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Oral and maxillofacial manifestations of autoimmune diseases

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Since the start of recent healthcare, medicine and dentistry have existed as separate healthcare domains. The systemic separation began a century ago, and health care policy has historically reinforced it. While this separation seemed to serve for several years, significant changes in healthcare have occurred and this separation is now obsolete and should be harmful. This artificial division of care into organizational silos ignores the very fact that the mouth is a component of the body. The emergent understanding of how oral health affects overall health, and the other way around, suggests that continuation of this separation results in incomplete, inaccurate, inefficient and inadequate treatment of both medical and dental disease. We are entering the age of accountability and wish to specialise in oral and craniofacial health also as its connection to systemic health, research and education. albeit technology and therefore the market are constantly changing, there's one thing which always remains an equivalent – the human concern for health. The strength of overall healthcare during a community relies on an interdisciplinary approach. Its integration.

The classical clinical manifestation is represented by a daily round or slightly red irregular area. this will be characterized by atrophy or the presence of ulceration. The red area is characterized by typical white radiating striae and telangiectasia. These signs may resemble those of lichen ruber planus, despite the shortage of symmetry. Although the oral condition isn't major, petechial lesion and gingival bleeding like desquamative gingivitis, marginal gingivitis, or erosive mucosal lesions are reported in up to 40% of patients and should indicate serious thrombocytopenia.

The diagnosis of mucosa pemphigoid is predicated on clinical and histological samples. The histologic examination shows the detachment of the epithelium from the underlying animal tissue. Direct immunofluorescence is diriment when there are doubtful histological samples showing a linear involvement at the extent of the basal membrane. The immunofluorescence is especially useful within the medical diagnosis with pemphigus and lichen also like periodontitis and SLE. Epithelial degeneration isn't observed; the animal tissue appears pervaded by an intense inflammatory infiltrate mainly consisting of plasma cells and eosinophils.

It has been said that there aren't pathognomonic laboratory findings. so as to diagnose the Behcet syndrome, consistent with the ISG criteria, a minimum of two of the most features (oral, genital, or ocular lesions) must be present when another clinical explanation is excluded. Indeed, the medical diagnosis may be a challenge considering that oral aphthous lesions are quite common within the general population. Moreover, aphthous lesions are linked to HIV, Crohn's disease, sarcoidosis, and SLE, as long as the dual-site-specific ulcerations seem to be the unique sign wont to differentiate the Behcet syndrome.

The treatment of Behcet syndrome is predicated on the utilization of local and systemic cortisones intrinsically or including immunosuppressant drugs. the utilization of immunosuppressive drugs is justified by the shortage of prevention of relapses thanks to the monocorticosteroid treatment strategy. the most objective of Behcet syndrome patient care is to treat in time the oral mucocutaneous lesions so as to hinder the progression of the disease and to stop the irreversible organ involvement especially during the active phase. Behcet syndrome might be fatal especially within the case of vascular involvement: aneurism rupture and thrombosis are the most causes of death.