

Correlation of Serum ANA and Direct Immunofluorescence Studies in Elderly Thai Patients with Red and White Oral Lesions

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Short Communication

In our recent study entitled “Correlation of serum ANA and direct immunofluorescence studies in elderly Thai patients with red and white oral lesions”, the oral lesions in elderly Thais were clinically evaluated and histopathologically diagnosed as Oral Lichen Planus (OLP) [1]. However, their Direct Immunofluorescence (DIF) results could be differentially interpreted as OLP/Lupus Erythematosus (LE), immune complex mediated disease, Chronic Ulcerative Stomatitis (CUS)-like lesions, or negative findings.

Our results indicated that the oral manifestations of OLP or LE were clinically similar and that it was difficult to make an initial differential diagnosis between them, particularly in middle-aged or elderly patients who were taking medications. This was because these patients could not remember how long they had been taking their medications or whether their oral lesions erupted before or after taking medications [2]. Therefore, those lesions were initially diagnosed as OLP, Oral Lichenoid Drug Reaction (OLDR), or drug induced lupus erythematosus. Serum Antinuclear Antibody (ANA) and DIF analysis is required when the lesion cannot be definitively diagnosed after clinical evaluation. However, serum ANA positive at the first evaluation in these patients typically demonstrated a low titer (1:80). Moreover, long-term follow-up on these cases is required to confirm the correct diagnosis. In our Oral Medicine clinic, one patient who had been taking Atenolol, an antihypertensive drug, for over 10 years was serum ANA positive with speckled pattern and her titer had significantly increased from 1:320 to 1:1,280 after 5 years of follow-up. However, her serum ANA was still positive with cytoplasmic pattern with the same previous titer of 1:80.

Recently, three cases with oral manifestations similar to ulcerative/atrophic OLP and white radiate striae around the lesions on the gingival palatal mucosa and buccal mucosa were ANA positive with high titers (1: 1,280). The clinical and histopathological diagnosis of these 3 cases were compatible with OLP, 2 cases with speckled pattern and one with centromere pattern. However, DIF interpretation of the specimens showed 2 cases with non-specific findings and one

case was OLP (however lupus erythematosus could not be ruled out).

By clinical experiences in our oral medicine clinic, the oral lesions in those recalcitrant cases often showed no response to any medications including systemic steroids or potent topical steroids. Recently, potent topical steroid- Fluocinonide Acetonide (FA) 0.1% have been reported to be effective in the treatment of various symptomatic oral mucosal diseases but FA 0.1% did not show the effectiveness in the treatment of the oral lesions with ANA positive and high titers [3].

Therefore, red and white oral lesions in middle-aged or elderly patients with oral manifestations similar to OLP lesions with histopathological reports compatible with OLP should be carefully monitored, particularly when DIF staining presents with a granular pattern at the basement membrane zone. This is because these lesions may actually be due to Systemic Lupus Erythematosus (SLE), and this disease can affect other organs in the body. Importantly, lesion biopsy, serum ANA assessment, and DIF evaluation should be repeated in cases without a definitive diagnosis every year for early, correct diagnosis and to prevent the serious outcomes of an autoimmune disease such as SLE.

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