

## UPDATE ON THE CHALLENGES OF TREATING BURNING MOUTH SYNDROME

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**ABSTRACT:** Burning Mouth Syndrome (BMS), an idiopathic oral disease and also neuropathy of trigeminal nerves appear in oral cavity with the burning sensation in tongue. Other presentation of BMS as its synonyms sore mouth, sore tongue, oral dysesthesia and scalding of mouth. This chronic debilitating oral condition has an obscure aetiology and pathogenesis, causing an abroad way to treat this disease. The medication for BMS must concern its local or systemic condition, which focusing on the relief of symptoms so the clinicians may able to improving the patients quality of life. The literature contains the summary of type drugs and supplements. Although effective therapies have been conducted in many concrete cases, a treatment modality offering efficacy in most cases of BMS, yet remains to be established. It is important to achieve an intensive knowledge to the physiopathological mechanism of BMS, and to compare and establish for developing drugs to improve the efficacy and safety profiles in the treatment of BMS.

**Key words :** Burning Mouth Syndrome, orofacial pain, clonazepam, vitamin B complex

### INTRODUCTION

Burning mouth syndrome (BMS) (oral dysesthesia; glossodynia; stomatodynia) is a medical condition characterized by chronic orofacial pain without any mucosal abnormalities or other organic disease. The BMS epidemiology is uncertain, with an reported prevalence varying from 0.7% to 4.6%. The variety of prevalence across studies may related to the differences in inclusion criteria utilized in the research. The range for BMS is typically in the fifth to seventh decade of life and is more popular in women than men, with an approximate ratio of 3:1 to 16:1 (Klasser *et al*, 2008).

According to The International Headache Society (IHS) in the International Classification of Headache Disorders III (ICHD-3), BMS is classified into the category of painful cranial neuropathies and other facial pain. In ICHD-3, the diagnostic criteria of BMS is (i) Daily occur periodically for >2 h per day for 3 months, (ii) Pain sensation has all of the following characteristics: burning condition and superficial sensation in the oral mucosa (iii) Oral mucosa is of normal appearance and clinical evaluation including sensory examination is normal and (iv) Not different than any ICHD-3 diagnosis. The

postulated category of neuropathy of BMS may be due to a decrement of thermal pain tolerance and increased recognition thresholds to intensity of heat pain found in BMS patients (Korczeniewska *et al*, 2019).

There are several classification of BMS. In the clinical settings, classification based on etiology is widely use. Based on etiology, BMS classified into primary/idiopathic BMS used in idiopathic condition is indicated and secondary BMS when underlying local/systemic conditions founded. Based on their pathophysiology, BMS can be divided into three subgroups. The first (50-65 percent) is distinguished by peripheral small diameter fiber nerve damage of oral mucosa, the second (20-25 percent) is defined by subclinical lingual, mandibular, or trigeminal system pathology, and lastly the third (20-40%) is associated with central pain resulting from dopaminergic neuron hypofunction in the basal ganglia (Jaaskelainen, 2012).

Although, the enigmatic characteristic of BMS etiopathogenesis, several study postulated that BMS may related to peripheral and central sensory neuropathy or neuropathic disproportion in taste and sensory systems.