

## LETTERS TO THE EDITOR

## Oral erythema multiforme: trends and clinical findings of a large retrospective: European case series



To the Editor:

Celentano et al.<sup>1</sup> are to be congratulated on their recent publication. This excellent addition to the literature reports a retrospective case series of 60 oral erythema multiforme (EM) patients. However, presently, diagnostic criteria that distinguish between EM major (EMM), EM minor (EMm), Stevens-Johnson syndrome (SJS), and toxic epidermal necrolysis (TEN) are available. Celentano et al.<sup>1</sup> have combined all of these diagnostic entities within the category of EM. This grouping is certainly appropriate, since the study patient population was initiated in 1982, when all such diagnoses would have been described within the category of EM. The authors commented that diagnostic criteria between EMM, EMm, SJS, and TEN presently are not universally accepted. However, a case can be made that such diagnostic criteria are presently relatively well established, although not universally accepted.<sup>1-7</sup>

In 2005, Williams and Conklin<sup>2</sup> summarized the dermatologic diagnostic standards for EM, SJS, and TEN, as reported by Bastuji-Garin et al.,<sup>3</sup> Assier et al.,<sup>4</sup> and Auquier-Dunant et al.,<sup>5</sup> and Cote et al.<sup>6</sup> These standards describe EM, SJS, and TEN as separate diagnostic entities with relatively well-defined diagnostic characteristics. Furthermore, Ayangco and Rogers<sup>7</sup> defined the similarities and differences between EMm and EMM.

Hopefully in the near future, the oral medicine and oral and maxillofacial pathology communities will undertake confirmation of universally accepted diagnostic standards for EMM, EMm, SJS, and TEN, possibly at the next World Workshop of Oral Medicine.

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## REFERENCES

1. Celentano A, Tovar S, Yap T, Adamo D, Aria M, Mignogna MD. Oral erythema multiforme: trends and clinical findings of a large retrospective: European case series. *Oral Surg Oral Med Oral Pathol Oral Radiol.* 2015;120:707-716.
2. Williams PM, Conklin RJ. Erythema multiforme: a review and contrast from Stevens-Johnson syndrome/toxic epidermal necrolysis. *Dent Clin North Am.* 2005;49:67-76.
3. Bastuji-Garin S, Rzany B, Stern RS, Shear NH, Naldi L, Roujeau JC. Clinical classification of cases of toxic epidermal necrolysis, Stevens-Johnson syndrome, and erythema multiforme. *Arch Dermatol.* 1993;129:92-96.
4. Assier H, Bastuji-Garin S, Revus J, Roujeau JC. Erythema multiforme with mucous membrane involvement and Stevens-Johnson syndrome are different disorders with distinct causes. *Arch Dermatol.* 1995;131:539-543.
5. Auquier-Dunant A, Mockenhaupt M, Naldi L, Correia O, Schroder W, Roujeau JC. Correlations between clinical patterns and causes of erythema multiforme major, Stevens-Johnson syndrome, and toxic epidermal necrolysis. Results of an international prospective study. *Arch Dermatol.* 2002;138:1019-1024.
6. Cote B, Wechsler J, Bastuji-Garin S, Assier H, Revus J, Roujeau J-C. Clinicopathologic correlation in erythema multiforme and Stevens-Johnson syndrome. *Arch Dermatol.* 1995;131:1268-1272.
7. Ayangco L, Rogers RS III. Oral manifestations of erythema multiforme. *Dermatol Clin.* 2003;21:195-205.

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## In reply: Oral erythema multiforme: trends and clinical findings of a large retrospective: European case series



In reply:

The authors are very appreciative of comments presented by Professor Brown regarding our recent publication,<sup>1</sup> which highlighted the applicability of diagnostic criteria proposed by several authors in the last two decades.<sup>2-7</sup>

We agree that future studies should consider the use of these presently well-established diagnostic criteria differentiating between erythema multiforme minor (EMm), erythema multiforme major (EMM), Stevens-Johnson syndrome (SJS), and toxic epidermal necrolysis (TEN). This may allow the clinical community to achieve more accurate epidemiologic data that can contribute to a better understanding and management of the disease.

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## REFERENCES

1. Celentano A, Tovu S, Yap T, Adamo D, Aria M, Mignogna MD. Oral erythema multiforme: trends and clinical findings of a large retrospective European case series. *Oral Surg Oral Med Oral Pathol Oral Radiol.* 2015;120:707-716.
2. Williams PM, Conklin RJ. Erythema multiforme: a review and contrast from Stevens-Johnson syndrome/toxic epidermal necrolysis. *Dent Clin North Am.* 2005;49:67-76.
3. Bastuji-Garin S, Rzany B, Stern RS, Shear NH, Naldi L, Roujeau JC. Clinical classification of cases of toxic epidermal necrolysis, Stevens-Johnson syndrome, and erythema multiforme. *Arch Dermatol.* 1993;129:92-96.
4. Assier H, Bastuji-Garin S, Revuz J, Roujeau JC. Erythema multiforme with mucous membrane involvement and Stevens-Johnson syndrome are different disorders with distinct causes. *Arch Dermatol.* 1995;131:539-543.
5. Auquier-Dunant A, Mockenhaupt M, Naldi L, Correia O, Schroder W, Roujeau JC. Correlations between clinical patterns and causes of erythema multiforme major, Stevens-Johnson syndrome, and toxic epidermal necrolysis. Results of an international prospective study. *Arch Dermatol.* 2002;138:1019-1024.
6. Cote B, Wechsler J, Bastuji-Garin, Assier H, Revuz J, Roujeau J-C. Clinicopathologic correlation in erythema multiforme and Stevens-Johnson syndrome. *Arch Dermatol.* 1995;131:1268-1272.
7. Ayanoglu L, Rogers RS III. Oral manifestations of erythema multiforme. *Dermatol Clin.* 2003;21:195-205.

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## Simultaneous removal of third molars and completion of a sagittal split osteotomy: effects of age and presence of third molars—a commentary



*To the Editor:*

This was a new research hypothesis, and the authors tried to address the same with a retrospective cohort study design.<sup>1</sup> We congratulate the authors on their approach and effort to address the same. We could not draw any conclusions from the article and request the authors to provide clarifications in the some areas as described below.

The authors have stated in the results section: “When correlating the occurrence of adverse fractures by the number of patients, slight evidence of a difference was noted for presence or absence of third molar or degree of impaction and no statistical differences were noted for sex ( $P = .073$ ;  $P = .069$ ; and  $P = .336$ , respectively) (Table 4)” and later in the results section again stated: “As shown above, there was no relation between presence of third molar and adverse fracture when the occurrence per patient was considered.” These two statements contradict each other. Can statistical difference be considered in this comparison?

Another instance was in the results section: “However, when evaluating the occurrence of adverse fracture correlated to the presence of third molar with the number of osteotomies performed, there was a significance association between the bad splits with presence of third molar in the site of the osteotomy ( $P = .05$ )” but later below Table 5, the authors stated, “The association between rows (groups) and columns (outcomes) is considered to be not quite statistically significant.” Can statistical difference be considered in this comparison? Can we compute the odds ratio and confidence intervals to quantify the association?

In Table 4, the authors have compared the mean age between “yes” and “no” of a bad split variable using the analysis of variance F test. Can this comparison be done with the help of independent sample *t* test or Student *t* test? The mean ages in the tables and the text did not match. We request the authors to address the above queries so that readers can have a definitive conclusion from this manuscript.

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