

Dr. Tom Shackleton - View from the Chairside: Managing Burning Mouth Disorder

- Dr. Shackleton: Hi, I'm Tom Shackleton. Today we're going to discuss burning mouth disorder. Fortunately, not a very common condition, but a very uncomfortable and disruptive condition to people's lives. There are two main types that we classify burning mouth disorder into, there is a secondary and a primary. And secondary is simply that there's a cause. There is an identifiable cause be it an endocrine disorder, be it some sort of oral pathology, but there's something that we can pinpoint that's causing the burning sensation. And primary burning mouth disorder has no identifiable cause. We don't really know, everything looks normal. Serology is normal, all tests are, are fine. There's no endocrine disorder., they're not diabetic or if they are, they're well controlled. But everything is really just everything is normal. So, these are our two main types. And it certainly behooves us to do a thorough exam, not just an interview.
- Dr. Shackleton: Somebody who was referred to my office, not long ago, came in complaining of burning mouth. On the referral form it said this person has burning mouth. And through our interview she identified, you know, burning sensation, spicy food makes it worse. Cool water makes it feel better. It's there all the time. It's been around for the past 10 months. No medications. So, in my brain I was thinking well, it sounds like primary burning mouth disorder and then she opened her mouth and we could see oral lesions throughout her entire mouth. So obviously this is a secondary burning mouth disorder. As we can see in these images, possibly [inaudible] or some sort of ulcer or lichen planus. And so, if we manage that primary condition, then hopefully we'll help her get a little bit better.
- Dr. Shackleton: And again, no tobacco use, rare social drinker and no drug use. 'And by rare Somebody rare social drinker she said she had a glass of wine every week or two, but nothing consistent and nothing outrageous.
- Dr. Shackleton: Clinical presentation with burning mouth disorder: Usually these people are going to report having it for four to six months. You know, if somebody reports having something for a couple of weeks, it's usually the type of condition we'll monitor. But if it's persisting over a course of several months, we need to do some further investigation. They do tend to report, typically, a burning sensation, hence the name. It tends to be, in terms of its severity, if we think of 0 to 10, they tend to report it on maybe somewhere between a 3 and a 5. It's not derailing their day, so to speak, but it is having an impact. It's always there. It's always, you know, many of us have eaten something spicy, so imagine experiencing that throughout most of your day. It's just not a pleasant experience.
- Dr. Shackleton: Food tastes weird. Their mouth feels dry. These are common complaints. And so primary has no other identifiable cause. No new medications. So, ask you're

asking them about their history, any new medications, any medical conditions, any changes in your life, you know, are you going through a particularly stressful time, new job, moving, death in the family, divorce, illness, whatever, but there's no identifiable cause. Secondary has the same issues, dry mouth, food tastes funny, burning sensation which is there, but there, but there is an identifiable cost. It's often related to medications. Hey, I've started a new medication and then, you know, a week or two later all of a sudden my mouth started burning, or you know, perhaps they have an undiagnosed medical condition, which is why you want to be really good friends with the physicians in your community so that you can certainly get a consultation with them if you have those concerns..

Dr. Shackleton: Our patient characteristics: Women more than men 3:1. Has many pain conditions. Women typically older than 30. Typically, they're post-menopausal. So, if somebody in their 20s and they come into your office complaining of burning mouth, I'd be very hesitant to say this is burning mouth disorder. Men are typically older than 40. So again, it tends to be another, like many pain conditions, our population tends to be a little bit older. And so, our diagnosis, so we have to exclude oral and systemic pathology. So, we want to exclude any oral infections. We want to make sure that the teeth are fine. We want to make sure there's no intraoral swellings or extraoral swellings. We want to rule out things like candidiasis. So, swabbing some tissues in their mouth. Sometimes it includes biopsy, sometimes maybe we will see a suspicious lesion that's causing the problem.

Dr. Shackleton: Like that lady we saw in the previous slides. Blood work, ordering some blood work. We want to make sure there's no vitamin deficiencies. We want to make sure there's no autoimmune conditions going on, especially something like Sjogren's, because again, many of these patients will complain of dry mouth. So again, having a good relationship with your local physician and making them part of your team in diagnosing these patients. We want to make sure they're not diabetic. And so as you're having a discussion with them, any recent weight loss, you're going to the bathroom a lot, you're always thirsty? So again, you want to make sure there's no new medications on [inaudible]. Just, has anything changed that would predispose them to this? So just again, very thorough in your interview and very thorough in your examination. So how do we treat these patients?

Dr. Shackleton: This can sometimes be equally difficult as arriving at a diagnosis. And so, with all diagnoses you have to look at your response to treatment. And so, diagnosis to many people, and myself included, isn't really completed until we see a response to treatment. Because if we have diagnosis A and we prescribe a certain treatment or therapy, or course of treatment and they don't respond at all. So, either we need to re-evaluate what is our course of treatment, is that being effective? Or maybe we need to rethink our diagnosis? So, for a

secondary, if you treat the primary problem often the brain mouth goes away. So, if it is a medication, talk to their physician, say, look, you put them on this hypertensive medication, they now have burning mouth, is there an alternative? And if there is an alternative, okay, then you may have to start managing it like a primary condition.

Dr. Shackleton: But, you know, as soon as you clear up the primary problem, the burning mouth tends to go away. But with primary burning mouth disorder we often prescribed a zinc supplement, which you can get in any pharmacy, 14mg per day. We have them do alpha lipoic acid, 600 mg per day. And for many people this offers some relief. Sometimes we'll have people do a clonazepam rinse and so they take a 0.5–1 mg and they crush that up, put a little water in it, swish it for 3 minutes, and then spit it out. You have to really make sure if you're going to do this, that you make sure that they spit it out. I have had patients come back to me and they're just popping the Clonazepam like tic tacs thinking this is going to help my burning mouth, which some report that it actually does.

Dr. Shackleton: We don't want them doing that because again, they're an older population. It's a centrally acting medication so we don't want to make them foggy, dizzy, lose their balance or have any issues that way. You can also prescribe an elixir. Some people prefer that. Some people prefer crushing up the medication. It's all patient, it's all driven by the patient, whatever they want. If those work great, if not, sometimes we'll even add in a little bit of Gabapentin and that can offer some relief because we think, um, especially in primary burning mouth disorder, that this is being driven as it, we consider it a neurological condition. So, that seems to offer some relief for these folks who just don't respond really well to the other more conservative approach. But, and there's a caveat here with all of these treatments, a 2016 systematic review showed that a lot of the treatments for burning mouth disorder that are commonly used there's no really good evidence to support them, there's no really good evidence to refute them.

Dr. Shackleton: We do know that, in terms of comorbidities, we see a common comorbidity with these patients and it's depression and sometimes anxiety. So, it's about double what we'd see in the regular population. So, a psychological assessment would never hurt with these folks too, Again, having a really good relationship with your local physician or if you know a psychologist and they're open to having a discussion, I think that's great for these folks. And if nothing else, even if there is no depression or anxiety or history of any of them, helping somebody having a healthy relationship with their pain is a very positive thing to do. It helps them deal with the daily aspects of their pain. It helps them not to get derailed when the burning happens, or any neuropathic condition happens.

Dr. Shackleton: So, it helps them, recommit to engaging in their life. So I think that's wonderful. It's kind of behavioral therapy or mindfulness based cognitive behavioral therapy. A few clinical pearls: Be very sympathetic with these folks because,

especially [inaudible] with the primary burning mouth disorder, or even secondary if there's an identifiable cause, but it hasn't been identified yet. People will look in their mouth, they'll look at their face, their skin and everything looks more. They are otherwise healthy person walking into your office and they say, my mouth is burning all the time. And so, they've usually been to several people, they've been to several dentists, maybe some dental specialists, maybe ear, nose and throat, maybe they've been to a rheumatologists and they've been to a lot of people and they're not getting answers. And people, they're talking to them like they're kind of crazy and, and they start to feel like, maybe I am crazy.

Dr. Shackleton: Maybe this is only in my head. I mean, it is all in their head. But you know what I mean? They begin to think, I'm not making this up, but nobody's believing me. So, there's a sense of desperation with a lot of these patients too. So just, a lot of sympathy, be caring, and make sure you do your thorough in your diagnosis and rule out other causes. Like many neuropathic conditions, it's a diagnosis at least in part of an exclusion. And support them, you know, always be there for them. Answer their questions, take the time out of your day to respond to them. If they send you an email, if they phone you, return their call, try to do it in a timely fashion just so that they know that you're there to help them out because that goes a long way in helping their relationship with their pain.

Dr. Shackleton: And again, don't over promise, don't say, oh, we're going to give you these medications. It's going to be great. You know, no problem. Because some people, even though you give them all these medications and you've ruled out everything, they just don't respond particularly well to these therapies. So, don't over promise unless you love heartache. So, you can imagine Waylon Jennings or Elvis singing in your ear. So, this is really who you want to be. You want to be calm, you want to be reassuring. You want to just let that patient know that this is real, that what they're experiencing is valid, it is legitimate and that there are treatment options, and that it's imperfect but many people do respond quite well to these therapies. So, a few sources for you to look at and thank you for your time.

Dr. Shackleton: Thank you for your attention. So, if you see these patients in your office, again a step wise approach, if you are get stuck, which we all get stuck, again relying on your community, other dentists who maybe have a special interest in this. Maybe a physician who you know is a pain physician who's comfortable in dealing with these patients. Great, wonderful. So, and by the way, even though they have this neurogenic condition, you can still do hygiene, you can still do crown and bridge work. because they still get decay, they still get gum disease, you know, they still need these other therapies and you can proceed. You may have to provide local anesthetic, which is fine. You may have to have them do a lidocaine rinse or something like that before you do hygiene. Fine. All of these things are okay. You can still treat them. So, I think as dentists and as a general

dentist it's great to be able to provide these people with the care that they need.

Dr. Shackleton: So, thank you for your time and attention and have a great day.