MINISTRY OF EDUCATION OF AZERBAIJAN REPUBLIC

AZERBAIJAN MEDICAL UNIVERSITY

**Chapters from book :**

**DIFFERENTIAL DIAGNOSTICS OF ORAL MUCOUSE DISEASES**

**(**Educational supplies for the students of Medical faculties**)**

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**Chapters from book “ DIFFERENTIAL DIAGNOSTICS OF ORAL DISEASE (Educational supplies for the students of Medical faculties)”**

**LESION ELEMENTS IN ORAL MUCOUSE**

Development of pathological processes of the oral mucosa

accompanied by the appearance of various elements on its surface

defeat. Features of genesis, morphological features, clinical

manifestations allow you to combine all the elements of the lesion into several

groups. The main ones are the following:

1) Color change

2) Relief change

3) Limited accumulations of exudate

4) Layering and stratification on the surface

5) Mucosal defects

6) Tissue growth

Homogeneous formations of lesions on the mucosa

considered as a monoform rash.

The appearance on the mucosa of various kinds of elements creates

multiform rash.

Color change

**Macula** is a change in the color of the mucous membrane.

Depending on the size of the spot, there are:

**Roseola** - erythematous macula of rounded shape from 1.5 -2 to 10 mm in

diameter;

**Ecchymosis** - round, oval, hemorrhagic diffuse spots

larger than petechiae;

**Stripes (vibices)** - hemorrhagic diffuse formations,

taking the form of bands, which are formed mainly on

mucosa of the bottom of the mouth, less often - on the cheeks .;

Age spots are persistent formations that occur under

exposure to various exogenous and endogenous causes. When deposited

copper mucosa acquires a purple-red color, silver-slate-

gray, lead-gray-black. Mucosal pigmentation occurs

in diseases of the liver, bronze and Addison's disease, under the influence of

medical preparations.

The localization of the maculas and their shape are different: in some cases they are clearly

limited, in others - more spilled. Lead, bismuth, mercury

predominantly located in the form of a border along the gingival margin.

Maculas during the deposition of silver are usually irregular in shape, more

diffuse. In addition to gums, pigmented formations are found on the mucosa

lips, in the corners of the oral cavity, buccal mucosa. Spilled discoloration

mucosa is observed in general diseases (diseases of the blood,

infectious diseases, endocrine pathology).

**Relief change**

A change in the relief of the oral mucosa is observed under

the influence of inflammatory, dystrophic processes, cicatricial changes.

There are elements of the lesion that increase the relief of the mucosa and

that form its defect.

**Papule** / nodule / limited mucosal elevation,

whose dimensions do not exceed 3-4 mm in diameter. The shape of the papules is different -

pointed, semi-circular, round, pin-like, etc. In some cases

papule is formed due to the growth of the epithelium, in others - active participation

accepts the mucosa itself, most often changes

are observed both in the epithelium and in its own mucosa. papular

rashes are predominantly inflammatory. Merged

papules form plaques.

**The tubercle** clinically resembles a nodule, differing from it only in that

that with the development of the tubercle, all layers of the mucosa are involved in the process.

The reverse development of the tubercle leads to the appearance of secondary changes

mucous.

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**Scar / secondary lesion element** / appears during healing of defects

proper mucosal and submucosal layers, histologically represents

intertwined bundles tightly adjacent to each other

fibrous-modified collagen fibers covered with a thin, even

strip of epithelium. There are hypertrophic and atrophic scars.

Hypertrophic and keloid scars occur after trauma and

surgical interventions; they are usually linear in shape, dense on

touch, often hinder the mobility of the mucosa.

Atrophic scars occur after tuberculosis, syphilis,

lupus erythematosus. Differ in irregular shape and significant

depth.

Limited accumulations of fluid

**A vesicle** is a limited accumulation of serous fluid in

epithelial layer. Bubble sizes range from 1.5 to 3-4 mm in

diameter. Due to the fact that the walls of the bullae are formed by a thin layer

epithelium, the latter is rapidly destroyed, and its contents are judged by

fragments of the epithelium.

**Bullae** - a limited accumulation of fluid in the subepithelial or

in the mucosal layer itself. The vesicle is filled with serous

hemorrhagic exudate. Bullae sizes range from 5-6 mm to

several centimeters in diameter.

**An abscess** is a small cystic formation filled with purulent

exudate. It can be located in different layers of the oral mucosa

cavities. Depending on this, its contours change.

**An abscess** is a cavity formation of various sizes. located

predominantly in the submucosal layer, in muscle tissue or

subperiosteal. In the area of ​​localization of the abscess, there are various

the size of the protrusion, when located in the mucous and submucosal layer

its boundaries are clearly defined, the surface is tense, and when formed in

muscle layer or subperiosteal - its boundaries are smoothed.

Layering and stratification of the mucosal surface

**Plaque** is a consequence of increased keratinization of the epithelium and

deterioration of conditions conducive to the rejection of dead cells,

which is observed if the function is not impaired.

Depending on nutrients and secretion

oral plaque turns white, grey, brown or black

color. Excess formation of plaque forms scales. Uncertain

form and localization plaque can also occur due to abundant

vegetation of fungal microflora in fungal lesions of the mucosa.

Its localization is different, the color is white with a milky tinge.

Generalized plaque formation is also observed during the development

xerostomia. In such patients, plaque covers large areas

mucosa, especially powerful layers of plaque are formed on surfaces,

self-cleaning is difficult.

**The crust** is formed after drying of the excidate from the bubbles,

pustules, cracks or when healing wounds, wound surfaces,

blood cells, desquamated epithelium. The color of the crusts is different,

it is closely related to the nature of the exudate, which serves as a matrix for their

education.

Mucosal defects

Distinguish between superficial, deep and moderate lesions

depths. With a superficial lesion, the integrity of the epithelium is violated,

with moderate - the mucosa proper is involved in the process, with deep

- submucosa, muscle layer, and sometimes bone.

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**Erosion** - discodering of the integrity of the layer of the epithelial cover

mucous. The size of erosion is small, the shape is different. An area devoid of

epithelium, slightly hyperemic, free from plaque.

**Aphta** is a small round or oval formation that

occurs equally often in different parts of the mucosa, rarely in

gums. Superficial defect of the epithelium is located on the inflamed

mucosal area. The periphery is surrounded by a thin hyperemic

rim( halo). Its surface directly above the epithelium is impregnated

fibrous effusion, which gives the aphtha a white or slightly icteric

shade. In the submucosal tissue there is a round-cell infiltration

and swelling.

**Excoriation** is a violation of the integrity of all layers of the epithelium.

Mucous proper, free from epithelium, stained bright red

color, the boundaries of the lesion are clear, the shape is different.

**The crack** is formed mainly on the mucous membrane of the upper or

lower lip, at the corner of the mouth. Less commonly, cracks occur as a secondary

element in areas of keratosis and can affect the epithelium, in fact

mucosa and submucosa. The crack is shaped like a wedge,

the top of which is turned deep into the tissues, sometimes the crack becomes

crater-like shape. The walls of the crack are usually free from plaque, bright

red, the inlet is gaping, sometimes surrounded by a slight

saturation of crust-like elements. The surrounding mucosa is moderately

edematous, dense to the touch, slightly painful on palpation.

**The ulcer** affects all layers of the oral mucosa. Often in

deep-lying tissues are also involved in the process. In the differential

diagnosis of ulcers of various origins is essential

acquires the definition of the depth, shape, degree of density of the element,

the state of the bottom of the ulcer, surrounding tissues.

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**Discorders of the keratinization in oral mucosa**

**Parakeratosis** - incomplete keratinization of superficial cells

spiny layer while maintaining flattened elongated

nuclei. In this process, the phase of formation of keratohyalin falls out,

so the granular layer is completely or partially absent. The adhesive substance, keratin, disappears from the cells of the stratum corneum,

resulting in a pronounced peeling of the epidermis,

loosening of the stratum corneum. The resulting scales are easily rejected. The result of parakeratosis is the appearance of spots, lichenification,

vegetation, node, nodule. Areas of parakeratosis are whitish in color and cannot be scraped off.

Diseases associated with this

pathological process: leukoplakia, hypovitaminosos A, C, B,

lichen planus; exfoliative cheilitis (dry form), atopic cheilitis, lupus erythematosus.

Keratosis is a group of diseases of the skin and mucous membranes of a non-inflammatory nature, manifested by thickening of the stratum corneum, the formation of the stratum corneum.

**Dyskeratosis** is a form of irregular keratinization, characterized by pathological keratinization of cells of the spin layer.

The cells become larger, rounded, with granulas in the cytoplasm - "Dariaer bodies", then turn into homogeneous acidophilic formations with small pictonic nuclei, called grains and located in the stratum corneum. Cell dysplasia is observed, the connection between them is broken, the cells are arranged randomly. Dyskeratosis is observed with aging. Malignant dyskeratosis is characteristic of Bowen's disease, a squamous cell carcinoma.

**Hyperkeratosis** is an excessive thickening of the stratum corneum of the epithelium.

It may develop as a result of excess keratin formation when the granular and spiny layers of the stratified squamous

epithelium thicken, or due to delayed desquamation of the epithelium. Hyperkeratosis is based on the intensive synthesis of keratin as a result of an increase in the functional activity of epithelial cells.

(chronic irritation or metabolic disorders).

In addition, a granular layer develops. Depending on the

the thickness of the stratum corneum allocate different degrees of hyperkeratosis.

This process accompanies the following diseases: intoxication

mercury, lead, aluminum, bismuth, zinc, etc., lichen planus; exfoliative cheilitis (dry form), lupus erythematosus.

**Acanthosis** - thickening of the epithelial layer of the mucous membrane

due to the proliferation of basal and spiny cells. The process is accompanied by an elongation of the interpapillary outgrowths of the epithelium and more

their pronounced growth in the connective tissue. The result of acanthosis is the appearance of a nodule, node, lichenification. Diseases that accompany this pathological process: red flat

lichen; leukoplakia, hypo- and beriberi, lupus erythematosus, Manganotti precancerous cheilitis, exfoliative cheilitis (dry form),

atopic cheilitis, actinomycosis, mucosal changes in endocrine disorders.

Pathological processes of the oral mucosa

proliferative nature

**Papilomatosis** - proliferation of the papillary layer of the lamina propria, protruding above the level of the mucosa

membranes of the oral cavity, violating its configuration. Papillomatosis

can be primary, congenital, and also secondary. Last

observed in chronic trauma (for example, trauma to the mucosa

palate with a lamellar prosthesis).

**Granulosis** - an increase in the rows of the granular layer or the appearance

granular layer in areas of the mucosa where it should not be.

**Angiomatosis** is a congenital overdevelopment of blood vessels or

acquired dilatation of pre-existing capillaries (telangiectasia). It manifests itself in the form of pink-red-cyanotic spots, sometimes protruding above the surface of the mucous membrane or

skin. The surface of the spots may be bumpy, if the spot is injured

bleed easily.

**Inflammatory infiltration** - the accumulation of cellular elements of blood and lymph in the proper mucous layer, accompanied by

local compaction and increase in tissue volume.

**Vacuolar degeneration** - intracellular edema of epithelial cells with the appearance in the cytoplasm of vacuoles that destroy cells. Sometimes the vacuole occupies almost the entire cell, pushing the nucleus to the periphery. In this case, the core takes a saddle shape. The cause of vacuolar degeneration are degenerative changes in the cytoplasm of epithelial cells. Diseases associated with

by this process: pemphigus vulgaris; simple herpes; red

lupus; changes in the mucosa in endocrine diseases (gingivitis of pregnant women, Itsenko-Cushing's syndrome, etc.).

**Spongiosis** - accumulation of fluid between the cells of the styloid

layer. The intercellular spaces are expanded, filled

fluid, cytoplasmic protrusions are elongated. The process begins with the expansion of intercellular tubules, which are filled

exudate coming from the connective tissue. This exudate

stretches and then breaks intercellular bonds, forming a cavity.

In the resulting cavity, serous contents and epithelial cells are formed that have lost contact with the epithelium. The result of this

process is a blister, vesicle, bubble. Spongiosis accompanies

the following diseases: herpes simplex, pemphigus vulgaris,

lichen planus, erythema multiforme exudative,

chronic recurrent aphthous stomatitis, eczema.

**Ballooning dystrophy** is a focal change in the cells of the spinous layer associated with the accumulation of fluid in them. As a result

cells take the form of "balls", significantly increase in size, separate, forming cavities filled with exudate. Define multinucleated "giant cells".

**Acantholysis** is a pathomorphological process based on autoimmune processes. The main pathological role belongs to circulating autoantibodies directed to antigens.

desmosomes of stratified squamous epithelium. The destruction of intercellular contacts occurs mainly in the zone of proliferating basal cells. Histologically, in the spinous layer, there is a melting of intercellular connections, the cells are rounded, much

decrease in size, separate. Intercellular

spaces filled with exudate form intra- and subepithelial blisters. Thus, acantholytic

cells are Tzank cells.

**A tumor (blastoma)** is a pathological process, which is based on the potentially unlimited reproduction of cellular

structures of one or another organ, characterized by morphological and biochemical atypism. Tumors of the oral mucosa

divided into mature (benign) and immature (malignant).

In the oral cavity, tumors are most often found from the epithelium, connective tissue, less often from vascular, muscle, and nervous tissues.

The initial site of tumor growth are most often areas of tissue,

where cells capable of reproduction are stored. This germinal layer of the epithelium, perivascular tissue, epithelium of the excretory ducts of the glands.

In each tumor, parenchyma and stroma can be distinguished.

Benign mucosal tumors are composed of

differentiated cells similar in structure to the original tissue. There is tissue atypia. These tumors grow slowly

expansively, clearly limited, never grows into the surrounding

tissues, do not metastasize, increasing in volume, pushing apart neighboring

tissues, as a rule, do not cause noticeable functional disorders.

Malignant tumors are built from low- and undifferentiated cells and bear little resemblance to maternal tissue. Not only tissue, but also cellular atypism is characteristic: a change in shape

cells, enlargement of the nucleus, polymorphism, the appearance of giant cells.

Malignant tumors are characterized by rapid, infiltrative,

destructive growth, prone to metastasis and recurrence.

The criterion for malignancy is the classic triad: atypia, polymorphism, invasive growth.

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| **DIFFERENTIAL DIAGNOSTICS OF THE ORAL DISEASES**    **1. Traumatic injuries**  •Mechanical factors, high and low temperatures, radiation, unpleasant meteorological factors (meteorological cheilitis, cracks of the lips), traumatic injuries caused by chemicals, etc.  **2. Infectious diseases**  •Injuries of oral mucosa in acute and chronic infectious diseases (measles, scarlet fever, chicken pox, tuberculosis, syphilis, leprosy, etc.).  •Specific infectious and parasitic diseases of oral mucosa and lips  •Virus (herpes, AIDS, warts, etc.)  •Fuzospiroxetosis  •Bacterial (strepto- and staphylococcus, gonorrhea, etc.)  •Fungus (candidiasis, actinomycosis, etc.)  **3. Allergic and toxic-allergic diseases**  •Contact allergic stomatitis, gingivitis, glossitis, cheilitis (medicines, plastics, and other dental materials, dyes, toothpastes, elixirs, and other chemicals in contact with the mucous membranes and red border of the lips, ultraviolet rays, etc.).  • Fixed and widespread toxic-allergic lesions (due medication- induced , food and other allergens that enter the body in various ways)  •Dermatoses accompanied with toxic-allergenic oral lesions (including erythema multiforme , Stevens-Johnson syndrome, Lyell's syndrome, primary systemic vasculitis, including Wegener's syndrome)  **4. Diseases with autoimmune component of pathogenesis**  • Recurrent aphthous stomatitis, including scarring aphthae  • Behçet syndrome, including extensive Toure aphthous  • Sjogren’s syndrome  •Dermatoses observed in oral injury (pemphigus , pemphigoid, Dühring's disease, systemic lupus erythematosus, systemic scleroderma)  **Traumatic injuries**  **Traumatic ulcer should be differentiated with: 1.Cancer ulcer 2.Tuberculous ulcer 3.Syphilis ulcer (chancre)  4. Vincent 'chronic necrotizing ulcerative stomatitis  5.Trophic ulcers 6. Bowen’s disease**  **7. Leukoplakia**  **8. Lichen planus (hyperkeratotic form)**  **9. Chronic recurrent aphthous stomatitis**  **10.Diseases of the blood (leukemia, agranulocytosis)**  **11.Viral diseases**  **12. Pemphigus vulgaris**  **1.Differential diagnostics of both traumatic decubital and cancer ulcers:  Common symptoms:**     •The prevalence among the elderly persons; • Enlarged, painful lymph nodes.  **Differences:**      • Traumatic ulcer has hyperemic edges, is painful on palpation, its floor is covered with necrotic plaque. The cancer ulcer is deep, has a dense granular floor and elevated , inverted dense edges, covered with either a dense plaque or bloody purulent crusts. There may be no inflammation around the cancer ulcer.   • In cancer, atypical epithelial cells are found in scrapings of ulcers and punctate of lymph nodes.    ***Fig****.1 Traumatic ulcer* ***Fig.2*** *Cancerous ulcer*  • After elimination of the stimulus, rapid epithelisation of the traumatic ulcer occurs. Elimination of the traumatic factor does not affect the healing of the cancerous ulcer.  •Regional lymph nodes in a cancer ulcer are enlarged, soldered to the surrounding tissues, painless.  **2.Differential diagnostics of traumatic (decubital ) and tuberculosis ulcers  Common symptoms are:**      • Localization in the places of the highest injury;      • The presence of enlarged, movable, and painful lymph nodes  •The presence of isolated painful ulcers situated on the swollen basis.  •Ulcer, pain when eating, talking  **Differences:**     • Tuberculous ulcer is shallow, irregular in shape, has undermined uneven soft edges, a granular floor with a yellowish plaque, does not epithelize after elimination of the stimulus.  Often there are yellow dots around the ulcer - Trel grains. Traumatic ulcer has an oval shape and a slightly depressed surface with dense edges and a base (if it exists for a long time), the central part of which is yellowish-gray.  After elimination of the stimulus, rapid epithelisation of the decubital ulcer occurs.  10-traumatic-ulcer  ***Fig.3*** *Traumatic ulcer* ***Fig.4*** *Tuberculosis*  • Decubital ulcers are more common in older people. Tuberculosis most often affects middle-aged people.      • In contrast to decubital ulcers in tuberculosis, the general condition of the patient worsens, from history -pulmonary tuberculosis is revealed.  • In tuberculosis, epithelioid and giant cells of Langerhans are found in the scraping taken from the ulcer, and when staining according to Tsil-Nielsen, mycobacterium tuberculosis is often detected. In a decubital ulcer, these cells are not found.   • Decubital ulcer occurs as a response of the mucous membrane to various stimuli. A tuberculous ulcer occurs as a result of the inoculation of Koch's bacillus into the mucous membrane.  **3.Differential diagnostics of traumatic(decubital) and syphilis' (chancre) ulcers Common symptoms:**    • Solitary ulcers on the oral mucosa and the red border of the lips **Differences:**     • The causative agent of syphilis is treponema pallidum. A traumatic ulcer is an inflammatory response of tissues to the irritants.     • In syphilis, a painless saucer-shaped ulcer of meat-red color with elevated smooth edges is formed, at the base of which a dense cartilage-like infiltrate is palpable. The surrounding mucous membrane is not changed. The traumatic ulcer has an oval shape and a slightly depressed surface, with painful hyperemic edges, its central part is of yellowish-gray color, only when prolonged existence, the edges and base of the ulcer become denser.  F320966  ***Fig.5*** *Traumatic ulcer* ***Fig.6*** Primary syphilis  • In syphilis, the lymph nodes become cartilaginous-dense, painless. In traumatic ulcers, the  lymph nodes are enlarged, mobile, painful.      • After elimination of the stimulus, rapid epithelisation of the traumatic ulcer occurs. Elimination of the traumatic agent does not affect the course of the solid chancre.   • The diagnosis in primary syphilis, in contrast to a traumatic ulcer, is clarified by the presence of a pale spirochetes in the discharge of an ulcer or punctate of regional lymph nodes and positive serological reactions.  **4. Differential diagnostics of traumatic(decubital) ulcer and Vincent's ulcerative necrotizing stomatitis (chronic) Common symptoms:**  •   presence of ulcer on mucosa ,pain when eating  **Differences:**  •The ulcer in Vincent’s ulcerative necrotizing stomatitis is localized on the gingiva, in the retromolar region. Decubital ulcer is localized at the sites of injury (lateral surfaces and tip of the tongue, cheeks along the dental closing line, floor of the oral cavity)   • Vincent's ulcerative necrotizing stomatitis affects mainly men aged 17-30 years. Traumatic ulcers are more common in older people.       • In Vincent's ulcerative necrotizing stomatitis, in contrast to a traumatic ulcer, the gingiva is hyperemic, edematous, its edges are ulcerated, necrotic foci are visible in the interdental spaces.  • Vincent's ulcerative necrotizing stomatitis is an infectious disease. Decubital ulcer occurs as a response of the oral mucosa to various stimuli.  img_glossary_t19-1  ***Fig.7*** *Traumatic ulcer* ***Fig.8***  *Vincent's ulcerative necrotizing stomatitis*  • Rapid healing of the ulcer after elimination of the irritant and its epithelisation indicate the traumatic origin of the ulcer.  •For Vincent's ulcerative necrotizing stomatitis , a deteriation of the general condition of the patient is characteristic (fever, weakness, headache, sleep disorder)  •In a bacteriological examination of Vincent's ulcerative necrotizing stomatitis , plenty fusobacteria are revealed.  **5.Differential diagnostics between both traumatic(decubital) and trophic ulcers Common symptoms:**     • The presence of solitary ulcers on oral mucosa;       •necrotic plaque on the surface of the ulcers;  • Painfulness when eating  •There is a possible relationship with traumatic factors  **Differences:**     • A trophic ulcer differs from a traumatic ulcer in a more sluggish course, mild symptoms of inflammation.       • Trophic ulcers are observed in systemic diseases (in patients with cardiovascular and cardiopulmonary insufficiency of the II-III degree).  834279-867080-1985C:\Documents and Settings\Пользователь\Рабочий стол\10-19.jpg  ***Fig.9*** *Traumatic ulcer* ***Fig.10*** *Trophic ulcer*      • Rapid healing of the ulcer after elimination of the irritant and its epithelisation indicate the traumatic origin of the ulcer. Trophic ulcers after elimination of the traumatic factor do not tend to heal unless general therapy is carried out.  • In trophic ulcers, the necrotic process can spread to neighboring areas of the face, nasopharynx, jaw bone tissue (through defects of the cheeks, severe bleeding is possible).  •In trophic ulcers, the lymph nodes are not enlarged.  **6.Differential diagnostics between traumatic (decubital)ulcer and Bowen' s disease** **Common symptoms:**      •The prevalence among the elderly persons       • Solitary foci  **Differences:**       • Traumatic ulcer has hyperemic edges, is painful on palpation, its floor is covered with necrotic plaque. The pathological lesion in Bowen's disease is in the form of easily bleeding erosions situated on a hyperemic background, slightly sinking in comparison with the surrounding areas.       • Histologically, in Bouen's disease, giant cells with multiple nuclei are found.  travmaticheskiy-stomatitC:\Documents and Settings\Пользователь\Рабочий стол\asdfghn.jpg  ***Fig.11*** *Traumatic ulcer* ***Fig.12*** *Bouen disease*        • After elimination of the stimulus, rapid epithelisation of the traumatic ulcer occurs. Elimination the injury does not affect the course of Bowen's disease.       • Favorite localizations of Bowen's disease on the oral mucosa are the soft palate, uvula, tongue, retromolar region. Traumatic ulcers are more often localized on the tongue, lips, cheeks along the dental closing line.  •In Bowen's disease, skin lesions are observed.  **7.Differential diagnostics of traumatic (decubital)ulcers and leukoplakia**  **Common signs:**  •Pathological focus is in the form of white spot(plane form) or plaque(hyperkeratotic form)  •Prevalence among middle-aged and elderly people.  **Differences:**  • Leukoplakia is often caused by smoking or other bad habits  • The most common localization of leukoplakia is the anterior sections of the mucous membrane of the cheeks, tongue. Traumatic ulcers are more often localized on the mucous membrane of the cheeks along the dental closing line, tongue.  C:\Documents and Settings\Пользователь\Рабочий стол\Desktop\leukoplakui\leukoplakia.jpg  ***Fig.13*** *Leukoplakia* ***Fig.14*** *Traumatic ulcer*  • In contrast to traumatic ulcer, foci in leukoplakia are located on an unaltered oral mucosa.  • A traumatic ulcer, in contrast to leukoplakia, is painful, surrounded by an inflammatory infiltrate.  **8.Differential diagnostics of traumatic (decubital)ulcer and lichen planus (hyperkeratotic form)**  **Common symptoms:**  • The lesion is whitish in color  **Differences:**  •Lichen planus is more common among women over 40. Injury to the mucous membrane under the influence of chronic irritants is more common in elder people.  •In Lichen planus, there are papules which are solitary and merged into a pattern in the form of a mesh, lace, stripes , significantly elevating above the level of the mucous membrane.    ***Fig. 15*** *Lichen planus* ***Fig.16****. Traumatic ulcer*  •Traumatic ulcer has an oval shape and a slightly depressed surface, with painful hyperemic edges.  •After elimination of the stimulus, rapid epithelisation of the traumatic ulcer occurs.  •In lichen planus, skin lesions are possible.  **9. Differential diagnostics of traumatic(decubital) ulcers and Chronic recurrent aphtous stomatitis**  **Common symptoms:**  • Ulcers on oral mucosa  **Differences:**  •Localization of decubital ulcers in case of trauma corresponds to the traumatic factor.  • A traumatic ulcer is located on an uniformly hyperemic oral mucosa.  In Chronic recurrent aphtous stomatitis , erosions of an oval shape are sharply painful, covered with a dense plaque that cannot be removed by scraping, with a halo of hyperemia.  •Erosions in Chronic recurrence aphtous stomatitis recur, localized in areas of the oral mucosa, normally not keratinized.  • Elimination of trauma leads to rapid epithelization of the decubital ulcer.    ***Fig.17*** *Traumatic ulcer*  **Chronic recurrent aphtous stomatitis**  **10. Differential diagnostics of decubital ulcer and blood diseases (leukemia, agranulocytosis):**  **Common symptoms:**  •Ulcer of the oral mucosa  • Painfulness when eating  **Differences:**  • In case of blood diseases, a deteriation of the general condition is observed: weakness, pallor of the skin  • In blood diseases, the ulcer is rarely solitary , more often there are ulcerative lesions of the gingivae, mucous membrane, not associated with trauma  • In case of blood diseases, the mucous membrane is pale  **11. Differential diagnostics of decubital ulcer and viral diseases:**  **Common symptoms:**  •Erosion, pain when eating  • Hyperemia of the oral mucosa  **Differences:**  •The appearance of erosion in viral diseases is preceded by vesicles rashes.  •The edges of erosions in viral diseases are scalloped, due to the fusion of small vesicles or erosions  • In case of viral diseases, deteriation of the general condition is possible, more or less expressed phenomena of intoxication, there is no relationship with traumatic factors  **12. Differential diagnostics of decubital ulcer and pemphigus vulgaris:**  **Common symptoms:**  •Erosion, pain when eating  **Differences:**  •In pemphigus vulgaris , multiple erosions are formed due to the burst of the bubbles  • In case of pemphigus vulgaris, the mucous membrane is not changed or is slightly hyperemic  • In pemphigus vulgaris, erosions have no tendency to epithelisation  •Cytological examination in pemphigus vulgaris determines acantholytic cells, Nikolsky symptom is positive  **Papillomatous hyperplasia is differentiated with :**  **1.Allergic reaction of the oral mucosa to the prosthesis base material**  **2. Chronic hyperplastic candidiasis**  **1.Differential diagnostics of papillomatous hyperplasia and allergic reaction of the mucous membrane to the material of the prosthesis base**  **Common symptoms:**  • Hyperemia of the mucous membrane of the prosthetic bed  **Differences:**  • In papillomatous hyperplasia, the lesion has a granular surface  • In papillomatous hyperplasia, the alveolar margin is soft, mobile  • In papillomatous hyperplasia, there is bone resorption of the alveolar bone  **2. Differential diagnostics of papillomatous hyperplasia and chronic hyperplastic candidiasis**  **Common symptoms:**  • Hyperemia of the mucous membrane of the prosthetic bed  •Candida fungi are found in the scrapings  **Differences:**  •In papillomatous hyperplasia, the lesion has a granular surface, in chronic hyperplastic candidiasis, a thick layer of densely sitting plaque in the form of nodules or plaques  • In papillomatous hyperplasia, the alveolar margin is soft, mobile  • In papillomatous hyperplasia, there is bone resorption of the alveolar bone  • In chronic hyperplastic candidiasis, when scraping by a spatula, a bleeding erosive surface is exposed  **Traumatic gingival hyperplasia is differentiated with:**  **1.Hypertrophic gingivitis**  **2.Epulis**  **1.Differential diagnostics of traumatic gingival hyperplasia and hypertrophic gingivitis**  **Common symptoms:**  • Overgrowth of gingival margin  **Differences:**  • Traumatic gingival hyperplasia appears only in the area of permanent injury by the overhanging edge of the crown or the clasp of the prosthesis; in hypertrophic gingivitis, gingival overgrowth is observed in the area of the group or all teeth  •Hypertrophic gingivitis is more common in adolescents and pregnant women  • In hypertrophic gingivitis, the epithelial attachment is not destroyed, there is a pseudo pocket  • In hypertrophic gingivitis, changes are not associated with mechanical trauma  **2.Differential diagnostics of traumatic gingival hyperplasia and epulis**  **Common symptoms:**  • overgrowth of the gingival margin  **Differences:**  • Traumatic gingival hyperplasia appears only in the area of permanent injury by the overhanging edge of the crown or the clasp of the prosthesis, epulis is more often observed in the gingivae of premolars, canines  • In epulis,there is a local tumor-like growth of a brownish or reddish color  **Habitual biting of the oral mucosa is differentiated with :**  **1. Candidiasis**  **2. White sponge nevus of cannon**  **1. Differential diagnostics of habitual biting of the oral mucosa and candidiasis**  **Common symptoms:**  • Whitish lesions  • The lesions are scraped off when scraped by a spatula  **Differences:**  • In habitual biting of the oral mucosa in the scrapings, there are no Candida  •The mucous membrane in candidiasis is hyperemic, in habitual biting – it is whitish, macerated, scaly  • In candidiasis, patients complain of dryness, itching, burning of the mucous membranes  **2. Differential diagnostics of habitual biting of the mucous membrane and White sponge nevus of cannon**  **Common symptoms:**  • Whitish lesions  •The lesions are scraped off when scraped by a spatula  **Differences:**  • In Cannon's nevus, symmetrical lesions of the buccal mucosa are observed  • In Cannon's nevus, the buccal mucosa is strongly folded, spongy  • In Cannon's nevus, similar lesions are observed on the mucous membrane of the genitals and rectum  **Acute mechanical trauma is differentiated with :**  **1.Allergic stomatitis (medication- induced )**  **2.Allergic contact stomatitis**  **3. Vesicovascular syndrome**  **4. Thermal injury (exposure to high temperatures: hot water, steam)**  **5.Radiation injury (remote X-ray and gamma therapy)**  **6. Werlhof's disease**  **7. Acute leukemia**  **8. Capillary hemangioma**  **1.Differential diagnostics of acute mechanical trauma and allergic medication- induced stomatitis:**  **Common symptoms:**  •Mild painfulness  •Burning, rawness  •Catarrhal inflammation  **Differences:**  • In case of allergic medication- induced stomatitis, diffuse, less often limited hyperemia caused by taking the medication is observed  **2. Differential diagnostics of acute mechanical trauma and allergic contact stomatitis:**  **Common symptoms:**  •Burning, pain of the mucous membrane  • Integrity loss of the mucous membrane, hyperemia  **Differences:**  • In case of allergic contact stomatitis, changes occur at the contact point of the oral mucosa with amalgam, metal alloys (prostheses), medical dressings (in the treatment of periodontal diseases)  • In case of allergic contact stomatitis, clinical manifestations are noted 7-10 days after the first contact  **3. Differential diagnostics of acute mechanical trauma and vesicovascular syndrome:**  **Common symptoms:**  •Limited cavity filled with hemorrhagic contents  **Differences:**  • Vesicovascular syndrome often occurs on the mucous membrane of the palate in persons over 40-50 years old with diseases of the cardiovascular system  • In case of vesicovascular syndrome, after the bubble burst , erosion remains, which quickly epithelializes  **4. Differential diagnostics both of acute mechanical and thermal injuries:**  **Common symptoms:**  •Limited or diffuse acute inflammation: pain, burning, hyperemia, integrity loss of the mucous membrane  •Hemorrhages (petechiae, ecchymosis)  **Differences:**  • In case of thermal trauma, the effect of the corresponding stimuli is revealed from the anamnesis  **5. Differential diagnostics both of acute mechanical and radiation injuries:**  **Common symptoms:**  • Burning, pain when eating  **Differences:**  •During radiation therapy, changes progress (hyperemia, edema, keratinization, focal and merge radiomucositis)  • Hyposalivation is observed in radiation therapy  **6.Differential diagnostics of acute mechanical injury and Werlhof's disease:**  **Common symptoms:**  •Hemorrhages on the oral mucosa  **Differences:**  • In Werlhof's disease, bleeding from the nose, hemorrhages in the gingivae and other parts of the oral mucosa are observed  •Thrombocytopenia is observed in Werlhof 'disease  **7. Differential diagnostics of acute mechanical trauma and acute leukemia:**  **Common symptoms:**  •Hemorrhages on the oral mucosa  **Differences:**  •In acute leukemia, there are extensive hemorrhages not associated with trauma, nasal hemorrhages, bleeding from the alveolus of the extracted tooth.  • In acute leukemia, there is a deteriation of the general condition  • In acute leukemia, there are changes in blood tests  **8. Differential diagnostics of acute mechanical trauma and capillary hemangioma:**  **Common symptoms:**  • Formation of the hematoma on the oral mucosa ,it has a purple, cyanotic color  **Differences:**  •A capillary hemangioma is of a long life  •A capillary hemangioma is sometimes first discovered in childhood  •A capillary hemangioma is based on the proliferation of newly formed capillaries and arterioles  **Chronic traumatic erythema is differentiated with:**  **1.Contact allergic stomatitis**  **2.Galvanosis**  **3.Exudative-hyperemic form of lichen planus**  **1. Differential diagnostics of chronic traumatic erythema and contact allergic stomatitis:**  **Common symptoms:**  • Burning, pain when taking spicy and hot food  • Hyperemia of the oral mucosa  **Differences:**  • In case of contact allergic stomatitis, diffuse hyperemia is observed at the place of the contact with amalgam, prosthesis materials (gold, plastic) 7-10 days after the first contact  **2. Differential diagnostics of chronic traumatic erythema and galvanosis:**  **Common symptoms:**  • Unpleasant sensations, burning  • Hyperemia of the oral mucosa  **Differences:**  • In galvanosis, there is no clear localization, there is no relationship with trauma  • In galvanosis, patients complain of a metallic taste in the mouth  • In case of galvanosis in the mouth, there are dentures made of dissimilar metals  **3. Differential diagnostics of chronic traumatic erythema and exudative-hyperemic form of lichen planus:**  **Common symptoms:**  • Burning, pain when eating the irritating food  • Hyperemia of the mucous membrane  **Differences:**  • In lichen planus, there are papular rashes on a background of hyperemia, which are often symmetrical  • The course of lichen planus is long-term  • In lichen planus, there is a lesion of the skin  •Lichen planus often affects women aged 40-60 years  **Chemical trauma is differentiated with :**  **1.Mechanical injury**  **2.Physical trauma**  **3.Allergic medication- induced stomatitis**  **4. Addison-Birmer anemia**  **5.Exudate - hyperemic form of lichen planus**  **1. Differential diagnostics both of chemical and mechanical injuries:**  **Common symptoms:**  • Burning, pain of varying intensity  •A hyperemic spot of indefinite shape and size on an edematous base, painful on palpation  **Differences:**  • In case of mechanical injury, the localization of an inflammatory erythema corresponds to the location of the traumatic factor  • In case of mechanical injury, the elimination of the traumatic factor leads to the disappearance of the lesions  **2.Differential diagnostics both of chemical and physical injuries:**  **Common symptoms:**  • Burning, pain of the mucous membrane  • The cause of the appearance of hyperemic spots is indicated by the data of the anamnesis  • Discomfort in the oral cavity  •Catarrhal inflammation of the mucosa  **Differences:**  • In case of physical injury (in case of exposure to hot water, steam, fire), bubble and erosions after their burst may form  • In case of physical injury (if there are prostheses made of various metals in the oral cavity), galvanosis develops  • In case of physical injury, the appearance of changes on the mucous membrane coincides in time with the setting of prostheses or metal fillings  **3. Differential diagnostics of chemical trauma and allergic medication- induced stomatitis:**  **Common symptoms:**  • Burning, pain in the oral cavity  •diffuse or localized hyperemia and edema of the oral mucosa  **Differences:**  • In case of allergic stomatitis, changes are preceded by orally taking of medications or their topical application in the oral cavity  • In discontinuation of the medications, there is a recovering  **4. Differential diagnostics of chemical injury and Addison-Birmer's anemia:**  **Common symptoms:**  •Hyperemic spots on various parts of the oral mucosa  •Burning of the mucous membrane  **Differences:**  • In anemia, there is atrophy of the fungiforme , filiform papillae of the tongue  • In anemia, the oral mucosa is pale, there is general malaise  •Anemia is more common in women  • In anemia, there are changes in the blood  **5. Differential diagnostics of chemical injury and exudative-hyperemic form of lichen planus:**  **Common symptoms:**  • Painfulness, hyperemia, edema of the oral mucosa  **Differences:**  • In lichen planus, along the periphery of the hyperemic spot, there are papules in the form of a mesh  •The lesions are more often observed in the middle and posterior parts of the oral cavity  • Lichen planus is more common among women  **Leukoplakia is differentiated from :**  **1. Lichen planus (LP)**  **2.Lupus erythematosus**  **3. Secondary syphilis**  **4.Chronic hyperplastic candidiasis**  **5. Bowen's disease**  **6. Pashkov’s mild leukoplakia**  **7 .Keratinous squamous cell carcinoma**  **8. Clouding of the epithelium during its regeneration**  **9.Limited precancerous hyperkeratosis of the red lip border**  **10. White sponge nevus of cannon**  **11. Manganotti's cheilitis**  **12 .Traumatic ulcer**  **13 .Candidiasis associated with HIV- infection**  **14.Leukoplakia associated with HIV- infection**  **1.Differential diagnostics of leukoplakia and lichen planus (LP)**  **Common symptoms:**  • Prevalence among the middle-aged and older people  • Presence of whitish-gray foci of hyperkeratosis with a rough surface  • Parakeratosis, hyperkeratosis, a chronic inflammatory process in the lamina propria of the mucous membrane are histologically determined  **Differences:**  • In Lichen planus , the pathological element is in the form of papules, forming a mesh, lace pattern with clear, jagged edges on the background of expressed inflammatory phenomena. In leukoplakia, the pathological elements are in the form of a plaque with even borders on the background of the slightly expressed or no inflammation.  • Lichen planus is more common in women. Leukoplakia predominantly occurs in men.  • In Lichen planus , typical skin rashes are possible. In leukoplakia, the skin is not affected.  • In Lichen planus , the cheeks in the molar region, transitional folds, the retromolar region, the lateral surfaces and dorsum of the tongue, gingivae , lips, palate, floor of the mouth are affected.  In leukoplakia, the cheeks are affected along the dental closing line in the anterior section in the form of a triangle with the apex posteriorly, the red border of the lower lip, tongue, palate.  1322160905_leukoplakia-300x254  ***Fig.18*** *Leukoplakia* ***Fig. 19*** *Lichen planus*  • In UVA light (fluorescent diagnostics) in Lichen planus , lesions give a whitish-yellow glow. In UVA light, lesions of leukoplakia give a blue glow.  **2.Differential diagnostics of leukoplakia and lupus erythematosus**  **Common symptoms:**  • Whitish foci of hyperkeratosis  **Differences:**  • Lupus erythematosus is more common in women aged 20-40 years. Leukoplakia affects people of middle and older age, more often men.  • In lupus erythematosus, the skin of the exposed areas of the face is affected, like the wings of a butterfly, neck, scalp, ears. In leukoplakia, the skin is not affected.  • In lupus erythematosus, the red border of the lips, the buccal mucosa along the dental closing line is more often affected. In leukoplakia, the buccal mucosa is affected along the dental closing line in the anterior section in the form of a triangle with the apex posteriorly, the red border of the lower lip, tongue, palate are also affected  .• In lupus erythematosus, pathological elements are in the form of bright erythema with atrophy in the center, covered with delicate white dots and stripes, and hyperkeratosis in the form of flame tongues along the periphery. In leukoplakia, pathological elements are in the form of a plaque (like glued thin tissue paper) with smooth, clear boundaries, without bright erythema and atrophy.  leykoplakia rta  ***Fig. 20*** Leukoplakia  • In lupus erythematosus in UVA light (luminescent diagnostics), the lesions give a snow-white or cloudy- white glow. In leukoplakia in UVA light, lesions give a blue glow.  • In lupus erythematosus, in contrast to leukoplakia, the lesions are located in the form of a ribbon.  **3.Differential diagnostics of leukoplakia and secondary syphilis (papular form)**  **Common symptoms:**  •Pathological focus with clear boundaries  •The presence of a grayish-white plaque  **Differences:**  • The causative agent of syphilis is pale treponema. Local irritants play the main role in the occurrence of leukoplakia.  • Papular syphilis often affects the tonsils, soft palate and arches. Leukoplakia often affects the red border of the lower lip, the buccal mucosa along the dental closing line in the anterior region in the form of a triangle with the apex posteriorly, the palate.  • In papular syphilis, the main morphological element is dense, large papules that have an inflammatory halo and do not merge with each other. In leukoplakia, the morphological element is a plaque with hyperkeratosis, reminiscent of pasted papyrus paper, and without an inflammatory halo.  body_467_0  ***Fig. 21*** *Leukoplakia*  • The plaque is easily scrabbed off from the surface of the syphilitic papule. It is impossible to scrab off the plaque from the surface of leukoplakia, since it is a consequence of hyperkeratosis.  • In syphilis, the base of the focus is infiltrated, which is not observed in the case of leukoplakia.  • In leukoplakia, patients complain of a burning sensation, tightness, roughness of the mucous membrane, which is not observed in the case of syphilis.  • In contrast to leukoplakia, in syphilis, polyadenitis, a roseolous rash on the skin, is possible  • Persons of both sexes are suffered with syphilis. Men suffer from leukoplakia more often than women.  • The diagnosis of syphilis is confirmed by positive serological reactions and the detection of pale treponema in the lesions.  **4. Differential diagnostics of leukoplakia and chronic hyperplastic candidiasis**  **Common symptoms:**  •Foci of the lesion are in the form of white plaques  •Dryness, burning sensation in the oral cavity  **Differences:**  • Chronic hyperplastic candidosis is more common in older and weakened adults.Leukoplakia is more common in middle-aged and older men.  • Chronic hyperplastic candidiasis is caused by yeast-like fungi of the genus Candida. Leukoplakia occurs as a result of various injuries.  • In Chronic hyperplastic candidiasis, a thick layer of plaque is located on the hyperemic oral mucosa, which, when scraped, is hardly removed and a bleeding erosive surface is exposed.  The morphological element of defeat in leukoplakia is a hyperkeratotic spot with clear boundaries, located on the apparently unchanged mucous membrane, it is rough and dry, and cannot be removed by scraping.  • The diagnosis of Chronic hyperplastic candidiasis is confirmed by the presence of a fungus of the genus Candida in scrapings taken from the surface of the affected oral mucosa.  • Typical localization of leukoplakia foci is the buccal mucosa along the dental closing line in the anterior region, the corners of the mouth and the red border of the lower lip. Chronic hyperplastic candidiasis often affects the dorsum of the tongue in the form of rhomboid glossitis and the palate in the form of papillary hyperplasia.  •From a history in Chronic hyperplastic candidiasis, prolonged taking of antibiotics, glucocorticosteroids, cytostatics and the effect of antifungal treatment is observed.  **5. Differential diagnostics of leukoplakia and Bowen's disease**  **Common symptoms:**  • Grayish-white focus of hyperkeratosis  •Prevalence among the men  •Clear boundaries of the pathological lesion  **Differences:**  • Typical localization of leukoplakia foci is the buccal mucosa along the dental closing line in the anterior region, the corners of the mouth and the red border of the lower lip. Typical localization of Bowen's disease is the retromolar region, uvula, tongue, soft palate.  • The morphological element of Bowen's disease is a slightly sunken macular-nodular lesion located on a hyperemic mucosa, when scraped, a velvety stagnant red surface with uneven edges is exposed.  Moreover, the focus of the lesion keratinizes unevenly.  The morphological element of defeat in leukoplakia is a hyperkeratotic spot located on the apparently unchanged mucous membrane,it is rough and dry, and cannot be removed by scraping.  leukoplakia-10-a-foto  ***Fig. 22*** *Leukoplakia*  • The histological picture in Bowen's disease corresponds to intraepithelial spinocellular carcinoma with preservation of the integrity of the basement membrane.  • In leukoplakia, patients are worried about the feeling of tightness, burning, dryness of the mucous membrane.  There are no subjective sensations in Bowen's disease or they are slightly painful.  **6.Differential diagnostics of leukoplakia (plane) and Pashkov’s mild leukoplakia**  **Common symptoms:**  • The affected area is of whitish-gray color without signs of inflammation on the cheek along the dental closing line, in the area of the mouth corners  **Differences:**  • Plane leukoplakia occurs mainly in middle-aged and older men. Pashkov’s mild leukoplakia is more common in children and young women.  • In plane leukoplakia, patients are worried about the feeling of tightness, burning, dryness of the mucous membrane. Subjective sensations in Pashkov’s mild leukoplakia are often absent.  • The morphological element in leukoplakia is a hyperkeratotic spot with clear boundaries, located on the apparently unchanged mucous membrane, it is rough and dry, and cannot be removed by scraping.  365_365_3  ***Fig.23*** *Plane leukoplakia* ***Fig.24*** *Pashkov’s mild leukoplakia*  • Pashkov’s mild leukoplakia is the areas of peeling of an edematous, pasty mucous membrane with fuzzy boundaries, which are removed by scraping.  • In Pashkov’s mild leukoplakia the habit of biting the mucous membrane of the cheeks, lips is revealed from a history.  **7.Differential diagnostics of leukoplakia and keratinizing squamous cell carcinoma**  **Common symptoms:**  •Dense tuberous formations or warty growths that elevate above the level of the mucous membrane (in the case of differentiation of verrucous leukoplakia)  • Ulcers and erosions in the lesion (in the case of differentiation of erosive leukoplakia)  **Differences:**  • The morphological element of defeat in leukoplakia is a hyperkeratotic spot with clear boundaries, without compaction at the base, it is rough and dry.  The morphological element of defeat in keratinizing squamous cell carcinoma is a warty outgrowth located on a pedicle, or an infiltrate, or an ulcer (depending on the form of cancer), but always with compaction at the base, there are papillary growths, bleeding by trauma, painlessness on palpation.  • Histologically, in keratinizing squamous cell carcinoma, in contrast to leukoplakia, atypical cells are found.  • In cancer, the regional lymph nodes are dense, painless, soldered to the surrounding tissue.  **8. Differential diagnostics of leukoplakia and opacification of the epithelium during its regeneration (lichenoid reaction of the mucous membrane)**  **Common symptoms:**  •A grayish-white area of hyperkeratosis that cannot be removed by scraping  **Differences:**  • In contrast to leukoplakia, epithelial opacity disappears spontaneously after the completion of epithelisation of erosions , ulcers.  **9.Differential diagnostics of leukoplakia (on the red border of the lips) and limited precancerous hyperkeratosis of the red border of the lips**  **Common symptoms:**  •Prevalence is more common among middle-aged and older men  • The presence of a grayish-white lesion that is not be scraped off when scraping  **Differences:**  • The morphological element of defeat in leukoplakia is a hyperkeratotic spot of various shapes and sizes with clear boundaries, it is rough and dry.  kdcsphfxkns_2  ***Fig.25*** *Leukoplakia*  Limited precancerous hyperkeratosis has a even surface, slightly sinking in relation to the surface of the lip, , covered with thin, densely sitting scales.  • The focus of limited precancerous hyperkeratosis is small in comparison with leukoplakia.  • The final diagnosis of limited precancerous hyperkeratosis of the red border of the lips is confirmed by the results of histological examination.  **10.Differential diagnostics of leukoplakia and white spongy nevus**  **Common symptoms:**  • The presence of a lesion of whitish-gray color on the background of unchanged mucosa  •Complaints about an unusual appearance of the oral mucosa  **Differences:**  • White spongy nevus occurs in early childhood and reaches its maximum development during puberty. Plane leukoplakia occurs mainly in middle-aged and older men.  • In plane leukoplakia, patients are worried about the feeling of tightness, burning, dryness of the mucous membrane. Subjective sensations in a white spongy nevus are absent.  • The morphological element of defeat in leukoplakia is a hyperkeratotic spot with clear boundaries, located on the apparently unchanged mucous membrane, it is rough and dry, and cannot be removed by scraping.  In a white spongy nevus, the oral mucosa is strongly folded, sometimes so much that the folds hang down into the oral cavity.  • In a white spongy nevus, in contrast to leukoplakia, the mucous membrane of the genitals and rectum is affected  **11. Differential diagnostics of leukoplakia (erosive form) and Manganotti' cheilitis**  **Common symptoms:**  • Spreading is more common among middle-aged and older men  • Defeat of the red border of the lips  • Ability to malignancy  **Differences:**  • The morphological element of defeat in the erosive form of leukoplakia are erosions, cracks or ulcers of various shapes and sizes with clear boundaries on the background of hyperkeratosis..  The morphological element in Manganotti's cheilitis is oval-shaped erosion with a smooth, polished surface, of deep red color , sometimes covered with bloody crusts.  • In contrast to Manganotti's cheilitis, in the erosive form of leukoplakia, pain is observed, which increases with food intake and conversation.  • The final diagnosis of Manganotti's cheilitis is confirmed by the results of histological examination  **12. Differential diagnostics of leukoplakia and traumatic ulcers**  **Common symptoms:**  • The lesion is of whitish color ,and in the form of a spot or plaque  **Differences:**  • The cause of leukoplakia is more often smoking and other bad habits.  The cause of traumatic ulcers is sharp edges of teeth, dental calculus , poorly made crowns, dentures  • The most common localization of leukoplakia is the anterior parts of the mucous membrane of the cheeks, corners of the mouth, tongue, red border of the lips.  Traumatic ulcers are more often localized on the mucous membrane of the cheeks along the dental closing line, and tongue.  • Leukoplakia, in contrast to a traumatic ulcer, is located on the apparently unchanged oral mucosa.  • A traumatic ulcer, in contrast to leukoplakia, is painful, surrounded by an inflammatory infiltrate.  • Lymph nodes in a traumatic ulcer are enlarged, painful  **13. Differential diagnostics of leukoplakia and candidiasis on the background of HIV infection**  **Common symptoms:**  •white and dry lesions  •burning sensation in the mouth  •Long course of the disease  **Differences:**  • Candidiasis associated with HIV infection is a disease of the oral mucosa associated with immunodeficiency .Leukoplakia occurs as a result of various injuries.  • In candidiasis on the background of HIV infection, the lesion is in the form of a plaque without clear boundaries, resembling curdled milk, which, when scraped, is easily removed and located on the hyperemic oral mucosa. The lesion of leukoplakia is in the form of a hyperkeratotic plaque with clear, even edges, which cannot be removed when scraped, it is located on a seemingly unchanged mucous membrane resembling a glued thin tissue paper.  pub63p03C:\Documents and Settings\Xp\Desktop\leukoplakui\Leukoplakia-dyskeratosis-pre-cancerous.jpg  ***Fig.26*** *Leukoplakia* ***Fig.27*** *HIV-related candidiasis*  • Diagnosis of candidiasis related to HIV infection is confirmed by the presence of Candida fungi in the scrapings taken from the surface of the affected oral mucosa , as well as immunosorbent analysis and immunoblotting.  • Leukoplakia is more often localized on the buccal mucosa along the dental closing line in the anterior section, the corners of the mouth, and the red border of the lower lip.  Candidiasis on the background of HIV infection is localized on the mucous membrane of the tongue, cheeks, floor of the mouth, gums.  • In candidiasis on the background of HIV infection, in contrast to leukoplakia, the general condition of patients worsens (weight loss, weakness, pneumonia, lymphadenitis, etc.)  **14. Differential diagnostics of plane leukoplakia and hairy leukoplakia on the background of HIV infection**  **Common symptoms:**  •Foci of defeat are of whitish color  •Lack of inflammatory reaction along the periphery of the focus  **Differences:**  • Hairy leukoplakia is a lesion of the oral mucosa associated with immunodeficiency and HIV infection.  Local irritants play the main role in the occurrence of true leukoplakia.  • Hairy leukoplakia on the background of HIV infection is more often localized on the lateral surfaces of the tongue. Typical localization of plane leukoplakia is the buccal mucosa membrane along the dental closing line in the anterior region, the corners of the mouth and the red border of the lower lip.  67-ec02d177  ***Fig.28*** *Hairy leukoplakia associated with HIV-infection*  • Lesions in hairy leukoplakia on the background of HIV infection are in the form of folds or villi that elevate above the surface of the oral mucosa.  The morphological element of defeat in plane leukoplakia is a hyperkeratotic spot that does not elevate above the level of the oral mucosa.  • In hairy leukoplakia on the background of HIV infection, in contrast to true leukoplakia, the general condition of patients worsens (weight loss, weakness, pneumonia, lymphadenitis, etc.)  • The diagnosis of hairy leukoplakia associated with HIV infection is confirmed by immunosorbent analysis and immunoblotting.  **Pashkov's Pashkov’s mild leukoplakia is differentiated with :**  **1.Plane leukoplakia**  **2.Typical form of lichen planus**  **3.Acute candidiasis**  **4. Erosive medication stomatitis**  **1.Differential diagnostics of Pashkov’s mild leukoplakia and plane leukoplakia**  **Common symptoms:**  •Presence of a whitish-gray focus  •Lack of mucosal inflammation  **Differences:**  • Plane leukoplakia occurs mainly in middle-aged and older men. Pashkov’s mild leukoplakia is more common in children and young women.  • In plane leukoplakia, patients are worried about the feeling of tightness, burning, dryness of the mucous membrane. Subjective sensations in Pashkov’s mild leukoplakia are often absent.  • The morphological element of defeat in leukoplakia is a hyperkeratotic spot with clear boundaries, located on the apparently unchanged mucous membrane, it is rough and dry, and cannot be removed by scraping.  Pashkov’s mild leukoplakia is the areas of peeling of an edematous, pasty mucous membrane with fuzzy boundaries, which are removed when scraped (lesions are in the form of spilled spots with an uneven fringed and rough surface, as if eaten away by moths, due to multiple small patches of epithelium).  1322161771_7-6 365_365_3  ***Fig.29*** *Pashkov’s mild leukoplakia* ***Fig.30*** *Plane leukoplakia*  • From a history of mild leukoplakia, the habit of biting the mucous membrane of the cheeks, lips is revealed  **2.Differential diagnostics of Pashkov’s mild leukoplakia and typical form of lichen planus**  **Common symptoms:**  •Presence of whitish-gray lesions  • Prevalence among women  **Differences:**  • In Lichen planus , the pathological element is in the form of papules, forming a mesh, lace pattern with clear, jagged edges on the apparently unchanged oral mucosa, which cannot be removed by scraping.  Pashkov’s mild leukoplakia is the areas of peeling of an edematous, pasty mucous membrane with fuzzy boundaries, which are removed when scraped (lesions are in the form of diffuse spots with an uneven fringed and rough surface, as if eaten away by moths, due to multiple small patches of epithelium).  1322161386_1  ***Fig.31****Pashkov’s mild leukoplakia*  • Lichen planus occurs more often at the age of 40-60 years. Pashkov’s mild leukoplakia often occurs up to the age of 30.  • In Lichen planus, the inner surface of the forearms, wrist joints, lower legs, sacrum, and genitals are affected. In Pashkov’s mild leukoplakia, the skin is not affected.  • In Lichen planus , the cheeks in the molar region, transitional folds, the retromolar region, and the lateral surfaces and dorsum of the tongue are more commonly affected. In Pashkov’s mild leukoplakia, the mucous membrane of the cheeks along the dental closing line, and lips is more often affected.  **3.Differential diagnostics of Pashkov's mild leukoplakia and acute candidiasis**  **Common symptoms:**  •Foci of defeat are of white color with indistinct boundaries  •The surface of the lesions is scraped by scraping  **Differences:**  • Candidiasis affects infants and the elderly, especially those who are weakened by chronic diseases. Pashkov’s mild leukoplakia is more often observed in patients with neuropathy, predominantly of young age.  • The cause of candidiasis is yeast-like fungi of the genus Candida. The cause of Pashkov’s mild leukoplakia is trauma to the oral mucosa.  Etiology of Pashkov’s mild leukoplakia – is inheritance,it is a type of epithelial dysplasia  • In candidiasis, lesions are in the form of a plaque resembling curdled milk, located on a hyperemic, dry oral mucosa.  In Pashkov's leukoplakia, lesions are in the form of diffuse spots with an uneven, fringed and rough surface (as if eaten away by moths) due to multiple small patches of epithelium located on an edematous, pasty mucosa without inflammation.  • The diagnosis of candidiasis is confirmed by the presence of fungi of the genus Candida and pseudomycelium in scrapings taken from the surface of the lesions.  • Candidiasis often affects the mucous membrane of the dorsum of the tongue, cheeks, palate, lips. Pashkov’s mild leukoplakia is localized mainly along the dental closing line and on the mucous membrane of the lips.  **4.Differential diagnostics of Pashkov’s mild leukoplakia and medication- induced stomatitis**  **Common symptoms:**  •Presence of painful erosions  **Differences:**  • The cause of Pashkov’s mild leukoplakia is trauma to the oral mucosa. Medication- induced stomatitis is an allergic reaction to medications.  • Pashkov’s mild leukoplakia is more often observed in patients with neuropathy, predominantly of young age. Medication- induced stomatitis can occur regardless at any age.  • In Pashkov's leukoplakia, lesions are in the form of diffuse spots with an uneven, fringed and rough surface (as if eaten away by moths) due to multiple small patches of epithelium or erosions located on an edematous, pasty mucosa without inflammation.  In medication- induced stomatitis, on the background of hyperemic oral mucosa, bubbles appear, which burst and form extensive erosive surfaces.  • Pashkov’s mild leukoplakia, in contrast to medication- induced stomatitis, is localized mainly along the dental closing line and on the mucous membrane of the lips.  **White sponge nevus of cannon is differentiated with :**  **1.Leukoplakia**  **2.Candidiasis**  **1.Differential diagnostics of white spongy nevus and leukoplakia**  **Common symptoms:**  • The presence of a whitish-gray lesion  •Injury of the buccal mucosa  • Complaints about an unusual appearance of the oral mucosa  **Differences:**  • White spongy nevus occurs in early childhood and reaches its maximum of development during puberty.  Plane leukoplakia occurs mainly in middle-aged and older men.  • In plane leukoplakia, patients are worried about the feeling of tightness, burning, dryness of the mucous membrane. Subjective sensations in a white spongy nevus are absent.  • The morphological element of defeat in leukoplakia is a hyperkeratotic spot with clear boundaries, located on the apparently unchanged mucous membrane, which is rough and dry, and cannot be removed by scraping.  ***Fig.32*** *Leukoplakia*  In a white spongy nevus, the oral mucosa is strongly folded, sometimes so much that the folds hang down into the oral cavity.  **• In a white spongy nevus, in contrast to leukoplakia, the mucous membrane of the genitals and rectum is affected .**  **2.Differential diagnostics of white spongy nevus and acute candidiasis**  **Common symptoms:**  •Foci of defeat are of white color with indistinct boundaries  •The surface of the lesions is removed by scraping  **Differences:**  • Candidiasis affects infants and the elderly, especially those who are weakened by chronic diseases. White spongy nevus occurs in early childhood and reaches its maximum development during puberty.  • The cause of candidiasis is yeast-like fungi of the genus Candida. White spongy nevus is a hereditary disease.  • In candidiasis, lesions are in the form of a plaque resembling curdled milk, located on a hyperemic, dry oral mucosa.  In a white spongy nevus, the oral mucosa is strongly folded, sometimes so much that the folds hang down into the oral cavity.  The defeat of the mucous membrane in a white spongy nevus is always symmetrical.  • The diagnosis of candidiasis is confirmed by the presence of fungi of the genus Candida in scrapings taken from the surface of the lesions.  • Candidiasis often affects the mucous membrane of the dorsum of the tongue, cheeks, palate, lips. The typical localization of a white spongy nevus is the buccal mucosa.  •In a white spongy nevus, in contrast to cadidiasis, the mucous membrane of the genitals and rectum is affected.  **Allergic diseases**  **Chronic recurrent aphthous stomatitis (CHRAS) is differentiated from:**  **1.Tuberculosis**  **2. Primary syphilis**  **3.Secondary syphilis (papular syphilis)**  **4.Neoplasms**  **5.Recurrent herpetic stomatitis (RHS)**  **6.Acute herpetic (aphthous) stomatitis (AHS)**  **7. Pemphigus vulgaris**  **8 .Behçet 's syndrome**  **9 Sutton’s aphthae**  **10. Traumatic ulcer**  **1. Differential diagnostics of Chronic recurrent aphtous stomatitis and tuberculous lesions**  **Common symptoms:**  • Ulcers have soft edges  •Presence of scars after healing of ulcers leading to deformity  **Differences:**  • The etiology of Chronic recurrent aphtous stomatitishas not been finally clarified. The causative agent of tuberculosis is mycobacterium tuberculosis (Koch's bacillus).  •By Chronic recurrent aphtous stomatitis they get sick at any age. Middle-aged people are more likely to be affected by tuberculous lesions.  • The shape of the ulcer in Chronic recurrent aphtous stomatitisis often oval or round.  In tuberculosis, there is an ulcer of irregular shape with pitted, undermined edges.  cdcdcd8e5b84  ***Fig.33*** *Chronic recurrent aphtous stomatitis*  •The floor of the ulcer in Chronic recurrent aphtous stomatitis is flat, covered with a grayish-yellow plaque. In tuberculosis, the floor of the ulcer is covered with easily bleeding granulations (it reminds the juicy of raspberries); Treel grains are visible around the ulcer - small yellowish abscesses.  •In Chronic recurrent aphtous stomatitis , there is no tendency of ulcer to growth. In tuberculosis, along the periphery of the main ulcer, small, new ones are formed, merging with the ulcers that appeared initially.  •In Chronic recurrent aphtous stomatitis, there is no tendency of ulcer to growth. In tuberculosis, along the periphery of the main ulcer, small, new ones are formed, merging with the ulcers that appeared initially.  • In tuberculosis, the bone tissue of the interdental septa is destroyed, the teeth become mobile and fall out. In Chronic recurrent aphtous stomatitis, these phenomena are absent.  • In case of tuberculosis, cytological examination of materials revealed giant cells of Pirogov - Langhans, Koch's bacillus. In Chronic recurrent aphtous stomatitis, these cells are absent.  •In Chronic recurrent aphtous stomatitis, serological reactions are negative. In tuberculosis, a positive Mantoux reaction is observed.    •For tuberculosis, in contrast to Chronic recurrent aphtous stomatitis, the symptom of apple jelly and a probe test (the Pospelov phenomenon) are characteristic.  • In Chronic recurrent aphtous stomatitis, the aphthae are very painful. In tuberculosis, aphthae are less painful (depending on the form)  • In tuberculosis, in contrast to Chronic recurrent aphtous stomatitis , the skin of the nose, upper lip, and the red border of the lips can also be affected.  • In tuberculosis, in contrast to Chronic recurrent aphtous stomatitis , there are recurrences of ulceration in the area of scars (fresh tubercles periodically appear on them).  **2. Differential diagnostics of Chronic recurrent aphtous stomatitis and primary syphiloma.**  **Common symptoms:**  •Presence of solitary large round ulcers, covered with a grayish-yellow plaque  **Differences:**  •By Chronic recurrent aphtous stomatitis they get sick at any age. Syphilis is more common at a young age.  •Primary syphiloma is more often localized on the red border of the lips. Chronic recurrent aphtous stomatitis most often occurs on the mucous membrane of the cheeks, lips, lateral surfaces and the tip of the tongue  • Ulcer in Chronic recurrent aphtous stomatitis with a soft base and edges, elevates above the level of the mucous membrane,it is flat, covered with a dense plaque , painful. The ulcer in syphilis is meat-red in color with dense, roller-like, even edges, without plaque or covered with a "greasy" plaque , localized on a powerful cartilage-like infiltrate, painless.  храс1  ***Fig.34*** *Chronic recurrent aphtous stomatitis*  • In syphilis, regional lymphadenitis is observed, the lymph nodes are enlarged, painless, of dense-elastic consistency, mobile  •Cytological examination in Chronic recurrent aphtous stomatitis revealed epithelial cells in the material. In syphilis, pale treponemas are found in the lesions.  •Serological reactions in Chronic recurrent aphtous stomatitis are negative. In syphilis, a positive Wasserman reaction is observed after 3-4 weeks after infection.  • In contrast to Chronic recurrent aphtous stomatitis, in syphilis, the lymph nodes are cartilaginous-dense and painless on palpation.  **3.Differential diagnostics of Chronic recurrent aphtous stomatitis and secondary (papular) syphilis**  **Common symptoms:**  •Presence of large, solitary, rounded lesions  **Differences:**  •By Chronic recurrent aphtous stomatitis they get sick at any age. Syphilis is more common at a young age.  •in Chronic recurrent aphtous stomatitis , the morphological element is painful aphtha, which is soft to the touch, slightly elevating above the surrounding tissues, surrounded by a brightly hyperemic, edematous halo and covered with a dense yellowish-gray plaque.  In syphilis, the morphological element is a flat, slightly painful papule with an infiltrate at the base, of meat -red color , surrounded by a stagnant inflammatory halo along the periphery and covered with an easily removable grayish-white plaque.  11-12  ***Fig.35*** *Chronic recurrent aphtous stomatitis*  •In Chronic recurrent aphtous stomatitis , in contrast to syphilis, the rash is preceded by a burning sensation and pain  • Rash in Chronic recurrent aphtous stomatitis is more often localized on the mucous membrane of the cheeks, lips, lateral surfaces of the tongue. In secondary syphilis, the tonsils, soft palate, arch, and corner of the mouth are more often affected.  Афтозный стоматит у взрослых  ***Fig.36*** Chronic recurrent aphtous stomatitis  •In Chronic recurrent aphtous stomatitis ,aphthae have no tendency to growth. In syphilis, papules are prone to peripheral proliferation.  • The diagnosis of syphilis is confirmed by the presence of pale treponema in the lesions and positive serological reactions.  Cytological examination of the aphthae in Chronic recurrent aphtous stomatitis reveals a picture of chronic inflammation and the presence of epithelial cells.  •Aphthae in Chronic recurrent aphtous stomatitis , in contrast to syphilis, are recurrent.  • In syphilis, in contrast to Chronic recurrent aphtous stomatitis , a papular rash is observed on the skin of the face and body.  • In syphilis, expressed polymorphic lymphadenitis is observed, the lymph nodes are enlarged, painless, of dense-elastic consistency, mobile  **4. Differential diagnostics of Chronic recurrent aphtous stomatitis and neoplasms.**  **Common symptoms:**  •Presence of 1-2 erosions.  • Enlarged dense lymph nodes  **Differences:**  •By Chronic recurrent aphtous stomatitis they get sick at any age. Neoplasms appear more often in old age.  • The shape of the ulcer in Chronic recurrent aphtous stomatitis is often oval or round with soft edges. In neoplasms, the shape of the ulcer depends on the site of localization and the primary focus, and its edges are dense, elevated , uneven and often corroded.  •The floor of the ulcer in Chronic recurrent aphtous stomatitis is flat, covered with a grayish-yellow plaque. The floor of the ulcer in neoplasms is uneven, covered with a viscous bloody- purulent disintegrating mass or crust, under which granulation or vegetation can be seen.  porslo_0411r5  ***Fig.37*** *Chronic recurrent aphtous stomatitis*  •In Chronic recurrent aphtous stomatitis , there is no tendency of the ulcer to growth. In neoplasms, the tendency to growth depends on the type of tumor (growth in depth or along the periphery).  •Cytological examination in Chronic recurrent aphtous stomatitisrevealed epithelial cells in the material. In neoplasms,there are atypical epithelial cells.  • In Chronic recurrent aphtous stomatitis , the lymph nodes are painful, mobile, in a cancer ulcer- they are painless, soldered to the tissues  **5. Differential diagnostics of Chronic recurrent aphtous stomatitis and chronic recurrent herpetic stomatitis (RHS)**  **Common symptoms:**  •Presence of painful erosions  • burning and pain before the onset of aphthae  • Recurrent nature of the disease  **Differences:**  •Recurrent herpetic stomatitis is always preceded by acute respiratory diseases or exacerbations of chronic infections, hypothermia. The provoking factors in Chronic recurrent aphtous stomatitis are exacerbation of gastrointestinal and allergic diseases, infections, frequent climate change, young age  •From the anamnesis, it turns out that patients with Recurrent herpetic stomatitis , in contrast to Chronic recurrent aphtous stomatitis, had acute herpetic stomatitis in childhood.  •The frequency of exacerbations in patients with Recurrent herpetic stomatitis is high, but a permanent course of the disease is also possible. The frequency of exacerbations in patients with Chronic recurrent aphtous stomatitisdepends on the general condition of the organism.  •In Recurrent herpetic stomatitis , the morphological elements are small vesicles, which quickly burst up with the formation of erosions with scalloped edges. In Chronic recurrent aphtous stomatitis , morphological elements are in the form of large, solitar aphthae (3-6 mm in diameter) with a soft base, which elevate above the level of the mucous membrane.  st3_r10  ***Fig.38*** *Chronic recurrent aphtous stomatitis*  • In Recurrent herpetic stomatitis , aphthae are more often located on the mucous membrane, the red border and the skin around the lips, the anterior parts of the hard palate, the wings of the nose, the dorsum of the tongue, less often on the cornea of the eyes, the skin and mucous membranes of the genitals, and the trunk. In Chronic recurrent aphtous stomatitis, aphthae are more often located on the mucous membrane of the cheeks, lips, lateral surfaces and the tip of the tongue  •In case of Recurrent herpetic stomatitis , the healing of erosions occurs without scars formation. In Chronic recurrent aphtous stomatitis , after healing, scars leading to the microstome may remain (depending on the form)  **6. Differential diagnostics of Chronic recurrent aphtous stomatitis and acute herpetic stomatitis (AHS).**  **Common symptoms:**  •Presence of painful aphthae  •Presence of a tight-sitting plaque on the aphthae  **Differences:**  • The etiology of Chronic recurrent aphtous stomatitis has not been finally clarified. The common herpes virus is the cause of acute herpetic stomatitis.  •By Chronic recurrent aphtous stomatitis they get sick at the age of 10 to 60 years. Acute herpetic stomatitis affects children aged 6 months to 3 years.  •In Chronic recurrent aphtous stomatitis , the general condition of the organism does not suffer. In acute herpetic stomatitis, the phenomena of intoxication of the organism and deterioration of the general condition of the patient are observed (weakness, headache, fever, nausea, vomiting, joint pain, disturbed heart rhythm, pallor of the skin).  •In Chronic recurrent aphtous stomatitis, morphological elements are in the form of solitar large aphthae (in diameter 3-6 mm) with a soft base, elevating above the level of the oral mucosa. Aphtha is surrounded by a sharply delimited, brightly hyperemic, edematous halo .  In acute herpetic stomatitis, pathological elements are in the form of multiple painful vesicles on the background of hyperemic edematous mucosa, which quickly burst with the formation of polycyclic erosions  • In Chronic recurrent aphtous stomatitis , aphthae are more often located on the mucous membrane of the cheeks, lips, lateral surfaces and the tip of the tongue. In acute herpetic stomatitis, vesicles are located on the tip and lateral surfaces of the tongue, mucous membrane of the lips, the vestibule of the mouth, cheeks, nasopharynx, skin of the perioral region, eyelids, earlobes, fingers (depending on the severity of the disease).  •In Chronic recurrent aphtous stomatitis , the pathological elements are solitary , there is no tendency to merge. In acute herpetic stomatitis, the pathological elements often merge and form extensive erosive-ulcerative and necrotic areas of the mucous membrane.  •In Chronic recurrent aphtous stomatitis , in contrast to acute herpetic stomatitis, rough scars may remain, leading to deformation of the oral mucosa and narrowing of natural openings (in severe form).  **7. Differential diagnostics of Chronic recurrent aphtous stomatitis and pemphigus vulgaris**  **Common symptoms:**  •Painful erosions  **Differences:**  •By Chronic recurrent aphtous stomatitis everyone gets sick, regardless of gender and age. Pemphigus vulgaris affects persons over 35 years old, more often women.  •In Chronic recurrent aphtous stomatitis , in contrast to pemphigus vulgaris, the appearance of pathological elements is preceded by itching and burning.  •In Chronic recurrent aphtous stomatitis , the mucous membrane of the cheeks, lips, tongue is more often affected. In pemphigus vulgaris, the retromolar space, pharynx, soft palate, gingivae , tongue, floor of the mouth are affected  **st3_r12**  ***Fig.39*** Chronic recurrent aphtous stomatitis  •In Chronic recurrent aphtous stomatitis , large, solitary, oval or round-shaped aphthae with a soft base and edges are formed, elevating above the level of the normal mucous membrane. These aphthae are covered with a grayish-yellow dense plaque and are surrounded by a thin, brightly hyperemic, edematous halo , without a tendency to merge.  In pemphigus vulgaris , bright red, bleeding erosions with an unpleasant odor are formed, with scraps of epithelium of the bubble's covering along the periphery. Erosions are covered with a grayish "greasy" plaque with clear, even borders, tend to merge and are located on a slightly edematous, pale pink color of the oral mucosa.  •In pemphigus vulgaris, in contrast to Chronic recurrent aphtous stomatitis , the skin is affected  •Cytological examination of aphthae in Chronic recurrent aphtous stomatitis reveals epithelial cells and a picture of chronic inflammation. Cytology in pemphigus vulgaris reveals acantholytic cells.  **8. Differential diagnostics of Chronic recurrent aphtous stomatitis and Behçet 's syndrome**  **Common symptoms:**  • Severely painful aphthae on the oral mucosa  **Differences:**  •In contrast to Chronic recurrent aphtous stomatitis , in Behçet 's syndrome, there is a simultaneous appearance of aphthae on the mucous membrane of the mouth, eyes, and genitals.  • Epithelisation of the affected areas in Behçet 's syndrome is long-term (1-6 months).  • In Chronic recurrent aphtous stomatitis , the oral mucosa is more often affected at the sites of injuries,but in Behçet 's syndrome- the distal parts of the oral cavity is affected  **9. Differential diagnostics of Chronic recurrent aphtous stomatitis and Sutton’s aphthae**  **Common symptoms:**  • Painful aphthae on the oral mucosa  **Differences:**  • In contrast to Chronic recurrent aphtous stomatitis , Sutton’s aphthae exist for a long time, then turn into deep ulcers with hardened edges.  • Epithelisation of Sutton’s aphthae is prolonged (1-4 months) with the formation of scars.  **10. Differential diagnostics of Chronic recurrent aphtous stomatitis and traumatic ulcers**  **Common symptoms:**  • Ulcers on the oral mucosa  **Differences:**  •Localization of ulcers in case of trauma corresponds to the traumatic factor.  • Traumatic ulcer is located on the evenly hyperemic oral mucosa.  • Elimination of trauma leads to rapid epithelisation of the traumatic ulcer  **Sutton’s aphthae is differentiated from :**  **1. Vincent's ulcerative necrotizing stomatitis**  **2 .Behçet 's disease**  **3 .Traumatic ulcer**  **4. Cancer ulcer**  **5.Specific ulcers (syphilis, tuberculosis)**  **1.Differential diagnostics of Sutton’s aphthae and Vincent's ulcerative necrotizing stomatitis:**  **Common symptoms:**  • Severely painful ulcers on mucosa  • Crater-like ulcers  **Differences:**  • Ulcers in Vincent's ulcerative necrotizing stomatitis are covered with a profuse necrotic plaque with a fetid odor  • In Vincent's ulcerative necrotizing stomatitis in the lesion, fusobacteria and spirochetes are detected in large quantities  • Ulcers in Vincent's ulcerative necrotizing stomatitis occur on the background of intoxication, bleed heavily  • In Vincent's ulcerative necrotizing stomatitis , the gums, the retromolar region are more often affected, but in Sutton’s aphthae, the lateral surfaces of the tongue, the mucous membrane of the lips, cheeks are more often affected  •After the healing of Sutton’s aphthae , gross deforming scars are formed.  **2. Differential diagnostics of Sutton’s aphthae and Behçet 's disease:**  **Common symptoms:**  • Severely painful mucosal ulcers  • Crater-like ulcers  •After healing, rough deforming scars are formed  **Differences:**  • In Behçet 's disease, combined aphthous-ulcerative lesions of the oral mucosa, eyes, genitals are observed  • In Behçet 's disease, recurrent nodosum erythema, patergya occur on the skin  • Ulcers in Behçet 's disease are more often located in the distal parts of the oral cavity, in Sutton’s aphthae, the lateral surfaces of the tongue, the mucous membrane of the lips, cheeks are more often affected  **3. Differential diagnostics of Sutton’s aphthae and traumatic ulcer:**  **Common symptoms:**  • Painful ulcers on the mucous membrane  •Localization  •Solitary lesions on mucosa  **Differences:**  •In case of traumatic injury, the traumatic factor is always determined, the elimination of which contributes to the rapid healing of the ulcer  • In Sutton’s aphthae, the ulcer is crater-shaped  • Traumatic ulcers are more common in the elderly due to prostheses wearing  • Sutton’s aphthae are prone to relapse  •After the Sutton’s aphthae heal, gross deforming scars are formed  **4. Differential diagnostics of Sutton’s aphthae and cancerous ulcer:**  **Common symptoms:**  • Ulcers on the mucous membrane  •Localization  •Solitary mucosal lesions  **Differences:**  • In a malignant ulcer, the edges are dense, slightly painful, Sutton’s aphtha is severely painful  • In cancer, the lymph nodes are enlarged, painless, soldered to the surrounding tissues  • In case of a malignant ulcer, cytological examination reveals atypism, cellular polymorphism  **5. Differential diagnostics of Sutton’s aphthae and specific ulcers:**  **Common symptoms:**  • Ulcers on the mucous membrane  **Differences:**  • Solid chancre is distinguished by a longer development period, the formation of a dense infiltrate at the base, painlessness, a clean surface  •Microscopic examination of a smear taken from the surface of a solid chancre reveals pale treponemas  •The appearance of a solid chancre is accompanied by regional lymphadenitis  • Ulcers in tuberculosis are formed on the background of the underlying disease, have a granular yellow-orange floor  • By microscopic examination of the contents taken from the surface of the ulcer in tuberculosis, Langhans cells, Koch bacilla are found  • In tuberculosis, fluorography allows to identify cavernous foci in the lungs  **Herpetiforme chronic recurrent aphthous stomatitis is differentiated from :**  **1. Herpetic stomatitis**  **2.Erosive and ulcerative medication- induced stomatitis**  **3.Erythema multiforme**  **1.Differential diagnostics of chronic recurrent herpetiform aphthous stomatitis and herpetic stomatitis:**  **Common symptoms:**  • Small erosions on the mucous membrane, merging into extensive erosive surfaces  **Differences:**  •In case of herpetic stomatitis, the primary pathological element is a vesicle, erosions with polycyclic edges  • Herpetic stomatitis is accompanied by gingivitis, lesions of the red border of the lips  • In case of herpetiform chronic recurrent aphthous stomatitis, the floor of the mouth is more often affected  • Chronic recurrent herpetiform aphthous stomatitis is more common in women under the age of 30  • In case of herpetiformis chronic recurrent aphthous stomatitis, the skin is not affected  **2. Differential diagnostics of chronic recurrent herpetiform aphthous stomatitis and erosive -ulcerative medication stomatitis:**  **Common symptoms:**  • Painful erosions on the mucous membrane, merging into extensive erosive surfaces  **Differences:**  • In case of herpetiform chronic recurrent aphthous stomatitis, the floor of the mouth is more often affected  • Chronic recurrent herpetiform aphthous stomatitis is more common in women under the age of 30  • In case of herpetiformis chronic recurrent aphthous stomatitis, the skin is not affected  • In case of erosive-ulcerative stomatitis, erosions are preceded by bubbles and vesicles  •In case of erosive -ulcerative stomatitis, it is of great importance to collect anamnesis for the use of medications  • In case of erosive - ulcerative stomatitis, the discontinuation of the medication contributes to the attenuation of the erosive process and recovery  **3. Differential diagnostics of chronic recurrent herpetiform aphthous stomatitis and erythema multiforme:**  **Common symptoms:**  • Painful erosions on the mucous membrane  • Recurrent nature of the disease  **Differences:**  •In erythema multiforme, there are signs of general intoxication  • In case of erythema multiforme, polymorphism of rashes, "cockades" on the skin are observed  • Chronic recurrent herpetiform aphthous stomatitis is more common in women under the age of 30  • In case of herpetiformis chronic recurrent aphthous stomatitis, the skin is not affected  **Erythema multiforme is differentiated from:**  **1.Acantholytic pemphigus**  **2.Non-acantholytic pemphigus only of the oral mucosa**  **3.Acute herpetic stomatitis**  **4. Secondary syphilis**  **5. Dühring's herpetiformis dermatitis**  **6. Impetigo**  **7 .Lichen planus**  **8. Erosive –medication stomatitis**  **9. Lyell's disease**  **10 . Manganotti's cheilitis**  **11. Vesicovascular syndrome in cardiovascular diseases**  **12. Hand and foot and mouth disease**  **13. Stevens-Johnson syndrome**  **14.Chronic recurrent herpes**  **1.Differential diagnostics of erythema multiforme and acantholytic pemphigus**  **Common symptoms:**  • Painful, bleeding erosions with even borders and scraps of epithelium of the bubble's covering along the edges with a tendency to fusion  •Bubbles and crusts on the skin  • Painfulness and burning sensation of the oral mucosa, aggravated by eating  **Differences:**  •Pemphigus vulgaris affects people over 35, more often women. Erythema multiforme mainly affects young people (20-40 years old), more often men.  • In contrast to pemphigus vulgaris, Erythema multiforme has an acute onset, seasonality of relapses, short duration of the course.  • Pemphigus vulgaris affects the retromolar space, pharynx, soft palate, gums, tongue. Erythema multiforme affects the anterior parts of the mouth: the vestibule of the mouth, lips, palate, tongue, cheeks.  Mnogoformnaya_jekssudativnaya_jeritema  ***Fig.40*** *Erythema multiforme*  •In pemphigus vulgaris, erosions with an unpleasant odor, covered with a grayish or white "greasy" plaque and located on an unchanged or slightly hyperemic mucous membrane, do not epithelize for a long time.  In Erythema multiforme ,there are erosions of significant size, covered with a yellowish-gray plaque and located on a highly edematous, hyperemic oral mucosa.  •In pemphigus vulgaris, in contrast to erythema multiforme , Nikolsky's symptom is positive, the bubbles are located intraepithelially (in erythema multiforme- subepithelial), acantholysis phenomena are present, acactolytic cells are found in smears.  • In pemphigus vulgaris, bubbles and erosions on the skin are located in areas prone to injury and friction. In Erythema multiforme , the skin of the forearms, palms, legs, and feet is more often affected.  **2.Differential diagnostics of erythema multiforme and non-acantholytic pemphigus only of the oral mucosa**  **Common symptoms:**  •Presence of bubbles and erosions  •Histologically, subepithelial location of bubbles , absence of acantholysis  • Along the edges of erosion, there are scraps of epithelium of the bubble's covering  **Differences:**  • Erythema multiforme mainly affects young people (20-40 years old), more often men. Non-acantholytic pemphigus of the oral mucosa only usually occurs in persons over 50 years of age  •Erosions in Erythema multiforme are extensive, with even borders, tend to merge, sharply painful, bleeding, covered with a yellowish-gray plaque.  zabolevaniya_slizistoj_obolochki_rta_i_gub_6  ***Fig.41*** Erythema multiforme  Erosions in non-acantholytic pemphigus only of the oral mucosa are small, slightly painful, without a tendency to increase, covered with fibrinous plaque.  •The appearance of skin elements in the form of cockades is in Erythema multiforme .  • Erythema multiforme , in contrast to non-acantholytic pemphigus only of the oral mucosa , is characterized by an acute course, seasonality of relapses and more expressed inflammation of the oral mucosa.  • In case of non-acantholytic pemphigus only of the oral mucosa the skin is not affected  **3. Differential diagnostics of erythema multiforme and acute herpetic stomatitis (AHS).**  **Common symptoms:**  •Acute onset of the disease, general weakness, high body temperature, headache, muscle pain  • Hypersalivation  • Acure painfulness of the mucous membrane when talking, eating, at rest  **Differences:**  •Acute herpetic stomatitis is more common in children aged 6 months to 3 years. Erythema multiforme affects young people (usually men) under the age of 30.  • Etiology of erythema multiforme is infectious-allergic. Acute herpetic stomatitis is caused by the herpes simplex virus.  • In case of erythema multiforme, erosions are large, along their edges fragments of the bubble's covering epithelium remain and do not have polycyclic outlines.  eritema-multiforme-165-a-foto  ***Fig.42*** Erythema multiforme  In Acute herpetic stomatitis , erosions are small-pointed, prone to fusion, or large with polycyclic edges.  •In case of erythema multiforme, cytological examination of the content of bubbles and erosions shows the absence of multinucleated giant cells. In Acute herpetic stomatitis, these cells are present in smears-prints.  •For erythema multiforme when skin lesions, true polymorphism is characteristic.  For Acute herpetic stomatitis when skin lesions, pseudo polymorphism (vesicles and crusts) is characteristic, there are no erythematous spots, "cockades", bubbles  • Acute herpetic stomatitis is distinguished from erythema multiforme by the absence of pathological elements in areas of the oral mucosa typical for erythema multiforme (floor of the mouth, soft palate).  •In contrast to Acute herpetic stomatitis , erythema multiforme is characterized by the presence of seasonality of exacerbations (spring and autumn).  •Erythema multiforme lasts for years. Acute herpetic stomatitis lasts for 1-3 weeks.  • In case of erythema multiforme, the subepithelial location of the bubbles and the absence of acantholysis phenomena are histologically determined. In Acute herpetic stomatitis , the intraepithelial location of the vesicles is histologically determined, there are the phenomena of acantholysis.  **4.Differential diagnostics of erythema multiforme and secondary (papular) syphilis**  **Common symptoms:**  •Large lesions  •Affection of young people  • Skin lesions  **Differences:**  • In contrast to syphilis, erythema multiforme begins acutely.  • Secondary syphilis often affects the tonsils, soft palate, and arches. Erythema multiforme often affects the red border and mucous membrane of the lips, the oral vestibule, tongue, cheeks, palate.  • In papular syphilis, mildly painful papules with clear edges, infiltrate at the base and an inflammatory halo around are formed. They are covered with a grayish-white cplaque , which is easily removed by scraping.  In erythema multiforme, bleeding erosions are formed with the fragments of bubble's covering epithelium the along the edges, covered with a dense yellowish-gray plaque or dense brown-black crusts and located on a hyperemic, edematous mucous membrane.  eritema-multiforme-178-a-foto  ***Fig.43***Erythema multiforme  •For papular syphilis, the focusness of the arrangement of the elements is characteristic (they are located isolated from each other). For erythema multiforme, a tendency to fusion of lesions is characteristic.  • Persons of both sexes are suffered from syphilis. Erythema multiforme often affects men.  • In syphilis, data from cytological examination of scrapings taken from the surface of papules reveal the presence of pale treponema. The diagnosis is also confirmed by positive serological tests. In erythema multiforme, the cytology of scrapings taken from the surface of erosions reveals the presence of epithelial cells, leukocytes , abundant microflora. Serological reactions in erythema multiforme are negative.  •In erythema multiforme, in contrast to syphilis, relapses are seasonal.  **5.Differential diagnostics of erythema multiforme and Dühring's dermatitis herpetiformis (DDH)**  **Common symptoms:**  •The presence of skin elements in the form of erythematous spots of different shades, vesicles  •Erosions located on the hyperemic and edematous mucous membrane  •Negative Nikolsky's symptom and subepithelial location of the bubbles  •Eosinophilia in peripheral blood  •Polymorphism  **Differences:**  •By Dühring's dermatitis herpetiformis they get sick at any age. By Erythema multiforme they get sick at a young age, more often up to 30 years.  • Dühring's dermatitis herpetiformis is a polyetiological syndrome, which is the organism's reaction to exo- and endoallergens. The etiology of erythema multiforme is infectious and allergic.  Dühring's dermatitis herpetiformis is a chronic disease in which the general condition of the patient is usually good. Erythema multiforme begins as an acute infectious disease with general weakness, fever, rheumatoid pain.  •In Dühring's dermatitis herpetiformis superficial , solitary , slightly painful, bright red erosions with scalloped edges, partially covered with plaque and a tearing film, are formed. In erythema multiforme, painful, extensive erosions are formed, with even outlines, merging, covered with a yellowish-gray plaque, along the edges –there are the scraps of the bubble's covering epithelium.  Ehritema_mnogoformnaya  ***Fig.44*** *Erythema multiforme*  • In case of erythema multiforme, in contrast to Dühring's dermatitis herpetiformis, submandibular and cervical lymphadenitis is observed.  • In Dühring's dermatitis herpetiformis, eosinophilia is observed in the contents of the bubbles  • In Dühring's dermatitis herpetiformis, in contrast to erythema multiforme, patients have an increased sensitivity to iodine preparations.  **6. Differential diagnostics of erythema multiforme and impetigo:**  **Common symptoms:**  •Acute onset of the disease  • Affection of the facial skin  •Presence of wet joined erosions  **Differences:**  •Impetigo is more common in children. Erythema multiforme mainly affects young people (20-40 years old).  • In impetigo, erosions are covered with abundant golden-yellow "honey" crusts, which can be easily removed.  In erythema multiforme, erosions are covered with a tightly seated fibrinous plaque or bloody crusts of black-brown color (when fusospirochetosis is joined, the crusts are yellowish-gray).  • In case of impetigo, the erosions are small, but in case of erythema multiforme, the erosions are large, extensive, along their edges, grayish-white remnants of the bubble's covering epithelium are visible.  •Erythema multiforme, in contrast to impetigo, has a seasonal character (relapses are observed in autumn and spring).  **7. Differential diagnostics of erythema multiforme and lichen planus (LP)**  **Common symptoms:**  • The tendency of lesions to merge  • Skin lesions  **Differences:**  • Lichen planus is more common in women over 40 years of age. Erythema multiforme often affects young and middle-aged people.  • Lichen planus is a chronic disease that develops gradually. Erythema multiforme begins acutely, with a temperature rise, headache, muscle and joint pain.  • Lichen planus is localized more often on the cheeks in the area of molars with the capture of the transitional folds and on the lateral surfaces of the tongue, with a transition to the back and lower surface to the molars's region. Erythema multiforme often affects the anterior parts of the oral cavity: lips, cheeks, tongue, floor of the mouth, hard palate.  eritema-multiforme-43-a-foto  ***Fig.45*** *Erythema multiforme*  • In Lichen planus, pathological elements are papules , forming a typical reticular, lace pattern with clear, jagged edges. In erythema multiforme , the pathological elements are extensive, sharply painful, with even borders, bleeding erosions , covered with a yellowish-gray plaque, and with scraps of the bubble's covering epithelium.  **8.Differential diagnostics of erythema multiforme and erosive medication- induced stomatitis**  **Common symptoms:**  • Deterioration of the general condition  • Bubbles and erosions of the mucous membrane on a sharply hyperemic and edematous background  **Differences:**  •Erythema multiforme often affects men aged 20-40 years. Erosive stomatitis can occur in any person, regardless of age and gender.  • In case of erythema multiforme , in contrast to erosive stomatitis, the lesion of the oral mucosa is accompanied by acute pain even at rest.  • In case of erythema multiforme , in contrast to acute stomatitis, skin lesions in the form of cockades are observed.  eritema-multiforme-82-a-foto  ***Fig.46*** *Erythema multiforme*  •Erythema multiforme has a seasonal recurrent course.  •Medicication-induced stomatitis is always preceded by taking a medication  **9.Differential diagnostics of erythema multiforme and Lyell's disease**  **Common symptoms:**  •Acute onset of the disease  • Defeat to the skin and oral mucosa  • Bubbles formation  •Erythema and edema of the oral mucosa  **Differences:**  •Erythema multiforme is more common in men aged 20-40 years. Lyell's disease is preceded by a medication intake, so it can be observed in any person, regardless of age and gender.  • In erythema multiforme, erosions are formed, covered with fibrinous plaque or bloody crusts with grayish-white remnants of the cover along the edge. In Lyell's disease, extensive bleeding erosions are formed.  lajella-sindrom-epidermalnyj-toksicheskij-nekroliz-1  ***Fig.47*** *Lyell's disease*  • In Lyell's disease, Nikolsky's and Asbo-Hansen's symptoms are positive. In erythema multiforme , both symptoms are negative.  • In contrast to Lyell's disease, in erythema multiforme, cockades are formed on the skin.  52  ***Fig.48*** *Erythema multiforme*  **10.Differential diagnostics of erythema multiforme and Manganotti's cheilitis**  **Common symptoms:**  • Prevalence among men  •Presence of erosions covered with bloody crusts  **Differences:**  • Young people are more likely to suffer from erythema multiforme. Manganotti's cheilitis is common among elderly and older people.  •Erosions in Manganotti's cheilitis are painless. In erythema multiforme , erosions are severely painful even at rest.  •Erythema multiforme , in contrast to Manganotti 's cheilitis, has a seasonal recurrent nature of the course and an acute onset of the disease.  • In contrast to Manganotti's cheilitis, in erythema multiforme, cockades are formed on the skin.  • In case of erythema multiforme , erosions are located on the edematous and inflamed oral mucosa and have remnants of the bubble's covering epithelium along the edge.  zabolevaniya_slizistoj_obolochki_rta_i_gub_7  ***Fig.49*** *Erythema multiforme*  In Manganotti's cheilitis, erosions are located on a background of little or no inflammation.  •Erosions in Manganotti’s cheilitis are characterized by a sluggish and persistent course and do not respond well to medication therapy  **11.Differential diagnostics of erythema multiforme and vesicovascular syndrome**  **Common symptoms:**  •Presence of bubbles and erosions on the oral mucosa  • Same localization of the bubbles  **Differences:**  • Erythema multiforme is more common in men aged 20-40 years. Vesicovascular syndrome often occurs in women aged 40-75 years.  •The appearance of bubbles in the vesicovascular syndrome is associated with an increase in blood pressure, observed on the background of the main disease. Erythema multiforme has an infectious or toxic-allergic nature.  • In case of erythema multiforme , in contrast to the vesicovascular syndrome, skin lesions in the form of cockades are observed.  •Bubbles in vesicovascular syndrome are dense and can exist unchanged from several hours to several days.  In erythema multiforme , the bubbles quickly burst , the bubble's covering epithelium around the erosions are visible.  •Erythema multiforme is characterized by periods of exacerbation in the autumn-spring period.  **12. Differential diagnostics of erythema multiforme and Hand and foot and mouth disease**  **Common symptoms:**  •Affection of the anterior areas of the oral cavity (lips, cheeks, tongue, floor of the mouth, hard palate, gums)  •Acute onset of the disease  •Painful erosions  **Differences:**  • By Hand and foot and mouth disease a person is infected from sick animals. The etiology of erythema multiforme is infectious or toxic-allergic.  • Children are more likely to suffer from Hand and foot and mouth disease. Erythema multiforme mainly affects young men (20-40 years old).  • In case of Hand and foot and mouth disease, the skin of the wings of the nose, interdigital folds, the base of the nails, and soles are affected. In erythema multiforme , the skin of the hands, forearm, lower leg, face, and neck is affected.  •In Hand and foot and mouth disease, small erosions of bright red color with polycyclic outlines are formed. In erythema multiforme , sharply limited, bleeding when touched, large erosions with even edges, slightly elevating above the surrounding tissues, with the remnants of bubble's covering epithelium along the edges, are formed.  60371830  ***Fig.50*** *Hand and foot and mouth disease*  •For erythema multiforme , relapses are characteristic, which are seasonal. Epizootic conditions are of great importance for Hand and foot and mouth disease.  •For Hand and foot and mouth disease hypersalivation is characteristic (up to 5 liters per day)  **13. Differential diagnostics of erythema multiforme and Stevens-Johnson syndrome**  **Common symptoms:**  • Deterioration of the general condition  • On the skin, erythematous spots, bubbles, "cockades"  • Painfulness of the mucous membrane when eating, talking, at rest  • Severely painful erosions on the oral mucosa  **Differences:**  • In case of Stevens-Johnson syndrome, in addition to the oral mucosa, the mucous membranes of the nose, eyes, genitals are affected (rhinitis, conjunctivitis, urethritis, vulvovaginitis)  • In Stevens-Johnson syndrome, the mucous membrane of the distal oral cavity is also affected  • In Stevens-Johnson syndrome, bubbles with hemorrhagic contents and bleeding erosions are formed  **14. Differential diagnostics of erythema multiforme and chronic recurrent herpes:**  **Common symptoms:**  •Painful erosions on the oral mucosa  • The disease recurs  • Painfulness of the oral mucosa when eating, talking, at rest  **Differences:**  •Erythema multiforme mainly affects young men (20-40 years old). Chronic recurrent herpes affects everyone, regardless of gender and age.  • In chronic recurrent herpes, the general condition is not disturbed. Erythema multiforme begins acutely.  • In case of chronic recurrent herpes, there are no erythematous spots, cockades, bubbles on the skin  • In chronic recurrent herpes, in contrast to erythema multiforme on the skin and the red border of the lips, the skin of the nose, small vesicles, located more often in groups, prone to fusion are formed. After their bursting, erosions with polycyclic edges are formed.  • In chronic recurrent herpes, giant multinucleated Langhans cells are found in the scraping taken from erosions, PCR and IFR are ositive  **Quincke's angioedema is differentiated from :**  **1. Melkerson-Rosenthal's syndrome**  **2.Erysipelas of the skin**  **3.Collateral edema in periostitis**  **4.Trofedema (Meija's disease)**  **5. Mischer's syndrome**  **1.Differential diagnostics of Quincke's edema and Melkerson-Rosenthal’s syndrome**  **Common symptoms:**  • Swelling of lips, cheeks, eyelids  •Sudden onset of disease  **Differences:**  •Melkerson-Rosenthal’s syndrome is characterized by a triad: macrocheilitis, folded tongue, facial nerve palsy  •Macrocheilitis is more common in women. Quincke's edema can be in any person, regardless of gender.  •The cause of macrocheilitis has not been finally clarified. The cause of Quincke's edema is an allergy to medicications , food and other substances.  otek-kvinke  ***Fig.51****Quincke's edema*  • The provoking factors in macrocheilitis can be an infectious disease, hypothermia, trauma, skin diseases, inflammation of the lips, neuropsychic stress, sinusitis, tonsillitis, periodontitis. The provoking factors in Quincke's edema is contact with an allergen.  •In macrocheilitis, in contrast to Quincke's edema, there are difficulties in lip movement, paresthesia, paralysis of the facial nerve, folding of the tongue.  •In macrocheilitis, the color of the lips either does not change, or is of a cyanotic hue, the texture of the lip tissue on palpation is soft or densely elastic. In Quincke’s edema, the color of the lips does not change and the consistency of the lip tissue is dense on palpation.  oteki6-1296116928  ***Fig.52*** *Quincke's edema*    •In Quincke’s edema, in contrast to macrocheilitis, after elimination of the cause and desensitizing therapy, all phenomena disappear without a trace.  • Quincke's edema, in contrast to macrocheilitis, is rarely accompanied by pain.  **2.Differential diagnostics of Quincke's edema and erysipelas of the skin**  **Common symptoms:**  • Swelling of soft tissues in the area of ​​the nose, neck, cheeks, ears, oral mucosa  **Differences:**  •In Quincke’s edema, tissue tension is observed, painlessness on palpation, the color of the skin and oral mucosa is not changed.  In erysipelas, the skin of the face is bright red, hot, slightly elevated and sharply delimited from the surrounding healthy tissue, small vesicles appear on the background of hyperemia. On the face, erysipelas is localized in the cheeks, nose (like "butterfly")  54  ***Fig.53*** *Quincke's edema*  • In erysipelas, in contrast to Quincke's edema, regional lymphadenitis is observed.  • Erysipelas, in contrast to Quincke's edema, is an infectious disease with an incubation period of several hours to 4-5 days, accompanied by fever, chills, headache, fever.  •For Quincke's edema, in contrast to erysipelas, epileptiform seizures, aphasia, and hemiplegia are characteristic.  •In Quincke’s edema, in contrast to erysipelas, after elimination of the cause and desensitizing therapy, all phenomena disappear without a trace.  **3. Differential diagnostics of Quincke's edema and collateral edema of the lips in periostitis.**  **Common symptoms:**  • Swelling of different parts of the face  **Differences:**  •The cause of Quincke's edema is an allergic reaction to food, medications and other allergens. The cause of periostitis is an inflammatory process that occurs as a complication of dental and periodontal diseases  отек Квинке  ***Fig.54*** *Quincke's edema*  • In periostitis, in contrast to Quincke's edema, hyperemia and painfulness of the mucous membrane and soft tissues are observed in the projection of the root of the causative and adjacent teeth, facial asymmetry is possible  • Periostitis, in contrast to Quincke's edema, is accompanied by temperature rise , weakness, chills, headache.  •For Quincke's edema, in contrast to periostitis, the following symptoms are characteristic: aphasia, epileptiform seizures, hemiplegia.  **4.Differential diagnostics of Quincke's edema and trophedema (Meija's disease):**  **Common symptoms:**  •Sudden appearance of edema on the face, lower extremities  • Edema of the larynx, tongue  **Differences:**  •In trophedema, the appearance of edema in a limited area is preceded by a feeling of heat or cold.  • In trophedema, the edema decreases after a few hours, but does not completely disappear, leaving a thickened area of the skin  **5. Differential diagnostics of Quincke's edema and Mischer's syndrome:**  **Common symptoms:**  • Swelling of the lips is isolated, as well as in combination with swelling of various parts of the face, cheeks, palate, gums, tongue  **Differences:**  • In Misher's syndrome, small cracks and vesicles appear on an edematous hyperemic background. In each new crisis, their thickening, compaction occurs.  • Lips in Mischer's syndrome become bluish-red  **Anaphylactic shock is differentiated from:**  **1.Acute cardiovascular failure**  **2.Myocardial infarction**  **3.Epilepsy (with seizures)**  **4.Fainting**  **5. Collapse**  **1.Differential diagnostics of anaphylactic shock and acute heart failure**  **Common symptoms:**  • Difficulty of breathing, dizziness  •Sternal pain, shortness of breath, increased heart rate  •Paleness of the skin, chills, a sharp decrease in blood pressure  **Differences:**  • In acute cardiovascular failure , patients retain consciousness, but react sluggishly to the environment  • Acute heart failure occurs more often in women over 65 years of age. Anyone can have anaphylactic shock, regardless of gender or age.  • In acute heart failure, edema of the lower extremities, blueness of the nails and nasolabial triangle, darkening in the eyes, swelling of the cervical veins are observed.  These symptoms are absent in anaphylactic shock.  • Anaphylactic shock, in contrast to acute heart failure, begins from the moment the antigen is introduced and the time of its development ranges from several minutes to half an hour.  **2. Differential diagnostics of anaphylactic shock and acute myocardial infarction:**  **Common symptoms:**  •Bradycardia, chest pain  •Pallness, cyanosis of the skin  • Drop in blood pressure  •Increased sweating  • Wheezing, foam at the mouth, impaired consciousness  • Rapid pulse, shallow breathing  **Differences:**  •Myocardial infarction, in contrast to anaphylactic shock, begins with severe pain (up to several hours or days) in the chest region, which is of a pressing character, radiating to the left shoulder, hand, neck, teeth, tongue, epigastric region.  • Anaphylactic shock, in contrast to myocardial infarction, begins from the moment the antigen is administered and the time of its development ranges from several minutes to half an hour.  **3.Differential diagnostics of anaphylactic shock and epilepsy (in the presence of seizures)**  **Common symptoms:**  •Presence of seizures  •Cyanosis of the skin  •Deep depression of consciousness  **Differences:**  •Epilepsy is a chronic disease of the brain, which is characterized by lightning-fast loss of consciousness without the influence of a pre-existing psychogenic factor. Anaphylactic shock is the organism's reaction to the introduction of an antigen and the time of its development ranges from several minutes to half an hour.  •In contrast to anaphylactic shock, epilepsy is characterized by the absence of subjective and objective signs (noise, ringing in the ears, flashing "flies" before the eyes, weakness, drop in blood pressure)  • The provoking factors of epilepsy are: alcohol intake, mental and physical fatigue  •In contrast to anaphylactic shock, epilepsy is characterized by clonic convulsions with rhythmic twitching of the whole body.  **4. Differential diagnostics of anaphylactic shock and syncope:**  **Common symptoms:**  • Dizziness, pallor of the skin, cold sweat  • Loss of consciousness, dilated pupils  • Shallow breathing, lowering of the blood pressure  •Convulsions (in case of deep fainting)  **Differences:**  •In syncope, there is a short-term loss of consciousness (from 5 sec to 1 min) as a result of cerebral ischemia. Anaphylactic shock is the organism's reaction to the introduction of an antigen and the time of its development ranges from several minutes to half an hour  • In case of syncope , numbness of the tongue, lips is observed, consciousness is restored quickly  **5. Differential diagnostics of anaphylactic shock and collapse:**  **Common symptoms:**  • Pale skin, dizziness  • Sharp decrease in blood pressure, frequent shallow breathing  **Differences:**  • In case of collapse, peripheral veins become empty, their walls fall down as a result of a sharp drop in vascular tone  • In a collapse , the patients retain consciousness, but react sluggishly to the environment  • Anaphylactic shock is the organism's reaction to the introduction of an antigen and the time of its development ranges from several minutes to half an hour.  **Medication- induced allergy**  **Catarrhal and catarrhal-hemorrhagic stomatitis (cheilitis, glossitis) are differentiated from :**  **1.Changes of the oral mucosa in hypovitaminosis B, C**  **2.Changes of the oral mucosa in diseases of the gastrointestinal tract**  **3.Secondary syphilis (macular syphilis)**  **4.Changes of the oral mucosa in case of fungal diseases**  **5. Candidiasis associated with HIV- infection**  **1.Differential diagnostics of allergic catarrhal and catarrhal-hemorrhagic stomatitis and hypovitaminosis B, C**  **Common symptoms:**  • Edema and hyperemia of the oral mucosa and tongue  •Hemorrhagic syndrome  •Itching, burning  **Differences:**  • In hypovitaminosis, the disease begins suddenly, accompanied by an increase in weakness, fatigue  • In case of hypovitaminosis of group B, in contrast to allergy, paresthesias, neurotic conditions, neurodermatitis, seborrheic dermatitis, weakness, malaise, sluggishness, drowsiness are observed  • In case of hypovitaminosis C, the gums are crimson with a cyanotic shadow along the edge. Pseudo periodontal pockets form, teeth become mobile and fall out  •In the etiology of catarrhal and catarrhal-hemorrhagic stomatitis, taking of medications is revealed  **2.Differential diagnostics of allergic catarrhal and catarrhal-hemorrhagic stomatitis and alterations of oral mucosa in diseases of the gastrointestinal tract**  **Common symptoms:**  • Tongue is of crimson –red color, smooth, dry, painful when eating, there is an atrophy of filiform papillae  • Severely painful ulcers  • Deteriation of taste sensitivity  **Differences:**  • In diseases of the gastrointestinal tract, in contrast to allergy, there is a overlapping on the tongue (plaque of gray, gray-white, brown colors , depending on the oral microflora), desquamation, paresthesia of the tongue, as well as a clinic characteristic of these diseases.  •In the etiology of allergic catarrhal and catarrhal-hemorrhagic stomatitis, taking of medications is revealed .  11-9  ***Fig.55*** *Allergic stomatitis*  •In case of allergic catarrhal and catarrhal-hemorrhagic stomatitis, after discontinuation of the medication intake that caused the allergy, recovery occurs.  **3.Differential diagnostics of allergic catarrhal and catarrhal-hemorrhagic stomatitis and macular syphilis**  **Common symptoms:**  •Presence of spots on the mucous membrane  **Differences:**  • The causative agent of syphilis is treponema pallidum. The cause of allergic stomatitis is the organism's reaction to the medication intake .  • Macular syphilis affects the soft palate, tonsils, and arches.  Allergic stomatitis is characterized by the prevalence of lesions (cheeks, tongue, lips, palate, etc.)  2stomatit002  ***Fig.56*** *Allergic stomatitis*  •In contrast to macular syphilis, allergic stomatitis is accompanied by burning, painfulness of the oral mucosa.  •In case of allergic stomatitis, in contrast to macular syphilis , all symptoms quickly disappear after stopping the intake of medicinal substances. The course of macular syphilis is chronic.  • The diagnosis of syphilis is confirmed by the detection of pale treponema in scrapings taken from ulcers and positive serological reactions.  • In macular syphilis, the skin is affected  •In case of allergic stomatitis, in contrast to syphilis on the oral mucosa, hemorrhages and a "penicillin" tongue are observed  **4.Differential diagnostics of allergic catarrhal and catarrhal-hemorrhagic stomatitis and fungal diseases of the oral mucosa**  **Common symptoms:**  • Hyperemic, edematous oral mucosa  •Burning, painfulness, dryness of the mucous membrane  **Differences:**  • In candidiasis, a lesion is in the form of a plaque without clear boundaries, resembling curdled milk, which is easily removed by scraping. In allergic catarrhal stomatitis, the mucous membrane is without plaque, hemorrhages are noted on it.  img39_Stomatitis_06_671465414d  ***Fig.57*** *Allergic stomatitis*    •In candidiasis, in contrast to allergic stomatitis, there is a triad characteristic for it (depending on the form of candidiasis): inflammation of the palate, tongue, corners of the mouth.  • In candidiasis, microscopic examination of scrapings taken from the surface of the oral mucosa reveals spores and mycelium of the fungus of the genus Candida.  Microscopic examination of scrapings taken from the surface of the oral mucosa in allergic stomatitis reveals the presence of a large number of eosinophils.  •Candidiasis is more likely to affect children, weakened elderly, persons who have been taking corticosteroids, antibiotics, cytostatics for a long time  **5. Differential diagnostics of allergic catarrhal stomatitis and candidiasis (acute atrophic) on the background of HIV infection**  **Common symptoms:**  • Hyperemic, edematous oral mucosa  • A burning sensation and pain in the mucous membrane  **Differences:**  •In HIV infection, there always are present accompanying diseases associated with it  • In candidiasis on the background of HIV infection, a cheesy plaque is found in the deep folds of the oral cavity, which is easily removed by scraping. In allergic catarrhal stomatitis, the mucous membrane is without plaque, hemorrhages are noted on it.  • In case of candidiasis associated with HIV infection, spores and mycelium of the fungus of the genus Candida are found in scrapings taken from the surface of the oral mucosa. The diagnosis is also confirmed by immunosorbent assay and immunoblotting.  Microscopic examination of scrapings taken from the surface of the oral mucosa in allergic catarrhal stomatitis reveals the presence of a large number of eosinophils.  •In case of allergic catarrhal stomatitis, in contrast to candidiasis associated with HIV infection, after rational therapy, the process is quickly resolved.  • In candidiasis associated with HIV infection, in contrast to allergic catarrhal stomatitis, the general condition of patients worsens (weight loss, weakness, pneumonia, lymphadenitis, etc.)  12  ***Fig.58*** *HIV-infected patient*  **Erosive medication- induced stomatitis is differentiated from:**  **1.Acute herpetic stomatitis**  **2.Erythema multiforme**  **3. Pemphigus vulgaris**  **4. Recurrent herpetic stomatitis**  **5 .Shingles**  **6. Hand and foot and mouth disease**  **7. Impetigo**  **8. Pashkov’s mild leukoplakia**  **1.Differential diagnostics of erosive stomatitis and acute herpetic stomatitis**  **Common symptoms:**  • Hyperemia and edema of the oral mucosa  •Presence of bubbles and erosions  • Deterioration of the general condition  • Burning and painfulness of the oral mucosa  **Differences:**  • In acute herpetic stomatitis, there is a diffuse lesion of the gums, especially from palatal side.  • In acute herpetic stomatitis, the appearance of erosions is preceded by a rash of bubbles, more often a group: from 2-3 to several dozen  •Acute herpetic stomatitis is more common among children from 6 months to 12 years old. Erosive stomatitis can occur in everyone, regardless of gender and age.  •Erosions in herpetic stomatitis, in contrast to erosive stomatitis, have irregular, polycyclic outlines.  • Herpetic stomatitis is accompanied by hypersalivation, while erosive stomatitis is accompanied by hyposalivation.  •In the etiology of erosive stomatitis,there is taking of medications and after their discontinuation, there is a rapid elimination of the clinical symptoms of the lesion.  • By cytological examination of scrapings taken from the surfaces of erosions in herpetic stomatitis, giant herpetic cells are found.  **2.Differential diagnostics of erosive stomatitis and erythema multiforme**  **Common symptoms:**  • Deterioration of the general condition  •Presence of bubbles and erosions  • Edema and hyperemia of the oral mucosa  **Differences:**  •Erythema multiforme is more common in men aged 20-40 years. Erosive stomatitis can occur in any person, regardless of age and gender.  • In case of erythema multiforme , in contrast to erosive stomatitis, the lesion of the oral mucosa is accompanied by acute pain even at rest.  • In case of erythema multiforme , in contrast to acute stomatitis, skin lesions in the form of cockades are observed.  •Erythema multiforme has a seasonal recurrent course.  **3. Differential diagnostics of erosive stomatitis and pemphigus vulgaris.**  **Common symptoms:**  • Bleeding painful erosions with a tendency to merge  **Differences:**  •Pemphigus vulgaris affects the retromolar space, pharynx, soft palate, gums, tongue. The localization of rashes in erosive stomatitis is any, sometimes it depends on the medication that caused the injury to the oral mucosa.  •Erosions in pemphigus vulgaris have an unpleasant odor, fragments of the bubble's covering epithelium along the periphery and are located on a slightly edematous, pale pink oral mucosa.  Erosions in stomatitis are located on the hyperemic, edematous oral mucosa.  759  ***Fig.59*** *Erosive medication- induced stomatitis*  •In case of erosive stomatitis, in contrast to pemphigus vulgaris, the onset of the disease is acute and after rational therapy and discontinuation of the medication- allergen, rapid healing occurs.  • Pemphigus vulgaris affects people over 35 years old, more often women. All members of the population are susceptible to erosive stomatitis, regardless of age and gender.  • In case of erosive stomatitis, in contrast to pemphigus vulgaris , there is no acantholysis, Nikolsky's symptom is negative, acantholytic cells are absent, bubbles are located subepithelially  • In pemphigus vulgaris, the skin is affected in places of friction (armpits, groin area, friction points of underwear)  **4. Differential diagnostics of erosive stomatitis and recurrent herpetic stomatitis (RHS)**  **Common symptoms:**  • Hyperemia of the oral mucosa  •Burning and pain of the mucous membrane  •Presence of erosions covered with fibrinous plaque  **Differences:**  •The cause of the recurrent herpetic stomatitis is the herpes simplex virus. The cause of medication- induced stomatitis is a taking of medication.  • In case of erosive stomatitis, in contrast to recurrent herpetic stomatitis, hemorrhages are visible on the oral mucosa  •Typical places of rashes in recurrent herpetic stomatitis are the red border of the lips on the border with the skin and the skin around the lips, hard palate, tongue, cheeks, cornea of ​​the eyes, mucous membranes and skin of the genitals, trunk. Localization of rashes in erosive stomatitis is any, depends on the medication that caused the lesion (for example, when taking penicillin, the dorsum of the tongue becomes smooth, shiny, bright red - "lacquered tongue").  •In Recurrent herpetic stomatitis, the general condition of the patient does not change. In erosive stomatitis, the patient's general condition may worsen: weakness is observed, appetite decreases, headache, body temperature rises to 38 C.  •In recurrent herpetic stomatitis, one or several large irregular erosions with scalloped edges and separate small erosions around are formed. In medication- induced stomatitis, erosions are extensive, joining , easily bleeding  1328188641  ***Fig.60*** *Erosive medication- induced stomatitis*  **5. Differential diagnostics of erosive stomatitis and Shingles:**  **Common symptoms:**  •The presence of erosions on the edematous and hyperemic mucous membrane  • The onset of the disease is acute  **Differences:**  • Shingles is more common among children and the elderly  •Etiology of Shingles is a virus of Varicella zoster. The cause of erosive stomatitis is a reaction to taking a medication.  •In case of Shingles, the localization of the lesions along the branches of the trigeminal nerve is always one-sided.  In erosive stomatitis, the localization of the rash is any, depending on the medication that caused the lesion.  аллергический стоматит_stomatitis(1)  ***Fig.61*** *Erosive medication- induced stomatitis*  • In Shingles, erosions are small (from a pinhead to a lentil), polycyclic in shape due to the fusion of vesicles. In erosive stomatitis, erosions are extensive, bleeding easily.  • In Shingles, burning, paroxysmal, neuralgic pain along the branches of the affected nerves are observed. For erosive stomatitis, such pain is not typical.  • Shingles by the duration of the disease can be protracted. In erosive stomatitis, after appropriate therapy and discontinuation of the allergen- medication, rapid healing occurs.  •After Shingles, there may be complications in the form of hyperpathy, hyperesthesia, neuralgia for several months and years.  **6.Differential diagnostics of erosive medication- induced stomatitis and Hand and foot and mouth disease**  **Common symptoms:**  • The onset of diseases is acute  • A burning sensation of the mucous membrane  **Differences:**  • Hand and foot and mouth disease is a contagious disease and a person becomes infected from sick animals. The cause of medication- induced stomatitis is taking a medication .  • In case of Hand and foot and mouth disease, the anterior parts of the oral cavity (gums, tongue, palate, lips) are more often affected. Less commonly, the mucous membranes of the nose, eyes, gastrointestinal tract, urethra, skin of the wings of the nose, interdigital folds, base of nails, soles are affected. Localization of rashes in medication- induced stomatitis is any, sometimes depends on the medication that caused the lesion (for example, when taking penicillin, the dorsum of the tongue becomes smooth, shiny, bright red - "lacquered tongue").  • Children are more likely to suffer from Hand and foot and mouth disease. The disease depends on the epizootic situation. Everyone gets sick with medical stomatitis, regardless of age and gender.  •Erosions in Hand and foot and mouth disease are small, bright red with polycyclic outlines. In medication- induced stomatitis, easily bleeding, extensive, merging erosions are formed.  •In medication- induced stomatitis, in contrast to Hand and foot and mouth disease, hemorrhages are visible on the mucous membrane, sometimes foci of necrosis, the mucous membrane swells so much that teeth imprints are visible on the lateral surfaces of the tongue and cheeks.  • In case of Hand and foot and mouth disease, paroxysmal hypersalivation is observed (up to 5 liters per day)  **7. Differential diagnostics of erosive medication- induced stomatitis and impetigo:**  **Common symptoms:**  •Acute onset of the disease  •Moisted, merging erosions  •Presence of a corolla of hyperemia around the lesion  **Differences:**  • The cause of impetigo is strepto- and staphylococci. The cause of allergic rashes is taking a medication.  • Any localization of rashes in allergy, sometimes depends on the medication that caused the allergy. In impetigo, the skin of the face, the red border of the lips, the corners of the mouth, and less often the oral mucosa are more often affected.  •Impetigo is more common in children. All age groups are susceptible to allergy.  • In impetigo erosions are small and covered with abundant golden-yellow "honey" crusts. In allergic rashes, erosions are extensive and covered with fibrinous plaque.  • In case of allergic rashes on the oral mucosa, hemorrhages, foci of necrosis, teeth imprints on the lateral surfaces of the tongue and cheeks are noted (due to severe edema of the oral mucosa).  **8. Differential diagnostics of erosive medication- induced stomatitis and Pashkov's mild leukoplakia:**  **Common symptoms:**  • Presence of painful erosions  **Differences:**  • The cause of Pashkov’s mild leukoplakia is trauma to the oral mucosa. Medication- induced stomatitis is an allergic reaction to medications.  • Pashkov’s mild leukoplakia is more often observed in patients with neuropathy, predominantly of young age. Medication- induced stomatitis can occur at any age, regardless.  • In Pashkov's leukoplakia, lesions are in the form of diffuse spots with an uneven, fringed and rough surface (as if eaten away by moths) due to multiple small patches of epithelium or erosions located on the edematous, pasty mucosa without inflammation. In medication- induced stomatitis on the background of hyperemic oral mucosa, bubbles appear, which burst and form extensive erosive surfaces.  •Pashkov’s mild leukoplakia, in contrast to medication- induced -induced stomatitis, is localized mainly along the dental closing line and on the labial mucosa.  **Medication- induced ulcerative-necrotizing stomatitis (gingivitis) is differentiated from:**  **1. Vincent's ulcerative necrotizing stomatitis**  **2. Ulcerative lesions of the oral mucosa in blood diseases**  **3. Trophic ulcers in cardiovascular diseases**  **1.Differential diagnostics of medication- induced ulcerative-necrotizing stomatitis and Vincent’s ulcerative necrotizing stomatitis :**  **Common symptoms:**  •Acute onset of the disease  • Hyperemia, swelling of the oral mucosa, foci of necrosis  • Acute painfulness of the oral mucosa  **Differences:**  •In contrast to Vincent's gingivostomatitis, in medication- induced ulcerative necrotizing stomatitis, the skin is affected  •Vincent’s ulcerative necrotizing stomatitis affects mainly men aged 17-30 years. All age groups, regardless of gender, are susceptible to medication- induced ulcerative -necrotizing stomatitis.  • In Vincent’s ulcerative necrotizing stomatitis , the gums are primarily affected, which become, as it were, cut off, with uneven notches, then the mucous membrane adjoining to the lower wisdom tooth, the retromolar region, and the cheeks is affected.    ***Fig.62*** *Vincent's ulcerative necrotizing stomatitis*  In medication- induced ulcerative -necrotizing stomatitis, the entire oral mucosa is affected at once.  •In the etiology of medication- induced ulcerative - necrotizing stomatitis,there is a taking of medications and after they are canceled, there is a rapid elimination of the clinical symptoms of the lesion. Vincent’s ulcerative necrotizing stomatitis is caused by a symbiosis of a fusiform bacteria and a spirochetes.  •In scrapings taken from the surface of ulcers in Vincent’s ulcerative necrotizing stomatitis , an abundance of fusobacteria and spirochetes is found.  **2.Differential diagnostics of medication- induced ulcerative - necrotizing stomatitis and ulcerative lesions of the oral cavity in blood diseases**  **Common symptoms:**  • Deterioration of the general condition of patients  • Ulcerative necrotic lesions of the oral mucosa  • Pain when eating and swallowing  **Differences:**  • In medication- induced ulcerative -necrotizing stomatitis, the oral mucosa is sharply hyperemic and edematous. In blood diseases, the oral mucosa is pale, anemic, there is no inflammation.  •In the etiology of medication- induced ulcerative - necrotizing stomatitis, there is a taking of medications and after they are canceled, there is a rapid elimination of the clinical symptoms of the process.  •The results of blood tests are decisive in the diagnosis of blood diseases  • Ulcers in blood diseases, in contrast to medication- induced allergic ones, have a putrid fetid odor, and the jaw bone tissue may be involved in the ulcerative-necrotic process  • In blood diseases, gingival hypertrophy is observed, most expressed on the oral side  **3. Differential diagnostics of medication- induced ulcerative -necrotizing stomatitis and trophic ulcers in cardiovascular diseases (CVD):**  **Common symptoms:**  • Painfulness when eating  • Ulcerative necrotic lesions of the oral mucosa  • Bad breath  **Differences:**  •In the etiology of medication- induced ulcerative - necrotizing stomatitis, there is taking of medications and after they are canceled, a rapid elimination of the clinical symptoms of the process. Trophic ulcers develop in patients with II-III degree of circulatory disorders.  • In medication- induced ulcerative -necrotizing stomatitis, the oral mucosa is sharply hyperemic and edematous. In cardiovascular diseases, there is no inflammation of the oral mucosa.  •In case of allergic ulcerative-necrotizing stomatitis, the entire oral mucosa is affected. In cardiovascular diseases, ulcers are more often formed on the mucous membrane of the cheeks, the floor of the mouth, and the lateral surfaces of the tongue.  •In contrast to medication- induced stomatitis, in cardiovascular diseases, the necrotic process can spread to adjacent areas of the face, nasopharynx with sequestration of the jaw bone tissue  **Lyell's disease is differentiated from :**  **1. Pemphigus vulgaris**  **2.Erythema multiforme**  **1.Differential diagnostics of Lyell's disease and pemphigus vulgaris:**  **Common symptoms:**  •Presence of bleeding painful erosions  • Positive symptoms of Nikolsky and Asbo-Hansen  •Presence of intraepithelial bubbles  • Skin lesions  **Differences:**  • Lyell's disease, in contrast to pemphigus vulgaris, begins acutely.  •In pemphigus vulgaris, the retromolar space, pharynx, soft palate, tongue, gums are affected. In Lyell's disease, the tongue, gums, lips are affected.  • Pemphigus vulgaris begins with the formation of bubbles, in the place of which erosions then appears. Lyell's disease begins with the formation of hyperemic spots, in the center of which bubbles form after 2-3 days (resembles a 1-2 degree of burn), then turning into extensive erosions.  **2.Differential diagnostics of Lyell's disease and erythema multiforme :**  **Common symptoms:**  •Erythema and edema of the oral mucosa with subsequent formation of the bubbles  •Acute onset of the disease  •Disorders of the skin and oral mucosa  • Extensive painful erosions  **Differences:**  •Erythema multiforme is more often observed among men of 20-40 years old. Lyell's disease is a severe variant of allergic bullous dermatitis to certain medications (antibiotics, sulfonamides, antipyretics, bromine, iodine salts)  • In case of Lyell's disease, cachexia, dehydration of the organism are observed, and a fatal outcome is possible  1284675479_1494496  ***Fig.63*** *Lyell's disease*  • In Lyell's disease, Nikolsky's symptom is positive. In erythema multiforme , Nikolsky's symptom is negative.  • In contrast to Lyell's disease, In erythema multiforme , cockades are formed on the skin.  **Infectious diseases**  **Acute herpetic stomatitis (AHS) is differentiated from:**  **1. Hand and foot and mouth disease**  **2. Shingles**  **3.Recurrent herpetic stomatitis**  **4.Erythema multiforme**  **5. Erosive medication- induced stomatitis**  **6. Behçet 's disease**  **7.Cronic recurrent aphthous stomatitis**  **8. Herpangina**  **9. Influenza**  **1. Differential diagnostics of Acute herpetic stomatitis and Hand and foot and mouth disease:**  **Common symptoms:**  •Acute onset of the disease  •Polycyclic erosions located on the hyperemic mucosa  • A burning sensation accompanying the rash of vesicles  **Differences:**  • Hand and foot and mouth disease is an epidemiological disease. Acute herpetic stomatitis no.  • The spread of Hand and foot and mouth disease among people is associated with an epizootic situation. The source of Acute herpetic stomatitis infection is a sick person and a virus carrier.  • In Hand and foot and mouth disease, skin lesions are observed in typical places: on the wings of the nose, in the interdigital folds, on the terminal phalanges of the fingers and toes, soles, on the skin of the chest, neck, back. Acute herpetic stomatitis affects the skin of the perioral region, eyelids, earlobes, fingers.  500105-fx8  ***Fig.64*** *Acute herpetic stomatitis (AHS)*  • In case of Hand and foot and mouth disease, affection to the mucous membranes of the nose, eyes, urethra, gastrointestinal tract is possible. In Acute herpetic stomatitis, the oral mucosa , nasopharynx is affected.  •Erosions in Hand and foot and mouth disease are bright red. Erosions in Acute herpetic stomatitis are covered with a grayish-white plaque.  • Patients with Hand and foot and mouth disease are unable to talk and swallow, which is difficult for them, hypersalivation occurs (up to 2-4 liters per day)  •In Hand and foot and mouth disease, in contrast to Acute herpetic stomatitis, the mucous membrane of the tongue becomes covered with dry crusts, and later there is a expressed hyperemia of its tip in the form of a triangle.  **2. Differential diagnostics of Acute herpetic stomatitis and shingles.**  **Common symptoms:**  •Viral etiology  •Air-drop way of infection  • Hyperemia of the oral mucosa, rash of vesicles, erosions  **Differences**  • Acute herpetic stomatitis is more common in childhood from 6 months to 3 years. Shingles is more common in older people.  •For shingles, burning, paroxysmal, neuralgic pain preceding the rash, and unilateral rash on the skin and mucous membrane along the affected peripheral nerves are characteristic. This is not the case in Acute herpetic stomatitis.  • In case of shingles, the oral mucosa is very rarely affected in isolation. In Acute herpetic stomatitis, the oral mucosa can be injuried in isolation (depending on the severity of the disease).  65636596  ***Fig.65****Acute herpetic stomatitis*  • In shingles, there can be complications in the form of neuralgia, hyperpathy, hyperesthesia for several months and years. For Acute herpetic stomatitis, these complications are not typical.  • Acute herpetic stomatitis is characterized by a deterioration in the general condition of the patient and an acute onset of the disease. In shingles, the general condition of the patients does not always suffer  • In shingles, the virus is neurotropic, similar to the varicella-zoster virus. There is a possible infection from children with chickenpox  **3. Differential diagnostics of Acute herpetic stomatitis(AHS) and recurrent herpetic stomatitis (RHS).**  **Common symptoms:**  •Defeat of the skin of the perioral region  •Pathological elements can merge  • Painful erosions on the oral mucosa  **Differences:**  • In recurrent herpetic stomatitis, rashes are more often localized on the mucous membrane, the red border of the lips, the perioral skin, the anterior parts of the hard palate, the wings of the nose, the back of the tongue, less often on the cornea of ​​the eyes, the skin and mucous membrane of the genitals, and the trunk.  In Acute herpetic stomatitis, rashes are located on the tip and lateral surfaces of the tongue, mucous membranes of the cheeks, lips, the oral vestibule, nasopharynx, skin of the eyelids, earlobes, fingers.  67700200  ***Fig.66*** *Acute herpetic stomatitis*  •Acute herpetic stomatitis is observed in children aged 6 months to 12 years. By recurrent herpetic stomatitis they get sick regardless of age  •In case of recurrent herpetic stomatitis, in contrast to Acute herpetic stomatitis, frequent relapses are observed and in each case the element of the rash appear in the same place.  •In case of recurrent herpetic stomatitis, in contrast to Acute herpetic stomatitis, catarrhal gingivitis does not turn into ulcerative form .  • The provoking factors for recurrent herpetic stomatitis can be hypothermia, stressful situation, insolation.  •In contrast to Acute herpetic stomatitis in recurrent herpetic stomatitis, the general condition is not disturbed  •In chronic recurrent herpes, RIF detects IgG, in acute - IgM  **4.Differential diagnostics of Acute herpetic stomatitis and erythema multiforme :**  **Common symptoms:**  •Acute onset of the disease  •Erosions covered with plaque  • Hypersalivation  • Sharp painfulness of the mucous membrane when talking, while eating  **Differences:**  • Acute herpetic stomatitis is more common in children aged 6 months to 3 years. Erythema multiforme affects young people (more often men) under the age of 30.  • Etiology of erythema multiforme is infectious-allergic. Acute herpetic stomatitis is caused by the herpes simplex virus.  • In case of erythema multiforme , erosions are larger, along their edges fragments of the bubble's covering epithelium are preserved and do not have polycyclic outlines. In Acute herpetic stomatitis, erosions have irregular, polycyclic outlines.  1322162188_g24140202f  ***Fig.67*** *Acute herpetic stomatitis*  •In erythema multiforme in the blood there is eosinophilia. In Acute herpetic stomatitis in smears-prints there are multinucleated giant cells  •For erythema multiforme with skin lesions, true polymorphism is characteristic. For Acute herpetic stomatitis with skin lesions, pseudo polymorphism (vesicles and crusts) is characteristic.  • Acute herpetic stomatitis is distinguished from erythema multiforme by the absence of pathological elements in areas of the oral mucosa typical for erythema multiforme (floor of the mouth, soft palate).  •In contrast to Acute herpetic stomatitis, erythema multiforme is characterized by the presence of seasonality of exacerbations (spring and autumn).  •Erythema multiforme lasts for years. Acute herpetic stomatitis lasts 1-3 weeks.  • In case of erythema multiforme , the subepithelial location of the bubbles and the absence of acantholysis phenomena are histologically determined. In Acute herpetic stomatitis, the intraepithelial arrangement of vesicles is histologically determined, there are phenomena of acantholysis  • In case of erythema multiforme, the skin of the hands, forearms, legs is affected  **5.Differential diagnostics of Acute herpetic stomatitis and erosive medication- induced stomatitis**  **Common symptoms:**  • Hyperemia and edema of the oral mucosa  •Presence of bubbles and ulcers  • Deterioration of the general condition  **Differences:**  •Erosions in herpetic stomatitis, in contrast to erosive stomatitis, have irregular, polycyclic outlines.  gerpes  ***Fig.68*** *Acute herpetic stomatitis*  • Herpetic stomatitis is accompanied by hypersalivation, while erosive stomatitis is accompanied by hyposalivation.  •In the etiology of erosive stomatitis, there is a taking of medication and after its discontinuation a rapid elimination of the clinical symptoms of the process is revealed.  •In the cytological examination of scrapings taken from the surfaces of erosions in herpetic stomatitis, giant herpes cells are found.  • In erosive stomatitis, rashes like urticaria are observed on the skin  **6. Differential diagnostics of Acute herpetic stomatitis and Behçet 's disease**  **Common symptoms:**  •Presence of aphthae and their painfulness  • Skin rashes in the form of erythema  **Differences:**  • The cause of Acute herpetic stomatitis is the herpes simplex virus. The cause of Behçet 's disease has not been definitively established.  • Acute herpetic stomatitis is more common in children aged 6 months to 12 years. Young people (more often men) suffer from Behçet 's disease.  298889_html_m50a5f9e8  ***Fig.69*** *Acute herpetic stomatitis*  • In Acute herpetic stomatitis, the oral mucosa is more often affected. In Behçet 's disease, in addition to the oral mucosa and pharynx, the mucous membrane of the eyes, trachea, esophagus, intestines, and external genitalia are affected.  •In Behçet 's disease, ophthalmic nerve atrophyes, keratitis, conjunctivitis are observed, the complication of which is blindness, patergy (the appearance of an inflammatory infiltrate at the injection site with tissue disintegration in its center) of the skin in places of minor injuries. In Acute herpetic stomatitis, there are no such complications.  • In Acute herpetic stomatitis, aphthae heal without scarring. In Behçet 's syndrome, rough scars are formed that deform the mucous membrane.  **7. Differential diagnostics of Acute herpetic stomatitis and Chronic recurrent aphthous stomatitis.**  **Common symptoms:**  •Presence of painful erosions  •Presence of a dense plaque on erosions  **Differences:**  • The etiology of Chronic recurrent aphthous stomatitis has not been finally clarified. The herpes simplex virus is the cause of Acute herpetic stomatitis.  •By Chronic recurrent aphthous stomatitis they get sick at the age of 10 to 60 years. Acute herpetic stomatitis affects children aged 6 months to 12 years.  •In Chronic recurrent aphthous stomatitis, the general condition of the organism does not suffer. In Acute herpetic stomatitis, the phenomena of intoxication of the organism and deterioration of the general condition of the patient are observed (weakness, headache, fever, nausea, vomiting, joint pain, irregular heart rhythm, pallor of the skin).  • In Chronic recurrent aphthous stomatitis, morphological elements are in the form of solitar large aphthae (in diameter of 3-6 mm) with a soft base, elevating above the level of the oral mucosa. Aphtha is surrounded by a sharply demarcated, brightly hyperemic, edematous halo. In Acute herpetic stomatitis, pathological elements are in the form of multiple painful vesicles situated on the background of hyperemic edematous mucosa  • In Chronic recurrent aphthous stomatitis, aphthae are more often located on the mucous membrane of the cheeks and tongue. The skin and the red border of the lips are not affected. In Acute herpetic stomatitis, vesicles are located on the tip and lateral surfaces of the tongue, mucous membrane of the lips, the oral vestibule, cheeks, nasopharynx, the skin of the perioral region, eyelids, earlobes, fingers (depending on the severity of the lesion).  0252059401  ***Fig.70*** *Acute herpetic stomatitis*  •In Chronic recurrent aphthous stomatitis, the pathological elements are solitary, there is no tendency to merge. In Acute herpetic stomatitis, the pathological elements often merge and form extensive erosive and ulcerative surfaces  •In Chronic recurrent aphthous stomatitis, in contrast to Acute herpetic stomatitis , rough scars may remain, leading to deformation of the oral mucosa and narrowing of natural openings (in severe form).  **8. Differential diagnostics of Acute herpetic stomatitis and herpangina:**  **Common symptoms:**  •Viral etiology  • Children are more likely to get sick  •Acute onset of the disease  •Air-drop way of infection  • Small erosions on the hyperemic oral mucosa,  **Differences:**  •Herpangina is an epidemiological disease and more often occurs in the summer months but Acute herpetic stomatitis- no.  •In herpangina, the posterior parts of the oral cavity are more affected. The tongue is very rarely affected. In Acute herpetic stomatitis, the mucous membrane of the lips, cheeks, gums, tongue, hard palate is affected.  75771300  ***Fig.71*** *Acute herpetic stomatitis*  • Lymph nodes in herpangina are painless, enlarged  • In herpangina, abdominal pain (manifestations of myalgia), dysphagia (deteriation of the swallowing reflex) are possible. In Acute herpetic stomatitis , these phenomena are absent.  • In herpangina, painfulness of erosions persists only in the first days, recovery occurs after 4-6 days without complications  **9.Differential diagnostics of Acute herpetic stomatitis and influenza:**  **Common symptoms:**  • Hyperemia of the oral mucosa  •Pointed erosions on the gums, hard palate  **Differences:**  • In influenza, the mucous membrane of the pharynx, soft palate is mainly affected  • In flu, there is dryness of the mucous membrane  • Clinical manifestations on the mucous membrane can be observed after an influenza infection, which leads to an exacerbation of catarrhal gingivitis  **Recurrent herpetic stomatitis (RHS) is differentiated from :**  **1.** **Chronic recurrent aphthous stomatitis**  **2. Primary syphilis**  **3. Streptococcal impetigo**  **4. Erosive medication- induced stomatitis**  **5. Manganotti’s cheilitis**  **6.Acute herpetic stomatitis (AHS)**  **7. Pemphigus vulgaris**  **1. Differential diagnostics of recurrent herpetic stomatitis and Chronic recurrent aphthous stomatitis.**  **Common symptoms:**  •Presence of painful erosions  • Sensation of burning and pain before the onset of aphthae  • Recurrent nature of the disease  **Differences:**  • The provoking factors of recurrent herpetic stomatitis are acute respiratory disease or exacerbation of chronic infections, that is, weakening of the immune system. The provoking factors of Chronic recurrent aphthous stomatitis are exacerbation of gastrointestinal and allergic diseases.  •From the anamnesis it turns out that patients with recurrent herpetic stomatitis, in contrast to Chronic recurrent aphthous stomatitis, had acute herpetic stomatitis in childhood.  •The frequency of exacerbations in patients with recurrent herpetic stomatitis is high, but a permanent course of the disease is also possible. The frequency of exacerbations in patients with Chronic recurrent aphthous stomatitis depends on the general condition of the organism.  •In recurrent herpetic stomatitis morphological elements are in the form of small vesicles, then one or several large meat –red colored erosions of irregular shape with scalloped edges and separate small erosions around appear.  57895659  ***Fig.72*** *Recurrent chronic stomatitis*  In Chronic recurrent aphthous stomatitis, morphological elements are in the form of large, solitar aphthae (3-6 mm in diameter) with a soft base, which elevate above the level of the mucous membrane.  • In recurrent herpetic stomatitis, aphthae are more often located on the mucous membrane, the red border and the skin around the lips, the anterior parts of the hard palate, the wings of the nose, the back of the tongue, less often on the cornea of ​​the eyes, the skin and mucous membranes of the genitals, and the trunk. In Chronic recurrent aphthous stomatitis, aphthae are more often located on the buccal mucosa.  •In case of recurrent herpetic stomatitis, the healing of erosions occurs without scars. In Chronic recurrent aphthous stomatitis, after healing, scars may remain, leading to deformation (microstome).  **2. Differential diagnostics of recurrent herpetic stomatitis and primary syphilis.**  **Common symptoms:**  • Meat -red color of the pathological elements  • Identical places of localization of lesions on the skin and oral mucosa  **Differences:**  • The cause of the recurrent herpetic stomatitis is herpes simplex virus. The cause of syphilis is pale treponema.  • The duration of the recurrent herpetic stomatitis is 10 days and the disease has a relapsing course. Primary syphilis lasts an average of 7 weeks to 3 months, with no recurrence.  •In case of recurrent herpetic stomatitis, pathological elements are in the form of one or several large painful erosions of irregular shape with scalloped edges and separate small erosions around, located on a hyperemic and edematous mucous membrane. In syphilis, the pathological element is in the form of a solitary, painless, saucer-shaped ulcer with smooth elevated edges, at the base of which a dense cartilage-like infiltrate is palpable.  • In recurrent herpetic stomatitis, the pathological elements merge. Syphilis is characterized by the focusness of the arrangement of the elements, that is, they do not merge with each other, they lie in isolation.  • In recurrent herpetic stomatitis, in contrast to syphilis, the rash is preceded by vesicles and a burning sensation, itching and pain.  49910427  ***Fig.73*** *Recurrent chronic stomatitis*  •Herpetic erosions, in contrast to syphilitic erosions, are characterized by rapid onset and rapid epithelisation.  •Serological reaction in syphilis gives a positive result and pale treponemas are found in scrapings taken from the surface of papules. In recurrent herpetic stomatitis, Wasserman's reaction is negative and in scrapings taken from erosions during cytological examination, a large number of giant multinucleated cells are found.  **3. Differential diagnostics of recurrent herpetic stomatitis and streptococcal impetigo.**  **Common symptoms:**  •Presence of small, merging , red erosions, covered with a yellowish plaque  • Defeat of the red border of the lips and skin around the lips  • Affection of gingivae(catarrhal gingivitis)  **Differences:**  •Impetigo is more common in children. recurrent herpetic stomatitis appears at any age.  •The causative agent of recurrent herpetic stomatitis is the herpes simplex virus. The causative agent of impetigo are streptococci and staphylococci.  • In case of recurrent herpetic stomatitis , the following are affected: the red border of the lips on the border with the skin and the skin around the lips, the anterior parts of the hard palate, less often the dorsum of the tongue, cheeks, cornea of ​​the eyes, wings of the nose, skin of the buttocks, thighs.  1296297483_coldsorenose1  ***Fig.74*** *Recurrent chronic stomatitis*  In impetigo, the following are affected: facial skin, red border of the lips, pharynx and oral mucosa.  • In impetigo, in contrast to recurrent herpetic stomatitis, there is a halo of hyperemia around the lesions.  • In case of recurrent herpetic stomatitis, erosions are dry, irregular in shape with scalloped edges and covered with a thin plaque or crusts (hemorrhagic crusts on the skin). In impetigo, erosions are more humid with oozing lymph and covered with massive golden-yellow "honey" crusts.  •In contrast to recurrent herpetic stomatitis, the onset of impetigo disease is acute.  •In scrapings taken from the surface of erosions in recurrent herpetic stomatitis, the herpes simplex virus is detected, but in impetigo-streptococci.  **4.Differential diagnostics of recurrent herpetic stomatitis and erosive medication- induced stomatitis**  **Common symptoms:**  • Hyperemia of the oral mucosa  • Burning and pain of the mucous membrane  •Presence of erosions covered with fibrinous plaque  **Differences:**  •The cause of the recurrent herpetic stomatitis is the herpes simplex virus. The cause of medication- induced stomatitis is taking a medication  • In case of erosive stomatitis, in contrast to recurrent herpetic stomatitis, hemorrhages and foci of necrosis are visible on the oral mucosa (depending on the severity of the inflammatory reaction)  st2_r18  ***Fig.75*** *Recurrent chronic stomatitis*  •Typical places of rashes in recurrent herpetic stomatitisare the red border of the lips on the border with the skin and the skin around the lips, hard palate, tongue, cheeks, cornea of ​​the eyes, mucous membranes and skin of the genitals, trunk. Localization of rashes in erosive stomatitis is any, depends on the medication that caused the lesion (for example, when taking penicillin, the dorsum of the tongue becomes smooth, shiny, bright red - "lacquered tongue").  •In recurrent herpetic stomatitis, the general condition of the patient does not change. In erosive stomatitis, the patient's general condition may worsen: weakness is observed, appetite decreases, headache, body temperature rises to 38 C.  •In recurrent herpetic stomatitis, one or several large irregular erosions are formed with scalloped edges and separate small erosions around. In medical stomatitis, erosions are extensive, merging , bleeding easily.  • In case of erosive stomatitis, in contrast to recurrent herpetic stomatitis, there is edema of the oral mucosa, and teeth imprints are visible on the lateral surfaces of the tongue and cheeks.  **5. Differential diagnostics of recurrent herpetic stomatitis and Manganotti’s cheilitis**  **Common symptoms:**  • Lesions of the red lips border  •Bright red erosions covered with bloody crusts  •Localization of erosions on a background of slight inflammation  **Differences:**  • In contrast to Manganotti’s cheilitis, recurrent herpetic stomatitis is caused by the herpes simplex virus.  • Recurrent herpetic stomatitis, in contrast to Manganotti’s cheilitis, begins with a burning sensation, itching.  • In recurrent herpetic stomatitis, the red border of the lips is affected with the capture of the adjacent skin. Erosions in Manganotti’s cheilitis are localized on the lateral areas of the red border of the lips.  11339242  ***Fig.76*** *Recurrent chronic stomatitis*  • In case of recurrent herpetic stomatitis, in contrast to Manganotti’s cheilitis, other areas of the oral mucosa are affected.  •Erosions in recurrent herpetic stomatitis are painful, in Manganotti’s cheilitis, painless.  • In Manganotti’s cheilitis, in contrast to recurrent herpetic stomatitis, erosions are characterized by a sluggish and persistent course and are resistant to treat.  **6. Differential diagnostics of recurrent herpetic stomatitis and Acute herpetic stomatitis**  **Common symptoms:**  •Defeat of the skin of the perioral region  •Pathological elements can merge  •Painful erosions on the oral mucosa  •Gingival disease (catarrhal gingivitis)  **Differences:**  • In recurrent herpetic stomatitis, rashes are more often localized on the mucous membrane, the red border of the lips, the anterior parts of the hard palate, the wings of the nose, the back of the tongue, less often on the cornea of the eyes, the skin and mucous membranes of the genitals, and the trunk. In Acute herpetic stomatitis , rashes are located on the tip and lateral surfaces of the tongue, mucous membranes of the cheeks, lips, the oral vestibule, nasopharynx, skin of the eyelids, earlobes, fingers.  67700200  ***Fig.77*** *Acute herpetic stomatitis*  •In recurrent herpetic stomatitis, large amounts of rashes are grouped in the form of vesicles and then one or several large irregular erosions with scalloped edges and separate small erosions around. In Acute herpetic stomatitis , rashes are in the form of vesicles , and then erosions and ulcers of a round, oval or slit-like shape with smooth edges occur.  •In recurrent herpetic stomatitis, in contrast to Acute herpetic stomatitis, frequent relapses are observed and with each element of the rash appear in the same place.  • In case of recurrent herpetic stomatitis, in contrast to Acute herpetic stomatitis, catarrhal gingivitis does not turn into ulcerative.  • The provoking factors for recurrent herpetic stomatitis may be hypothermia, stressful situation, insolation.  •In contrast to Acute herpetic stomatitis, in recurrent herpetic stomatitis, the general condition of the patients is not disturbed.  **7. Differential diagnostics of recurrent herpetic stomatitis and pemphigus vulgaris:**  **Common symptoms:**  • Painful erosions on the oral mucosa  • Skin lesions  • There is no acute onset of the disease  **Differences:**  • In pemphigus vulgaris, the primary morphological element is a bubble, but in recurrent herpetic stomatitis - a vesicle  • In pemphigus vulgaris, erosions are superficial, "naked"  • In pemphigus vulgaris, Nikolsky's symptom is positive, but in recurrent herpetic stomatitis– negative  **Shingles is differentiated from :**  **1. Acute herpetic stomatitis**  **2. Pemphigus vulgaris**  **3. Vincent's ulcerative necrotizing stomatitis**  **4. Erysipelas**  **5. Pemphigoid**  **6. Erosive medication- induced stomatitis**  **1.Differential diagnostics of Shingles and Acute herpetic stomatitis**  **Common symptoms:**  •Viral etiology  •Air-drop way of infection  **Differences**  • Acute herpetic stomatitis is more common in childhood from 6 months to 3 years. Shingles are more common in older people.  •For shingles, burning, paroxysmal, neuralgic pain and rashes on the skin and mucous membrane (usually on one side) along the affected peripheral nerves are characteristic. This is not the case in Acute herpetic stomatitis.  • In case of Shingles, the oral mucosa membrane is very rarely affected in isolation. In Acute herpetic stomatitis , the oral mucosa can be isolatedly affected (depending on the severity of the disease).  • In shingles, there can be complications in the form of neuralgia, hyperpathy, hyperesthesia for several months and years. For Acute herpetic stomatitis, these complications are not typical.  • Acute herpetic stomatitis is characterized by a deterioration in the general condition of the patient and an acute onset of the disease. In shingles, the general condition of patients does not always suffer.  **2.Differential diagnostics of Shingles and pemphigus vulgaris**  **Common symptoms:**  •Presence of painful erosions with a tendency to merge  **Differences:**  • In Shingles lesions on the skin and oral mucosa are unilateral and are located along the affected peripheral nerves. In pemphigus vulgaris , lesions on the skin are localized mainly in places of friction by clothing, pressure, maceration (abdomen, back, axillary cavities, inguinal folds).  • In case of Shingles in lesions of the oral mucosa, the process begins with multiple vesicles on the background of hyperemia and edema, which quickly burst and form erosion with fibrinous plaque. In pemphigus vulgaris , the process begins with a clouding of the epithelium on the slightly edematous, pale pink oral mucosa, in the center of which erosions occur, rapidly spreading along the periphery.  • In Shingles, small erosions (from a pinhead to a lentil) have a polycyclic shape. In pemphigus vulgaris , erosions are of various sizes, bright red, bleeding, with an unpleasant odor, with clear even boundaries and along their periphery, fragments of the bubble's covering epithelium are visible.  • In Shingles, burning paroxysmal neuralgic pain appear along the affected nerves, aggravated by stimuli. For pemphigus vulgaris , such a pain is not typical.  • In Shingles, lesions on the skin and mucous membranes appear at the same time. In pemphigus vulgaris , the oral mucosa is initially affected, and these lesions for a long time may be the only symptoms of the disease.  •In pemphigus vulgaris, in contrast to Shingles, mucous membranes of the pharynx, esophagus, stomach, intestines can be affected.  • Pemphigus vulgaris is characterized by a positive Nikolsky's symptom, a symptom of an "arising bubble" (when rubbing by a finger, a bubble appears on apparently healthy skin or mucous membrane both between the bubble and at a distance from them), Asbo-Hansen symptom (pressure on the bubble cover increases its due to stratification of the epithelium or epidermis due to the pressure of the bubble fluid). In Shingles, these symptoms are absent.  •Cytological examination shows the presence of acantholytic cells (Tzank cells) in smears-prints in pemphigus vulgaris. Cytological examination in Shingles reveals giant multinucleated cells.  • Shingles occurs more often in the autumn-winter period. Seasonality is not typical for pemphigus vulgaris.  **3. Differential diagnostics of Shingles and Vincent's ulcerative necrotizing stomatitis**  **Common symptoms:**  •Acute onset of diseases  • Incidence in autumn  **Differences:**  • Elderly people are more likely to suffer from Shingles. Vincent's necrotizing ulcerative stomatitis often affects young people (17-30 years old), more often men.  • In shingles, both the oral mucosa and the skin are affected at the same time. In Vincent's necrotizing ulcerative stomatitis, only the oral mucosa is affected.  •In case of Shingles, the rash is located along the branches of the trigeminal nerve and is always one-sided. In Vincent's necrotizing ulcerative stomatitis , the gums are affected (the edge of the gingiva is, as it were, cut off, with uneven edges), especially the mucous membrane in the area of the lower wisdom tooth, cheeks, dorsum and lateral surfaces of the tongue, hard and soft palate, pharynx.  •In case of Shingles, erosions are small (from a pinhead to a lentil), polycyclic in shape due to the fusion of a group of vesicles . In Vincent's ulcerative necrotizing stomatitis, the ulcers are large with soft, uneven edges (up to 5-6 cm in diameter) and deep.  • In Shingles, erosions are covered with fibrinous plaque (on the mucous membrane) or crusts (on the skin). In Vincent's necrotizing ulcerative stomatitis , the ulcers are covered with a thick necrotic plaque with a fetid putrid odor, after elimination of which, a loose, heavily bleeding floor is visible.  •In Vincent's necrotizing ulcerative stomatitis, in contrast to Shingles, there is necrosis of the mucous membrane, the bones of the alveolar process, trismus and facial asymmetry due to edema of the surrounding tissues.  •Shingles is an independent disease. Vincent's necrotizing ulcerative stomatitis can occur as a complication of viral infections, erosive allergic stomatitis, erythema multiforme.  • For Shingles, burning, paroxysmal, neuralgic pain along the affected nerves is characteristic, which is not the case in Vincent's necrotizing ulcerative stomatitis.  **4.Differential diagnostics of Shingles and erysipelas inflammation of the skin**  **Common symptoms:**  •Skin pathological elements  • Transmission of infection by air- drop way  • Skin pigmentation remains after healing  • There may be complications  • The onset of the disease is acute  • Painfulness of the erosions  **Differences:**  •The causative agent of Shingles is the Varicella zoster virus. The causative agents of erysipelas of the skin are streptococci.  • In Shingles, the skin and oral mucosa are simultaneously affected along the affected nerves, and unilaterally.  grepes-zoster-221-foto  ***Fig.78*** *Shingles*  In erysipelas inflammation of the skin , the skin of the legs, hands, face, scalp, mammary glands, perineum, and external genital organs are affected.  • In Shingles, small erosions (from a pinhead to a lentil in size) are visible, covered with a plaque, having a polycyclic shape due to the fusion of vesicles. In erysipelas inflammation of the skin , there are sharply delimited dense, glossy, hot to the touch spots of pink or red color with uneven edges in the form of "tongues of flame", which increase by 2-10 cm per day.  • In Shingles, vesicles first appear, which burst and erosions form. In erysipelas inflammation of the skin , a spot appears first, on the background of which vesicles can form.  • Elderly people of both sexes are more likely to suffer from Shingles. Erysipelas inflammation of the skin often affects women after 40 years.  •Shingles leaves lasting immunity. Erysipelas inflammation of the skin of the skin has a high relapse rate.  **5. Differential diagnostics of Shingles and pemphigoid**  **Common symptoms:**  • Prevalence among older people  •Presence of erosions  •Prognosis for life is favorable  **Differences:**  • Shingles is caused by the Varicella zoster virus. The etiology of pemphigoid is not known.  • In Shingles, erosions are small (from a pinhead to a lentil), polycyclic in shape due to the fusion of vesicles. In pemphigoid, bubbles of different diameters (5-20 mm) with scraps of fragments of the bubble's covering epithelium along the edges are present.  1158  ***Fig.79*** *Shingles*  •In Shingles, the localization of rashes on the skin and oral mucosa along the branches of the trigeminal nerve is always one-sided. In pemphigoid, the skin and mucous membranes of the cheeks, the border of the soft and hard palate, gums, nose, genitals, and eyes are affected.  • In Shingles, after the erosions have recovered , pigmentation remains on the skin. In pemphigoid, after healing of erosions, scars and adhesions may remain.  • In Shingles, there is burning, paroxysmal, neuralgic pain along the affected nerves, aggravated by irritants. For pemphigoid, such pain is not typical.  • Shingles can cause complications such as neuralgia, hyperpathy, hyperesthesia for several months and years.  •Pemphigoid, in contrast to Shingles, is more common in women.  **6.Differential diagnostics of Shingles and erosive medication- induced stomatitis**  **Common symptoms:**  •The presence of erosions on the edematous and hyperemic mucous membrane  • The onset of the disease is acute  **Differences:**  •Etiology of Shingles is Varicella zoster virus. The cause of erosive stomatitis is a reaction to taking a medication  • In case of Shingles, the localization of the rashes along the branches of the trigeminal nerve is always one-sided. In erosive stomatitis, the localization of the rashes are any, depending on the medication that caused the lesion  • In Shingles, erosions are small (from a pinhead to a lentil), polycyclic in shape due to the fusion of vesicles. In erosive stomatitis, erosions are extensive, bleeding easily.  41147413  ***Fig.81*** *Shingles*  • In Shingles, burning, paroxysmal, neuralgic pain along the branches of the affected nerves is observed. For erosive stomatitis, such pain is not typical.  • Shingles by the duration of the disease can be protracted. Erosive stomatitis resolves quickly after rational therapy.  •After Shingles, there may be complications in the form of hyperpathy, hyperesthesia, neuralgia for several months and years.  **Hand and foot and mouth is differentiated from :**  **1.Acute herpetic stomatitis (AHS)**  **2. Chickenpox**  **3.Erosive medical stomatitis**  **4.Erythema multiforme**  **5. Vincent's ulcerative necrotizing stomatitis**  **1. Differential diagnostics of Hand and foot and mouth disease and Acute herpetic stomatitis.**  **Common symptoms:**  •Acute onset of the disease  •Polycyclic shape of erosions  • A burning sensation accompanying the rash of vesicles  **Differences:**  • Hand and foot and mouth disease is an epidemiological disease. Acute herpetic stomatitis no.  • The spreading of Hand and foot and mouth disease among people is associated with an epizootic situation. The source of Acute herpetic stomatitis infection is a sick person and a virus carrier.  • In Hand and foot and mouth disease, skin lesions are observed in typical places: on the wings of the nose, in the interdigital folds, on the terminal phalanges of the fingers and toes, soles, on the skin of the chest, neck, back. Acute herpetic stomatitis affects the skin of the perioral region, eyelids, earlobes, fingers.  • In case of Hand and foot and mouth disease, the injury the mucous membranes of the nose, eyes, urethra, gastrointestinal tract is possible. In Acute herpetic stomatitis , the mucous membrane of the oral cavity, nasopharynx is affected.  •Erosions in Hand and foot and mouth disease are of bright red color. Erosions in Acute herpetic stomatitis is covered with a grayish-white plaque.  •In Hand and foot and mouth disease, in contrast to Acute herpetic stomatitis, the mucous membrane of the tongue becomes covered with dry crusts, and later there is an expressed hyperemia of its tip in the form of a triangle.  **2. Differential diagnostics of Hand and foot and mouth disease and chickenpox.**  **Common symptoms:**  •Viral etiology  • Prevalence among children  •Acute onset of disease  **Differences:**  • The spread of Hand and foot and mouth disease among people is associated with an epizootic situation. The spread of chickenpox occurs by air- drop way from sick people.  • In case of Hand and foot and mouth disease, small bubbles and vesicles form on the skin and oral mucosa on the background of hyperemia, which quickly burst up and form painful erosions and ulcers. In chickenpox on the skin, rashes are in the form of small pink spots, which then turn into papules or vesicles, surrounded by a corolla of hyperemia.  In lesions of the oral mucosa, vesicles appear, which quickly macerate and turn into the ulcer with a yellow-gray floor and an impression in the center (navel), surrounded by a red halo.  yashhur  ***Fig.82*** *Hand and foot and mouth disease*  • In case of Hand and foot and mouth disease, in contrast to chickenpox, injury to the mucous membranes of the eyes, gastrointestinal tract, urethra is possible.  • Chickenpox affects any part of the skin and oral mucosa. In Hand and foot and mouth disease, the anterior parts of the oral cavity and the skin of the wings of the nose, interdigital folds, the base of the nails, and soles are affected.  **3.Differential diagnostics of Hand and foot and mouth disease and erosive medication- induced stomatitis**  **Common symptoms:**  • The onset of disease is acute  • A burning sensation of the mucous membrane  **Differences:**  • Hand and foot and mouth disease is a contagious disease and a person becomes infected from sick animals. The cause of medication- induced stomatitis is taking a medication.  • In case of Hand and foot and mouth disease, the anterior parts of the oral cavity (gums, tongue, palate, lips) are more often affected. Less commonly, the mucous membranes of the nose, eyes, gastrointestinal tract, urethra, skin of the wings of the nose, interdigital folds, base of nails, soles are affected.  Localization of the rashes in medication- induced stomatitis is any, sometimes depends on the medication that caused the lesion (for example, when taking penicillin, the dorsum of the tongue becomes smooth, shiny, bright red - "lacquered tongue").  • Children suffer from Hand and foot and mouth disease more often. Everyone gets sick with medical stomatitis, regardless of age and gender.  •Erosions in Hand and foot and mouth disease are small, bright red in color with polycyclic outlines.  In medical stomatitis, bleeding, extensive, merging erosions are formed.  •In medical stomatitis, in contrast to Hand and foot and mouth disease, hemorrhages are visible on the mucous membrane, sometimes foci of necrosis, the mucous membrane swells so much that teeth imprints are visible on the lateral surfaces of the tongue and cheeks.  **4.Differential diagnostics of Hand and foot and mouth disease and erythema multiforme**  **Common symptoms:**  •Affection of the anterior areas of the oral cavity (lips, cheeks, tongue, floor of the mouth, hard palate, gums)  •Acute onset of the disease  •Painful erosions  **Differences:**  • Aperson is infected with Hand and foot and mouth disease from sick animals. The etiology of erythema multiforme is infectious and allergic.  • Children suffer from Hand and foot and mouth disease more often. Erythema multiforme mainly affects young men (20-40 years old).  • In case of Hand and foot and mouth disease, the skin of the wings of the nose, interdigital folds, the base of the nails, and soles is affected. In erythema multiforme , the skin of the hands, forearm, lower leg, face, and neck is affected.  •In Hand and foot and mouth disease, small erosions of bright red color with polycyclic outlines are formed. In erythema multiforme , sharply limited, bleeding when touched, large erosions with even edges, slightly elevating above the surrounding tissues, with fragments of the bubble's covering epithelium along the edges, are formed.  60371830  ***Fig.83*** *Hand and foot and mouth disease*  •For erythema multiforme , relapses are characteristic, which are seasonal. Epizootic conditions are of great importance for Hand and foot and mouth disease.  **5. Differential diagnostics of Hand and foot and mouth disease and Vincent's ulcerative necrotizing stomatitis**  **Common symptoms:**  •Acute onset of diseases  • Painfulness of lesions  **Differences:**  • Children most often suffer from Hand and foot and mouth disease. Vincent's ulcerative necrotizing stomatitis mainly affects young men (17-30 years old.)  • In case of Hand and foot and mouth disease, the anterior parts of the mouth, the nasal mucosa, conjunctiva, genitals, the skin of the wings of the nose, interdigital folds, the base of the nails, and soles are more affected.  yacshur02  ***Fig.84*** *Hand and foot and mouth disease*  In Vincent's ulcerative necrotizing stomatitis , the area of ​​the lower wisdom tooth , cheeks, gums (the edge of the gums has uneven edges, as if cut off), hard palate, pharynx are affected.  •In Vincent's ulcerative necrotizing stomatitis , in contrast to Hand and foot and mouth disease, there are foci of necrosis of the mucous membrane and bone of the alveolar process, trismus, tooth loss, facial asymmetry due to edema of the surrounding tissues.  • In Hand and foot and mouth disease, erosions are small, bright red in color with polycyclic outlines. In Vincent's ulcerative necrotizing stomatitis ,the ulcers are large, multiple, deep, with a loose, heavily bleeding floor and soft, uneven edges. Ulcers are covered with a thick necrotic plaque of a grayish-green color with a fetid putrid odor.  • Vincent's ulcerative necrotizing stomatitis is characterized by the seasonality of the disease.  • Vincent's ulcerative necrotizing stomatitis , in contrast to Hand and foot and mouth disease, can occur as a complication of viral infections, erosive allergic stomatitis, erythema multiforme exudative.  **HIV- infections**  **Candidiasis associated with HIV infection is differentiated from:**  **1.Leukoplakia**  **2 .Lichen planus**  **3.Allergic catarrhal stomatitis**  **4.Hypovitaminosis B, C**  **1.Differential diagnostics of candidiasis associated with HIV infection and leukoplakia**  **Common symptoms:**  •White color and dryness of the lesions  • Burning sensation in the mouth  Long course of the disease  **Differences:**  •Candidiasis associated withHIV infection is caused by yeast-like fungi of the genus Candida. Leukoplakia occurs as a result of various injuries.  • In candidiasis associated withHIV infection, the lesion is in the form of a plaque without clear boundaries, resembling curdled milk, which, when scraped, is easily removed and is located on the hyperemic oral mucosa. The lesion lesion of leukoplakia is in the form of a hyperkeratic plaque with clear, even edges, which cannot be removed when scraped, located on a seemingly unchanged mucous membrane that resembles glued thin tissue paper.    pub63p03 C:\Documents and Settings\Xp\Desktop\leukoplakui\Leukoplakia-dyskeratosis-pre-cancerous.jpg  ***Fig.85*** *Leukoplakia* ***Fig.86*** *HIV-infection related candidiasis*  •The diagnosis of candidiasis associated withHIV infection is confirmed by the presence of a fungus of the genus Candida in the scrapings taken from the surface of the affected oral mucosa, as well as immunosorbent analysis and immunoblotting tests.  • Leukoplakia is more often localized on the buccal mucosa along the dental closing line in the anterior part, the corners of the mouth, the red border of the lower lip. Candidiasis associated withHIV infection is localized on the mucous membrane of the tongue, cheeks, floor of the mouth, gums.  •In candidiasis associated withHIV infection, in contrast to leukoplakia, the general condition of patients worsens (weight loss, weakness, pneumonia, lymphadenitis, etc.)  **2. Differential diagnostics of candidiasis associated with HIV infection and lichen planus (LP)**  **Common symptoms:**  • White color of the lesions  • Burning sensation in the mouth  **Differences:**  •Candidiasis associated withHIV infection is caused by yeast-like fungi of the genus Candida. The etiology of lichen planus is not clear.  •In case of candidiasis associated withHIV infection, the lesion is in the form of a plaque without clear boundaries, resembling curdled milk, which, when scraped, is easily removed and located on the hyperemic, dry oral mucosa. In lichen planus , the lesion is in the form of keratinized papules with clear jagged edges, which are not removed by scraping and form a reticular, lace pattern, located on a normal or hyperemic mucous membrane.  67-511e3d00  ***Fig.87*** *HIV-infection related candidiasis*  • In lichen planus , in contrast to candidiasis associated with, the skin of the inner surface of the forearms, wrist joints, lower legs, sacrum, and genitals can be affected.  •The diagnosis of candidiasis associated withHIV infection is confirmed by the presence of a fungus of the genus Candida in the scrapings taken from the surface of the affected oral mucosa , as well as by immunosorbent analysis and immunoblotting.  •In candidiasis associated withHIV infection, in contrast to lichen planus, the general condition of patients worsens (weight loss, weakness, pneumonia, lymphadenitis, etc.)  **3.Differential diagnostics of candidiasis (acute atrophic) associated with HIV infection and allergic catarrhal stomatitis**  **Common symptoms:**  • Hyperemic, edematous oral mucosa  • A burning sensation and pain in the mucous membrane  **Differences:**  •In candidiasis associated withHIV infection, a cheesy plaque is found in the deep folds of the oral cavity, which is easily removed by scraping. In allergic catarrhal stomatitis, the mucous membrane is without plaque, hemorrhages are noted on it.  • In case of candidiasis associated withHIV infection, spores and mycelium of the fungus of the genus Candida are found in scrapings taken from the surface of the oral mucosa. The diagnosis is also confirmed by immunosorbent assay and immunoblotting.  Microscopic examination of scrapings taken from the surface of the oral mucosa in n allergic catarrhal stomatitis reveals the presence of a large number of eosinophils.  •In case of allergic catarrhal stomatitis, in contrast to candidiasis associated withHIV infection, after rational therapy, the process is quickly resolved.  •In candidiasis associated withHIV infection, in contrast to allergic catarrhal stomatitis, the general condition of patients worsens (weight loss, weakness, pneumonia, lymphadenitis, etc.)  12  ***Fig.88*** *HIV-infected patient*  **4.Differential diagnostics of candidiasis (acute atrophic) associated with HIV infection and hypovitaminosis B, C**  **Common symptoms:**  • Edema and hyperemia of the oral mucosa and tongue  •Itching, burning  • Malaise, weight loss, weakness  **Differences:**  • In hypovitaminosis B, C, in contrast to candidiasis (acute atrophic) associated withHIV infection, paresthesias, neurotic conditions, neurodermatitis, seborrheic dermatitis are observed  • In case of candidiasis (acute atrophic) associated withHIV infection, a cheesy plaque is found in the deep folds of the oral cavity, which is easily removed by scraping. In hypovitaminosis B, C, the mucous membrane is without plaque, hemorrhages are noted on it.  • In case of candidiasis (acute atrophic) associated withHIV infection, spores and mycelium of the fungus of the genus Candida are found in scrapings taken from the surface of the oral mucosa. The diagnosis is also confirmed by immunosorbent assay and immunoblotting. Lack of vitamins B, C is confirmed by the results of blood tests.  **Hairy leukoplakia associated with HIV infection is differentiated from:**  **1. True leukoplakia**  **2.Leukoplakia of smokers**  **3. Lichen planus (LP)**  **4.Hyperplastic candidiasis**  **1. Differential diagnostics of hairy leukoplakia associated with HIV infection and true leukoplakia**  **Common symptoms:**  •Foci of lesions are whitish in color  •Lack of inflammatory reaction along the periphery of the focus  **Differences:**  • Hairy leukoplakia is a lesion of the oral mucosa associated with immunodeficiency and HIV infection. Local irritants play the main role in the occurrence of true leukoplakia.  • Hairy leukoplakia associated withHIV infection is localized more often on the lateral surfaces of the tongue. Typical localization of true leukoplakia is the buccal mucosa along the dental closing line in the anterior region, the corners of the mouth and the red border of the lower lip.  67-ec02d177  ***Fig.89*** *Hairy leukoplakia associated with HIV-infection*  •Foci of lesions in hairy leukoplakia associated withHIV infection are in the form of folds or villi that elevate above the surface of the oral mucosa. The morphological element of defeat in true leukoplakia is a hyperkeratic spot that does not elevate above the level of the oral mucosa.  •In hairy leukoplakia associated withHIV infection, in contrast to true leukoplakia, the general condition of patients worsens (weight loss, weakness, pneumonia, lymphadenitis, etc.)  •The diagnosis of hairy leukoplakia associated withHIV infection is confirmed by immunosorbent analysis and immunoblotting.  **2.Differential diagnostics of hairy leukoplakia associated with HIV infection and smokers' leukoplakia**  **Common symptoms:**  •Foci of lesions are whitish in color  •Lack of inflammatory reaction along the periphery of the focus  **Differences:**  • Hairy leukoplakia is a lesion of the oral mucosa associated with immunodeficiency and HIV infection. Smokers' leukoplakia occurs in heavy smokers (especially who smoke pipes).  • Hairy leukoplakia associated withHIV infection is localized more often on the lateral surfaces of the tongue. Typical localization of smokers' leukoplakia is the mucous membrane of the hard palate and the adjacent soft palate, sometimes the gums.  СПИД 24  ***Fig.90*** *Hairy leukoplakia associated with HIV infection*  •Foci of lesions in hairy leukoplakia associated withHIV infection are in the form of folds or villi that elevate above the surface of the oral mucosa. The morphological element of the leukoplakia lesion of smokers is a hyperkeratic focus, on the background of which the red gaping orifices of the excretory ducts of the salivary glands are visible.  •In hairy leukoplakia associated withHIV infection, in contrast to true leukoplakia, the general condition of patients worsens (weight loss, weakness, pneumonia, lymphadenitis, etc.)  •The diagnosis of hairy leukoplakia associated withHIV infection is confirmed by immunosorbent analysis and immunoblotting.  **3.Differential diagnostics of hairy leukoplakia associated with HIV infection and lichen planus (LP)**  **Common symptoms:**  •Grayish-white lesions  **Differences:**  •In lichen planus, the pathological element is in the form of papules, forming a mesh, lace pattern with clear, jagged edges on the background of expressed inflammation. In hairy leukoplakia associated withHIV infection, pathological elements are in the form of folds or villi on the background of the absence of an inflammatory reaction.  СПИД  ***Fig.91*** *Hairy leukoplakia associated with HIV infection*  • Lichen planus is more common in women. Hairy leukoplakia associated with HIV infection predominantly occurs in men.  • In lichen planus, the inner surface of the forearms, wrist joints, lower legs, sacrum, and genitals are affected. In hairy leukoplakia associated with HIV infection, the skin is not affected.  •In case of lichen planus, the cheeks in the molar region, transitional folds, the retromolar region, the lateral surfaces and dorsum of the tongue, gums, lips, palate, floor of the mouth are affected. In hairy leukoplakia associated withHIV -infection, the lateral surfaces of the tongue are more often affected.  СПИД 49  ***Fig.92*** *Hairy leukoplakia associated with HIV-infection*  •In UVA light (fluorescent diagnostics) in lichen planus, lesions give a whitish-yellow glow. The diagnosis of hairy leukoplakia associated with HIV infection is confirmed by immunosorbent assay and immunoblotting.  •In hairy leukoplakia associated withon the background of HIV infection, in contrast to lichen planus, the general condition of patients worsens (weight loss, weakness, pneumonia, lymphadenitis, etc.)  **4.Differential diagnostics of hairy leukoplakia associated with HIV infection and hyperplastic candidiasis**  **Common symptoms:**  •Foci of lesions are of a grayish-white color, elevating above the level of the oral mucosa  • Defeat of the tongue  **Differences:**  • Hairy leukoplakia is a lesion of the oral mucosa associated with immunodeficiency and HIV infection. Hyperplastic candidiasis is a disease caused by the yeast-like fungus of Candida.  • Hairy leukoplakia associated withHIV infection is localized more often on the lateral surfaces of the tongue. Hyperplastic candidiasis affects the tongue as a rhomboid glossitis.  67-826527f5  ***Fig.93*** *Hairy leukoplakia associated with HIV-infection*  • Plaque from the surface of the lesion in hairy leukoplakia cannot be scraped off. In hyperplastic candidiasis, the plaque is scraped off and a hyperemic bleeding erosive surface is exposed.  •In hairy leukoplakia associated withHIV infection, in contrast to hyperplastic candidiasis, the general condition of patients worsens (weight loss, weakness, pneumonia, lymphadenitis, etc.)  • In case of hyperplastic candidiasis, spores and mycelium of the fungus of the genus Candida are found in scrapings taken from the surface of the oral mucosa. The diagnosis of hairy leukoplakia associated with HIV infection is confirmed by immunosorbent analysis and immunoblotting.  **Vincent's ulcerative necrotizing stomatitis is differentiated from :**  **1. Hand and foot and mouth disease**  **2. Shingles**  **3 .Ulcerative lesions in acute leukemia**  **4.Chronic leukemia**  **5.Agranulocytosis**  **6.Gingivitis and stomatitis due to mercury poisoning**  **7. Scorbut**  **8.Miliary- ulcerative tuberculosis**  **9. Secondary syphilis (pustular syphilis)**  **10.Allergic ulcerative necrotizing stomatitis**  **11. Traumatic ulcer**  **12. Trophic ulcers**  **13. Disintegrating malignant tumor (cancer, sarcoma)**  **1. Differential diagnostics of Vincent's ulcerative necrotizing stomatitis and Hand and foot and mouth disease**  **Common symptoms:**  •Acute onset of disease  • Painfulness of lesions  **Differences:**  • Children most often suffer from Hand and foot and mouth disease. Vincent's ulcerative necrotizing stomatitis mainly affects young men (17-30 years old.)  • In case of Hand and foot and mouth disease, the anterior parts of the mouth, the mucous membrane of the nose, conjunctiva, genitals, the skin of the wings of the nose, interdigital folds, the base of the nails, and soles are more affected. In Vincent's ulcerative necrotizing stomatitis, the area of ​​the lower wisdom tooth , cheeks, gums (the edge of the gums has uneven edges, as if cut off), hard palate, pharynx are affected.  •In Vincent's ulcerative necrotizing stomatitis, in contrast to Hand and foot and mouth disease, there are foci of necrosis of the mucous membrane and bone of the alveolar process, trismus, tooth loss, facial asymmetry due to edema of the surrounding tissues.  • In case of Hand and foot and mouth disease, erosions are small, bright red in color with polycyclic outlines. In Vincent's ulcerative necrotizing stomatitis, the ulcers are large, multiple, deep, with a loose, heavily bleeding floor and soft, uneven edges. Ulcers are covered with a thick necrotic plaque of a grayish-green color with a fetid putrid odor.  • Vincent's ulcerative necrotizing stomatitisis characterized by the seasonality of the disease.  • Vincent's ulcerative necrotizing stomatitis , in contrast to Hand and foot and mouth disease, can occur as a complication of viral infections, erosive allergic stomatitis, erythema multiforme.  **2. Differential diagnostics of Vincent's ulcerative necrotizing stomatitis and Shingles**  **Common symptoms:**  •Acute onset of disease  • Incidence in autumn  **Differences:**  • Elderly people are more likely to suffer from Shingles. Vincent's ulcerative necrotizing stomatitis often affects young people (17-30 years old), more often men.  • In shingles, both the oral mucosa and the skin are affected at the same time. In Vincent's ulcerative necrotizing stomatitis, only the oral mucosa is affected.  •In case of Shingles, the localization of the rash is located along the branches of the trigeminal nerve and is always one-sided. In Vincent's ulcerative necrotizing stomatitis , the gums are affected (the edge of the gums is, as it were, cut off, with uneven edges), especially the mucous membrane in the area of the lower wisdom tooth, cheeks, dorsum and lateral surfaces of the tongue, hard and soft palate, pharynx.  04800965  ***Fig.94*** *Vincent's ulcerative necrotizing stomatitis*  •In case of Shingles, erosions are small (from a pinhead to a lentil), polycyclic in shape due to the fusion of a group of vesicles.In Vincent's ulcerative necrotizing stomatitis, the ulcers are large with soft, uneven edges (up to 5-6 cm in diameter) and deep.  • In Shingles, erosions are covered with fibrinous plaque (on the mucous membrane) or crusts (on the skin). In Vincent's ulcerative necrotizing stomatitis , the ulcers are covered with a thick necrotic plaque with a fetid putrid odor, after elimination of which, a loose, heavily bleeding floor is visible.  •In Vincent's ulcerative necrotizing stomatitis , in contrast to Shingles, there is necrosis of the mucous membrane, the bones of the alveolar process, trismus and facial asymmetry due to edema of the surrounding tissues.  •Shingles is an independent disease. Vincent's ulcerative necrotizing stomatitis can occur as a complication of viral infections, erosive allergic stomatitis, erythema multiforme.  • For Shingles, burning, paroxysmal, neuralgic pain along the affected nerves is characteristic, which is not the case in Vincent's ulcerative necrotizing stomatitis.  **3. Differential diagnostics of Vincent's ulcerative necrotizing stomatitis and ulcerative lesions in acute leukemia**  **Common symptoms:**  • Prevalence among young people (under 30 years old)  •Acute onset of disease  •Presence of large, jagged ulcers covered with a dirty -gray fetid plaque  •Presence of foci of necrosis on the oral mucosa  •Defeat of the same areas of the oral mucosa  **Differences:**  •Etiology of Vincent's ulcerative necrotizing stomatitis is fusiform bacillus and spirochete (borrelia) of Vincent. The etiology of blood diseases has not yet been completely clarified.  • In patients with blood diseases, hyperplastic syndrome is observed: painless enlargement of lymph nodes, liver, spleen, gums (hyperplasia is more expressed from the palatine or lingual surfaces), tonsils.  • In patients with blood diseases, in contrast to patients with Vincent's ulcerative necrotizing stomatitis , hemorrhagic syndrome is observed: small-pointed or small-spotted rashes on the skin and oral mucosa , extensive hemorrhages (on the buccal mucosa along the closing dental line, tongue), profuse bleeding (uterine, from the nose, socket of the extracted tooth, gum, tongue).  • Patients with blood diseases, in contrast to patients with Vincent’s ulcerative necrotizing stomatitis , may have pain in intact teeth, jaw, bones, pallor of the skin, loss of taste perception of the tongue.  •In Vincent’s ulcerative necrotizing stomatitis , the mucous membrane around the ulcers is swollen and hyperemic. In acute leukemia, the gums around the necrosis have a bluish color, while the entire oral mucosa is pale, anemic.  язвенный гингивит1  ***Fig.95*** *Vincent’s ulcerative necrotizing stomatitis*  •In Vincent’s ulcerative necrotizing stomatitis , in contrast to acute leukemia, the ulcerative-necrotic process in the oral cavity can spread to the bone tissue.  **4.Differential diagnostics of Vincent’s ulcerative necrotizing stomatitis and chronic leukemia**  **Common symptoms:**  • the same areas of the oral mucosa are affected  • Men get sick more often  **Differences:**  •Vincent’s ulcerative necrotizing stomatitis is more common in young people (17-30 years old). Chronic leukemia occurs in persons from 30 to 60 years.  •In Vincent’s ulcerative necrotizing stomatitis , the mucous membrane is hyperemic. In chronic leukemia, the oral mucosa is pale, the gums are bluish, bleeds when touched, hemorrhagic manifestations are visible.  •In chronic leukemia, in contrast to Vincent’s ulcerative necrotizing stomatitis , the lymph nodes are not dense and painless.  •In Vincent’s ulcerative necrotizing stomatitis , morphological elements on the mucous membrane are in the form of erosions and necrosis. In chronic leukemia they are in the form of nodes and nodules of soft consistency, elevating above the level of the oral mucosa.  106223639  ***Fig.96*** *Vincent’s ulcerative necrotizing stomatitis*  •In chronic leukemia, in contrast to Vincent’s ulcerative necrotizing stomatitis , there is pallor of the skin, the presence of papular and bullous formations on it, foci of necrosis in various parts of the body.  •Vincent’s ulcerative necrotizing stomatitis begins acutely, but chronic leukemia does not.  •In Vincent’s ulcerative necrotizing stomatitis , in contrast to chronic leukemia, the ulcerative-necrotic process can spread to the bone tissue.  **5. Differential diagnostics of Vincent’s ulcerative necrotizing stomatitis and agranulocytosis**  **Common signs:**  •Acute onset of diseases  •Defeat of the same areas of the oral mucosa  •Distribution of the ulcerative necrotic process to the bone tissue  •Presence of bleeding fetid ulcers  **Differences:**  • In agranulocytosis, in contrast to Vincent’s ulcerative necrotizing stomatitis , there is no inflammatory reaction of the tissues surrounding the foci of necrosis.  • In agranulocytosis, in contrast to Vincent’s ulcerative necrotizing stomatitis , ulcers appear along the digestive tract.  •The results of blood tests are decisive in the diagnosis of blood diseases  **6. Differential diagnostics of Vincent’s ulcerative necrotizing stomatitis and gingivitis (stomatitis) caused by mercury poisoning**  **Common symptoms:**  •Gum disease (presence of gingivitis)  •Defeat the same areas of the mucous membrane  •Presence of foci of necrosis with a fetid odor  **Differences:**  •The cause of Vincent’s ulcerative necrotizing stomatitis is the symbiosis of the fusiform bacillus and Vincent's spirochete. Mercury intoxication occurs as a result of exposure to harmful occupational factors in workers of mercury production.  • In Vincent’s ulcerative necrotizing stomatitis , when a defeat of the gums along its edge, the epithelium becomes cloudy, necrotic, covered with an easily removable grayish-green plaque.  62861776  ***Fig.97*** *Vincent’s ulcerative necrotizing stomatitis*  In mercury intoxication, a black border appears along the edge of the gum with an ulcerative-necrotic process.  •In case of mercury intoxication, in patients, affection of the gastrointestinal tract (abdominal pain, vomiting, diarrhea with blood), the central nervous system (periods of excitement alternate with drowsiness, tremors of the hands - "mercury tremor"), tracheobronchitis, toxic pneumonia) are observed. In Vincent’s ulcerative necrotizing stomatitis , these symptoms are absent.  •In mercury intoxication, in contrast to Vincent’s ulcerative necrotizing stomatitis , patients complain of a metallic taste in the mouth.  •In Vincent’s ulcerative necrotizing stomatitis , in contrast to mercury intoxication, there may be facial asymmetry due to edema of the surrounding tissues, trismus, necrosis of the bone of the alveolar process.  • In case of mercury intoxication, urinalysis confirms the diagnosis (mercury content in urine)  **7. Differential diagnostics of Vincent’s ulcerative necrotizing stomatitis and scurvy (scurvy).**  **Common symptoms:**  • Development of ulcerative gingivitis and stomatitis  • Sharp bleeding and looseness of the gums  • Deterioration of the general condition of the patient  • Mobility and loss of teeth  • Bad breath  **Differences:**  •Etiology of Vincent’s ulcerative necrotizing stomatitis is an infection caused by the symbiosis of the fusiform bacillus and Vincent's spirochete. A disease caused by a lack or incomplete absorption of vitamin C is scurvy.  •Vincent’s ulcerative necrotizing stomatitis develops more often in young men (17-30 years old). Scorbut is more common in children.  •Scurvy, in contrast to Vincent’s ulcerative necrotizing stomatitis , patients have cyanosis of the ears, nose, lips, fingers, nails.  •In Scurvy, in contrast to Vincent’s ulcerative necrotizing stomatitis , hemorrhages occur in the hair follicles of the skin, in the mucous membranes, subcutaneous tissue, in muscles, joints. A rash is formed first of a bright red color, then of blue-black on the legs, thighs, buttocks.  • In Vincent’s ulcerative necrotizing stomatitis , the gingival edge becomes necrotic, becomes uneven, covered with a grayish-yellow plaque. In Scurvy, the interdental papillae (of the present teeth) swell, spongy blue-purple growths (hemorrhages) appear around the teeth in the form of ridges.  язвенно-некротический гингивит  ***Fig.98*** *Vincent’s ulcerative necrotizing stomatitis*  • In Scurvy, hypochromic anemia develops, a decrease in the level of ascorbic acid in the blood is observed.  **8.Differential diagnostics of Vincent’s ulcerative necrotizing stomatitis and Miliary tuberculosis**  **Common symptoms:**  • Deterioration of the general condition of the patient  • Enlarged, painful, dense lymph nodes  •Presence of painful large bleeding ulcers with soft, irregular edges, located on a swollen base  **Differences:**  • Vincent's ulcerative necrotizing stomatitis is caused by Vincent's spindle-shaped bacillus and spirochete. Tuberculosis is caused by mycobacterium tuberculosis - Koch's bacillus.  •Vincent’s ulcerative necrotizing stomatitis often affects young men aged 17 to 30 years. Persons of middle age are more likely to suffer from tuberculosis.  • In Vincent’s ulcerative necrotizing stomatitis , multiple, deep ulcers with a loose floor are formed, covered with a thick necrotic plaque of a grayish-green color with a fetid putrid odor. In tuberculosis, a solitar shallow granular ulcer is more often formed, covered with a yellowish-gray plaque with a slight purulent discharge, around which small yellowish abscesses (Treel's grains) are visible.  •In case of tuberculosis, giant cells of Pirogov-Langhans and epithelioid cells, Koch's bacilli are found in scrapings taken from ulcers during cytological examination. In Vincent’s ulcerative necrotizing stomatitis , the cytological picture reveals an abundance of spirochetes and fusobacteria.  • In Vincent’s ulcerative necrotizing stomatitis , there is trismus, facial asymmetry due to edema of the surrounding tissues, necrosis of the mucous membrane and the bone of the alveolar process. For Miliary tuberculosis , these symptoms are not typical.  **9.Differential diagnostics of necrotizing ulcerative stomatitis of Vincent and pustular syphilis**  **Common symptoms:**  •Presence of painful ulcers covered with purulent-necrotic plaque  •Affection of young people  **Differences:**  •The causative agent of Vincent’s ulcerative necrotizing stomatitis is the fusiform bacilla and spirochete. The causative agent of syphilis is pale treponema.  • Men are more likely to suffer from Vincent’s ulcerative necrotizing stomatitis . Persons of both sexes get sick with syphilis.  • In papular syphilis, the pathological element is in the form of large rounded papules with clear edges, surrounded by an inflammatory halo and infiltrate at the base. Ulcers in Vincent’s ulcerative necrotizing stomatitis are multiple, large, deep, with a loose bleeding floor and soft uneven edges, located on a swollen, hyperemic base without infiltration.  • Ulcers in Vincent’s ulcerative necrotizing stomatitis are located in the area of ​​the lower wisdom tooth, the buccal mucosa, the dorsum and lateral surfaces of the tongue, the hard and soft palate.  **10. Differential diagnostics of Vincent’s ulcerative necrotizing stomatitis and allergic ulcerative necrotizing stomatitis**  **Common symptoms:**  •Acute onset of the disease  • Hyperemia, edema, foci of necrosis of the oral mucosa  • Acute painfulness of the oral mucosa  **Differences:**  •Vincent’s ulcerative necrotizing stomatitis affects mainly men aged 17-30 years. All age groups, regardless of gender, are susceptible to allergic ulcerative necrotizing stomatitis.  •In Vincent’s ulcerative necrotizing stomatitis , the gums are first of all affected, which become, as it were, cut off, with uneven notches, then the mucous membrane in the area of the lower wisdom tooth, the retromolar region, and the cheeks are affected.  08259197  ***Fig.99*** *Vincent’s ulcerative necrotizing stomatitis*  In allergic ulcerative necrotizing stomatitis, the entire oral mucosa is affected at once.  •In the etiology of ulcerative necrotizing stomatitis, there is a taking of medication and after its discontinuation, a rapid elimination of the clinical symptoms of the lesion. Vincent’s ulcerative necrotizing stomatitis is caused by a symbiosis of a fusiform bacilla and a spirochetes.  •In scrapings taken from the surface of ulcers in Vincent’s ulcerative necrotizing stomatitis , an abundance of fusobacteria and spirochetes is found.  **11.Differential diagnostics of Vincent's ulcerative-necrotizing stomatitis (chronic) and traumatic ulcers (complicated by secondary infection)**  **Common symptoms:**  •Presence of a greenish-gray fetid plaque  • In scrapings taken from the surface of ulcers, spirochetes and fusiform bacilli are found  • Painfulness of ulcers  **Differences:**  • Vincent's ulcerative necrotizing stomatitis mainly affects men aged 17-30 years. Traumatic ulcers are more common in older people.  • In case of Vincent’s ulcerative necrotizing stomatitis , in contrast to a traumatic ulcer, the gingiva is hyperemic, edematous, its edge is ulcerated, necrotic foci are visible in the interdental spaces.  •Vincent’s ulcerative necrotizing stomatitis is an infectious disease caused by spindle-shaped rods and spirochetes. Decubital ulcer occurs as a response of the mucous membrane to various stimuli.  • Rapid ulcer healing after elimination of the irritant and its epithelisation indicate the traumatic origin of the ulcer.  **12. Differential diagnostics of Vincent’s ulcerative necrotizing stomatitis** **and trophic ulcers**  **Common symptoms:**  • Deterioration of the general condition of patients  • Painfulness of ulcers  •Necrotic lesions of the oral mucosa  **Differences:**  • Vincent's ulcerative necrotizing stomatitis is an infectious disease caused by fusobacteria and spirochetes. Trophic ulcers occur in diseases of the cardiovascular system.  • In Vincent’s ulcerative necrotizing stomatitis , the mucous membrane of the gums, retromolar region, and cheeks is more often affected. Trophic ulcers often affect the mucous membrane of the tongue, cheeks, palate, floor of the mouth.  • The mucous membrane around the ulcers in Vincent’s ulcerative necrotizing stomatitis is edematous, hyperemic. There is no inflammatory reaction of the mucous membrane around trophic ulcers.  • In trophic ulcers, the necrotic process can spread to neighboring areas of the face, nasopharynx, jaw bone tissue (through defects of the cheeks, severe bleeding is possible).  •Vincent’s ulcerative necrotizing stomatitis has an acute onset and often occurs in the autumn-spring period.  • In Vincent’s ulcerative necrotizing stomatitis , fusobacteria and spirochetes are found in scrapings taken from the surface of ulcers.  • Healing of trophic ulcers does not occur without treatment of the underlying disease.  **13. Differential diagnostics of Vincent’s ulcerative necrotizing stomatitis**  **and decomposition malignant tumor (cancer, sarcoma)**  **Common symptoms:**  • Ulcers on the mucous membrane  •Regional lymph nodes are enlarged  **Differences:**  • Decomposition of a malignant tumor is observed mainly in the elderly, Vincent’s ulcerative necrotizing stomatitis is observed more often in young men aged 17-30 years  • Cancer ulcer has dense edges and base,is slightly painful  • In cancer, the lymph nodes are soldered with the surrounding tissues  • In cancer, cytology detects atypical cells,and bacterioscopy - the usual oral microflora.In Vincent’s ulcerative necrotizing stomatitis - there is an abundance of fusospirochetes  •In Vincent’s ulcerative necrotizing stomatitis , there are phenomena of general intoxication of the organism  **Impetigo is differentiated from :**  **1.Candidal perleche and perleche due to lowered bite in the elderly**  **2. Perleches in hypovitaminosis (B2, B6)**  **3. Atopic cheilitis**  **4. Seborrheic eczema**  **5. Erosive medication- induced stomatitis**  **6.Erythema multiforme**  **7. Syphilitic papules**  **8.Recurrent herpetic stomatitis**  **1. Differential diagnostics of impetigo and candidal perleche and perleche due to a lowered bite in the elderly.**  **Common symptoms:**  • Painful crack in the corners of the mouth (perleche)  • Burning and itching sensation  **Differences:**  • The causative agent of impetigo are streptococci and staphylococci. The causative agent of candidiasis is a yeast-like fungus of the genus Candida  •Impetigo is more common in children. Candidal perleche is mainly observed in elderly people with a lowered bite due to improper prosthetics, expressed attrition of hard dental tissues or edentulous.  •Candidal perleches are characterized by less expressed inflammatory phenomena than streptococcal ones.  • Erosions in impetigo are moist, red with abundant oozing lymph and covered with copious golden-yellow "honey" crusts. Erosions in candidiasis are dry, covered with delicate crusts or plaque, surrounded by thin gray scales.  •At old age, in candidiasis perleche, the process is bilateral and localized within the skin fold. In impetigo, the process extends beyond the skin fold.  • In case of candidiasis, in contrast to impetigo, elements of the fungus of the genus Candida are found in scrapings taken from erosions.  **2. Differential diagnostics of impetigo and perleches in hypovitaminosis (B2, B6)**  **Common symptoms:**  • Painful cracks in the mouth's corners  **Differences:**  •The causative agent of impetigo is staphylococci or streptococci. The reason for hypovitaminosis is insufficient intake of vitamin into the organism or a deteriation of its absorption.  •Impetigo is more common in children. All members of the population, regardless of age, are susceptible to hypovitaminosis.  • In case of impetigo , erosions, are moist with abundantly oozing lymph and are covered with abundant golden-yellow "honey" crusts.  bakterialnye_zabolevaniya_kozhi_s0301  ***Fig.100*** *Impetigo*  In vitamin deficiency - they are dry, without abundant exudation, with small grayish crusts.  •Hypovitaminosis B2, in contrast to impetigo, manifests itself in the form of a triad: dermatitis (peeling, redness and seborrheic crusts on the wings of the nose, nasolabial folds, eyelid skin), cheilitis (peeling, painful and bleeding vertical cracks of the red border of the lips), glossitis (tongue is bright red, smooth, shiny and dry). And also there is injury to the eyes (photophobia, lacrimation, iritis, keratitis, corneal opacity). In hypovitaminosis B6, in contrast to impetigo, flaccidity, drowsiness, increased excitability, peripheral neuritis, neurodermatitis, glossitis, glossalgia, seborrheic dermatitis, and cheilitis develop.  **3. Differential diagnostics of impetigo and atopic cheilitis**  **Common symptoms:**  •Defeat of the red border of the lips and facial skin  • Prevalence among the child population  • perleches in the corners of the mouth  •Acute onset of the disease  **Differences:**  • The cause of impetigo is staphylococci and streptococci. The cause of atopic cheilitis is a genetic factor that creates a predisposition to atopic allergy.  • In impetigo, flicktens form on the affected areas and then wet erosions with abundant golden-yellow crusts.  175  ***Fig.101*** *Impetigo*  In atopic cheilitis, small scales, cracks and grooves are formed in the affected areas.  • In contrast to impetigo, atopic cheilitis has a seasonal character (worsening occurs in autumn and winter).  • In atopic cheilitis, in contrast to impetigo, spontaneous recovery occurs by the age of 25-26.  **4. Differential diagnostics of impetigo and seborrheic eczema.**  **Common symptoms:**  •Moist erosions with abundant yellow scales  •Affection of the skin of the face, trunk, bends of the extremities  •Fusion of the lesions  **Differences:**  • Impetigo is an infectious disease caused by staphylococci or streptococci. Seborrheic eczema is the result of neuroendocrine disorders.  • Impetigo is more common in children. Seborrheic eczema does not depend on age and gender.  • In impetigo, in contrast to seborrheic eczema, flicktens (bubbles) form on the affected areas.  •Impetigo, in contrast to seborrheic eczema, has an acute onset of the disease.  • In impetigo, in contrast to seborrheic eczema, lesions are located on the hyperemic edematous surface and have a corolla of hyperemia around.  _10_20120213_1795330260  ***Fig.102*** *Impetigo*  •In scrapings taken from the surface of erosions in impetigo, staphylococci and streptococci are found.  **5. Differential diagnostics of impetigo and erosive medication- induced stomatitis**  **Common symptoms:**  •Acute onset of the disease  •Moist, merging erosions  •Presence of a hyperemic halo around the lesion  **Differences:**  • The cause of impetigo is streptococci and staphylococci. The cause of allergic rashes is taking a medication .  • Localization of rashes in allergy is any, sometimes depends on the medication that caused the allergy. In impetigo, the skin of the face, the red border of the lips, the corners of the mouth, and less often the oral mucosa are more often affected.  импетиго  ***Fig.103*** *Impetigo*  •Impetigo is more common in children. All age groups are susceptible to allergy  • In impetigo erosions are small and covered with abundant golden-yellow "honey" crusts. In allergic rashes, erosions are extensive and covered with fibrinous plaque.  • In case of allergic rashes on the oral mucosa, hemorrhages, foci of necrosis, prints of the teeth on the lateral surfaces of the tongue and cheeks (due to severe edema of the oral mucosa) are noted.  **6. Differential diagnostics of impetigo and erythema multiforme**  **Common symptoms:**  •Acute onset of the disease  • Facial skin lesions  •Presence of moist merging erosions  **Differences:**  •Impetigo is more common in children. Erythema multiforme mainly affects young people (20-40 years old).  • In impetigo erosions are covered with abundant golden-yellow "honey" crusts, which can be easily removed.  1313127942_kontagioznoe-impetigo  ***Fig.104*** *Impetigo*  In erythema multiforme , erosions are covered with a tightly seated fibrinous plaque or bloody crusts of black-brown color (when fusospirochetosis is attached, the crusts are yellowish- gray).  • In case of impetigo, the erosions are small, and in case of erythema multiforme , the erosions are large, extensive, along their edges, grayish-white remnants of the bubble's covering are visible.  •Erythema multiforme , in contrast to impetigo, has a seasonal character (relapses are observed in autumn and spring).  **7.Differential diagnostics of impetigo and syphilitic papules**  **Common symptoms:**  •Halo of hyperemia around the lesion  •High contagiousness of the disease  • The presence of perleches in the mouth's corners  **Differences:**  •Cause of impetigo is streptococci and staphylococci. The cause of syphilis is pale treponema.  • In case of impetigo, erosions are small, moist, merging , covered with abundant golden-yellow crusts. In syphilis, the papules are large, covered with a grayish-white plaque, lie isolated from each other (focal location), and the erosions are covered with a grayish plaque with an admixture of pus.  • In impetigo, lesions are located on a hyperemic edematous surface. In syphilis, papules are located on the unchanged oral mucosa (only the base of the papule is hyperemic).  80  ***Fig.105*** *Impetigo*  •In contrast to impetigo, papules and discharge from the surface of erosions in syphilis contain a large number of pale treponemas.  • The onset of the disease in impetigo is acute, and in syphilis it is chronic  **8. Differential diagnostics of impetigo and Recurrent herpetic stomatitis**  **Common symptoms:**  •Presence of small, merging , red erosions, covered with a yellowish plaque  • Defeat of the red border of the lips and skin around the lips  •Gum defeat (catarrhal gingivitis)  **Differences:**  •Impetigo is more common in children. Recurrent herpetic stomatitis appears at any age.  •The causative agent of Recurrent herpetic stomatitis is the herpes simplex virus. The causative agent of impetigo is streptococci and staphylococci.  • In case of Recurrent herpetic stomatitis , the following are affected: the red border of the lips on the border with the skin and the skin around the lips, the anterior parts of the hard palate, less often the dorsum of the tongue, cheeks, cornea of ​​the eyes, wings of the nose, skin of the buttocks, thighs. In impetigo, the following are affected: facial skin, red border of the lips, pharynx and oral mucosa.  17  ***Fig.106*** *Impetigo*  • In impetigo, in contrast to Recurrent herpetic stomatitis , there is a halo of hyperemia around the lesions.  • In case of Recurrent herpetic stomatitis, erosions are dry, irregular in shape with scalloped edges and covered with a thin plaque or crusts (hemorrhagic crusts on the skin). In impetigo, erosions are more humid with oozing lymph and are covered with massive golden-yellow "honey" crusts.  •In contrast to Recurrent herpetic stomatitis , the onset of impetigo is acute.  •In scrapings taken from the surface of erosions in Recurrent herpetic stomatitis, the herpes simplex virus is detected, but in impetigo-streptococci.  **Chancriforme pyodermia is differentiated from :**  **1. Primary syphilis**  **1.Differential diagnostics of chancriforme pyodermia and syphilitic solid chancre**  **Common symptoms:**  • Defeat of the red border of the lips  •Solitar , saucer-shaped red ulcer with a dense base and even dense edges  •Dense, enlarged, painless and mobile lymph nodes  **Differences:**  •Chancriforme pyodermia is caused by staphylococci and streptococci. The cause of syphilis is pale treponema.  • In chancriforme pyodermia, in contrast to syphilitic solid chancre, the ulcer is painful.  •In syphilitic chancre, in contrast to chancriforme pyodermia, serological reactions become positive and pale treponemas are found in scrapings taken from the surface of the ulcer.  •In syphilitic chancre, a dense infiltrate at its base does not go beyond the boundaries of erosions or ulcers. In chancriform pyodermia, the infiltrate in the floor of the ulcer goes beyond its limits.  •For chancriforme pyodermia, the presence of serous - purulent discharge from the surface of the ulcer is characteristic. The floor of the syphilitic chancre may be covered with a grayish-yellow "greasy" plaque.  **Pyogenic granuloma is differentiated from:**  **1. Kaposi's sarcoma**  **2.Keratoacanthoma**  **3. Melanoma**  **4. Glomangioma**  **5. Squamous cell cancer of the skin**  **1.Differential diagnostics of pyogenic granuloma and Kaposi sarcoma Common symptoms:**  • The focus of the lesion is red-violet color  •Painless tumor-like formation  **Differences:**  •Cause of pyogenic granuloma is streptococci and staphylococci. Kaposi sarcoma is a malignant neoplasm of the skin, the provoking factors of which include the herpes virus.  •Pyogenic granuloma of mushroom-shape is situated on a pedicle surrounded by a “collar”of detached epithelium ,has a smooth surface and a soft consistency. Kaposi sarcoma is a plane (in the form of a spot) or slightly elevated above the skin (in the form of nodules) tumor with clear boundaries, has an uneven surface and a dense consistency.  •Pyogenic granuloma often affects children and adults under age of 30 years.  1156779704_10_168_1_s  ***Fig.107*** *Pyogenic granuloma*  Kaposi sarcoma often affects men (70% more often in HIV-infected patients).  •In case of pyogenic granuloma, the lesion is solitar.  3-23  ***Fig.108*** *Pyogenic granuloma*  Symmetry and multifocal lesions are characteristic for Kaposi sarcoma .  •Pyogenic granuloma, in contrast to Kaposi sarcoma , often affects the oral mucosa.  **2.Differential diagnostics of pyogenic granuloma and keratoacanthoma**  **Common symptoms:**  •Solitar painless tumor-like formation  •Localization on the red border of the lips  178  ***Fig.109*** *Pyogenic granuloma*  **Differences:**  •Pyogenic granuloma has a mushroom-shape and located on a pedicle surrounded by “a collar”of detached epithelium , with a bleeding surface and soft consistency. Kerathoacanthoma is a dense nodule with a funnel-shaped depression in the center, filled with easily removable horny masses.  70509102  ***Fig.110*** *Pyogenic granuloma*  •Pyogenic granuloma, in contrast to kerathoacanthoma, grows slowly.  •Kerathoacanthoma, in contrast to pyogenic granuloma, can spontaneously regress or become malignant.  •Pyogenic granuloma often affects children and adults under 30 years of age. Keratoacanthoma is more common in people over 50 years of age.  **3. Differential diagnostics of pyogenic granuloma and melanoma**  **Common symptoms:**  •Tumor formation  • Tendency of the lesion to ulceration and bleeding  •Affection of young people  **Differences:**  •Pyogenic granuloma is a soft, bluish-red, mushroom-shaped formation located on a peduncle surrounded by a "collar" of exfoliated epithelium.  86059_html_15e543e9  ***Fig.111*** *Pyogenic granuloma*  Melanoma is a dense formation in the form of a dark spot or nodule that elevates slightly above the surface of the skin, with uneven, blurred edges.  • For pyogenic granuloma, painlessness of the lesion is characteristic. Melanoma is characterized by painfulness and itching of the lesion.  • In melanoma, in contrast to pyogenic granuloma, lesions often develop at or around the site of moles.  •Melanoma, in contrast to pyogenic granuloma, is characterized by rapid growth and early metastasis.  **4.Differential diagnostics of pyogenic granuloma and glomangioma**  **Common symptoms:**  •Affection of young people (up to 35 years old)  •Solitar cyanotic-violet tumor-like formation  •Slow growth of the tumor  **Differences:**  •Glomangioma, in contrast to pyogenic granuloma, is more common in women.  •Pyogenic granuloma is a painless mushroom-shaped formation located on a pedicle surrounded by a "collar" of exfoliated epithelium.  53  ***Fig.112*** *Pyogenic granuloma*  Glomangioma is a formation in the form of a papule, which is characterized by severe pain, especially by hypothermia. In contrast to pyogenic granuloma, pain syndrome in glomangioma may precede the appearance of lesions for a long time.  **5.Differential diagnostics of pyogenic granuloma and squamous cell carcinoma of the skin**  **Common symptoms:**  •Presence of a painless solitar tumor  • Defeat of the red border of the lips  • Tendency to ulceration  **Differences:**  •Pyogenic granuloma often affects children and adults under 30 years of age. Squamous cell skin cancer occurs in elderly and senile people.  •Pyogenic granuloma grows slowly. In squamous cell skin cancer, the process is fast.  •Pyogenic granuloma is a soft mushroom-shaped formation located on a pedicle, surrounded by a "collar" of exfoliated epithelium, bluish-red in color.  botriomikoma_101-foto  ***Fig.113*** *Pyogenic granuloma*  Squamous cell carcinoma of the skin is a dense formation in the form of a nodus , slightly elevating above the surface of the skin, yellowish or dull white, resembling a cauliflower.  **Tuberculosis**  **Lupus vulgaris is differentiated from:**  **1. Tubercles in tertiary syphilis**  **2. Leprosy**  **3. Lupus erythematosus**  **1.Differential diagnostics of Lupus vulgaris and tubercular (tertiary) syphilis**  **Common symptoms:**  •Presence of painless red tubercles situated in clusters  • Tendency to ulceration  •Scar formation after healing  **Differences:**  •Tuberculosis is caused by mycobacterium tuberculosis - Koch's bacillus. Syphilis is caused by pale treponema.  • In Lupus vulgaris , the ulcer has soft, corroded, uneven edges. In tubercle syphilis, the edges of the ulcer are even and dense.  4-12  ***Fig.114*** *Lupus vulgaris*  • In Lupus vulgaris , the forming scars are smooth, shiny, leading to deformities, fresh tubercles may appear on them. In tubercle syphilis, scars are rough, fresh tubercles do not appear on them.  •Syphilitic tubercles are large and dense. In Lupus vulgaris , the tubercles are smaller and softer.  •In tubercle syphilis, in contrast to Lupus vulgaris , serological reactions are positive.  •For Lupus vulgaris , in contrast to syphilis, the symptom of apple jelly is characteristic (when pressed by a glass slide on the affected tissue, it turns pale, lupomas become visible in the form of yellowish-brown nodules, similar in color to apple jelly) and a sample with a probe (when pressed, the bulbous probe easily falls into lupoma - the Pospelov phenomenon).  dermatolog1  ***Fig.115*** *Lupus vulgaris (apple jelly symptom)*  **2.Differential diagnostics of Lupus vulgaris and leprosy**  **Common symptoms:**  •Presence of tubercles  •Presence of ulcers with soft, uneven edges  •Presence of smooth, shiny scars  **Differences:**  •The causative agent of tuberculosis is mycobacterium tuberculosis-Koch's bacillus. The causative agent of leprosy is the Hansen-Neisser mycobacterium.  • In Lupus vulgaris , tubercles are of soft consistency, red or yellowish-red, located in groups. The leprosy tubercles are dense, dull pink in color, randomly located.  62862207  ***Fig.116*** *Lupus vulgaris*  • Tuberculous ulcers are covered with red, bleeding papillomatous growths resembling raspberries. Leprosy ulcers have a tuberous gray-white base.  • Mycobacterium tuberculosis is found in scrapings taken from tuberculous ulcers. In scrapings taken from ulcers in leprosy, mycobacteria of Hansen-Neisser are found.  • For leprosy, the first symptom is paresthesia or hyperesthesia preceding the appearance of lesions. In tuberculosis, these symptoms are absent.  **3. Differential diagnostics of Lupus vulgaris and lupus erythematosus Common symptoms:**  • Defeat of the facial skin  **Differences:**  • In Lupus vulgaris , soft tubercles of red or yellow-red color are formed, which then from the center turn into red bleeding ulcers. In lupus erythematosus, the pathological elements are in the form of erythema, in the center of which there is atrophy, and along the periphery there is hyperkeratosis from densely sitting whitish-gray scales in the form of tongues of flame.  dermatolog  ***Fig.117*** *Lupus vulgaris*  • In Lupus vulgaris , the ulcers are covered with bleeding papillomatous growths with soft, corroded, uneven edges. In lupus erythematosus, the ulcers are painful, with expressed inflammation, covered with bloody-purulent crusts, around which hyperkeratosis is visible.  • In lupus erythematosus, in contrast to Lupus vulgaris , lesions on the face have a characteristic arrangement - in the form of butterfly wings.  •Luminescent diagnostics of areas of hyperkeratosis in lupus erythematosus gives a snow-white-blue glow.  • Lupus erythematosus often affects women at a young age (from 20 to 40 years). Middle-aged people are more likely to suffer from tuberculosis.  • Lupus erythematosus, in contrast to tuberculosis, has a seasonal course.  •Accurate diagnosis of lupus erythematosus is made on the basis of the detection of lupus erythematosus cells in the peripheral blood and punctates of the bone marrow and the "rosette phenomenon" (an accumulation of neutrophils is observed around the destroyed nucleus).  **Miliary tuberculosis is differentiated from :**  **1.Gummous ulcers in tertiary syphilis**  **2 .Cancerous ulcers**  **3. Vincent 's Necrotizing ulcerative stomatitis**  **4. Traumatic ulcers**  **5. Trophic ulcers**  **1.Differential diagnostics of Miliary tuberculosis and gummous ulcers in syphilis**  **Common symptoms:**  • Identical location of ulcers  •Presence of painful, solitary ulcers  **Differences:**  • In Miliary tuberculosis , the ulcer is shallow, has a granular structure due to undisturbed tubercles, with uneven, undermined soft edges. The ulcer is covered with a yellowish-gray plaque with a slight purulent discharge, bleeds easily, has an irregular shape, and gradually increases along the periphery. Small yellow abscesses (Treel grains) are found around the ulcer, the tissues are edematous. In syphilis, a round ulcer of stagnant red color, covered with small granulations, it is deep crater-like with a necrotic core in the center with smooth, not undermined and dense edges. The ulcer is surrounded by an extensive dense infiltration of a brownish-cyanotic color.  • In case of miliary-ulcerative tuberculosis, in contrast to tertiary syphilis, the general condition of the patient suffers sharply.  • In syphilis, in contrast to Miliary tuberculosis , ulcer healing leads to the formation of a retracted stellate scar.  •Serological reactions in syphilis are positive. In case of Miliary tuberculosis , in the scrapings taken from ulcers, during cytological and bacterioscopic examination, giant Pirogov-Langhans cells, epithelioid cells and Koch's bacilli are found.  **2. Differential diagnostics of miliary-ulcerative tuberculosis and cancer ulcers**  **Common symptoms:**  •Presence of an ulcer with a granular floor covered with a yellowish-gray plaque  • Uneven undermined edges of ulcers  • Enlarged, painful, indurated lymph nodes  **Differences:**  • The ulcer in Miliary tuberculosis is shallow, has undermined soft edges, surrounded by small yellow abscesses (Treel's grains), the tissues surrounding the ulcer are edematous. The cancer ulcer is deep, has a dense floor and elevated , inverted dense edges, covered with either a dense plaque, or bloody-purulent crusts. There may be no inflammation around the cancer ulcer.  8  ***Fig.118*** *Miliary tuberculosis*  • Older men aged 60-70 are more likely to suffer from cancer. Middle-aged people are more likely to suffer from tuberculosis.  • In case of Miliary tuberculosis , giant cells of Pirogov-Langhans and epithelioid cells are found in scrapings taken from ulcers during cytological examination, while staining according to Ziehl-Nielsen, Koch's bacilli are found. In cancer, during cytological examination, atypical epithelial cells are found in the scrapings taken from ulcers and punctate of the lymph nodes.  **3.Differential diagnostics of Miliary tuberculosis and Vincent’s ulcerative necrotizing stomatitis**  **Common symptoms:**  • Deterioration of the general condition of the patient  • Enlarged, painful, dense lymph nodes  •Presence of painful large bleeding ulcers with soft, irregular edges, located on a swollen base  **Differences:**  • Vincent's ulcerative necrotizing stomatitis is caused by Vincent's spindle-shaped bacillus and spirochete. Tuberculosis is caused by mycobacterium tuberculosis - Koch's bacillus.  •Vincent’s ulcerative necrotizing stomatitis often affects young men aged 17 to 30 years. Middle-aged people are more likely to suffer from tuberculosis.  • In Vincent’s ulcerative necrotizing stomatitis , multiple, deep ulcers with a loose floor are formed, covered with a thick necrotic plaque of a grayish-green color with a fetid putrid odor. In Miliary tuberculosis , a solitar shallow granular ulcer is more often formed, covered with a yellowish-gray plaque with a slight purulent discharge, around which small yellowish abscesses (Treel's grains) are visible.  •In case of Miliary tuberculosis , giant cells of Pirogov-Langhans and epithelioid cells, Koch's bacilli are found in scrapings taken from ulcers during cytological examination. In Vincent’s ulcerative necrotizing stomatitis , the cytological picture reveals an abundance of spirochetes and fusobacteria.  • In Vincent’s ulcerative necrotizing stomatitis , there is trismus, facial asymmetry due to edema of the surrounding tissues, necrosis of the mucous membrane and the bone of alveolar process. For Miliary tuberculosis , these symptoms are not typical.  **4.Differential diagnostics of miliary-ulcerative tuberculosis and traumatic (decubital) ulcers**  **Common symptoms:**  •Localization at the sites of greatest injury  •Presence of enlarged, mobile and painful lymph nodes  •Presence of solitar painful ulcers on an edematous base  **Differences:**  • The tuberculous ulcer is shallow, irregular in shape, has undermined uneven soft edges, a granular floor with a yellowish plaque, does not epithelize after elimination of the stimulus. In case of injury, the ulcer has an oval shape and a slightly depressed surface with dense edges and a base (if it exists for a long time), its central part has a yellowish-gray color. After elimination of the stimulus, rapid epithelisation of the decubital ulcer occurs.  •Decubital ulcers are more common in older people. Tuberculosis most often affects middle-aged people.  •In contrast to decubital ulcers in tuberculosis, the general condition of the patient worsens.  • In case of tuberculosis, epithelioid cells and giant cells of Langhans are found in the scraping taken from the ulcer, and when staining according to Ziehl-Nielsen, mycobacterium tuberculosis is often detected. In a decubital ulcer, these cells are not found.  •Decubital ulcer occurs as a response of the mucous membrane to various stimuli. A tuberculous ulcer occurs as a result of the inoculation of Koch's bacilli into the mucous membrane.  **5.Differential diagnostics of miliary-ulcerative tuberculosis and trophic ulcers**  **Common symptoms:**  •Localization at the sites of the greatest injury  •Presence of painful ulcers with uneven, undermined soft edges  • Deterioration of the general condition of patients  **Differences:**  • The tuberculous ulcer has a granular floor with a yellowish plaque, the tissues surrounding the ulcer are edematous. Trophic ulcers, covered with a grayish-white necrotic plaque, are located on the mucous membrane without an expressed inflammatory reaction.  • In tuberculosis, hypersalivation is observed. In trophic ulcers - hyposalivation.  •Trophic ulcers, in contrast to tuberculosis, can affect the nasopharynx, face, upper parts of neck, jaw bones, form through defects in the cheeks, and cause severe bleeding.  •In case of tuberculosis, in the scrapings taken from ulcers, during cytological examination, giant cells of Pirogov-Langhans and epithelioid cells are revealed, while staining according to Ziehl-Nielsen, Koch's bacilli are found. A cytological examination of scrapings taken from the surface of a trophic ulcer determines a small number of epithelial cells with signs of degeneration.  • In patients with trophic ulcers, in contrast to tuberculosis patients, the oral mucosa is pale, with a cyanotic shadow.  **Syphilis**  **Primary syphilis is differentiated from:**  **1. Traumatic ulcer**  **2.Chronic recurrent aphthous stomatitis**  **3. Merged erosion at recurrent herpetic stomatitis**  **4. Pyodermia chancriforme**  **5. Cancerous ulcer**  **6. Sutton’s aphthae**  **7. Tuberculous ulcer**  **8.Erosions and ulcers arising from lichen planus, leukoplakia, lupus erythematosus**  **1.Differential diagnostics of primary syphilis and traumatic ulcers**  **Common symptoms:**  •Presence of solitar ulcers  **Differences:**  • The causative agent of syphilis is pale treponema. A traumatic ulcer is an inflammatory response of tissues to an irritant.  • In syphilis, a painless saucer-shaped ulcer of meat-red color with elevated , even edges is formed, at the base of which a dense cartilage-like infiltrate is palpated (depending on the localization, it can be in the form of an elongated erosion, gap, crack). The traumatic ulcer has an oval shape and a slightly depressed surface, with painful hyperemic edges, the central part of it is of yellowish-gray color, with prolonged existence, the edges and base of the ulcer become denser.  87715609  ***Fig.119*** *Primary syphilis*  • In syphilis, the lymph nodes become cartilaginous-dense, painless. In traumatic ulcers, the lymph nodes are enlarged, mobile, painful.  •After elimination of the irritant, rapid epithelisation of the traumatic ulcer occurs. Elimination of the injury does not affect the course of the solid chancre.  •Diagnosis in primary syphilis, in contrast to traumatic ulcers, is clarified by finding a pale spirochete in a discharge of an ulcer or punctate of regional lymph nodes and positive serological reactions.  **2. Differential diagnostics of primary syphilis and Chronic recurrent aphthous stomatitis**  **Common symptoms:**  •Presence of solitar large round ulcers, covered with a grayish-yellow plaque  **Differences:**  •By Chronic recurrent aphthous stomatitis they get sick at any age. Syphilis is more common at a young age.  •Primary syphiloma is more often localized on the red border of the lips. Chronic recurrent aphthous stomatitis often occurs on the buccal mucosa .  • Ulcer in Chronic recurrent aphthous stomatitis has a soft base and edges, elevates above the level of the mucous membrane, is flat, covered with a dense plaque , painful. The ulcer in syphilis is meat-red in color with dense, roller-like, even edges, without plaque or covered with a "greasy" plaque , localized on a powerful cartilage-like infiltrate, painless.  4  ***Fig.120*** *Primary syphilis*  •At the cytological study in Chronic recurrent aphthous stomatitis, epithelial cells were found in the material. In syphilis, pale treponemas are found in the lesions.  •Serological reactions in Chronic recurrent aphthous stomatitis are negative. In syphilis, a positive Wasserman reaction is observed after 6 weeks after infection.  • In contrast to Chronic recurrent aphthous stomatitis, in syphilis, the lymph nodes are cartilaginous-dense and painless on palpation.  **3.Differential diagnostics of primary syphilis and merged erosions in Chronic recurrent herpetic stomatitis**  **Common symptoms:**  • Meat -red color of the pathological elements  • Identical places of localization of lesions on the skin and oral mucosa  **Differences:**  •The cause of the Chronic recurrent herpetic stomatitis is herpes simplex virus. The cause of syphilis is pale treponema.  • The duration of the Chronic recurrent herpetic stomatitis is 10 days and the disease has a relapsing course. Primary syphilis lasts an average of 7 weeks to 3 months, with no recurrence.  • In case of Chronic recurrent herpetic stomatitis , pathological elements are in the form of one or several large painful erosions of irregular shape with scalloped edges and separate small erosions around, located on a hyperemic and edematous mucous membrane. In syphilis, the pathological element is in the form of a solitar painless saucer-shaped ulcer with smooth elevated edges, at the base of which a dense cartilage-like infiltrate is palpable (depending on the location, it can be in the form of an elongated erosion, gap, crack).  09681537  ***Fig.121*** *Primary syphilis*  • In Chronic recurrent herpetic stomatitis, the pathological elements merge. Syphilis is characterized by the focus of the elements 'arrangement, that is, they do not merge with each other, they lie in isolation.  • In Chronic recurrent herpetic stomatitis, in contrast to syphilis, the rash is preceded by vesicles and a burning sensation, itching and pain.  •Herpetic erosions, in contrast to syphilitic erosions, are characterized by rapid onset and rapid epithelisation.  •Serological reactions in syphilis give a positive result and pale treponemas are found in scrapings taken from the surface of papules. In Chronic recurrent herpetic stomatitis, Wasserman's reaction is negative and in scrapings taken from erosions during cytological examination, a large number of giant multinucleated cells are found.  **4.Differential diagnostics of primary syphilis and pyodermia chancriforme**  **Common symptoms:**  • Defeat of the red border of the lips  •Solitar , saucer-shaped red ulcer with a dense base and even dense edges  •Dense, enlarged, painless and mobile lymph nodes  **Differences:**  • Pyodermia chancriforme is caused by staphylococci and streptococci. The cause of syphilis is pale treponema.  • In Pyodermia chancriforme, in contrast to syphilitic solid chancre, the ulcer is painful.  •In syphilitic chancre, in contrast to Pyodermia chancriforme, serological reactions become positive and pale treponemas are found in scrapings taken from the surface of the ulcer.  •In syphilitic chancre, a dense infiltrate at its base does not go beyond the boundaries of erosion or ulcer. In Pyodermia chancriforme, the infiltrate in the floor of the ulcer goes beyond its limits.  СИФИЛИС  ***Fig.122*** *Primary syphilis*  •For Pyodermia chancriforme, the presence of serous - purulent discharge from the surface of the ulcer is characteristic. The floor of the syphilitic chancre may be covered with a grayish-yellow "greasy" plaque.  **5.Differential diagnostics of primary syphilis and cancerous ulcer**  **Common symptoms:**  •Presence of an ulcer with dense elevated edges  **Differences:**  • Young people are more likely to get sick with syphilis. Neoplasms are more likely to affect the elderly.  •Syphilitic ulcer is superficial, saucer-shaped, meat-red with a smooth shiny floor on a dense cartilage-like infiltrate with smooth edges. The ulcer is sometimes covered with a grayish-yellow "greasy" plaque. The cancerous ulcer is deep, the form of which depends on the location of the focus, has an uneven granular floor, covered with a dense plaque or bloody purulent crusts, with uneven, pitted and bleeding edges.  90331  ***Fig.123*** *Primary syphilis*  • The diagnosis of syphilis is confirmed by the detection of pale treponema in smears taken from the surface of the chancre or in the punctate of regional lymph nodes and positive serological reactions. Cytological examination of a cancerous ulcer reveals atypical epithelial cells.  **6.Differential diagnostics of primary syphilis and Sutton’s aphthae**  **Common symptoms:**  •Similar places of localizations  •Presence of oval or round ulcers on a dense infiltrate  **Differences:**  • In syphilis, the ulcer is painless, superficial, meat-red with smooth, elevated dense edges (depending on the location, it can be in the form of elongated erosion, fissures, cracks). Sutton’s aphthae are deep, painful, crater-like with soft edges and with slight hyperemia around.  •After the Sutton’s aphthae heal, scars remain, leading to deformities of the oral mucosa. After syphilitic chancre, no scars remain.  •In Sutton’s aphthae, in contrast to syphilis, aphthae and ulcers are found on the oral mucosa at the same time.  •Sutton’s aphthae, in contrast to syphilis, are characterized by frequent exacerbations.  • General condition of the patients with Sutton’s Sutton’s aphthae suffer. In syphilis, signs of intoxication of the organism are rare.  • Syphilis is more common at a young age. By Sutton’s aphthates they get sick at any age.  • The diagnosis of syphilis is confirmed by the detection of pale treponema in the smears taken from the surface of the chancre or in the punctate of regional lymph nodes and positive serological reactions. Cytological examination of the surface of Sutton’s aphthae reveals epithelial cells.  **7. Differential diagnostics of primary syphilis and tuberculous ulcer:**  **Common symptoms:**  •Long-existing ulcer on the oral mucosa  **Differences:**  • The tuberculous ulcer is painful, has uneven, undermined edges, around which Treel grains are visible  •After a tuberculous ulcer, atrophic or rough scars remain  •From history: active tuberculosis  • In tuberculosis, mycobacteria are found in scrapings, in syphilis - pale treponema  **8. Differential diagnostics of primary syphilis and erosions, ulcers arising from lichen planus, leukoplakia, lupus erythematosus:**  **Common symptoms:**  •Long-existing ulcer on the oral mucosa  **Differences:**  •Erosions and ulcers in these diseases do not have compaction at the base, in contrast to solid chancre  •Erosions and ulcers in these diseases are located on the mucous membrane that is characteristically changed for each disease, which is not the case in syphilis  •Erosions and ulcers in these diseases are not scraped off by a spatula when scraping, plaque in a solid chancre is scraped off  •For syphilis, the sex of the patient does not matter, which is not typical for these diseases  **Secondary syphilis is differentiated from :**  **1. Lichen planus (LP)**  **2. Leukoplakia**  **3. Acute pseudomembranous candidiasis**  **4. Erythema multiforme**  **5. Catarrhal allergic stomatitis**  **6. Lupus erythematosus**  **7. Vincent' ulcerative necrotizing stomatitis**  **8. Desquamative glossitis**  **9. Chronic recurrent aphthous stomatitis**  **10. Catarrhal sore throat**  **11. Pemphigus vulgaris**  **12.Chronic herpetic stomatitis**  **13. Candidal perleche**  **14. Streptococcal perleche**  **1.Differential diagnostics of secondary (papular) syphilis and lichen planus**  **Common symptoms:**  • Grayish-white plaque of lesions  •Presence of painful round papules with clear boundaries  **Differences:**  • Persons of both sexes suffer from syphilis, more often at a young age. Lichen planus is mostly seen in women between the ages of 40 and 60.  • In syphilis, papules are dense, large (1-1.5 cm), round or oval in shape, with clear edges and an inflammatory halo around, do not merge with each other (focal location). In Lichen planus , papules are small (0.2-5 mm), with jagged edges, keratinized, without an inflammatory halo around, prone to fusion in the form of a mesh, lace or plant pattern, slightly elevate above the level of the mucous membrane.  •From the surface of syphilitic papules, plaque is easily removed. It is not possible to remove plaque from the surface of the Lichen planus , since it is a consequence of hyperkeratosis.  • In Lichen planus , in contrast to syphilis, patients often complain of tightness, burning, roughness and dryness of the oral mucosa.  • In papular syphilis, the base of the lesion is infiltrated,but in lichen planus no.  • The diagnosis of syphilis is confirmed by positive serological reactions and the detection of pale treponema in the lesions. The histology of Lichen planus shows acanthosis, hyperkeratosis and parakeratosis in the epithelium.  •Papular syphilis often affects the tonsils, soft palate and arches. Lichen planus is more often localized on the buccal mucosa at the place of adjoining molars with the capture of transitional folds, on the lateral surfaces of the tongue's dorsum with a transition to the lower surface in the area of ​​ molars.  **2.Differential diagnostics of secondary (papular syphilide) syphilis and leukoplakia**  **Common symptoms:**  •Focal lesion with clear boundaries  • The presence of a grayish-white plaque  **Differences:**  • The causative agent of syphilis is pale treponema. Local irritants play the main role in the occurrence of leukoplakia.  •Papular syphilis often affects the tonsils, soft palate and arches.  250px-pharyngitis  ***Fig.124*** *Secondary syphilis* ***Fig.125*** *Leukoplakia*    Leukoplakia often affects the red border of the lower lip, the buccal mucosa along the dental closing line in the anterior region in the form of a triangle with the apex posteriorly, the palate.  • In papular syphilis, the main morphological element is dense, large papules that have an inflammatory halo and do not merge with each other. In leukoplakia, the morphological element is a plaque with hyperkeratosis, reminiscent of pasted papyrus paper, and without an inflammatory halo.  •From the surface of syphilitic papules, plaque is easily removed. It is impossible to remove plaque from the surface of leukoplakia, since it is a consequence of hyperkeratosis.  • In syphilis, the base of the focus is infiltrated, which is not the case in leukoplakia.  • In leukoplakia, patients complain of a burning sensation, tightness, roughness of the mucous membrane, which is not the case in syphilis.  • Persons of both sexes are ill with syphilis. Men suffer from leukoplakia more often than women.  • The diagnosis of syphilis is confirmed by positive serological reactions and the detection of pale treponema in the lesions.  **3.Differential diagnostics of secondary syphilis and acute pseudromembranous candidiasis**  **Common symptoms:**  •Presence of painful lesions  •Presence of a whitish-gray plaque  **Differences:**  • In syphilis, pale treponema is found from the surface of the chancre or in the punctate of the regional lymph nodes. In candidiasis, the Candida fungus is found in scrapings taken from the affected areas.  • Young people suffer from syphilis. Children and adults, more often elderly and weakened women, suffer from candidiasis.  • When removing the plaque from the surface of a syphilitic papule, erosion of a meat-red color with an infiltrate at the base and an inflammatory halo around is exposed, located on the unchanged oral mucosa. When scraping plaque in candidiasis, the hyperemic surface of the mucous membrane is exposed.  •Papular syphilis often affects the tonsils, arches, and soft palate. Candidiasis often affects the hard palate, tongue, mucous membrane of the cheeks, lips, corners of the mouth.  • Patients with candidiasis, in contrast to patients with syphilis, complain of a burning sensation and dryness of the oral mucosa.  • Plaque in candidiasis, in contrast to syphilitic plaque, resembles curdled milk or cottage cheese.  •Candidal perleche from syphilitic one is distinguished by the absence of infiltration at the base, the presence of thin gray scales around erosions with small detachable or tender crusts.  **4.Differential diagnostics of secondary (papular) syphilis and erythema multiforme**  **Common symptoms:**  •Large, painful lesions  •Affection of young people  **Differences:**  • In contrast to syphilis, erythema multiforme begins acutely.  • Secondary syphilis often affects the tonsils, soft palate, and arches. Erythema multiforme often affects the red border and mucous membrane of the lips, the oral vestibule, tongue, cheeks.  Syphilis_3_0508  ***Fig.126*** *Secondary syphilis*  • In papular syphilis, papules with clear edges, infiltration at the base and an inflammatory halo around are formed. They are covered with a grayish-white plaque, which is easily removed by scraping. In erythema multiforme , bleeding erosions are formed with scraps of bubble's covering epithelium along the edges, covered with a dense yellowish-gray plaque or dense brown-black crusts and located on a hyperemic, edematous mucous membrane.  •For papular syphilis, the focusness of the elements' arrangement is characteristic (located isolated from each other). For erythema multiforme , a tendency to fusion of lesions is characteristic.  • Persons of both sexes are ill with syphilis. Erythema multiforme often affects men.  • In syphilis, data from cytological examination of scrapings taken from the surface of papules reveal the presence of pale treponema. The diagnosis is also confirmed by positive serological tests. In erythema multiforme , the cytology of scrapings taken from the surface of erosions reveals the presence of epithelial cells, leukocytes , abundant microflora. Serological reactions in erythema multiforme are negative.  •In case of erythema multiforme, in contrast to syphilis, relapses are seasonal.  **5.Differential diagnostics of secondary (spotted) syphilis and catarrhal allergic stomatitis**  **Common symptoms:**  •Presence of spots on the mucous membrane  **Differences:**  • The causative agent of syphilis is pale treponema. The cause of allergic stomatitis is the organism's reaction to the action of the medication.  • Macular syphilis affects the soft palate, tonsils, and arches. Allergic stomatitis is characterized by the prevalence of lesions (cheeks, tongue, lips, palate, etc.)  •In contrast to macular syphilis, allergic stomatitis is accompanied by burning, painfulness of the oral mucosa.  •In case of allergic rashes, in contrast to syphilis, all symptoms quickly disappear after stopping the medication intake.  •The onset of the disease and the course of allergic stomatitis is acute, and chronic in macular syphilis.  • The diagnosis of syphilis is confirmed by the detection of pale treponema in scrapings taken from ulcers and positive serological reactions.  **6.Differential diagnostics of secondary syphilis (papular) and lupus erythematosus**  **Common symptoms:**  • The presence of a grayish-white plaque on the foci  •Affection of young people  **Differences:**  • People of both sexes are equally ill with syphilis. Lupus erythematosus is more common in women.  • The mucous membrane in syphilis is affected very often. Lesions of the oral mucosa in lupus erythematosus are very rare and are accompanied by a burning sensation.  • In papular syphilis, the pathological element is in the form of large rounded papules with clear edges, surrounded by an inflammatory halo and infiltration at the base. In lupus erythematosus, the pathological element is in the form of a focus of congestive hyperemia with hyperkeratosis around in the form of blurred tongues of flame and atrophy in the center, covered with delicate white dots and stripes, without an inflammatory halo and infiltration at the base.  syphilis_2_031123  ***Fig.127*** *Secondary syphilis*  • In syphilis, plaque from the papule is easily removed. In lupus erythematosus, plaque is not scraped off, since it is a consequence of hyperkeratosis.  • In case of skin lesions, the foci of lupus erythematosus have a characteristic pattern of butterfly wings.  • The diagnosis of syphilis is confirmed by the presence of pale treponema in the lesions and punctate of the lymph nodes, as well as positive serological reactions. The diagnosis of lupus erythematosus is made on the basis of the detection of red lupus cells in the peripheral blood and punctates of the bone marrow and the "rosette phenomenon" (an accumulation of neutrophils is observed around the destroyed nucleus).  **7. Differential diagnostics of secondary syphilis (pustular) and Vincent 's ulcerative necrotizing stomatitis.**  **Common symptoms:**  •Presence of painful ulcers covered with purulent-necrotic plaque  •Affection of young people  **Differences:**  •The causative agent of Vincent’s ulcerative necrotizing stomatitis is the fusiform bacillus and Vincent's spirochete. The causative agent of syphilis is pale treponema.  • Men suffer from Vincent’s ulcerative necrotizing stomatitis more often. Persons of both sexes are ill with syphilis.  • In papular syphilis, the pathological element is in the form of large rounded papules with clear edges, surrounded by an inflammatory halo and infiltration at the base. Ulcers in Vincent’s ulcerative necrotizing stomatitis are multiple, large, deep, with a loose bleeding floor and soft uneven edges, located on a swollen, hyperemic base without infiltration.  • Ulcers in Vincent’s ulcerative necrotizing stomatitis are located in the area of ​​the lower wisdom teeth, the buccal mucosa, the dorsum and lateral surfaces of the tongue, the hard and soft palate.  **8.Differential diagnostics of secondary syphilis (papular) and desquamative glossitis**  **Common symptoms:**  • Smooth, shiny lesions with clear edges  • Disappearance of filiform and fungiform papillae in the desquamation focus  **Differences:**  • In case of papular syphilis, desquamation foci with compaction at the base appear on the tongue that fall below the level of the mucous membrane ("plaques of the mown meadow"). In desquamative glossitis, around a bright red focus of desquamation without compaction at the base, there is a slightly elevated , non-desquamated area of ​​the epithelium of white color, rapidly growing along the periphery.  •For secondary syphilis, the location of the foci is characteristic. In desquamative glossitis, the foci are layered on top of each other, new foci appear on the background of old foci (resembles a geographic map).  •Desquamative glossitis, in contrast to syphilis, is characterized by a rapid change in the outlines of desquamation foci (changes in one day).  **9. Differential diagnostics of secondary syphilis (papular) and Chronic recurrent aphthous stomatitis**  **Common symptoms:**  •Presence of large, solitar , rounded lesions  **Differences:**  •By Chronic recurrent aphthous stomatitis they get sick at any age. Syphilis is more common at a young age.  •In Chronic recurrent aphthous stomatitis, the morphological element is painful aphtha, soft to the touch, slightly elevating above the surrounding tissues, surrounded by a brightly hyperemic, edematous halo and covered with a dense yellowish-gray plaque. In syphilis, the morphological element is a flat, slightly painful papule with infiltration at the base, of meat –red color , surrounded by a stagnant inflammatory halo along the periphery and covered with an easily removable grayish-white plaque.  •In Chronic recurrent aphthous stomatitis, in contrast to syphilis, the rash is preceded by a burning sensation and pain, as well as the appearance of vesicles.  • Rash in Chronic recurrent aphthous stomatitis is more often localized on the mucous membrane of the cheeks, lips, lateral surfaces of the tongue. In secondary syphilis, the tonsils, soft palate, and arches are more often affected.  •In Chronic recurrent aphthous stomatitis , aphthae have no tendency to growth. In syphilis, papules are prone to peripheral proliferation.  • The diagnosis of syphilis is confirmed by the presence of pale treponema in the lesions and positive serological reactions. Cytological examination of the aphthae in Chronic recurrent aphthous stomatitis reveals a picture of chronic inflammation and the presence of epithelial cells.  • Aphthae in Chronic recurrent aphthous stomatitis , in contrast to syphilis, are recurrent.  **10. Differential diagnostics of secondary syphilis and catarrhal sore throat:**  **Common symptoms:**  • Hyperemia of the tonsils  **Differences:**  • In catarrhal angina, there is severe pain when swallowing  •The signs of general intoxication of the organism are observed  • In case of catarrhal angina, the tonsils are bright red, edematous, the process is extended to other parts of the mucous membrane  • Serological reactions for syphilis in catarrhal sore throat are negative  **11. Differential diagnostics of secondary syphilis and pemphigus vulgaris:**  **Common symptoms:**  •Erosions on the oral mucosa  • Skin lesions  **Differences:**  •Erosions in pemphigus vulgaris are preceded by the formation of bubbles  • At the base of erosion in pemphigus vulgaris there is no dense infiltrate as in syphilis  •On the surface of erosion in pemphigus vulgaris, acantholytic cells are found, in syphilis - treponema pallidum  • In pemphigus vulgaris, only corticosteroid therapy leads to remission  **12. Differential diagnostics of secondary syphilis and chronic herpetic stomatitis:**  **Common symptoms:**  •Erosions on the oral mucosa  • Skin lesions  **Differences:**  •In chronic herpetic stomatitis, the appearance of erosions is preceded by the formation of vesicles on a hyperemic background  • In chronic herpetic stomatitis, erosions are formed with polycyclic edges without infiltration at the base, prone to rapid epithelisation  • In chronic herpetic stomatitis, serological reactions to syphilis are negative  **13. Differential diagnostics of syphilitic perleche and yeast perleche:**  **Common symptoms:**  •Cracks in the corners of the mouth with a plaque that is removed by scraping  • Painfulness when opening the mouth, talking  **Differences:**  •Yeast perleche is more common in older people wearing the removable dentures  • At the base of the yeast perleche there is no compaction character for syphilis  • In case of yeast perleche in scrapings, Candida fungi, pseudomycelium are found in large quantities  •Syphilitic perleche , in contrast to yeast ones , are deep, bleeding  **14. Differential diagnostics of syphilitic perleches and streptococcal perleches:**  **Common symptoms:**  • Painful, bleeding erosion in the corner of the mouth that is covered with crust  **Differences:**  • Streptococcal perleches are observed mainly in children  • In case of streptococcal perleche , the lesions are more extensive, spread beyond the skin fold, often appear on the lips, chin skin  • In streptococcal perleche , the course of the process is more active, abundant exudation is observed, thick yellow crusts are formed  • There is no dense infiltrate at the base of streptococcal perleches  • In case of yeast perleche in scrapings, Candida fungi, pseudomycelium are found in large quantities  **Tertiary syphilis is differentiated from :**  **1. Miliary tuberculosis**  **2. Lupus vulgaris**  **3. Cancer**  **4. Diffuse sclerosing glossitis**  **1. Differential diagnostics of tertiary syphilis (gummy) and Miliary tuberculosis**  **Common symptoms:**  • Identical location of ulcers  •Presence of painful, solitary ulcers  **Differences:**  • In tuberculosis, the ulcer is shallow, has a granular structure due to undisturbed tubercles, with uneven, undermined soft edges. The ulcer is covered with a yellowish-gray plaque with a slight purulent discharge, bleeds easily, has an irregular shape, and gradually increases along the periphery.  Small yellow abscesses (Treel grains) are found around the ulcer, the tissues are edematous. In syphilis, there is a round ulcer of stagnant red color, covered with small granulations, deep crater-like with a necrotic cord in the center with smooth, not undermined and dense edges. The ulcer is surrounded by an extensive dense infiltration of a brownish-cyanotic color.  • In case of miliary-ulcerative tuberculosis, in contrast to tertiary syphilis, the general condition of the patient suffers sharply.  гУММОЗНЫЙ СИФИЛИС  ***Fig.128*** *Tertiary syphilis*  tretichniy-sifilis  ***Fig.129*** *General view of a patient with tertiary syphilis*  • In syphilis, in contrast to tuberculosis, ulcer healing leads to the formation of a retracted stellate scar.  •Serological reactions in syphilis are positive. In case of tuberculosis, in the scrapings taken from ulcers, during cytological and bacterioscopic examinations, giant Pirogov-Langhans cells, epithelioid cells and Koch's bacilli are found.  **2.Differential diagnostics of tertiary syphilis (tubercular) and Lupus vulgaris**  **Common symptoms:**  •Presence of painless red tubercles located in clusters  • Tendency to ulceration  •Scar formation after healing  **Differences:**  •Tuberculosis is caused by mycobacterium tuberculosis - Koch's bacillus. Syphilis is caused by pale treponema.  siph13  ***Fig.130*** *General view of a patient with tertiary syphilis*  • In Lupus vulgaris, the ulcer has soft, corroded, uneven edges. In tubercle syphilis, the edges of the ulcer are even and dense.  • In Lupus vulgaris, the resulting scars are smooth, shiny, leading to deformities, fresh tubercles may appear on them. In tubercle syphilis, scars are rough, fresh tubercles do not appear on them.  •Syphilitic tubercles are large and dense. In Lupus vulgaris, the tubercles are smaller and softer.  •In tubercle syphilis, in contrast to Lupus vulgaris, serological reactions are positive.  •For Lupus vulgaris , in contrast to syphilis, a symptom of apple jelly is characteristic (when pressed by a glass slide on the affected tissue, it turns pale, lupomas become visible in the form of yellowish-brown nodules, similar in color to apple jelly) and a probe test (when pressed, a bulbous probe easily falls into lupoma - the Pospelov phenomenon).  **3. Differential diagnostics of tertiary syphilis (gummy) and cancer**  **Common symptoms:**  •Presence of a solitar limited compaction in the thickness of the mucous membrane  •Presence of deep ulcers with dense base and edges  **Differences:**  • The causative agent of syphilis is pale treponema. Cancer is caused by various diseases and injuries of the oral mucosa.  • Young people are more likely to get sick with syphilis. Cancer diseases are more likely to occur in men over the age of 40.  sifil_093r12  ***Fig.131*** *General view of a patient with tertiary syphilis*  • Gummous syphilis is more often localized on the soft and hard palate, tongue.  п9  ***Fig.132*** *Tertiary syphilis*  Cancer often affects the red border of the lower lip, the oral floor, and the tongue.  • The ulcer of gummous syphilis is crater-shaped with a necrotic cord in the center. It has even, smooth, uncovered edges and a bright red floor with fine granulations. Cancer ulcers have elevated , inverted, uneven and bleeding edges, an uneven granular floor, covered with a gray-yellow or gray necrotic plaque or bloody gray crusts.  •Healing of gummous ulcers leads to the formation of a retracted stellate scar, which is not the case in cancer.  • The diagnosis of syphilis is confirmed by positive serological tests. Cytological examination of a cancerous ulcer reveals atypical epithelial cells.  **4.Differential diagnostics of gummous syphilis and diffuse sclerosing glossitis**  **Common symptoms:**  • Defeat of the tongue  **Differences:**  • In gummous syphilis, solitar painless gummas are formed on the tongue.    ***Fig.133*** *Gummous syphilis*  In diffuse sclerosing glossitis, there is a painful lesion of the entire thickness of the tongue.  • In sclerosing glossitis, in contrast to gumma, the tongue becomes dense, tuberous with deep grooves (resembles a quilt), decreases by 1/3 in size, its mobility is limited.  •Gummas, in contrast to diffuse sclerosing glossitis, burst up with the formation of an ulcer  **5. Differential diagnostics of tertiary syphilis and traumatic ulcers:**  **Common symptoms:**  • Ulcers on the oral mucosa  **Differences:**  •In a traumatic ulcer, a traumatic factor is detected, the elimination of which leads to healing  • Traumatic ulcer is painful, soft, has inflammation around  • RIPT , serological, Wasserman reactions in traumatic ulcer are negative  •In traumatic ulcers, the lymph nodes are enlarged, painful, not soldered to the underlying tissues  **6.Differential diagnostics of tertiary syphilis and solid chancre:**  **Common symptoms:**  • Ulcers on the mucous membrane of the lips, tongue  **Differences:**  • In primary syphilis, regional lymphadenitis is observed, which is not in tertiary syphilis  • In tertiary syphilis, after healing of ulcers, rough scars remain  • Tertiary syphilis is characterized by such primary morphological elements as gumma and tubercle  • Tertiary syphilis is characterized by a "saddle" nose  **7. Differential diagnostics of tertiary syphilis and leprosy:**  **Common symptoms:**  • Ulcers on the mucous membrane of the lips, tongue  **Differences:**  • In case of leprosy, acid-resistant mycobacteria- Mycobacterium leprae and Mycobacterium lepromatosis are found in scrapings taken from the surface of the ulcer  • In case of leprosy, the Wasserman, RIPT, RIF reactions are negative  •For leprosy, a peculiar face of the patient is characteristic, which in medical language is called "facies leonine" - "lion's face"  **Candidiasis is differentiated from :**  **1.Leukoplakia**  **2. Lichen planus (LP)**  **3.Desquamative glossitis**  **4.Pashkov’s mild leukoplakia**  **5.Allergic catarrhal and catarrhal-hemorrhagic stomatitis**  **6.Secondary syphilis**  **7. Streptococcal perleche**  **8. Lupus erythematosus**  **9. Perleche due to ariboflavinosis (hypo- and vitamin B2 deficiency)**  **10. White sponge nevus of cannon**  **11. Tuberculosis's perleche**  **12. Glossalgia**  **13. Dry form of exfoliative cheilitis**  **14. Atopic cheilitis**  **15. Acute atrophic, pseudomembranous, chronic hyperplastic candidiasis associated to HIV infection**  **1.Differential diagnostics of acute pseudomembranous candidiasis and leukoplakia**  **Common symptoms:**  •White color and dryness of the lesions  • Burning sensation in the mouth  **Differences:**  •Candidiasis often affects children, elderly and weakened adults, more often women. Leukoplakia is more common in middle-aged and older men.  •Candidiasis is caused by yeast-like fungi of the genus Candida. Leukoplakia occurs as a result of various injuries.  • In candidiasis, the lesion is in the form of a plaque without clear boundaries, resembling curdled milk, which, when scraped, is easily removed and located on the hyperemic oral mucosa.  The lesion of leukoplakia is in the form of a hyperkeratic plaque with clear, even edges, which cannot be removed when scraped, located on a seemingly unchanged mucous membrane that resembles glued thin tissue paper.  037FluconazoleResistantCandida  ***Fig.134*** *Candidiasis*  • The diagnosis of candidiasis is confirmed by the presence of a fungus of the genus Candida in the scrapings taken from the surface of the affected oral mucosa.  **2.Differential diagnostics of acute pseudomembranous candidiasis and lichen planus (LP)**  **Common symptoms:**  •Prevalence among women aged 40-60.  • White color of the lesions  • Burning sensation in the mouth  **Differences:**  •Candidiasis is caused by yeast-like fungi of the genus Candida. The etiology of lichen planus is not clear.  • In candidiasis, a lesion is in the form of a plaque without clear boundaries, resembling curdled milk, which, when scraped, is easily removed and located on the hyperemic, dry oral mucosa. In lichen planus , the lesion is in the form of keratinized papules with clear jagged edges, which are not removed by scraping and form a reticular, lace pattern, located on a normal or hyperemic mucous membrane.  Kandidoz_rta_i_glotki%0A%0ADermatit_seborejnyj  ***Fig.135*** *Candidiasis*  • In lichen planus , in contrast to candidiasis, the skin of the inner surface of the forearms, wrist joints, lower legs, sacrum, and genitals can be affected.  •The diagnosis of candidiasis is confirmed by the presence of a fungus of the genus Candida in the scrapings taken from the surface of the affected oral mucosa.  **3.Differential diagnostics of acute and chronic atrophic candidiasis and desquamative glossitis**  **Common symptoms:**  • Defeat of the tongue  • Burning sensation in the mouth  **Differences:**  • In candidiasis, a lesion without clear boundaries, plaque is found in the deep folds of the oral cavity, the mucous membrane is dry, hyperemic.  kandidoz_mouth-6-a-foto  ***Fig.136*** *Candidiasis*  In desquamative glossitis, areas of desquamation of the epithelium of a reddish color with smooth, clear boundaries appear on the dorsum of the tongue, surrounded by a corolla of exfoliating epithelium and constantly migrating along the dorsum of the tongue (this gives the tongue the appearance of a geographical map). Intact mucous membrane has normal color.  • In desquamative glossitis, lesions quickly change their outlines (every day). Stability is characteristic of candidiasis.  kandidizpolostirta  ***Fig.137*** *Candidiasis*  • In case of desquamative glossitis, in contrast to candidiasis, other parts of the oral mucosa are rarely affected simultaneously with the tongue.  • In contrast to candidiasis, desquamative glossitis lasts, as a rule, all life.  **4.Differential diagnostics of acute pseudomembranous candidiasis and Pashkov’s mild leukoplakia**  **Common symptoms:**  •Lesions of white color with indistinct boundaries  •The surface of the lesions is removed by scraping  **Differences:**  •Candidiasis often affects infants, the elderly, especially those who are weakened by chronic diseases. Pashkov’s mild leukoplakia is observed in patients with neuropathy, predominantly of young age.  • The cause of candidiasis is yeast-like fungi of the genus Candida. The cause of Pashkov’s mild leukoplakia is trauma to the oral mucosa.  • In candidiasis, lesions are in the form of a plaque resembling curdled milk, located on a hyperemic, dry oral mucosa.  candidiasis1  ***Fig.138*** *Candidiasis*  In Pashkov's leukoplakia, lesions are in the form of diffuse spots with an uneven, fringed and rough surface (as if eaten away by moths) due to multiple small patches of epithelium located on an edematous, pasty mucosa without inflammation.  • The diagnosis of candidiasis is confirmed by the presence of fungi of the genus Candida in scrapings taken from the surface of the lesions.  •Candidiasis often affects the mucous membrane of the dorsum of the tongue, cheeks, palate, lips. Pashkov’s mild leukoplakia is localized mainly along the dental closing line and on the mucous membrane of the lips.  **5. Differential diagnostics of acute and chronic atrophic candidiasis and allergic catarrhal and catarrhal-hemorrhagic stomatitis**  **Common symptoms:**  • Hyperemic, edematous oral mucosa  • A burning sensation and pain in the mucous membrane  **Differences:**  • In candidiasis, a lesion has not clear boundaries, plaque is found in the deep folds of the oral cavity.  candidoz rta  ***Fig.139*** *Candidiasis*  In allergic catarrhal stomatitis, the mucous membrane is without plaque, hemorrhages are noted on it.  •In candidal stomatitis, in contrast to allergic stomatitis, there is a characteristic triad for it: inflammation of the palate, tongue, corners of the mouth.  • In candidiasis, microscopic examination of scrapings taken from the surface of the oral mucosa reveals spores and mycelium of the fungus of the genus Candida.  Microscopic examination of scrapings taken from the surface of the oral mucosa in allergic stomatitis reveals the presence of a large number of eosinophils.  •In case of allergic stomatitis, in contrast to candidiasis, after rational therapy, the process is quickly resolved.  **6.Differential diagnostics of acute pseudomembranous candidiasis and secondary syphilis**  **Common symptoms:**  •Presence of painful lesions  •Presence of a whitish-gray plaque  **Differences:**  •Syphilis is caused by pale treponema. Candidiasis is caused by yeast-like fungi of the genus Candida.  • Young people are more likely to get sick with syphilis. Candidiasis affects children and adults, more often elderly and weakened women.  s320x240  ***Fig.140*** *Candidiasis*  • By removing the plaque from the surface of a syphilitic papule, erosion of a meat-red color with an infiltrate at the base and an inflammatory halo around is exposed, located on the unchanged oral mucosa. By scraping the plaque in candidiasis, the hyperemic surface of the mucous membrane is exposed.  •Papular syphilis often affects the tonsils, arches, and soft palate. Candidiasis often affects the hard palate, tongue, mucous membrane of the cheeks, lips, corners of the mouth.  main_11  ***Fig.141*** *Candidiasis*  • Patients with candidiasis, in contrast to patients with syphilis, complain of a burning sensation and dryness of the oral mucosa.  • The plaque in candidiasis, in contrast to the syphilitic plaque, resembles curdled milk or cottage cheese.  • In syphilis, pale treponema is found from the surface of the chancre or in the punctate of regional lymph nodes. In candidiasis, the Candida fungus is found in scrapings taken from the affected areas.  •Candidal perleche is distinguished from syphilitic one by the absence of infiltration at the base, the presence of thin gray scales around the erosions with small detachable or tender crusts.  **7.Differential diagnostics both of yeast and streptococcal perleches**  **Common symptoms:**  •Localization at the corners of the mouth  •Presence of cracks  • Painfulness  **Differences:**  • Yeast perleche occurs more often in the elderly. Streptococcal perleche is more common in children.  • In yeast perleche, gray transparent scales or tender crusts form in the corners of the mouth. Streptococcal perleche begins with the formation of a bubble (flikten) with a thin flaccid cover, in the place of which erosion then forms, covered with abundant purulent-bloody crusts  24  ***Fig.142*** *Yeast perleche*  • For streptococcal perleche, in contrast to mycotic one, abundant exudation and hyperemia, extending beyond the skin fold, are characteristic.  • In case of yeast perleche, Candida fungus is found in scrapings taken from the affected areas. In streptococcus perleche, streptococci are found in the scrapings.  04515520  ***Fig.143*** *Yeast perleche*  **8. Differential diagnostics of candidal cheilitis and lupus erythematosus**  **Common symptoms:**  • Feeling of burning and pain  • Defeat of the red border of the lips  **Differences:**  • In candidal cheilitis, grayish scales and small transverse situated cracks form on the hyperemic and edematous red border of the lips. In lupus erythematosus on the red border, oval foci of crimson-red color with atrophy in the center are formed, covered with hyperkeratotic, densely sitting whitish-gray scales or bloody-purulent crusts.  •After healing of foci in lupus erythematosus, atrophic scars may remain, which is not the case in candidiasis.  • The diagnosis of candidiasis is confirmed by the presence of accumulations of budding yeast-like cells and thin branching filaments of pseudomycelium in the scraping taken from the affected surface. The diagnosis of lupus erythematosus is confirmed by a histological method that reveals the phenomena of hyperkeratosis, acanthosis and atrophy.  • Lupus erythematosus, in contrast to candidiasis, is a long-term (for decades) ongoing disease.  **9.Differential diagnostics of candidiasis's perleche and perleche due to ariboflavinosis (hypo- and avitaminosis B2)**  **Common symptoms:**  •Presence of painful dry cracks without profuse exudation with grayish thin crusts  •The presence of cheilitis  **Differences:**  • In case of candidal perleche, the process is localized within the skin fold. In perleche due to ariboflavinosis, skin lesions (dermatitis) of the nasal wings (appearance of seborrheic crusts), nasolabial folds, eyelids in the form of redness, tongue (appearance of aphthous elements), eyes (photophobia, lacrimation, keratitis, ireitis, corneal opacity) are observed.  59281009  ***Fig.144*** *Mycotic perleche*  •Candidal perleche is observed mainly in the elderly with a lowered bite height due to improper prosthetics, expressed attrition of hard dental tissues or edentulous. All members of the population are susceptible to hypo- and avitaminosis, regardless of gender and age.  76632911  ***Fig.145*** *Candidal perleche*  •The diagnosis of candidiasis is confirmed by the detection of yeast-like fungi of the genus Candida in the scrapings taken from the lesion site. The diagnosis of vitamin deficiency is confirmed by a decrease in the excretion of riboflavin in the urine and its content in the blood.  •The course of perleche in ariboflavinosis is long, the skin of the corners of the mouth is lichenized, with small cracks.  **10.Differential diagnostics of acute pseudomembranous candidiasis and White sponge nevus of cannon**  **Common symptoms:**  •Lesions of white color with indistinct boundaries  •The surface of the lesions is removed by scraping  **Differences:**  •Candidiasis affects infants and the elderly, especially those who are weakened by chronic diseases. White spongy nevus occurs in early childhood and reaches its maximum development during puberty.  • The cause of candidiasis is yeast-like fungi of the genus Candida. White spongy nevus is hereditary pathology.  • In candidiasis, lesions are in the form of a plaque resembling curdled milk, located on a hyperemic, dry oral mucosa. In a white spongy nevus, the oral mucosa is strongly folded, sometimes so much that the folds hang down into the oral cavity. The defeat of the mucous membrane with a white spongy nevus is always symmetrical.  • The diagnosis of candidiasis is confirmed by the presence of fungi of the genus Candida in scrapings taken from the surface of the lesions.  •Candidiasis often affects the mucous membrane of the dorsum of the tongue, cheeks, palate, lips. The typical localization of a white spongy nevus is the buccal mucosa.  kandidoz-polosti-rta2  ***Fig.146*** *Candidiasis*  •In a white spongy nevus, in contrast to cadidiasis, the mucous membranes of the genitals and rectum are affected  **11. Differential diagnostics both of yeast and tuberculous perleches:**  **Common symptoms:**  • Erosion or ulcer coated with plaque in the corners of the mouth is  • Painfulness  **Differences:**  • In tuberculosis, the general condition of the patient is severe  • In tuberculous perleche in the corners of the mouth, there is an ulcer with undermined edges  • There is an active tuberculous process in the lungs  •Mycobacterium tuberculosis is detected in sputum  **12. Differential diagnostics of candidal glossitis and glossalgia:**  **Common symptoms:**  • Burning of the tongue, plaque  •Dryness in the mouth  **Differences:**  • In glossalgia, the burning sensation of the tongue disappears while eating  • In glossalgia, the burning sensation of the tongue in the evening, with a prolonged conversation, with nervous excitement increases  • In glossalgia, burning is observed mainly in the tip and lateral surfaces of the tongue, the tongue is without visible changes  **13. Differential diagnostics of candidal cheilitis and dry form of exfoliative cheilitis:**  **Common symptoms:**  • Burning, dryness of the lips  • Peeling the red border of the lips with small scales  **Differences:**  • In exfoliative cheilitis, the scales are tightly attached in the center to the red border of the lips and lag behind at the edges  • In exfoliative cheilitis, the lesion looks like a tape from corner to corner of the mouth, strictly along the Klein line  **14. Differential diagnostics of candidal cheilitis and atopic cheilitis:**  **Common symptoms:**  •Itching , burning sensation, difficulty opening the mouth  • Hyperemia, edema of the red lips' borders  **Differences:**  • The course of atopic cheilitis is long-term  •An allergological study of atopic cheilitis reveals polyallergy  • In atopic cheilitis, skin lesions are simultaneously observed  **15. Differential diagnostics of acute atrophic, pseudomembranous, chronic hyperplastic candidiasis with the same forms of candidiasis associated woth HIV infection:**  **Common symptoms:**  • The clinical picture corresponds to the forms of candidiasis  **Differences:**  •In the same forms of candidiasis associated with HIV infection, an increase in lymph nodes is observed  • In the same forms of candidiasis associated with HIV infection, threre are positive serological reactions to HIV  • In the same forms of candidiasis associated with HIV infection, the course of the disease is long-term, persistent, does not respond to conventional treatment  **Changes of the oral mucosa in hypovitaminosis**  **Deficiency of ascorbic acid (scorbut), vitamins of B, PP groups should be differentiated from:**  **1. Vincent's ulcerative necrotizing stomatitis**  **2.Changes of the oral mucosa in acute leukemia**  **3.Hypertrophic gingivitis**  **4. Thrombocytopenic purpura**  **5.Allergic catarrhal and catarrhal-hemorrhagic stomatitis**  **6. Candidiasis (acute atrophic) associated with HIV infection**  **7. Impetigo**  **8. Candidiasis**  **9. Desquamative glossitis**  **10. Rhomboid glossitis**  **1.Differential diagnostics of hypovitaminosis C and Vincent 'sulcerative – necrotizing stomatitis**  **Common symptoms:**  •Development of ulcerative gingivitis and stomatitis  •Sharp bleeding and looseness of the gingiva  •Deterioration of the general condition of the patient  • Mobility of teeth and their and loss  • Bad breath  **Differences:**  • The etiology of Vincent’s ulcerative necrotizing stomatitis is an infection caused by the symbiosis of the fusiform bacillus and the Vincent's spirochete. A disease caused by a lack or incomplete absorption of vitamin C is scorbutus.  • Vincent's stomatitis develops more often in young men (17-30 years old). Scorbut is more common in children.  • In scorbutus, in contrast to Vincent’s ulcerative necrotizing stomatitis , patients have cyanosis of the ears, nose, lips, fingers, nails.  • In scorbutus , in contrast to Vincent’s ulcerative necrotizing stomatitis , hemorrhages in the hair's follicles of the skin, in the mucous membranes, subcutaneous tissue, in muscles, joints occur.    ***Fig.147*** *Petechiae on the oral mucosa in scorbutus*  A rash of a bright red color is formed first, then blue-black one on the legs, thighs, buttocks.  •In n Vincent’s ulcerative necrotizing stomatitis , the edge of the gums becomes necrotic, becomes uneven, covered with a grayish-yellow plaque. In scorbutus , the interdental papillae (of the present teeth) swell, and spongy blue-purple growths (hemorrhages) appear around the teeth in the form of ridges.  • In scorbutus, hypochromic anemia develops, a decrease in the level of ascorbic acid in the blood is observed.  **2.Differential diagnostics of hypovitaminosis C and acute leukemia**  **Common symptoms:**  •Deterioration of the general condition of the patient  •Hematomas and hemorrhages of the oral mucosa  • Bleeding and gingival hyperplasia  •Necrosis of the gingival margin  **Differences:**  • In hypovitaminosis C, the gums are edematous , hyperemic. In acute leukemia, the oral mucosa is pale, anemic, pasty.  • In hypovitaminosis C, the skin becomes dark, dry, and easily peels off. In acute leukemia, pallor of the skin is observed.  • In scorbutus , hypochromic anemia develops, a decrease in the level of ascorbic acid in the blood is observed. The results of blood tests are decisive in the diagnosis of leukemia.  **3.Differential diagnostics of hypovitaminosis C and hypertrophic gingivitis**  **Common symptoms:**  •Gingival overgrowth  •Bleeding of gums (in edematous form, and no bleeding in fibrous form)  **Differences:**  •In hypovitaminosis C, mobility and loss of teeth, as well as an ulcerative-necrotic process, are observed. In hypertrophic gingivitis, these symptoms are absent.  • **In** scorbutus**,** hypochromic anemia develops, a decrease in the level of ascorbic acid in the blood is observed.  **4.Differential diagnostics of hypovitaminosis C and thrombocytopenic purpura**  **Common symptoms:**  •Hemorrhages in the skin, mucous membranes  **Differences:**  •In hypovitaminosis C, the gums are edematous , hyperemic. Thrombocytopenic purpura is characterized by pale, anemic, pasty oral mucosa.  • For thrombocytopenic purpura, hemorrhages in the retina of the eyes, heart, brain, and nosebleeds are characteristic.  •The skin in hypovitaminosis C becomes dark, dry, easily peels off.    ***Fig.148*** *Hypovitaminosis C (dryness of the oral mucosa and red border of the lips)*  In thrombocytopenic purpura, pallor of the skin is observed.  • In scorbutus , hypochromic anemia develops, a decrease in the level of ascorbic acid in the blood is observed.  The results of a blood test are decisive in the diagnosis of thrombocytopenic purpura.  • Thrombocytopenic purpura is more common in young women. Hypovitaminosis C does not depend on age and gender.  **5.Differential diagnostics of hypovitaminosis B, C and allergic catarrhal and catarrhal-hemorrhagic stomatitis**  **Common symptoms:**  • Edema and hyperemia of the oral mucosa and tongue  •Hemorrhagic syndrome  •Itching, burning  **Differences:**  • In hypovitaminosis, in contrast to allergy, paresthesias, neurotic conditions, neurodermatitis, seborrheic dermatitis, weakness, malaise, apathy**,** drowsiness are observed  •In the etiology of catarrhal and catarrhal-hemorrhagic stomatitis, taking of medications is revealed.  **6.Differential diagnostics of hypovitaminosis B, C and candidiasis (acute atrophic) associated with HIV infection**  **Common symptoms:**  • Edema and hyperemia of the oral mucosa and tongue  •Itching, burning  • Malaise, weight loss, weakness  **Differences:**  • In hypovitaminosis B, C, in contrast to candidiasis (acute atrophic)associated with of HIV infection, paresthesias, neurotic conditions, neurodermatitis, seborrheic dermatitis are observed  • in candidiasis (acute atrophic) associated with HIV infection, a plaque is found in the deep folds of the oral cavity, which is easily removed by scraping. In hypovitaminosis B, C, the mucous membrane is without plaque, hemorrhages are noted on it.  ***Fig.149*** *Angular cheilitis*  • In candidiasis (acute atrophic) associated with HIV infection, spores and mycelium of the fungus of the genus Candida are found in scrapings taken from the surface of the oral mucosa. The diagnosis is also confirmed by immunosorbent assay and immunoblotting. The deficiency of vitamins B, C is confirmed by the results of blood tests.  **7. Differential diagnostics of hypovitaminosis (B2, B6) (perleche) and impetigo**  **Common symptoms:**  •Painful cracks in the mouth's corners  **Differences:**  • The causative agent of impetigo are staphylococci or streptococci. The reason of hypovitaminosis is insufficient intake of vitamin into the body or a deteriation of its absorption.  • Impetigo is more common in children. All members of the population, regardless of age, are susceptible to hypovitaminosis.  • In impetigo erosions are moist with abundant oozing lymph and are covered with abundant golden-yellow "honey" crusts. In vitamin deficiency – they are dry, without abundant exudation, with small grayish crusts.  • Hypovitaminosis B2, in contrast to impetigo,is manifested in the form of a triad: dermatitis (peeling, redness and seborrheic crusts on the nasal wings, nasolabial folds, eyelid skin), cheilitis (peeling, painful and bleeding vertical cracks of the red lips border), glossitis (the tongue is bright - red, smooth, shiny and dry).  And also there is injury to the eyes (photophobia, lacrimation, iritis, keratitis, corneal opacity).  In hypovitaminosis B6, in contrast to impetigo, **apathy**, drowsiness, increased excitability, peripheral neuritis, neurodermatitis, glossitis, glossalgia, seborrheic dermatitis, and cheilitis develop.  **8.Differential diagnostics of hypovitaminosis B2 (perleche) and candidal perleche**  **Common symptoms:**  •Presence of painful dry perleches without profuse exudation with grayish thin crusts  •The presence of cheilitis  **Differences:**  • In candidiasis, the process is localized within the skin fold.  In avitaminosis, skin lesions (dermatitis) of the nasal wings (appearance of seborrheic crusts), nasolabial folds, eyelids in the form of redness, tongue (appearance of aphthous elements), eyes (photophobia, lacrimation, keratitis, iriitis,  corneal opacity) are observed.    ***Fig.150*** *Hypovitaminosis B2 ("angular cheilitis" perleche)*  • Candidal perleche is observed mainly in elderly people with a lowered bite height due to improper prosthetics, expressed attrition of hard dental tissues or edentulous.  All layers of the population, regardless of gender and age, are susceptible to hypo- and avitaminosis.  • The diagnosis of candidiasis is confirmed by the detection of yeast-like fungi of the genus Candida in scrapings taken from the lesion site. The diagnosis of vitamin deficiency is confirmed by a decrease in the excretion of riboflavin in the urine and in the blood content.  **9. Differential diagnostics of hypovitaminosis B2, B 6, B 12 and desquamative glossitis**  **Common symptoms:**  • Defeat of the tongue  **Differences:**  • In hypovitaminosis B2 and B6, in contrast to desquamative glossitis, there are lesions of the skin (in the form of redness, peeling, cracks, crusts, erosions),and eyes, cheilitis, neuritis, neurodermatitis.    ***Fig.151*** *Hypovitaminosis B2*  • In hypovitaminosis B12, in contrast to desquamative glossitis, there are dysfunctions of the digestive tract, nervous system and hematopoiesis.  • In desquamative glossitis, desquamation sites alternate with areas of normal mucosa ("geographic tongue").  In B hypovitaminosis, the tongue is bright red, smooth, shiny ("polished tongue").  **10.Differential diagnostics of rhomboid glossitis and hypovitaminosis (B2, PP, B12)**  **Common symptoms:**  •Defeat of the tongue  **Differences:**  • Rhomboid glossitis is more common in men (smokers and alcohol abusers). Hypovitaminosis occurs equally often in different age groups.  • In rhomboid glossitis, the lesion is located closer to the root of the tongue along the midline, clearly delimited from the rest of the areas, is slightly compacted.  In hypovitaminosis PP, B2 and B12, the tongue becomes bright red, smooth, shiny and dry, the papillae become atrophic.    ***Fig.152*** *Hypovitaminosis PP ("pellagra" tongue)* ***Fig.153*** *Rhomboid glossitis*  •For hypovitaminosis B2, dermatitis, cheilitis are characteristic.  For hypovitaminosis PP, dementia, diarrhea, dermatitis are characteristic.    ***Fig.154*** *Pellagra (hypovitaminosis PP)*  For hypovitaminosis B12, defeat of the peripheral nerves is characteristic.  All of these signs are absent in case of rhomboid glossitis.  **Changes of the oral mucosa in cardiovascular diseases (CVD)**  **Edema and discoloration of the oral mucosa in CVD is differentiated from :**  **1.Edematous condition of the oral mucosa in pathology of the gastrointestinal tract (GIT)**  **2.Catarrhal stomatitis (infectious)**  **3.Allergic medication- induced catarrhal stomatitis**  **1.Differential diagnostics of an edematous condition and discoloration of the oral mucosa in CVD and an edematous state of the oral mucosa in gastrointestinal pathology:**  **Common symptoms:**  • Edema of the mucous membranes of the mouth, tongue, discomfort  • Feeling of enlargement of the tongue, its biting  **Differences:**  • In case of pathology of the gastrointestinal tract, there are no phenomena of cardiovascular insufficiency, circulatory disorders, general symptoms (shortness of breath, weakness)  • In case of pathology of the gastrointestinal tract ,corresponding pathologies are revealed  **2. Differential diagnostics of edema and discoloration of the oral mucosa in CVD and catarrhal infectious stomatitis:**  **Common symptoms:**  • Burning, pain and hyperemia of the oral mucosa  **Differences:**  •Catarrhal stomatitis is a consequence of trauma with decayed teeth, dental deposits, observed in acute respiratory infections (ARVI, influenza)  • In catarrhal infectious stomatitis, intoxication phenomena are possible (fever, general weakness)  • In case of catarrhal infectious stomatitis, the pathology of the cardiovascular system is not determined  **3. Differential diagnostics of edematous condition and discoloration of the oral mucosa in CVD and allergic medication- induced catarrhal stomatitis**  **Common symptoms:**  • Burning of the oral mucosa, pain when eating the irritating food  **Differences:**  • In case of allergic medication- induced catarrhal stomatitis, catarrhal inflammation develops after taking a medication due to an allergic reaction of a delayed type  • In case of allergic medication- induced catarrhal stomatitis, discontinuation of the causal medication leads to the disappearance of catarrhal phenomena  • In case of allergic medication- induced catarrhal stomatitis, in contrast to pathologies in CVD, the oral mucosa is deep red, without cyanosis  •In case of allergic medication- induced catarrhal stomatitis, the pathology of the cardiovascular system is not determined  **Vesicovascular syndrome of the oral cavity is differentiated from :**  **1.Acantolytic pemphigus**  **2.Angioma**  **3.Erythema multiforme**  **4. Hemangioma**  **5. Bullous pemphigoid**  **6.Bullous lichen planus**  **7.Medication -induced stomatitis**  **1.Differential diagnostics of Vesicovascular syndrome and pemphigus vulgaris**  **Common symptoms:**  •Bubbles formation on the mucous membrane, the presence of erosions  •Predominantly middle-aged and elderly people are affected  **Differences:**  • Bubbles in Vesicovascular syndrome are subepitelial and dense and can exist unchanged from several hours to several days.  In acantholytic pemphigus, the bubbles are intraepithelial, not solitar , have a very thin cover and quickly burst, it is extremely rare to see them in the oral cavity (more often the remnants of the bubble cover are visible).  • In contrast to pemphigus vulgaris , the occurrence of bubbles in the Vesicovascular syndrome is associated with an increase in blood pressure.  • In the Vesicovascular syndrome, erosions are epithelized within 3-7 days.  In pemphigus vulgaris , painful erosions are formed and don’t have a tendency to heal.  • In pemphigus vulgaris, in contrast to the Vesicovascular syndrome, the skin is affected.  • In case of Vesicovascular syndrome, in contrast to pemphigus vulgaris, there are no acantholytic cells in smears - prints taken from the area of erosion, Nikolsky's symptom is negative.  **2.Differential diagnostics of Vesicovascular syndrome and senile angioma**  **Common symptoms:**  • Prevalence among the elderly  •Hypertension  **Differences:**  • The appearance of bubbles in the Vesicovascular syndrome is associated with an increase in blood pressure.  • Vesicovascular syndrome occurs more often in women. Senile angioma is equally common in men and women.  • In Vesicovascular syndrome, dense bubbles appear, after rupture of which erosions are formed.  In senile angioma, bluish nodules of a pinhead-lentil size are formed.  • In senile angioma, in contrast to the Vesicovascular syndrome, multiple ruby-colored spots and nodules are formed on the trunk and extremities.  **3.Differential diagnostics of Vesicovascular syndrome and erythema multiforme**  **Common symptoms:**  •Presence of bubbles and erosions on the oral mucosa  • Same localization of the bubbles  **Differences:**  • Erythema multiforme is more common in men aged 20-40 years. Vesicovascular syndrome often occurs in women aged 40-75 years.  • The appearance of bubbles in the Vesicovascular syndrome is associated with an increase in blood pressure. Erythema multiforme has an infectious or toxic-allergic nature.  • In erythema multiforme, in contrast to the Vesicovascular syndrome, skin lesions in the form of cockades are observed,there is polymorphism  • Bubbles in Vesicovascular syndrome are dense and can exist unchanged from several hours to several days.    ***Fig.155*** *Vesicovascular syndrome in hypertension*  In erythema multiforme, the bubbles quickly burst, the remains of the bubbles' covering are visible.  • Erythema multiforme is characterized by exacerbation periods in the autumn-spring.  **4.Differential diagnostics of Vesicovascular syndrome and hemangioma:**  **Common signs:**  • Blue-colored, solitary formation on the oral mucosa  **Differences:**  •Hemangioma refers to tumor processes  •Hemangioma often develops in childhood, increases slowly. Vesicovascular syndrome occurs more often in women 40-75 years old, occurs suddenly  •In hemangioma, there is a filling symptom - an increase in hematoma when the head is down and a symptom of compression - whitening of the formation when pressed  **5. Differential diagnostics of vesicular -vascular syndrome and bullous pemphigoid:**  **Common signs:**  •Painless formation of the bubbles onthe oral mucosa  •Persons over 50 years of age are ill  •Nikolsky's symptom is negative, no acantholytic cells  **Differences:**  •Bullous pemphigoid may cause skin injury  •In bullous pemphigoid, several bubbles appear  **6. Differential diagnostics of vesicovascular syndrome and bullous form of lichen planus:**  **Common signs:**  •Bubbles on the mucous membrane  • Middle-aged and elderly people are affected  **Differences:**  •In lichen planus, the bubbles are not solitar , papules are located around the lesions in the form of a mesh  • In lichen planus erosions are sharply painful, with indistinct contours  **Trophic ulcers are differentiated from :**  **1. Traumatic ulcer**  **2.Cancerous ulcer**  **3.Tuberculous ulcer**  **4 Vincent's ulcerative- necrotizing stomatitis**  **5.Necrotic lesions of the oral mucosa in blood diseases**  **6.Allergic ulcerative -necrotizing stomatitis**  **7.Chronic recurrent aphthous stomatitis**  **1.Differential diagnostics both of trophic and traumatic ulcers**  **Common symptoms:**  •Presence of solitary ulcers  •Necrotic plaque on the surface of the ulcers  •Pain when eating, talking  **Differences:**  • A trophic ulcer differs from a traumatic ulcer in a more sluggish course, mild symptoms of inflammation.  • In trophic ulcers, in contrast to traumatic ulcers, the general condition of the patient is sharply disturbed.  • Rapid healing of the ulcer after elimination of the irritant and its epithelisation indicate the traumatic origin of the ulcer.  Trophic ulcers after elimination of the traumatic factor do not tend to heal if general therapy is not carried out.  • In trophic ulcers, the necrotic process can spread to neighboring areas of the face, nasopharynx, jaw bone tissue (through cheek defects, severe bleeding are possible).  • Traumatic ulcer has undermined edges and is located on a hyperemic, edematous mucous membrane  **2.Differential diagnostics both of trophic and cancerous ulcers**  **Common symptoms:**  • Prevalence among the elderly  •Lack of inflammation around the ulcers  • The ulcer does not heal for a long time  **Differences:**  • A trophic ulcer has uneven edges and a floor covered with a grayish-white necrotic plaque.  The cancerous ulcer is painless , deep, has a dense granular floor and elevated , inverted dense edges, covered with either a dense plaque or bloody purulent crusts. Vegetation is possible on the surface of a cancerous ulcer  • In cancer, atypical epithelial cells are found in scrapings taken from ulcers and punctate of lymph nodes.  • In trophic ulcers, the necrotic process can spread to neighboring areas of the face, nasopharynx, jaw bone tissue (perforating cheek defects, severe bleeding are possible).  • In trophic ulcers, patients complain of severe pain in the mouth.  **3.Differential diagnostics both of trophic and tuberculous (biliary- ulcerative tuberculosis) ulcers**  **Common symptoms:**  •Localization at the sites of greatest injury  •Presence of painful ulcers that cause difficulty to eat  •Deterioration of the general condition of patients  • Enlargement of regional lymph nodes  **Differences:**  **•** The tuberculous ulcer has a granular floor with a yellowish plaque, the tissues surrounding the ulcer are edematous.  Trophic ulcers, covered with a grayish-white necrotic plaque, are located on the areactive mucous membrane without an expressed inflammatory reaction.  • In tuberculosis, hypersalivation is observed. In trophic ulcers – hyposalivation is observed.  • Trophic ulcers, in contrast to tuberculosis, can affect the nasopharynx, face, upper parts of neck, jaw bones, form perforating defects in the cheek, and cause severe bleeding.  • In tuberculosis, in scrapings taken from ulcers, during cytological examination, giant Pirogov-Langhans cells and epithelioid cells are revealed, while staining according to Ziehl-Nielsen, Koch's bacilli are found.  A cytological examination of scrapings taken from the surface of a trophic ulcer determines a small number of epithelial cells with signs of degeneration.  • In patients with trophic ulcers, in contrast to patients with tuberculosis, the oral mucosa is pale, with a cyanotic shadow.  **4.Differential diagnostics of trophic ulcers and Vincent's ulcerative- necrotizing stomatitis**  **Common symptoms:**  • Deterioration of the general condition of patients  • Painfulness of ulcers  •Ulcerous -Necrotic lesions of the oral mucosa  **Differences:**  • Vincent's ulcerative- necrotizing stomatitis is an infectious disease caused by fusobacteria and spirochetes. Trophic ulcers occur in diseases of the cardiovascular system.  • In Vincent’s ulcerative necrotizing stomatitis , the mucous membranesof the gums, retromolar region, and cheeks are more often affected. Trophic ulcers often affect the mucous membranes of the tongue, cheeks, palate, floor of the mouth.  • The mucous membrane around the ulcers in Vincent’s ulcerative necrotizing stomatitis is edematous, hyperemic. There is no inflammatory reaction of the mucous membrane around trophic ulcers.  • In trophic ulcers, the necrotic process can spread to neighboring areas of the face, nasopharynx, jaw bone tissue (through cheek defects, severe bleeding are possible).  • Vincent’s ulcerative necrotizing stomatitis has an acute onset and often occurs in the autumn-spring period.  •In Vincent’s ulcerative necrotizing stomatitis , fusobacteria and spirochetes are found in scrapings taken from the surface of ulcers.  • Healing of trophic ulcers does not occur without treatment of the underlying disease.  • Vincent’s ulcerative necrotizing stomatitis affects mainly young people  **5. Differential diagnostics of trophic ulcers and necrotic lesions of the oral mucosa in blood diseases (acute leukemia, agranulocytosis)**  **Common symptoms:**  • Lack of inflammation around the ulcers  • Ulcerative necrotic lesions of the oral mucosa  • Painful ulcers with uneven edges, covered with necrotic plaque  •Tendency to spread to adjacent areas of the mucous membrane  • Deterioration of the general condition of patients  **Differences:**  • Trophic ulcers often affect the mucous membranes of the tongue, cheeks, palate, floor of the mouth. Ulcers in blood diseases are localized on the gums, lips, tonsils, in the retromolar region.  •In trophic ulcers, there may be perforating defects of the cheek  • The results of blood tests and bone marrow's punctate are decisive in the diagnosis of blood diseases.  •Gingival hyperplasia is characteristic for blood diseases  • Acute leukemia mainly affects children and young people  **6.Differential diagnostics of trophic ulcers and allergic ulcerative- necrotizing stomatitis**  **Common symptoms:**  • Painfulness when eating  • Ulcerative- necrotic lesions of the oral mucosa  • Bad breath  **Differences:**  • In the etiology of ulcerative necrotizing stomatitis, there was taking of medications ,and after their discontinuation, there is a rapid elimination of the clinical symptoms of the lesion. Trophic ulcers develop in patients with II-III degree of circulatory disorders.  • In ulcerative- necrotizing stomatitis, the oral mucosa is sharply hyperemic and edematous. In CVD, there is no inflammation of the oral mucosa.  • In allergic ulcerative-necrotizing stomatitis, the entire oral mucosa is affected. In CVD, ulcers are more often formed on the mucous membranes of the cheeks, the floor of the mouth, and the lateral surfaces of the tongue.  • In contrast to allergic stomatitis, in CVD the necrotic process can spread to adjacent areas of the face, nasopharynx with sequestration of the jaw bone tissue.  •In case of allergic ulcerative-necrotizing stomatitis, phenomena of general intoxication of the organism are observed  **7.Differential diagnostics of trophic ulcers and Chronic recurrent aphthous stomatitis :**  **Common symptoms:**  • Severely painful erosion on the mucous membrane  **Differences:**  •Aphthae have a round or oval shape with clear edges and a hyperemic halo in areas of the mucous membrane that are not normally keratinized  •In Chronic recurrent aphthous stomatitis, the general condition is not disturbed  • In Chronic recurrent aphthous stomatitis, the pathology of the cardiovascular system is not detected  **Changes of the oral mucosa in gastrointestinal diseases**  **1. Differential diagnostics of changes of the oral mucosa in gastrointestinal diseases and acute pseudomembranous candidiasis:**  **Common symptoms:**  • White plaque on the tongue, unpleasant sensations, roughness  **Differences:**  • In candidiasis, the plaque is easily removed by scraping with exposure of the hyperemic mucosa, the papillae of the tongue are smoothed  • In case of candidiasis, bacteriological examination determines the abundance of budding forms, mycelium, Candida's fungus  •Candidiasis is determined in persons with diabetes mellitus and who took antibiotics, cytostatics,  **2. Differential diagnostics of changes on the oral mucosa in gastrointestinal diseases and plane leukoplakia:**  **Common symptoms:**  • White plaque on the tongue, roughness, unusual appearance of the tongue  **Differences:**  • In leukoplakia, the focus of hyperkeratosis is not removed by scraping  • In case of leukoplakia, injury to other parts of the mucous membrane is possible, the patient has a feeling of tightness of the mucous membrane  •In the etiology of leukoplakia, the leading role belongs to local irritating factors: smoking, hot food, chewing the betel, nut, etc.  **3. Differential diagnostics of changes on the oral mucosa in gastrointestinal diseases and influenza, acute respiratory viral infections, tonsillitis:**  **Common symptoms:**  • Plaque of varying density on the tongue, discomfort  **Differences:**  • In case of influenza, ARVI and sore throat, plaque is a consequence of insufficient self-cleaning of the tongue, imbalance of exfoliation and the formation of epithelium of the tongue (slowing down the descavamation)  **4. Differential diagnostics of changes on the oral mucosa in gastrointestinal diseases and black hairy tongue:**  **Common symptoms:**  • Yellowish -brown, black plaque  **Differences:**  •In a black hairy tongue, there is hyperplasia of filiform papillae in the posterior third of the tongue up to 2 cm in size  • The color of the black hairy tongue depends on the vital activity of the pigment-forming bacteria  •In a black hairy tongue, a large number of leptotrichia is observed  **Changes of the oral mucosa in endocrine diseases**  **Addison's disease is differentiated from :**  **1.Congenital pigmentation of the oral mucosa in some peoples**  **2.Intoxication with salts of heavy metals**  **1. Differential diagnostics of Addison's disease and Congenital pigmentation of the oral mucosa in some peoples**  **Common symptoms:**  •Skin pigmentation  •Pigmentation of the oral mucosa without signs of inflammation  **Differences:**  • Addison's disease is the result of insufficient adrenal cortex function. Congenital skin pigmentation in some peoples is a feature of race,appears in childhood and persists throughout life.  • In Addison's disease, there is a deterioration in the general condition of patients.  **2.Differential diagnostics of Addison's disease and intoxication with the salts of heavy metals**  **Common symptoms:**  •Pigmentation of the oral mucosa  • Deterioration of the general condition of patients  **Differences:**  • Addison's disease is the result of insufficient adrenal cortex function. Intoxication with the salts of heavy metals is observed when working in hazardous industries, treatment with preparations of these salts  • In Addison's disease, in contrast to intoxication with the salts of heavy metals, the patients have no inflammation of the oral mucosa and subjective sensations.  • In case of intoxication with the salts of heavy metals, ulcerative-necrotizing gingivostomatitis develops in the oral cavity, signs of saturnism, "mercury tremor" are observed.  **Changes of the oral mucosa in diseases of the hematopoietic system**  **Acute leukemia is differentiated from:**  **1.Hypertrophic gingivitis of other etiology**  **2. Vincent's ulcerative- necrotizing stomatitis**  **3.Hypovitaminosis C**  **4. Intoxication with the salts of heavy metals**  **5. Trophic ulcers**  **6. Allergic ulcerative necrotizing stomatitis**  **1.Differential diagnostics of acute leukemia and hypertrophic gingivitis of other etiology**  **Common symptoms:**  •Gingival overgrowth  • Bleeding of gums (in case of edematous form)  •Painfulness (in case of edematous form)  **Differences:**  • In acute leukemia, gingival hyperplasia is more expressed in the area of all teeth on the inner (palatal and lingual) surface than on the vestibular.    ***Fig.156*** *Acute leukemia (hyperplastic syndrome)*  • In gingivitis of another etiology, gingival hypertrophy is observed mainly in the area of the anterior teeth of the maxilla and mandible from the vestibular surface.  • In acute leukemia, in contrast to hypertrophic gingivitis of another etiology, pallor, pastiness of the mucous membrane, hematomas, hemorrhages and ulcerative -necrotic processes on the gums are noted.    ***Fig.157*** *Acute leukemia (necrosis of the mucous membrane along the dental closing line)*  • Acute leukemia is characterized by a rapid increase in the gingival papillae.  •In acute leukemia, the general condition of the patient worsens  •Decisive in the diagnosis of leukemia are the results of blood tests  **2.Differential diagnostics of acute leukemia and Vincent's ulcerative -necrotizing stomatitis**  **Common symptoms:**  •Prevalence among young people (under 30 years old)  •Acute onset of disease  •Presence of large ulcers with jagged margins and covered with a dirty gray fetid plaque  •Presence of foci of necrosis on the oral mucosa  •Defeat of the same areas of the oral mucosa  **Differences:**  • Etiology of Vincent's ulcerative -necrotizing stomatitisis fusiform bacillus and spirochete (borrelia) of Vincent. The etiology of blood diseases has not yet been completely clarified.  • In patients with blood diseases, hyperplastic syndrome is observed: painless enlargement of the lymph nodes, liver, spleen, gums (hyperplasia is more expressed from the palatine or lingual surfaces), tonsils.  • In patients with blood diseases, in contrast to patients with Vincent’s ulcerative- necrotizing stomatitis , hemorrhagic syndrome is observed: small-pointed or small-spotted rashes on the skin and oral mucosa, extensive hemorrhages (on the mucous membrane of the cheeks along the dental closing line, tongue), profuse bleeding (from uterine,from nose, socket of the extracted tooth, gum, tongue).    ***Fig.158*** *Acute leukemia*  • Patients with blood diseases, in contrast to patients with Vincent’s ulcerative- necrotizing stomatitis , may have pain in intact teeth, jaw, bones, pallor of the skin, loss of taste perception of the tongue.  • In Vincent’s ulcerative- necrotizing stomatitis , the mucous membrane around the ulcers is swollen and hyperemic. In acute leukemia, the gums around the necrosis have a bluish color, while the entire oral mucosa is pale, anemic.  • In Vincent’s ulcerative necrotizing stomatitis , in contrast to acute leukemia, the ulcerative-necrotic process in the oral cavity can spread to the bone tissue.  **3.Differential diagnostics of acute leukemia and hypovitaminosis C**  **Common symptoms:**  •Deterioration of the general condition of the patient  •Hematomas and hemorrhages of the oral mucosa  • Gingival bleeding and hyperplasia  •Necrosis of the gingival margin  **Differences:**  • In hypovitaminosis C, the gums are edematous, hyperemic. In acute leukemia, the oral mucosa is pale, anemic, pasty.  •The skin in hypovitaminosis C becomes dark, dry, easily peels off. In acute leukemia, pallor of the skin is observed.  • In scorbutus, hypochromic anemia develops, a decrease in the level of ascorbic acid in the blood is observed. The results of blood tests are decisive in the diagnosis of leukemia.  **4. Differential diagnostics of acute leukemia and intoxication with the salts of heavy metals**  **Common symptoms:**  •Ulcerative-necrotic processes of the oral mucosa  • Deterioration of the general condition of the patients  **Differences:**  • In case of intoxication with the salts of heavy metals, the gums are edematous, hyperemic. In acute leukemia, the oral mucosa is pale, anemic, pasty.  •In case of intoxication with the salts of heavy metals, there are signs of saturnism, "mercury tremor", "lead colic", a metallic taste in the mouth.  • The results of blood tests are decisive in the diagnosis of leukemia.  • In contrast to leukemia, in intoxication with the salts of heavy metals, pigmentation in the form of a black border is observed on the oral mucosa.  • In acute leukemia, gingival hyperplasia is observed in the area of all teeth, which is more expressed from the inner (palatal and lingual) surface.  **5.Differential diagnostics of acute leukemia and trophic ulcers**  **Common symptoms:**  •Lack of inflammation around the ulcers  •Necrotic lesions of the oral mucosa  • Painful ulcers with uneven edges, covered with necrotic plaque  • Tendency to spread to adjacent areas of the mucous membrane  • Deterioration of the general condition of the patients  **Differences:**  • Trophic ulcers often affect the mucous membranes of the tongue, cheeks, palate, floor of the mouth. Ulcers in blood diseases are localized on the gums, lips, tonsils, in the retromolar region.  •In trophic ulcers, there may be perforating defects of the cheek  • The results of blood tests and bone marrow punctate are decisive in the diagnosis of blood diseases.  •Gingival hyperplasia is characteristic of blood diseases  **6.Differential diagnostics of acute leukemia and allergic ulcerative- necrotizing stomatitis**  **Common symptoms:**  • Deterioration of the general condition of the patients  • Ulcerative- necrotic lesions of the oral mucosa  •Painful eating and swallowing  **Differences:**  • In ulcerative -necrotizing stomatitis, the oral mucosa is sharply hyperemic and edematous. In diseases of the blood, the oral mucosa is pale, anemic, there is no inflammation.  •In the etiology of ulcerative- necrotizing stomatitis, there was taking of medications and after their discontinuation, there is a rapid elimination of the clinical symptoms of the lesion.  • The results of blood tests are decisive in the diagnosis of blood diseases.  • Ulcers in blood diseases, in contrast to allergic ones, have a putrid fetid odor, and the jaw bone tissue may be involved in the ulcerative-necrotic process.  **Agranulocytosis is differentiated from :**  **1. Vincent's ulcerative -necrotizing stomatitis**  **2.Other blood dyscrasias**  **1.Differential diagnostics of agranulocytosis and Vincent's ulcerative -necrotizing stomatitis**  **Common symptoms:**  •Acute onset of the disease  • Defeat of the same areas of the oral mucosa  • Spreading of the ulcerative -necrotic process to the bone tissue  •Presence of bleeding fetid ulcers  **Differences:**  • In agranulocytosis, in contrast to Vincent’s ulcerative necrotizing stomatitis , there is no inflammatory reaction of the tissues surrounding the foci of necrosis.    ***Fig.159*** *Agranulocytosis (necrosis of the gingival margin)*  • In agranulocytosis, in contrast to Vincent’s ulcerative necrotizing stomatitis , ulcers appear along the digestive tract.  •The results of blood tests are decisive in the diagnosis of blood diseases  **2.Differential diagnostics of agranulocytosis and other blood diseases**  **Common symptoms:**  •Lack of inflammation around the ulcers  •Necrotic lesions of the oral mucosa  •Painful ulcers with uneven edges, covered with necrotic plaque  • Tendency to spread to adjacent areas of the mucous membrane  •Deterioration of the general condition of the patients  **Differences:**  • The results of blood tests and bone marrow punctate are decisive in the diagnosis of blood diseases.  **Thrombocytopenic purpura is differentiated with:**  **1. Hemophilia**  **2.Scorbut (hypovitaminosis C)**  **3.Hemorrhagic vasculitis (Schönlein-Henoch disease)**  **1.Differential diagnostics of thrombocytopenic purpura and hemophilia**  **Common symptoms:**  • Hemorrhages in the skin, mucous membranes, muscles, joints, internal organs  • Bleeding due to minor trauma  **Differences:**  • Hemophilia is a hereditary disease characterized by blood clotting disorders, more often men suffer. Thrombocytopenic purpura is more common in young women.    ***Fig.160*** *Petechiae on the lateral surface of the tongue in thrombocytopenic purpura*  • In contrast to thrombocytopenic purpura, hemophilia is characterized by the formation of contractures and ankylosis.  • The results of blood tests and bone marrow punctate are decisive in the diagnosis of blood diseases.  **2.Differential diagnostics of thrombocytopenic purpura and scorbutus**  **Common symptoms:**  •Hemorrhages in the skin, mucous membranes  **Differences:**  • In hypovitaminosis C, the gums are edematous, hyperemic. Thrombocytopenic purpura is characterized by pale, anemic, pasty oral mucosa.  • For thrombocytopenic purpura, hemorrhages in the retina of the eyes, heart, brain, and nosebleeds are characteristic.  • In hypovitaminosis C, the skin becomes dark, dry, and easily peels off. In thrombocytopenic purpura, pallor of the skin is observed.  • In scorbutus , hypochromic anemia develops, a decrease in the level of ascorbic acid in the blood is observed. The results of blood tests are decisive in the diagnosis of thrombocytopenic purpura.  • Thrombocytopenic purpura is more common in young women. Hypovitaminosis C does not depend on age and gender.  **3.Differential diagnostics of thrombocytopenic purpura and hemorrhagic vasculitis**  **Common symptoms:**  •Hemorrhages in the skin, mucous membranes  •General malaise  •Pallor, pasty skin  • Temperature rise  **Differences:**  •Hemorrhagic vasculitis affects children of 4-7 years old, adolescents or men, more often in the spring. Thrombocytopenic purpura is more common in young women.  • In hemorrhagic vasculitis, symmetrical rashes of bright red and bluish-purple color appear more often on the buttocks, legs, and feet. Complications are observed in the form of glomerulonephritis, abdominal syndrome, polyarthritis, gastrointestinal lesions. These symptoms are absent in thrombocytopenic purpura.  •The results of blood tests and bone marrow punctate are decisive in the diagnosis of blood diseases.  **Changes in the oral mucosa in diseases of the nervous system**  **Stomalgia (glossalgia) is differentiated with:**  **1.Neuralgia of the lingual nerve**  **2.Neuropathy of the lingual nerve**  **3.Acute or chronic trauma of the tongue and other parts of the mucous membrane**  **4.Allergy to plastic**  **5. Desquamative glossitis**  **6. Candidiasis**  **7. Glossitis associated with vitamin B12-folate-deficiency anemia**  **8 .Tumor, abscess of the tongue**  **9.Neuritis of the lingual nerve**  **1.Differential diagnostics of stomalgia and neuralgia of the lingual nerve**  **Common symptoms:**  •Pain in the tongue  •Dysgeusia (disorder of taste sensitivity)  **Differences:**  •Stomalgia is more common among women.  • In patients with stomalgia, the daily rhythm of the onset of pain is clearly traced: pain appears in the morning, intensify during the day and reach a maximum in the evening. Neuralgia is characterized by lightning(fulminant) pain, independent of the time of day (suddenly starting and just as suddenly stopping).  There is a severe paroxysmal pain in one half of the tongue that occurs suddenly while eating, talking, radiating along the nerve.  • Stomalgia is characterized by the disappearance of all painful manifestations during the intake of hot and spicy food. This symptom is not typical for neuralgia.  • In neuralgia, there is a trigger zone  • In neuralgia, it is often revealed from history: severe hypothermia  **2.Differential diagnostics of stomalgia and neuropathy of the lingual nerve**  **Common symptoms:**  •Pain in the tongue  •Dysgeusia (disorder of taste sensitivity)  **Differences:**  •Stomalgia is more common among women.  •In patients with stomalgia, the daily rhythm of the onset of pain is clearly traced: they appear in the morning, intensify during the day and reach a maximum in the evening. This symptom is not typical for neuropathy.  • Stomalgia, in contrast to neuropathy, is characterized by the disappearance of all painful manifestations during the intake of hot and spicy food. Neuropathy is characterized by a decrease in tactile sensitivity and a lack of pain sensitivity (anaesthesia of the tongue).  **3. Differential diagnostics of stomalgia and acute or chronic trauma of the tongue and other parts of the mucous membrane:**  **Common symptoms:**  •Pain, burning  **Differences:**  •In acute or chronic trauma of the tongue and other parts of the oral mucosa, the pain is constant, localized, aggravated by eating, talking. In stomalgia, pain when eating the food disappears  • In case of injuries, when examining the tongue and mucous membrane, a traumatic factor (sharp edges of the teeth, prosthesis), hyperemia, erosion or ulcer on the mucous membrane, respectively, are revealed.  •In case of injury, by the elimination of the traumatic factor, the pain disappears  **4. Differential diagnostics of stomalgia and allergy to plastic:**  **Common symptoms:**  • Burning sensation in the tongue, gums, mucous membranes of the lips, palate, prosthetic bed  **Differences:**  •In case of allergy, a burning sensation occurs shortly after the using of removable acrylic dentures. Edema and hyperemia of the oral mucosa correspond to the boundaries of the prosthesis.  • In case of allergy, complaints and hyperemia disappear in a few days after stopping the use of prostheses.  •In case of allergy, allergic tests for plastic are positive  **5. Differential diagnostics of stomalgia and desquamative glossitis:**  **Common symptoms:**  • Burning, pain in the tongue  **Differences:**  • In contrast to stomalgia, in desquamative glossitis, pain in the tongue appears and intensifies when eating the irritating food.  • In desquamative glossitis on the dorsum of the tongue,there observed desquamation foci in the form of reddish spots with a tendency to permanent migration. In stomalgia, there are no visible changes in the tongue  **6. Differential diagnostics of stomalgia and candidiasis:**  **Common symptoms:**  •Burning in the tongue and other parts of the oral mucosa  •Dryness in the mouth  **Differences:**  • Candidiasis does not depend on age and gender. Stomalgia is common among women in menopause  • In the history of candidiasis,there is diabetes mellitus, a taking of antibiotics, glucocorticosteroids,  • In candidiasis, the tongue and oral mucosa are hyperemic, white plaque is visible. In stomalgia, there are no visible changes in the tongue  •In case of candidiasis, bacterioscopy reveals abundant contamination with Candida's fungus, mycelium, blastospores  **7. Differential diagnostics of stomalgia and glossitis associated with vitamin B12-folate deficiency anemia:**  **Common symptoms:**  • Burning, pain in the tongue  **Differences:**  •Anemia occurs due to achilic gastritis  • In anemia, there are complaints of severe pain when eating the irritating food. In stomalgia, the pain subsides when eating  •In case of anemia, the tongue is crimson, on the mucous membrane there are crimson spots and stripes. In stomalgia, there are no visible changes in the tongue and mucous membrane  •In case of anemia, there is a rapid effect of parenteral administration of vitamin B12  **8.Differential diagnostics of stomalgia and tumors and abscess of the tongue:**  **Common symptoms:**  • Pain in the tongue  **Differences:**  • In tumors and abscess of the tongue, the patient has fuzzy speech (he spares the tongue)  • In tumors and abscess of the tongue, due to its low mobility, the tongue is coated with a thick plaque. In stomalgia, there are no visible changes in the tongue  • In case of tumors and abscess of the tongue, palpation determines its thickening, density, painfulness  **9.Differential diagnostics of stomalgia and neuritis of the lingual nerve:**  **Common symptoms:**  • Pain in the tongue  **Differences:**  • In neuritis, mainly the anterior 2/3 part of the tongue is affected as a result of trauma during mandibular anesthesia, traumatic extraction of the lower wisdom tooth, as a complication of an acute infectious disease, hypothermia.  • In neuritis, the pain is constant, aggravated by eating, talking. In stomalgia, pain during eating disappears.  • In neuritis, the pain is accompanied by paresthesias, loss of pain, tactile, temperature sensitivity in the corresponding half of the tongue  **Changes of the oral mucosa in dermatoses**  **The pemphigus is differentiated with:**  **1.Bullous pemphigoid**  **2.Erythema multiforme**  **3.Erosive medication- induced stomatitis**  **4.Bullous form of lichen planus (LP)**  **5 Dühring's dermatitis herpetiforme**  **6 Bubble epidermolysis (Lyel's disease)**  **7.Chronic recurrent aphthous stomatitis**  **8. Shingles**  **9. Manganotti’s cheilitis**  **10. Vesicovascular syndrome in cardiovascular diseases**  **11. Pemphigus of the eyes**  **12. Acute herpetic stomatitis**  **13.Erosive and ulcerative form of lupus erythematosus of the oral mucosa**  **1.Differential diagnostics of pemphigus vulgaris and bullous pemphigoid**  **Common symptoms:**  • The presence of painful erosions  **Differences:**  •Pemphigus mainly affects people over 35 years old. Bullous pemphigoid affects people over 60 years.  • Pemphigus affects the retromolar space, pharynx, soft palate, gums, tongue. Pemphigoid is localized on the border of the hard and soft palate, cheeks.  puzirceatk3-1285139530  ***Fig.161*** *Pemphigus vulgaris*  • In pemphigus vulgaris , bright red, bleeding erosions with an unpleasant odor are formed, covered with a grayish plaque, with clear even borders and scraps of bubble's covering epithelium along the periphery. They tend to merge, located on the slightly edematous oral mucosa of pale pink color . In pemphigoid, erosions are formed on the background of edematous and hyperemic oral mucosa.  • In contrast to pemphigus vulgaris , in pemphigoid, there is no acantholysis, no acantholytic cells, Nikolsky's symptom is negative, bubbles develop subepithelially.  •In pemphigus vulgaris , the bubbles have a very thin cover, they quickly burst, so it is not possible to see them in the oral cavity. In pemphigoid, the bubbles have a dense, tense covering , so they can persist for several hours, and sometimes days.  **2.Differential diagnostics of pemphigus vulgaris and erythema multiforme**  **Common symptoms:**  • Painful, bleeding erosions with a tendency to fusion, with even borders and scraps of bubble's covering epithelium along the edges  •Skin lesions  **Differences:**  • Pemphigus affects people over 35 years old, more often women. Erythema multiforme mainly affects young people (20-40 years old), more often men.  • In contrast to pemphigus vulgaris , erythema multiforme has an acute onset, seasonality of relapses, short duration of the course.  • Pemphigus vulgaris affects the retromolar space, pharynx, soft palate, gums, tongue. Erythema multiforme affects the anterior parts of the mouth: the oral vestibule, lips, palate, tongue, cheeks.  164  ***Fig.162*** *Pemphigus vulgaris*  • In pemphigus vulgaris there are erosions with an unpleasant odor, covered with a grayish or white "greasy" plaque and located on a slightly edematous, pale pink oral mucosa.  In erythema multiforme , the erosions have a bright inflammatory halo of considerable size, and they are covered with a yellowish-gray plaque and located on a highly edematous, hyperemic oral mucosa.  • In pemphigus vulgaris , in contrast to erythema multiforme , Nikolsky's symptom is positive, the bubbles are located intraepithelially (in erythema –they are located subepithelially), the phenomena of acantholysis are present.  • Erythema multiform is characterized by an acute onset of the disease, seasonality of relapses, relatively short duration  **3.Differential diagnostics of pemphigus vulgaris and erosive medication- induced stomatitis**  **Common symptoms:**  •Bleeding painful erosions with a tendency to merge  **Differences:**  • Pemphigus vulgaris affects the retromolar space, pharynx, soft palate, gums, tongue. The localization of rashes in erosive medicamentous stomatitis is any, sometimes it depends on the medication that caused the injury to the oral mucosa.  •Erosions in pemphigus vulgaris are with an unpleasant odor, on the periphery they have fragments of the bubble's covering epithelium and are located on a slightly edematous, pale pink oral mucosa. Erosions in medicamentous stomatitis are located on the hyperemic, edematous oral mucosa.  pemphigus-90-a-foto  ***Fig.163***  *Pemphigus vulgaris*  •IIn erosive medicamentous stomatitis, in contrast to pemphigus vulgaris , the onset of the disease can be acute and after rational therapy and discontinuation of the allergen -medication , rapid healing occurs.  • Pemphigus vulgaris affects people over 35 years old, more often women. Erosive medicamentous stomatitis affects all layers of the population, regardless of age and gender.  •In erosive medicamentous stomatitis, in contrast to pemphigus vulgaris, there is no acantholysis, Nikolsky's symptom is negative, acantholytic cells are absent, bubbles are located subepithelially.  •In case of erosive medication- induced stomatitis, the reactions of blast transformation of leukocytes and leukocytolysis are positive  **4.Differential diagnostics of pemphigus vulgaris and bullous form of lichen planus (LP)**  **Common symptoms:**  • Prevalence among women over 35 years of age  •Presence of erosions, covered with a grayish-white plaque  **Differences:**•Pemphigus vulgaris affects the retromolar space, pharynx, soft palate, gums, tongue. Lichen planus affects the cheeks in the molar region, transitional folds, the lateral surfaces and dorsum of the tongue, lips, palate, floor of the mouth.  •In pemphigus vulgaris, bright red, bleeding, painful erosions with an unpleasant odor are formed, along the periphery of which there are fragments of the bubble's covering epithelium, and they located on the slightly edematous, pale pink oral mucosa. In the bullous form of the Lichen planus , the pathological elements are in the form of bubbles with a dense cover, which quickly burst with the formation of erosions, around which there are multiple keratinized whitish- pearlescent papules, forming a reticular, lace pattern, located on a hyperemic oral mucosa.  • In pemphigus vulgaris , the boundaries of the lesion are even. In a bullous form of Lichen planus , the borders of the lesion are jagged.  • In the bullous form of Lichen planus, in contrast to pemphigus vulgaris , the bubbles are located subepithelially, there is no acantholysis.  •In pemphigus vulgaris , the resulting erosions do not heal for a long time. In bullous form of Lichen planus, erosions are rapidly epithelialized.  **5. Differential diagnostics of pemphigus vulgaris and Dühring's dermatitis herpetiforme (DUH)**  **Common symptoms:**  •Presence of bright red erosions covered with plaque  • Defeat of the skin  **Differences:**  •People over 35 years old, more often women, get sick by pemphigus vulgaris . Everybody gets sick by Dühring's dermatitis herpetiforme, regardless of age and gender.  •The etiology of pemphigus vulgaris is unknown. Etiology of Dühring's dermatitis herpetiforme is a polyetiological syndrome, which is the organism's response to exo - and endoallergens.  •In pemphigus vulgaris, in contrast to Dühring's dermatitis herpetiforme, the patient's general condition suffers (malaise, liver disease, kidney disease, dermatosis)  Pemphigus vulgaris begins with lesions of the oral mucosa, and then spreads to the skin. In Dühring's dermatitis herpetiforme, the oral mucosa is extremely rarely affected, pathological elements appear on it only after a skin rash.  •Morphological element in pemphigus vulgaris is a bubble with a very thin covering (therefore, it is extremely rare to see it), followed by the formation of painful erosions with clear, even boundaries, with an unpleasant odor, along the edges with scraps of the bubble's covering epithelium, located on a slightly edematous, pale pink oral mucosa. The morphological element in Dühring's dermatitis herpetiforme is located in groups of papules, bubbles and vesicles with a thick cover, followed by the formation of superficial, solitar , slightly painful erosions with scalloped edges located on the hyperemic oral mucosa.  • Dühring's dermatitis herpetiforme, in contrast to pemphigus vulgaris , is characterized by a subepithelial arrangement of bubbles, as well as the presence of eosinophils in them, Nikolsky symptom is negative, absence of acantholytic cells, and there is eosinophilia in the blood.  • Patients with Dühring's dermatitis herpetiforme, in contrast to patients In pemphigus vulgaris , have an increased sensitivity to iodine.  • In Dühring's dermatitis herpetiforme, the pathological elements are located in groups, polymorphism is characteristic  **6.Differential diagnostics of pemphigus vulgaris and epidermolysis (Lyell's disease)**  **Common symptoms:**  •Presence of bleeding painful erosions  •Positive Nikolsky symptom  •Presence of intraepithelial bubbles  • Defeat of the skin  **Differences:**  • Lyell's disease, in contrast to to pemphigus vulgaris , begins acutely.  •In pemphigus vulgaris , the retromolar space, pharynx, soft palate, tongue, gums are affected. In Lyell's disease, the tongue, gums, lips are affected.  •Pemphigus vulgaris begins with the formation of bubbles, in the place of which erosions then appear. Lyell's disease begins with the formation of hyperemic spots, in the center of which bubbles form after 2-3 days (resembles a 1-2 degree of burn), then turning into extensive erosions.  •In Lyell's disease, in contrast to pemphigus vulgaris , there are no acantholytic cells, there are subepithelial bubbles.  **7. Differential diagnostics of pemphigus vulgaris and Chronic recurrent aphtous stomatitis**  **Common symptoms:**  •Painful erosions  **Differences:**  •Everyone gets sick by Chronic recurrent aphtous stomatitis, regardless of gender and age. Pemphigus vulgaris affects persons over 35 years old, more often women.  •in Chronic recurrent aphtous stomatitis, in contrast to pemphigus vulgaris , the appearance of lesions is preceded by itching and burning.  • In Chronic recurrent aphtous stomatitis, the mucous membranes of the cheeks, lips, tongue are more often affected. In pemphigus vulgaris , the retromolar space, pharynx, soft palate, gums, tongue are affected.  •In Chronic recurrent aphtous stomatitis , large, solitary, oval or rounded aphthae with a soft base and edges are formed, elevating above the level of the normal mucous membrane. These aphthae are covered with a grayish-yellow dense plaque and are surrounded by a thin, brightly hyperemic, edematous halo, without a tendency to merge. In pemphigus vulgaris , bright red, bleeding erosions with an unpleasant odor are formed, with scraps of the bubble's covering epithelium along the periphery. Erosions are covered with a grayish "greasy" plaque with clear, even borders, tend to merge and are located on a slightly edematous, oral mucosa of the pale pink color.  • Cytological examination of aphtae in Chronic recurrent aphtous stomatitis reveals epithelial cells and a picture of chronic inflammation. Cytology in pemphigus vulgaris reveals acantholytic cells.  •In Chronic recurrent aphtous stomatitis, in contrast to pemphigus vulgaris, the skin and the red border of the lips are not affected  **8.Differential diagnostics of pemphigus vulgaris and shingles**  **Common symptoms:**  •Presence of painful erosions with a tendency to merge  **Differences:**  •In Shingles, lesions on the skin and oral mucosa are unilateral and are located along the affected peripheral nerves. In pemphigus vulgaris , lesions on the skin are localized mainly in places of friction by clothing, pressure, maceration (abdomen, back, axillary cavities, inguinal folds).  image2693176271096536768  ***Fig.164*** *Pemphigus vulgaris*  • In Shingles with lesions of the oral mucosa, the process begins with multiple bubbles on the background of hyperemia and edema, which quickly burst and form erosions with fibrinous plaque. In pemphigus vulgaris , the process begins with a clouding of the epithelium on the slightly edematous, pale pink oral mucosa, in the center of which erosion occurs, rapidly spreading along the periphery.  •in Shingles, small erosions (their sizes are from a pinhead to a lentil) have a polycyclic shape. In pemphigus vulgaris , erosions are of various sizes, bright red, bleeding, with an unpleasant odor, with clear even boundaries, and along their periphery, fragments of the bubble's covering epithelium are visible.  163  ***Fig.165*** *Pemphigus vulgaris*  • In Shingles, burning paroxysmal neuralgic pain appears along the affected nerves, aggravated by stimuli. For pemphigus vulgaris , such pain is not typical.  In Shingles, lesions on the skin and mucous membranes appear at the same time. In pemphigus vulgaris, the oral mucosa is initially affected, and these lesions may be the only symptoms of the disease for a long time.  •In pemphigus vulgaris, in contrast to Shingles, mucous membranes of the pharynx, esophagus, stomach, intestines can be affected.  • Pemphigus vulgaris is characterized by a positive Nikolsky's symptom, a symptom of an "emerging bubble" (when rubbing by a finger, a bubble appears on apparently healthy skin or mucous membrane both between the bubble and at a distance from them), Asbo-Hansen's symptom (pressure on the bubble covering increases its area due to stratification of the epithelium or epidermis due to the pressure of the bubble fluid). In Shingles, these symptoms are absent.  • Cytological examination shows the presence of acantholytic cells (Tzank cells) in smears-prints in pemphigus vulgaris . Cytological examination in Shingles reveals giant multinucleated cells.  •Shingles occurs more often in the autumn-winter period. Seasonality is not typical for pemphigus vulgaris.  • Shingles is common among children and weakened elderly, pemphigus vulgaris - among people over 35  **9.Differential diagnostics of pemphigus vulgaris and Manganotti’s cheilitis**  **Common symptoms:**  •Bright red erosions, covered with hemorrhagic crusts located on red lip border  **Differences:**  •In Manganotti’s cheilitis, erosions are painless. In pemphigus vulgaris , the pain is severe, most intense when talking and eating.  •In pemphigus vulgaris, in contrast to Manganotti’s cheilitis, the skin, mucous membranes of the esophagus, intestines, stomach, pharynx, internal organs and central nervous system are affected.  Pemphigus_vulgaris_7_050328  ***Fig.166*** *Pemphigus vulgaris*  • Pemphigus vulgaris is characterized by a positive Nikolsky's symptom, the presence of acantholytic cells in scrapings taken from the surface of erosions.  • In pemphigus vulgaris, erosions are formed after the bubbles burst  **10.Differential diagnostics of pemphigus vulgaris and Vesicovascular syndrome**  **Common symptoms:**  •Primary morphological element is a bubble  •Presence of erosions  **Differences:**  •Bubbles in Vesicovascular syndrome are dense and can exist unchanged from several hours to several days. In pemphigus vulgaris, the bubbles have a very thin cover and quickly burst, it is extremely rare to see them in the oral cavity (more often the remnants of the bubble coverings are visible).  •In contrast to pemphigus vulgaris, the occurrence of bubbles in vesicular -vascular syndrome is associated with an increase in blood pressure.  • In the Vesicovascular syndrome, erosions are epithelized within 3-7 days. In pemphigus vulgaris , painful erosions form without a tendency to heal.  •In pemphigus vulgaris, in contrast to the Vesicovascular syndrome, the skin is affected.  422b2fbfa84976535d6c274ef4ffb1ff  ***Fig.167*** *Pemphigus vulgaris*  • In case of Vesicovascular syndrome, in contrast to pemphigus vulgaris, there are no acantholytic cells in smears - prints taken from the area of erosions, Nikolsky's symptom is negative.  **11. Differential diagnostics of vulgar pemphigus and pemphigus of the eyes :**  **Common symptoms:**  • Rash on the conjunctiva  **Differences:**  • In pemphigus of the eyes, cicatricial changes remain on the conjunctiva, leading to blindness.  • In pemphigus vulgaris , RIF indicates the absence of deposits of immune complexes containing İgG in the area of the membranes of spiny cells  **12. Differential diagnostics of pemphigus vulgaris and erosive and ulcerative forms of lupus erythematosus of the oral mucosa:**  **Common symptoms:**  • Severely painful erosions of the oral mucosa  • Defeat of the skin  **Differences:**  • In lupus erythematosus on an edematous hyperemic background,there observed one or more painful erosions covered with a dense fibrinous plaque. In pemphigus vulgaris on the background of the absence of inflammation, there are "naked" sharply painful erosions without a plaque  • In case of lupus erythematosus around erosion on the background of erythema, foci of hyperkeratosis, radially diverging from the center, are visible  • In pemphigus vulgaris, the primary morphological element is the bubble  • In lupus erythematosus, lesions of the oral mucosa are preceded by skin lesions. Isolated lesion of the oral mucosa is practically not found  **Lupus erythematosus is differentiated from :**  **1. Lichen planus (LP)**  **2.Leukoplakia**  **3.Dry form of actinic cheilitis**  **4 Manganotti's abrasive precancerous cheilitis**  **5. Atopic cheilitis**  **6.Limited precancerous hyperkeratosis of the red border of the lips**  **1.Differential diagnostics of lupus erythematosus and lichen planus (LP)**  **Common symptoms:**  •Prevalence among women  •Burning and pain of the oral mucosa intensifying when exposed to stimuli  • Whitish foci of hyperkeratosis  • On the hyperemic mucous membrane, areas of keratinization of the epithelium, erosions or ulcers of various shapes and sizes, covered with fibrinous plaque  **Differences:**  •Lupus erythematosus is more common at the age of 20-40 years. They are sick with Lichen planus after the age of 40.  • In lupus erythematosus, the skin of the open areas of the face, the neck, the scalp, and the auricles is affected like the wings of a butterfly. In Lichen planus , the inner surface of the forearms, wrist joints, lower legs, sacrum, and genitals are affected.  md_00-06-0034  ***Fig.168*** *Lupus erythematosus*  • In lupus erythematosus, the red border of the lips is more often affected, the buccal mucosa along the dental closing line. In Lichen planus , the mucous membranes of the cheek in the molar region, transitional folds, the retromolar region, the lateral surfaces and dorsum of the tongue, gums, lips, palate, floor of the oral cavity are affected.  Untitled-26  ***Fig.169*** *Lupus erythematosus*  • In lupus erythematosus, pathological elements are in the form of bright erythema with atrophy in the center, covered with delicate white dots and stripes, and hyperkeratosis in the form of blurry flames along the periphery. In Lichen planus , the pathological elements are in the form of papules, forming a reticular, lacy pattern with clear, jagged boundaries.  • In lupus erythematosus in UVA light (luminescent diagnostics), the lesions give a snow-white-blue glow. In Lichen planus in UVA light, the lesions give a whitish-yellow glow.  •Lupus erythematosus, in contrast to Lichen planus , rarely occurs in isolation on the oral mucosa and the red border of the lips.  •In lupus erythematosus, in contrast to Lichen planus , the lesions are located in the form of a ribbon.  **2.Differential diagnostics of lupus erythematosus and leukoplakia**  **Common symptoms:**  •Whitish foci of hyperkeratosis  **Differences:**  • Lupus erythematosus is more common in women aged 20-40 years. Leukoplakia affects middle-aged and older people, more often men.  • In lupus erythematosus, the skin of the open areas of the face like the wings of a butterfly, the neck, the scalp, and the auricles is affected. In leukoplakia, the skin is not affected.  uuuuuuu-1213363903  ***Fig.170*** *Lupus erythematosus*  • In lupus erythematosus, the red border of the lips, the mucous membrane of the cheeks along the dental closing line are more often affected. In leukoplakia, the buccal mucosa along the dental closing line in the anterior section in the form of a triangle with the apex posteriorly, the red border of the lower lip, tongue, palate are affected.  • In lupus erythematosus, pathological elements are in the form of bright erythema with atrophy in the center, covered with delicate white dots and stripes, and hyperkeratosis in the form of blurry flames along the periphery. In leukoplakia, the pathological elements are in the form of a plaque (like glued thin tissue paper) with smooth, clear boundaries, without bright erythema and atrophy.    ***Fig.171*** *Lupus erythematosus*  • In lupus erythematosus in UVA light (luminescent diagnostics), the lesions give a snow-white or dull white glow. In leukoplakia, the lesions in UVA light, give a blue glow.  • In lupus erythematosus, in contrast to leukoplakia, the lesions are located in the form of a ribbon.  **3. Differential diagnostics of lupus erythematosus of the lips without expressed atrophy and dry form of actinic cheilitis**  **Common symptoms:**  •Burning and pain of the red border of the lips  •Presence of silvery white scales and foci of hyperkeratosis  **Differences:**  •Lupus erythematosus is more common in women aged 20-40 years. Actinic cheilitis is more common in men aged 20-60.  • In lupus erythematosus, in contrast to actinic cheilitis, the red border of the lips and mainly the skin of the face are affected.  discoid-lupus  ***Fig.172*** *Lupus erythematosus*  •In lupus erythematosus on the red border of the lips, there is a diffuse congestive hyperemia with easily removable scales, there is no itching,and oval-shaped erosions, located like a ribbon, are possible. In actinic cheilitis, the pathological process captures the red border of the lower lip, which becomes a bright red color, becomes covered with small scales, sometimes small bubbles appear, patients are worried about itching.  • In actinic cheilitis, there is no cicatricial atrophy  **4.Differential diagnostics of lupus erythematosus (erosive and ulcerative forms) and Manganotti 's abrasive precancerous cheilitis**  **Common symptoms:**  •Defeat of the red border of the lower lip  •Oval-shaped, bright red pathological focus  **Differences:**  • Lupus erythematosus is more common in women aged 20-40 years. Manganotti 's abrasive precancerous cheilitispredominantly occurs in men over 50.  •In the erosive and ulcerative forms of lupus erythematosus, in contrast to Manganotti 's abrasive precancerous cheilitis, lesions of the red border of the lips are combined with skin lesions.  volchanka  ***Fig.173*** *Lupus erythematosus*  • In the erosive and ulcerative forms of lupus erythematosus on the background of expressed inflammation, edematous painful erosions, ulcers, cracks, covered with bloody purulent crusts appear, around which hyperkeratosis is visible in the form of blurred tongues of flame. In Manganotti 's abrasive precancerous cheilitis , on a background of minor catarrhal inflammation, painless erosion with a smooth, as if polished surface, sometimes covered with a bloody or serous crust appears.  •Erosions in the erosive and ulcerative forms of lupus erythematosus epithelialize comparatively quickly. Erosions in Manganotti 's abrasive precancerous cheilitisepithelize spontaneously or, during treatment, become covered with transparent epithelium.  •In lupus erythematosus, in contrast to Manganotti 's abrasive precancerous cheilitis , the lesions are located in the form of a ribbon.  • In Manganotti 's abrasive precancerous cheilitis , there is no congestive hyperemia and cicatricial atrophy  **5. Differential diagnostics of lupus erythematosus without severe atrophy and atopic cheilitis.**  **Common symptoms:**  •Lip changes associated with facial skin lesions  •Periods of exacerbation and remission are character  **Differences:**  • Lupus erythematosus is more common in women between the ages of 20 and 40. Atopic cheilitis is more common in children and adolescents of both sexes between the ages of 7 and 17.  • In lupus erythematosus without expressed atrophy, diffuse congestive hyperemia with easily removable scales on the red border of the lips is observed, there is no itching, oval-shaped erosions, located like a ribbon, are possible. In atopic cheilitis, lichenization of the red lips' border is observed, especially the corners of the mouth, where the process passes to the skin, patients are worried about severe itching.    ***Fig.174***  *Lupus erythematosus*  • In atopic cheilitis, in contrast to lupus erythematosus, spontaneous recovery occurs by the age of 25-26.  **6. Differential diagnostics of lupus erythematosus and limited precancerous hyperkeratosis of the lips' red border**  **Common symptoms:**  •Lip lesions  •Presence of grayish white scales  **Differences:**  • Lupus erythematosus is more common in women aged 20-40 years. Limited precancerous hyperkeratosis is more common among middle-aged and older men.  •In contrast to limited precancerous hyperkeratosis, clinical forms of lupus erythematosus are accompanied by burning and pain, aggravated by eating and talking.  • Limited precancerous hyperkeratosis has a small, even, slightly sinking surface in relation to the surface of the lip, from which it is not possible to remove scales during scraping. The pathological focus in lupus erythematous has atrophy in the center (after elimination of scales), along the periphery of which there is hyperkeratosis in the form of tongues of flame.  dle-lip-s  ***Fig.175*** *Lupus erythematosus*  • Lupus erythematosus of the lips, in contrast to limited precancerous hyperkeratosis, can be complicated by glandular cheilitis.  • In UVA light, areas of hyperkeratosis in lupus erythematosus, in contrast to limited precancerous hyperkeratosis, give a snow-white-blue glow.  • Final diagnosis of limited precancerous hyperkeratosis of the red border of the lips is confirmed by the results of histological examination  **Lichen planus (LP) is differentiated from :**  **1.Leukoplakia**  **2.Candidiasis**  **3. Lupus erythematosus**  **4 .Papular syphilis**  **5.Allergic stomatitis**  **6. Chronic trauma**  **7. Bowen's disease**  **8. Pemphigus vulgaris**  **9. Erythema multiforme**  **10. Desquamative glossitis**  **11. Pashkov’s mild leukoplakia**  **12.Limited precancerous hyperkeratosis of the lips ' red border**  **13. Manganotti’s cheilitis**  **14. Traumatic ulcer**  **15. Candidiasis assopciated with HIV infection**  **16. Hairy leukoplakia associated with HIV infection**  **17.Vasicovesicular syndrome**  **18.Verrucous leukoplakia**  **1. Differential diagnostics of typical form of Lichen planus and Leukoplakia**  **Common symptoms:**  •Prevalence among middle-aged and older people  •Presence of whitish-gray foci of hyperkeratosis with a rough surface  •No complaints  **Differences:**  C:\Documents and Settings\Xp\Desktop\leukoplakui\LeukoplakiaUnderTongue.jpg •In Lichen planus ,the pathological element is in the form of papules, forming a reticular, lace pattern with clear, jagged edges on the background of expressed inflammation. In leukoplakia, the pathological element is a hyperkeratotic spot with even borders on the background of the absence or slightly expressed inflammation, as a rule, it is solitar .  asdfg  ***Fig.176*** *Lichen planus* ***Fig.177*** *Leukoplakia*  • Lichen planus is more common in women. Leukoplakia predominantly occurs in men.  •In case of Lichen planus , the inner surface of the forearms, wrist joints, lower legs, sacrum, and genitals are affected. In leukoplakia, the skin is not affected.  krasnii_ploskii_lishai  ***Fig.178*** *Lichen planus*  •In case of Lichen planus , the cheeks in the molar region, transitional folds, the retromolar region, the lateral surfaces and dorsum of the tongue, gums, lips, palate, floor of the mouth are affected. In leukoplakia, the cheeks are affected along the dental closing line in the anterior section in the form of a triangle with the apex posteriorly, the red border of the lower lip, tongue, palate.  •In UVA light (fluorescent diagnostics) in Lichen planus, lesions give a whitish-yellow glow. In UVA light, leukoplakia lesions give a blue glow.  **2. Differential diagnostics of exudative- hyperemic form of Lichen planus and candidiasis**  **Common symptoms:**  •Burning, painfulness of the mucous membrane, aggravated by eating  • On the hyperemic oral mucosa,there are multiple whitish formations  **Differences:**  •Candidiasis is caused by yeast-like fungi of the genus Candida. The etiology of Lichen planus is not clear.  • In candidiasis, the lesion is in the form of a plaque without clear boundaries, resembling curdled milk, which can be easily removed by scraping. In Lichen planus , the lesion is in the form of keratinized papules with clear jagged edges, which, when scraped, can not be removed ,and form a mesh, lace pattern  •In Lichen planus, in contrast to candidiasis, the skin of the inner surface of the forearms, wrist joints, lower legs, sacrum, and genitals can be affected.  •The diagnosis of candidiasis is confirmed by the presence of a fungus of the genus Candida in the scrapings taken from the surface of the affected oral mucosa.  1322395433_ris  ***Fig.179*** *Lichen planus*  • In a history of candidiasis, prolonged use of antibiotics, corticosteroids, cytostatics is revealed.  **3.Differential diagnostics of erosive - ulcerative form of Lichen planus and Lupus erythematosus:**  **Common symptoms:**  • Burning and pain of the oral mucosa, aggravated by exposure to irritants  • On the hyperemic mucous membrane, areas of keratinization of the epithelium, erosions or ulcers of various shapes and sizes  •Long course of the disease  •Skin lesions  **Differences:**  • Lupus erythematosus is more common at the age of 20-40 years. They are sick with Lichen planus after the age of 40.  • In lupus erythematosus, the skin of the open areas of the face, like the wings of a butterfly, neck, scalp, ears is affected. In Lichen planus, the inner surface of the forearms, wrist joints, lower legs, sacrum, and genitals are affected.  • In lupus erythematosus, the red border of the lips, the buccal mucosa along the dental closing line is more often affected. In Lichen planus , the mucous membranes of the cheek in the molar region, transitional folds, the retromolar region, the lateral surfaces and dorsum of the tongue, gums, lips, palate, floor of the oral cavity are affected.  7  ***Fig.180*** *Lichen planus*  •In lupus erythematosus, pathological elements are in the form of bright erythema with atrophy in the center, covered with delicate white dots and stripes, and hyperkeratosis in the form of blurry flames along the periphery.  After the healing of erosions, atrophic scars remain. In Lichen planus, the pathological elements are in the form of papules, forming a reticular, lacy pattern with clear, jagged boundaries.  • In lupus erythematosus in UVA light (luminescent diagnostics), the lesions give a snow-white-blue glow. In UVA light, the lesions give a whitish-yellow glow.  • Lupus erythematosus, in contrast to Lichen planus, rarely occurs in isolation on the oral mucosa and the red border of the lips. Moreover, the defeat of the oral mucosa is preceded by characteristic erythemal spots on the skin (more often a face is affected in the form of a "butterfly", a red border of the lips is involved in the process)  • In Lupus erythematosus, in contrast to Lichen planus, the lesions are located in the form of a ribbon.  •In case of Lupus erythematosus, sunlight is a provoking factor, since the sensitivity of the skin to sunlight is sharply increased in patients.  **4.Differential diagnostics of Lichen planus and papular syphilis**  **Common symptoms:**  • Grayish-white plaque of lesions  •Presence of painful rounded papules with clear boundaries  **Differences:**  • Persons of both sexes suffer from syphilis, more often at a young age. Lichen planus is mostly seen in women between the ages of 40 and 60  • In syphilis, the papules are dense, large (1-1.5 cm), round or oval, with clear edges and an inflammatory halo is around, they do not merge with each other (focal location). In Lichen planus , papules are small (0.2-5 mm), with jagged edges, keratinized, without an inflammatory halo around, prone to merge in the form of a mesh, lace or plant pattern, slightly elevate above the level of the mucous membrane.  ima  ***Fig.181*** *Lichen planus*  •From the surface of syphilitic papules, plaque is easily removed. It is not possible to remove plaque from the surface of the Lichen planus, since it is a consequence of hyperkeratosis.  •In Lichen planus , in contrast to syphilis, patients often complain of tightness, burning, roughness and dryness of the oral mucosa.  • In papular syphilis, the base of the lesion is infiltrated, in Lichen planus -no  • The diagnosis of syphilis is confirmed by positive serological reactions and the detection of pale treponema in the lesions. The histology of Lichen planus shows acanthosis, hyperkeratosis and parakeratosis in the epithelium.  •Papular syphilis often affects the tonsils, soft palate and arches. Lichen planus is more often localized on the mucous membranes of the cheeks at the place of adjoining molars with the capture of transitional folds, on the lateral surfaces of the tongue with a transition to its lower surface in the area of ​​ molars.  **5. Differential diagnostics of erosive-ulcerous form of Lichen planus and allergic stomatitis**  **Common symptoms:**  • Oral mucosa is edematous, hyperemic  •Burning of the oral mucosa  **Differences:**  •Lichen planus often affects women of 40-60 years old. Allergic stomatitis affects everyone, regardless of age and gender.  • In Lichen planus , the pathological elements are in the form of keratinized papules, forming a reticular, lace pattern with clear jagged edges. In case of allergic stomatitis, pathological elements are in the form of cystic rashes, erythema or easily bleeding, extensive, confluent erosions.  Moreover, erosions are rapidly epithelialized (4-10 days). There are no papules. It does not recur if contact with the allergen is excluded.  • Lichen planus is a long-term chronic disease. Allergic stomatitis has an acute onset, and after elimination of the action of the allergen and rational therapy, it quickly resolves.  • The etiology of Lichen planus has not been finally clarified. Allergic stomatitis is the organism's response to taking a medication.  **6. Differential diagnostics of Lichen planus and Chronic trauma**  **Common symptoms:**  • The same localization of the lesions  **Differences:**  • The etiology of Lichen planus has not been finally clarified. Mechanical trauma is the response of the mucous membrane in the form of inflammation to stimuli.  •In case of mechanical injury, in contrast to Lichen planus , the pathological focus does not go beyond the range of the stimulus and quickly disappears after the cause is eliminated.  • In Lichen planus , the lesion is keratinized papules that form a typical reticular, lacy patternwith clear, jagged edges.  In chronic trauma, the mucous membrane is edematous, hyperemic, proliferation phenomena are observed, there may be ulcers and erosions, a secondary infection joins.No papules  •Lichen planusis characterized by skin lesions  **7. Differential diagnostics of Lichen planus and Bowen's disease**  **Common symptoms:**  •Foci of keratinization with clear uneven edges situated on a hyperemic background  • Prevalence among people over 40 age  **Differences:**  •Lichen planus is more common in women.  •Bowen's disease is more common in men.  • In Lichen planus , the lesion is keratinized, slightly elevating above the level of the mucous membrane, papules of a whitish-gray color, prone to merge in the form of a pattern resembling a lace mesh or a snowflake.  In Bowen's disease, the lesion is more often a solitar bright red spot with a velvety, non-elevated surface.  •In Bowen's disease, in contrast to Lichen planus , the lesion focus atrophies and sinks in comparison with the surrounding tissues.  • In Lichen planus, it is impossible to remove plaque from the surface of the papules, since it is a consequence of hyperkeratosis.  In Bowen's disease, plaque can be removed.  **8.Differential diagnostics of Lichen planus (bullous form) and pemphigus vulgaris**  **Common symptoms:**  • Prevalence among women over 35 years  •Presence of erosions, covered with a grayish-white plaque  • Skin lesions, bubbles  **Differences:**  • Pemphigus vulgaris affects the retromolar space, pharynx, soft palate, gums, tongue.  Lichen planus affects the cheeks in the molar region, transitional folds, the lateral surfaces and dorsum of the tongue, lips, palate, floor of the mouth.  • In pemphigus vulgaris , bright red, bleeding, painful erosions with an unpleasant odor are formed, along the periphery of which there are fragments of the bubble's covering epithelium, and located on the slightly edematous, pale pink oral mucosa.  In the bullous form of the Lichen planus , the pathological elements are in the form of bubbles with a dense covering,which quickly burst with the formation of erosions, around which there are multiple keratinized whitish- pearlescent papules, forming a reticular, lace pattern, located on a normal or hyperemic oral mucosa.  • In pemphigus vulgaris , the boundaries of the lesion are even.  In a bullous form of Lichen planus , the borders of the lesion are jagged.  •In the bullous form of Lichen planus , in contrast to pemphigus vulgaris , the bubbles are located subepithelially, there is no acantholysis.  •In pemphigus vulgaris , the resulting erosions do not heal for a long time. In Lichen planus , erosions are rapidly epithelialized.  **9. Differential diagnostics of Lichen planus and erythema multiforme**  **Common symptoms:**  • The tendency of lesions to merge  • Skin lesions  **Differences:**  •Lichen planus is more common in women over 40 years of age. Erythema multiforme often affects young and middle-aged people.  • Lichen planus is a chronic disease that develops gradually. Erythema multiforme begins acutely, with a rise in temperature, headache, pain in muscles and joints.  • Lichen planus is localized more often on the cheeks at the area of the molars with the capture of the transitional folds and on the lateral surfaces of the tongue, with the transition to the dorsum and the lower surface in the area of the molars.  Erythema multiforme often affects the anterior parts of the oral cavity: lips, cheeks, tongue, floor of the mouth, hard palate.  •In Lichen planus , elements of lesion are the papules , forming a typical reticular, lace pattern with clear, jagged edges.  In erythema multiforme , the pathological elements are extensive, sharply painful, with even borders, bleeding erosions, covered with a yellowish-gray plaque, and with scraps of the bubble's covering epithelium.  **10. Differential diagnostics of Lichen planus (typical form) and desquamative glossitis**  **Common symptoms:**  •Lesions of whitish-gray color  • Burning sensation  **Differences:**  •Lichen planus is more common in women aged 40-60 years. Desquamative glossitis occurs equally often in different age groups.  • In the typical form of Lichen planus , small papules form with clear, jagged edges in the form of a lace mesh. They are located on the apparently unchanged oral mucosa and slightly elevate above its level.  In desquamative glossitis, on the background of the swollen epithelium of the tongue's filiform papillae, desquamation areas clearly delimited from the surrounding mucous membrane in the form of sinking red spots are formed.  4  ***Fig.182*** Lichen planus  • In Lichen planus, in contrast to desquamative glossitis, the red border of the lips, skin, mucous membranes of the urethra, genitals, stomach, esophagus, anus, conjunctiva can be affected.  •In desquamative glossitis, in contrast to Lichen planus, the outlines of desquamation foci change daily.  794  ***Fig.183*** *Lichen planus*  **11.Differential diagnostics of Lichen planus (typical form ) and Pashkov's soft (mild)leukoplakia**  **Common symptoms:**  •Presence of whitish-gray lesions  • Prevalence among women  **Differences:**  •In Lichen planus, the pathological element is in the form of papules, forming a mesh, lace pattern with clear, jagged edges on the apparently unchanged oral mucosa, which cannot be removed by scraping.  Soft leukoplakia is the areas of peeling of an edematous, pasty mucous membrane with indistinct boundaries, which can be removed by scraping.  • Lichen planus occurs more often at the age of 40-60 years. Pashkov’s mild leukoplakia often occurs at the age of 30.  •In case of Lichen planus, the inner surface of the forearms, wrist joints, lower legs, sacrum, and genitals are affected. In Pashkov’s mild leukoplakia, the skin is not affected.  гоо  ***Fig.184*** *Lichen planus*  • In Lichen planus, the cheeks in the molar region, transitional folds, retromolar region, lateral surfaces and dorsum of the tongue are more often affected. In Pashkov’s mild leukoplakia, the mucous membranes of the cheeks and lips are more often affected.  • In Lichen planus, the cheeks in the molar region, transitional folds, retromolar region, lateral surfaces and dorsum of the tongue are more often affected.  In Pashkov’s mild leukoplakia, the mucous membranes of the cheeks and lips are more often affected.  •In UVA light (fluorescent diagnostics) in Lichen planus, lesions give a whitish-yellow glow.  In UVA light, leukoplakia's lesions give a dull white glow.  **12. Differential diagnostics of lichen planus (hyperkeratotic form ) and Limited precancerous hyperkeratosis of the red border of the lips**  **Common signs:**  •Foci of whitish-gray color which cannot be removed when scraped by a spatula  **Differences:**  •Lichen planus, is more common in women. Limited precancerous hyperkeratosis is more common among men.  •In Lichen planus, in contrast to limited precancerous hyperkeratosis, patients often complain of a burning sensation, tightness, and dryness.  •Limited precancerous hyperkeratosis has a flat surface, slightly sinking in relation to the surface of the lip, covered with thin, densely sitting scales.  In Lichen planus , papules are formed, which coalesce to form a stellate pattern.  • Lichen planus, in contrast to limited precancerous hyperkeratosis, can be complicated by glandular cheilitis.  • In Lichen planus, in contrast to limited precancerous hyperkeratosis, the skin of the inner surface of the forearms, lower leg, sacrum, wrist joints, and genitals is affected.  •In UVA light, lesions of Lichen planus, in contrast to limited precancerous hyperkeratosis, give a whitish-yellow glow.  •Finally, the diagnosis of limited precancerous hyperkeratosis of the red border of the lips is confirmed by the results of histological examination  **13. Differential diagnostics of the erosive form of Lichen planus and Manganotti’s cheilitis**  **Common symptoms:**  •Presence of bleeding erosions appeared after elimination of crusts or plaque  • Prevalence among people over 40 years  •Erosions do not respond well to medication therapy, are characterized by a persistent course, give relapses  **Differences:**  •Lichen planus is more common in women. Manganotti 's cheilitis is more common in men.  • In the erosive form of Lichen planus, on the background of an expressed inflammation of the oral mucosa, irregular erosions are located, covered with fibrinous plaque, with papules around in the form of a lace pattern. The morphological element in Manganotti’s cheilitis is oval-shaped erosion, located on a background of slight inflammation, with a smooth, polished surface, has a deep red color , sometimes covered with bloody crusts.  • In contrast to Manganotti’s cheilitis, Lichen planus can affect the skin.  •Erosions in Manganotti’s cheilitis are often solitary. Erosions in the erosive form of Lichen planus are often multiple and painful.  • Finally, the diagnosis of Manganotti’s cheilitis is confirmed by the results of histological examination  **14. Differential diagnostics of Lichen planus (hyperkeratotic form) and Traumatic ulcers**  **Common symptoms:**  • The lesion is whitish in color  • Same localization of the foci  **Differences:**  • Lichen planus is more common among women over 40 years.  Defeat to the mucous membrane under the influence of chronic irritants is more common in older people  • In lichen planus, there are papules which can be solitary and merged into a pattern in the form of a mesh, lace, stripes , significantly elevating above the level of the mucous membrane.  The traumatic ulcer has an oval shape and a slightly depressed surface, with painful hyperemic edges.  •After elimination of the irritant, rapid epithelisation of the traumatic ulcer occurs.  **15. Differential diagnostics of Lichen planus and candidiasis associated with HIV infection:**  **Common symptoms:**  • White color of the lesions  • A burning sensation in the mouth  **Differences:**  •Candidiasis associated withHIV infection is its concomitant disease. The etiology of Lichen planus is not clear.  •In case of candidiasis associated withHIV infection, the lesion is in the form of a plaque without clear boundaries, resembling curdled milk, which, when scraped, is easily removed and located on the hyperemic, dry oral mucosa. In Lichen planus, the lesion is in the form of keratinized papules with clear jagged edges, which can not be removed by scraping and form a reticular, lace pattern, located on a normal or hyperemic mucous membrane.  67-511e3d00  ***Fig.185*** *HIV-related candidiasis*  • In Lichen planus , in contrast to candidiasis, the skin of the inner surface of the forearms, wrist joints, lower legs, sacrum, and genitals can be affected.  •The diagnosis of candidiasis associated withHIV infection is confirmed by the presence of a fungus of the genus Candida in the scrapings taken from the surface of the affected oral mucosa, as well as by immunosorbent analysis and immunoblotting.  •In candidiasis associated withHIV infection, in contrast to Lichen planus , the general condition of the patients worsens (weight loss, weakness, pneumonia, lymphadenitis, etc.)  **16. Differential diagnostics of Lichen planus and Hairy leukoplakia associated with HIV infection**  **Common symptoms:**  •Foci of lesions are of grayish-white color , which cannot be removed when scraped by a spatula  **Differences:**  • Patients with hairy leukoplakia are mainly HIV-infected, the causative agent is the Epstein-Barr virus. The etiology of Lichen planus is not clear.  •In Lichen planus , the pathological element is in the form of papules, forming a reticular, lace pattern with clear, jagged edges on the background of expressed inflammation. In hairy leukoplakia associated withof HIV infection, pathological elements are in the form of folds or villi on the background of the absence of an inflammatory reaction.  СПИД  ***Fig.186*** *Hairy leukoplakia associated with HIV infection*  Lichen planus is more common in women. Hairy leukoplakia associated with HIV infection predominantly occurs in men.  •In case of Lichen planus, the inner surface of the forearms, wrist joints, lower legs, sacrum, and genitals are affected. In hairy leukoplakia associated withHIV infection, the skin is not affected.  •In case of Lichen planus, the cheeks in the molar region, transitional folds, the retromolar region, the lateral surfaces and dorsum of the tongue, gums, lips, palate, floor of the mouth are affected. In hairy leukoplakia associated withHIV infection, the lateral surfaces of the tongue are more often affected.  СПИД 49  ***Fig.187*** *Hairy leukoplakia associated with HIV-infection*  •In UVA light in Lichen planus, lesions give a whitish-yellow glow. The diagnosis of hairy leukoplakia associated with HIV infection is confirmed by immunosorbent assay and immunoblotting.  •In hairy leukoplakia associated withHIV infection, in contrast to Lichen planus, the general condition of patients worsens (weight loss, weakness, pneumonia, lymphadenitis, etc.)  **17. Differential diagnostics of the bullous form of Lichen planus and vesicovascular syndrome:**  **Common symptoms:**  • Complaints of painfulness of the mucous membrane  •Subepithelial bubbles on the hyperemic mucosa, existing from several hours to several days  • They are common among women over 40 years  **Differences:**  •Bubbles in vesicovascular syndrome are formed as a result of injury to the mucous membrane by the prosthesis, food lump, etc. The content of the bubbles is hemorrhagic.  • Vesicovascular syndrome occurs on the background of cardiovascular diseases, hypertension.  **18. Differential diagnostics of hyperkeratotic form of Lichen planus and verrucous leukoplakia:**  **Common symptoms:**  • Complaints of roughness, unusual appearance of the oral mucosa  • Plaques of various shapes and outlines with clear boundaries elevate above the surrounding mucous membrane  • Tendency to malignancy  **Differences:**  • Lichen planus is more common in women, leukoplakia is more common in men  • In verrucous leukoplakia, the focus of hyperkeratosis is often solitar , its location corresponds to the effect of a traumatic factor (sharp edges of teeth, prosthesis, cigarette smoke). In Lichen planus, papules are located around the foci of hyperkeratosis in the form of a Wickham striae.  •Typical localization of verrucous leukoplakia is the anterior part of the oral cavity, Lichen planus often affects the retromolar region, dorsum and lateral surfaces of the tongue  • Skin lesions may occur in Lichen planus  **Dühring's dermatitis herpetiforme (HDD) is differentiated from:**  **1.Acantholytic pemphigus**  **2.Non-acantholytic pemphigus**  **3.Erythema multiforme**  **4. Bullous pemphigoid**  **1. Differential diagnostics of Dühring's dermatitis herpetiforme and acantholytic pemphigus.**  **Common symptoms:**  •Presence of bright red erosions covered with plaque  **Differences:**  • People over 35 years old, more often women, get sick with pemphigus vulgaris. Everybody gets sick with Dühring's dermatitis herpetiforme, regardless of age and gender.  •The etiology of pemphigus vulgaris is unknown. Etiology of Dühring's dermatitis herpetiformeincludes polyetiological syndrome, which is the organism's response to exo - and endo-allergens.  •In Pemphigus vulgaris , in contrast to Dühring's dermatitis herpetiforme, the patient's general condition suffers (malaise, liver disease, kidney disease, dermatosis)  Pemphigus vulgaris begins with lesions of the oral mucosa, and then spreads to the skin. In Dühring's dermatitis herpetiforme, the oral mucosa is extremely rarely affected, pathological elements appear on it only after a skin rash.  •Morphological element in pemphigus vulgaris is a bubble with a very thin covering (therefore, it is extremely rare to see it), followed by the formation of painful erosions with clear, even boundaries, with an unpleasant odor, along the edges with scraps of the bubble's covering epithelium, located on a slightly edematous, pale pink oral mucosa.  The morphological elements in Dühring's dermatitis herpetiformeare papules located in groups, bubbles and vesicles with a thick covering, followed by the formation of superficial, solitary , slightly painful erosions with scalloped edges located on the hyperemic oral mucosa.  dermatit-dyuringa2  ***Fig.188*** *Dühring's dermatitis herpetiforme*  • Dühring's dermatitis herpetiformein contrast to pemphigus vulgaris , is characterized by a subepithelial arrangement of bubbles, as well as the presence of eosinophils in them, a negative Nikolsky's symptom, the absence of acantholytic cells, and eosinophilia in the blood.  •Patients with Dühring's dermatitis herpetiforme , in contrast to patients In pemphigus vulgaris , have an increased sensitivity to iodine.  **2. Differential diagnostics of Dühring's dermatitis herpetiforme and non-acantholytic pemphigus**  **Common symptoms:**  •The location of morphological elements on the hyperemic and edematous mucous membrane  •The general condition of the patients suffers little  **Differences:**  •They get sick with Dühring's dermatitis herpetiformeat any age. Non-acantholytic pemphigus occurs in people over 50 years of age.  • Dühring's dermatitis herpetiformeis a polyetiological syndrome, which is the organism's reaction to exo - and endo-allergens. The etiology of non-acantholytic pemphigus is not completely understood.  In Dühring's dermatitis herpetiforme, small bubbles with a thick coverings and transparent contents are formed, which are grouped and, after their burst, solitar , bright red, slightly painful erosions are formed, partially covered with plaque and a rejecting film.  dermatit_herpetiformis-35-foto  ***Fig.189*** *Dühring's dermatitis herpetiforme*  In non-acantholytic pemphigus, small and large bubbles with serous or hemorrhagic content are formed, after rupture of which painful erosions covered with fibrinous plaque are formed.  • In Dühring's dermatitis herpetiforme , the mucous membrane is extremely rarely affected, morphological elements (vesicles, aphthae, erosions) appear on it only after a skin rash.  In non-acantholytic pemphigus, both skin and mucous membrane are affected.  •In Dühring's dermatitis herpetiforme , in contrast to non-acantholytic pemphigus, eosinophilia is observed in the peripheral blood and the contents of the bubbles in the patients.  •In patients with Dühring's dermatitis herpetiforme , in contrast to patients with non-acantholytic pemphigus, there is an increased sensitivity to iodine preparations (in children, it may be absent).  •In case of Dühring's dermatitis herpetiforme , on the skin, in addition to bubbles and erosions, erythematous spots of different shades can be observed. In non-acantholytic pemphigus, there are no spots.  **3.Differential diagnostics of Dühring's dermatitis herpetiforme and erythema multiforme**  **Common symptoms:**  •The presence of skin elements in the form of erythematous spots of different shades, vesicles  •Erosions located on the hyperemic and edematous mucous membrane  • Negative Nikolsky's symptom and subepithelial location of the bubbles  •Polimorfizm  **Differences:**  •They get sick with Dühring's dermatitis herpetiformeat any age,but in erythema multiforme at a young age, more often up to 30 years.  •Dühring's dermatitis herpetiformeis a polyetiological syndrome, which is the organism 's reaction to exogenous - and endogenous allergens. The etiology of erythema multiforme is infectious and allergic.  • Dühring's dermatitis herpetiformeis a chronic disease in which the general condition of the patient is usually good.  Erythema multiforme begins as an acute infectious disease with general weakness, fever, rheumatoid pain  •In Dühring's dermatitis herpetiforme , surface, solitar , slightly painful, bright red erosions with scalloped edges, partially covered with plaque and a rejecting film, are formed.  In erythema multiforme , painful, extensive erosions are formed, with even outlines, they are merging, covered with a yellowish-gray plaque, along the edges –there are scraps of the bubble's covering epithelium.  • In case of erythema multiforme , in contrast to Dühring's dermatitis herpetiforme , submandibular and cervical lymphadenitis is observed.  •In case of Dühring's dermatitis herpetiforme , cytology of the bubbles and erosions' contents reveals a large number of polyblasts, epithelial cells, leukocytes, microflora.  In Dühring's dermatitis herpetiforme , eosinophilia is observed in the peripheral blood and in the contents of the bubbles.  • In Dühring's dermatitis herpetiforme , in contrast to erythema multiforme , patients have an increased sensitivity to iodine preparations.  **4.Differential diagnostics of Dühring's dermatitis herpetiforme and bullous pemphigoid**  **Common symptoms:**  •Defeat of the skin and mucous membranes  •Presence of bubbles with thick covering and erosions  • edematous and hyperemic oral mucosa  **Differences:**  •In patients with Dühring's dermatitis , in contrast to bullous pemphigoid, hypersensitivity to iodine preparations is noted.  • In Duhring's dermatitis herpetiforme , in contrast to bullous pemphigoid, papules , bubbles and vesicles form on the oral mucosa(polimorfizm).  • In Dühring's dermatitis herpetiformeNikolsky's symptom is negative. In bullous pemphigoid, Nikolsky's symptom (pseudo)may be positive.  • In bullous pemphigoid, the mucous membrane of the border of the hard and soft palate, cheeks is affected. In Dühring's dermatitis herpetiforme, the entire oral mucosa is affected.  • In Dühring's dermatitis herpetiforme , eosinophilia is observed in the peripheral blood and bubbles' contents  • In Dühring's dermatitis herpetiforme , after the vesicles burst, erosions with polycyclic edges are formed  **Bullous pemphigoid is differentiated with :**  **1.Acantholytic pemphigus**  **2.Dühring's dermatitis herpetiforme**  **1.Differential diagnostics of bullous pemphigoid and acantholytic pemphigus**  **Common symptoms:**  •Presence of painful erosions  **Differences:**  • Pemphigus vulgaris mainly affects people over 35 years old. Bullous pemphigoid affects people over 60 years of age.  pemfigoid  ***Fig.190*** *Bullous pemphigoid*  • Pemphigus vulgaris affects the retromolar space, pharynx, soft palate, gums, tongue. Bullous Pemphigoid is localized on the border of the hard and soft palate, cheeks.  •In pemphigus vulgaris , bright red, bleeding erosions with an unpleasant odor,and covered with a grayish plaque, with clear even borders and scraps of bubble 's covering epithelium along the periphery are formed. They tend to merge, located on the slightly edematous, oral mucosa of pale pink color .In bullous pemphigoid, erosions are formed on the background of edematous and hyperemic oral mucosa.  • In contrast to pemphigus vulgaris , in pemphigoid, there is no acantholysis, no acantholytic cells, Nikolsky's symptom is negative, bubbles develop subepithelially.  32  ***Fig.191*** *Bullous pemphigoid*  • In pemphigus vulgaris , the bubbles have a very thin coverings, they quickly burst, so it is not possible to see them in the oral cavity. In bullous pemphigoid, the bubbles have a dense, tense covering, so they can persist for several hours, and sometimes days.  **2.Differential diagnostics of bullous pemphigoid and Dühring's dermatitis herpetiforme**  **Common symptoms:**  •Defeat of the skin and mucous membranes  •Presence of bubbles and erosions  • Swollen and hyperemic oral mucosa  **Differences:**  •Bullous pemphigoid is more common in people over 50 years old.  • In patients with Dühring's dermatitis herpetiforme , in contrast to bullous pemphigoid, hypersensitivity to iodine preparations is noted.  • In Dühring's dermatitis herpetiforme , in contrast to bullous pemphigoid, papules, bubbles and vesicles form on the oral mucosa.  • In Dühring's dermatitis herpetiforme, Nikolsky's symptom is negative. In bullous pemphigoid, Nikolsky's symptom(pseudo) may be positive.  24177918  ***Fig.192*** *Bullous pemphigoid*  •In bullous pemphigoid, the mucous membrane of the border of the hard and soft palate, cheeks is affected. In Dühring's dermatitis herpetiforme , the entire oral mucosa is affected.  **3.Differential diagnostics of bullous pemphigoid and Shingles**  **Common symptoms:**  • Prevalence among the elderly  •Presence of erosions  •Prognosis for life is favorable  **Differences:**  • Shingles is caused by the Varicella zoster virus. The etiology of pemphigoid is not known.  • In Shingles, erosions are small (from a pinhead to a lentil), polycyclic in shape due to the fusion of vesicles. In pemphigoid,there observed bubbles of different diameters (5-20 mm) with scraps of the bubbles' covering epithelium along the edges.  1158  ***Fig.193*** *Shingles*  •In case of Shingles, the localization of rashes on the skin and oral mucosa along the branches of the trigeminal nerve is always one-sided. In pemphigoid, the skin and mucous membranes of the cheeks, the border of the soft and hard palate, gums, nose, genitals, and eyes are affected.  • In Shingles, after the erosions have been healed, pigmentation remains on the skin.  • In Shingles, there are burning, paroxysmal, neuralgic pain along the affected nerves, aggravated by irritants. For pemphigoid, such pain is not typical.  • Shingles can cause complications such as neuralgia, hyperpathy, hyperesthesia for several months and years.  • In bullous pemphigoid, the bubbles are located subepithelially, in Shingles, the vesicles are located intraepithelially  **Independent cheilitis**  **Exfoliative cheilitis is differentiated with:**  **1. Meteorological cheilitis**  **2.Contact allergic cheilitis**  **3. Atopic cheilitis**  **4.Erosive and ulcerative forms of lupus erythematosus**  **5.Pre-cancerous Manganotti’s cheilitis**  **6.Exudative form of actinic cheilitis**  **7. Dry form of actinic cheilitis**  **8. Eczematous cheilitis**  **9.Dry and exudative forms of exfoliative cheilitis are differentiated among themselves**  **1. Differential diagnostics of the dry form of exfoliative cheilitis and meteorological cheilitis.**  **Common symptoms:**  • The defeat of the red border of the lips, a feeling of dryness, peeling and tightening of the lips, which leads to their licking, increased dryness and peeling  •Presence of transparent scales  •Hyperemic red border of the lips  **Differences:**  • Etiology of exfoliative cheilitis is impaired function of the nervous system, anxious depressive reactions. The causes of meteorological cheilitis are solar insolation and other meteorological factors.  •Exfoliative cheilitis is more common in women. Meteorological cheilitis often occurs in people with white and delicate skin, as well as with skin diseases, accompanied by increased dryness.  •In exfoliative cheilitis, mica-like scales of gray or grayish-brown color are formed, tightly attached by their center to the red border of the lips and elevated along the edges, after elimination of which a brightly hyperemic surface is formed (erosion is not formed). In meteorological cheilitis, small scales form on the red border of the lips, erosions and cracks with compaction of their base. In meteorological cheilitis, small scales form on the red border of the lips, erosions and cracks with compaction of their base .  40_10  ***Fig.194*** *Exfoliative cheilitis*  • In exfoliative cheilitis, half of the lips' red border is affected - from the zone of transition of the mucous membrane into the red border of the lip (Klein zone) to the middle of it, without lowering down to the skin of the lips and chin. In meteorological cheilitis, the entire surface of the lips 'red border is affected with more expressed symptoms of inflammation, sometimes the process slightly captures the skin .  •Meteorological cheilitis is difficult to diagnose, on its background, precancerous diseases often develop  **2. Differential diagnostics of the dry form of exfoliative cheilitis and contact allergic cheilitis**  **Common symptoms:**  • Is more common in women over 20 years  • Hyperemic and edematous red border of the lips  • Burning sensation  **Differences:**  • The etiology of exfoliative cheilitis is a dysfunction of the nervous system, anxious depressive reactions. The cause of allergic cheilitis is an allergic reaction to substances in contact with the red border of the lips(lipstick, toothpastes, plastic dentures, mouthpiece of wind instrument).  •In exfoliative cheilitis, mica-like scales of gray or grayish-brown color are formed, tightly attached by their center to the red border of the lips and elevated along the edges, after elimination of which a brightly hyperemic surface is formed (erosion is not formed). In allergic cheilitis, small bubbles form, which are quickly burst and form erosions, cracks.  • In exfoliative cheilitis, half of the red border of the lips is affected - from the zone of transition of the mucous membrane into the red border of the lip (Klein zone) to the middle of it, without going down to the skin of the lip and chin. In allergic cheilitis, the entire surface of the red border of the lips is affected, sometimes with the transition to the skin.  • For allergic cheilitis, in contrast to exfoliative cheilitis, rapid elimination of inflammatory phenomena after elimination of the allergen is characteristic.  **3. Differential diagnostics of dry forms of both exfoliative and atopic cheilitis.**  **Common symptoms:**  • The defeat of the red border of the lips, dryness, peeling, cracking  • An important role of the genetic factor is the presence of pathology of the vegetative nervous system  • The mucous membrane of the lips is not affected  **Differences:**  •In dry form of exfoliative cheilitis, half of the red border of the lips is affected - from the zone of transition of the mucous membrane into the red border of the lip (Klein zone) to the middle of it (the corners of the mouth are not affected), without going down to the skin of the lip and chin. In atopic cheilitis, part of the red border of the lips is affected with the involvement of the adjacent areas of the skin, facial skin (dryness, peeling), and the area of ​​the mouth's corners .  176  ***Fig.195*** *Exfoliative cheilitis*  •Dry form of Exfoliative cheilitis is more common in women between the ages of 20 to 40. Atopic cheilitis is more common in children and adolescents of both sexes between the ages of 7 and 17.  •For atopic cheilitis, in contrast to Dry form of exfoliative cheilitis, lichenization of the skin and lips and erythema are characteristic.  •For atopic cheilitis, in contrast to Dry form of exfoliative cheilitis, a change in periods of exacerbations with remissions, often of a seasonal nature, is characteristic.  •Atopic cheilitis is a symptom of atopic dermatitis or diffuse neurodermatitis. Allergy to food, medications, microorganisms, cosmetics are always detected  **4. Differential diagnostics of exudative form of exfoliative cheilitis and erosive and ulcerative form of lupus erythematosus.**  **Common symptoms:**  •Is more common in women aged 20-40  • Defeat of the red border of the lips  **Differences:**  • In exfoliative cheilitis, the skin of the perioral area is not affected. In lupus erythematosus, the skin of the face is affected, like the wings of a butterfly, including the perioral region, the neck, and the scalp.  •In the exudative form of exfoliative cheilitis, massive scales hanging from the lips in the form of an “apron” are formed. Erosions in exfoliative cheilitis are not formed. In lupus erythematosus, diffuse congestive hyperemia with easily removable scales is observed, along the periphery, hyperkeratosis in the form of tongues of flame, cicatricial atrophy, the formation of erosions and oval-shaped ulcers, located like a ribbon are observed.  398273_html_m1faa74be  ***Fig.196*** *Exfoliative cheilitis*  • In Lupus erythematosus, in contrast to exfoliative cheilitis, there is a strong sensation of burning and itching.  • In exfoliative cheilitis, in contrast to lupus erythematosus, the oral mucosa is not affected  **5. Differential diagnostics of exudative form of exfoliative cheilitis and pre-cancerous Manganotti 'scheilitis o.**  **Common symptoms:**  •Defeat of the red border of the lips  **Differences:**  •Exfoliative cheilitis is more common in women aged 20-40 years. Manganotti’s cheilitis is more common in men aged 40-50 years.  • In exfoliative cheilitis, half of the red border of the lips is affected - from the zone of transition of the mucous membrane into the red border of the lip (Klein zone) to the middle of it. In Manganotti’s cheilitis, the lateral areas of the lower lip are affected.  58  ***Fig.197*** *Exfoliative cheilitis*  •In the exudative form of exfoliative cheilitis, massive scales and crusts of a dark gray color are formed in the form of an “apron”. In Manganotti’s cheilitis, an oval or irregular red erosion is formed with a smooth, polished surface, sometimes covered with a bloody crust, which is difficult to remove.  •In the exudative form of exfoliative cheilitis, the lips are swollen, hyperemic and painful. In Manganotti’s cheilitis, erosions are painless and are sometimes located on a slightly inflamed soft base.  **6.Differential diagnostics of exudative form of exfoliative cheilitis and exudative form of actinic cheilitis**  **Common symptoms:**  •Edema and hyperemia of the red border of the lower lip  •Presence of crusts on the lips  •Painfulness and burning of the lips  **Differences:**  •Exfoliative cheilitis is more common in women between the ages of 20 and 40 years. Actinic cheilitis is more common in men between the ages of 20 and 60.  • The etiology of exfoliative cheilitis is a dysfunction of the nervous system, anxious depressive reactions. The cause of actinic cheilitis is the development of a delayed-type reaction to UV rays.  •In the exudative form of exfoliative cheilitis from the zone of transition of the mucous membrane to the red border of the lip (Klein zone) to the middle of it, without going down to the skin of the lip and chin, massive crusts are formed, hanging from the lip in the form of an apron, after the elimination of which the brightly hyperemic surface of the lip is exposed ,no erosions form. In the exudative form of actinic cheilitis, the lesion captures the entire surface of the red border, bright red erythema, small bubbles, moist erosions, covered with crusts, are formed on it.  •In the exudative form of actinic cheilitis, in contrast to the exudative form of exfoliative cheilitis, there is a relationship with the season (exacerbation in the spring-summer period and remission in the autumn-winter).  **7.Differential diagnostics both of dry forms of exfoliative cheilitis and actinic cheilitis**  **Common signs:**  • Presence of dry scales  •Dryness, burning and painfulness of the lips  **Differences:**  • Exfoliative cheilitis is more common in women between the ages of 20 and 40 years . Actinic cheilitis is more common in men between the ages of 20 and 60.  • Etiology of exfoliative cheilitis is a dysfunction of the nervous system. The cause of actinic cheilitis is the development of a delayed-type reaction to UV rays.  • In the dry form of exfoliative cheilitis, only a part of the red border of the lips from the Klein line to its middle is affected, mica-like scales of gray or grayish-brown color are formed on it, attached by their center to the red border and somewhat lagging along the edges, erosions are not formed. In the dry form of actinic cheilitis, the entire surface of the red border is often affected , often of the lower lip, small silvery-white scales, abrasions, and erosions are formed on it.      ***Fig.198*** *Actinic cheilitis* ***Fig.199*** *Exfoliative cheilitis*  •In dry form of exfoliative cheilitis, in contrast to actinic cheilitis, the pathological process never passes to the skin.  **8. Differential diagnostics of exudative form of exfoliative cheilitis and eczematous cheilitis.**  **Common symptoms:**  • Burning, swelling, redness and painfulness of the lips  •Easy removable scales  **Differences:**  •In the exudative form of exfoliative cheilitis from the Klein zone to the middle of the red border of the lips, without going down to the skin, massive crusts are formed, hanging from the lip in the form of an apron, after removing of which the bright red granular surface of the red border is exposed, no erosions are formed. In eczematous cheilitis, erythema, vesicles, oozings, erosions, cracks, crusts appear on the entire red border of the lips, involving the skin of the perioral region.  • Exfoliative cheilitis is more common in women between the ages of 20 and 40 years. Eczematous cheilitis often affects children of both sexes aged 3 to 16 years, sometimes the elderly.  • In exudate form of exfoliative cheilitis, the scales attach to the red border of the lips only in the center and lag behind along the edges. In eczematous cheilitis, small ring-shaped scales are formed, localized around the areas of hyperemia.  • The etiology of exfoliative cheilitis is a dysfunction of the nervous system, anxious depressive reactions. The cause of eczematous cheilitis is the allergic nature of the disease.  •In contrast to exfoliative cheilitis, in eczematous cheilitis, patients complain of intence itching on the lips.  **9.Dry and exudative forms of exfoliative cheilitis are differentiated among themselves:**  **Common symptoms:**  •Defeat of the red border of the lips, the possibility of the transition from one form of the disease to another. In both forms, various psychopathies are observed.  • Self-healing is impossible  •Defeat of the Klein zone  **Differences:**  • In the case of an exudative form,there is an expressed cosmetic defect, constant, rather severe painfulness of the lips.  •In the exudative form, there is almost always exudate along the lips' closing line, which makes it difficult to eat and speak, therefore the patient's mouth is always slightly open  •In the exudative form, the inflammatory reaction is strongly expressed  **Contact allergic cheilitis is differentiated with:**  **1.Dry form of exfoliative cheilitis**  **2.Dry form of actinic cheilitis**  **3. Atopic cheilitis**  **4.Meteorological cheilitis**  **5. Eczematous cheilitis**  **1.Differential diagnostics of contact allergic cheilitis and dry form of exfoliative cheilitis**  **Common symptoms:**  •It is more common in women over 20 years  •Hyperemic and edematous red border of the lips  • Burning sensation  **Differences:**  • The etiology of exfoliative cheilitis is a dysfunction of the nervous system, anxious depressive reactions. The cause of allergic cheilitis is an allergic reaction to substances by contact with the red border of the lips.  • In exfoliative cheilitis, mica-like scales of gray or grayish-brown color are formed, tightly attached by their center to the red border of the lips and elevated along the edges, after the elimination of which a brightly hyperemic surface is formed (erosion is not formed). In allergic cheilitis, small vesiclles form,which quickly burst and form erosions, cracks.  Kanapulya111  ***Fig.200*** *Allergic cheilitis* ***Fig.201*** *Exfoliative cheilitis*  •In exfoliative cheilitis, half of the red border of the lips is affected - from the zone of transition of the mucous membrane into the red border of the lip (Klein zone) to the middle of it, without going down to the skin of the lip and chin. In allergic cheilitis, the entire surface of the red border of the lips is affected, sometimes with the transition to the skin.  • For allergic cheilitis, in contrast to exfoliative form , rapid elimination of inflammatory phenomena after elimination of the allergen is characteristic.  **2.Differential diagnostics of contact allergic cheilitis and dry form of actinic cheilitis**  **Common symptoms:**  •Defeat of the red border of the lips  • Burning and painfulness of the lips  •Allergic reaction  **Differences:**  •Contact allergic cheilitis is more common in women. Actinic cheilitis is more common in men.  • In contact allergic cheilitis, the red border of the lips and sometimes the skin is affected with the formation of small bubbles that quickly burst and form erosions. In the dry form of actinic cheilitis, the red border of only the lower lip is affected with the formation of small, dry, silvery-white scales. In a long course, hyperkeratosis and vegetation appear  • In contrast to contact allergic cheilitis, malignancy of the dry form of actinic cheilitis is possible.  •Contact allergic cheilitis is a reaction to lipstick, toothpaste, mouthpiece of wind instrument. Actinic cheilitis is a reaction to UV radiation  **3. Differential diagnostics of contact allergic cheilitis and atopic cheilitis.**  **Common signs:**  •Affection of the red border of the lips and adjacent areas of the skin  • Itching and burning of the lips  •Erythema of the red border of the lips  **Differences:**  • Contact allergic cheilitis is more common in women over the age of 20 years . Atopic cheilitis is more common in children and adolescents of both sexes between the ages of 7 and 17 years .  •In contact allergic cheilitis, small vesicles on the red border of the lips that quickly burst are formed. In atopic cheilitis, small vesicles,cracks,scales form on the red border of the lips (especially in the corners of the mouth).  • In atopic cheilitis, in contrast to contact allergic cheilitis, the skin of the face, neck, elbows, popliteal hollows is affected.  • Atopic cheilitis spontaneously heals by the age of 25-26, contact allergic cheilitis - after elimination of the irritant  **4. Differential diagnostics of contact allergic cheilitis and meteorological cheilitis.**  **Common symptoms:**  • A burning sensation, tightness and dryness of the lips  **Differences:**  •Contact allergic cheilitis is more common in women. Meteorological cheilitis often occurs in people with white and delicate skin, or in people with skin diseases, accompanied by increased dryness.  • In contact allergic cheilitis, sharply outlined hyperemia, edema develop at the site of contact with the allergen, there may be vesicular rashes, sometimes the process slightly captures the skin. In meteorological cheilitis, the red border of the lower lip is slightly and unevenly hyperemic, infiltrated, dry, covered with small scales.  **5. Differential diagnostics of contact allergic cheilitis and eczematous cheilitis.**  **Common symptoms:**  •Allergic nature of the disease  • Lesion of the red border of the lips and skin of the perioral region  • Itching and burning of the lips  •Edematous and hyperemic red border of the lips  **Differences:**  •In contact allergic cheilitis on the red border of the lips, small vesicles which rapidly burst form, followed by a transition to erosions and cracks. In eczematous cheilitis, polymorphism of pathological elements on the red border of the lips is observed: vesicles, ring-shaped scales, crusts, cracks, oozing, nodules (lesions can become denser due to inflammatory infiltration), erythematous spots.  • Contact allergic cheilitis is more common in women over the age of 20years .  • By the transition to the chronic form of eczematous cheilitis, inflammation decreases, the red border of the lips is infiltrated, covered with scales, cracks, nodules  **Actinic cheilitis is differentiated with:**  **1.Dry form of exfoliative cheilitis**  **2.Exudative form of exfoliative cheilitis**  **3.Lupus erythematosus without expressed atrophy**  **4 .Contact allergic cheilitis**  **5. Atopic cheilitis**  **6. Manganotti’s cheilitis**  **7. Meteorological cheilitis**  **8. Eczematous cheilitis**  **1.Differential diagnostics both of dry forms of actinic and exfoliative cheilitis**  **Common signs:**  •Presence of dry scales  •Dryness, burning and painfulness of the lips  **Differences:**  •Exfoliative cheilitis is more common in women between the ages of 20 and 40. Actinic cheilitis is more common in men between the ages of 20 and 60 years.  •Etiology of exfoliative cheilitis is a dysfunction of the nervous system. The cause of actinic cheilitis is the development of a delayed-type reaction to UV rays.  • In the dry form of exfoliative cheilitis, only a part of the red border of the lips from the Klein line to its middle part is affected, mica-like scales of gray or grayish-brown color are formed on it, attached by their center to the red border and somewhat lagging along the edges, erosion is not formed. In the dry form of actinic cheilitis, the entire surface of the red border is affected , more often of the lower lip, small silvery-white scales, abrasions, and erosions are formed on it.  •In exfoliative cheilitis, in contrast to actinic cheilitis, the pathological process never passes to the skin.  •In a dry form of actinic cheilitis, in contrast to exfoliative cheilitis, foci of hyperkeratosis, vegetation are formed  **2.Differential diagnostics both of the exudative forms of actinic and exfoliative cheilitis**  **Common symptoms:**  •Edema and hyperemia of the red border of the lower lip  •Presence of crusts on the lips  • Painfulness and burning of the lips  **Differences:**  • Exfoliative cheilitis is more common in women between the ages of 20 and 40. Actinic cheilitis is more common in men between the ages of 20 and 60.  actinic-cheilitis-sq-cell-lip-134-foto  ***Fig.202*** *Actinic cheilitis*  • The etiology of exfoliative cheilitis is a dysfunction of the nervous system, anxious depressive reactions. The cause of actinic cheilitis is the development of a delayed-type reaction to UV rays.  •In the exudative form of exfoliative cheilitis from the zone of transition of the mucous membrane to the red border of the lip (Klein zone) to the middle part of it, without going down to the skin of the lip and chin, massive crusts are formed, hanging from the lip in the form of an apron, after the elimination of which the brightly hyperemic surface of the lip is exposed without erosion. In the exudative form of actinic cheilitis, the lesion captures the entire surface of the red border, bright red erythema, small vesicles , moist erosions, covered with crusts, are formed on it.  •In the exudative form of actinic cheilitis, in contrast to the exudative form of exfoliative cheilitis, there is a relation to the season (exacerbation in the spring-summer period and remission in the autumn-winter period).  **3.Differential diagnostics of dry form of actinic cheilitis and lupus erythematosus without severe atrophy**  **Common symptoms:**  • Burning and pain of the red border of the lips  • Presence of silvery white scales and foci of hyperkeratosis  **Differences:**  • Lupus erythematosus is more common in women aged 20-40 years. Actinic cheilitis is more common in men aged 20-60.  actinic-cheilitis-sq-cell-lip-145-foto  ***Fig.203*** *Actinic cheilitis*  • In lupus erythematosus, in contrast to actinic cheilitis, mainly the skin of the face is affected.  • In lupus erythematosus on the red border of the lips, there is a diffuse congestive hyperemia with easily removable scales, there is no itching,but oval-shaped erosions, located like a ribbon are possible. In the dry form of actinic cheilitis, the pathological process captures the red border of the lower lip, which becomes of a bright red color, covered with small scales, by a long process - foci of hyperkeratosis, vegetation, patients are worried about itching.  **4.Differential diagnostics of dry form of actinic cheilitis and contact allergic cheilitis**  **Common symptoms:**  • Defeat of the red border of the lips  •Burning and painfulness of the lips  **Differences:**  • Contact allergic cheilitis is more common in women. Actinic cheilitis is more common in men.  actinic-cheilitis-sq-cell-lip-5FU-foto  ***Fig.204*** *Actinic cheilitis*  • In contact allergic cheilitis, the red border of the lips and sometimes the skin is affected with the formation of small vesicles, which quickly burst and form erosions. In the dry form of actinic cheilitis, the red border of only the lower lip is affected with the formation of small, dry, silvery-white scales  • In contrast to contact allergic cheilitis, malignancy of the dry form of actinic cheilitis is possible.  **5. Differential diagnostics of exudative form of actinic cheilitis and atopic cheilitis.**  **Common symptoms:**  •Itching and burning of the lips  • Seasonality of the diseases is character  •Presence of erythema on the red border of the lips  • In pathogenesis there is an allergic reaction  **Differences:**  • Actinic cheilitis is more common in men between the ages of 20 and 60. Atopic cheilitis is more common in children and adolescents of both sexes between the ages of 7 and 17.  • In the exudative form of actinic cheilitis, the red border of the lower lip is affected with the formation of small vesicles, moist erosions, covered with crusts. In atopic cheilitis, the red border of the lips (especially the corners of the mouth) is affected with the formation of small scales, cracks, grooves, with the involvement of the skin of adjacent areas of the face, neck, elbow folds, popliteal cavities in the pathological process.  actinic-cheilitis-sq-cell-lip-33-foto  ***Fig.205*** *Actinic cheilitis*  •Atopic cheilitis, in contrast to actinic cheilitis, spontaneously heals by the age of 25-26.  **6. Differential diagnostics of dry form of actinic cheilitis and Manganotti’s cheilitis.**  **Common symptoms:**  •Prevalence among men  •Defeat of the red border of the lower lip  • Tendency to malignancy  **Differences:**  • In the dry form of actinic cheilitis, the entire red border of the lip is affected. In Manganotti’s cheilitis, the lateral part of the lower lip is affected, less often in the center.  •In the dry form of actinic cheilitis, small, dry silvery-white scales, abrasions, erosions on the background of areas of congestive hyperemia are formed. In Manganotti's cheilitis, on a background of slight inflammation or frequently its absence , oval-shaped erosions with a smooth surface of a deep red color, covered with dense bloody or serous crusts are formed.  • In the dry form of actinic cheilitis, burning, itching, painfulness of the lips are observed. In Manganotti's cheilitis, painfulness of the lips is not observed.  •In contrast to actinic cheilitis, erosion in Manganotti’s cheilitis can spontaneously epithelize, do not respond well to medication therapy.  **7. Differential diagnostics of dry forms of actinic cheilitis and meteorological cheilitis.**  **Common symptoms:**  •Defeat of the lower lip  •Presence of small scales  • The cause is - meteorological conditions (insolation, wind, cold)  **Differences:**  • Actinic cheilitis is more common in men. Meteorological cheilitis often occurs in people with white and delicate skin, or in people with skin diseases accompanied by increased dryness.  • In the dry form of actinic cheilitis, the entire red border of the lip becomes bright red. In meteorological cheilitis, the red border of the lip is unevenly slightly hyperemic and infiltrated, dry.  **8. Differential diagnostics of exudative form of actinic cheilitis and eczematous cheilitis**  **Common symptoms:**  • Itching, burning, edema and redness of the lips  •Presence of vesicles, wet erosions, erythema, crusts on the red border of the lips  **Differences:**  •Actinic cheilitis is more common in men between the ages of 20 and 60. Eczematous cheilitis often affects children of both sexes from 3 to 16 years old, sometimes the elderly.  • In the exudative form of actinic cheilitis, the red border of the lower lip is affected. In eczematous cheilitis, the red border of both lips and necessarily the skin of the perioral region is affected.  actinic-cheilitis-sq-cell-lip-44-foto  ***Fig.206*** *Actinic cheilitis*  • By a prolonged course of eczematous cheilitis, nodules form on the red border of the lips, there is a thickening of the affected areas due to inflammatory infiltration  **Meteorological cheilitis is differentiated with:**  **1.Dry form of actinic cheilitis**  **2.Allergic contact cheilitis**  **3.Dry form of exfoliative cheilitis**  **1.Differential diagnostics of meteorological cheilitis and dry form of actinic cheilitis**  **Common symptoms:**  •Defeat of the lower lip  •Presence of small scales  • The cause is - meteorological factors (cold, insolation, wind)  **Differences:**  •Actinic cheilitis is more common in men. Meteorological cheilitis often occurs in people with white and delicate skin, or in people with skin diseases accompanied by increased dryness.  Priznaki-meteorologicheskogo-heylita  ***Fig.207*** *Meteorological cheilitis*  • In the dry form of actinic cheilitis, the entire red border of the lip becomes bright red. In meteorological cheilitis, the red border of the lip is unevenly slightly hyperemic and infiltrated, dry.  • By a prolonged course of the dry form of actinic cheilitis, foci of hyperkeratosis, vegetation are formed on the red border of the lower lip  **2.Differential diagnostics of meteorological cheilitis and allergic contact cheilitis**  **Common symptoms:**  • A burning sensation, tightness and dryness of the lips  **Differences:**  •Contact allergic cheilitis is more common in women. Meteorological cheilitis often occurs in people with white and delicate skin, or in people with skin diseases, accompanied by increased dryness.  • In contact allergic cheilitis, sharply outlined hyperemia, edema develop at the site of contact with the allergen, there may be vesicular rashes, sometimes the process slightly captures the skin. In meteorological cheilitis, the red border of the lower lip is slightly and unevenly hyperemic, infiltrated, dry, covered with small scales.  •After elimination of the allergen, contact allergic cheilitis is cured  **3.Differential diagnostics of meteorological cheilitis and dry form of exfoliative cheilitis**  **Common symptoms:**  •Feeling of dryness and peeling off the lips  •Presence of transparent scales  • Red border of the lips is hyperemic  **Differences:**  •Etiology of exfoliative cheilitis is impaired function of the nervous system, anxious depressive reactions. The causes of meteorological cheilitis are solar insolation and other meteorological factors.  •Exfoliative cheilitis is more common in women. Meteorological cheilitis often occurs in people with white and delicate skin, as well as with skin diseases, accompanied by increased dryness.  • In dry form of exfoliative cheilitis, mica-like scales of gray or grayish-brown color are formed, tightly attached by their center to the red border of the lips and elevated along the edges, after the elimination of which a slightly hyperemic surface is formed (erosion is not formed). In meteorological cheilitis, small scales form on the slightly hyperemic red border of the lips, erosions and cracks with compaction of their base.  398273_html_240ba87d  ***Fig.208*** Meteorological cheilitis  •In exfoliative cheilitis, half of the red border of the lips is affected - from the zone of transition of the mucous membrane into the red border of the lip (Klein zone) to the middle part of it, without lowering to the skin of lips and chin to. In meteorological cheilitis, the entire surface of the red border of the lips is affected with more expressed symptoms of inflammation, sometimes the process slightly captures the skin.  In meteorological cheilitis, the entire surface of the red border of the lips is affected  **Atopic cheilitis is differentiated by:**  **1.Exudative form of actinic cheilitis**  **2.Contact allergic cheilitis**  **3. Streptococcal perleche**  **4.Exfoliative cheilitis**  **5.Lupus erythematosus without expressed atrophy**  **6 .Eczematous cheilitis**  **7. Impetigo**  **1.Differential diagnostics of atopic cheilitis and exudative form of actinic cheilitis**  **Common symptoms:**  **•**Allergic reaction, itching and burning of the lips  • Itching and burning of the lips  • They are characterized by the seasonality  •Presence of erythema on the red border of the lips  **Differences:**  •Actinic cheilitis is more common in men between the ages of 20 and 60. Atopic cheilitis is more common in children and adolescents of both sexes between the ages of 7 and 17.  12  ***Fig.209*** *Atopic cheilitis*  • In Patients with actinic cheilitis history clearly shows the dependence of exacerbations on insolation. After exposure to the sun, the entire red border of the lower lip becomes bright red, covered with small scales. In the exudative form of actinic cheilitis, the lesion is accompanied by the formation of small vesicles, weeping erosions, covered with crusts. In atopic cheilitis, the red border of the lips (especially the corners of the mouth) is affected with the formation of small scales, cracks, furrows, with the involvement of the adjacent areas of the skin of the face, neck, elbow folds, popliteal cavities in the pathological process.  •Atopic cheilitis, in contrast to actinic cheilitis, spontaneously heals by the age of 25-26**2. Differential diagnostics of atopic cheilitis and contact allergic cheilitis**  **Common signs:**  •Affection of the red border of the lips and adjacent areas of the skin  • Delayed allergic reaction, itching and burning of the lips  •Erythema of the red border of the lips  **Differences:**  • In allergic cheilitis, there is a clear relationship between inflammation of the lips and the allergen: lipstick, a specific type of toothpaste, new dentures made of plastic, the place where the mouthpiece of wind instruments is held in the mouth  **•** Contact allergic cheilitis is more common in women over the age of 20. Atopic cheilitis is more common in children and adolescents of both sexes between the ages of 7 and 17.  •In contact allergic cheilitis, small vesicles that quickly burst, form on the red border of the lips. In atopic cheilitis, small scales form on the red border of the lips (especially in the corners of the mouth).  Simptomyi-atopicheskogo-heylita  ***Fig.210*** *Atopic cheilitis*  • In atopic cheilitis, in contrast to contact allergic cheilitis, the skin of the face, neck, elbows, popliteal hollows is affected.  •Atopic cheilitis, in contrast to allergic cheilitis, spontaneously heals by the age of 25-26.  **3.Differential diagnostics of atopic cheilitis and streptococcal perleche**  **Common symptoms:**  •Prevalence among children  •Defeat the corners of the mouth  •Painfulness  **Differences:**  •In the etiology of atopic cheilitis,there is a predisposition to allergy. In the etiology of streptococcal perleche, streptococci play an important role.  •In atopic cheilitis, the lips are infiltrated, peel off with small scales. Streptococcal perleche begins with the formation of a bubble with a flaccid thin cover, after rupture of which erosion, covered with a purulent bloody crust forms.  • In streptococcal perleche, red moist bleeding erosions are formed. Dryness of the lips are characteristic of atopic cheilitis.  •Lip lesions in atopic cheilitis are often combined with dryness, peeling off the skin of the face.  1294747413_ang  ***Fig.211*** *Atopic cheilitis*  •For atopic cheilitis, in contrast to streptococcal perleche, exacerbations are characteristic in the autumn-winter period.  **4.Differential diagnostics of atopic cheilitis and dry form of exfoliative cheilitis**  **Common symptoms:**  •Presence of scales  • Dryness, itching , burning, peeling of the lips  **Differences:**  • In exfoliative cheilitis, half of the red border of the lips is affected - from the zone of transition of the mucous membrane into the red border of the lip (Klein zone) to the middle part of it (the corners of the mouth are not affected), without going down to the skin of the lip and chin. In atopic cheilitis, part of the red border of the lips is affected with the involvement of skin of the the adjacent areas, of facial skin (dryness, peeling), and the area of ​​the corners of the mouth.  148001-foto  ***Fig.212*** *Atopic cheilitis*  •Exfoliative cheilitis is more common in women between the ages of 20 and 40. Atopic cheilitis is more common in children and adolescents of both sexes between the ages of 7 and 17.  •For atopic cheilitis, in contrast to exfoliative cheilitis, lichenization and erythema are characteristic.  •For atopic cheilitis, in contrast to exfoliative cheilitis, a change in periods of exacerbations (autumn-winter)with remissions, often of a seasonal nature, is characteristic. Exfoliative cheilitis proceeds monotonously, without remission.  **5.Differential diagnostics of atopic cheilitis and lupus erythematosus without expressed atrophy**  **Common symptoms:**  •Lip changes associated with facial skin lesions  • Periods of exacerbation and remission are character  **Differences:**  • Lupus erythematosus is more common in women between the ages of 20 and 40. Atopic cheilitis is more common in children and adolescents of both sexes aged 7 to 17 years.  •In lupus erythematosus without expressed atrophy, diffuse congestive hyperemia with easily removable scales on the red border of the lips is observed, there is no itching, but oval-shaped erosions, located like a ribbon, are possible. In atopic cheilitis, lichenization of the red border of the lips is observed, especially of the corners of the mouth, where the process passes to the skin, patients are worried about severe itching.  • In atopic cheilitis, in contrast to lupus erythematosus, spontaneous recovery occurs by the age of 25-26.  • In atopic cheilitis, the oral mucosa is not affected. In lupus erythematosus, lesions of the oral mucosa occur after cutaneous manifestations  **6. Differential diagnostics of atopic cheilitis and eczematous cheilitis.**  **Common symptoms:**  **•** The defeat of half of the lips' red border with the involvement of the adjacent skin areas in the process  • • Itching, burning and peeling of the lips  •Allergic nature of the disease  • The mucous membrane of the lips is not affected  **Differences:**  • In atopic cheilitis, there is lichenization and erythema of the red border of the lips, especially in the corners of the mouth, where the process passes to the skin, small scales are formed. In acute flow of eczematous cheilitis, vesicles, oozing, crusts, easily removable ring-like scales localized around the areas of hyperemia, cracks are formed on the edematous and hyperemic red border of the lips.  In the chronic form, the skin around the mouth thickens, the edema disappears, congestive hyperemia persists, scales, cracks, bloody crusts, and perleches form  •Atopic cheilitis, in contrast to eczematous cheilitis, spontaneously heals by the age of 25-26. In eczematous cheilitis, the process becomes chronic with subsequent outbreaks. The disease lasts for years. The action of the allergen has not been eliminated, since most often there is polyallergy  • In atopic cheilitis, in contrast to eczematous cheilitis, in addition to the red border of the lips, the skin of the face, neck, elbow folds, popliteal hollows is affected.  **7.Differential diagnostics of atopic cheilitis and impetigo**  **Common symptoms:**  •Defeat of the red border of the lips and facial skin  • Prevalence among the child population  • Perleches in the mouth's corners  •Acute onset of the disease  **Differences:**  •The cause of impetigo is both staphylococci and streptococci . The cause of atopic cheilitis is a genetic factor that creates a predisposition to atopic allergy.  • In impetigo, flickens on the affected areas and then moist erosions with abundant golden-yellow crusts form. In atopic cheilitis, small scales, cracks and grooves form in the affected areas.  •In contrast to impetigo, atopic cheilitis has a seasonal character (it is exacerbated in autumn and winter).  • In atopic cheilitis, in contrast to impetigo, spontaneous recovery occurs by the age of 25-26.  175  ***Fig.213*** *Impetigo*  **Eczematous cheilitis is differentiated from :**  **1. Atopic cheilitis**  **2.Allergic contact cheilitis**  **3.Exudative form of actinic cheilitis**  **4.Exudative form of exfoliative cheilitis**  **1.Differential diagnostics of eczematous cheilitis and atopic cheilitis**  **Common symptoms:**  •Affection of a half of the red border of the lips with the involvement of the adjacent skin areas in the process  • • Itching, burning and peeling of lips  •Allergic nature of the disease  • The mucous membrane of the lips is not affected  **Differences:**  •In atopic cheilitis, there is lichenization and erythema of the red border of the lips, especially in the corners of the mouth, where the process passes to the skin, small scales are formed. In acute currency of eczematous cheilitis, vesicles, oozing, crusts, easily removable ring-like scales localized around the areas of hyperemia, cracks are formed on the edematous and hyperemic red border of the lips. In the chronic form, the skin around the mouth thickens, the edema disappears, congestive hyperemia persists, scales, cracks, bloody crusts, and perleches form  atlderm_016  ***Fig.214*** *Eczematous cheilitis*  •Atopic cheilitis, in contrast to eczematous cheilitis, spontaneously heals by the age of 25-26.  In eczematous cheilitis, the process becomes chronic with subsequent outbreaks. The disease lasts for years. The action of the allergen has not been eliminated, since most often there is polyallergy  • In atopic cheilitis, in contrast to eczematous cheilitis, in addition to the red border of the lips, the skin of the face, neck, elbow folds, popliteal hollows is affected.  **2. Differential diagnostics of eczematous cheilitis and allergic contact cheilitis**  **Common symptoms:**  •Allergic nature of the disease  •Affection of the red border of the lips and skin of the perioral region  •Itching and burning of the lips  •Swollen and hyperemic red border of lips  **Differences:**  • In contact allergic cheilitis on the red border of the lips, small vesicles which rapidly bur st form, followed by a transition to erosions and cracks. In eczematous cheilitis, polymorphism of pathological elements is observed on the red border of the lips: vesicles, ring-shaped scales, crusts, cracks, oozing, nodules (lesions can become denser due to inflammatory infiltration), erythematous spots.  • Contact allergic cheilitis is more common in women over the age of 20. After elimination of the allergen, the disease disappears. In eczematous cheilitis, the process becomes chronic with subsequent outbreaks. The disease lasts for years. The action of the allergen has not been eliminated, since most often there is polyallergy  • The oral mucosa in eczematous cheilitis is not affected  **3.Differential diagnostics of eczematous cheilitis and exudative form of actinic cheilitis**  **Common symptoms:**  • Itching, burning, edema and redness of the lips  •Presence of vesicles, erythema, crusts on the red border of the lips  **Differences:**  •Actinic cheilitis is more common in men between the ages of 20 and 60. This is a reaction to ultraviolet radiation, exacerbations are observed in spring-summer. Eczematous cheilitis is a reaction to food, various substances, it is often a hereditary allergy in close relatives  • In the exudative form of actinic cheilitis, the red border of the lower lip is affected. In eczematous cheilitis, the red border of both lips and necessarily the skin of the perioral region are affected.  398273_html_m7dab1120  ***Fig.215*** *Eczematous cheilitis*  •İn the exudative form of actinic cheilitis, moist erosions appear on the red border of the lip. In eczematous cheilitis, ring-shaped scales are formed on the red border of the lips, localized around the areas of hyperemia, cracks, oozing, nodules (there is hardening of the affected areas due to inflammatory infiltration).  **4.Differential diagnostics of eczematous cheilitis and exudative form of exfoliative cheilitis**  **Common symptoms:**  •Burning, edema , redness and painfulness of the lips  •Easy removable scales  **Differences:**  •İn the exudative form of exfoliative cheilitis from the Klein zone to the middle of the red border of the lips, without going down to the skin, massive crusts are formed, hanging from the lip in the form of an apron, after removing of which the bright red granular surface of the red border is exposed, no erosion is formed. İn eczematous cheilitis, erythema, vesicles, oozing, erosions, cracks, crusts appear on the entire red border of the lips, involving the skin of the perioral region.  •Exfoliative cheilitis is more common in women between the ages of 20 and 40.  • In exfoliative cheilitis, the scales are attached to the red border of the lips only in the center and lag behind at the edges. In eczematous cheilitis, small ring-shaped scales are formed, localized around the areas of hyperemia.  •Etiology of exfoliative cheilitis is a dysfunction of the nervous system, anxious depressive reactions. The cause of eczematous cheilitis is the allergic nature of the disease.  • The cause of eczematous cheilitis is an allergic reaction to food, various substances, often hereditary allergy in close relatives. The disease lasts for years, the effect of the allergen is not eliminated, since most often there is polyallergy  •In eczematous cheilitis, in contrast to exfoliative cheilitis, patients complain of intolerable itching in the lips  **Melkerson-Rosenthal' macrocheilitis is differentiated with:**  **1.Quincke's edema**  **2.Erysipelas**  **3.Lymphangioma**  **4.Hemangioma**  **5.Collateral edema of the lips in periostitis**  **6. Lip abscess**  **1.Differential diagnostics of Melkerson-Rosenthal' macrocheilitis and Quincke's edema**  **Common symptoms:**  • Edema of the lips, cheeks, eyelids  •Sudden onset of disease  **Differences:**  • Melkerson-Rosenthal' macrocheilitis is more common in women. Quincke's edema can be in any person, regardless of gender.  1322484138_t4_2144810  ***Fig.216*** *Melkerson-Rosenthal' macrocheilitis*  •The cause of Melkerson-Rosenthal' macrocheilitis has not been completely clarified. The cause of Quincke's edema is an allergy to medications , food and other substances.  otek_kvinke  ***Fig.217*** *Quincke's edema*  • The provoking factors in Melkerson-Rosenthal' macrocheilitis can be an infectious diseases, hypothermia, trauma, skin diseases, inflammation of the lips, neuropsychic stress, sinusitis, tonsillitis, periodontitis.  History reveales the allergy.The provoking factor for Quincke's edema is contact with an allergen.  otek-kvinke3  ***Fig.218*** *Quincke's edema*  •In Melkerson-Rosenthal' macrocheilitis , in contrast to Quincke's edema, there are difficulties in lip movements, paresthesia, paralysis of the facial nerve, folding of the tongue.  •In Melkerson-Rosenthal' macrocheilitis, the color of the lips either does not change, or is of a bluish shadow, the texture of the lip tissue on palpation is soft or densely elastic. In Quincke's edema, the color of the lips does not change and the consistency of the lip tissue on palpation is dense. In Quincke’s edema, the color of the lips does not change, the patient notes a feeling of tension in the tissues of the lip  212  ***Fig.219*** *Quincke's edema*  •In Quincke's edema, in contrast to Melkerson-Rosenthal' macrocheilitis , after elimination of the cause and desensitizing therapy, all phenomena disappear without a trace.  дб  ***Fig.220*** *Quincke's edema*  •In Quincke’s edema, there is a rapid development of edema, a rapid increase in edema of the face, neck, tongue. Laryngeal edema is possible  **2.Differential diagnostics of Melkerson-Rosenthal' macrocheilitis and erysipelas**  **Common symptoms:**  • Painfulness and edema of the pathological foci  **Differences:**  • In Melkerson-Rosenthal' macrocheilitis, there is a shapeless, sometimes uneven swelling of the lips, the color of which is not changed, sometimes they acquire a bluish shadow. In erysipelas, the skin of the face is bright red, hot, slightly elevated and sharply delimited from the surrounding healthy tissue, small vesicles appear on the background of hyperemia.  1322484179_ris  ***Fig.221*** *Melkerson-Rosenthal' macrocheilitis*  •In erysipelas, in contrast to Melkerson-Rosenthal' macrocheilitis, regional lymphadenitis is observed.  • Erysipelas, in contrast to Melkerson-Rosenthal' macrocheilitis, is accompanied by fever, chills, headache, fever.  •For Melkerson-Rosenthal' macrocheilitis, in contrast to erysipelas, a triad of symptoms is characteristic: swelling of the lips, paralysis of the facial nerve, folded tongue.  •Erysipelas is an acute, often recurrent infectious disease caused by beta-hemolytic streptococcus of group A. In Quincke's edema, allergy is revealed from a history  **3. Differential diagnostics of Melkerson-Rosenthal' macrocheilitis and lymphangioma.**  **Common symptoms:**  •Deformation of the affected organs  • Defeat of the tongue, lips  • Painfulness, discomfort while talking, swallowing, chewing  **Differences:**  • Lymphangioma is a benign tumor from lymphoid tissue. It develops slowly over the years. Melkerson-Rosenthal' macrocheilitis is a rare neurological disorder characterized by recurrent facial paralysis, swelling of the face and lips (usually the upper lip), and the development of  folds and furrows in the tongue.  398273_html_m772fd4fc  ***Fig.222*** *Melkerson-Rosenthal' macrocheilitis*  •For Melkerson-Rosenthal' macrocheilitis , in contrast to hemangioma, paralysis of the facial nerve is characteristic.  •In lymphangioma, in contrast to Melkerson-Rosenthal' macrocheilitis, infection of the pathological lesions is observed, causing serious problems.  • Most often, lymphangioma is detected during the first year of a child's life, as a rule, most of such formations are detected by the 3rd year of the life. Melkerson-Rosenthal' macrocheilitis is more common in women  **4.Differential diagnostics of Melkerson-Rosenthal' macrocheilitis and hemangioma**  **Common symptoms:**  • Affection of the lips, tongue  • Blue color of the pathological lesion  •Deformation of the affected organs is observed  •Discomfort while talking, swallowing, chewing  **Differences:**  • Melkerson-Rosenthal' macrocheilitis is a rare neurological disorder that is more common in women. Hemangioma is a benign tumor of blood vessels, often it is a congenital disease or manifests itself in a short period immediately after birth.  • In Melkerson-Rosenthal' macrocheilitis , a shapeless, sometimes uneven swelling of the affected organs is observed. Hemangioma appears as a plane red surface (if capillary) or a lesion elevated above healthy tissue, consisting of wide, large sinuses filled with blood (if cavernous).  • In Melkerson-Rosenthal' macrocheilitis , no impressions remain after palpation. In a hemangioma, when pressed, the lesion turns pale and falls, but then restores its color again.  •In contrast to Melkerson-Rosenthal' macrocheilitis, in hemangioma, the joining of a secondary infection causes ulceration of the lesions.  •For Melkerson-Rosenthal' macrocheilitis , in contrast to hemangioma, paralysis of the facial nerve and folded tongue is characteristic.  **5. Differential diagnostics of Melkerson-Rosenthal' macrocheilitis and collateral edema of the lips in periostitis.**  **Common symptoms:**  • Swelling of the lips  **Differences:**  • The etiology of Melkerson-Rosenthal' macrocheilitis has not been completely clarified. The cause of periostitis is an inflammatory process that occurs as a complication of diseases of the teeth and periodontal tissues.  • In periostitis, in contrast to Melkerson-Rosenthal' macrocheilitis, there is hyperemia, swelling and painfulness of the mucous membrane and soft tissues in the area of ​​the projection of the root of the causative and adjacent teeth.  •Periostitis, in contrast to Melkerson-Rosenthal' macrocheilitis, is accompanied by an increase in body temperature, weakness, chills, and headache.  •Melkerson-Rosenthal' macrocheilitis, in contrast to periostitis, is characterized by the following symptoms: folded tongue and paralysis of the facial nerve.  index_clip_image003  ***Fig.223*** *Melkerson-Rosenthal' macrocheilitis*  •In Melkerson-Rosenthal' macrocheilitis, in contrast to periostitis, there is a shapeless uneven swelling of the lips and sometimes their bluish shadow.  •In periostitis, in contrast to Melkerson-Rosenthal' macrocheilitis, after appropriate treatment, all phenomena disappear without a trace.  **6.Differential diagnostics of Melkersson-Rosenthal syndrome and lip's abscess:**  **Common symptoms:**  • Lip increases in size  **Differences:**  • In case of lip's abscess, patients complain of painfulness of the lip. Palpation of the lip is painful  • In case of lip's abscess, patients usually indicate the cause of the disease. The etiology of macrocheilitis is not fully understood.  • In lip abscess, there may be temperature rise  •Macrocheilitis, in contrast to periostitis, is characterized by the following symptoms: folded tongue and paralysis of the facial nerve  **Differential diagnostics of glandular cheilitis is not difficult due to the typical clinical picture. As can be seen from the table, Differential diagnostics** **should be carried out to determine the clinical form of glandular cheilitis:**  **Differences:**   |  |  |  | | --- | --- | --- | | **Clinical form** | **Common clinical signs** | **Отличительные признаки** | | **Simple primary glandular cheilitis** | Hyperplasia and inflammation of the small salivary glands of the lower lip due to its anomaly. The appearance of salivary glands in the Klein area Clinical signs are poorly expressed. No complaints | Клинические признаки выражены слабо. Жалоб нет | | **Simple secondary glandular cheilitis** | The mouths of the small salivary glands are dilated .It develops again on the background of various diseases of the lips (lichen planus, lupus erythematosus, leukoplakia) without congenital hyperplasia of the salivary glands. Therefore, the elements of these diseases are determined, the phenomenon of inflammation of the epithelium. Patients complain of pain that aggravates by irritation, a sensation of tuberosity of the mucous membrane of the lips, roughness | Развивается вторично на фоне различных заболеваний губ (красный плоский лишай, красная волчанка, лейкоплакия) без врожденной гиперплазии слюнных желез. Поэтому определяются элементы данных заболеваний, явления воспаления эпителия. Больные жалуются на боль, усиливающуюся при раздражении, ощущение бугристости слизистой оболочки губы, шероховатость | | **Purulent glandular cheilitis** | The mouths of the small salivary glands are dilated The general condition is disturbed, there is painfulness, swelling, enlargement of the lower lip, discharge of purulent exudate from the ducts, lip abscess. Submental lymph nodes are enlarged, painful, soft to the touch | Общее состояние нарушено, наблюдается болезненность, отечность, увеличение нижней губы, выделение гнойного экссудата из протоков, абсцесс губы. Подподбородочные лимфатические узлы увеличены, болезненны, мягкие на ощупь |   **4.Differential diagnostics of chronic recurrent lip's cracks:**  **1. Herpes simplex**  **2.Vitamin B12 - folate deficiency anemia**  **3.Acute or chronic lip injury**  **4. Malignancy of chronic recurrent lip's crack**  **1.Differential diagnostics of chronic recurrent lip's crack and herpes simplex:**  **Common symptoms:**  •Recurrent lesion of the red border of the lips  **Differences:**  • In herpes simplex, rashes are in the form of vesicles and erosions, spreading to the perioral skin. In a chronic recurrent lip's crack , one or more cracks covered with a bloody crust are found. On palpation, the cracks are soft, moderately painful. Sometimes old scars or hyperkeratosis around the cracks are visible  •Simple herpes has a viral etiology. The pathology of chronic recurrent lip's crack is based on vascular-tissue and neurogenic mechanisms, and often a deteriation of the psychoemotional sphere.  • The duration of herpes simplex on the lips is 7 days on average. Chronic recurrent lip's crack heals in the summer, and in the cold season it recurs for many years. Self-healing is extremely rare and temporary. Traditional treatment usually gives a short-term effect, relapses occur in the same place  •Chronic recurrent lip's cracks usually begin in childhood or adolescence, most often in men aged 16 to 46  **2. Differential diagnostics of chronic recurrent lip's cracks**  **and vitamin B12-folate deficiency anemia:**  **Common symptoms:**  • Lip's cracks are mostly situated in the corners of the mouth, they are painful, bleeding  **Differences:**  • In case of vitamin B12-folate deficiency anemia, the color index of the blood is below 1  • Cracks in B12-folate deficiency anemia do not recur. Chronic recurrent lip's cracks heal in the summer, and in the cold season they recur for many years, with relapses occurring in the same place  • In case of vitamin B12-folate deficiency anemia, a rapid positive effect is observed by parenteral administration of vitamin B12. In chronic recurrent cracks, self-healing occurs extremely rarely and is temporary. Traditional treatment usually has a short-term effect  • In case of B12-folate deficiency anemia, Gunter's glossitis, red spots on the mucous membrane of the cheeks and lips, are found.  •B12-folate deficiency anemia is more common in women over 50 years of age. Chronic recurrent cracks usually begin in childhood or adolescence, most often in men aged 16 to 46  **3.Differential diagnostics of chronic recurrent lip's cracks** **and acute or chronic trauma of the lip:**  **Common symptoms:**  • Pain in the lip that makes it difficult to speak, smile, eat  **Differences:**  • In acute or chronic trauma, hyperemia, erosion, ulcer, wound on the red border of the lip are found, according to the traumatic factor. In a chronic recurrent lip's cracks , one or more cracks covered with a bloody crust are found. On palpation, the cracks are soft, moderately painful. Sometimes old scars or hyperkeratosis around the cracks are visible  • By the elimination of the traumatic factor, pain and clinical manifestations disappear. In case of acute trauma, it should be taken into account the data of the anamnesis. In chronic recurrent cracks, self-healing occurs extremely rarely and is temporary. Traditional treatment usually has a short-term effect,moreover, relapses occur in the same place  **4. Differential diagnostics of chronic recurrent lip's cracks** **and its malignancy:**  **Common symptoms:**  • Chronic lip's crack  **Differences:**  • In cancer, the course is longer, conservative treatment becomes ineffective  • In case of malignancy of the crack, there is a compaction of its edges and base, painlessness. On palpation of a chronic recurrent crack, it is soft, moderately painful. Sometimes old scars or hyperkeratosis around the crack are visible  • In cancer, the lymph nodes are enlarged, dense, soldered, moderately painful  **Anomalies and independent diseases of the tongue**  **Black ("hairy") tongue is differentiated with:**  **1. Pigmentation of the tongue papillae due to nutrition and medications intake**  **2.Pigmented -papillary dystrophy**  **3. Hairy leukoplakia**  **4 .Discoloration of the tongue in Addison's disease**  **1.Differential diagnostics of black(“hairy”) tongue and pigmentation of the tongue papillae due to nutrition and medications intake (pseudo black tongue)**  **Common symptoms:**  •Tongue coloration  •Unusual appearance of the tongue  **Differences:**  • Black(“hairy”) tongueoccurs in middle-aged and older men. Pigmentation of the tongue's papillae due to nutrition and medications intake can be in any person, regardless of gender and age.  •In a black(“hairy”) tongue, the filiform papillae reach up to 2-3 cm in length, up to 2 mm in diameter, the lesion has an oval or triangular shape and is located along the midline of the tongue.  317  ***Fig.224*** *Black ("hairy") tongue*  In the case of exogenous staining, expressed hyperplasia of the filiform papillae is absent, the entire dorsum of the tongue is stained.  • In exogenous staining of the tongue, in contrast to the black("hairy") tongue, after the medication is discontinued, the color normalizes within a few days.  •In a black ("hairy") tongue, in contrast to exogenous staining, patients are worried about the sensation of a foreign body on the dorsum of the tongue, the appearance of a gag reflex when talking, a feeling of itching in the palate.  Black-Hairy-Tongue  ***Fig.225*** *Black ("hairy")*  **2. Differential diagnostics of black ("hairy") tongue and pigmented -papillary dystrophy.**  **Common symptoms:**  •Discoloration of the tongue  •Sensation of a foreign body in the mouth  • Prevalence among people over 40 years of age  **Differences:**  • In case of pigmented-papillary dystrophy, in contrast to the black ("hairy") tongue,both the skin (in the form of brown hypermelanous spots with a velvety surface, in which the skin pattern is enhanced) and the oral mucosa (in the form of abundant papillomatous growths, small dense nodules of a grayish-slate color) are affected.  •In a black ("hairy") tongue, keratinization of the papillae is observed and they seem to be "combed" from front to back.  a96029592085  ***Fig.226*** *Black ("hairy") tongue*  In pigmentary-papillary dystrophy, the papillae do not become keratinized and the tongue looks "shaggy".  •Pigmented-papillary dystrophy, in contrast to the black ("hairy") tongue, is characterized by an abrupt onset, a severe course of the disease and an unfavorable prognosis (after a diagnosis, such patients rarely live more than 2 years).  **3.Differential diagnostics of black hairy tongue and hairy leukoplakia:**  **Common symptoms:**  •Discoloration of the mucous membrane of the tongue  **Differences:**  • Hairy leukoplakia is more often localized on the lateral surfaces of the tongue, the entire epithelium of the mucous membrane is affected. In a black hairy tongue, the lesion is triangular in the posterior and middle thirds of the back of the tongue.  • Hairy leukoplakia has dense, irregularly shaped diffuse elements. In a black tongue, hypertrophy of the filiform papillae is observed.  • Hairy leukoplakia is associated with HIV infection. HIV blood tests are positive  **4.Differential diagnostics of black hairy tongue and discoloration of the tongue in Addison's disease:**  **Common symptoms:**  • Discoloration of the mucous membrane of the tongue  •No mucosal inflammation  **Differences:**  • In Addison's disease, there are brown stripes, rings, ovals, spots on the lateral surfaces of the tongue. Lips, cheeks, gums are also affected. In black hairy tongue, the lesion is triangular in the posterior and middle thirds of the back of the tongue.  • In Addison's disease, skin hyperpigmentation (bronze color) is observed due to chronic insufficiency of the adrenal cortex  **Desquamative glossitis is differentiated from:**  **1. Lichen planus (LP)**  **2. Plane Leukoplakia**  **3.Glossalgia**  **4. Plaques in secondary syphilis**  **5.Hypovitaminosis B 2, B 6, B 12**  **6.Allergic glossitis**  **7. Rhomboid glossitis**  **8.Acute pseudomembranous candidiasis**  **1.Differential diagnostics of desquamative glossitis and Lichen planus (typical form)**  **Common symptoms:**  •Whitish-gray color of the pathological lesions  • Burning sensation  **Differences:**  • Lichen planus is more common in women aged 40-60. Desquamative glossitis occurs equally often in different age groups.  • In the typical form of Lichen planus, small papules form with clear, jagged edges in the form of a lace mesh. They are located on the apparently unchanged oral mucosa and slightly elevate above its level. In desquamative glossitis, on the background of the swollen epithelium of the filiform papillae of the tongue, desquamation areas, clearly delimited from the surrounding mucous membrane, are formed in the form of sinking red spots.  a1d5da55dfdc279ed15b5006251ea4dc  ***Fig.227*** *Desquamative glossitis*  •In Lichen planus , in contrast to desquamative glossitis, the red border of the lips, retromolar area, mucous membrane of the urethra, genitals, stomach, esophagus, anus, conjunctiva can be affected.  •In desquamative glossitis, in contrast to Lichen planus , the outlines of desquamation foci change daily.  •Papular skin rashes may occur with Lichen planus  **2. Differential diagnostics of desquamative glossitis and plane leukoplakia**  **Common symptoms:**  •Grayish areas of opacity and keratinization of the epithelium  •Burning, pain and itching of the tongue  •Affection of the dorsum and lateral surfaces of the tongue  **Differences:**  • Desquamative glossitis occurs equally often in different age groups. Leukoplakia occurs in middle-aged and older people, more often in men.  • In desquamative glossitis, smooth and round areas of desquamation alternate with areas of keratinization (the surface of the tongue resembles a geographical map).  cd3eb30ac15997ebc22435729f3fbb91  ***Fig.228*** *Desquamative glossitis*  In leukoplakia, a hyperkeratotic spot or plaque is formed with clear boundaries of the lesion, resembling a lapis burn or glued thin tissue paper.  •On the tongue, leukoplakia is localized more often on the lateral surface, often according to the traumatic factor. Other parts of the oral mucosa may also be affected.  •In leukoplakia, the oral mucosa is affected much more often than in desquamative glossitis.  •In desquamative glossitis, the appearance of the lesions changes daily.  •Desquamative glossitis is a congenital condition that is often familial. Leukoplakia is an acquired disease that occurs as a protective reaction of the mucous membrane to local stimuli.  **3. Differential diagnostics of desquamative glossitis and glossalgia.**  **Common symptoms:**  • Burning and painfulness of the tongue  **Differences:**  • Desquamative glossitis is an inflammation of the tongue. Glossalgia is a disease of the nervous system.  •In desquamative glossitis, local changes in the form of foci of desquamation and keratinization are visible in the tongue. In glossalgia, there are no local changes in the tongue.  •Desquamative glossitis occurs equally often in different age groups. Among the patients with glossalgia, women over 40 are predominate.  1322401147_glossit2  ***Fig.229*** *Desquamative glossitis*  •In glossalgia, in contrast to Desquamative glossitis, there is swelling, heaviness, discomfort of the tongue, slurred speech, a symptom of "sparing the tongue", dry mouth.  • In glossalgia, pain during eating disappears. In Desquamative glossitis, pain while eating is aggravated by mechanical, physical, chemical factors, but may be absent.  •In glossalgia, in contrast to Desquamative glossitis, vegetative disorders are observed: hyperemia or paleness of the mucous membrane of the tongue or mouth, swelling of the tongue, cheeks.  • In Desquamative glossitis, pain in the tongue is observed at the site of injury. In glossalgia, pain is observed on the entire surface of the tongue.  **4.Differential diagnostics of desquamative glossitis and plaques in secondary syphilis**  **Common symptoms:**  • Smooth, whitish, shiny, rounded patches on the dorsum and lateral surfaces of the tongue  **Differences:**  •In case of papular syphilis, desquamation foci with compaction at the base appear on the tongue sinking below the level of the mucous membrane ("plaques of the mown meadow"). In desquamative glossitis, around a bright red desquamation focus without compaction at the base, there is a slightly elevated , non-desquamated white epithelium that grows rapidly along the periphery.  169_lor  ***Fig.230*** *Desquamative glossitis*  •For secondary syphilis, the focusness of the location of the foci is characteristic. In desquamative glossitis, the foci overlap each other, new foci appear on the background of old foci (resembles a geographical map).  •Desquamative glossitis, in contrast to syphilis, is characterized by a rapid change in the outlines of desquamation foci (changes in one day).  • In secondary syphilis, polyadenitis, papular, roseolous skin rashes are possible  •Serological blood reactions to syphilis are sharply positive, in bacteriological examination, pale treponemas are found in large numbers  **5. Differential diagnostics of desquamative glossitis and hypovitaminosis B2, B 6, B 12.**  **Common symptoms:**  •Defeat of the tongue  **Differences:**  •In hypovitaminosis B2 and B6, in contrast to desquamative glossitis, there are lesions of the skin (in the form of redness, peeling, cracks, crusts, erosions), eyes, cheilitis, neuritis, neurodermatitis.  • In hypovitaminosis B12, in contrast to desquamative glossitis, dysfunctions of the digestive tract, nervous system and hematopoiesis are observed.  • In desquamative glossitis, desquamation sites alternate with areas of normal mucosa ("geographic tongue"). In hypovitaminosis of B group, the tongue is bright red, smooth, shiny ("polished tongue").  **6. Differential diagnostics of desquamative glossitis and allergic glossitis.**  **Common symptoms:**  • Burning sensation in the tongue, hyperemic spots on the dorsum of the tongue  **Differences:**  •In allergic catarrhal glossitis, in contrast to desquamative glossitis, there are hemorrhages, edema, diffuse or limited hyperemia of the oral mucosa.  •Allergic glossitis is characterized by a “lacquered” tongue (bright red), desquamative glossitis is characterized by a “geographic” tongue.  60  ***Fig.231*** *Desquamative glossitis*  •In the etiology of allergic glossitis, there observed taking of medications or removable dentures made of acrylic resin. Moreover, in case of allergy to plastic - edema and hyperemia of the mucous membrane, according to the boundaries of the prosthesis are revealed. The etiology of desquamative glossitis has not been completely clarified.  • In case of allergic glossitis , after stopping the medication intake that caused the disease, complaints disappear a few days after stopping the use of dentures is observed  **7.Differential diagnostics of desquamative and rhomboid glossitis**  **Common symptoms:**  • Defeat of the tongue  • Sometimes a burning and tingling sensation in the tongue  •Long course of the disease  **Differences:**  •Rhomboid glossitis is more common in men (smokers and alcohol abusers). Desquamative glossitis occurs equally often in different age groups.  • In desquamative glossitis, the foci of desquamation alternate with foci of keratinization ("geographic tongue").  2-9  ***Fig.232*** *Desquamative glossitis* ***Fig.233*** *Rhomboid glossitis*  In rhomboid glossitis, the lesion is located closer to the root of the tongue along the midline, clearly delimited from the rest of the areas,is slightly compacted.  •Rhomboid glossitis, in contrast to desquamative glossitis, can become malignant  **8. Differential diagnostics of desquamative glossitis and acute pseudomembranous candidiasis:**  **Common symptoms:**  • Whitish areas on the dorsum of the tongue, threads, white stripes, burning sensation in the tongue  **Differences:**  • From a history in candidiasis, long-term use of antibiotics, glucocorticoids, cytostatics, diabetes mellitus is observed.  • In the scraping during bacteriological examination, blastospores, filaments of the mycelium of the Candida fungus in large quantities are found. Accordingly, antifungal treatment has a positive effect  • In candidiasis, the mucous membrane is hyperemic, plaque is found in the deep folds of the oral cavity  **Rhomboid glossitis is differentiated with :**  **1. Desquamative glossitis**  **2.Hypovitaminosis B2, PP, B12**  **3. Chronic hyperplastic candidiasis**  **4. Papillomatosis**  **5. Secondary syphilis**  **6.Tumor-like formations of the tongue**  **1.Differential diagnostics of rhomboid and desquamative glossitis**  **Common symptoms:**  • The lesion is rounded or oval,of red color , loss of papillae  • Sometimes a burning and tingling sensation in the tongue  •Long course of the disease  **Differences:**  •Rhomboid glossitis is more common in men (smokers and alcohol abusers). Desquamative glossitis occurs equally often in different age groups.  • in desquamative glossitis, the foci of desquamation alternate with foci of keratinization ("geographic tongue").  The previously desquamated zones are again covered with filiform papillae.  • In rhomboid glossitis, the lesion is located closer to the root of the tongue along the midline, clearly delimited from the rest of the areas,is slightly compacted.  2-17-18  ***Fig.234*** *Rhomboid glossitis*  •Rhomboid glossitis, in contrast to desquamative glossitis, can become malignant.  • In desquamative glossitis, the lesion is rarely solitar , in rhomboid glossitis- is more often solitar  **2.Differential diagnostics of rhomboid glossitis and hypovitaminosis (B2, PP, B12)**  **Common symptoms:**  • Defeat of the tongue  **Differences:**  •Rhomboid glossitis is more common in men (smokers and alcohol abusers). Hypovitaminosis occurs equally often in different age groups.  • In case of rhomboid glossitis, the lesion is located closer to the root of the tongue along the midline, clearly delimited from the rest of the areas,is slightly compacted.  en34_206  ***Fig.235*** *Rhomboid glossitis*  In hypovitaminosis PP, B2 and B12, the tongue becomes bright red, smooth, shiny and dry, the papillae get atrophy.  •For B2 hypovitaminosis, dermatitis, cheilitis are characteristic. PP hypovitaminosis is characterized by dementia, diarrhea, dermatitis. For hypovitaminosis B12, defeat of the peripheral nerves are characteristic. All of these signs are absent in case of rhomboid -shaped glossitis.  **3. Differential diagnostics of rhomboid glossitis (tubercular and papillomatous forms) and chronic hyperplastic candidiasis:**  **Common symptoms:**  • Defeat of the tongue  • Milky white color of the center of the focus  **Differences:**  •Rhomboid glossitis is more common in men (smokers and alcohol abusers). Candidiasis is more common in infants and the elderly, especially those who are weakened by chronic diseases.  • In rhomboid glossitis, the lesion is located closer to the root of the tongue along the midline in the form of tuberous growths with the areas of keratinization.  smomatology186  ***Fig.236*** *Rhomboid glossitis*  In candidiasis, on the background of a hyperemic mucous membrane of the tongue and other parts of the oral cavity, a dense grayish-yellow plaque is found. If plaque is scraped off, a bleeding eroded surface is exposed  • In candidiasis, there is a burning sensation, painfulness in the mouth. These symptoms are observed in rhomboid glossitis in case of inflammation.  •The diagnosis of candidiasis is clarified on the basis of microscopic examination of scraping taken from the affected area.  **4.Differential diagnostics of rhomboid glossitis (tubercular and papillomatous forms) and papillomatosis**  **Common symptoms:**  • Areas of keratinization of grayish-white color  •Focal lesion elevating above the surface of the mucous membrane  •Ability to malignancy  **Differences:**  • In rhomboid glossitis, the lesion is located closer to the root of the tongue along the midline in the form of tuberous growths.  4  ***Fig.237*** *Rhomboid glossitis*  In papillomatosis, the lesion has a fungiform or rounded shape, located on a leg or broad base.  •Papillomas can also affect other parts of the oral mucosa.  **5. Differential diagnostics of rhomboid glossitis and secondary syphilis:**  **Common symptoms:**  •Red shiny areas of rounded outlines on the dorsum of the tongue, dense on palpation  **Differences:**  • The lesion site in secondary syphilis is rarely solitar , in rhomboid glossitis - more often solitar  • In syphilis, the element of defeat is papule. In addition to the tongue, the tonsils, soft palate, and arches are affected.  •Serological blood reactions in syphilis are positive. Bacterioscopy reveals pale treponemas in large numbers  • In syphilis, polyadenitis, papular, roseolous skin rash is possible  **6.Differential diagnostics of rhomboid glossitis and tumor-like formations of the tongue:**  **Common symptoms:**  **•** Tuberous formations and papillomatous growths on the dorsum of the tongue, dense and painless on palpation  **Differences:**  **•**Anamnesis, clinic, cytological examination confirm the tumor  **The fissured tongue is differentiated from :**  **1.Sclerosing glossitis in tertiary syphilis**  **1.Differential diagnostics of fissured tongue and sclerosing glossitis in tertiary syphilis**  **Common symptoms:**  • Lobularity of the tongue  **Differences:**  • In tertiary syphilis, the tongue becomes denser, and inactive  •Serological blood reactions to syphilis are positive  • In tertiary syphilis, painful cracks, an ulcer are found in the tongue, malignancy is observed  **Precancerous diseases of the oral mucosa and the red border of the lips**  **Bowen's disease is differentiated with :**  **1.Leukoplakia**  **2. Lichen planus**  **3.Chronic injuries**  **4. Lupus erythematosus**  **5. Papular syphilis**  **1.Differential diagnostics of Bowen's disease and leukoplakia**  **Common symptoms:**  • Focuses of hyperkeratosis in the form of grayish-white plaques  • Prevalence among men  •Clear boundaries of the pathological focus  **Differences:**  • Typical localization of leukoplakia foci is the buccal mucosa along the dental closing line in the anterior region, the corners of the mouth and the red border of the lower lip. Typical localization of Bowen's disease is the retromolar region, uvula, tongue, soft palate.  • The morphological element of Bowen's disease is a macular-nodular lesion located on a hyperemic mucosa, when scraped, a velvety stagnant red surface with uneven edges is exposed.  The morphological element of defeat in leukoplakia is a hyperkeratotic spot located on the apparently unchanged mucous membrane, it is rough and dry, and cannot be removed by scraping.  •Histologically, in Bowen's disease, in contrast to leukoplakia, giant cells are found.  • In leukoplakia, patients are worried about the feeling of tightness, burning, dryness of the mucous membrane. There are no subjective sensations in Bowen's disease.  • In leukoplakia, the lesion may slightly elevate above the mucous membrane, in Bowen's disease, it sinks  **2. Differential diagnostics of Bowen's disease and lichen planus (LP)**  **Common symptoms:**  •Foci of keratinization with clear uneven edges on a hyperemic background  • Prevalence among people over 40 years of age  • Skin lesions  **Differences:**  • Lichen planus is more common in women. Bowen's disease is more common in men.  •In lichen planus, the lesion is keratinized, slightly elevating above the level of the mucous membrane, papules of a whitish-gray color, prone to fusion in the form of a pattern resembling a lace mesh or a snowflake. In Bowen's disease, the lesion is often a solitar bright red spot with a velvety, non- surface which with long-term existence it sinks  • In Bowen's disease, histological examination reveals a picture of dyskaryosis, polymorphism or a sharp atypia of epithelial cells characteristic of cancer  • In contrast to Bowen's disease, lichen planus also affects the skin.  •In Bowen's disease, in contrast to lichen planus, the pathological focus atrophies and sinks in comparison with the surrounding tissues.  • In lichen planus, it is impossible to remove plaque from the surface of the papules, since it is a consequence of hyperkeratosis. In Bowen's disease, plaque can be removed.  **3.Differential diagnostics of Bowen's disease and chronic trauma**  **Common symptoms:**  • Prevalence among the elderly  •Solitary foci  **Differences:**  • The traumatic ulcer has hyperemic edges,is painful on palpation, its floor is covered with necrotic plaque. The pathological focus in Bowen's disease is in the form of easily bleeding erosions on a hyperemic background, slightly sinking in comparison with the surrounding areas.  •Histologically, in Bowen's disease, giant cells with multiple nuclei are found.  •After elimination of the irritant, rapid epithelisation of the traumatic ulcer occurs. Removing the injury does not affect the course of Bowen's disease.  • Favorite localization of Bowen's disease on the oral mucosa is the soft palate, uvula, tongue, retromolar region. Traumatic ulcers are more often localized on the tongue, lips, cheeks along the dental closing line.  **4. Differential diagnostics of Bowen's disease and lupus erythematosus:**  **Common symptoms:**  • A congestive -red lesion may sink slightly, around it there is a phenomenon of hyperkeratosis  •Skin lesions  •Phenomena of mucosal atrophy  **Differences:**  • In lupus erythematosus, the lesion does not have clear contours  • In lupus erythematosus, on the skin of the face,there are characteristic changes in the form of a "butterfly"    **5. Differential diagnostics of Bowen's disease and papular syphilis:**  **Common symptoms:**  • Whitish lesions  • Skin lesions  **Differences:**  • In papular syphilis, lesions are rarely solitary, have a regular rounded shape, with a dense infiltrate at the base  • If removing the plaque from the foci, a meat-red colored erosion with even elevated edges is exposed. In Bowen's disease, the lesion is a maculo-nodular lesion or erosion with a velvety surface  • Bowen's disease is more common among men over 40  • In papular syphilis, serological reactions are positive  **Warty precancer is differentiated from:**  **1.Papilloma**  **2. Common wart**  **3. Keratoacanthoma**  **4.Cutaneous horn**  **5. Pyogenic granuloma**  **6. Malignancy of warty precancer**  **1.Differential diagnostics of warty precancer and papilloma**  **Common symptoms:**  •Roundish tumor-like formation, elevating above the surrounding tissues  •Painlessness of formations  •Tuberous surface of formations  •Acanthosis is histologically detected  •May be keratinized, acquiring a gray color  **Differences:**  •Warty precancer is localized only on the red border of the lower lip. The papilloma on the lip occupies a borderline position between the red border and the oral mucosa or is located only on the oral mucosa.  •In warty precancer, there is a nodule of stagnant red color, dense consistency,its surface is covered with a layer of hard-to-remove, densely-seated gray scales.  398273_html_bb66e06  ***Fig.238*** *Warty precancer*  Papilloma is soft in consistency, often mobile, located on a pedicle or on a broad base, pearly white, with a smooth or wrinkled surface  • In contrast to papilloma, warty precancer rapidly becomes malignant (in 1-2 months).  •Histologically, in Bowen's disease, giant cells with multiple nuclei are found.  **2. Differential diagnostics of warty precancer and common wart:**  **Common symptoms:**  •Cauliflower-like hemispherical formation  **Differences:**  • Warty precancer is localized only on the red border of the lower lip. The preferred localization of the wart is the anterior part of the oral cavity: the mucous membrane of the lateral surfaces and the tip of the tongue, the corners of the mouth, the skin around the lipsborodavka_mouth-7-a-foto  ***Fig.239*** *Wart on the tongue*  •In warty precancer, a nodule has a stagnant red color, its surface is covered with a layer of hard-to-remove, densely-seated gray scales.  1322487049_ris  ***Fig.240*** *Warty precancer*  Warts are usually multiple elements of a pale pink color, with a characteristic papillary surface that can merge, or a flattened papule with clear rounded contours of bright color.  •In contrast to warty precancer, warts of the oral mucosa are combined with lesions of the skin of the hands, genital mucosa.  •Finally, the diagnosis of warty precancer is confirmed by the results of histological examination  • In contrast to warts, warty precancer quickly becomes malignant (in 1-2 months).  •Warty precancer is common in men over 50. The common wart is more common in children.  **3.Differential diagnostics of warty precancer and keratoacanthoma**  **Common symptoms:**  •Presence of a painless, reddish nodule  • Defeat of the red border of the lips  **Differences:**  • In case of keratoacanthoma, in the center of the nodule there is a funnel-shaped depression filled with easily removed corneous masses. In warty precancer, the surface of the nodule is covered with a layer of hard-to-remove, densely-seated gray scales.  •In contrast to warty precancer, in keratoacanthoma, spontaneous disappearance, as well as relapses of the disease, are possible.  • In contrast to karatoacanthoma, warty precancer quickly becomes malignant (in 1-2 months).  •In keratoacanthoma, after self-healing, an atrophic pigmented scar remains  **4. Differential diagnostics of warty precancer and cutaneous horn:**  **Common symptoms:**  • Dense, limited, elevating lesion on the red border of the lip, up to 1 cm in diameter  •May become malignant  **Differences:**  •Cone-shaped cutaneous horn is in the form of a horn, of a dirty- gray or brownish –gray color. In warty precancer, the nodule is stagnant-red, its surface is covered with a layer of hard-to-remove, densely-seated gray scales.  •Warty precancer quickly becomes malignant (in 1-2 months)  **5. Differential diagnostics of warty precancer and pyogenic granuloma:**  **Common symptoms:**  • An elevating solitary formation on the red border of the lip  **Differences:**  •Pyogenic granuloma is of deep red color, soft consistency, may be on the leg. The surface is macerated, covered with purulent crusts. If squeezed, pus may appear. In warty precancer, there is a dense nodule of stagnant red color, its surface is covered with a layer of hard-to-remove, densely-seated gray scales.  •Warty precancer quickly becomes malignant (in 1-2 months)  •Warty precancer is more common among men over 50 years . Pyogenic granuloma is more common in children and adolescents  •Pyogenic grunuloma is a benign post-traumatic proliferation of capillary-type vessels occurring on the background of chronic, sluggish inflammation caused by staphylo-streptococcal infection. Possible causes of warty precancer are: mechanical trauma, lingering herpes (changes in the epithelium under the influence of the virus), constant dryness, peeling and lips' cracks  • In contrast to warty precancer, pyogenic granuloma, in addition to the red border of the lips, is localized on the tongue, gums, mucous membrane of the edentulous alveolar margin  **6. Differential diagnostics of warty precancer and its malignant form:**  **Common symptoms:**  • Dense, stagnant colored red nodule  **Differences:**  • Enlargement of the focus and strengthening of its keratinization  • On the surface, cracks bleeding, compaction at the base appear  **Limited precancerous hyperkeratosis of the lips' red border is differentiated with :**  **1.Leukoplakia**  **2.Lupus erythematosus**  **3. Lichen planus**  **4.Exfoliative cheilitis**  **5. Malignancy of limited precancerous hyperkeratosis**  **1.Differential diagnostics of limited precancerous hyperkeratosis of the 'red border and leukoplakia (on the red border of the lips)**  **Common symptoms:**  • The presence of a grayish-white color of the hyperkeratotic focus on the lips' red border  •Prevalence among the middle-aged and the elderly  **Differences:**  • The morphological element of defeat in leukoplakia is a hyperkeratotic spot of various shapes and sizes with clear boundaries, rough and dry, depending on the shape, it can elevate above the level of the mucous membrane, without scales  ***Fig.241*** *Leukoplakia*  Limited precancerous hyperkeratosis has a flat surface slightly sinking in relation to the surface of the lip, , covered with thin, densely sitting scales.  •The focus of the limited precancerous hyperkeratosis is small in comparison with leukoplakia.  •Finally, the diagnosis of limited precancerous hyperkeratosis of the lips' red border is confirmed by the results of histological examination  • Leukoplakia affects the mucous membrane of the mouth's corners , cheeks along the dental closing line, tongue  **2.Differential diagnostics of limited precancerous hyperkeratosis of the** lips' **red border and lupus erythematosus**  **Common symptoms:**  • Area of atrophy and hyperkeratosis on the lips' red border  with grayish-white scales  **Differences:**  •Lupus erythematosus is more common in women aged 20-40 years. Limited precancerous hyperkeratosis is more common among middle-aged and older men.  • In contrast to limited precancerous hyperkeratosis, clinical forms of lupus erythematosus are accompanied with burning sensation and pain, aggravated by eating and talking.  • Limited precancerous hyperkeratosis has a small, even, slightly sinking in relation to the surface of the lip, a surface without inflammation. The focus of atrophy and hyperkeratosis in lupus erythematosus is more extensive, located on the hyperemic and limitedly infiltrated lips'red border.  1322487388_ris  ***Fig.242*** *Precancerous hyperkeratosis*  Lupus erythematosus is characterized by a typical lesion of the facial skin in the form of a "butterfly"  • Lupus erythematosus of the lips, in contrast to limited precancerous hyperkeratosis, can be complicated by glandular cheilitis.  • In UVA light, areas of hyperkeratosis in lupus erythematosus give a snow-white or dull white glow.  •Finally, the diagnosis of limited precancerous hyperkeratosis of the lips' red border is confirmed by the results of histological examination  **3.Differential diagnostics of limited precancerous hyperkeratosis of the** lips'  **red border and lichen planus (LP)**  **Common signs:**  • Whitish-gray lesions of hyperkeratosis on the lips' red border  **Differences:**  •Lichen planus is more common in women. Limited precancerous hyperkeratosis is more common among men.  • Limited hyperkeratosis is located only on the lips' red border, Lichen planus, in addition to the lips' red border, affects the mucous membrane of the retromolar region, tongue  • In Lichen planus, in contrast to limited precancerous hyperkeratosis, patients often complain of a burning sensation, tightness, and dryness.  •Limited precancerous hyperkeratosis has a flat surface slightly sinking in relation to the lip, , covered with thin, densely sitting scales.  398273_html_m5a5f5788  ***Fig.243*** *Precancerous hyperkeratosis*  In Lichen planus , papules form, which coalesce to form a stellate pattern.  • Lichen planus , in contrast to limited precancerous hyperkeratosis, can be complicated by glandular cheilitis.  •In Lichen planus, in contrast to limited precancerous hyperkeratosis, the skin of the inner surface of the forearms, lower leg, sacrum, wrist joints, and genitals is affected.  •In UVA light, lesions in Lichen planus , in contrast to limited precancerous hyperkeratosis, give a whitish-yellow glow.  •Finally, the diagnosis of limited precancerous hyperkeratosis of the lips' red border is confirmed by the results of histological examination  **4. Differential diagnostics of limited precancerous hyperkeratosis and exfoliative cheilitis:**  **Common symptoms:**  • Scales on the lips' red border  **Differences:**  • In exfoliative cheilitis, the Klein zone is covered with scales  • In exfoliative cheilitis, the scales are easily removed or have elevated edges and are tightly fixed in the center.In limited hyperkeratosis, the scales are not scraped off  •Exfoliative cheilitis is common among women, limited hyperkeratosis - among men over 60 years old  **5. Differential diagnostics of limited precancerous hyperkeratosis and its malignant form:**  **Common symptoms:**  •Foci of hyperkeratosis on the red border of the lips  **Differences:**  •In case of a malignant form, the keratinization process intensifies, the appearance of erosion, bleeding, compaction at the base is possible  **Manganotti's abrasive precancerous cheilitis is differentiated with:**  **1.Erosive form of leukoplakia**  **2.Erosive form of lichen planus (LP)**  **3.Erosive form of lupus erythematosus**  **4. Pemphigus vulgaris**  **5 .Actinic cheilitis**  **6.Erythema multiforme**  **7.Herpetic erosion**  **8. Manganotti's abrasive precancerous cheilitis**  **1.Differential diagnostics of Manganotti's abrasive precancerous cheilitis and erosive form of leukoplakia**  **Common symptoms:**  •Spread more common among middle-aged and older men  •Erosion on the red border of the lips  •Ability to malignancy  •Erosions do not respond well to medication therapy  **Differences:**  • The morphological element of defeat in the erosive form of leukoplakia is erosion, cracks or ulcers of various shapes and sizes with clear boundaries in the center of the focus of hyperkeratosis.The morphological element in Manganotti's abrasive precancerous cheilitisis oval-shaped erosion with a smooth, polished surface,of deep red color, sometimes covered with bloody crusts.  •In contrast to Manganotti's abrasive precancerous cheilitis, in the erosive form of leukoplakia, pain is observed, which increases by eating, talking.  • Erosions in Manganotti's abrasive precancerous cheilitisspontaneously disappear, then recur again  **2. Differential diagnostics of Manganotti's abrasive precancerous cheilitis and erosive form of Lichen Planus**  **Common symptoms:**  •Presence of bleeding erosions after elimination of crusts or plaque  • Prevalence among people over 40 years  •Erosions do not respond well to medication therapy  **Differences:**  •Lichen Planus is more common in women. Manganotti's abrasive precancerous cheilitis is more common in men.  • In erosive form of Lichen Planus , on the background of expressed inflammation of the oral mucosa, irregular erosions are located, covered with fibrinous plaque, with papules around in the form of a lace pattern. The morphological element in Manganotti's abrasive precancerous cheilitisis oval-shaped erosion, located on a background of slight inflammation or more often its absence, with a smooth polished surface, deep red in color, sometimes covered with bloody crusts.  • In contrast to Manganotti's abrasive precancerous cheilitis, in Lichen planus , a typical pattern is possible on the mucous membrane of the cheeks, tongue, and the skin may be affected.  •Erosions in Manganotti's abrasive precancerous cheilitis are often solitary. Erosions in the erosive form of Lichen Planus are often multiple and painful.  •Finally, the diagnosis of Manganotti's abrasive precancerous cheilitis is confirmed by the results of histological examination.  **3.Differential diagnostics of Manganotti's abrasive precancerous cheilitis** **and lupus erythematosus (erosive form)**  **Common symptoms:**  • Erosion on the lips' red border  •Oval-shaped, pathological lesion of bright red color  **Differences:**  •Lupus erythematosus is more common in women aged 20-40 years. Manganotti's abrasive precancerous cheilitis predominantly occurs in men over 50.  •In the erosive and ulcerative forms of lupus erythematosus, in contrast to Manganotti's abrasive precancerous cheilitis , lesions of the red border of the lips are combined with skin lesions.  • In the erosive and ulcerative forms of lupus erythematosus on the background of expressed inflammation, edematous painful erosions, ulcers, cracks, covered with bloody purulent crusts appear, around which hyperkeratosis is visible in the form of blurred tongues of the flame. In Manganotti's abrasive precancerous cheilitis, on a background of minor catarrhal inflammation or more often its absence, painless erosion appears with a smooth, as if polished surface, sometimes covered with a bloody or serous crust.  l2do  ***Fig.244*** *Manganotti's abrasive precancerous cheilitis*  • In lupus erythematosus, its typical manifestations on the skin of the face are observed in the form of a "butterfly"  **4.Differential diagnostics of Manganotti's abrasive precancerous cheilitis and pemphigus vulgaris**  **Common symptoms:**  •In pemphigus vulgaris, the primary morphological element is a bubble  •Bright red erosions, covered with hemorrhagic crusts  •Localization of erosions on a background of slight inflammation  **Differences:**  • In Manganotti's abrasive precancerous cheilitis , erosion is painless. In pemphigus vulgaris , the pain is severe, most intense when talking and eating.  •In pemphigus vulgaris , in contrast to Manganotti's abrasive precancerous cheilitis , the skin, mucous membranes of the esophagus, intestines, stomach, pharynx, internal organs and central nervous system are affected.  • Pemphigus vulgaris is characterized by a positive Nikolsky's symptom, the presence of acantholytic cells in scrapings taken from the surface of erosion.  **Common symptoms:**  •Prevalence among males  • Erosion on the red border of the lip  **Differences:**  • In the dry form of actinic cheilitis, the entire lips'red border is affected. In Manganotti's abrasive precancerous cheilitis, the lateral part of the lower lip is affected, less often in the center.  398273_html_77311d38  ***Fig.245*** *Manganotti's abrasive precancerous cheilitis*    • In the dry form of actinic cheilitis, small, dry silvery-white scales, abrasions, erosions on the background of areas of congestive hyperemia are formed. In Manganotti's abrasive precancerous cheilitis, on the background of slight inflammation, oval-shaped erosions with a smooth surface of a deep red color, covered with dense bloody or serous crusts are formed.  •In the dry form of actinic cheilitis, burning, itching, painfulness of the lips are observed. In Manganotti's abrasive precancerous cheilitis, painfulness of the lips is not observed.  •In contrast to actinic cheilitis, erosions in Manganotti's abrasive precancerous cheilitis can spontaneously epithelize.  • The dry form of actinic cheilitis is exacerbated in the spring-summer period. Full recovery is possible in winter  **6.Differential diagnostics of Manganotti's abrasive precancerous cheilitis and erythema multiforme**  **Common symptoms:**  • Prevalence among men  •Presence of erosions covered with bloody crusts  **Differences:**  • Young people are more likely to suffer from erythema multiforme. Manganotti's abrasive precancerous cheilitisis common among elder and senile people.  •Erosions in Manganotti's abrasive precancerous cheilitisare painless. In erythema multiforme , erosions are severely painful even at rest.  •Erythema multiforme , in contrast to Manganotti's abrasive precancerous cheilitis, has a seasonal recurrent course and an acute onset of the disease.  • In contrast to Manganotti's abrasive precancerous cheilitis, in erythema multiforme, cockades are formed on the skin.  • In case of erythema multiforme , erosions are located on the edematous and inflamed oral mucosa and have remnants of the bubble covering along the edges. Other areas of the oral mucosa are also affected. In Manganotti's abrasive precancerous cheilitis erosions are located on the background of a slight inflammation of the lips' red border.  •Erosions in Manganotti's abrasive precancerous cheilitisare characterized by a sluggish and persistent course and do not respond well to medication therapy.  Epithelisation of erosions in erythema multiforme occurs in 7-12 days.  •Erythema multiforme is characterized by polymorphism (bubbles, urtica, spots, erosion, crust)  **7.Differential diagnostics of Manganotti's abrasive precancerous cheilitis and erosions in chronic recurrent herpes**  **Common symptoms:**  • Defeat of the lips' red border  •Bright red erosions covered with bloody crusts  •Localization of erosions on a background of slight inflammation  **Differences:**  •Erosions in chronic recurrent herpes have a polycyclic shape due to the burst group of vesicles  • In contrast to Manganotti's abrasive precancerous cheilitis, chronic recurrent herpes is caused by the herpes simplex virus.  • Chronic recurrent herpes, in contrast to Manganotti's abrasive precancerous cheilitis, begins with a burning sensation, itching.  • In chronic recurrent herpes, the lips'red border is affected with the capture of the adjacent skin. Erosions in Manganotti's abrasive precancerous cheilitis are localized on the lateral areas of the lips' red border.  398273_html_m31a441e1  ***Fig.246*** *Manganotti's abrasive precancerous cheilitis*  •In chronic recurrent herpes, in contrast to Manganotti's abrasive precancerous cheilitis, other parts of the oral mucosa are affected.  •Erosions in chronic recurrent herpes are painful, in Manganotti's abrasive precancerous cheilitis these are painless.  •Erosions in Manganotti's abrasive precancerous cheilitis, in contrast to erosions in chronic recurrent herpes, are characterized by a sluggish and persistent course and are difficult to treat.  Healing of erosions in chronic recurrent herpes occurs in 7-10 days  • In chronic recurrent herpes, giant cells can be found in the scraping  **8. Differential diagnostics of Manganotti's abrasive precancerous cheilitis and lip's cancer**  **Common symptoms:**  • Defeat of the red border of the lower lip  • Prevalence among men over 50 years  •Presence of irregular ulcers or erosions  •When removing the crusts from the surface of erosions, bleeding is observed  **Differences:**  • Erosions in Manganotti's abrasive precancerous cheilitis have a smooth, polished surface. In cancer, ulcers have an uneven granular floor and ridge-like, inverted edges.  398273_html_m53c11e60  ***Fig.247*** *Manganotti's abrasive precancerous cheilitis*  •Erosions in Manganotti's abrasive precancerous cheilitis are painless. In lip's cancer, itching, discomfort while eating, involuntary salivation occur.  •Finally, the diagnosis of lip's cancer is confirmed by the results of histological examination  • In lip's cancer, there is a compaction at the base and around the erosion, bleeding at the slightest injury, papillary growths on the erosion surface.  •Finally, the diagnosis of lip's cancer is confirmed by histological examination - conglomerates of atypical cells are found  **Keratoacanthoma is differentiated with :**  **1.Papilloma**  **2. Ordinary wart**  **3. Warty precancer**  **4. Cancer of lip's**  **red border**  **1.Differential diagnostics of keratoacanthoma and papilloma**  **Common symptoms:**  •Tumor-like formation, elevating above the surrounding tissues  •Painlessness of the formations  • Acanthosis is histologically detected  • Ability to malignancy  **Differences:**  •Keratoacanthoma, in contrast to papilloma , is more often localized on the lip's red border, very rarely on the tongue.  398273_html_76ebadc4  ***Fig.248*** *Keratoacanthoma*  Papilloma on the lip occupies a borderline position between the red border and the mucous membrane or is located only on the mucous membrane.  •In keratoacanthoma,there is a nodule of grayish-red color, dense consistency,with a small funnel-shaped depression in the center, filled with easily removable horny masses observed. Papilloma is soft in consistency, often mobile, located on a pedicle or broad base, pearly white, with a smooth or wrinkled surface  • In contrast to papilloma, keratoacanthoma can spontaneously disappear with the formation of an atrophic pigmented scar.  •Source of papillomas - is the sick person or virus carrier.  **2.Differential diagnostics of keratoacanthoma and ordinary wart**  **Common symptoms:**  •Tumor-like formation, elevating above the surrounding tissues  •Spontaneous disappearance  **Differences:**  •Keratoacanthoma is localized on the lip's red border, very rarely on the tongue. The preferred localization of the wart is the anterior part of the oral cavity: the mucous membrane of the lateral surfaces and the tip of the tongue, the corners of the mouth, the skin around the lips  borodavka_mouth-8-a-foto  ***Fig.249*** *Ordinary wart*  borodavka_mouth-5-a-foto  ***Fig.250*** *Ordinary wart*  •In keratoacanthoma, a nodule of grayish-red color, dense consistency,  with a small funnel-shaped depression in the center, filled with easily removable horny masses is observed.  keratoakantoma_262-a-foto  ***Fig.251*** *Keratoacanthoma*  Warts in the oral cavity are usually multiple with a characteristic papillary surface, pale pink, or in the form of a flattened papule with clear rounded contours of bright color. Is more common in children  •In contrast to keratoacanthoma, wart lesions of the oral mucosa are combined with lesions of the skin of the hands and genital mucosa.  • Keratoacanthoma, in contrast to a wart, can transform into cancer.  •The source of warts is the sick person or a virus carrier.  **3.Differential diagnostics of keratoacanthoma and warty precancer**  **Common symptoms:**  •Presence of a painless, reddish nodule  •Defeat of the lip's red border  **Differences:**  • In case of keratoacanthoma, in the center of the nodule there is a funnel-shaped depression filled with easily removed horny masses.  keratoakantoma_14-a-foto  ***Fig.252*** *Keratoacanthoma*  In warty precancer, the surface of the nodule is covered with a layer of hard-to-remove, densely-seated gray scales.  • In contrast to warty precancer, in keratoacanthoma, spontaneous disappearance, as well as relapses of the disease, are possible.  • In contrast to karatoacanthoma, warty precancer quickly becomes malignant (in 1-2 months).  • Histological examination of warty precancer reveals atypical cells upon transformation into cancer  **4. Differential diagnostics of keratoacanthoma and cancer of the lip's red border**  **Common symptoms:**  •Defeat of red border of the lower lip  •Prevalence among men over 50 years  **Differences:**  •In case of keratoacanthoma, the morphological element is a nodule of grayish-red color, dense consistency, with a small funnel-shaped depression in the center, filled with easily removed horny masses.  keratoakantoma_10-a-foto  ***Fig.253*** *Keratoacanthoma*  In cancer of the lip's red border ,a morphological element is or an ulcer with an uneven granular floor and roller-like, inverted edges, or a rough hardening covered with a scab.  • Keratoacanthoma is painless, mobile, not soldered to the underlying tissues. In lip's cancer, itching, discomfort while eating, involuntary salivation occur.  •Finally, the diagnosis of lip's cancer is confirmed by the results of histological examination  •In contrast to cancer, in keratoacanthoma, spontaneous disappearance and relapses of the disease are possible.  **TESTS**  1.In medication-induced stomatitis ***it is not*** appeared on the oral mucosa:  A) proliferation of circumvallate papillae B) erosion and bullae C) edema and hyperemia D) positive test E) hemorrhage 2.Diagnosis if contact stomatitis is mainly based on: A) additional examination methods B) laboratory analysis C) clinical symptoms D) cytology E) anamnesis  3.They **are not** used in the treatment of ulcers :  A) antibiotics and proteolytic enzymes B) corticosteroids and nitric acid  C) mouth rinse of furasilin  D)anesthetics and keratoplastics  E) antiseptic and anesthetic applications 4. Traumatic injuries caused by alkali are treated with: A) enzymes ,solcoseril ointment , mouth rinse of KMnO4 B) carbolic (phenol ) acid , antibiotics , sea buckthorn C) analgesics , vitamins A and E , antibiotics D) 0,5 Citric acid, nitric and hydrochloric acids  E) corticosteroid ointment , antiseptics , chamomile broth 5.When injury of oral mucosa caused by radiation they are manifested as: A) dryness, glossitis, glossalgia B) hypersalivation , hyperemia , erosion C) dryness, catarrhal gingivitis, edema , erosion  D) aphthae , gingivitis , erosion E) edema , gingivitis , glossitis 6.It is referred to local radiomucositis:  A) radiation injury B) alkaline injury C) acid defeat D) viral damage E) candidiasis 7.Linear defect of the mucous membrane is named as : A) crust B) erosion C) ulcer D) aphtha E) crack  8. Cellular lysis occurred in horny layer of epithelium is named:  A) parakeratosis B) acantholysis  C) acanthosis D) dyskeratosis E) spongiosis 9.Keratinized element is characteristic for : A) chronic recurrent afthous stomatitis B) recurrent herpes and erythema multiforme  C) pemphigus and herpes simplex D) lichen planus and leukoplakia  E) tuberculosis and syphilis 10.Travmatic ulcer **is not** differentiated with : A) syphilis B) Tuberculosis C) Pemphigus vulgaris  D) cancer E) Bowen's disease  11.On the upper jaw along the edge of prosthesis a traumatic injury is called as: A) prosthetic granuloma B) prosthetic stomatitis C) papillae hyperplasia D) decubital ulcer E) leukoplakia 12.Lupus erythematous is referred to:  A) traumatic lesions B) specific infections C) benign tumors D) viral diseases E) collagen diseases  13. Lupus erythematous **is not** differentiated with: A) lichen planus B) Pemphigus vulgaris  C) actinic cheilitis D) Manganotti cheilitis  E) leukoplakia 14.Causal agent of Vincent's ulcerative- necrotizing stomatitis is : A) streptococci B) Candida albicans C) Treponema pallidum D) fuzo -spirochetes  E) Koch's bacillus 15.**It is not** referred to infectious disease: A) fungal defeat  B) specific diseases C) leukoplkia  D) viral E) Vincett stomatitis  16.Typical symptom of AIDS is:  A) diffuse lymphadenopathy B) tubercles  C) blisters D) erythema on the face E) bullae 17.It is used in the treatment of chronic recurrent aphthous stomatitis: A) salicylates and vitamins B) antibiotics and antiseptics C) analgesics and hypotensive drugs D) antimicrobial and antihistamines E) antiviral therapy and immune-modulators  18.It is referred to the red border of lips : A) eosinophilic granuloma B) crack  C) desquamative glossitis D) decubital ulcer E) crack, granuloma 19.***It is not*** used in Vincent stomatitis : A) ascorutin B) flagil and metronidazole  C) vitamins of B group  D) cytostatics  E) broad-spectrum antibiotics 20.***It is not*** an early symptom of AIDS : A) Kaposi 's sarcoma B) candidiasis C) pemphigus  D) recurrent aphthae E) Hairy leukoplakia  21. ***It is not*** differentiated with traumatic ulcer : A) recurrent aphthous stomatitis B) syphilis C) tuberculosis D) trophic ulcer E) cancer  22. ***It is not***  used in severe acute herpetic stomatitis : A) ascorutin B) Calcium gluconate C) suprastin or tavegil D) vitamin C and P E) carbolic acid (phenol )  23. ***It is not***  referred to primary morphological elements : A) papule B) aphtha  C) blister D)pustule  E) nodus 24. ***It is not*** referred to secondary morphological elements : A) erosion B) ulcer C) crack D) spot  E) scar 25.**It is not** an indicator of general clinical analysis of blood : A) leukocytes B) red blood cells C) total protein  D) color index E) trombocytes  26. What is a local radiomucosittis : A) injury of mucosa by rays B) injury of mucosa by acids C) injury of mucosa by virus D) traumatic damage of mucosa  E) candidiasis of the oral mucosa 27.Laboratory diagnosis of leukoplakia is : A) electrodiagnostics B) X-ray C) nuclear magnetic resonance D) tomogram E) histology and cytology  28.***It is not*** referred to laboratory diagnostics methods :  A) cytology B) blister test  C) Bacteriology D) serological tests E) biopsy 29.Pemfigus ***is not*** differentiated from: A) erythema multiforme B) pemphigoid C) drug allergies D) candidiasis  E) bullous form of lichen planus 30. ***It is not*** used in topical treatment of pemphigus: A) anti-candidiasis B) epithelization  C) antiviral  D) anti-inflammatory E) Hormone  31. Nicolsky's symptom is positive in : A) pemphigus vulgaris  B) syphilis C) drug allergy D) erythema multiforme E) bullous form of lichen planus 32. Lesions in lichen planus are manifested : A) on the oral mucosa  B) on the throat C) only on the skin D) on the lips E) on the skin and oral mucosa  33.Main morphological element of lichen planus is : A) aphtha B) keratinized papule  C) erosion D) pustule E) tubercle 34. Main morphological element of pemphigus is : A) papule B) blister C) erosion D) bullae  E) pustule 35.***It is not*** used in the treatment of lichen planus: A) sedation therapy B) vitamins C) antibiotics  D) delagil - hingamin E) antihistamine 36.Depending on degree of malignancy , the diseases are divided into: A) obligate and facultative precancers  B) obligate precancers C) flat and erosive precancers D) facultative precancers and keratosis E) ulcerative form lichen planus  37.It is referredto Bowen's disease : A) diseases of the endocrine system B) facultative precancers C) keratosis D) diseases of the hematopoietic system E) obligate precancers  38.Symptom of warty precancer is : A) Painful palpation B) painless palpation  C) bleeding on mucosa D) erosion on mucosa E) scars on mucosa 39. Manganotti's cheilitis is provocated by : A) bacterial infection B) stress C) bad habits D) sunlight  E) leukoplakia 40.Causal agent of candidiasis is: A) treponema pallidum B) Mycobacterium of tuberculosis C) yeast fungus  D) virus of herpes simplex E) Streptococcus and staphylococcus  41. Causal agent of candidiasis is : A) antibiotics B) anesthetics  C) sulfonamides D) corticosteroids E) antihistamine 42.It is used in the treatment of candidiasis: A) butadione B) heparin C) bonafton D) clotrimazole  E) Indomethacin 43. Lesions in hyperplastic of candidiasis are : A) pustules B) large papules  C) petechiae D) hematomae  E) erythema 44.Candidal cheilitis ***is not*** differentiated from: A) lichen planus B) eczematous cheilitis C) avitaminous cheilitis D) simple herpetic stomatitis  E) lupus erythematous  45. It is effective when candidiasis perleche: A) ethacridine lactate B) potassium permanganate C) levorin ointment  D) " Oksikort " ointment  E) tetracycline ointment 46.It is effective in long –term candidous process: A) diflukan B) antibiotics C) corticosteroids D) metronidazole E) sulfonamides 47. Main symptom of desquamative glossitis is : A) strong emotion B) headache  C) depression D) syncope E) cancerophobia  48.***It is not***  used in the treatment of hairy tongue : A) sanitation of oral cavity B) glucocorticoid ointments  C) keratoplasty means  D) cryo-destruction  E) hyposensitization therapy 49.Fissured tongue belongs to the syndrome of : A) Papillon - Lefevre B) Stevens - Johnson C) Isenko -Cushing D) Melkerson -Rosenthal  E) Sjögren 50.Romboid glossitis is combined with: A) diabetes mellitus B) colitis C) candidiasis  D) vitamin B2 deficiency E) gastritis 51.Desquamative glossitis ***is not*** differentiated from: A) erythema multiforme  B) rhomboid glossitis C) secondary syphilis D) lichen planus E) candidiasis 52.It is referred to the forms of rhomboid glossitis : A) papillary , erosive , tubercle B) erosive , plane , verrucous  C) typical , bullous , hyperkeratotic  D) hyperkeratotic , papillary , atrophy E) plane, tubercle , papillary  53.The color of the lesion in desquamative glossitis is : A) cyanotic B) red  C) orange D) purple  E) yellow up to coffee 54.Pathological elements in exfoliate cheilitis is : A) crust B) ulcer C) vesicle D) squama(scale)  E) erosion 55.***It is not*** referred to the etiology of exfoliate cheilitis : A) bad habits B) thyroid disease C) spicy food  D) emotional stress E) genetic factor 56.Types of exfoliate cheilitis are : A) dry and exudate B) erosive and cortical C) dry and aphthous D) exudative and bullous  E) erosive and ulcerative  57.After removal of scales it is appeared on the mucosa : A) aphtha B) erosion C) plaque D) ulcer E) thinned epithelium  58.Atopic cheilitis is : A) an independent disease B) symptom of systemic atopy  C) the manifestation of herpes infection D) referred to gastrointestinal pathologies E) neuroendocrine pathology 59.It is affected when atopic cheilitis: A) only the corners of the mouth B) area of oral mucosa C) the surface of the lips and tongue D) red lip border, mouth corners and peri-lip area  E) surface of the lips  60.Mucosa membrane of the mouth is composed of : A) 4 -layers B) 2 -layers C) 3 -layers  D) 5 -layers E) 7 -layers 61. Oral mucosa contains of : A) stratified squamous epithelium B) three-layered squamous epithelium C) a single-layer cylindrical epithelium D) double-layer cylindrical epithelium E) double-layer corneal epithelium  62.Submucous layer of the oral cavity is most expressed : A) on the tongue B) under the gum C) on the soft palate D) on the hard palate E) along the muco-alveolar fold  63***. It is not*** referred to functions of oral mucosa : A) protective B) odontotropic  C) plastic D) sensitive E) absorptive 64.Primary element of oral mucosa is : A) scar B) erosion C) crust D) tubercle  E) crack 65. Secondary element of oral mucosa is: A) nodule B) spot C) crust  D) blister E) pustule  66. An accumulation of fluid between the cells of spinous layer is named: A) spongiosis B) acantholysis C) parakeratosis D) hyperkeratosis E) balloon degeneration 67. The diagnostic method used in the examination of mucous membrane is : A ) electro diagnostics B) percussion C) thermal diagnostics D) ultrasonic  E) inspection  68. When fluorescent diagnosis of oral diseases the rays are used of : A) infra-red B) Vud  C) ultrasonic  D) helio  E) roentgen  69 . ***It is not*** referred to the functional methods when examination of mucous membranes**:** A) fluorescent diagnostics B) blister test C) histamine test D) serological examination  E) diagnostics in the rays of Vud  70. ***It is not*** an infectious disease of the oral mucosa:  A) bacterial B) viral C) collagen diseases  D) venereal (syphilis , tuberculosis) E) candidamycosis  71. ***It is not*** referred to allergic manifestations in the oral cavity: A)Sjögren's syndrome B) Quincke angioedema C) anaphylactic shock D) drug-induced stomatitis E) Stevens -Johnson syndrome 72. The main microorganisms revealed in gingivostomatitis of Vincent are: A) fungi B) viruses C) Staphylococcus D) Bacteria E) fuzospirochetes  73. ***It is not*** referred to the cause of exogenous intoxication of the oral mucosa :  A) lead B) sodium chloride  C ) mercury D) aluminum E) bismuth 74. Character change in the blood when viral diseases: A) an increase of erythrocytes B) leukocytosis C)thrombocytopenia D) leukopenia  E) reduction of red blood cells 75. The main element in acute herpetic stomatitis : A) blister, scale B) ulcer, tubercle C) bubble , erosion  D) crack , nodus E) aphtha ,cyst 76. ***It is not*** a clinical form of chronic recurrent aphthous stomatitis : A) Duhring's disease B) Behcet's syndrome C) Setton syndrome  D) large aphthosis of Touraine E) scarring aphthous stomatitis 77. Causative agent of tuberculosis in the oral cavity is : A) Leffler bacillus B) sticks of Schroeder C) treponema pallidum D) pigmented viruses E) Koch's bacillus  78.***It is not*** referred to viral diseases of oral cavity: A) Foot and Mouth Disease B) thrush  C) herpes zoster D) acute herpetic stomatitis E) herpangina 79. Clinical type of tertiary syphilis in the oral cavity is : A) pustular B) papular  C) spot D) gummous  E) ulcerative 80***. It is*** referred to viral diseases of oral cavity : A) necrotic stomatitis B) lichen planus C) shingles  D) chronic aphthous stomatitis E) an acute pseudomembranous stomatitis  81. Symptom that differentiates an acute herpetic stomatitis from chronic is: A) temperature rise  B) the presence of bullae C) pain in the mouth  D) frequent recurrence of the disease E ) increase of regional lymph nodes 82. **It is not** referred to the true allergic diseases: A) contact drug allergy B) anaphylactic shock C) angioedema D) Lyell disease  E) erythema multiforme  83. They are referred to the endo-allergens: A) vaccines B) tissues of the organism  C) serums D) viruses E) household dust  84. Anaphylaxis may be caused by administration of drugs : A) intracanally B) intravenously C) injected subcutaneously D) when all methods of administration  E) into the alveoli of extracted tooth  85. Differential diagnosis of anaphylactic shock is performed with : A) epilepsy , neurosis , colitis B) myocardial infarction, gastritis , rheumatism C) acute heart failure, myocardial infarction, epilepsy  D) collapse , gastric ulcer , rhinitis E) hypertension , cholecystitis , schizophrenia 86. The sequence of the treatment when anaphylactic shock : A) the termination of allergen , normalization of blood pressure ,removal of spasm , elimination of asphyxia B) improve of the blood circulation, respiratory stimulation , increasing of diuresis  C) normalization of cardiac activity , eliminating of the bronchospasm , regulation of the gastrointestinal tract D) appointment of antibiotics , desensitizing agents, cardiac glycosides E) introduction of caffeine ,cordiamine , prevention of falling back of tongue, the administration of corticosteroids 87.In Quincke angioedema alterations include: A) sublingual area, gums , forehead B) the skin, gums , eyes C) oral mucosa , cheeks , nose, D) mucosa of muco-alveolar folds, the area of the hard palate , ears E) the eyelids, lips, tongue  88. Chronic recurrent aphthous stomatitis is differentiated with : A) pemphigus , traumatic lesions of the mucous B) herpetic stomatitis , ulcerative -necrotizing stomatitis  C) lupus vulgaris , Foot and Mouth Disease D) chancre (syphilis ), HIV -infection E) lichen planus , leukoplakia 89 . Emergency help to the patient with angioedema includes : A) injection of hypertensive drugs , enzymes B) injection of the anesthetic, normalization of the blood pressure C) warming the patient, injection of vitamin C D) injection of desensitisation means , if necessary tracheostomy should be done E) injection of the heart means(caffeine, kordiamine ), artificial respiration 90. What organs and tissues are involved into the process when Behcet's syndrome : A) skin of the hand , mucous of the lips B) mucosa of the gastrointestinal tract , urogenital tract C) oral mucosa , genital organs, eyes  D) skin of the trunk , mucous membrane of the larynx E) buccal mucosa , nose, skin of scalp 91. Sequence of the help when anaphylactic shock : A) injection of 0.5 ml of 0.1 % adrenaline solution, 2ml of 10% caffeine ,antisensitation drug,10ml of 2.4 % sodium euphilline  B) injection of cardial means , anti-bronchospasm means , desensitizing medications C) injection of anticonvulsants , cardiac means , desensitizing agents , vitamins D) injection of corticosteroids , vitamins, desensitizing drugs  E) injection of anti-bronchospasm means , cardiac , desensitization , analgesics  92 Mouth ***is not*** affected when follow form of pemphigus: A) true B) seborrheic C) vegetate  D) vulgar E) leaf-like  93. How many types of Nickolsky symptom are presence : A) Two B) three  C) four D) five E) one 94. Main drugs used in the treatment of pemphigus : A) desensitization , anesthetics B) antibiotics , cytostatics C)corticosteroids , sulfonamides D) corticosteroids , cytostatics  E) enzymes , antiseptics 95. An additional method for precise diagnosis of true pemphigus is: A) pathomorphological B) histological C) cytological  D) serological E) bacteriological 96. Typical signs of the acantholytic Tsank cells (pemphigus) A) round cells with large nucleus , two-layered cytoplasm  B) cells are large, polymorphous C) cells are polymorphic, covered with a light film D) smaller cells with a large nucleus E) cells of the spinous layer with small nuclei  97. What diseases should be differentiated with true pemphigus : A) lichen planus , candidiasis, herpes zoster  B) drug allergies , leukoplakia , herpetic stomatitis C) herpetic stomatitis , chronic aphthous stomatitis , leukemia D) syphilis , tuberculosis, foot and mouth disease E) pemphigoid , erythema multiforme , drug allergies 98. The t est, confirming the edema of the tongue is named : A) Yasinovky's sample B) McClure -Oldrich  C) sample of Pisarev - Schiller D) sample of Meller E) Sample of Kulajenko 99. Resolution time of the blister when edema of the tongue is : A) 40-45 minutes B) 15-22 minutes C) 20-32 minutes D) 10-12 minutes  E) 50-60 minutes 100. Coated tongue is observed when diseases of the gastrointestinal tract : A) hypertrophy of leaf –like papillae B) hypertrophy of fungi -shaped papillae  C) hypertrophy of filiforme papillae  D) atrophy of the filiform papillae E) atrophy of leaf –like papillae 101. Change of taste sensitivity of the tongue is observed when : A) atrophy and desquamation of the fungi -shaped papillae B) hypertrophy of filiform papillae C) hypertrophy and hyperkeratosis of papillae D) hyperkeratosis and desquamation of the filiforme papillae E), hyperkeratosis of all tongue papillae 102. Lesions in the mouth like aphtae are frequently observed when : A) diseases of the biliary tract B) hyperacid gastritis C) atrophic ( anacid) gastritis D) liver diseases  E) colon diseases ( colitis)  103. How do look the changes in the soft palate when liver diseases : A) hyperemia, edema, hemorrhage B) jaundice , presence of hemorrhage, telangiectasia  C) hyperkeratosis, hemorrhage , dryness D) desquamation , cyanosis , atrophy E) acanthosis , desquamation , hyperemia 104 . Bullae with hemorrhagic content are observed on the soft palate when follow cardiovascular disease of: A) myocardial infarction B) hypotension C) atherosclerosis D) hypertension  E) cardiovascular deficiency  105. Character changes in the oral cavity of the patients with cardiovascular diseases are : A) hypertrophy of all tongue papillae B) development of candidiasis C) trophic ulcers  D) desquamation and edema of the tongue E) redness and swelling of the soft palate 106. Metabolic disorders in Cushing's disease are: A) fat, protein , water B) protein , mineral , carbohydrate C) mineral , carbohydrate , salt D) water , sodium , zinc E) protein , fluoride , acid 107. Changes in the oral cavity when diabetes mellitus are: A) aphthae , paresthesia , dry mouth B) paresthesia, catarrhal gingivitis C) glossitis , atrophy of tongue papillae D) hypersalivation , herpetic rash , pain E) dry mouth , fungal stomatitis , sores  108. Xerostomia is observed when endocrine pathology: A) Sjögren's syndrome B) diabetes mellitus  C) Mikulic disease  D) sialoadenitis  E) sialodochitis  109 . For more accurate diagnosis of trophic disorders in diabetes mellitus it is necessary: A) use of histological and cytological studies B) investigate the saliva ,collect anamnesis C) investigate the microflora of the mouth, to determine the sensitivity D) to examine the blood and urine for presence of sugar  E) stomatoscopy , Wasserman's reaction  110.Lichen planus occurs :  A) in women over 70 years  B) in children aged 10-15 years  C) in women aged 40 to 65 years  D) in men aged 35 to 65 years  E) in men older than 70 years  111.**It is not** referred to the concept concerning to lichen planus :  A) endocrine  B) viral  C) bacterial  D) autoimmune  E) neurogenic  112.**It is not** referred to diseases that play a role in the occurrence of lichen planus :  A) dysbiotic state  B)of gastrointestinal tract  C) of cardiovascular system  D)of endocrine system  E) of urogenital system  113.When diagnosis of lichen planus examination methods **are not** used:  A) histological  B) cytological  C) microbiological  D)immunofluorescence reaction  E) Vud rays  114.Clinical signs of lichen planus are :  1.cockades  2.pink – purple papules  3.lupoma  4.dense grayish- white pattern  5.hematoma  6. Greenspan sindrome  A) 2,3,5  B) 1,3,5  C) 1,3,6  D) 2,4,6  E) 4,5,6  115.When typical form of lichen planus they are observed :  A) ulcers  B) erosions  C) pearly papules  D)bullae  E) cockades  116.Determine the appropriateness:  I.Typical form of lichen planus  II.Exudative - hyperemic form of lichen planus  1.pearly papules  2 . pathological lesions are joined in the form of half-rings  3.expressed inflammatory response  4.stagnant hyperemia  5 . lesions create a mesh pattern  6.dense grayish - white pattern , consisting of multiple papules  I II  A) 1,2,5; 3,4,6  B) 3;4;6 1;2;5  C) 1;3;6 1;2;6  D) 2;4;5 2;4;6  E) 2;4;6 3;4;5  117. Determine the appropriateness:  I.exudate - hyperemic form of lichen planus  II.erozive -ulcerative form of lichen planus  1.stagnant hyperemia  2. erosions  3.dense grayish- white pattern  4.keratinized epithelial changes are radially situated  5.sometimes they are combined with diabetes mellitus and hypertension  6.pattern consists of multiple papules  I II  A) 3,4.5; 1,4,6  B) 2,4,5; 1,3,6  C) 1,4,5; 2,3,6  D) 3,5,6; 4,5,6  E) 1,3,6; 2,4,5;  118. Determine the appropriateness: :  I.erozive -ulcerous form of lichen planus  II.bullous form of lichen planus  1. Greenspan sindrome  2.after rupture of pathological element an erosion is formed  3.keratinized epithelial changes are radially situated  4.erozions are formed on the elements of lichen planus  5.sometimes they are combined with diabetes mellitus  6. sometimes they are combined with hypertension  I II  A) 2,4 1,3,5,6  B) 1,3,5,6; 2,4;  C) 2.4,5 1,3,4  D) 1,3,4 3,4,5,6  E) 4,5,6 4,5,6  119.If solid foci of keratinization with sharp boundaries are formed on the background of against typical eruptions of lichen planus , then this one is called as:  A) exudate- hyperemic  B) typical  C) erosive- ulcerous  D) hiperkeratotic  E) bullous  120.**It is not** referred to clinical forms of lichen planus :  A) exudate -hyperemic  B) typical  C) miliary - ulcerous  D) erosive- ulcerous  E) hyperkeratotic  121.Complete the clinical forms of lichen planus:  1.typical  2.exudate - hyperemic  3 . ...................  A) hyperkeratotic  B) verrucose  C) dry  D) vegetating  E) leaf-like  122.Differential diagnosis of bullous and erosive form of lichen planus is done with :  A) lupus vulgaris  B) leukoplakia ( plane form)  C)foot-and-mouth disease  D) candidiasis  E) erythema multiforme  123.Lichen planus is distinguished from erythema multiforme and pemphigus vulgaris with :  A) presence of erosions  B) symmetry of the lesions  C) presence of bullae  D) presence of inflammation  E) edema in connective tissue  124.Treatment of typical , hyperkeratotic and exudate forms of lichen planus includes:  1. electrocoagulation  2.sedative drugs  3.surgical excision  4.keratoplastic ointments  5.lazer-therapy  6.treatment of the lesion with chloroethane  A) 2,4,6  B) 1,3,6  C) 1,2,3,6  D) 2,4,5;  E) 3,5,6  125.When erosive- ulcerous and bullous forms of lichen planus the treatment includes :  1.chloroquine (delagil) with methylurasil  2.krizanol  3.antiviral means  4.lazer-therapy  5.chemical-therapy  6.abundance of alkaline water drinking  A) 4,5,6  B) 2,4,5  C) 1,3,4;  D) 2,5,6  E) 3,5.6  126.Determine the appropriateness :  I.typical form of lichen planus  II.leukoplakia  1.pearly papules  2. segments of epithelial opacities  3.foci are joined in half-ring shaped form  4. triangular shaped foci of hyperkeratosis  5.there is mesh pattern in the corners of the mouth  6. combination of different forms in the different areas of oral mucosa in one patient is possible  I II  A) 1,3,5; 2,4,6;  B)2,4,6 1,3,5  C) 3,5,6 1,3,6  D) 1,3,4 3,5.6  E) 2,4,5 2,4,5  127. Determine the appropriateness ::  I.Lichen planus  II.lupus erythematous  1.erythema on the face , ears  2.whitish - pearly papules  3.oral mucosa is occasionally damaged  4.sense of burning, tightness , roughness of the oral mucosa  5.In the center of the lesion an atrophy is formed  6. it may be discovered accidentally during examination by dentist  I II  A) 2,3,5 1,4,6  B) 1,3,5 2,4,6  C) 1,3,6 2,4,5  D) 2,4,6 4,5,6  E) 2,4,6; 1,3,5  128. Determine the appropriateness ::  I. Lichen planus  II.papulous syphilis  1. whitish - pearly papules  2. the tonsils, arches , soft palate are often affected  3.grayish - white plaque may be easily removed  4. sense of burning, tightness , roughness of the oral mucosa  5 . " Plaque of cut field "  6.picture like a pattern  I II  A) 2,3,5 1,4,6  B) 1,4,6; 2,3,5  C) 1,2,3 2,4,5  D) 2,4,6 2.4,6  E) 3,4,5 3,4,6  129. Determine the appropriateness ::  I. Lichen planus  II.candidiasis  1.whitish - pearly papules  2.it often accompanies diabetes mellitus  3.plaque resembles curdled milk or cottage cheese  4. plaque may be removed when scrabbing  5. sense of burning, tightness , roughness of the oral mucosa  6. it may be discovered accidentally during examination by dentist  I II  A) 4,5,6 2,4,6  B) 2,3,4 1,5,6  C) 1,4,5 1,3,5  D) 1,5,6; 2,3,4  E) 3,5.6 3,5,6  130. Determine the appropriateness :  I. Lichen planus ( erosive form)  II. erythema multiforme  1.bubbles with serous or hemorrhage content  2.presence of cockades  3.appearance of skin elements  4 . whitish- pearly papules  5.sometimes the bullae precede the papules  6.limited erythema and swelling of mucous membrane  I II  A) 1,3,6 1,5,6  B)2,3,6 1,4,5  C) 1,4,5 2,3,6  D)3,4,6 2,4,5  E)2,3,5 3,4,5  131. Determine the appropriateness ::  I. Lichen planus ( bullous form)  II.pemphigus vulgaris vulgaris  1. positive symptom of Nikolsky  2.bluish - red spots  3.presence of intraepithelial bullae  4.it is differented with Duhring dermatitis  5.peripheral part of the pathological element remains pinkish -red colored  6. Nicolsky symptom is negative  I II  A) 2,5,6; 1,3,4  B) 1,3,4 2,5,6  C) 1,2,5 2,3,4  D) 3,4,5 4,5,6  E) 3,4,6 2,3,5  132. Mechanism of diabetes mellitus includes the disturbance of :  A) oxidation- reduction reactions  B) mineral metabolism  C) acid- alkali balance  D) water - salt balance  E) carbohydrate metabolism  133.**It is not** referred to the clinical manifestations of diabetes mellitus :  A) xerostomia  B) hypersalivation  C) catarrhal stomatitis  D) paresthesia of mucosa  E) trophic disorders  134.Clinical manifestations of diabetes mellitus are :  1.formation of bullae  2.xerostomia  3.hypersalivation  4.catarrhal glossitis  5.formation of papular picture  6.paresthesiya of mucosa  A) 2,4,5,6  B) 1,5,6  C) 1,2,4  D) 2,4,6  E) 3,4,5,6  135.Xerostomia **is not** marked when disease:  A) sialoadenitis  B) Mikulich disease  C) Foot- and -Mouth Disease  D) diabetes mellitus  E) sialodochitis  136.Clinical signs when xerostomia accompanying the diabetes mellitus are :  1.hypersalivation  2.hyposalivation  3.oral mucosa is dry , shiny  4.expressed inflammation  5.increased thirst  6.formation of papules  A) 2,4,5  B) 1,3,5  C) 2,4,5,6  D) 3,4,5  E) 1.4,5,6  137.Diseases that are accompanied with xerostomia are :  1.foot-and-mouth disease  2.leukoplakia  3. diabetes mellitus  4.sialodochitis  5.acute herpetic stomatitis  6. impaired nasal breathing  7.disturbance of nervous system  A) 4,5,6  B) 1,2,3,4  C) 2,4,6  D) 1,2,3  E) 3,4,6,7  138. Catarrhal stomatitis in diabetes mellitus is accompanied with :  A) increase of saliva  B) decrease of saliva  C) increased lacrimation  D) decomposition of tubercles  E) join of papules  139.Clinical symptoms of catarrhal stomatitis , glossitis in diabetes mellitus:  1.infection  2.absence of inflammation  3.vulnerability  4.presence of papulous rash  5.pain when eating  6. hemorrhage  A) 2,3,4  B) 1,2,4,6  C) 3,4,5  D) 1,3,5,6  E) 3,4,6  140.Paresthesia of oral mucosa in diabetes mellitus occurs along with :  A) hypovitaminosis  B) anaemia  C) xerostomia  D) hyporglycemia  E) hypersalivation  141.In disorders of nervous system accompanying diabetes mellitus it is decreased the sensitivity of:  A) taste  B) visual  C) hearing  D) tactile  E) olfactory  142.When trophic disorders accompanying the diabetes mellitus they are formed :  A) bullae  B) papules  C) scales  D) scars  E) ulcers  143. Trophic ulcers in diabetes mellitus are characterized with :  A) enhanced epithelization  B) slow recovery  C) formation of keloids  D) presence of inflammation  E) presence of small abscesses around the pathological element  144.Treatment of the patients with diabetes mellitus should be carried out together with :  A) cardiologist  B) phthisiatrician  C) dermatologist  D) an endocrinologist  E) proctologist  145.When treatment of changes in the mucous membrane of the mouth in diabetes mellitus it is used:  A) krizanol  B) ferrumleks  C) dekamin in caramel  D) bismoverol  E) mebendazole  146. When fungal infections of oral mucosa in diabetes mellitus it is used:  A) levorin  B) bonafton  C) zoveraks  D) acyclovir  E) maraslavin  147. Medications used in the treatment of lesions of oral mucosa accompanying diabetes mellitus :  1. dekamin in caramel  2 . sodium thiosulphate  3 . liniment of sangviritrin  4 . mebendazole  5 . thiamine  6. acyclovir  А) 2,3,6  В) 2,4,6  С) 1,4,6  D) 3,5,6  Е) 1,3,5  148.Medications prescribed for the treatment of diabetes mellitus are directed to:  A) prevention of malignancy  B) improving of carbohydrate metabolism  C ) decelerating of regeneration  D) decrease of salivation  E) improvement of mineral metabolism  149.Mechanism of Addison's disease includes a chronic insufficiency of :  A) gonads  B) pituitary  C) thyroid gland  D) adrenal cortex  E) parathyroid glands  150.It is the most characteristic feature of Addison's disease:  A) formation of patterned drawing on the skin and mucous membranes  B) erosions of the skin and mucous membranes  C) pigmentation of the skin and mucous membranes  D) hyperkeratosis of the skin and mucous membranes  E) mucocutaneous parakeratosis  151.Clinical signs of Addison's disease:  1.spots or bluish stripes  2.cartilage-like infiltrate  3.the places exposed to light are damaged  4.graticule of Uitkense  5.asthenia , dyspepsia  6. Greenspan syndrome  A) 1,3,5  B) 1,4,6  C) 2,3,6  D) 1,2,6  E) 2,4,3  152.Complete the common phenomenon in Addison's disease:  1.asthenia  2. dyspepsia  3 . ......................  A) Trigeminal neuralgia  B) obesity  C) xerostomia  D) neuritis of facial nerve  E) exhauation  153.They are referred to the common manifestation of Addison's disease:  A) fever  B) diarrhea  C) sepsis  D) loss of consciousness  E) bronchospasm  154.There are clinical forms of pemphigus vulgaris :  A) 2  B) 6  C) 3  D) 4  E) 1  155.They **are not** referred to the clinical forms of pemphigus vulgaris :  A) vegetating  B) vulgar  C) verrucosa  D) leaf-like  E) seborrheic  156.Frequently pemphigus vulgaris starts with lesions of :  A) oral mucosa  B) nasal mucosa  C) mucous membranes of the eyes  D) genital mucosa  E) skin of extremities  157.It is referred to the theories of development of pemphigus vulgaris :  A) fungal  B) endocrine  C) bacterial  D) neurogenic  E) viral  158. It is referred to the theories of development of pemphigus vulgaris:  A) endocrine  B) autoimmune  C) bacterial  D) neurogenic  E) viral  159.Clinical symptoms of pemphigus vulgaris are:  1.formation of bullae on a large site of erythema  2.erosions are placed on unmodified or slightly inflamed mucosa  3. bullaes are sub-epithelial situated  4. Nikolsky symptom is positive  5.acute onset , seasonal recurrences  6.sometimes the hoarseness occurs  A) 3,4,5,6  B) 1,3,5  C) 2,3,5,6  D) 2,4,6  E) 4,5,6  160. Determine the appropriateness :  I. pemphigus vulgaris  II. erythema multiforme  1.intraepithelial bullae  2.subepithelial bullae  3.erosions are located on unchanged or slightly inflamed mucosa  4. erosions are located on in the area of the lesion  5. Nikolsky symptom is positive  6. Nikolsky symptom is negative  I II  A) 1,2,4 1,2,3  B) 2,4,6 1,3,5  C) 1,3,5; 2,4,6  D) 2,4,5 2,4,5  E) 1,4,5 3,4,6  161. Determine the appropriateness ::  I. pemphigus vulgaris  II.bullous pemphigoid  1.subepithelial location of bullae  2.intraepithelial location of bullae  3.frequently the people over 60 years are sick  4.acantholytic cells are found  5. acantholytic cells are not detected  6. Nikolsky symptom is positive  I II  A) 2,4,6; 1,3,5  B) 1,3,5 2,4,6  C) 2,3,4 1,4,6  D) 1,4,6 1,5,6  E) 2,3,5 3,4,6  162. Determine the appropriateness :  I. Pemphigus vulgaris  II.Bullous pemphigus vulgaris  1.subepithelial location of bullae  2.intraepithelial location of bullae  3. acantholytic cells are found  4. acantholytic cells are not found  5. Nicolsky symptom is positive  6. Nicolsky symptom is negative  I II  A) 2,3,5 3,5,6  B)1,4,6 2,3,5  C)2,4,6 1,3,5  D)3,4,6 2,4,6  E) 2,3,5 1,4,6  163. Determine the appropriateness ::  I. Pemphigus vulgaris  II.Bullous form of lichen planus  1. intraepithelial location of bullae  2. subepithelial location of bullae  3.it is found in persons over 50 years  4. men and women over 35 years are sick  5.hoarseness evidences about the damage of larynx  6. symptom of sub-epithelial peryfocal detachment may be positive  I II  A) 2,3,6 1,4,5  B) 1,4,5; 2,3,6  C) 1,3,6 1,4,6  D) 2,4,6 2,4,5  E) 4,5,6 4,5,6  164. Determine the appropriateness :  I. Pemphigus vulgaris  II.Herpetiforme Dermatitis of Duhring  1.sometimes larynx is affected  2. intraepithelial location of bullae  3.akantolysis is absence  4. subepithelial location of bullae  5.there are multiple eosinophils in bullae  6.akantolisis    I II  A) 1,4,5 2,3,6  B) 3,4,5 1,2,6  C) 2,3,5 1,2,5  D) 1,2,6; 3,4,5  E) 4,5,6 1,3,6  165.There are follow modifications of Nicolsky symptom in pemphigus vulgaris :  A) 4  B) 2  C) 3  D) 1  E) 5  166.Second, and especially the third type of Nicolsky symptom indicates about increase of intensity of :  A) acantholysis  B) acanthosis  C) hyperkeratosis  D) parakeratosis  E) ballooning degeneration  167.When untreated, pemphigus vulgaris spreads to the skin of trunk, face and extremities after:  A)1 week  B) 2-year  C) 5 years  D) 3 years  E) 1-6 months  168.**It is not** referred to pemphigus vulgaris :  A) exacerbation is replaced by periods of remission  B) high sensitivity to iodine  C) intoxication  D) cachexy  E) when absence of treatment – death occurs  169. **It is not** referred to different types of pemphigus the presence of :  A) vegetations  B) erosive surfaces  C) bullae  D) cockades  E) exfoliation of epithelium  170. **It is not** referred to clinical symptoms of pemphigus vulgaris :  A) erosion of bright red color  B) pain  C) ulcers, covered with a thick necrotizing plaque  D) extensive erosive surfaces  E) cachexy  171 .**It is not** referred to pemphigus vulgaris :  A) xerostomia  B) hypersalivation  C)bullae  D) painful cracks  E) hoarseness  172. Reduce death risk from pemphigus vulgaris is associated with the use of drugs like :  A) calcitonin  B) antiviral  C) antifungal  D) vitamins  E) corticosteroids  173. **It is not** referred to drugs used in general treatment of pemphigus vulgaris :  A) prednisolone  B) chlorhexidine  C) Triamcinolone  D) urbazon  E) asparcam  174.**It is not** referred to the side effects of long-term use of corticosteroids in the treatment of pemphigus vulgaris :  A) bone osteoporosis  B) blood pressure increasing  C) glycosuria  D) hemodilution  E) formation of blood clots  175. For reducing the complications of corticosteroid therapy in the treatment of pemphigus vulgaris it is recommended:  A) fatty food  B) excessive drinking  C) water restriction  D) pickles  E) drinking of a large amount of juice  176.For general treatment of pemphigus vulgaris it is used:  A) methotrexate  B) krizanol  C) bonafton  D) acyclovir  E) chlorhexidine  177.Sytostatics in the treatment of pemphigus vulgaris are appointed at a dose of :  A) 3-5 mg  B) 6-100 mg  C) 100-200 mg  D) 5-10 mg  E) 35-40 mg  178. Sytostatics in the treatment of pemphigus vulgaris are appointed:  A) 3 times per week  B) 1 time a week  C) two times a week  D) 1 time per month  E) 1 time every 2 weeks  179.They are referred to cytostatic drugs used in the treatment of pemphigus vulgaris :  A) prednisolone  B) asparcam  C) Triamcinolone  D) methotrexate  E) urbazon  180.Individual maintenance dose of prednisone in the treatment of pemphigus vulgaris is usually :  A) 0,5-1 mg  B) 50-60 mg  C) 10-15 mg  D) 5-20 mg  E) 40-50 mg  181.Individual maintenance dose of dexamethasone for the treatment of pemphigus vulgaris is :  A) 0,5-1 mg  B) 10-15 mg  C) 50-60 mg  D) 15-20 mg  E) 40-50 mg  182.When treatment of pemphigus vulgaris triamcinolone is prescribed depending on the condition of the patient at a dose of :  A) 100-200 mg  B) 8-10 mg  C) 10-15 mg  D) 10-30 mg  E) 40-80 mg  183.Dose of prednisolone in the treatment of pemphigus vulgaris is reduced after stopping of the formation of new bullae in every :  A) 10 days  B) 5 days  C) 3 days  D) 2 months  E) 2 weeks  184.Dose of prednisolone in the treatment of pemphigus vulgaris after stopping of rash is reduced on:  A) 15 mg  B) 10 mg  C) 20 mg  D) 5 mg  E) 1 mg  185.Local therapy in the treatment of pemphigus vulgaris is directed to:  A) prevention of osteoporosis  B) decrease of toxicity  C) prevention of secondary infection of erosions and ulcers  D) prevention of high blood pressure  E) prevention of thrombosis  186.Medications used for the topical treatment of pemphigus vulgaris are :  1.corticosteroids  2.weak solution of potassium permanganate  3. adrenaline solution  4. calcium pantothenate solution  5. chloramine solution  6. ephedrine hydrochloride solution  7.oil solution of vitamin A  A) 1,2,5,7;  B) 3,4,6  C) 1,2,4,6  D) 2,4,5  E) 4,5,6  187. Local treatment when pemphigus vulgaris with defeat of the vermilion border involves the use of ointments on the base of:  A) iodine  B) methotrexate  C) bonafton  D) Acyclovir  E) Antibiotic  188.In case of complication of pemphigus vulgaris with candidiasis it is appointed  A) prednisolone  B) levorin  C) bonafton  D) acyclovir  E) dibasol  189.For epithelization of erosions in pemphigus vulgaris it is used the solution of:  A) calcium pantothenate  B) Vitamin C  C) ephedrine hydrochloride  D) oiled Vitamin A  E) chlorhexidine  190.By correctly and timely treatment of true pemphigus vulgaris :  A) there are not recurrences  B) prognosis is favorable  C) prognosis remains serious  D) the need for corticosteroid is eliminated  E) vulgar form is transformed into the seborrheic one  191.For diagnosis of pemphigus vulgaris is the examination is conducted:  A) cytological  B) X-ray  C) bacteriological  D) serological  E) reographic  192.By cytological examination of pemphigus vulgaris the cells are found :  A) monomorphic  B) non-acantholytic  C) atypical  D) Langhans  E) Tsank  193.By pemphigus vulgaris the cells are found :  A) atypical  B) Monsters  C) non-acantholytic  D) Langhans  E) monomorphic  194. When histopathological studies in pemphigus vulgaris they are identified:  A) spongiosis and ballooning degeneration  B) acanthosis and hyperemia  C) spongiosis and hyperemia  D) acantholysis and swelling  E) acanthosis and acantholysis  195. Use of follow drugs influence to the reduction of acantholytic cells in pemphigus vulgaris in remission period :  A) antifungal  B) antibiotics  C) corticosteroids  D) antiviral  E) desentisation  196.Floor of the bullae in pemphigus vulgaris is mostly lined with cells :  A) acantholytic  B) non- acantholytic  C) Langhans  D) epithelioid  E) monoforme  197.Diseases that are differentiated with acute leukemia are:  1.leukoplakia  2.ulcerous- necrotic stomatitis of Vincenti  3.lichen planus  4.C hipovitaminosis  5.foot-and-mouth disease  6.hypertrophic gingivitis of pregnancy  7.intoxication by the salts of heavy metals  A) 2,3,5  B) 1,3,5  C) 1,2,5  D) 3,4,5,7  E) 2,4,6,7  198. Determine the appropriateness :  I. Acute leukemia  II.Hypertrophic ( fibrous form ) gingivitis of pregnancy  1.gingival overgrowth from palatal side  2.sclerosive therapy is effective  3. gingival overgrowth from buccal side  4.infiltration of connective tissue by myeloid cells  5.bleeding is absence  6. bleeding out of the tongue  I II  A) 1,4,5 1,4,6  B) 1,4,6 2,3,5  C) 2,3,5 3,4  D) 3,4,5 2,3,4  E) 1,2,5 2,4,5  199. Determine the appropriateness:  I. Acute leukemia  II.Ulcerous- necrotic stomatitis of Vincenti  1.using of metronidazole is effective  2.around the necrotic lesion the gingiva is bluish in color, while the entire mucosa is anaemic  3.reactive alterations around the ulcer are absence  4.is caused by representatives of the resident microflora of the mouth  5.no hemorrhage  6.there are infiltrates on the skin and mucosa  I II  A) 2,4,6 1,3,6  B)1,4,5 2,3,6  C)1,4,6 2,4,6  D) 2,3,6 1,4,5  E)3,4,5 3,5,6  200 . Determine the appropriateness:  I. Acute leukemia  II. Hypovitaminosis C  1.skin becomes dark  2. skin becomes pale  3. Rotter sample is used for diagnosis  4 . puncture is used for diagnosis  5. state of the digestive system plays an important role in the development of disease  6.presence of the specific infiltrates  I II  A) 2,3,5 2,4,5  B) 1,3,5 2,4,6  C) 2,4,6; 1,3,5  D) 3,4,6 1,4,6  E) 1,2,5 3,5,6  201. Determine the appropriateness:  I. Acute leukemia  II.Intoxications by the salts of heavy metals  11.presence of the specific infiltrates  22. presence of black and blue spots on the buccal mucosa  33.Vibration of hands  4. 4.puncture is used for diagnosis  5.5.formation of dense whitish plaque in the form of pearl plaques  6.6. hemorrhages are presence on oral mucosa  I II  A) 1,4,6; 2,3,5  B) 2,3,5 1,4,6  C) 2,4,5 1,3,6  D) 4,5,6 1,4,6  E) 1,3,5 2,4,5  202.**It is not** referred to the clinical manifestations of acute leukemia :  A) necrosis  B) gingival hyperplasia  C) gingival bleeding  D) specific infiltrates  E) sclerosis of the skin  203. Clinical manifestations of acute leukemia are:  1.negative sample of Yakovs  2. gingival overgrowth  3.presence of "young" cells in the bone marrow  4.it is found at old age  5. Rotter sample is positive  6. anemia of oral mucosa  A) 1,2,4  B) 2,3,6  C) 1,5,6  D) 2,4,6  E) 3,4,5  204. **It is not** referred to the clinical manifestations of acute leukemia :  A) gingival hyperplasia  B) hemorrhage  C) necrosis  D) redness of oral mucosa  E) gingival bleeding  205. **It is not** referred to the complaints of patient with acute leukemia :  A) general weakness  B) sharp pain when eating  C) metallic taste in the mouth  D) putrid smell out of mouth  E) disorder of swallowing  206.It is crucial (main)in the diagnosis of acute leukemia :  A) blood analysis  B) reography  C) Rotter sample  D) polarography  E) photoplethysmography  207.Treatment of acute leukemia includes:  1.local treatment is not required  2.treatment and extraction of teeth should be done in hospital  3.appointment of metronidazole as base means of treatment  4.anesthetics  5.keratolytic means  6.ferments  A) 2,3,4  B) 1,2,3  C) 4,5,6  D) 3,4,5  E) 2,4,6  208. **It is not** referred to drugs used in the topical treatment of acute leukemia :  1.bismoverol  2.chloramin  3.romazulan  4.krizanol  5.auronofin  6.etony  A) 2,3  B) 1,4,5;  C) 2,3,6  D) 3,6  E) 2,6  209.For stimulation of epithelization in the treatment of acute leukemia they **are not** used :  1. hydrogen peroxide solution  2.propolis  3. vitamin A solution  4.chloramin  5.dog rose oil  6.etony  A) 5,6  B) 2,3,5  C) 3,5  D) 1,4,6  E) 3,6  210.By presence of necrotic lesions of oral mucosa they **are not used**:  1.ferments  2.vasoconstrictors  3 . 0.05 % solution of etacridine lactate  4.furasilin  5.etony  6.40 % solution of glucose  7.10 % solution of hydrochloric acid  A) 1,4,5,7  B) 1,4,5  C) 2,6  D) 5,4  E) 1,7  211.Where are pathological elements in lupus vulgaris situated ?  A) in area of upper frontal teeth , hard and soft palate  B) in area of genitals , eyes, frontal teeth  C) in area of eyes, genitals , soft palate  D) in area of soft palate , genitals  E) in area of hard palate , tonsils  212.Primary pathological element character for lupus vulgaris is :  A) blister  B) ulcer  C) chancre  D) erythema  E) tubercle  213.Describe the primary element of lupus vulgaris :  A) cartilage-like , red colored, with a diameter of 5-7 mm  B) soft , red or yellowish -red colored , with a diameter of 1-3 mm  C) stone-like consistency with a diameter of 1-3 mm  D) covered with thick necrotic gray plaque  E) solid, surrounded by hyperemic halo  214.As a result of peripheral growth the lesion in lupus vulgaris reminds :  A) cactus  B) dog rose  C) blackberries  D) raspberries  E) strawberries  215 .Characteristic symptom of lupus vulgaris is :  A) Vincenti  B) Nicolsky  C) of apple jelly  D) “cut field”  E) vazoparesis  216. Characteristic symptom of lupus vulgaris is :  A) Pospelov  B) Nicolsky  C) Vincenti  D) “cut field”  E) vazoparesis  217.Lymph nodes when lupus vulgaris are :  A) stone consistency  B) not changed  C) not mobile  D) cartilage consistency  E) increased , dense  218.In most cases in lupus vulgaris the reaction of Pirke is :  A) negative  B) positive  C) negative at the beginning  D) not used  E) used in the midst of illness  219. lupus vulgaris is differentiated with:  A) foot and mouth disease  B) herpes simplex  C) shingles  D) leprosy  E) leukoplakia  220. lupus vulgaris is differentiated from:  A) agranulocytosis  B) melanoma  C) lupus erythematous  D) candidiasis  E) leukoplakia  221. Lupus vulgaris is differentiated from:  A) tertiary syphilis  B) Foot and Mouth Disease  C) leukoplakia  D) candidiasis  E) agranulocytosis  222. Ulcers in miliary –ulcerous tuberculosis are especially localized in the field of :  A) midline of tongue  B) hyperkeratosis  C) the corners of the mouth  D) retromolar area  E) trauma  223.Characteric feature of ulcers in miliary –ulcerous tuberculosis is :  A) the floor of the ulcer is smooth  B) the floor of the ulcer is granular  C)the base of ulcers is cartilage-like  D) the base of ulcers is stony consistency  E) the edges of ulcers are right  224.Around the ulcers in miliary –ulcerous tuberculosis it is sometimes found :  A) pigmentation  B) small erosions  C) small scars  D) small abscesses  E) plaque  225. Regional nodes in miliary –ulcerous tuberculosis are :  A) not increased  B) increased, non- elastic , painless  C) increased , elastic , hard, painful  D) cartilage consistency , mobile  E) stony consistency, not mobile  226.The state of the patient with miliary –ulcerous tuberculosis:  A)he is exhausted, difficult breathing , temperature rise , changes in blood  B) is not changed  C) there is a skin rash  D) asymmetry of the face , hyperemia of the face in form like a butterfly  E) temperature rise , leukemic infiltrates  227. Pirke reaction in miliary –ulcerous tuberculosis is :  A) accompanied by a skin rash  B) positive  C) not used  D) positive only in the midst of illness  E) negative  228.Cytological examination in miliary –ulcerous tuberculosis reveals :  A) acantholytic and atypical cells  B) Langhans giant cells and epithelioid cells  C) mast cells and acantholytic  D) non- acantholytic cells and Tsank cells  E) monomorphic and atypic cells  229.Differential diagnosis of miliary –ulcerous tuberculosis should be performed with :  A) lichen planus  B) Foot and Mouth Disease  C) leukoplakia  D) traumatic ulcer  E) shingles  230.Differential diagnosis of miliary –ulcerous tuberculosis should be performed with :  A) leukoplakia  B) lichen planus  C) gummous ulcers  D) herpes zoster  E) pemphigoid  231.Differential diagnosis of miliary –ulcerous tuberculosis should be performed with :  A) cancer  B) Stevens-Johnson Syndrome  C) Osler disease  D) Lyell's disease  E) leukoplakia  232.Differential diagnosis of miliary –ulcerous tuberculosis includes:  A) recurrent herpetic stomatitis  B) herpangina  C) lichen planus  D) shingles  E) necrotic stomatitis of Vincenti  233.Causal agent of syphilis is :  A) streptococcus mutans  B) treponema pallidum  C) staphylococcus auris  D) herpes Zoster  E) Coxaci virus  234.Aquired syphilis is mainly transmitted through way :  A) food products  B) air-drop  C) contact  D) sexually  E) through drinking water  235.Placentar syphilis infection occurs :  A) when external pelvic examination of mother  B) when trauma  C) from infected mother to fetus  D) in premature born  E) when late born  236.Element of primary syphilis is :  A) chancre  B) tubercle  C) bladder  D) pigmentation  E) scale  237.In primary syphilis the pathological element is usually located in the area of :  A) eyes  B) abdomen  C) face  D) neck  E) genitals  238.Patological element when primary syphilis after incubation period appears in:  A) 45 days  B) 21 days  C) 30 days  D) 10 days  E) 5 days  239.In primary syphilis the pathological element is located in the area of:  A) face  B) the lower lip  C) the tongue  D) inoculation  E) cheek  240.In primary syphilis serologic reactions become positive since:  A) end of 2nd week- beginning of 3rd week  B) end of 1st week- beginning of 2nd week  C) end of 3rd  week- beginning of 4th week  D) end of 4th week- beginning of 5th week  E) end of 5th week- beginning of 6th week  241.Organ which is often damaged with primary syphilis is :  A)red lip borders  B) eyes  C) ears  D) nose  E) face  242.Classic chancre is :  A) a painful crater –like ulcer with a stony base and digged edges  B) a painful ulcer with raised smooth edges and soft base  C) painless bleeding ulcer with raised edges and soft base  D) a painful ulcer with digged edges and cartilage base  E) a painless ulcer with raised smooth edges and dense base  243.Patological elements when primary syphilis usually is :  A) grouped  B) solitary  C) connected in form of chain  D) bilateral  E) accompanied by blister rash  244.Without treatment the primary period of syphilis lasts up to :  A) 2 days  B) 1 year  C) 18 weeks  D) 2-3months  E) 5 days  245.Laboratory tests in primary syphilis include the examination for the revealing of its causal agent :  A) Staphilococcus  B) Streptococcus  C) Treponema pallidium  D) E.Coli  E) S.auris  246.Severe clinical symptoms of anaphylaxis occur after administration of allergen into the body through :  A) 5-10 minutes  B) 1hour  C) 45 minutes  D) 1 day  E) 48 hours  247.Symptoms of severe clinical manifestation of anaphylactic shock are:  A) convulsions , hives, myosis  B) coma , high blood pressure , convulsions  C) bronchospasm , increased blood pressure  D) collapse , increase of blood pressure  E) collapse, blood pressure reduce , convulsions  248.Symptom of severe clinical manifestation of anaphylactic shock is :  A) ulceration  B) urination  C) increase of blood pressure  D) lacrimation  E) diplopia  249.Recovering of anaphylactic shock is accompanied with appearance of :  A) reduce of blood pressure  B) cyanosis  C) diplopia  D) shivering  E) collapse  250. Recovering of anaphylactic shock is accompanied with :  A) cyanosis  B) temperature reduce  C) temperature rise  D) paleness of skin  E) bullae formation  251.Differential diagnosis of anaphylactic shock should be done with :  A) myocardial infarction  B) pulmonary infarction  C) chronic ischemia  D) Quincke oedema  E) eczema  252. Differential diagnosis of anaphylactic shock is done with :  A) Quincke oedema  B) eczema  C) with chronic cardiac sufficiency  D) with acute renal insufficiency  E) epilepsy  253. The sequence of the stages of treatment of anaphylactic shock :  1. normalization of cardiac function by injecting of 2 ml of 10 % solution of caffeine or kordiamine  2 .normalization of blood pressure by administering of 0.5 ml of 1 % solution of adrenaline  3 .oxygen therapy and artificial respiration  4 . Antihistamines like 1% diphenhydramine (dimedrol)  5.administration of 30-60 mg of prednisolone  A) 5,4,3,2,1  B) 2, 1, 4, 3 ,5  C) 4,1,2,3,5  D) 3,1,4,2,5  E) 3,2,1,5,4  254.When anaphylactic shock is accompanied with bronchospasm , it is used :  A) intravenously injection of 0,1 % solution of adrenaline  B) intravenously injection of 1 ml of seduxen  C) intravenously injection of 10 ml of 10% aminophylline  D) intravenously injection of 10 ml of 2.4% solution of aminophylline  E) intramuscularly injection of solution of prednisolone  255.If anaphylactic shock is accompanied with convulsions , it is recommended injection of :  A) dimedroli  B) eufilline  C) seduxen  D) epinephrine  E) prednisolone  256.If anaphylactic shock was caused by the injection of penicillin, it is recommended injection of :  A) 1 dose of penicillinase  B) seduxen  C) 3 doses of penicillinase  D) 50-60 mg of prednisolone  E) 50-60 mg hydrocortisone  257.Quinckeoedema is referred to:  A) Arthus phenomenon  B) delayed allergic reactions  C) cutaneous allergic reactions  D) Melkerson -Rosenthal syndrome  E) immediate allergic reactions  258.Pathogenesis of Quincke oedema :  A) it is different from the pathogenesis of anaphylaxis  B) it is the same to anaphylaxis  C) it is the same to contact allergies  D) decrease of the permeability of microvascular network  E) sclerosis of the vessels of microvascular network  259.Mechanism of the development of Quincke oedema is :  A) is like to contact allergy  B) decrease of the permeability of microvascular network  C) is like to inflammation  D) increase of the permeability of microvascular network  E) is different from pathogenesis of anaphylactic shock  260.Mechanism of the development of Quincke oedema involves the formation of :  A) ulcer  B) erosion  C) edema  D) rash  E) hyperemia  261. It is referred to the symptoms of Quincke oedema:  A) increasing of lips because of swelling  B) increasing of the tongue because of hypertrophy  C) increasing of the eyelids due to inflammation  D) increasing of the tongue because of sclerosis  E) there is no increasing of the organs  262.Palpation of the affected organs in Quincke oedema :  A) reveals the fluctuation  B)is slightly painful  C) is sharply painful  D) is not used  E) is painless  263. The skin above the affected organs in Quincke oedema is :  A) cyanotic  B) not changed  C) hyperemic  D) pigmented  E) eroded  264. Patient when Quincke oedema can die by defeat of :  A) eye  B) tonsils  C) uvulae  D) larynx  E) tongue  265.In severe cases of Quincke oedema , first of all it is indicated :  A) antihistamines  B) cardiac massage  C) tracheostomy  D) antibiotics  E) anesthesia  266. Quincke oedema is differentiated with:  A) Melkerson -Rosenthal syndrome  B) Osler syndrome  C) Letterer - Siwe syndrome  D) epilepsy  E) cardiac infarction  267. Quincke oedema is differentiated from:  A) erythema multiforme  B) hemophilia  C) leukemia  D) epilepsy  E) lymphostasis  268.Treatment of Quincke oedema includes:  1.discontinuance of the allergen into the organism  2.antihistamine drugs  3 . .......................  A) seduxen  B) ascorutin  C) droperidol  D) antibiotics  E) cytostatics  269.Recurrence aphthous stomatitis (easy form)is characterized by recurrent rash of :  A) pustules  B) papules and erosions  C) ulcers  D) aphtae  E) vesicles  270.**It is not referred** to the forms of recurrent aphthous stomatitis:  A) necrotic  B) fibrinous  C) hyperkeratotic  D)glandular  E) scarring  271.In the pathogenesis of recurrent aphthous stomatitis an important role belongs to :  A) immune system  B) cardiac function  C) respiratory disorders  D) renal insufficiency  E) osteoporosis  272.Recurrence aphthous stomatitis (easy form ) is characterized by:  A) polymorphism of pathological elements  B) multiple elements covered with fibrinous plaque , and epithelization period from 7 to 14 days  C) solitary elements covered with fibrinous plaque , and epithelization period from 1 to 5 days  D) painlessness of pathological elements  E) solitary elements covered with fibrinous plaque , and epithelization period from 7 to 14 days  273.In etiology of recurrence aphthous stomatitis an important role belongs to :  A) acute infection  B) foci of chronic infection  C) of the dental - jaw anomalies  D) viruses  E) medications  274.An important role in the etiology of chronic recurrent aphthous stomatitis belongs to :  A) lack of fluoride in the drinking water  B) gingival hyperplasia  C) overload of periodontium  D) unfavourable factors  E) viruses  275.Clinical forms of recurrent aphthous stomatitis are :  A) easy, middle and heavy  B) acute and chronic  C) easy and heavy  D) primary and secondary  E) congenital and acquired  276.Recurrence aphthous stomatitis (easy form ) begins with the appearance of :  A) spot with a diameter up to 1 cm  B) spots with a diameter up to 1.5 cm  C) erythema with a diameter up to 2 cm  D) bullae with a diameter up to1 cm  E) oedema  277.Pathological element in chronic recurrent aphthous stomatitis is eroded and covered with grayish- white fibrinous film after:  A) 3 days  B) 1 day  C) few months  D) immediately  E) few hours  278.Pathlogical element in chronic recurrent aphthous stomatitis is often surrounded by :  A) hyperkeratotic halo  B) hyperemic halo  C) small abscesses  D) papules  E) bullaes  279.Aphta in chronic recurrent aphthous stomatitis is :  A) slightly painful on palpation , firm  B) painless on palpation , soft  C) painless on palpation , firm  D) very painful on palpation , soft  E) very painful on palpation, of cartilage –like consistency  280.Necrotic masses in chronic recurrence aphthous stomatitis are rejected in :  A) 5-7 days  B) 12-24 days  C) 2-4 days  D) 1-2 days  E) 9-10 days  281.Specific feature of chronic recurrence aphthous stomatitis ( easy form )is :  A) recurrences  B) the formation of bullaes  C) eroding  D) healing with the formation of keloids  E)letal exodus  **TESTS' ANSWERS**   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | 1 | A | 29 | D | 57 | E | 84 | D | 113 | B | 156 | A | 184 | D | 212 | E | 240 | C | | 2 | E | 30 | C | 58 | B | 85 | C | 114 | D | 157 | E | 185 | C | 213 | B | 241 | A | | 3 | B | 31 | A | 59 | D | 86 | A | 115 | C | 158 | B | 186 | A | 214 | D | 242 | E | | 4 | D | 32 | E | 60 | C | 87 | E | 116 | A | 159 | D | 187 | E | 215 | C | 243 | B | | 5 | C | 33 | B | 61 | A | 88 | B | 117 | E | 160 | C | 188 | B | 216 | A | 244 | D | | 6 | A | 34 | D | 62 | E | 89 | D | 118 | B | 161 | A | 189 | D | 217 | E | 245 | C | | 7 | E | 35 | C | 63 | B | 90 | C | 119 | D | 162 | E | 190 | C | 218 | B | 246 | A | | 8 | B | 36 | A | 64 | D | 91 | A | 120 | C | 163 | B | 191 | A | 219 | D | 247 | E | | 9 | D | 37 | E | 64 | D | 92 | E | 121 | A | 164 | D | 192 | E | 220 | C | 248 | B | | 10 | C | 38 | B | 65 | C | 93 | B | 136 | A | 165 | C | 193 | B | 221 | A | 249 | D | | 11 | A | 39 | D | 66 | A | 94 | D | 137 | E | 166 | A | 194 | D | 222 | E | 250 | C | | 12 | E | 40 | C | 67 | E | 95 | C | 138 | B | 167 | E | 195 | C | 223 | B | 251 | A | | 13 | B | 41 | A | 68 | B | 96 | A | 139 | D | 168 | B | 196 | A | 224 | D | 252 | E | | 14 | D | 42 | E | 69 | D | 97 | E | 140 | C | 169 | D | 197 | E | 225 | C | 253 | B | | 15 | C | 43 | B | 70 | C | 98 | B | 141 | A | 170 | C | 198 | B | 226 | A | 254 | D | | 16 | A | 44 | D | 71 | A | 99 | D | 142 | E | 171 | A | 199 | D | 227 | E | 255 | C | | 17 | E | 45 | C | 72 | E | 100 | C | 143 | B | 172 | E | 200 | C | 228 | B | 259 | D | | 18 | B | 46 | A | 73 | B | 101 | A | 144 | D | 173 | B | 201 | A | 229 | D | 260 | C | | 19 | D | 47 | E | 74 | D | 102 | E | 145 | C | 174 | D | 202 | E | 230 | C | 261 | A | | 20 | C | 48 | B | 75 | C | 103 | B | 146 | A | 175 | C | 203 | B | 231 | A | 262 | E | | 21 | A | 49 | D | 76 | A | 105 | C | 147 | E | 176 | A | 204 | D | 232 | E | 263 | B | | 22 | E | 50 | C | 77 | E | 106 | A | 149 | D | 177 | E | 205 | C | 233 | B | 264 | D | | 23 | B | 51 | A | 78 | B | 107 | E | 150 | C | 178 | B | 206 | A | 234 | D | 265 | C | | 24 | D | 52 | E | 79 | D | 108 | B | 151 | A | 179 | D | 207 | E | 235 | C | 266 | A | | 25 | C | 53 | B | 80 | C | 109 | D | 152 | E | 180 | C | 208 | B | 236 | A | 267 | E | | 26 | A | 54 | D | 81 | A | 110 | C | 153 | B | 181 | A | 209 | D | 237 | E | 279 | D | | 27 | E | 55 | C | 82 | E | 111 | A | 154 | D | 182 | E | 210 | C | 238 | B | 280 | C | | 28 | B | 56 | A | 83 | B | 112 | E | 155 | C | 183 | B | 211 | A | 239 | D | 281 | A | |