The treatment of oral apthous ulceration or erosive lichen planus with toppical clobetasol propionate in three preparations. A clinical study on 54 patients (Lo Muzio et al.)

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Dear Sir

Lo Muzio et al. (1) investigated the treatment of oral aphthous lesions erosive oral lichen planus with three preparations of topical clobetasol propionate. They reported surprisingly good results, especially with the use of a bioadhesive system, which achieved a mean time to remission of symptoms of 35 days in patients with aphthous ulceration and 8 days in patients with erosive lichen planus, a significantly better outcome than they found with the use of clobetasol propionate in topical ointment or oral analgesic base form.

However, they provided scant information on the clinical characteristics of the patients with erosive oral lichen planus in their study, which was limited to the patient's report of the time normally taken for these lesions to heal without treatment, an average of 15 days. It therefore appears that their series of patients suffered recurrent erosive lichen planus that tended to spontaneous resolution without treatment, although no data were provided on the frequency of the recurrences. This is an important issue because the greatest clinical challenge is posed by the chronic erosive forms of oral lichen planus, especially when severe (extensive, multiple and very painful), because these do not tend to spontaneously remit and require sustained treatment with systemic or topical corticoids. The clinical condition of the patients should be precisely defined in this type of study, because the adhesive paste form of clobetasol may not be as efficacious in patients who present with severe erosive forms of the disease.

The authors also claimed that the adhesive paste demonstrated good stability and bioadhesive properties during a 12-h period, above all on the buccal mucosa, producing a slow release of the drug during this time span. However, this assertion was not based on an objective procedure to evaluate the amount of paste adhered to the mucosa at 12 h after its application. This is a critical par-

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ameter, because one of the main factors influencing the success of treatment is the time of contact between the corticoid and lesion, which should be as well controlled as possible. Maintaining the prolonged adherence time reported by these authors is not easy, because oral movements of chewing, swallowing and talking, combined with the wet environment of the mouth, tend to displace the paste from its initial localisation. Moreover, if the paste did remain in contact with the mucosa for 12 h, the total contact time would have been 24 h per day, given the twice-daily application described in the study. This time appears to be excessive, both because of problems of patient compliance with such a demanding regimen and because of the potential risk of corticoid-related adverse effects.

Our group reported adverse effects (moon face and hirsutism) in a series of patients with severe oral lesions after 4–6 weeks of treatment with an aqueous solution of 0.05% clobetasol propionate (2). These effects disappeared when the frequency of mouthwash was reduced after control of the lesion was achieved. We concluded that topical corticoids should be used with caution, avoiding high concentrations and long contact times, with careful follow-up to detect side-effects. In our view, the use of an 0.05% clobetasol propionate mouthwash may provide the best control over the contact time and access of the drug to all of the lesions. Topical creams would be indicated in small localised lesions or when they can be applied with the use of a tray (3).

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