly mucous	3–4%
Minor SGs	Mainly mucous	—

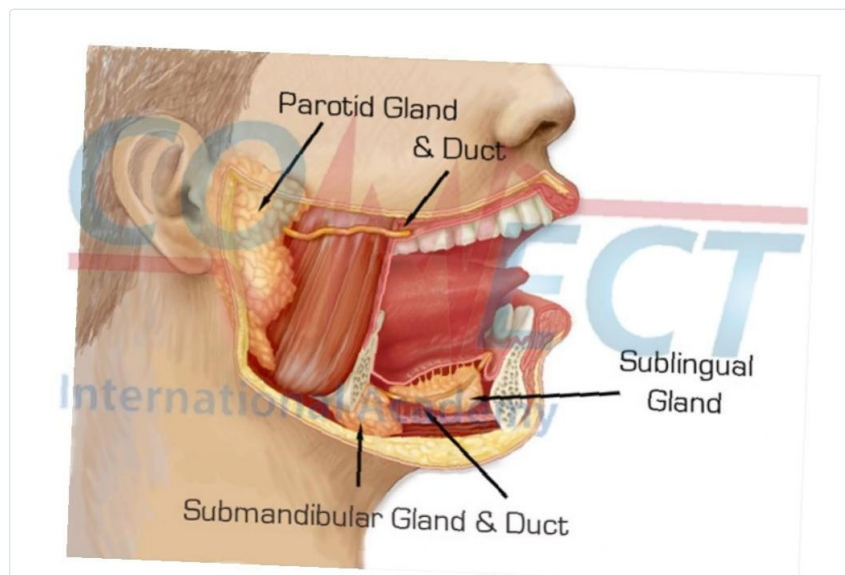


Fig. 1 — Major SGs and ducts: parotid (pre-auricular, duct opens opposite upper molars) · submandibular · sublingual (floor of mouth).

★ EXAM PEARL

Submandibular = 70% of resting output, not the parotid — the commonest single-best-answer trap in this topic, and the reason 80–90% of stones are submandibular (§7).

§2 Classifying salivary gland disorders

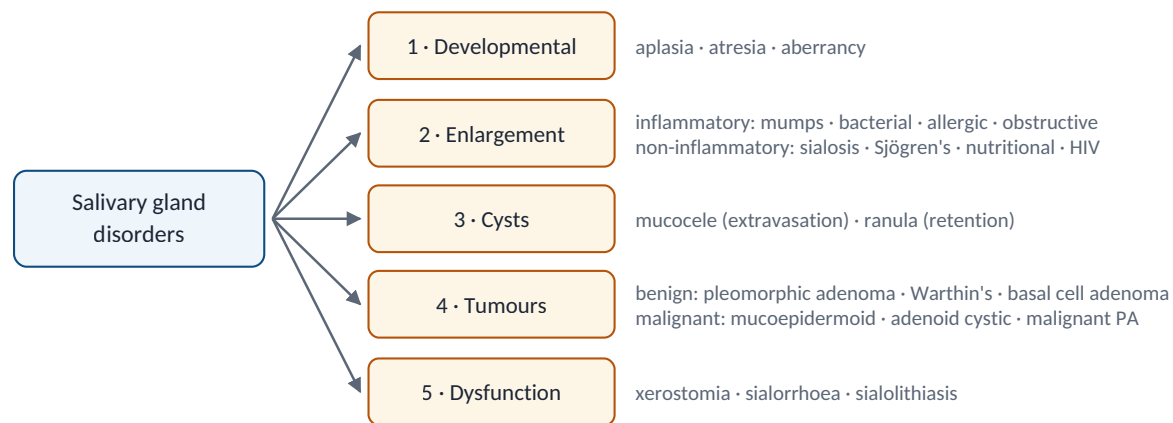


Diagram 1 — The lecture's five-group classification of salivary gland disorders; groups 2–5 are expanded in §3–§7.

2.1 Developmental

- **Aplasia**: absence of the **gland**
- **Atresia**: absence of the **duct**
- **Aberrancy**: **ectopic** gland

2.2 Cysts — mucocele and ranula

Table 2 — Mucous extravasation cyst vs mucous retention cyst

	Mucocele (extravasation)	Ranula (retention)
Usual site	Lower lip	Floor of the mouth
Mechanism	Trauma to overlying mucosa → mucous escapes outside the gland ducts	Partial duct obstruction
Pools of mucous	Present (extravasated)	Absent



Fig. 2 — Mucocele: lower-lip swelling after mucosal trauma.



Fig. 3 — Ranula: floor-of-mouth swelling, partial duct obstruction.

★ EXAM PEARL

Site + **presence of mucous pools** separate the two: lip & pools = extravasation mucocele; floor of mouth & no pools = retention ranula.

§3 Gland enlargement — inflammatory and non-inflammatory

3.1 Mumps (viral)

- **Nature:** viral inflammatory gland enlargement · unilateral **or** bilateral infection + swelling → esp. **parotid**
- **Age:** young children, ★ **around 6 years**
- **Organism:** **paramyxovirus** — lecture adds that this family also causes measles, rubella & Paget's disease (see pearl)
- **Course:** self-limiting
- **Main complication:** spread of infection to the **gonads** → patient becomes infertile



Fig. 4 — Mumps: swollen parotid gland, swelling lifting the ear lobe.

★ EXAM PEARL

Verify the lecture's virology: **measles** is a paramyxovirus, but **rubella** is a *togavirus*, and the paramyxovirus link to **Paget's disease** is an unproven hypothesis, not established causation.

3.2 Bacterial sialadenitis

- **Nature:** bacterial inflammatory gland enlargement
- **Predisposing — localised:** e.g. **calculus**
- **Predisposing — systemic:** e.g. part of **Sjögren's syndrome**
- **Clinically:** enlarged **painful** gland · sudden acute onset · redness of the covering skin
- **Pathognomonic sign:** ★ **purulent discharge from the duct orifice**
- **Untreated:** recurrent episodes if the acute phase is not treated → chronic phase → **gland fibrosis**



Fig. 5 — Bacterial sialadenitis: pus at the duct orifice on milking the gland.

- **Management:**
 - ★ **amoxicillin 500 mg for 5–7 days** · milk the gland repeatedly · increase hydration (drink more water) · sialogogues e.g. citrus lemon · control the predisposing factors · surgical excision if the damage is severe

3.3 Allergic sialadenitis

- **Predisposing:** drugs · allergens e.g. **iodine in sialography**

- **Clinically:** acute phase of gland enlargement, with or without skin rash
- **Management:** self-limiting → avoid the allergen · increase hydration

3.4 Sialosis (non-inflammatory)

- **Definition:** gland enlargement of **unknown aetiology** — painless, non-inflammatory, non-neoplastic mass → **diagnosed by exclusion**
- **Predisposed by:** anorexia nervosa · drug induced e.g. iodine-containing drugs · alcoholism
- **Management:** control the underlying factors

Table 3 — Distinguishing the enlarged gland

	Pain	Onset / course	Key feature
Mumps	Tender	Acute, self-limiting	Children ~6 y · gonadal spread
Bacterial	Painful	Sudden acute · recurrent	Purulent discharge · red skin
Allergic	Variable	Acute, self-limiting	Allergen exposure ± skin rash
Sialosis	Painless	Chronic	Alcohol · anorexia · iodine drugs
Sjögren's (S6)	Non-tender	Chronic, recurrent	Bilateral · dry eyes + dry mouth

§4 Salivary gland tumours

4.1 Pleomorphic adenoma (PA)

- **Frequency:** most common benign SG tumour — ★ **up to 90% of all benign SG tumours**
- **Site:** parotid → then minor SGs of **palate and lip** → less commonly submandibular
- **Sex:** more common in **females**
- **Presentation:** small painless nodule at the **angle of the mandible** or **beneath the ear lobe** → gradual increase in size → can reach marked size **without ulceration**
- **Histopathology:** variety of cell deformation
- **Feel:** well circumscribed · encapsulated · movable ✗ fixation to underlying tissues
- **Management:** wide surgical excision with a safety margin (accounts for possible **projections** through the capsule)
 - parotid lesions → excise the **involved lobe + the tumour**

MNEMONIC

Rule of 80 — 80% of parotid tumours are benign · 80% of parotid tumours are PA · 80% of PAs occur in the parotid · 80% of PAs are in the **superficial lobe** · 80% of untreated PAs remain benign.

4.2 Warthin's tumour

- **Full name:** **papillary cystadenoma lymphomatosum** — benign SG tumour
- **Sex:** **males** more affected
- **Site:** parotid most affected, esp. the **tail** → firm **non-tender** mass at the angle or ramus of the mandible
- **Origin:** entrapped salivary epithelial rests during development of lymph nodes (LNs)
- **Diagnosis / treatment:** biopsy to confirm → surgical excision



Fig. 6 — Parotid-region swelling (arrows), frontal and lateral views — the classic site for both PA and Warthin's tumour.

Table 4 — Pleomorphic adenoma vs Warthin's tumour

	Pleomorphic adenoma	Warthin's tumour
Sex	Females	Males
Site	Parotid → palate/lip minor SGs → submandibular	Parotid, esp. the tail
Feel	Circumscribed, encapsulated, movable	Firm, non-tender
Origin	—	Salivary epithelial rests trapped in LNs
Treatment	Wide excision + margin; parotid → lobe + tumour	Surgical excision (biopsy first)

4.3 Malignant tumours

- **Signs of malignancy:** rapid rate of growth · pain · **fixation** to underlying tissues · ulceration · **nerve involvement** · LN involvement · younger age groups · bone plate perforation

Table 5 — The three malignant salivary gland tumours

	Sites	Behaviour
Mucoepidermoid carcinoma	Minor glands of palate, buccal mucosa, tongue, retrograde areas	Low, intermediate and high grade
Adenocarcinoma	Most commonly hard and soft palate	Slow growing, asymptomatic · recurrence almost 14%
Adenoid cystic carcinoma (ACC)	Parotid lesions → facial paralysis	Local involvement with perineural invasion

- **Management:** excision with a wide safety margin, esp. in high-grade tumours · local radiotherapy **except ACC** (★ACC is resistant to radiation)
- **List discrepancy:** the classification slide names **malignant pleomorphic adenoma** as the third malignancy; the detail slide substitutes **adenocarcinoma** → know both

★ EXAM PEARL

Perineural invasion → **facial palsy** is the ACC signature, and ACC is the one tumour you do *not* irradiate. Facial nerve weakness with a parotid mass = malignant until proven otherwise.

§5 Xerostomia

KEY POINTS

Sialometry: normal 1–3 ml/min · **< 1 ml/min = true xerostomia** · false xerostomia = dryness sensation with normal flow. Manage in three tiers — preventive, symptomatic, stimulatory.

- **Measurement:** normal salivary secretion measured by **sialometry** → ranges ★1 ml/min to 3 ml/min
- **True xerostomia:** secretions ★< 1 ml/min
- **False xerostomia:** ✗ salivary hypofunction → sensation of dryness, bad taste or burning mouth

- **Patient complaints:** high caries risk — sudden increase in caries rate **esp. in rare sites** · sudden discomfort wearing a denture · increase in periodontal diseases · vague pain in all the teeth

5.1 Causes

- **1 · Loss of secretory tissue:** Sjögren's syndrome · sarcoidosis
- **2 · Disturbed secretory innervation:** neurologic disorders · xerogenic drugs
- **3 · Systemic factors:** renal disturbance · endocrine disturbance
- **4 · Radiation:** to head and neck
- **5 · Cognitive disorders:** depression · anxiety
- **6 · Aging**

5.2 Xerogenic drugs

- **Decongestants · anti-histamines**
- **Anticholinergics:** block the neurotransmitter acetylcholine → used in COPD, bladder conditions, GIT disturbances
- **Antidepressants:** TCA (tricyclic antidepressant) · MAOI (monoamine oxidase inhibitor) · SSRI (selective serotonin re-uptake inhibitor)
- **Anti-Parkinsonian drugs**
- **Tranquilizers and hypnotics**
- **Appetite suppressants**

5.3 Management

- **1 · Preventive therapy:** control the factors increasing the problem — smoking, alcohol, caffeine drinks · fluoride rinses and gel · oral hygiene measures
- **2 · Symptomatic treatment:** hydration · artificial saliva (e.g. Orthana & Liborant) · vaseline ointment · topical antifungal drugs
- **3 · Salivary stimulatory aids:** chewing sugar-free gums · systemic stimulation e.g. **pilocarpine HCl**

★ EXAM PEARL

Caries "**in rare sites**" — cervical margins, incisal edges, cusp tips — plus new denture intolerance is the examiner's way of saying dry mouth without saying dry mouth.

§6 Sjögren's syndrome

- **Definition:** chronic **autoimmune** disease destructive to the **exocrine** glands (lecture slide says "endocrine" — see pearl)
- **Core presentation:** **true xerostomia + joint pain**
- **Gland:** mostly the **parotid** SGs → bilateral SG swelling
- **Demographics:** females **★9 : 1** more than males · middle and old age groups

Table 6 — Primary vs secondary Sjögren's syndrome

	Primary	Secondary
Core	Dry eyes + dry mouth	Same, plus joint pain + systemic manifestations
Systemic / joints	Absent	Arthritis in > 50% of patients
Glands	Bilateral non-tender diffuse firm parotid swelling	Same
Saliva	↓ flow rate + altered composition	Same
Eyes	Keratoconjunctivitis sicca (dry conjunctiva + cornea)	Same
Other	—	Dry persistent cough · dysphagia, nausea, epigastric pain · peripheral and cranial neuropathy

6.1 Diagnosis

- **Symptoms:** dry eyes > **3 months** · sensation of foreign body in the eye · dry mouth > **3 months** · always need fluid to swallow dry foods · recurrent swellings of the parotid SGs

- **Sialography:** abnormal → ★ **snowstorm appearance**
- **Schirmer's test:** assesses **eye** dryness
- **Sialometry:** assesses salivary flow rate — lecture states "less than 1.5 ml/day" (see pearl)
- **Histopathology:** focal **lymphocytic sialadenitis** (labial gland biopsy)



Fig. 7 — Sjögren's: dry eyes with ocular surface damage, dry mouth, increased tooth decay.



Fig. 8 — Snowstorm appearance on sialography: scattered punctate contrast pooling.

6.2 Management and complications

- **Treat as xerostomia:** fluoride · hydration · artificial saliva
- **If persistent and tumour suspected:** MRI and CT → refer to an **oncologist**
- **Important complications:** sialadenitis · **B-cell lymphoma** (lecture: "beta cell lymphoma") · lymph node cancer

★ EXAM PEARL

Three slide slips worth correcting: Sjögren's destroys **exocrine** (not endocrine) glands; the lymphoma risk is **B-cell** (MALT) lymphoma; and the flow-rate criterion is unstimulated whole saliva ≤ 1.5 ml in 15 minutes, not "1.5 ml/day" — check against your textbook before quoting a number.

§7 Obstructive and secretory disorders

7.1 Sialolithiasis (salivary gland stones)

- **Alias:** meal time syndrome · aetiology unknown
- **Site:** ★ **80–90% in the submandibular SG** — why?
 - duct runs **against gravity** · **tortuous** duct course · secretion mainly **mucous** more than serous
- **Clinically:** acute painful **intermittent** swelling → swells while eating then subsides
- **Chronic cases:** → infections and **fibrosis**
- **Diagnosis:** mainly x-ray using an **occlusal film** to locate the stone
- **Treatment:** surgical removal in the acute condition · control the predisposing factors for long-term management

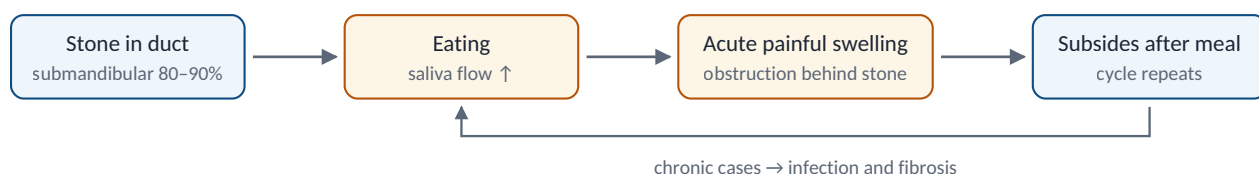


Diagram 2 — Meal-time syndrome: the repeating swell-with-eating, subside-after cycle of an obstructing sialolith.

7.2 Sialorrhoea

- **Definition:** excessive salivation — ★ **considered abnormal after the age of 4**

- **Causes:** excessive production of saliva **or** secondary to neurological disorders — sclerosis · cerebral palsy · Parkinson's disease

§8 White and red lesions

Six entities in this lecture: leukoplakia · candidiasis · geographic tongue · Fordyce's granules · median rhomboid glossitis · lupus erythematosus.

8.1 Leukoplakia

- **Definition:** a **clinical descriptive** term meaning "white patch" — **premalignant** condition
- **Diagnostic rule:** ★ **cannot be rubbed off** and cannot be entitled under any other condition → **diagnosis by exclusion**
- **Cause (per lecture):** HPV — see pearl
- **3 categories:** homogenous (most common) · speckled (less common) · verrucous (rare)
 - the **rougher** the surface → the more dangerous the lesion



Fig. 9 — Leukoplakia: adherent white patch, buccal mucosa.

- **Biopsy is mandatory:** **incisional** — remove part of the lesion **with part of healthy tissue** to facilitate comparison
- **Who biopsies:** the general dental practitioner (GDP) cannot, except in simple cases with good prognosis
- **Refer when:** 1 breaking bad news · 2 difficult management
- **Mild:** leave and observe **every 6 months** + redo the biopsy to check dysplasia
- **Moderate or severe:** surgical removal of the lesion
- **Advise the patient to stop:** smoking · alcohol · spicy food

★ EXAM PEARL

Rubbed off? Candidiasis yes, leukoplakia no — the single most reliable white-lesion discriminator. Note the lecture's "caused by HPV": leukoplakia is *idiopathic by definition* (tobacco is the main risk factor) — verify before writing it in an exam.

8.2 Hairy leukoplakia

- **Significance:** characteristic lesion of **HIV**
- **Appearance:** white asymptomatic elevated **un-removable** patch · **bilaterally** on the lateral margins of the tongue · corrugated with a **vertical** orientation
- **Malignant potential:** ★ **none** — unlike true leukoplakia
- **Diagnosis / treatment:** biopsy + PCR → antiviral therapy



Fig. 10 — Hairy leukoplakia: corrugated vertical white streaks, lateral tongue.

8.3 Candidiasis

- **Frequency:** most common oral **fungal** infection · **Candida albicans**
- **Predisposing factors:** poor oral hygiene · xerostomia · anaemia · dentures · diabetes mellitus (DM)
- **Primary:** oral lesions alone · **Secondary:** oral lesions are part of a muco-cutaneous disease
- **Forms:** pseudomembranous · thrush · erythematous · papillary hyperplasia in the palate
- **Key sign:** ★ can be rubbed off
- **Associated with:** angular cheilitis · rhomboid glossitis · denture stomatitis



Fig. 11 — Denture stomatitis: erythema confined to the denture-bearing palate.



Fig. 12 — Pseudomembranous candidiasis: removable white plaques.

- **Investigations:** cytology and tissue culture · incisional biopsy in severe cases
- **Treatment:** control the underlying condition · topical antifungals — azole derivatives (**miconazole**)
- **Systemic antifungal:** if the patient is severely immunocompromised with risk of spread of infection to the blood stream

CAUTION

Miconazole is contraindicated with **warfarin** → ↑ INR → ↑ bleeding risk; use **nystatin** (safe). The lecture groups **statins** under the same "bleeding" heading — the real statin interaction is ↑ statin levels → **myopathy** / **rhabdomyolysis**, not bleeding; avoid miconazole either way.

8.4 Geographic tongue

- **Alias:** **benign migratory glossitis** — common benign condition, aetiology unknown
- **Appearance:** multiple well-demarcated erythematous patches **restricted to the tongue** · periods of remission and exacerbation in different areas of the tongue
- **Factors involved:** family history · stress · skin conditions · habit of excessive tongue rubbing
- **Management:** reassure the patient → ✗ treatment required

8.5 Fordyce's granules (spots)

- **Nature:** ectopic sebaceous glands of the oral mucosa
- **Appearance:** yellowish-white spots on the **vermilion border of the upper lip**
- **Management:** ✗ treatment · patient reassurance



Fig. 13 — Geographic tongue: migrating well-demarcated erythematous patches.



Fig. 14 — Fordyce's granules on the upper lip vermilion border.

8.6 Median rhomboid glossitis

- **Nature:** rare condition restricted to the **dorsum of the tongue**
- **Appearance:** well-demarcated erythema in the **midline**, immediately **anterior to the circumvallate papillae**
- **Management:** ✗ treatment required
 - fungal infection found on **smear test** → antifungal agents
 - fungal infection **resistant** to treatment → biopsy for examination

8.7 Lupus erythematosus

- **Nature:** chronic **immuno-mediated** disease · skin rash · ★ **butterfly appearance on the face skin**
- **Discoid LE:** oral lesions in 15–25% of lesions
- **Systemic LE:** oral lesions in 30–45% of lesions
- **Diagnosis:** biopsy and **immunofluorescence**
- **Management:** refer to a specialist for a potent anti-inflammatory — **steroids**



Fig. 15 — Median rhomboid glossitis: midline depapillated erythema.



Fig. 16 — Systemic LE: butterfly facial rash and cutaneous hand lesions.

§9 Oral ulceration

- **Ulceration:** breach of oral epithelium → exposes nerve endings in the underlying **lamina propria** → pain and soreness, esp. with citrus and spicy foods

- **Causes:**
 - 1 systemic diseases e.g. TB & syphilis · 2 malignant conditions e.g. squamous cell carcinoma · 3 local factors: traumatic ulcers · 4 RAU (recurrent aphthous ulceration)
- **** Detailed history is very important** — the lecturer's emphasis

9.1 Traumatic ulcer

- **Frequency:** very common · caused by sharp or broken teeth or restorations
- **Appearance:** **single**, painful, smooth red surface · soft on palpation · heals **without scarring**
- **Treatment:** remove the cause · use mouthwash

9.2 Recurrent aphthous ulceration (RAU)

- **Frequency:** the most common oral mucosal lesions · affects ★**10–30% of the population**
- **Predisposing factors:** trauma · stress · allergy · low immunity · genetic predisposition · NSAIDs · anaemia · smoking
 - lecturer's annotation: smoking **cessation** — RAU classically flares when a patient stops smoking

Table 7 — The three forms of RAU

	Minor	Major	Herpetiform
Size	3–6 mm, rounded	1–2 cm, deep and large	1–2 mm, tiny
Number	Single or multiple, up to 6	Usually one or two	Groups of many
Course	Self-healing in 7–10 days, no scar	Persist 3–6 weeks without healing	Recurrent crops
Other features	Small, painful, rounded	Deep and large	White to yellow · labial mucosa + ventral tongue · non-keratinised mucosa



Fig. 17 — Minor aphthous ulcers: small, round, labial mucosa.



Fig. 18 — Major aphthous ulcer: deep, large, slow to heal.



Fig. 19 — Herpetiform aphthous ulcers: crops of 1–2 mm ulcers.

- **Herpetiform — name trap:** it was **wrongly believed** to be caused by HSV (the lecturer flagged this on the slide) → the name describes the **appearance** only
- **Investigations:** smear · biopsy in the **major** form · good history of drugs
- **Treatment:** control the medical background and the underlying factors · minimise symptoms by mouthwash and **topical steroids**

★ EXAM PEARL

Herpetiform ≠ herpetic. No HSV, no vesicles, no gingival involvement, and it sits on **non-keratinised** mucosa — primary herpetic gingivostomatitis is the opposite on every count. A single ulcer > 3 weeks is not RAU until malignancy is excluded.