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Case Study

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ANGINA BULLOSA HEMORRHAGICA: A CASE REPORT

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ABSTRACT

Angina bullosa hemorrhagica (ABH) is an enigmatic oral disorder described for the first time by Badham in 1967 to define blisters with a hematic content in the oral cavity and oropharynx unrelated to any haematological, dermatological or systemic disease. This process is considered nowadays to have a multifactorial etiopathogenesis, where mild oral traumatisms can trigger the blisters in susceptible individuals. The haemorrhagic bullae spontaneously burst after a short time resulting in ragged, often painless, superficial erosions that heal spontaneously within 1 week without scarring. We present the case of a 35 year old female with Angina bullosa hemorrhagica.

INTRODUCTION

Angina bullosa hemorrhagica (ABH), a term coined by Badham in 1967,[1] is a benign phenomenon, appearing as painless single or multiple blood-filled blisters over oropharyngeal mucosa. Angina bullosa haemorrhagica (ABH) is an uncommon and benign subepithelial disorder appearing as hematic blisters on the oral and oropharyngeal mucosa andno relation with any dermatological, haemostaticor systemic condition.[1] Kirtschig and Happle pointed out, the term ABH is misleading because most bullae arise in the oral cavity and are not consistent with lesions usually called 'angina'; they proposed a more appropriate name for the disease: stomato pompholyx haemorrhagica.[2] This entity has received multiple names, such as Benign Hemorrhagic Bullous Stomatitis[3] or Localized Oral Purpura[4] or "Traumatic Oral Hemophlyctenosis" or Baliña.[5]

CASE REPORT

A 35 year old female patient reported to dermatology opd with chief complaints of blister on the side and base of tongue for past 3 days. The patient was apparently normal before 3 days when she first noticed the blister when patient was consuming food during breakfast. She complains of unspecific discomfort and mild burning sensation. It was not associated with pain fever,difficulty in swallowing or speech. There is no past history of similar complaint. She didn't have any medical history related to blood dyscariasis, anticoagulant therapy, inhaled corticosteroid medication, liver disease.

On general physical examination there were no significant findings. On oral examination a blood filled blister was present on the lateral and ventral surface of tongue, which was painless, raised, round, dark red in color and measured around 2 cm in diameter (Figure 1). There was no visible pulsations. On palpation the blister was non tender.

Routine blood examination which included complete haemogram, bleeding time, clotting time, platelet count, prothrombin time, random blood glucose levels were within normal limit.

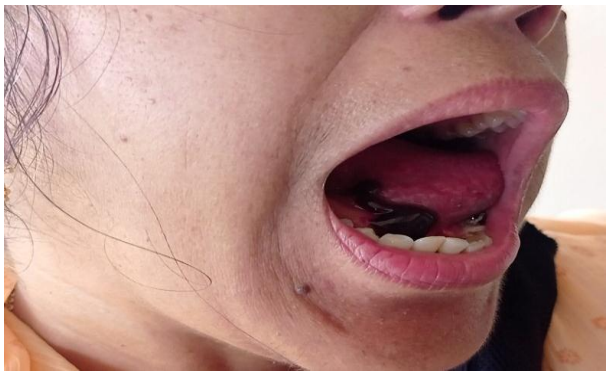

Fig 1: shows clinical aspect of angina bullosa hemorrahagica.

DISCUSSION

ABH presents clinically with blood-filledblisters that occur predominantly on the softpalate. They generally reach a diameter of 2±3cm.[6] The characteristic lesion of ABH is a dark red-violet blister with a hematic content.[1] They tend to burst spontaneously, leaving a ragged ulcer that heals without scarring. Approximately 30% of patients may have arecurrence.[7]

ABH has been considered as an idiopathic condition. The onset is sudden and minor mucosal insults may be involved in the pathogenesis. It may also follow trauma caused by eating, hot drinks, dental procedures or shouting. It is also noteworthy that mastication significantly increases the blood flow rate in the soft palate via parasympathetic reflex vasodilatation, and hard or crispy food may injure the palate, which leads to ABH.[8]

ABH mainly affects the soft palate, but lesions can also develop on other oral sites including the buccal mucosa, lip and the lateral surface of the tongue; the masticatory mucosa of the hard palate and gingiva does not seem to be affected.It is important to note that all of these locations are part of the "lining mucosa" of the oral cavity which is non-keratinized.

Together with local traumatic factors, certain inhaled drugs, mainly the chronic use of topical corticosteroids, have been associated with the onset of ABH.[9,10]

The prolonged contact of the steroid with the oral mucosa may cause epithelial atrophy and may alter the distribution of the chorionic elastic fibers, which would weaken the epithelium-connective tissue junction, and would favor the onset of a subepithelial blister in a local traumatic event.[9,10,11]

DECLARATION OF PATIENT CONSENT

The authors certify that they have obtained all appropriate patient consent forms. In the form the patient(s) has/have given his/her/ their consent for his/her/their images and other clinical information to be reported in the journal. The patients understand that their names and initials will not be published and due efforts will be made to conceal their identity, but anonymity cannot be guaranteed.

CONFLICT OF INTEREST

Nil.

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