







acidic meals as well as beverages can typically make the discomfort bearable. A variety of topical and systemic treatments have been offered, with slight or no confirmation of effectiveness when officially evaluated. Several outcomes of therapies might be due to a placebo effect. Treatment aims to ease discomfort, improve healing and minimize the frequency of ulceration episodes, although no therapy is curative.

**Tropical treatment:** Corticosteroids, cyclosporine, retinoids, antimicrobials and anesthetics may be used for topical therapy. The topical corticosteroids are used to minimize the local inflammation that causes ulceration. Dexamethasone (0.5 mg/5 mL), triamcinolone (0.1% gel), fluocinonide (0.05 % gel) and clobetasol are among them (0.05% gel). Clobetasol is a superpotent steroid of that produces improved outcomes.

Anesthetics like topical lidocaine and benzocaine are both utilized for relieving the discomfort of RAS. Gelclair, sucralfate, bismuth subsalicylate, and 2-octyl cyanoacrylate among other occlusive and bio adherent agents, have been effectively utilized in RAS treatment as it form a preventive layer which covers open and overstimulated nerve terminals.

**Systemic treatment:** Progestogen or modified oral contraceptive can be proved helpful in women whose ulcers are linked to their menstruation or oral contraceptives. Nicotine replacement treatment has also been documented for persons who have acquired mouth ulcers after quitting smoking. Resuming smoking does not generally improve the situation. Avoiding rough or sharp foods along with care of teeth while cleaning can help to minimize trauma. If sodium lauryl sulphate is the cause, avoiding goods that contain this ingredient may be beneficial in preventing recurrence in some people. Likewise, patch testing might reveal hypersensitivity reaction to specific food product is held responsible so the intake should be adjusted appropriately. If deficiency states are discovered during the research, correcting the deficit may result in the ulceration disappearing. Vitamin B12 supplementation, for example, has been shown to reduce the risk of recurrence in certain people.

**Others:** Many other treatment modalities have been mentioned in the literature. Although clinical removal of aphthae is documented, it is an inefficient and unsuccessful therapy. The chemical cauterant silver nitrate has also been utilized. Apart from the above-mentioned mainstream techniques, there are plenty of other untested therapies varying from herbal remedies to unconventional cures, for example aloe vera, *Myrtus communis*, *Rosa damascena*, potassium alum, zinc sulphate, omega-3, nicotine, polio virus vaccine and prostaglandin E2. At last, dexamethasone elixir has been demonstrated to be highly helpful against both pre-sores and existing sores.

### CONCLUSION

Recurrent aphthous stomatitis is a prevalent condition affecting oral mucosa although there can be other causes for recurring ulcers in the oral cavity. It is considered as

non-infectious stomatitis. The specific cause of its occurrence is unknown but various factors play a major role in it such as bacterial infection, immunologic abnormalities, iron, vitamin B12 and folic acid deficiency and genetic factors. Diagnosis is mostly and reliably based on the clinical appearance. The most important diagnostic feature is a history of recurrent, self-healing ulcers at fairly regular intervals. A systemic cause is more likely in adults who suddenly develop recurrent oral ulceration with no prior history. Appropriate knowledge of probable cause and contributory risk factors may help to treat the aphthous stomatitis.

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