International Journal of Enhanced Research in Medicines & Dental Care (IJERMDC),
ISSN: 2349-1590, Vol. 13 Issue 1, January 2026

Desquamative Gingivitis: From Diagnosis to Treatment—A Case-Based Perspective.

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ABSTRACT

Desquamative gingivitis (DG) is a descriptive term used to indicate epithelial desquamation, erythema, erosion, and or vesiculobullous lesions of the attached and marginal gingiva [1[2]]. We report a case of a 35-year-old medically fit female with severe gingival bleeding and burning sensation aggravated by spicy food. Clinical examination revealed erythematous and edematous gingiva with erosions and whitish striations. The patient responded well to systemic and topical corticosteroids, emphasizing early diagnosis and multidisciplinary management.

Keywords: Desquamative gingivitis, oral mucosal lesions, corticosteroid therapy, topical steroids, case report

INTRODUCTION

Desquamative gingivitis is a descriptive term for oral manifestations associated with autoimmune and mucocutaneous disorders such as lichen planus and pemphigoid. characterized by erythema, epithelial desquamation, and various intraoral lesions. It is characterized by erythema, desquamation, tenderness, and bleeding.

Histopathological examination or use of immunofluorescence is essential for determining the underlying disorder [3]. Prompt recognition is crucial for symptom relief and prevention of progression.

Managing desquamative gingivitis (DG) is challenging, as affected gingiva often responds less consistently to treatment than similar lesions in OLP, PV, or MMP. Limited treatment response may be partly due to difficulty maintaining oral hygiene, leading to plaque accumulation. Continuous monitoring of oral hygiene, guided by dental hygienists, and motivating patients during follow-up are essential to optimize plaque control and improve outcomes [3].

CASE REPORT

35-year-old medically fit female presented with a one-month history of severe gingival bleeding and burning sensation in the maxillary and mandibular teeth regions. The bleeding was aggravated by brushing, and the burning sensation worsened with spicy foods. The patient reported a history of skin lesions and had been on antihistamines for two months. On examination, she was moderately built and nourished. Intraoral findings included bright, shiny, erythematous, and edematous labial and buccal gingiva, with erosions on the palatal aspect of teeth 14–16 and gingival erosions with whitish striations at tooth 36 and the adjacent alveolar ridge. The lesions were tender, non-scrapable, and bled on probing. Pain was assessed as 8/10 on the Visual Analog Scale. A provisional diagnosis of desquamative gingivitis was made, with differential diagnoses including allergic reaction and hormonal disorder. The patient was managed with systemic Betnesol 0.5 mg twice daily and topical Tenovate cream applied twice daily, both for 15 days. Additionally, she was referred to prosthodontics for the fabrication of a soft splint to facilitate effective topical application.

Follow-up:
At follow-up, lesions had **regressed**, and VAS score improved to **5/10**. Regular follow-up was advised.

DISCUSSION

DG is commonly associated with autoimmune mucocutaneous diseases. Diagnosis is primarily clinical, supported by patient history. The clinical presentation of desquamative gingivitis (DG) is variable, and the presence of bacterial plaque can make diagnosis challenging. Vesiculobullous disorders often manifest with epithelial desquamation, gingival erosion, blister formation, occasional extraoral lesions, and pain, particularly after spicy foods. Nikolsky's sign is positive when gentle shearing of normal-appearing gingiva induces epithelial detachment. DG may spare the marginal gingiva but can involve the entire attached gingiva, and its appearance is not markedly improved by routine oral hygiene or conventional therapy. Severity is classified as mild (erythema without pain), moderate (bright red and

grey patchy areas, smooth and shiny gingiva, slight pitting, and epithelial peeling on pressure), or severe (extensive involvement, shredded epithelium, bubble formation with air-blowing, and painful burning sensation).

Management of desquamative gingivitis (DG) poses a significant challenge for oral health practitioners, largely due to its unclear etiology. No standardized treatment protocol exists, and therapeutic strategies are influenced by factors such as physician preference, patient age, the underlying condition causing DG, disease severity, presence of extraoral lesions, and the patient's medical history, including systemic considerations and potential medication-related complications. Once a diagnosis is established, the control phase focuses on intensive therapy to suppress the disease. Treatment primarily involves identifying and eliminating the underlying cause, when possible, such as avoiding known allergens or irritants; improving oral hygiene to reduce plaque-induced inflammation; addressing the primary disease; and using local or systemic immunosuppressive agents, including corticosteroids and other anti-inflammatory drugs. Additional options may include antimetabolites (cyclophosphamide, azathioprine, mycophenolate mofetil, methotrexate), antibiotics (tetracyclines), dapsone, immunoglobulins, plasmapheresis, or surgical interventions such as gingival grafting and laser therapy [4].

Early intervention alleviates pain and improves quality of life.

CONCLUSION

This case highlights the importance of early recognition and multidisciplinary management of desquamative gingivitis, with systemic and topical therapy providing effective symptom relief.

Figure A, B –Pre treatment

Figure C, D – Post treatment

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