sitates evaluation to rule out malignant melanoma.
Overall, this case adds clinical evidence that TNF-α plays a critical role in the differentiation and proliferation of melanocytes, inducing the development of melanocytic nevi.

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Benefits of Screening for Oral Lichen Planus

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Dear Editor:
Kim et al.[1] in their interesting study compared the allergological data on the oral lichen planus (OLP) with those of other published articles regarding the oral lichenoid reactions (OLRs). We would underscore that the prognostic value of the screening patch test on the clinical behaviour of these diseases is significantly different. Regarding to the OLRs induced by dental alloy restorations, both the metals and particles/ions of the corrosive process are believed that could perturb the surface antigens of the basal layer keratinocytes in neighboring mucous membranes, resulting an autoimmune activation and T-cell-mediated reaction[2]. Clinical evidence is supported by fact that ORLs can disappear as consequence of replacing of the metal alloy—mostly the amalgam fillings—with non-metal materials[2]. Conversely, in OLP the triggering for the immune-activation of the basal layer keratinocytes remains unrecognized and the lesions can rarely achieve a complete healing[2]. Medical history and oral examination of a subject with OLRs may provide suggestions for the potential sensi-

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tizers, leading to selection of the patch testing allergens.
Regrettably, a baseline patch testing series it is not sufficiently adequate on the basis of just suspicious allergens because, often, unsuspected ones can be useful to determine the allergic sensibilization[3]. In addition, supplementary patch testing materials that take into account of the anamnesis and period of exposure of the subject at potential antigens should be considered. For this reason, each patient should get a custom setting of antigenic substances, in keeping with his history of allergy[3].
Where not provided, the cross-reactivity between metals and other substances, can lead to scarce outcomes for management of OLRs, giving rise to doubt about the predictability of patch testing. This investigation remains anyway useful to identify the type of dental material that can be used to substitute the suspect substance(s) that causes OLRs. Nevertheless, it seems that the substitution of the amalgam fillings can produce meaningful improvements in a large part of subjects with OLRs, regardless of patch testing results[4].
Kim et al.[1], have reported clinical relevance in 50% of the OLP patients, and improvement in symptoms after removal of the allergen in one case. These findings make the screening patch testing advisable also in the OLP patients, although its prognostic value in the OLP and OLRs diseases should be clarified in further study.
Hopefully, the screening patch testing on a wide amount of allergens, in accordance to the history of exposure of the patient, should be performed before positioning of exogenous biomaterials in oral cavity, in particular in ORLs and OLP patients. Accordingly, a positive patch testing outcome (expression of immune activation) is not enough reliable to justify the signs and symptoms of clinical illness in the allergic contact dermatitis. Therefore, it should not take definitive measures of treatment (replacement of dental materials) on the basis of an only positive patch testing outcome.
These aspects can be considered of prominence, especially in relation to OLRs and OLP which have shown a potential tendency to develop a malignant change.

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