ANGINA BULLOSA HEMORRHAGICA (RECURRENT ORAL HAEMOPHLYCTENOSIS)

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A case of recurrent oral haemophlyctenosis, characterized by sudden onset of tense blisters on the tongue is being reported. The blisters were filled with haemorrhagic fluid and healed within a week.

Key words : Recurrent Oral Haemophlyctenosis, Angina bullosa haemorrhagica

Case Report

A 65-year-old man presented with sudden onset of two haemorrhagic blisters over the left side of the tongue, with burning sensation on eating. He gave history of similar episodes, on 3 occasions during the last 5 years. There was no history of consumption of any drugs in the recent past. The lesions were not associated with fever or any other constitutional symptoms.

Clinical examination revealed 2 tense blisters, 0.75 and 0.5cm in diameter (Fig.1), on the left border of the tongue. Roof of the blister was formed by transluscent mucosa and it was filled with haemorrhagic fluid. Regional lymph glands were not enlarged. Systemic examination did not reveal any abnormality. His blood glucose level, platelets, haemogram, bleeding time and clotting time were within normal limits. As the patient knew that the lesions healed of their own in the past, he refused to undergo biopsy. After reviewing the literature, [1-3] we diagnosed him as a case of recurrent oral haemophlyctenosis (ROH). Considering the sudden onset and recurrent nature, we prescribed acyclovir 2 (g) in divided doses. The lesions healed within 8 days without any scar formation.

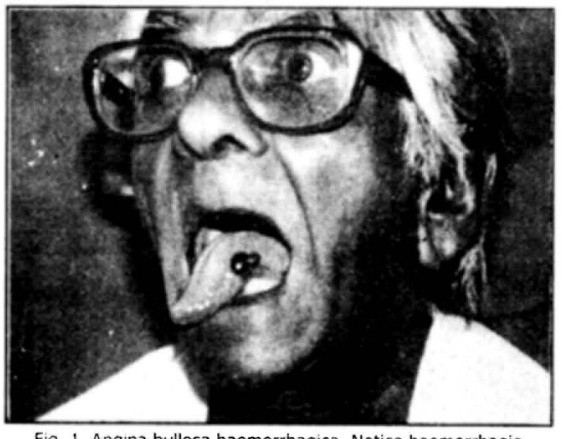

Fig. 1. Angina bullosa haemorrhagica. Notice haemorrhagic bulla on the tongue.

Discussion

Recurrent oral haemophlyctenosis or angina bullosa haemorrhagica was earlier known as traumatic oral haemophlyctenosis. It presents as oral

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haemorrhagic bullae, single or multiple, 0.75 mm to 10 mm in diameter, recurrent, non inflammatory, induced by trauma[1,4] and heal without scarring. The lesions are commonly seen over the soft palate, but can also affect the buccal mucosa. These blisters tend to rupture during meals and blood oozes out leaving behind erosions which heal within 7 to 10 days without any scar. Other mucosae are spared. The etiopathogenesis is not fully understood. Few predisposing factors like long term use of steroid inhalers,[5] diabetes, trauma caused by dentures or hard or spicy food material have been reported. Histopathology reveals uniloculate subepidermal haemorrhagic blister. Deposition of immunoglobulin G and C3 at the basement membrane was documented in some cases.[3] In the differential diagnosis, haematologic disorders should be considered. The recurrent nature, absence of bleeding or clotting abnormalities and self limiting nature helps in establishing the diagnosis of this disorder. There was no history of trauma in our case. No obvious predisposing factor could be traced in this patient. As the patient was not willing to undergo any further investigations, we could not get his mucosal biopsy or anti HSV titres done.[3] Taking into consideration the recurrent nature and sudden onset of the lesions we prescribed acyclovir. Kirtschig et al have also tried acyclovir in their patient.[3] We are probably reporting the first case of ROH in the Indian literature.

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