MARVIX AI

SAMPLE ORAL ULCER & MUCOSAL DISEASE SOAP NOTE

DESQUAMATIVE GINGIVITIS & EROSIVE LESIONS — VESICULOBULLOUS WORKUP (EROSIVE OLP VS MMP)

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1 PATIENT INFORMATION

1 PATIENT DETAILS

NAME	Rosalind M. Tan
DATE OF SERVICE	06/25/2026
DOB	09/12/1965
PROVIDER	Dr. Nathaniel Park, DDS, MD — Oral Medicine
AGE / SEX	60 / Female
CREDENTIALS	DDS, MD, Diplomate ABOM
MRN / PATIENT ID	OM-52788c
VISIT TYPE	Oral Ulcer / Mucosal Disease Evaluation (new referral)

REFERRAL SOURCE

Referred by Dr. K. Alvarez (periodontist) for painful, peeling, non-plaque-related gingival inflammation and erosions unresponsive to periodontal therapy.

DENTAL / PRIMARY CARE PROVIDER

Periodontist: Dr. Karen Alvarez, DDS, MS · PCP: Dr. J. Whitcombe, MD

CC CHIEF COMPLAINT

2 PRIMARY MUCOSAL CONCERN

> *'My gums are raw and peeling, and I keep getting painful sores in my cheeks and on my tongue. Brushing makes them bleed, and my dentist said the gum treatments aren't helping. Lately my eyes feel gritty too.'*

Duration: Rosalind reports ~7 months of progressive, painful, **desquamative (peeling) gingivitis** with recurrent erosions of the buccal mucosa and lateral tongue. Periodontal scaling and improved hygiene have not helped, prompting oral medicine referral for a suspected **immune-mediated vesiculobullous / lichenoid mucosal disease.** She now also reports intermittent ocular grittiness — a finding that must be taken seriously in this context.

S SUBJECTIVE

3 PATIENT-REPORTED MUCOSAL HISTORY

3a ONSET, COURSE, PATTERN & LOCATION

- **Onset:** Gradual, ~7 months ago; initially 'sensitive, red gums,' then peeling and painful erosions. Slowly worsening, with periods of partial improvement but never full clearance.

- **Lesion pattern:** Multiple, bilateral, and **chronic rather than episodic** — a mix of erosive/erythematous gingival desquamation, buccal erosions with surrounding white striae, and shallow tongue erosions. She reports fragile mucosa that 'peels' and occasionally 'blisters' before breaking down.
- **Location:** Attached gingiva (upper & lower, generalized), bilateral buccal mucosa, and left > right lateral/ventral tongue. Denies floor-of-mouth, palate, or oropharyngeal ulceration.
- **Reported blistering:** She has twice noticed a 'clear blister' on the gum that ruptured within a day — a history suggestive of a vesiculobullous process (raises mucous membrane pemphigoid on the differential).

3b ASSOCIATED SYMPTOMS, TRIGGERS & FUNCTION

- **Associated symptoms:** Pain and burning (5–8/10), gingival bleeding with brushing, food sensitivity to spicy/acidic/crunchy foods, and mild intermittent bleeding of erosions. Denies drainage, halitosis beyond usual, altered taste, or dry mouth.
- **Functional impact:** Avoids tooth-brushing in tender areas (worsening a vicious cycle of plaque and inflammation), has changed to a soft/bland diet, and reports poor sleep on bad nights. Weight stable.
- **Triggers / relief:** Spicy, acidic, crunchy foods and vigorous brushing worsen; bland diet and a prior short steroid course (from PCP) transiently helped.

3c RELEVANT HISTORY

- **Dental / oral history:** Generalized mild-moderate periodontitis under periodontal care; multiple amalgam and composite restorations (relevant to possible lichenoid contact reaction). No new appliances or dentures. Recurrent buccal 'sores' for years, worse in the last 7 months.
- **Medical history:** Type 2 diabetes, hypertension, hyperlipidemia, hypothyroidism, and dry-eye symptoms (new). No formally diagnosed autoimmune disease; no known IBD or celiac. Post-menopausal.
- **Extraoral / systemic:** Reports intermittent **ocular grittiness and redness** (concern for ocular MMP), occasional scalp/skin itch, no genital lesions she is aware of, no joint pain, no fevers or weight loss.
- **Medication / exposure history: Lisinopril** and **metformin** — both associated with **lichenoid drug reactions**; also atorvastatin, levothyroxine, and an OTC NSAID PRN. Never-smoker; rare alcohol; no vaping or betel nut.
- **Prior evaluation & treatment:** Periodontal scaling/root planing (no benefit for desquamation); a 1-week oral prednisone taper from PCP (partial, temporary improvement); OTC benzocaine and chlorhexidine (chlorhexidine worsened burning). No prior biopsy.

3d PERTINENT NEGATIVES

Denies a single non-healing/indurated ulcer, rapidly enlarging mass, fixed lesion, unexplained bleeding, neck mass, dysphagia, odynophagia, severe trismus, paresthesia, airway symptoms, fever, or weight loss. No feature suggesting malignancy; presentation is that of a chronic, multifocal, immune-mediated mucosal disease.

ROS ORAL ULCER / MUCOSAL DISEASE REVIEW OF SYSTEMS

4 PERTINENT POSITIVES & NEGATIVES

- **Erosions / desquamation / vesicles:** POSITIVE — desquamative gingivitis, buccal erosions with striae, tongue erosions; reported transient gingival blisters
- **Oral pain / burning / bleeding:** POSITIVE — 5–8/10, gingival bleeding with brushing
- **White / red / mixed changes:** POSITIVE — reticular
- **Ocular symptoms:** POSITIVE — intermittent

white striae with erythema/erosion (lichenoid pattern)

- **Skin / genital lesions:** Mild scalp/skin itch; NO known genital lesions
- **Dry mouth / altered taste:** NEGATIVE
- **Exposures:** Never-smoker; rare alcohol; no vaping / betel nut

grittiness/redness (possible ocular MMP — needs ophthalmology)

- **Dysphagia / odynophagia / trismus:** NEGATIVE
- **Systemic:** NEGATIVE for fever, night sweats, weight loss; POSITIVE for chronic fatigue

O OBJECTIVE

5 OBSERVED FINDINGS

V VITALS

TEMPERATURE
36.9°C — afebrile

BLOOD PRESSURE
142/86 mmHg

PAIN SCORE
6/10 at rest; 8/10 with brushing/eating

WEIGHT / BMI
148 lbs / BMI 25.6 — stable

5a EXAMINATION

- **General:** Well-appearing, no acute distress, fully communicative. No difficulty speaking or swallowing during the visit.
- **Extraoral:** No facial swelling; no skin bullae or crusting on face/lips today; mild bilateral conjunctival injection noted. No cervical/submandibular lymphadenopathy. Salivary glands normal; TMJ non-tender, full ROM; cranial nerves intact.
- **Intraoral — gingiva: Generalized desquamative gingivitis** — bright erythema, epithelial sloughing, and fragile mucosa on the attached gingiva (maxillary & mandibular). **Positive Nikolsky sign** — gentle lateral pressure/air produces epithelial sloughing (supports a vesiculobullous process).
- **Intraoral — buccal mucosa:** Bilateral erosions surrounded by **reticular (Wickham) white striae** — classic lichenoid morphology; located adjacent to amalgam restorations on the right (possible contact lichenoid component).
- **Intraoral — tongue:** Shallow erosions of the left lateral/ventral tongue with peripheral striae; no induration, no fixation, no mass.
- **Palate / floor / oropharynx:** No ulceration or vesicles. No indurated or fixed lesion anywhere; findings are diffuse and mucosal, not focal/mass-like.

LD LESION DESCRIPTION

6 PER-LESION CHARACTERIZATION

LESION GROUP 1 — GINGIVA
Generalized desquamative gingivitis, maxillary + mandibular attached gingiva; erythema with epithelial sloughing; Nikolsky positive; non-indurated; friable, bleeds on contact.

LESION GROUP 2 — BUCCAL MUCOSA

Bilateral erosions 4–12 mm with surrounding reticular white striae; right lesions adjacent to amalgam restorations; erosive base, non-removable striae, tender, no induration.

LESION GROUP 3 — TONGUE

Left lateral/ventral shallow erosions 3–8 mm with peripheral striae; erosive, tender, non-indurated, non-fixed.

CHARACTER

Erosive/atrophic with striae; non-indurated, non-fixed, friable; no necrosis or exophytic component. Striae non-removable; sloughing epithelium removable.

RELATIONSHIP / DOCUMENTATION

Right buccal lesions correspond to amalgam contact areas. No sharp tooth/appliance trauma source for the generalized pattern. Clinical photographs obtained of gingiva, bilateral buccal mucosa, and tongue.

MC MUCOSAL DISEASE CLASSIFICATION / DIAGNOSTIC CONSIDERATIONS

7 SUSPECTED MUCOSAL PROCESS

Chronic, multifocal, **immune-mediated erosive mucosal disease** presenting as desquamative gingivitis with erosions and striae. Leading considerations, in order:

1. **Erosive oral lichen planus (OLP)** — favored by bilateral reticular striae, buccal + tongue + gingival involvement, and chronic erosive course.
2. **Mucous membrane pemphigoid (MMP)** — supported by desquamative gingivitis, positive Nikolsky, reported transient blisters, and **new ocular symptoms**; DIF is essential to distinguish from OLP and to prevent ocular scarring.
3. **Lichenoid contact / drug reaction** — right buccal lesions adjacent to amalgam (contact) and use of lisinopril + metformin (drug-related lichenoid reaction).
4. **Pemphigus vulgaris** — less likely but on the vesiculobullous differential; DIF/serology will address.
5. **Candidal superinfection** — commonly complicates erosive OLP and prior steroid use; brush cytology obtained.

PP PROCEDURES PERFORMED

8 PROCEDURES THIS VISIT

Two mucosal biopsies (H&E + DIF) and brush cytology performed today — the standard workup to separate erosive OLP from MMP/pemphigus.

- **Consent:** Informed consent obtained and signed; risks (pain, bleeding, swelling, infection, need for further procedures) reviewed. Patient calm and receptive.
- **Anesthesia:** Local infiltration 2% lidocaine 1:100,000 epinephrine at each biopsy site periphery.
- **Biopsy 1 — H&E (lesional/perilesional):** 4 mm punch from the edge of a left buccal erosion including striae margin; placed in 10% formalin.
- **Biopsy 2 — DIF (perilesional, uninvolved):** 4 mm punch from perilesional intact gingival mucosa (NOT ulcerated) placed in **Michel's transport medium** — critical for detecting basement-membrane vs intercellular immunoreactant patterns (MMP vs pemphigus vs lichenoid).

- **Brush cytology:** Dorsal/buccal brush for Candida (PAS) given erosions + prior steroid exposure.
- **Hemostasis:** Direct pressure; a single 4-0 chromic gut suture at each punch site. Post-op instructions given; patient tolerated the procedures well, no complications.

L LAB & DIAGNOSTIC RESULTS

9 REVIEWED & ORDERED DATA

PATHOLOGY (H&E) — SUBMITTED TODAY

Left buccal incisional/punch biopsy submitted; expected 5–7 days. Requested comment on lichenoid interface vs subepithelial split and on dysplasia.

DIRECT IMMUNOFLUORESCENCE (DIF) — SUBMITTED TODAY

Perilesional gingival specimen in Michel's medium; expected 7–10 days. Key to the diagnosis: linear BMZ IgG/C3 → MMP; shaggy fibrinogen → lichenoid; intercellular IgG → pemphigus.

BRUSH CYTOLOGY (CANDIDA)

PAS-stained brush for candidal superinfection; result pending 3–5 days.

SEROLOGY — ORDERED

BP180/BP230 and desmoglein 1/3 antibodies ordered to complement DIF if a bullous process is confirmed.

LABS — ORDERED (BASELINE FOR SYSTEMIC THERAPY)

CBC, CMP, HbA1c, lipid panel, and glucose (steroid/immunomodulator planning); prior HbA1c 7.4%.

RECORDS REVIEWED

Periodontal chart and prior prednisone course reconciled; PCP medication list obtained (lisinopril, metformin noted for lichenoid potential).

A ASSESSMENT

10 MUCOSAL DISEASE CLINICAL INTERPRETATION

Primary working diagnosis: chronic immune-mediated erosive mucosal disease — most likely erosive oral lichen planus, with mucous membrane pemphigoid to be actively excluded. Confidence: HIGH for an immune-mediated erosive process; **specific diagnosis pending H&E + DIF.**

1. Bilateral reticular striae with erosions on buccal mucosa and tongue strongly favor **erosive OLP.**
2. Desquamative gingivitis + positive Nikolsky + reported blisters + **new ocular symptoms** mandate excluding **MMP** (risk of irreversible ocular/conjunctival scarring) — DIF is decisive.
3. Amalgam-adjacent right buccal lesions + lisinopril/metformin raise a **lichenoid contact/drug component** that may modify management.
4. Likely **secondary candidal colonization** of erosions (prior steroids, diabetes).
5. **No red-flag/malignant features**; however erosive OLP carries a small long-term malignant-transformation risk requiring surveillance.
6. Comorbid **diabetes** (HbA1c 7.4%) is relevant to steroid/immunomodulator planning.

P PLAN

11 MUCOSAL DISEASE MANAGEMENT

1. **Definitive diagnosis:** Await H&E + DIF (± serology). Call-back arranged; if DIF indicates MMP or pemphigus, escalate systemic therapy and coordinate multidisciplinary care.
2. **Topical corticosteroid (first-line):** High-potency **clobetasol 0.05% gel** applied to erosions BID–TID; for generalized gingival involvement, **custom vacuum-formed trays** for occlusive steroid delivery fabricated with periodontics. **Dexamethasone elixir** 0.5 mg/5 mL swish-and-spit for widespread lesions.
3. **Candidal prophylaxis:** Nystatin or fluconazole cover during topical steroid therapy given diabetes + erosions; confirm with brush result.
4. **Lichenoid contributors:** Coordinate with PCP re: substituting lisinopril and reviewing metformin necessity; plan for staged amalgam replacement of the right buccal contact lesions if lesions persist and patch testing supports contact allergy.
5. **Ophthalmology referral (urgent-ish):** Placed today for slit-lamp evaluation to exclude ocular MMP given grittiness/injection — do not defer.
6. **Dermatology / rheumatology:** Referral if DIF/serology confirm pemphigoid/pemphigus or if skin/genital sites become involved; systemic agents (e.g., dapsone, steroid-sparing immunomodulators) considered in that pathway.
7. **Periodontal & hygiene:** Gentle non-abrasive oral hygiene, SLS-free toothpaste, avoid alcohol-based rinses; continue periodontal maintenance with Dr. Alvarez once inflammation controlled.
8. **Education & surveillance:** Reviewed the chronic, controllable (not curable) nature of OLP, the malignant-transformation surveillance rationale, medication use, and return precautions for any new firm/non-healing ulcer, lump, or eye changes.

F FOLLOW-UP

12 REASSESSMENT PLAN

- **Result call:** H&E within 5–7 days; DIF within 7–10 days. Diagnosis and therapy finalized on results; MMP/pemphigus triggers same-week escalation.
- **Oral medicine follow-up 07/16/2026 (3 weeks):** assess topical steroid response, candidal status, tray fit, ocular referral outcome, and medication substitutions.
- **Ongoing surveillance:** Erosive OLP monitored every 3–6 months for symptom control and dysplasia/malignant-transformation risk; re-biopsy any focal change, induration, or non-healing area.

TIME DOCUMENTATION & BILLING

TOTAL TIME
70 minutes

COUNSELING / COORDINATION TIME
25 minutes (diagnosis/surveillance education, ophthalmology & PCP coordination, medication-substitution counseling, tray planning with periodontics)

CPT / E/M CODE(S)
99204 — New patient E/M, high complexity; D7286 ×2 — biopsy of oral soft tissue (H&E + DIF); 87220/cytology brush

BASIS FOR BILLING
Medical Decision Making — High; vesiculobullous workup, two biopsies + DIF, serology, multidisciplinary referrals, systemic-therapy planning

PRIMARY ICD-10
L43.9 — Lichen planus, unspecified (erosive OLP, working) — pending DIF

SECONDARY ICD-10
K05.10 Gingivitis (desquamative) · L12.1 Cicatricial (mucous membrane) pemphigoid — r/o · K13.24 Leukoplakia/striae of oral mucosa · B37.0 Candidal stomatitis · E11.65 T2DM w/ hyperglycemia

PROVIDER SIGN-OFF

ORAL MEDICINE SPECIALIST	CREDENTIALS	SPECIALTY	DATE	TIME
Nathaniel Park, DDS, MD	DDS, MD, Diplomate ABOM	Oral Medicine	06/25/2026	3:40 PM