Reservation Form for Annual WFHS Meeting

Friday November 12, 2022 / Saturday November 13, 2022

Name _____

Address _____

City _____ State _____ Zip _____

Email _____ No. of persons in your party _____

Total amount due $_____

FRIDAY , NOV. 12, 2022
Capital Grille
155 East 42nd Street
6:30 PM
$130 per person

SATURDAY, NOV. 13, 2022
Morning Residents' presentations
NYUCD
Registration 8:30 AM
Dr. Stuart Lieblich at 1 PM

SATURDAY EVENING
Scarpetta Restaurant
88 Madison Avenue
6:30 PM
$150 per person

Please remit to Dr. Claudine Cafferata, 1101 Stewart Avenue, Suite 302, Garden City, NY 11530

Please bring proof of vaccination for COVID and bring face masks to be used if required.

WILLIAM F. HARRIGAN SOCIETY
163 Locust Fence Road
St. Helena Island, SC 29920

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Newsletter

William F. Harrigan
ANNUAL MEETING

THE 2022 ANNUAL MEETING OF THE WFHS will be held on Saturday Nov 13, 2022. Presently, we are planning on a live meeting on site at the NYUCD.

The Harrigan Award winner for this year is R. Gilbert Triplett D.D.S., PhD. He will speak on zygomatic implants. Dr. Triplett is a graduate of the Loyola University school of Dentistry in New Orleans. He earned his PhD in Physiology and Biophysics from Georgetown University. He did his residency in OMFS at National Navy Medical Center in Bethesda, Maryland and the Boston Naval Hospital in Chelsea Mass. He had a distinguished 21 year career in the Navy Dental Corps including a stint as head of the Dental Branch Combat Casualty Care Section of the Navy Medical Research Institute in Bethesda and Program director of OMS Residency at San Diego Naval Medical Center. He joined the University of Texas Health Science Center in San Antonio in 1984 as OMS Program Director. He subsequently became Chairman of the Department of OMFS Surgery and Pharmacology and Assistant Dean for Hospital Affairs at Baylor College of Dentistry in Dallas. He has received multiple awards during his teaching career including a Research Recognition Award from the OMFS Foundation, the Harry Archer Award for Teaching Excellence the ACOMS and the AAMOS Robert V Walker Distinguished Service Award in 2020. He has served as a reviewer for the NIH Dental Research from 1987 till 1993. He has published extensively, including coauthoring a text on War Injuries to the Jaws and Related Structures seen in the Vietnam War.

MEETING INFORMATION

The annual meeting will be held on Saturday November 13, 2022. There will be a Board dinner on Friday night which will be at the Capital Grille on 42nd Street. Non- Board members are welcome to attend if space is available. The cost will be $130 per person.

The actual annual meeting will be on Saturday November 13 and we are planning to have it live at NYUCD with a starting time of 9:00 AM. We will begin with resident presentations from participating programs. This will be followed by Dr. Triplett's presentation on zygomatic implants.

The Saturday night dinner will be held at the Spartina Restaurant on Madison Avenue. The cost will be $130 per person. Those wishing to attend should send their checks to Claudine Cafferata.(see reservation form).

These arrangements are all subject to change depending on the state of the COVID pandemic in NYC. We will attempt to keep you informed if we have to change any of our plans.

Vesiculo-bullous disease of Oral Mucosa.

Part 1: Diagnostic Considerations

Oral and maxillofacial surgeons are often called upon to evaluate patients with vesiculo-bullous lesions of oral mucosa. Patients with these conditions are often symptomatic, uncomfortable and concerned about their condition. It is incumbent for the Oral and Maxillofacial Surgeon to diagnose and manage these patients.

Essentially vesiculo-bullous diseases can be categorized based upon etiology. These include:

- Viral
- Hereditary.
- Bacterial
- Mycotic
- Autoimmune
- Idiopathic

When evaluating a patient with mucosal vesicles or ulcerations, the clinician should consider various factors when developing a differential diagnosis. Age is important because some entities occur in young patients (epidermolysis bullosa) and generally primary herpetic gingivostomatitis. Others such as pemphigoid occur after age 50. Another factor to consider is location of involvement. If lesions recur in the same area, consider recurrent herpes that involve the anatomic area innervated by a sensory nerve. If they recur in different areas, consider aphthous ulcers. Aphthous ulcers involve nonkeratinized mucosa as compared to recurrent herpetic vesicles that involve keratinized mucosa or skin. If vesicles occur in multiple mucosal sites including ocular or nasal mucosa with or without skin lesions, then consider autoimmune entities such as pemphigus, pemphigoid or lupus (if there is erythema or white plaques adjacent to the hairline). The presence of vesicles can rule out mycotic or bacterial entities. Candidiasis can present as an erythematous area or white plaque that can be removed relatively easily leaving a bleeding surface.

Recurrent Aphthous ulcers are an annoying malady for patients. They are thought to be a hypersensitivity response to minor trauma or bacterial infiltration. Aphthae can occur in three variants: minor, major and herpetiform. Aphthae are usually less than 1 cm, painful and involve nonkeratinized mucosa. They occur as solitary or multiple lesions. Major aphthae or Sutton's disease is associated with large ulcers that are greater than 1 cm in diameter. Rather than a duration of 10-14 days as minor aphthae, ulcers associated with Sutton's disease can last for weeks or months with scarring.

Herpes is a family of DNA viruses ranging from herpes simplex to herpes type 8. Herpes involving the oral and maxillofacial area is considered type I although herpes type 2 can also involve this region. Primary herpetic gingivostomatitis often occurs in children but can be diagnosed at any age because of lower rates of serum antibody conversion in the United States. Primary herpetic lesions involve keratinized and nonkeratinized mucosa and classically the gingival papilla appears "punched out". Patients with acute primary herpetic disease exhibit signs and symptoms of a systemic viral infection. The skin may also be involved in more severe cases, The onset is rapid occurring over 24 to 48 hours. Many primary herpetic infections can be subclinical. If skin involvement occurs in the anatomic distribution of the first division of the trigeminal nerve, then an ophthalmologic consultation is imperative to evaluate for herpetic involvement of the eye. As mentioned previously, secondary or recurrent herpes involves keratinized mucosa or the vermillion of the lip. Patients will notice prodromal symptoms such as tingling 24 to 48 hours before the onset of vesicles. The vesicles recur in the same anatomic site innervated by the involved sensory nerve. Cytologic evaluation of a punctured intact vesicle may be beneficial to aid in the diagnosis.

Herpangina is caused by an RNA enterovirus (enterovirus 71). Included in this group of enteroviruses are herpangina and hand foot and mouth disease. Herpangina can occur in epidemic fashion with oral vesicles appearing initially. The vesicles are small and confined to the soft palate and tonsillar pillars. Hand foot and mouth disease (another enterovirus) is characterized by vesicles involving both anterior and posterior oral mucosa and the hands and feet. Patients with diseases caused by enteroviruses have signs and symptoms of a systemic viral infection.

Vesicular, ulcerated and erythematous lesions that are hereditary or autoimmune occur in Epidermolysis Bullosa. These are either congenital or occur in the first decade of life. Oral mucosal involvement occurs with gingival erythema, recession, tooth mobility and loss of teeth. There are hereditary variants and an auto-immune mediated variant. Patients have difficulty with mastication and oral hygiene. The dentist must be cognizant that trauma to oral mucosa should be avoided during dental treatment. Some variants have skin involvement with significant scarring. Surface lesions caused by viruses usually have a sudden onset, vesicular stage and may be accompanied by systemic symptoms.

Mucosal lesions of bacterial origin are rare even though streptococcal pharyngitis is common and does not exhibit a vesicular stage. Mycotic lesions are also extremely rare except in compromised individuals, (with the exception of candidiasis). Candidiasis can often be recurrent and chronic. Vesicles do not occur but there can be erythema and ulceration. A white area when present can be wiped off leaving a bleeding surface.

Autoimmune mucosal diseases are usually chronic with periodic exacerbation and partial remission. Vesicles or bullae usually occur with these entities (with the exception of lupus erythematosus). Lichen planus classically has white areas with or without erythema. There is epithelial thickening and subbasement layer inflammation. Erythematous lichen planus with ulceration may be difficult to differentiate from pemphigus or pemphigoid. Nikolsky's sign is usually more consistent with pemphigus or pemphigoid than lichen planus. Lichen planus may have cutaneous involvement and a variety of oral mucosal patterns. Another classic feature is white areas with striae (Wickham's striae) involving the buccal mucosa. Biopsy is indicated to confirm the diagnosis of lichen planus.

Pemphigoid is an autoimmune disorder characterized by subepithelial vesicle formation that can affect mucosa and skin. There is a spectrum of pemphigoid that involves just oral mucosa or more severe variants affecting skin, multiple mucosal sites including ocular mucosa that potentially can progress to blindness. When confined to oral mucosa, it can present with gingival erosion, erythema or multiple ulcers. It generally occurs over the age of 50 and affects women 2:1. Biopsy for light microscopic examination or direct immunofluorescence will demonstrate subepithelial cleft formation.

Pemphigus, an autoimmune condition, has an intraepithelial vesicle as its characteristic microscopic feature. Pemphigus can affect varied mucosal sites and skin. In 50 percent of cases, oral mucosal lesions precede skin lesions. As with pemphigoid, Nikolsky's sign is evident. Biopsy submitted in formalin for routine microscopic examination is necessary for diagnosis. A specimen submitted in Michel's solution for immunofluorescence may be helpful for diagnosis (the same can be said for pemphigoid).

Idiosyncratic drug reactions (lichenoid drug reactions) have been associated with non-steroidal anti-inflammatories, diuretics and antidepressants and can mimic lichen planus. A thorough history with the medications taken by the patient must be obtained.

Erythema multiforme is uncommon and may occur after the administration of certain medications such as sulfonamides, vaccines and following herpetic infections. A classic finding in patients with erythema multiforme is hemorrhagic crusted lips. Diagnosis of erythema multiforme is usually based upon the exclusion of other disease entities.

Erythroplakia involves nonkeratinized mucosa and should be considered squamous cell carcinoma until proven otherwise by biopsy and microscopic examination. Prior to biopsy of any lesion considered to be potentially malignant, the clinician must perform a thorough head and neck examination

Bechet syndrome, now thought to be a vasculitis, can present as aphthous ulcers that are difficult to manage. The aphthae like lesions in Bechet syndrome occur as multiple rather than solitary lesions. The ulcers last longer than minor aphthae. To diagnose Bechet disease, the ulcers should recur three times in twelve months. Patients may have recurrent genital ulcerations, ocular involvement such as anterior or posterior uveitis or retinal vasculitis. Patients may also have erythema nodosum like skin lesions.

Reiter syndrome is thought to be a reactive arthritis. Characteristic of the disease is peripheral arthritis associated with conjunctivitis and non-gonococcal urethritis. Oral lesions can occur and may resemble geographic tongue with ulcerations of oral mucosa. The diagnosis is made upon the clinical findings.

In summary, obtaining a thorough history and physical examination can provide a great deal of information leading to the diagnosis. The presence and location of skin lesions narrow the differential diagnosis particularly in autoimmune entities such as pemphigoid, pemphigus and lupus erythematosus. For suspected primary herpetic gingivostomatitis, puncture of an intact vesicle for cytologic smear may be helpful. Viral subtyping may also be helpful for the evaluation of patients with enteroviruses such as herpangina and hand foot and mouth disease.

In cases of suspected squamous cell carcinoma, toluidine blue vital staining can indicate areas of increased cellular activity and provide an indication of where to biopsy (not when to biopsy).

Aphthous ulcers, recurrent herpes, and pigmented lesions can be confirmed by history and physical examination. For suspected candidiasis, a smear of affected mucosa will confirm the diagnosis. If the history and physical examination cannot establish the diagnosis, then a biopsy is indicated. If the decision is made to biopsy suspected lichen planus or chronic mucosal disease, the attached gingiva should be avoided due to the presence of an underlying inflammatory infiltrate that can occur adjacent to the gingival margin. For entities with ulcerated areas, these should not be selected for incisional biopsy as nonulcerated epithelium is more likely to have diagnostic features.

Part 2 will discuss management of these entities.