A Structured Approach for the Management of Orodynia (Burning Mouth Syndrome)

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Orodynia (OD) manifests as an unexplained burning sensation in the oral cavity, often persisting for years without clear clinical findings. Currently, there is no clear protocol for managing OD. We propose a systematic approach that aims to exclude common potential causes and attempt proactive treatments. Anecdotally, we have found that our structured approach improves clinical outcomes.

Practice Gap

Orodynia (OD)—together with glossodynia colloquially termed "burning mouth syndrome"—is a chronic disorder characterized by a burning sensation within the oral cavity without objective clinical signs. It is most common in perimenopausal and postmenopausal women.[1,2]

Orodynia is a diagnosis of exclusion and is considered after 4 to 6 months of normal imaging and laboratory test results.[1,2] Its pathophysiology is poorly understood, as it can be intermittent or continuous, manifest with a variety of symptoms, and affect various entities of the oral cavity.[3,4] The most common structure affected is the tongue, and symptoms may include xerostomia, dysgeusia, and discomfort.[1,2] Orodynia is a frustrating condition, as many patients do not respond to treatment and experience symptoms for years.[1-4]

The current approach to management of OD typically involves a combination of psychosocial strategies and pharmacologic agents. The psychosocial component consists of coping mechanisms (eg, stress management techniques and behavioral therapies) aimed at alleviating the psychological impact of the condition. Pharmacologic agents such as antidepressants, anticonvulsants, and topical medications often are prescribed to address neuropathic pain and dry mouth symptoms.[1,2] Additionally, oral rinses, saliva substitutes, and dietary supplements may be recommended to counteract the discomfort associated with xerostomia.[1,2] However, there is no stepwise protocol, leaving these treatments to be trialed in a disorganized manner.[2]

The Tools

In our unique approach to managing OD, physicians may employ a variety of tools, including autoantibody profiles, noninvasive salivary gland analysis, saliva analysis, patch testing for allergens, and—if deemed necessary—a minor salivary gland biopsy. The use of specific prescription medications is included in the later stages of our approach.

The Technique

First, exclude inflammatory conditions such as geographic tongue, oral lichen planus, autoimmune bullous disorders, and other treatable conditions such as dyspepsia and Sjögren syndrome using the tools described above. Noninvasive modalities should be exhausted first, and dermatologists/clinicians should exercise clinical judgement to determine whether all options should be trialed, including more invasive/costly ones.

If symptoms persist, clinicians may want to obtain a culture for oral candida. If results are positive, candida

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may be treated quickly with oral fluconazole. If that treatment fails and fissuring is present, advise the patient on treating the tongue; we recommend lightly brushing the tongue once daily with a hydrogen peroxide 3% solution, followed by rinsing. Next, the patient can allow an active probiotic yogurt to sit on the tongue for at least 1 minute to repopulate it with healthy oral bacteria.

If symptoms persist, prescribe gabapentin 100 to 300 mg to be taken at bedtime. Cevimeline 30 mg 3 times daily can be added to treat symptoms of xerostomia. As a last resort, a low daily dose of trifluoperazine 1 to 2 mg may alleviate the dysesthesia of OD. Because this medication is an antipsychotic, there is an increased risk for adverse effects such as tardive dyskinesia; however, given that we recommend using at most one-twentieth of the dose recommended for psychiatric illnesses such as schizophrenia, the risk appears to be minimal.[5]

We have found this protocol to be more structured, and in our practice, it has led to better outcomes than previously described therapeutic interventions.

Practice Implications

As a chronic condition, OD can be frustrating for patients, as many of them have attempted multiple treatments without success. It also may be challenging for dermatologists who are unfamiliar with its management. This approach to OD provides simple step-by-step diagnostic and therapeutic plans for a condition with an often-uncertain etiology and stubborn response to initial treatments. By following this protocol, dermatologists can be confident in their ability to help patients find relief from OD.

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