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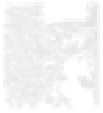
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**IMPROVEMENT OF THE TREATMENT REGIMEN FOR RECURRENT APHTHOUS STOMATITIS**

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*Abstract: Chronic repetitive mouth sores stomatitis remains one the most urgent problems in practical dentistry, as evidenced by its greater incidence and ineffective treatment. This article goes into great detail on a clinic comparison and recurring stomatitis in patients.*

*Keywords: oral cavity infections, aphtha, relapse, stomatitis, ulcer*

**Introduction:**

Chronic repetitive aphthous stomatitis (CRAS) remains the most common ulcerative disease of the oral mucosa (OM) [1, 4]. Repetitive aphthous stomatitis (RAS) is characterized by multiple recurrent small rounds or ovoid ulcers with circumscribed margins, erythematous haloes, and yellow or grey floors [2]. Bouts of ulcers can recur at intervals of between a few months to a few days, afflicting otherwise healthy people [5]. Aphthous ulcers are usually extremely painful for the first 4-5 days and can interfere with eating and speaking during that period. The first lesions occur in childhood or adolescence and up to 25% of the worldwide population is estimated to be affected by RAS [5]. Several factors have been proposed as possible causative agents for RAS, including local factors, such as trauma in individuals who are genetically susceptible to RAS; microbial factors; nutritional factors, such as deficiency of folate and B-complex vitamins; immunologic factors; psychosocial stress; and allergy to dietary constituents [4]. Despite numerous scientific studies in recent decades, the etiology of this disease remains incompletely understood [16].

One of the promising zones of scientific investigation within the field of regenerative medication is the advancement and optimization of strategies of conventional pharmaceuticals to progress the viability of anticipation and treatment of patients with common incendiary maladies, counting in such a common dental malady as incessant aphthous stomatitis [12, 14].

CPPS is an inflammatory disease of the SOR characterized by recurrent aphthae and a long-term course with periodic exacerbations [18].

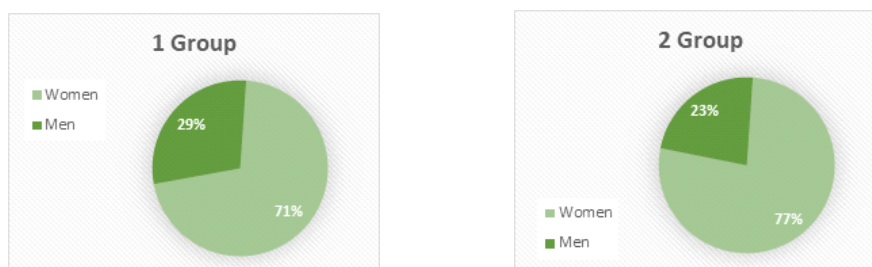
There are several theories of the origin of this disease, which have been confirmed both in scientific research and in practical medicine. These are allergic theory [ 11], autoimmune [6], genetic [8], neurotrophic [ 9], presence of GI diseases [10], and local trauma as a predisposing factor.

However, nowadays, the leading role of immunopathological reactions in the pathogenesis of RAS is increasingly spoken about [3, 7]. This may explain the occurrence of aphthae on PWS in Crohn's disease, ulcerative colitis, Behcet's syndrome, where there is also an autoimmune component in the pathogenesis [15, 17]. Due to polyetiological factors of RAS, the aim of the work was to optimize the treatment regimen of the disease according to the established etiology.

**Material and methods:**

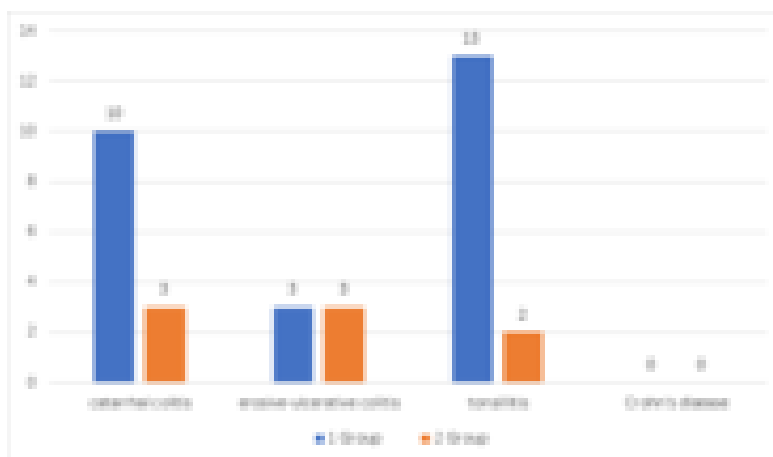
Thirty-seven patients with the appearance of constant aphthous stomatitis within the

verbal depression tended to inquire about the center of the Workforce of Dentistry of Bukhara State Therapeutic Organized. All patients complained of burning and torment of the mucous layer of the mouth when eating or talking. A few famous the event of single agonizing "ulcers" within the verbal depression in places open to their vision. All patients had a history of the rehashed event of CPAs components (2-4 times per year). All patients were isolated into two bunches depending on the recurrence of repeats. Group 1, with recurrence frequency from 1 to 3 times a year, included 28 (76%) patients, of whom 20 (71%) were women and 8 (29%) were men. Group 2, with a recurrence rate of 2 to 6 times per year, included 9 (24%) patients, of whom 7 (77%) were women and 2 (23%) were men. (Graph 1)



**Graph 1**

All patients underwent dental examination to determine their complaints, frequency of relapses, ongoing treatment, duration of remission, and existing somatic pathology. When examining the oral cavity, the localization of aphthae varied. Their location on the mucous membrane of the cheeks and lips, the transitional fold of the vestibule, the mouth, and the lateral surfaces of the tongue was detected. The surrounding surface of the verbal mucosa was not discolored. Single (less often two) painful erosions had round or oval shapes with clear boundaries were covered with fibrinous plaque and had characteristic hyperemic contour on the periphery. The hygienic state in all patients was poor (OHI-S 3.0 and higher). There were abundant soft and hard dental deposits, the loose gingiva was moderately hyperemic and edematous, and the integrity of the periodontal attachment was intact. All patients were referred to a gastroenterologist for examination to rule out Crohn's disease and ulcerative colitis. None of the patients were diagnosed with Crohn's disease on general examination. The diagnosis of "catarrhal colitis" was made in groups 1 to 10 patients and in groups 2 - to 3 patients. The diagnosis of "erosive-ulcerative colitis" was made in the 1st group of 3 patients and in the 2nd group - of 3 patients. The conclusion of constant tonsillitis was made in 13 patients in Group 1, and in Group 2 - in 2 patients. (Graph 2). After the dental examination, there was carried out sanitation of the verbal cavity includes professional hygiene, extraction of destroyed teeth and roots, treatment of caries, and its complications. Rational prosthetics were recommended. In the case of gastrointestinal diseases, the patient was mandatorily referred to a gastroenterologist for consultation and treatment. If the diagnosis of "chronic tonsillitis" was established, the patient was referred for consultation and treatment by an ENT specialist. When drawing up a treatment plan for recurrent aphthous stomatitis, all possible etiological factors of the disease were taken into account.



**Graph 2**

The following treatment regimen was offered to the first group of patients. General: 1) antihistamines (Kestin, Cetrine, erius, tavegil) for 10-12 days, 2) vitamin therapy (vitamin C, B vitamins, ascorutin) for 1-2 months, 3) sedative therapy (Persen, Novopassit, motherwort forte, Tenoten, Nervohelle, etc.) for 2-3 months, 4) and therapies: 1), therapeutic methods.) for 2-3 months, 4) immunoprotective therapy (polyoxidon in tablet, Imudon, Metiluracil) for 12-14 days, 5) prebiotics (normobakt, linex, Mexaform, Colibacterin, etc.). Local: 1) anesthesia (1% lidocaine solution, trimecaine) in the form of applications, baths; 2) antiseptic treatment (solution of miramistine, OCI, chlorhexidine 0.05% solution, etc.); 3) epithelializing therapy (vitamin A oil solution, carotolin, cholysal, solcoseryl ointment, medical gel, methyluracil ointment, etc.) in the form of applications; 4) anti-inflammatory therapy (ointments prednisolone, celestoderm, elocom, etc.) in the form of applications; 5) physical therapy (helium-neon laser). For group 2 patients the treatment regimen remained the same. However, in immunoprotective therapy Polioxidonium was recommended not in tablets, but injections of 6 ml w/v/m for a course of 10 injections. Detoxifying therapy was prescribed - 30% sodium thiosulfate solution intravenously, 10 ml for a course of 6-8 injections. Nonspecific hypersensitizing therapy was also added. To start such therapy, remission within 2-3 weeks had to be achieved. Nonspecific hypersensitizing therapy was performed with histoglobulin preparations (?-globulin, ?-globulin) 2 ml. The injections were made subcutaneously in 2 ml twice a week with an interval of 2-3 days. There were 8-10 injections per course.

**Results.**

The patient management tactics are of great importance in the treatment of CPPS: establishment of good psychological contact with the patient, selection of optimal drug regimens, and follow-up observation between relapses. CPPS with frequent recurrence of aphthae on the oral mucosa is quite difficult to treat if its complex therapy does not include examination and correction of immunity and treatment of concomitant gastrointestinal diseases. After complex treatment in the 1st group, the recurrence rate in 20 patients was reduced to 2-3 times per year; in 7 patients no recurrences were observed during the examination period. In Group 2, the frequency of relapses during the examination period in 5 patients reduced to 3-4 times a year, in 4 patients - to 4-6 times a year. It should be noted that not all patients (about 60%) sought the help of specialists for the treatment of somatic pathology, which certainly influenced the results of treatment.



**Conclusion.**

Regularly scheduled sanitation of the oral cavity, further dispensary observation, detection and treatment by specialists of patients with insufficient immunological protection of the body, gastrointestinal diseases, reduce the number of relapses of the disease. Thus, after the study and positive results of the proposed scheme of complex treatment of oral cavity disease we can recommend this scheme for use by dentists in everyday practice.



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