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Short Communication
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Crohn's Disease and Its Oral Manifestations

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Crohn's disease (CD) together with the ulcerative colitis belongs to the inflammatory bowel diseases. CD is a chronic granulomatous inflammatory disorder that can affect any part of the gastrointestinal tract from the mouth to the anus with the most common localization in the ileocecal region. The etiopathogenesis of CD is unclear, and includes genetic, immunological and environmental factors with impaired intestinal microbiota [1]. The incidence of CD has been increasing on a global scale, and it appears that is related to a "Western" lifestyle and diet, which shows the strong impact of the environment on the CD occurrence [1,2]. The course of CD is chronic with periodic exacerbations and remissions of symptoms. Activ CD can be easy assessed by clinical and laboratory tests and the CD activity index (CDAI). Patients suffer from abdominal pain, often diarrhea, fever, weight loss with subsequent impaired water and electrolyte balance, iron deficiency anemia, and nutrient deficiencies [1]. There are several CD complications like fistulas, narrowing of the intestine or intraabdominal abscesses. In about 25% to 80% of patients they are localized in perianal region [3]. All CD consequences affect the quality of life and the general state of the patient.

CD can manifest with extraintestinal symptoms in many organs including liver, skin, joints, and oral cavity. The prevalence of oral lesions in CD patients vary over a wide range from 5% to 20% due to contradictory data [4-6].

Oral CD may precede the intestinal manifestations or may be present at the same time after the occurrence of the gastrointestinal symptoms [5,7,8]. Oral CD is important in the diagnosis of CD due to its easy access during physical examination, characteristic clinical features, and can commonly harbor diagnostically useful material for histopathological examination [6, 9-13].

The CD manifestations in the oral cavity were first described by Dudeney et al.and confirmed by other authors [6-9,14-15]. Oral lesions secondary to infection, nutritional deficiency or adverse effect of medications have been described more often than a variety of CD-specific lesions characterized by noncaseating granulomas of the oral mucosa [6,10-13]. Therefore oral CD is divided into specific caused by granulomatous inflammation, and non-specific, caused by various factors [3,4,11,14].

The specific manifestations of CD have been identified and described by Mallins et al., Scheper and Brand, Laurenco et al., Harty et al., and others [3,4,9,11,14]. The CD-specific lesions have different clinical picture, including diffuse swelling of the lips or cheek, inflammation of the mucosa and gingiva, cobblestoning, angular cheilitis, deep linear ulcerations and the mucosal tags [3,4,6,9]. Cobblestone appearance of the mucosa in the posterior buccal region is characteristic oral manifestation that can be found in 10% to 12% of patients [4,7,6,11]. Angular cheilitis represents the most common oral lesion in CD and may be caused by dietary restrictions during exacerbation of symptoms, malabsorption, drug reactions, iron deficiency anemia, deficiency of vitamin B12, folic acid or fat-soluble vitamins [3,6,11]. Aphthous ulcers and oral candidiasis are more frequently seen than in healthy subjects [6,9,11,13]. Various factors are involved in the etiopathogenesis of oral CD which are still waiting for the elucidation. There are widely discussed the deficiency of vitamins, trace elements and other nutritional components, and the underlying CD granulomatous inflammation for a proportion of CD-specific lesions.

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