MARVIX AI

SAMPLE ORAL MEDICINE CONSULTATION SOAP NOTE

ORAL LICHEN PLANUS — EROSIVE/ATROPHIC + BIOPSY

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1 PATIENT INFORMATION

1 PATIENT DETAILS

NAME
Eleanor V. Sutton

DATE OF SERVICE
05/06/2026

DOB
03/18/1968

PROVIDER
Dr. Nathaniel Park, DDS, MD — Oral Medicine

AGE / SEX
58 / Female

MRN / PATIENT ID
OM-2026-0291

CREDENTIALS
DDS, MD, Diplomate ABOM

VISIT TYPE
Oral Medicine Consultation — New Patient

REFERRAL SOURCE
Dr. Patricia Walsh, DDS — General Dentistry

DENTAL PROVIDER / PCP
Dr. Patricia Walsh, DDS; Dr. Susan Kim, MD — Internal Medicine

REASON FOR REFERRAL
Bilateral white striae and plaques on buccal mucosa x8 months; erosive/atrophic component right buccal x3 months; burning mouth; refractory to antifungal trial

CC CHIEF COMPLAINT

2 PRIMARY ORAL MEDICINE CONCERN

> *'I have these white patches in my mouth for months and they burn. My dentist tried a cream but it didn't work. Now the right side is getting sore — it's painful to eat anything acidic or spicy.'*

Duration: White patches first noticed ~8 months ago (September 2025). Burning and sensitivity began 6 months ago. The right buccal erosive component and pain began 3 months ago, worsening progressively. Significantly impacting eating and oral hygiene.

S SUBJECTIVE

3 PATIENT-REPORTED SYMPTOMS & HISTORY

3a SYMPTOM ONSET, COURSE & LOCATION

- **Onset:** September 2025 — white markings noticed incidentally in the mirror, initially attributed to food residue. Dr. Walsh identified bilateral buccal mucosal lesions at the October 2025 cleaning and initiated monitoring.
- **Course:** Progressive worsening. White striae initially stable bilaterally; then February 2026 — an erosive/atrophic area developed right buccal, with right-sided pain that has been increasing.
- **Location:** Bilateral buccal mucosa (right worse than left). Also gingival sensitivity in the right mandibular posterior region. No tongue, palate, or lip involvement identified by patient.

- **Current status:** WORSENING — erosive right buccal component enlarging per patient report.

3b SEVERITY, FUNCTIONAL IMPACT & AGGRAVATING/RELIEVING FACTORS

- **Pain:** Right buccal 5/10 at rest, 8/10 with acidic or spicy foods. Left side 1/10 (mild burning only).
- **Burning:** Bilateral 4/10 at rest.
- **Functional impact:** Dietary modification — eliminated tomatoes, citrus, coffee, and spicy foods; eating soft, bland foods only. Switched to children's mild toothpaste. Declined social dining invitations twice in the past month. 'This is affecting my life more than I expected.'
- **Aggravating:** Acidic foods, spicy foods, toothpaste. **Relieving:** Soft bland diet, cool water rinse.

3c DENTAL/ORAL HISTORY & MEDICAL HISTORY

- **Dental:** No recent dental work. No new prostheses or appliances. No dentures. No bruxism. No prior oral ulcers beyond occasional aphthous ulcers in her 20s. No prior oral surgery or biopsy.
- **Prior treatment:** Nystatin oral suspension (swish and swallow) x14 days — NO IMPROVEMENT. Antifungal failure is a critical finding supporting a non-candidal etiology.
- **Medical:** (1) Hypothyroidism — levothyroxine 88 mcg daily, well-controlled (TSH 1.8). (2) Hypertension — amlodipine 5 mg daily; a calcium channel blocker strongly associated with oral lichenoid drug reactions (addressed in assessment). (3) Seasonal allergic rhinitis — loratadine PRN. No diabetes. No autoimmune disease diagnosed (ANA 1:80 speckled, low-positive; Sjögren's panel negative). 3 years post-menopause, no HRT — may contribute to mucosal atrophy. No cancer, immunosuppression, GI, or dermatologic disorder. No skin rash on wrists, ankles, or genitalia (asked directly — negative).

3d MEDICATION / EXPOSURE & PERTINENT NEGATIVES

- **Medications:** Levothyroxine 88 mcg daily; amlodipine 5 mg daily (LICHENOID DRUG REACTION RISK); loratadine 10 mg PRN; ibuprofen PRN.
- **Exposure:** Non-smoker (never). Alcohol 1–2 glasses wine/week. No vaping, betel nut, or occupational exposures.
- **Prior workup:** Sjögren's panel (SSA/SSB) NEGATIVE; ANA 1:80 speckled (low-positive); Schirmer's test by ophthalmology normal.
- **Pertinent negatives:** No skin rash, genital lesions, or ocular symptoms. No fever, weight loss, or night sweats. No dysphagia, odynophagia, or trismus. No rapidly enlarging lesion, induration, fixation, or cervical lymphadenopathy.

ROS ORAL MEDICINE REVIEW OF SYSTEMS

4 PERTINENT POSITIVES & NEGATIVES

- **Oral pain / burning / ulceration / lesions:** POSITIVE — bilateral burning (right > left); right buccal erosive pain 5–8/10; white striae bilateral buccal mucosa; gingival sensitivity right posterior mandibular
- **Gingival bleeding / swelling / periodontal symptoms:** POSITIVE — gingival sensitivity and erythema right mandibular posterior; desquamative gingivitis pattern
- **Xerostomia / altered taste / salivary changes:** POSITIVE — subjective xerostomia; taste slightly blunted; Saxon test 2.0 g/2 min (mild salivary flow reduction)
- **Dysphagia / odynophagia / chewing difficulty:** NEGATIVE — no dysphagia/odynophagia; chewing difficulty limited by pain from acidic/spicy foods; no structural limitation

- **Jaw pain / trismus / TMJ:** NEGATIVE — full mandibular ROM; no TMJ symptoms
- **Skin rash / genital ulcers / ocular symptoms:** NEGATIVE — no skin rash (wrists, ankles, genitalia examined/asked); no genital lesions; Schirmer's normal
- **Tobacco / alcohol / other exposure:** NEGATIVE for tobacco/vaping; alcohol 1–2 glasses wine/week; no other relevant exposures
- **Facial pain / numbness / swelling:** NEGATIVE — no facial pain, swelling, or numbness beyond intraoral burning
- **Fever / weight loss / night sweats:** NEGATIVE — no systemic symptoms; no lymphadenopathy

O OBJECTIVE

5 OBSERVED FINDINGS

V VITALS

TEMPERATURE
37.1°C — afebrile

BLOOD PRESSURE
132/80 mmHg

PAIN SCORE
5/10 right buccal at rest; 1/10 left; 4/10 bilateral burning

WEIGHT / BMI
148 lbs / BMI 24.2

5a EXTRAORAL EXAMINATION

Facial symmetry intact. No facial swelling. No skin lesions on face, neck, arms, or wrists — no Wickham's striae on skin, no violaceous papules. No cervical, submandibular, or submental lymphadenopathy. Parotid and submandibular glands non-tender and non-enlarged bilaterally. Mandibular ROM 45 mm interincisal opening (full). No TMJ tenderness or joint sounds. Cranial nerves V and VII intact bilaterally.

5b INTRAORAL EXAMINATION

LIPS / LABIAL MUCOSA
Normal pink-red moist mucosa. No lesions, fissuring, or crusting.

BUCCAL MUCOSA — RIGHT (PRIMARY SITE)
Three components: (1) WICKHAM'S STRIAE — lacy white interlacing lines throughout, non-removable; (2) ATROPHIC ZONE — 15 × 20 mm of mucosal atrophy with erythema and surface fragility at the mid-buccal occlusal line; (3) EROSIVE AREA — 6 × 4 mm shallow erosion within the atrophic zone, bleeds mildly on gentle contact. All NON-REMOVABLE.

BUCCAL MUCOSA — LEFT
Wickham's striae throughout — less prominent than right. No erosive or atrophic component. No pain on palpation.

GINGIVA / PERIODONTIUM
Right mandibular posterior (#19–21): DESQUAMATIVE GINGIVITIS — loss of stippling, bright erythema from the free gingival margin, mild bleeding on gentle probing. No pockets >4 mm, no mobility. Elsewhere: mild generalized gingivitis (pain-limited hygiene).

TONGUE
Dorsal: normal filiform/fungiform papillae, no atrophy or lesions. Ventral: normal. Lateral surfaces: NO LESIONS bilaterally (important for malignancy screening).

FLOOR OF MOUTH
Normal. No masses or swelling. Wharton's ducts bilaterally patent. Salivary pooling minimal.

PALATE (HARD / SOFT)

OROPHARYNX

Normal. No lesions or erythema.

DENTITION / PROSTHESES

Full dentition. Multiple posterior amalgam restorations bilaterally. Amalgam at #19–20 in direct-contact proximity with the right buccal lesion — clinically relevant for the amalgam-contact lichenoid reaction differential.

Normal. No lesions. Tonsils grade 1, no exudate.

SALIVARY FLOW

Slightly dry mucosa. Saxon test 2.0 g/2 min (mild reduction; normal >2.75). Not at Sjögren's level (panel previously negative).

LD LESION DESCRIPTION

6 ORAL LESION CHARACTERIZATION

LOCATION / LATERALITY

Bilateral buccal mucosa (right dominant). Right mid-buccal mucosa (occlusal line). Right posterior mandibular gingiva (#19–21).

NUMBER OF LESIONS

2 primary lesion zones (right buccal atrophic/erosive; right gingival desquamation). Bilateral Wickham's striae (same disease process).

SIZE

Right buccal atrophic zone 15 × 20 mm. Erosive component within it 6 × 4 mm. Right gingival involvement ~15 mm band (#19–21).

SHAPE

Atrophic zone: irregular ellipse. Erosive component: irregular with ragged margins. Gingival: band-like along the free gingival margin.

COLOR

Mixed red and white: lacy white striae + erythematous atrophic zone + yellow-white erosion base. Gingival: diffuse erythema with loss of stippling.

SURFACE TEXTURE

Striae: flat, non-removable. Atrophic zone: smooth, lacking normal keratin. Erosive area: raw, fragile.

BORDERS / MARGINS

Striae: well-defined lacy borders. Atrophic zone: ill-defined, transitioning from striae. Erosive area: slightly raised irregular peripheral border.

INDURATION / FIXATION / TENDERNESS

NO INDURATION — critical finding (induration would raise malignancy concern). Not fixed. Tender on contact at the erosive area. Bleeds on gentle contact.

SURROUNDING MUCOSAL CHANGES

Bilateral Wickham's striae surrounding the atrophic/erosive lesion — a bilateral lacy striae pattern is pathognomonic for oral lichen planus.

REMOVABLE / NON-REMOVABLE

NON-REMOVABLE — does not scrape off with gauze (critical distinction from pseudomembranous candidiasis, which is removable).

CLINICAL PHOTOGRAPHS

YES — 8 photographs at standardized distances, saved to EHR (OM-2026-0291-PHOTO-01 through -08). Lesion progression confirmed versus Dr. Walsh's baseline photos from October 2025.

PP PROCEDURES PERFORMED

7 BIOPSY THIS VISIT

Incisional biopsy — right buccal mucosa. Indication: erosive/atrophic oral lesion with bilateral Wickham's striae — biopsy required to confirm OLP, exclude dysplasia, and establish a histologic baseline.

- **Consent:** Informed consent obtained and signed; risks discussed (pain, bleeding, infection, paresthesia, need for further procedures).

- **Anesthesia:** Infiltration with 2% lidocaine 1:100,000 epinephrine, 0.9 mL right buccal mucosa; full anesthesia within 2 minutes.
- **Technique:** 5 mm punch biopsy at the lateral margin of the erosive area transitioning into the atrophic zone (not the necrotic center — the lesion periphery with transitional epithelium is the optimal biopsy site for LP). Hemostasis: direct pressure x3 minutes; primary closure with one 3-0 chromic gut suture. Bleeding minimal (not anticoagulated).
- **Second specimen for DIF:** Additional 5 mm punch from perilesional mucosa (normal-appearing tissue 3 mm from the erosive margin) — critical to differentiate OLP from pemphigoid and pemphigus. Placed in Michel's medium (NOT formalin).
- **Specimen handling:** Specimen 1 — 'Right buccal mucosa, incisional biopsy' in 10% buffered formalin for H&E, PAS, and routine histopathology. Specimen 2 — 'Right buccal mucosa, perilesional, DIF' in Michel's medium for IgG, IgA, IgM, C3, fibrinogen immunofluorescence.
- **Tolerance:** Good. **Post-procedure:** Soft diet 48 hours; avoid hot liquids 2 hours; no spicy/acidic foods at the biopsy site x1 week; chlorhexidine 0.12% alcohol-free rinse BID x7 days; written instructions provided. Return for uncontrolled bleeding, increasing pain, or fever.

L LAB & DIAGNOSTIC RESULTS

8 REVIEWED DATA

8A PRIOR LABS & LABS ORDERED TODAY

- **Prior labs (from Dr. Kim):** Anti-SSA/Ro NEGATIVE; Anti-SSB/La NEGATIVE; ANA 1:80 speckled (low-positive, uncertain significance); CBC WNL; CMP WNL; HbA1c 5.4% (normal); TSH 1.8 mIU/L (well-controlled hypothyroidism).
- **Labs ordered today:** CBC with differential; ferritin, serum iron, TIBC, B12, folate, zinc (nutritional deficiency workup — deficiencies exacerbate LP); CRP, ESR (inflammatory baseline); HbA1c (diabetes worsens OLP severity).
- **No fungal culture ordered** — antifungal failure, non-removable lesions, and bilateral Wickham's striae morphology effectively exclude candidiasis clinically.

8B PATHOLOGY / IMAGING / PRIOR RECORDS

BIOPSY SPECIMENS SUBMITTED TODAY

H&E + PAS pathology (Specimen 1): results expected 7–10 business days. DIF (Specimen 2): results expected 10–14 business days.

DENTAL IMAGING

Full-mouth radiographs from Dr. Walsh (March 2026) reviewed — no periapical pathology. Amalgam restorations at #19–20 noted in direct-contact proximity with the lesion site.

PRIOR RECORDS REVIEWED

Dr. Walsh referral (04/28/2026): 8-month course documented, antifungal failure documented, 4 baseline photographs (October 2025) — comparison confirms enlargement and erosive progression. Dr. Kim records: medication list confirmed (amlodipine, levothyroxine, loratadine); Sjögren's workup as above.

A ASSESSMENT

9 ORAL MEDICINE CLINICAL INTERPRETATION

Working diagnosis: Oral lichen planus (OLP) — erosive/atrophic and reticular subtypes, bilateral buccal mucosa + desquamative gingivitis. Pending biopsy confirmation. Clinical diagnosis is highly probable based on:

1. Bilateral Wickham's striae — pathognomonic clinical finding.
2. Non-removable lesions (candidiasis excluded by antifungal failure and morphology).
3. Erosive/atrophic component right buccal — consistent with the atrophic-erosive OLP variant.
4. Desquamative gingivitis pattern — a recognized OLP mucosal presentation.
5. NO induration, NO fixation, NO cervical lymphadenopathy — malignancy features absent.

- **Differential diagnoses:** (1) LICHENOID DRUG REACTION — HIGH: amlodipine is strongly associated with oral lichenoid reactions, and amalgam contact at #19–20 may contribute to right-sided predominance; drug history is critical. (2) MUCOUS MEMBRANE PEMPHIGOID — lower; DIF distinguishes (linear BMZ IgG/C3 vs. fibrinogen/shaggy IgM in OLP). (3) PEMPHIGUS VULGARIS — lower; acantholysis on H&E + intercellular IgG on DIF. (4) CANDIDIASIS — effectively excluded.
- **Malignancy risk:** OLP is a WHO potentially malignant disorder — estimated transformation 0.5–3% over time; highest in erosive/atrophic subtypes; the patient is a non-smoker, which substantially reduces risk. Annual oral cancer surveillance required for all OLP patients.

P PLAN

10 ORAL MEDICINE MANAGEMENT

1. **Diagnostic:** Biopsy results expected 05/13–05/16/2026 (H&E); DIF expected 05/17–05/20/2026. Follow-up scheduled 05/20/2026 to review results. Nutritional labs ordered (Dr. Kim's office to draw).
2. **Immediate treatment (pending confirmation):** (a) Clobetasol propionate 0.05% oral gel (compounded in adhesive base) — apply to the right buccal area with fingertip 3–4x daily x2 weeks, then taper to BID; do not eat/drink for 30 minutes after application; rinse before applying. (b) Chlorhexidine 0.12% alcohol-free rinse BID (continuing from post-biopsy instructions). (c) Continue soft diet and irritant avoidance; switch to SLS-free toothpaste.
3. **Amlodipine assessment:** Written communication sent to Dr. Kim today requesting review of when amlodipine was started relative to OLP onset (September 2025) and consideration of substituting it with an alternative antihypertensive (lisinopril or losartan) to test for medication-related improvement. Patient instructed: do NOT stop amlodipine without Dr. Kim's guidance.
4. **Dental coordination:** Written note to Dr. Walsh recommending (a) evaluation of the right mandibular amalgams (#19–20) for possible elective replacement with composite; (b) continued supportive care for desquamative gingivitis (soft-bristle brush, gentle care, chlorhexidine rinse).
5. **Patient education:** Explained OLP as an immune condition of the oral mucosa — not contagious, not caused by anything the patient did, not directly cancerous but requiring surveillance. Explained the need for annual oral cancer examinations. Written OLP handout provided.
6. **Follow-up:** 05/20/2026 — biopsy and DIF review, treatment response, pain improvement, topical steroid tolerance. Thereafter 3-month surveillance (08/2026) with lesion photography and amlodipine substitution response assessment.

F FOLLOW-UP

11 REASSESSMENT PLAN

- **Follow-up:** 05/20/2026 (2 weeks) — biopsy pathology and DIF results review, treatment response to clobetasol, pain improvement assessment.
- **Subsequent:** 3 months (08/2026) — lesion surveillance with photography, DIF and amlodipine substitution response.
- **Long-term:** Annual oral cancer surveillance thereafter if OLP confirmed.

TIME DOCUMENTATION & BILLING

TOTAL TIME
70 minutes

COUNSELING / COORDINATION TIME
15 minutes (coordination with Dr. Walsh and Dr. Kim; patient education)

CPT / E/M CODE(S)
99204 — New patient E/M, moderate-high complexity; D7285 — Incisional biopsy of oral tissue (×2 specimens reported as one biopsy procedure)

BASIS FOR BILLING
Medical Decision Making — Moderate-High Complexity; biopsy performed

PRIMARY ICD-10 CODE
K13.79 — Other oral mucosa lesions (oral lichen planus pending biopsy confirmation)

SECONDARY ICD-10 CODE(S)
K05.11 — Chronic periodontitis (desquamative gingivitis); E03.9 — Hypothyroidism; I10 — Hypertension

PROVIDER SIGN-OFF

ORAL MEDICINE SPECIALIST	CREDENTIALS	SPECIALTY	DATE	TIME
Nathaniel Park, DDS, MD	DDS, MD, Diplomate ABOM	Oral Medicine	05/06/2026	3:30 PM