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## Angina Bullosa Hemorrhagica- A Rare Eruption

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### ABSTRACT

Angina bullosa haemorrhagica is a rare blood filled vesiculobullous lesion of the oropharynx with the most common site being reported is the soft palate. Many etiological factors have been reported including trauma, hypertension, hyperglycemia and even iatrogenic causes. Management is based on the dimension of the lesion. Usually smaller lesions are self limiting, but larger lesions require surgical intervention. We report a case of rapidly expanding blood-filled bulla of the soft palate of size 2x4.5 mm with successful management by steroids. It was associated with tightness as prodromal symptom in the area followed by the bullae. The etiology, clinical features, differential diagnosis and management of the lesion is discussed.

**Keywords:** Angina bullosa haemorrhagica (ABH), Soft palate, Diabetes mellitus

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## INTRODUCTION

ABH is a condition of blood blisters in the oropharynx that appear in the absence of any identifiable systemic disorder. The soft palate is a common site. Aetiology is unclear although trauma is thought to play a role. It is a benign condition.<sup>1</sup>

## CASE REPORT:

A male patient 48 years of age presented to the department of Oral Medicine and Radiology, College of Dental Sciences, Davanagere with a complaint of pain in the palate region past 1 day which was sudden in onset, localized, throbbing in nature and moderate in intensity. He also gave a history of tightness, stinging type pain before the appearance of lesion. After the pain immediately appeared the swelling which ruptured next day morning, which was associated with difficulty in swallowing food in the morning. After the rupture of swelling no pain persisted. No history of trauma, chemical, hot food intake and allergy to food.

Patient gave history of diabetes past 14 years and on medication. He was a cigarette smoker past 35 years 5 to 6 per day. On the day of examination his blood pressure was 165/95 mm of Hg.

Local examination of lesion on inspection revealed a swelling in the soft palate right side from midline. Mediolaterally it was extending from midpalatine raphae to 1.5 mm from tuberosity. Anterioposteriorly from distal of 3<sup>rd</sup> molar to superior surface of uvula. It was of size 4x2.5 mm, round in shape, blood filled dark red in colour with few area yellowish brown in colour, margin was well defined, surrounding area was normal (Verbal consent from the patient was taken for photographs). On palpation tenderness was absent, consistency was soft with discharge of blood on pressure, and surface was smooth with ruptured area superiomedially (figure 1). He also had inflamed minor salivary gland orifices in the palate. Based on these findings ABH involving soft palate was given as provisional diagnosis. An array of investigations was carried out which revealed increased hyperglycaemia and hypercholestraemia (table).

**Table 1: Investigations**

No.	Tests	Values	Normal range
1	Hemoglobin	12 g/dl	(13.8 to 18.0 g/dl)
2	Glycated hemoglobin	7.78%	(4-5.9%)
3	Fasting blood sugar	270 mg/dl	(110 mg/dl)
4	Random blood sugar	200 mg/dl	(70 - 140 mg/dl)
5	Serum urea	38 mg/dl	(20-40 mg/dl)
6	Serum cholesterol	219 mg/dl	(200 mg/dl)



**Figure 1: On examination day**

Patient was treated with prednisolone 10 mg BID for 2 days with salt water gargling TID with counseling to quit the habit. Patient was followed for a period of 2 weeks and dosage of steroid was tapered. At the second visit lesion appeared as superficial ulceration with grayish white pseudomembrane floor with well defined margins and normal surrounding mucosa followed by healing without scarring at the 3<sup>rd</sup> visit (figure 2, 3).



**Figure 2: After 1 week follow up**



**Figure 3: After 2 week follow up**

## RESULTS AND DISCUSSION:

ABH is the term used to describe acute, benign, and generally subepithelial oral mucosal blisters filled with blood that are not attributable to a systemic disorder or hemostatic defect. This condition was first described in 1933 as traumatic oral hemophlyctenosis. Badham first used the currently accepted term angina bullosa hemorrhagica in 1967.<sup>2</sup>

Some authors suggest mild trauma as the causative agent in ABH to break the epithelial-connective-tissue junction, causing bleeding of superficial capillaries and resulting in the formation of a subepithelial hemorrhagic bullae.<sup>2</sup> Grinspan et al reported that 44% of his patients in a series of 24 cases published in 1999 suffered from type II diabetes, hyperglycemia, or family history of diabetes. No conclusive evidence of a cause-and-effect relationship between the

presence of ABH and glucose metabolism exists.<sup>3</sup> Slightly more than 50% of the cases described are related to the minor trauma of hot foods, restorative dentistry, or periodontal therapy. Other potential causes of ABH that have been mentioned in the literature are dental injections of anesthetics, steroid inhalers, and chlorhexidine gluconate mouthrinse. A report of 16 cases affecting the soft palate described hypertension as the most frequent underlying systemic condition (6 of 16 subjects); however, its relationship remains speculative, as hypertension is common in adults.<sup>4,5,6,7,8,9</sup>

The soft palate is the most commonly affected site in ABH.<sup>10</sup> Occasional lesions have been reported in the buccal mucosa and tongue.<sup>2</sup>

The lesions may be confused with other more serious disorders (eg, mucous membrane pemphigoid, epidermolysis bullosa, linear IgA, dermatitis herpetiformis); however, the isolated nature, rapid healing, and rare recurrence of ABH blisters generally are sufficient findings to rule out the previously mentioned conditions. The lesions of ABH may be indistinguishable from blood blisters related to thrombocytopenia; however, blood tests and the absence of areas of ecchymosis, epistaxis, or gingival bleeding are helpful signs to rule it out.<sup>2</sup>

No treatment is required for ABH because the blood blisters spontaneously rupture and heal. Coagulation tests and platelet count may be indicated to rule out a blood dyscrasia. Any large, intact blood blister should be incised to prevent further enlargement that could cause airway obstruction.<sup>2</sup>

## CONCLUSION:

Although encountering an ABH is uncommon in clinical practice, it has been encountered in the literature. A clear knowledge is mandatory to distinguish ABH from other bleeding disorders involving the oral mucosa. This would help the clinicians to segregate the lesions so that a proper diagnosis is possible.

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