COCHRANE-REVIEW

Burning mouth syndrome

Behandling er vanskelig, men patienterne har gavn af tidlig information om syndromets karakter og om symptomerne

Winnie Brodam

Burning mouth syndrome (BMS) er et syndrom med ukendt ætiologi, som angiveligt forekommer hos op til 15 % af en almindelig befolkning. Mange af patienterne lider ifølge Cochrane samtidig af angst, depression og personlighedsforstyrrelser.

Ni undersøgelser indgår i et Cochrane-review om BMS, som er publiceret i 2008. De omhandler brug af antidepressiva, kognitiv adfærdsterapi, smertestillende medicin, hormonbehandling, lipoinsyrebehandling (lipoinsyre er et koenzym og en antioxidant) og krampedæmpende medicin (clonazepam).

Reviewet viser ikke evidens for, at smertestillende mediciner, hormoner og antidepressiva er effektive i behandling af BMS. Der er nogen evidens for, at medicin i form af krampedæmpende midler og lipoinsyre kan hjælpe – og så kan kognitiv adfærdsbehandling hjælpe patienterne til at leve bedre med sygdommen.

Cochranes forfattere understreger, at når man ikke har fundet effekt af fx hormon- og smertestillende behandling, så kan det skyldes metodefejl i undersøgelserne, og ikke nødvendigvis at metoderne mangler effekt.

Kommentar af lektor *Anne Marie Lynge Pedersen* fra Tandlægeskolen i København:

– Forfatterne til Cochranes review konkluderer, at der er et betydeligt behov for at finde en effektiv behandling af BMS, og at der er behov for at optimere kvaliteten af fremtidige interventionsstudier.

Reviewets undersøgelser er randomiserede og klinisk kontrollerede studier med det primære effektmål at lindre orale brændende symptomer – og ifølge reviewet synes udelukkende clonazepam, lipoinsyre samt kognitiv adfærdsterapi at have effekt.

Der findes i dag ingen kausal behandling af BMS, da årsagen endnu er uafklaret. Behandlingen er derfor primært rettet mod symptomlindring. Clonazepam er et benzodiazepin-derivat, og indtagelse er forbundet med risiko for udvikling af tolerans og afhængighed samt bivirkninger som sedation og nedsat koncentrationsevne. Clonazepam anbefales derfor kun til særligt vanskelige tilfælde (i form af lokal applikation af tablet på tungen).

Den gunstige effekt af antioxidanten a-lipoinsyre, et mitokondrie-koenzym, har i nyere dobbeltblinde, randomiserede, klinisk kontrollerede studier ikke kunnet bekræftes.

Behandling af BMS med tri- og tetracykliske antidepressiva samt serotonin-reuptake-hæmmere har vist sig at have begrænset effekt, og mundskylning med benzydamin hydroklorid (Andolex Ò) 0,15 % i et dobbeltblindt randomiseret studie har været uden væsentlig effekt.

Derimod har systemisk behandling med tablet indeholdende capsaicin i et placebokontrolleret studie vist sig at have gavnlig effekt. Ligeledes hævdes mundskylning med en blanding af capsaicin fra chilipeber og vand i blandingsforholdet 1:2 at have gunstig effekt på symptomer ved BMS, men dette er ikke dokumenteret i et klinisk studie. I denne forbindelse kan nævnes, at effekten af applikation af capsaicingel på tungen aktuelt undersøges i et forskningsprojekt på Tandlægeskolen i København.

Afslutningsvis skal det fremhæves, at tidlig intervention i form af information om syndromets karakter og symptomatologi er væsentlig for at styrke patientens psykosociale funktionsniveau og forhindre somatisk overbehandling.

Abstract

Background

The complaint of a burning sensation in the mouth can be said to be a symptom of other disease or a syndrome in its own right of unknown aetiology. In patients where no underlying dental or medical causes are identified and no oral signs are found, the term burning mouth syndrome (BMS) should be used. The prominent feature is the symptom of burning pain which can be localized just to the tongue and/or lips but can be more widespread and involve the whole of the oral cavity. Reported prevalence rates in general populations vary from 0.7% to 15%. Many of these patients show evidence of anxiety, depression and personality disorders.

Objectives

The objectives of this review are to determine the effectiveness and safety of any intervention versus placebo for relief of symptoms and improvement in quality of life and to assess the quality of the studies.

Search strategy

We searched the Cochrane Oral Health Group Trials Register (20 October 2004), the Cochrane Central Register of Controlled Trials (CENTRAL, The Cochrane Library, Issue 4, 2004), MEDLINE (January 1966 to October 2004), EMBASE (January 1980 to October). Clinical Evidence Issue No. 10 2004, conference proceedings and bibliographies of identified publications were searched to identify the relevant literature, irrespective of language of publication.

Selection criteria

Studies were selected if they met the following criteria: study design – randomised controlled trials (RCTs) and controlled clinical trials (CCTs) which compared a placebo against one or more treatments; participants – patients with burning mouth syndrome, that is, oral mucosal pain with no dental or medical cause for such symptoms; interventions – all treatments that were evaluated in placebo-controlled trials; primary outcome – relief of burning/discomfort.

Data collection and analysis

Articles were screened independently by two reviewers to confirm eligibility and extract data. The reviewers were not blinded to the identity of the studies. The quality of the included trials was assessed independently by two reviewers, with particular attention given to allocation concealment, blinding and the handling of withdrawals and drop outs. Due to both clinical and statistical heterogeneity statistical pooling of the data was inappropriate.

Main results

Nine trials were included in the review. The interventions examined were antidepressants (two trials), cognitive behavioural therapy (one trial), analgesics (one trial), hormone replacement therapy (one trial), alpha-lipoic acid (three trials) and anticonvulsants (one trial). Diagnostic criteria were not always clearly reported. Out of the nine trials included in the review, only three interventions demonstrated a reduction in BMS symptoms: alpha-lipoic acid (three trials), the anticonvulsant clonazepam (one trial) and cognitive behavioural therapy (one trial). Only two of these studies reported using blind outcome assessment. Although none of the other treatments examined in the included studies demonstrated a significant reduction in BMS symptoms, this may be due to methodological flaws in the trial design, or small sample size, rather than a true lack of effect.

Authors' conclusions

Given the chronic nature of BMS, the need to identify an effective mode of treatment for sufferers is vital. However, there is little research evidence that provides clear guidance for those treating patients with BMS. Further trials, of high methodological quality, need to be undertaken in order to establish effective forms of treatment for patients suffering from BMS.

Zakrzewska JM, Forssell H, Glenny AM. Interventions for the treatment of burning mouth syndrome. Cochrane Database of Systematic Reviews 2005, Issue 1. Art. No.: CD002779. DOI: 10.1002/14651858.CD002779.pub2.