My patient is a 78-year-old woman with heart failure and type 2 diabetes, both of which are well controlled. She underwent coronary artery bypass grafting 11 years ago. Recently, burning mouth syndrome (BMS) developed. I have tried a variety of strategies--from stopping her angiotensin-converting enzyme (ACE) inhibitor for short periods to prescribing oral preparations--but nothing seems to help. She obtains relief only by eating Popsicles, but these increase her sugar intake. I have heard that the condition may persist for 7 to 8 years. What else can I offer this patient to alleviate her symptoms? -- Morton Krakow, PA-C

Homewood, Ill The diagnosis and management of BMS can be challenging. However, improved understanding of the pathogenesis of the condition offers hope to affected patients. BMS is a type of neuropathic pain that develops in clinically normal mucosa. It rarely has an underlying systemic cause. Developing theories link BMS to disinhibition that results from altered taste function. The tongue and lips are the most commonly involved sites, and symptoms are bilateral. If symptoms are unilateral, conditions that may cause unilateral nerve damage--including tumor--must be ruled out. BMS is most commonly seen in perimenopausal or postmenopausal women. In addition to her age and sex, your patient has 2 other potential risk factors for the condition: diabetes and use of ACE inhibitors. (Hypersensitivity to dental materials, including acrylics, does not seem to play a role in the development of BMS.) However, in most patients with BMS, no risk factors are identified--and in your patient, discontinuation of ACE inhibitors did not mitigate her symptoms. A thorough oral examination is necessary to rule out potential local causes of burning, such as:

- Candidiasis.
- Oral mucosal changes, such as those that result from infections.
- Dry mouth.
- Tongue habits (eg, pressing the tongue against the teeth).

BMS can be very troubling to the patient. If local causes have been ruled out, and underlying, potentially aggravating conditions have been eliminated or cannot be altered, symptomatic management is indicated. Topical therapies provide limited benefit in some patients. Topical capsaicin has been associated with modest relief of symptoms when applied to isolated sites up to 4 times daily. Although the evidence supporting treatment of BMS with centrally acting medications is limited, you may want to try low-dose clonazepam as an initial strategy. If clonazepam is not effective or side effects are excessive, other centrally acting medications--such as neurontin, lamotrigine, or a tricyclic antidepressant--may be tried at a low dosage. No studies have assessed combination therapy with these agents. In addition--as with any chronic symptom--consider that psychological factors may be the cause of the pain of BMS or may at least play a role in the experience and presentation of pain. A recent study found that various types of neuroticism--including anxiety, depression, anger, hostility, impulsiveness, and vulnerability--correlated with BMS; moreover, these findings differentiated affected patients from controls. Review the patient's psychological profile and any known DSM diagnoses; in some instances, counseling may be an important part of management. -- Joel Epstein, DMD, MSD, FRCD(C)

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