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Letter to the editor: Oral lesions in Covid 19 positive patients

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Dear Editor,

I read with great interest the recent article published by Dr. Fidan and colleagues titled “Oral lesions in Covid 19 positive patients” [1]. I congratulate the authors for their effort to shed light on oral manifestations of Coronavirus disease 2019 (COVID-19) and help solve a burning controversy related to the incidence and etiology of oral lesions in COVID-19 patients. However, and while the study supports the high incidence of oral lesions in Covid-19 patients, the categorization of such lesions in the present study raises questions.

Firstly, the authors reported that 20.6% of the oral lesions were oral lichen planus. Oral lichen planus is a multifocal condition, and its diagnosis requires histopathological analysis and meeting clinical criteria [2,3]. The authors did not mention biopsy of the lesions, which makes it presumptive that this diagnosis was only based on clinical findings. In this case, the diagnosis of lichen planus is questionable, as several oral conditions mimic lichen planus clinically [2]. Interestingly, the study shows that all patients with oral lichen planus had the disease in only one oral anatomic location (tongue, buccal mucosa, gingiva, or palate). This is very unusual for oral lichen planus as multiple locations are typically affected due to the multifocal nature of the disease [2].

Secondly, 32.8% of the oral lesions were categorized as “erythema.” Erythema is a non-specific sign of inflammation. In fact, it is commonly seen in mucosal lichen planus, especially the atrophic form of the disease [2]. Therefore, it will be significantly helpful to elaborate on how the “erythema” group was differentiated from the “lichen planus” group. Furthermore, the authors state that “erythema is a T-cell mediated immune condition” and cite two articles concerning erythema multiforme [4]. This is quite puzzling. Are the authors referring to erythema multiforme in the “erythema” group? There was no mention of erythema multiforme in the present study whatsoever. It will be valuable that the authors provide an explanation.

Lastly, the authors report that 36.5% of patients with oral lesions had aphthous-like ulcers. Of those, 14.8% had aphthous-like ulcers on the gingiva. This is remarkable, as aphthous-like ulcers typically do not affect keratinized mucosa such as the attached gingiva, unlike viral ulcerative lesions [5]. It would be interesting to know the authors' explanation of this occurrence and how viral lesions such as herpes simplex virus (HSV) were excluded. It might be presumed that those

gingival lesions the author described were solitary lesions; therefore, the diagnosis of HSV-related gingival lesions was not favored. However, there is no mention of this in the manuscript.

Once again, I acknowledge the importance and value provided by Dr. Fidan and colleagues' study. I believe this study will provoke thoughts and encourage other researchers to investigate the oral manifestations of COVID-19 further. Nevertheless, appropriate categorization and description of these manifestations are of equal importance.

CRedit authorship contribution statement

Alhanouf Bin Dakhil: Conceptualization and writing.

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Declaration of competing interest

None.

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