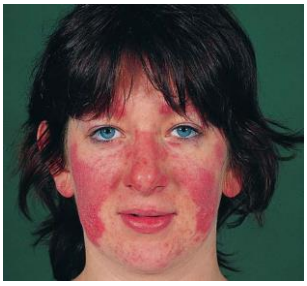
Systemic lupus erythematosus:

Systemic lupus erythematosus: it's autoimmune systemic disease.

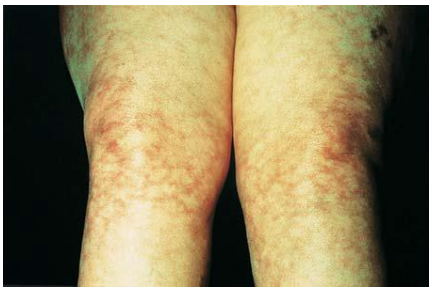
Some 90% of affected patients are female and the peak age at onset is SLE is associated with considerable morbidity .between 20 and 30 years and a fivefold increase in mortality compared to age- and gender-matched controls, mainly because of an increased risk of premature cardiovascular disease.



Features Characteristics

1-Malar rash Fixed erythema, flat or raised, sparing the nasolabial fold

2-Discoid rash Erythematous raised patches



3-Photosensitivity Rash due to unusual reaction to sunlight

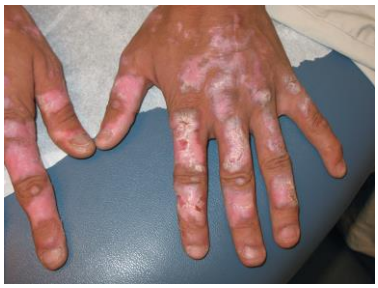
4-Oral ulcers Oral or nasopharyngeal ulceration, which may be painless

5-Arthritis Non-erosive

6-Renal disorder

7-Neurological disorder

8-Haematological disorder



Oral and dental complications:

Oral manifestations of SLE are frequently encountered and may include:
1-Oral ulceration: with a prevalence rate ranging between 7 and 41%, which is observed to be more severe as the disease

2-Honeycomb plaque, raised keratotic plaque, nonspecific erythema, purpura, petechiae. Research shows that 25% of SLE patients have oral .mucous membrane and lip involvement with possible petechiae

3-Cheilitis.

4-Both xerostomia and hyposalivation predispose patients with SLE to dental caries and recurrent noninfectious pharyngitis and oral ulcerations.
5-Oral candidiasis and infections are also common due to the usage of corticosteroid which is used in the treatment of SLE.

6-Among the oral manifestations is periodontal disease (PD): study showed that a relationship does exist between SLE activity and periodontal status.

A more recent study as well showed that treatment of periodontal disease aids in reducing the symptoms of SLE

7-Mucocutaneous lesions (desquamative gingivitis, marginal gingivitis or erosive mucosal lesions).

8-Temporomandibular joint disorders (arthralgia, arthritis)

9- Suboptimal oral hygiene because of painful oral lesions

Management:

1-The Dentist must enforce preventive dental care and monitor patients with SLE closely.

2-Thorough clinical examination is required to avoid overlooking infections. Infections can progress rapidly in patients with SLE because of disease or therapy-related immunosuppression.

3-To further complicate matters, patients with SLE can have a superimposed antiphospholipid antibody syndrome that predisposes them to thromboembolic events, such as arterial and venous thrombosis, pulmonary embolism, stroke and myocardial infarction. It is therefore important to document whether these patients are managed with anticoagulation therapy, aspirin or warfarin before dental surgery.

Recent laboratory tests may be indicated preoperatively to determine platelet count, prothrombin time and the international normalized ratio (INR) for blood clotting time. Local measures for maintaining hemostasis may also be required.

4-Patients suffering from chronic renal failure are often on dialysis. Dental surgery should be planned one day after dialysis treatment to ensure elimination of administered medications and their by-products

5-Patients on long-term corticosteroids may require supplemental dosing on the day of a potentially stressful dentoalveolar surgery.

6-Attention to the possibility of drug interactions because this patient group may be taking many different medications.

Celecoxib is sulfa based and may lead to rashes as many patients with SLE react.

Avoid ibuprofen if possible due to risk of causing aseptic meningitis