Oral Ulcers and Patches: Primary Care Assessment

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> Oral ulcers and patches are common presentations in primary care, ranging from benign aphthous stomatitis to potentially malignant lesions. The challenge for general practitioners lies in accurately assessing these lesions to determine the need for specialist referral, balancing patient reassurance with timely diagnosis of serious conditions.

KEY TAKEAWAYS

- The Pivot: Differentiating benign from potentially malignant oral lesions requires a structured approach in primary care.
- The Data: Approximately 50% of oral squamous cell carcinomas present as ulcers or white/red patches.
- The Action: Implement a systematic assessment of lesion characteristics, duration, and associated symptoms to guide referral decisions.

Oral lesions, including ulcers and patches, are a frequent reason for consultation in primary care. While many are self-limiting and benign, a subset represents dysplastic changes or malignancy, predominantly oral squamous cell carcinoma (OSCC). Early detection of OSCC is critical for prognosis, with 5-year survival rates significantly higher for localised disease compared to regional or distant metastasis. The primary care clinician's role involves a systematic approach to history taking and clinical examination to identify features suggestive of malignancy or other serious conditions requiring specialist input.

A thorough history should ascertain the duration of the lesion, any changes in size or appearance, associated pain or discomfort, and the presence of systemic symptoms such as fever, weight loss, or lymphadenopathy. Risk factors for OSCC, including tobacco use (smoking or smokeless), heavy alcohol consumption, and betel quid chewing, must be specifically inquired about. A history of previous oral lesions, autoimmune conditions, or immunosuppression is also relevant.

Clinical examination requires adequate lighting and visualisation of the entire oral cavity, including the buccal mucosa, tongue (dorsal, ventral, and lateral borders), floor of the mouth, hard and soft palates, and tonsillar pillars. Lesions should be palpated to assess for induration, fixation to underlying tissues, and tenderness. Regional lymph nodes (submandibular, cervical) should also be palpated for enlargement or tenderness.

Key characteristics to assess for any oral ulcer or patch include:

• Colour: White patches (leukoplakia) are often benign but can be dysplastic. Red patches (erythroplakia) carry a higher risk of dysplasia or malignancy than leukoplakia. Mixed red and white lesions (erythroleukoplakia) have the highest malignant potential. Pigmented lesions may indicate melanoma or other conditions.

• Size and Shape: Note the dimensions and whether the borders are well-defined or irregular.

• Surface Texture: Ulcers can be smooth or granular. Patches may be homogeneous, verrucous, or nodular.
• Induration: A firm, hardened base on palpation is a concerning sign for malignancy.
• Fixation: Lesions fixed to underlying structures are more suspicious.
• Duration: Any oral ulcer or patch persisting for more than 2-3 weeks without an obvious cause (e.g., trauma) warrants further investigation or referral.
• Pain: While pain is often associated with benign ulcers (e.g., aphthous), persistent or unexplained pain in a non-healing lesion can be a feature of malignancy. However, many early OSCCs are painless.
Common benign conditions include aphthous ulcers, which are typically painful, recurrent, well-demarcated, and heal within 1-2 weeks. Herpes simplex labialis presents as vesicles that rupture to form ulcers, often preceded by prodromal symptoms. Traumatic ulcers usually have an identifiable cause and resolve once the irritant is removed. Oral candidiasis presents as white, removable plaques, often associated with immunosuppression or antibiotic use.
Referral to an oral medicine specialist, oral surgeon, or ENT surgeon is indicated for any oral ulcer or patch that is persistent (more than 2-3 weeks), indurated, fixed, erythroplakic, erythroleukoplakic, or has irregular borders. Any lesion with unexplained pain, associated lymphadenopathy, or occurring in a high-risk patient (e.g., heavy smoker/drinker) should also prompt urgent referral for biopsy and definitive diagnosis. The goal is to ensure that potentially malignant lesions are identified and managed promptly, improving patient outcomes.

Beyond direct referral, primary care clinicians play a crucial role in patient education regarding oral hygiene, self-examination, and the importance of regular dental check-ups, especially for those with identified risk factors. Empowering patients to recognise concerning changes in their oral cavity can facilitate earlier presentation and intervention. Furthermore, a collaborative approach with dental professionals can enhance screening efforts, as dentists are often the first to identify subtle oral mucosal changes during routine examinations.

While clinical assessment provides valuable indicators, it is important to acknowledge its limitations. The definitive diagnosis of dysplasia or malignancy relies on histopathological examination of a biopsy specimen. Therefore, a low threshold for referral, particularly for high-risk individuals or lesions with suspicious features, is paramount. Advances in adjunctive diagnostic tools, such as vital tissue staining (e.g., toluidine blue) or brush biopsies, are being explored to aid in risk stratification, but these generally require specialist interpretation and do not replace conventional incisional biopsy for definitive diagnosis.

Future directions in primary care assessment may involve integrating artificial intelligence (AI) tools for preliminary lesion analysis, potentially enhancing the detection of subtle changes that might be missed by the unaided eye. However, such technologies are still in developmental stages and would serve as adjuncts to, rather than replacements for, thorough clinical examination and specialist referral.

> **CLINICAL IMPLICATIONS**
> The persistent challenge of oral lesion assessment in primary care underscores the need for clear, actionable guidelines. While the vast majority of oral ulcers and patches are benign, the low incidence but high morbidity of

> oral cancer means that vigilance is paramount. Relying solely on pain as a diagnostic indicator is a dangerous oversight, given that many early malignancies are asymptomatic. The emphasis must shift towards duration and morphological characteristics, particularly induration and colour changes, as the primary triggers for specialist referral.
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> For clinicians, this means integrating a systematic oral examination into routine practice, especially for patients with established risk factors like tobacco and alcohol use. The 2-3 week rule for non-healing lesions should be a non-negotiable threshold for referral, rather than a flexible guideline. This proactive approach, while potentially increasing referral rates for benign conditions, is a necessary trade-off to capture early-stage cancers, which significantly improves patient prognosis and reduces the burden of advanced disease.
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> The industry could support primary care by developing accessible educational tools and perhaps even AI-assisted diagnostic aids for oral lesion screening, though these would require rigorous validation. Ultimately, the onus remains on the individual practitioner to maintain a high index of suspicion and adhere to established referral pathways. The cost of missing an early oral cancer far outweighs the inconvenience of an unnecessary referral.

EDITORIAL & AI STANDARDS

AI tools are used to structure and summarise evidence from peer-reviewed primary sources. Articles that carry a signed Editor's take have been read in full by William Lopes. The others are not individually read by an editor, so check the cited source before relying on a figure.

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