

ANALYSING CLINICAL AND DEMOGRAPHIC DATA FROM A STUDY ON ORAL LICHEN PLANUS PATIENTS

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Oral lichen planus (OLP) is a common mucocutaneous disorder affecting approximately 1–2% of the population, predominantly middle-aged women. This study aims to analyse the demographic and clinical characteristics of OLP patients treated at the Oral Medicine Centre of Institute of Stomatology, Rīga Stradiņš University. The cohort comprised adult patients diagnosed with OLP, who underwent structured clinical evaluations. The study identified significant patterns in age, gender distribution, clinical forms, and associated discomfort levels. Females constituted 75.76% of the cohort, with a mean age of 60 years. The reticular form of OLP was most prevalent, while the erosive form, associated with considerable discomfort, was more common in females. Treatment regimens varied, with Sol Kenalog 0.2% and Ointment Clobetasol 0.05% being the primary therapies. Sol Kenalog 0.2% was more effective in providing symptom relief and reducing relapse frequency. Chronic diseases and stress were prevalent among patients, complicating management and treatment outcomes. The study emphasises the need for personalised treatment strategies that consider the severity of the clinical form, patient comfort, and comorbid conditions. Further research is recommended to validate these findings and explore the underlying mechanisms of gender differences and the impact of comorbidities on OLP. The insights from this study aim to enhance clinical practices and improve patient outcomes.

Keywords: clinical evaluations, treatment effectiveness, stress, chronic conditions.

INTRODUCTION

Oral lichen planus (OLP) is a relatively common mucocutaneous disorder characterised by T-cell-mediated autoimmune attacks on the basal keratinocytes of the oral mucosa. It affects approximately 1–2% of the population, with a predilection for middle-aged women (Xue *et al.*, 2020). Variations in the prevalence and presentation of oral lichen planus across different populations necessitate a nuanced understanding for effective management and treatment. Key factors such as gender, age, clinical form, and comorbidities profoundly influence the disease's progression and treatment response (Rodríguez *et al.*, 2019). OLP can present in

various clinical forms, ranging from asymptomatic white striations to painful erosive lesions, significantly impacting the quality of life. The exact pathogenesis of OLP remains unclear, but it involves a complex interplay between genetic susceptibility, immune system dysregulation, and environmental factors (Scully *et al.*, 2021). Certain HLA alleles have been associated with an increased risk of OLP, suggesting a genetic predisposition (Chen *et al.*, 2022). OLP is characterised by a chronic T-cell-mediated immune response. CD8+ cytotoxic T-cells target and destroy basal keratinocytes, leading to the characteristic lesions (Rad *et al.*, 2020). Factors such as dental materials, viral infections (e.g., hepatitis C), and certain medications have been impli-

cated in triggering or exacerbating OLP (Gandolfo *et al.*, 2019).

OLP can manifest in several clinical forms, including reticular (the most common form, characterised by interlacing white lines known as Wickham's striae, erosive (presents as painful ulcers and erythematous areas), atrophic (thinned mucosa with erythema), plaque-like (resembling leukoplakia, with raised white patches), papular (small white papules, less common and often asymptomatic) and bullous (formation of blisters that may rupture, leaving erosive areas) (Carrozzo *et al.*, 2019). Diagnosis of OLP is primarily clinical, supported by histopathological examination and direct immunofluorescence (Alrashdan *et al.*, 2021). The management of OLP focuses on symptom relief and controlling inflammation. Treatment strategies include topical corticosteroids and systemic corticosteroids, which are reserved for severe or refractory cases. In some cases, immunosuppressive agents such as cyclosporine, tacrolimus, or azathioprine are prescribed for patients unresponsive to corticosteroids (Sugerman *et al.*, 2020).

Despite extensive research, the aetiology of OLP remains unclear, although it is believed to involve an immune-mediated mechanism. The prevalence and presentation of oral lichen planus can vary widely among different populations, and understanding these variations is crucial for effective management and treatment (Thornhill *et al.*, 2020). Gender differences, age distribution, clinical forms, and associated comorbidities are significant factors that can influence the disease's progression and patients' response to treatment (Eisen *et al.*, 2019).

This study provides a detailed examination of the demographic and clinical characteristics of patients diagnosed with OLP. The cohort comprises patients who visited the Rīga Stradiņš University (RSU) Institute of Stomatology, where they participated in a structured clinical evaluation and provided informed consent. Each participant consented to the study following a comprehensive explanation of the research objectives, potential risks, and benefits. The study was conducted in accordance with the ethical standards set forth by the institutional review board of RSU.

The focus of this investigation includes gender prevalence, age distribution, clinical forms of the disease, associated discomfort levels, treatment regimens, relapse rates, and the impact of chronic diseases and stress. By identifying patterns and correlations within this cohort, we aim to enhance clinical practices and therapeutic strategies for managing OLP.

The insights derived from this study are anticipated to contribute significantly to the existing body of knowledge on oral lichen planus. They will also aid dental professionals in developing more personalised and effective treatment plans. This research underscores the importance of a holistic approach to managing oral lichen planus, addressing the multifaceted nature of the disease and its broader impact on patient health and well-being.

MATERIALS AND METHODS

This cross-sectional study was conducted at Rīga Stradiņš University Institute of Stomatology, Clinic of Oral and Maxillofacial Surgery and Oral Medicine, Rīga, Latvia. The study involved patients diagnosed with OLP who visited for consultation and treatment. The inclusion criteria were adult patients diagnosed with OLP based on clinical examination and histopathological confirmation. All participants provided informed consent prior to inclusion in the study.

Data collection. Data were collected from patient medical records and through structured interviews conducted during their visits to the RSU Institute of Stomatology. The data collection process included the following steps:

- Patient identification: patients diagnosed with OLP were identified from the clinic's patient registry. Only those who met the inclusion criteria and provided informed consent were included in the study.
- Demographic data: information on the patient's name, initials, gender, date of birth, and age was recorded. This data helped in understanding the age and gender distribution of the condition.

Clinical data: Detailed clinical data were collected, including:

1. Date of visit
2. Location of lesions (e.g., buccal mucosa, lingual mucosa, vestibular mucosa)
3. Clinical form of oral lichen planus (e.g., erosive, reticular, plaque-like)
4. Discomfort level (categorised as nonexistent, slight, moderate, or considerable)
5. Treatment data: Information on the treatment regimen was documented, including: type of treatment (e.g., Sol Kenalog 0.2%, Ointment Clobetasol 0.05%), duration of treatment
6. History of relapse and the duration since the last relapse
7. Chronic diseases and stress: The presence of chronic diseases such as hypertension, cardiac conditions, gastrointestinal reflux (GERD), and others were recorded. Additionally, the prevalence of stress and its potential impact on the condition were noted.

Data analysis. The collected data were entered into an Excel spreadsheet for analysis. The analysis focused on identifying patterns and correlations in the demographic and clinical characteristics of the patients. Key aspects of the analysis included:

- Descriptive statistics: Calculation of mean, median, and range for continuous variables such as age. Frequency and percentage distributions were calculated for categorical variables such as gender and clinical forms.

- Gender prevalence: The prevalence of oral lichen planus among males and females was determined by calculating the proportion of each gender in the study cohort.
- Age distribution: The age distribution was analysed to identify any significant trends or patterns related to the onset and progression of oral lichen planus.
- Clinical forms and discomfort levels: The relationship between different clinical forms of oral lichen planus and the associated discomfort levels was examined.
- Treatment efficacy and relapse: The effectiveness of different treatment regimens was assessed by evaluating the duration of symptom relief and the frequency of relapses.

Impact of chronic diseases and stress: The influence of chronic diseases and stress on the severity and management of OLP was analysed.

Limitations. This study was limited by its cross-sectional design, which precludes the establishment of causality. Additionally, the reliance on self-reported data for certain variables, such as stress prevalence, may introduce reporting bias. Future studies with longitudinal designs and larger sample sizes are recommended to validate the findings and provide more comprehensive insights into the management of OLP.

RESULTS

The analysis revealed significant patterns in the clinical and demographic characteristics of the patients. The findings are detailed below.

Age and gender distribution and localisation. The patients' ages ranged from 37 to 77 years, with a mean age of 60 years. The study cohort consisted of 33 patients, with a significant predominance of female patients (75.76%) compared to male patients (24.24%) (Table 1). The average year of birth for female patients was 1963, while for male patients, it was 1965, indicating a similar age distribution across genders. This finding suggests that OLP affects adults within a similar age range regardless of gender, aligning with existing literature that highlights its prevalence in middle-aged and older adults (Gamal-AbdelNaser and Azab, 2024; Myers *et al.*, 2024).

Clinical forms and discomfort levels. The clinical presentation of OLP varied among patients, with three main forms observed: erosive, reticular, and plaque-like (Table 2). The erosive form, which is associated with significant discomfort, was more common in females (12 cases) than in males (4 cases). Patients with erosive lichen planus experienced considerable discomfort, often requiring intensive treatment (Fig. 1). The reticular form was the most prevalent, observed in both genders, but slightly more common in females (11 cases) compared to males (5 cases). This form was more common and generally associated with moderate to slight discomfort (Fig. 2). The plaque-like form, a less common but distinct variant, was noted only in female patients (2 cases). Despite the fact that it is a less common

Table 1. Gender differences in mucosal locations of oral lesions

Mucosal location	Total (n = 33)	Female (n = 25)	Male (n = 8)
Buccal	16	11	5
Lingual	6	5	1
Labial	1	0	1
Vestibular	2	2	0
Palatal	1	1	0
Multiple locations	7	6	1
Buccal + Labial	1	1	0
Buccal + Labial + Lingual	1	1	0
Buccal + Labial + Vestibular	1	1	0
Buccal + Lingual	3	3	0
Buccal + Lingual + Vestibular	1	0	1

Description: Analysis of mucosal lesion locations among 33 patients, detailing the prevalence of buccal, lingual, labial, vestibular, and palatal sites, including multiple location involvement, with comparisons between female (n = 25) and male (n = 8) patients.

Table 2. Gender differences in oral lichen planus (OLP) forms

OLP form	Total (n = 33)	Female (n = 25)	Male (n = 8)
Erosive	12	12	0
Reticular	13	7	6
Plaque like	2	2	0
Multiple forms	6	4	2
Reticular + Plaque like	4	2	2
Reticular + Erosive	1	1	0
Erosive + Atrophic	1	1	0

Description: Distribution of Oral Lichen Planus (OLP) forms among 33 patients, showing the prevalence of erosive, reticular, plaque-like, and multiple form combinations between female (n = 25) and male (n = 8) patients.



Fig. 1. Clinical presentation of erosive oral lichen planus (Source: RSU Clinic of Oral and Maxillofacial Surgery and Oral Medicine patient archive).

This image depicts the erosive form of oral lichen planus (OLP) affecting the oral mucosa. The lesions are characterised by erythematous areas with central ulcerations, primarily visible on the buccal mucosa and the dorsal aspect of the tongue. The mucosa exhibits a shiny, inflamed appearance with notable erosions and atrophic patches. This subtype of OLP is often more symptomatic, causing significant discomfort and pain, and demonstrates the chronic and relapsing nature of the disease.



Fig. 2. Clinical presentation of reticular oral lichen planus (Source: RSU Clinic of Oral and Maxillofacial Surgery and Oral Medicine patient archive).

This image illustrates the reticular form of oral lichen planus (OLP) involving the oral mucosa. The mucosal surface is characterised by interlacing white lines and striations forming a lacy, web-like pattern, known as Wickham's striae. These features are predominantly observed on the buccal mucosa, though they can also be present on the gingiva and tongue. This form is often asymptomatic, but may be accompanied by mild discomfort or a burning sensation, and is indicative of the chronic, immunologically mediated nature of the disease.

form, it presented unique challenges in treatment. Discomfort levels ranged from nonexistent to considerable, with patients experiencing erosive lichen planus reporting higher levels of discomfort.

Treatment regimens. Treatment regimens primarily included Sol Kenalog 0.2% and Ointment Clobetasol 0.05%, with varying efficacy. Patients treated with Sol Kenalog 0.2% generally reported significant symptom relief and longer durations of symptom-free periods, averaging around six months. This treatment also correlated with a lower frequency of relapses. In contrast, Ointment Clobetasol 0.05% provided relief, but with shorter symptom-free periods and more frequent relapses, averaging around four months (Table 3). These findings suggest that Sol Kenalog 0.2% might be more effective, particularly for severe cases, and highlight the importance of tailored treatment plans based on individual patient responses.

Relapse and chronic diseases. Relapse periods ranged from 2 months to 12 months, indicating varying degrees of chronicity. Chronic diseases such as hypertension, cardiac conditions, and gastrointestinal reflux (GERD) were prevalent among the patients, often complicating the treatment process.

Stress prevalence. Stress prevalence was documented for some patients, highlighting the psychological impact of chronic oral conditions.

DISCUSSION

The data from this study provide several insights into the demographic and clinical characteristics of patients with oral lichen planus.

Table 3. Gender differences in mucosal treatment outcomes and discomfort levels

	Total (n = 33)	Female (n = 25)	Male (n = 8)
Median age	56	57	55
Treatment			
Sol Kenalog 0.2%	11	8	3
Ointment Clobetasol 0.05%	19	16	3
no treatment	3	1	2
Discomfort			
none	7	4	3
slight	6	2	4
moderate	8	8	0
considerable	12	11	1
Comorbidities			
Yes	24	19	5
No	9	6	3
Relapse			
Yes	20	16	3
No	13	8	5
No information	0	1	0

Description: Analysis of 33 patients, detailing median age, treatment types, discomfort levels, comorbidities, and relapse rates, highlighting variations between female (n = 25) and male (n = 8) patients.

Age and gender distribution. Several studies have reported a higher prevalence of OLP in females compared to males, with women constituting approximately 60–75% of cases. This gender difference is significant and indicates a potential gender-specific susceptibility to OLP (Moayeri *et al.*, 2024; Sengupta *et al.*, 2024). Additionally, female patients generally report higher Oral Health Impact Profile (OHIP) scores, reflecting a greater impact on their quality of life. The type of OLP lesions also varies by gender, with women more likely to exhibit localised forms such as reticular patterns, while men tend to experience more generalised and severe forms of the disease (Moayeri *et al.*, 2024).

OLP predominantly affects middle-aged and older adults, with the highest incidence typically observed in individuals between the ages of 30 and 60. Various studies have indicated that the average age of OLP patients can be around 62 years, highlighting a significant prevalence in this age group (Gamal-AbdelNaser and Azab, 2024; Myers *et al.*, 2024). Specifically, Sengupta *et al.* (2024) reported an age range of 38 to 73 years, with a mean age of approximately 50.66 years, further emphasising that the risk of developing OLP increases notably for those aged 40 years and older (Sengupta *et al.*, 2024).

Clinical forms and discomfort levels. The clinical presentation of OLP varies with both age and gender. Women tend to present with reticular forms of OLP, characterised by white, lacy patterns on the mucous membranes, while men may experience more severe and generalised forms. This variability in presentation underscores the need for personalised approaches in the management and treatment of OLP,

considering both demographic factors and the specific clinical characteristics of the lesions (Moayeri *et al.*, 2024; Sengupta *et al.*, 2024).

Correlation with chronic diseases. OLP has been linked to various chronic diseases, particularly those involving immune system dysregulation. The inflammatory nature of OLP shares common pathways with other chronic inflammatory diseases. Chronic stress can also exacerbate inflammation, which is a crucial factor in the pathogenesis of both OLP and other chronic conditions such as cardiovascular diseases and metabolic disorders (Gamal-AbdelNaser and Azab, 2024). This suggests that the mechanisms driving chronic diseases and OLP may overlap, particularly in the context of immune response and inflammation.

OLP and gastrointestinal diseases share common inflammatory pathways, suggesting a potential link between these conditions. The gut microbiota plays a crucial role in regulating inflammation within the gastrointestinal tract. Disruptions in gut microbiota can lead to chronic inflammation, which is a hallmark of both gastrointestinal diseases such as inflammatory bowel disease (IBD) and conditions like OLP. It is also researched that oxidative stress and inflammation in the gut can exacerbate gastrointestinal disorders, which may also have implications for other inflammatory conditions including OLP (Gamal-AbdelNaser and Azab, 2024).

Impact of stress. Stress plays a pivotal role in the exacerbation of OLP symptoms. Patients with OLP often experience higher levels of stress, anxiety, and depression compared to healthy controls. These psychological factors significantly impact their quality of life, aggravating the clinical manifestations of OLP (Moayeri *et al.*, 2024). Furthermore, chronic stress has been shown to trigger inflammatory responses in the body, contributing to the persistence and severity of OLP lesions.

Moreover, stress is a critical factor in a wide range of chronic diseases, including autoimmune disorders like OLP (De Porras-Carrique *et al.*, 2023). Stress-induced inflammation is identified as a common pathway that not only worsens existing conditions, but also predisposes individuals to new health issues (Sengupta *et al.*, 2024). This underscores the importance of addressing psychological health in the management of chronic diseases and conditions including OLP.

Stress significantly impacts both gastrointestinal health and conditions including OLP. The neurobiology of stress and its impact on gastrointestinal diseases shows that chronic stress can aggravate symptoms of functional gastrointestinal disorders, such as irritable bowel syndrome (IBS) and gastro-esophageal reflux disease (GERD). These stress-induced exacerbations are similarly observed in OLP, where psychological stress can worsen oral lesions and symptoms (Gamal-AbdelNaser and Azab, 2024).

Furthermore, significant association between gastrointestinal disturbances and mental health issues such as depression

and anxiety has been demonstrated. Individuals experiencing gastrointestinal problems often report higher levels of psychological stress, which can further aggravate their condition. This interplay between gastrointestinal health and stress is also relevant to OLP, where stress management is crucial for symptom control (Sengupta *et al.*, 2024).

The correlation between OLP, gastrointestinal diseases, and stress underscores the complex interplay between psychological and physiological health. Chronic stress and inflammation serve as common links, exacerbating both gastrointestinal disorders and OLP. Effective management strategies that address both the physical and psychological aspects of these conditions are essential for improving patient outcomes.

Integrating stress management techniques and promoting a healthy gut microbiota through diet and lifestyle changes can be beneficial in managing these interrelated conditions.

Many patients with chronic conditions like hypertension, heart problems, and gastrointestinal reflux (GERD) often made it harder to manage oral lichen planus, because they could worsen symptoms and make treatments less effective. Additionally, stress was common among these patients, with some reporting high levels of psychological stress, which can further affect the severity of the disease and its treatment outcomes. This highlights the importance of a comprehensive treatment plan that addresses both the main condition and any associated health issues (Deshpande *et al.*, 2024).

A comprehensive systematic review (De Porras-Carrique *et al.*, 2023) that investigated the connection between autoimmune disorders and OLP, found a higher prevalence of autoimmune conditions among OLP patients, particularly thyroid diseases and diabetes mellitus. The review suggested that dental professionals should consider these comorbidities in OLP management for better treatment outcomes.

The connection between OLP and arterial hypertension can be elucidated through several mechanisms: both OLP and hypertension involve chronic inflammatory processes, with inflammatory cytokines and mediators potentially increasing blood pressure (De Porras-Carrique *et al.*, 2023). Treatments for OLP, particularly corticosteroids, can cause sodium and fluid retention, leading to increased blood pressure. Common risk factors such as stress, smoking, and metabolic syndrome also link OLP and hypertension, with stress inducing autonomic hyperactivity and raising blood pressure. Additionally, immune system dysregulation in OLP may contribute to hypertension through increased vascular resistance and endothelial dysfunction, and psychological stress prevalent among OLP patients can exacerbate both conditions, highlighting the need for stress management in treatment strategies (De Porras-Carrique *et al.*, 2023).

A published case-control study (Shariff and Philipone, 2021) involving 156 OLP patients and 156 matched controls, identified significant associations with thyroid disorders, cancer, type 2 diabetes, hyperlipidemia, oral sedative use, and vitamin D supplementation. These findings highlight the importance of thorough medical evaluations for OLP patients to detect potential underlying systemic conditions.

A comprehensive systematic review and meta-analysis (González-Moles *et al.*, 2021) assessed the global prevalence of OLP, analysing 71 studies involving 500,464 patients. The study reported a global pooled prevalence of 1.01%, with significant geographical variations, the highest in Europe (1.43%) and the lowest in India (0.49%). The authors emphasised the need for consistent diagnostic criteria and improved education for healthcare professionals to enhance OLP diagnosis and treatment.

Published data on the presence of Epstein-Barr virus (EBV) in OLP lesions and normal oral mucosa using polymerase chain reaction (PCR) showed no EBV detection in both OLP patients and controls, leaving the role of EBV in OLP inconclusive and warranting further research (Sahebamee *et al.*, 2007). However, a systematic review and meta-analysis evaluated the association between EBV and OLP, including 10 studies with 386 OLP patients and 304 controls. The meta-analysis indicated a significant association between EBV and OLP (OR = 4.41, 95% CI: [2.74, 7.11], $p < 0.0001$), suggesting an increased risk of OLP in individuals with EBV infection. However, the authors considered that the results should be interpreted cautiously due to study limitations and heterogeneity, highlighting the need for further large-scale studies (Ashraf *et al.*, 2020).

A four-year clinical follow-up study in Lithuania examined the prevalence, clinical forms, and risk factors of OLP in 133 histologically confirmed patients. The study found a higher prevalence in females (82.7%) and those over 50 years old. The reticular form was most common (45.1%), followed by the erosive-ulcerative form (33.8%). Significant histological differences were noted among forms, particularly in erosive-ulcerative OLP. The malignant transformation rate was 2.3%, with no significant differences in risk factor distribution among forms, except for medication use in atrophic OLP (Rimkevičius *et al.*, 2017).

Treatment efficacy. The treatment of oral lichen planus (OLP) presents a significant challenge due to the chronic nature of the disease and its potential for malignancy. The treatments for OLP vary based on the clinical forms and severity of the condition. Sol Kenalog 0.2% is frequently used for managing erosive forms of OLP due to its potent anti-inflammatory properties, which help in reducing the severity of the lesions and providing symptomatic relief. Ointment Clobetasol 0.05% is commonly prescribed for reticular forms of OLP. This high-potency corticosteroid is effective in decreasing inflammation and controlling the characteristic white, lacy patterns observed in these lesions. In cases where patients experience minimal or no discom-

fort, a conservative approach of no treatment is often adopted to avoid unnecessary medication use and potential side effects (Sardar *et al.*, 2020).

Topical corticosteroids (TopCORT) remain the mainstay treatment for OLP primarily due to their proven efficacy in reducing symptoms and promoting clinical resolution (Sengupta *et al.*, 2024). However, the long-term use of corticosteroids is associated with side effects such as mucosal atrophy and secondary candidiasis (Moayeri *et al.*, 2024). The study by Leong *et al.* (2023) confirmed the efficacy of TopCORT, but also highlighted the need for adjunctive treatments to mitigate these adverse effects.

Purslane and aloe vera have emerged as promising alternatives for OLP treatment due to their anti-inflammatory properties. Purslane has been identified as particularly effective in clinical improvement (Leong *et al.*, 2023), which aligns with previous research highlighting its potent anti-inflammatory and antioxidant effects (Moayeri *et al.*, 2024). Aloe vera has also demonstrated significant efficacy and safety, making it a viable alternative, especially for patients who experience adverse reactions to corticosteroids (Leong *et al.*, 2023; Sengupta *et al.*, 2024). Topical calcineurin inhibitors (TopCALN), including tacrolimus and pimecrolimus, have shown effectiveness in achieving clinical resolution but are associated with a higher incidence of adverse effects, such as a burning sensation and increased risk of infections (Leong *et al.*, 2023; Sengupta *et al.*, 2024). This trade-off between efficacy and safety necessitates careful patient selection and monitoring during treatment.

Photodynamic therapy (PDT) showed superior results in reducing both clinical and pain scores, positioning it as a valuable treatment for severe OLP cases. PDT's targeted approach and minimal invasiveness contribute to its effectiveness in pain management and lesion reduction (Leong *et al.*, 2023). These findings are supported by Sengupta *et al.* (2024), who also noted the potential of PDT in clinical settings.

Despite these advancements, the systematic review by Sengupta *et al.* (2024) and the meta-analysis by Moayeri *et al.* (2024) underscore the need for more high-quality randomised controlled trials. The current variability in study design, patient populations, and outcome measures indicates a need for standardised research protocols. Further studies should aim to establish clearer guidelines and optimise treatment regimens for OLP.

In conclusion, while topical corticosteroids remain a cornerstone in OLP treatment, alternative therapies like purslane, aloe vera, and photodynamic therapy show promise. These treatments offer benefits for patients who do not respond to or experience adverse effects from conventional therapies. Ongoing research and high-quality clinical trials are essential to validate these findings and develop comprehensive, patient-tailored treatment strategies for OLP.

CONCLUSION

This study underscores the complexity of OLP, emphasising the need for a comprehensive treatment approach. Predominantly affecting middle-aged women, OLP presents in various forms, requiring personalised strategies. Chronic conditions like hypertension and gastrointestinal reflux, along with psychological stress, complicate management, exacerbating symptoms and reducing treatment efficacy. While topical corticosteroids remain the primary treatment, alternatives like purslane, aloe vera, and photodynamic therapy show promise, especially for patients with adverse reactions to standard treatments. Effective management must address both physical and psychological aspects, tailoring treatments to individual needs and integrating stress management to enhance patient outcomes and quality of life.

ETHICS

The study protocol was reviewed and approved by the RSU Ethical Committee (the Ethical Committee decision number is Nr. 6.-1/09/03, which was signed on 10 September 2020). Informed consent was obtained from all participants after a thorough explanation of the study objectives, procedures, potential risks, and benefits. Participants were assured of the confidentiality of their data and their right to withdraw from the study at any point without any consequence to their ongoing medical treatment.

CONFLICT OF INTEREST

The authors declare no conflict of interest.

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KLĪNISKO UN DEMOGRĀFISKO DATU ANALĪZE PĒC PĒTĪJUMA PAR MUTES PLAKANĀS ĒDES PACIENTIEM

Mutes plakanā ēde (*oral lichen planus*, OLP) ir bieži sastopama gļotādas slimība, kas skar aptuveni 1-2% iedzīvotāju, pārsvarā sievietes pusmūžā. Šī pētījuma mērķis bija analizēt Rīgas Stradiņa Universitātes, Stomatoloģijas institūta Mutes medicīnas centrā ārstēto OLP pacientu demogrāfiskos un klīniskos rādītājus. Kohortā bija iekļauti pieauguši pacienti ar OLP diagnozi, kuriem veica strukturētu klīnisko novērtēšanu. Pētījumā konstatēja nozīmīgu saistību starp vecuma, dzimuma sadalījuma, klīnisko formu un dažādiem diskomforta rādītājiem. Sievietes veidoja 75,76% no kohortas ar vidējo vecumu 60 gadi. OLP retikulārā forma bija visizplatītākā, savukārt erozīvā forma, kas saistīta ar ievērojamu diskomfortu, bija biežāk sastopama sievietēm. Pielietotās ārstēšanas shēmas bija dažādas ar Sol Kenalog 0,2% un Clobetasol 0,05% ziedi kā primāro terapiju. Sol Kenalog 0,2% novērots kā efektīvāks simptomu mazināšanai un recidīvu biežuma samazināšanai. Ārstēšanas gaitu un rezultātus ietekmēja hronisku blakus slimību un stresa esamība, kas bieži bija atrodami pacientu anamnēzē. Pētījumā uzsvērtā nepieciešamība pēc personalizētas ārstēšanas stratēģijas, kas ņemtu vērā klīniskās formas smagumu, pacienta komfortu un blakus slimību esamību. Ir ieteicama turpmāka izpēte, lai apstiprinātu šī pētījuma konstatējumus un izprastu dzimumu atšķirību pamatā esošos mehānismus un to ietekmi uz OLP. Šajā pētījumā iegūto atziņu mērķis ir sekmēt klīnisko diagnostiku un uzlabot pacientu ārstēšanas rezultātus.