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CASE REPORT:

Misdiagnosis of Oral Candidiasis in Primary Care: Erosive Oral Lichen Planus in a Young Patient

Sobrediagnóstico de candidiasis oral en atención primaria: liquen plano oral erosivo en un paciente joven

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ABSTRACT: Oral candidiasis is one of the most common fungal infections, and its diagnosis is typically clinical; however, misinterpretation may lead to confusion with other conditions that share similar features, such as oral lichen planus (OLP), a chronic immune-mediated inflammatory disease. The aim of this study is to describe a case of erosive OLP initially treated as candidiasis, emphasizing the importance of differential diagnosis in persistent ulcerative lesions. A 19-year-old male presented with multiple painful diffuse erosions and ulcerations that interfered with speech and eating, with a pain intensity of 10/10 on the visual analog scale. He was initially diagnosed with oral candidiasis in primary care and treated with nystatin without improvement. Clinical examination revealed bilateral involvement of the buccal and labial mucosa with erosive and ulcerative lesions, along with reticular whitish plaques consistent with Wickham's striae and a negative Nikolsky sign. A clinical diagnosis of erosive OLP was established and later confirmed by histopathological analysis. Treatment with systemic corticosteroids, with gradual tapering and nighttime nystatin as antifungal prophylaxis, was initiated, resulting in complete clinical resolution within one month and stable evolution over two years, with mild episodes associated with trauma or stress. Accurate differential diagnosis of oral lesions is essential for timely management. Erythematous or ulcerative oral lesions that do not respond to antifungal therapy should be reassessed, and OLP should be considered in the differential diagnosis. Biopsy and clinicopathological correlation are key to avoiding misdiagnosis and unnecessary treatments.

KEYWORDS: Oral lichen planus; Oral candidiasis; Differential diagnosis; Oral mucosa; Oral lesions; Oral ulcers.

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RESUMEN: La candidiasis oral es una de las infecciones fúngicas más frecuentes y su diagnóstico suele ser clínico; sin embargo, su sobreinterpretación puede llevar a confundir otras patologías con características similares; como el liquen plano oral (LPO), una enfermedad inflamatoria crónica de origen inmunológico. El objetivo de este trabajo es describir un caso de LPO erosivo inicialmente tratado como candidiasis, para enfatizar el diagnóstico diferencial ante lesiones ulcerativas persistentes. Paciente masculino de 19 años consultó por múltiples erosiones y ulceraciones difusas dolorosas que dificultaban el habla y la alimentación, con intensidad de dolor de 10/10 en la escala visual análoga. Inicialmente fue diagnosticado con candidiasis oral en atención primaria y tratado con nistatina sin mejoría. El examen clínico mostró compromiso bilateral de mucosa yugal y labial con lesiones erosivas y ulceradas en mucosa labial y yugal, junto con placas blanquecinas en red compatibles con estrías de Wickham y signo de Nikolsky negativo. Se planteó diagnóstico clínico de LPO erosivo, confirmado mediante estudio histopatológico. Se indicó tratamiento con corticosteroides sistémicos con descenso progresivo y nistatina nocturna como profilaxis antimicótica, con resolución clínica completa al mes y evolución estable a dos años con episodios leves asociados a trauma/estrés. El diagnóstico diferencial adecuado de lesiones orales es esencial para un manejo oportuno. Las lesiones orales eritematosas o ulceradas que no responden a antifúngicos deben reevaluarse e incluir LPO en el diagnóstico diferencial. La biopsia y la correlación clínico-patológica permiten evitar errores diagnósticos y tratamientos innecesarios.

PALABRAS CLAVE: Liquen plano oral; Candidiasis oral; Diagnóstico diferencial; Mucosa oral; Lesiones orales; Úlcera bucal.

INTRODUCTION

The oral mucosa acts as a protective barrier, forming a continuous layer that defends against environmental exposure, mechanical and chemical injury, microorganisms, and toxins through its physical and immunological functions. This barrier may be disrupted in pathological conditions or due to external factors (1,2).

Oral candidiasis is one of the most common fungal infections affecting the oral mucosa (3). Several clinical forms have been described, including pseudomembranous, erythematous (or atrophic), and hyperplastic candidiasis (4). It primarily occurs in patients with predisposing factors such as immunosuppression, prolonged antibiotic or inhaled corticosteroid use, xerostomia, and denture wear (5). Diagnosis is usually clinical and based on the presence of removable white plaques or erythematous areas of the oral mucosa (4).

However, Candida albicans, the main etiological agent of oral candidiasis, is a commensal organism commonly present in the oral mucosa of healthy individuals, where its coexistence is typically asymptomatic (6,7). Disease occurs when there is abnormal proliferation and a transition to a pathogenic phenotype, highlighting the importance of recognizing this pathological shift (7).

Oral lichen planus (OLP) is a chronic immune-mediated inflammatory disease affecting the oral mucosa, driven by T lymphocyte-mediated cytotoxicity against basal keratinocytes (8-10). Clinically, it presents in reticular (most common, characterized by white striations) and erosive/atrophic forms (painful and ulcerative), as well as less frequent variants such as papular or plaque-type lesions (11). Lesions are typically bilateral and most commonly involve the buccal mucosa, tongue, and gingiva (12,13). Its clinical relevance lies in its chronic course and potential for malignant transformation (14,15).

Diagnosis of OLP is based on both clinical and histopathological findings, characterized by a band-like inflammatory infiltrate and basal cell degeneration (16). Treatment is symptomatic and aimed at controlling inflammation and relieving pain (17). Topical corticosteroids represent first-line therapy, while systemic treatment is reserved for severe cases (18).

In clinical practice, there is an increasing tendency toward overdiagnosing of oral candidiasis, particularly in settings where oral examinations are performed rapidly (7). White and red oral lesions encompass a broad differential diagnosis, as many conditions share similar clinical phenotypes. Moreover, it has been reported that physicians may demonstrate lower accuracy in recognizing and characterizing oral candidiasis-related lesions compared to dental professionals, contributing to diagnostic errors and empirical treatment approaches (15,19).

The aim of this case report is to present a case of erosive OLP initially misdiagnosed as oral candidiasis in primary care, highlighting their clinical similarity and emphasizing the importance of differential diagnosis and histopathological confirmation in refractory oral lesions.

CASE REPORT

A 19-year-old male patient from Costa Rica, single and a second-year systems engineering student, presented with multiple oral ulcerations that interfered with speech and food intake, associated with severe pain rated 10/10 on the visual analog scale (VAS). He reported a history of occasional aphthous ulcers; however, he noted that the current condition differed in clinical characteristics and had not resolved with conventional treatments. He stated that an initial diagnosis of oral candidiasis had been made by a primary care physician, who prescribed nystatin oral suspension 100,000 IU/mL, 5 mL as a 5-minute rinse followed by swallowing every 6 hours for 7 days, without clinical improvement. Instead, the lesions progressively worsened over approximately five months.

On directed medical history, the patient reported allergies to egg and casein, with prior gastrointestinal manifestations and aphthous episodes. He indicated strict adherence to dietary restrictions over the last five months, although compliance had been inconsistent previously. He denied any systemic diseases and current medication use other than the aforementioned antifungal therapy. He reported being sexually active and denied tobacco and alcohol consumption.

Clinical examination revealed erosive and ulcerative areas affecting the labial and buccal mucosa. These findings were compared with clinical photographs provided by the patient, which clearly demonstrated lesion progression over time (Figure 1). The patient reported severe oral pain during the examination. The Nikolsky sign was negative. Bilateral reticular white striae consistent with Wickham striae were observed in the posterior buccal mucosa and could not be removed with gauze. No cervical lymphadenopathy or facial, nail, or cutaneous abnormalities were detected.

Based on the clinical history and characteristic findings, a clinical diagnosis of erosive OLP was established. Laboratory evaluation included complete blood count, fasting glucose, rheumatoid factor, lipid profile, and liver and renal function tests. The patient was instructed to avoid mechanical and chemical trauma to the oral mucosa (spices, chewing gum, acidic fruit juices, and carbonated beverages), maintain a soft diet, ensure adequate hydration, reduce stress, and continue dietary restrictions of egg and casein. Supportive therapy included Oddent® desensitizing toothpaste and mouth rinses with Oddent® hyaluronic acid gel (0.2% hyaluronic acid). An

incisional biopsy of the right buccal mucosa was performed for histopathological and direct immunofluorescence analysis. Analgesic therapy with Enantyum® (dexketoprofen trometamol) 25 mg every 8 hours for 3 days was prescribed, along with topical application of Oddent® periodontal gel (0.20% chlorhexidine digluconate) three times daily for 8 days.

At one-week follow-up, laboratory results were within normal limits. Histopathological examination revealed stratified squamous epithelium with moderate parakeratinization and no evidence of hyperkeratosis. A band-like chronic lymphocytic inflammatory infiltrate was observed in the lamina propria, along with basal cell vacuolar degeneration and Civatte bodies (Figure 2). Direct immunofluorescence was negative for IgA, IgG, C3, C4, and fibrinogen, with focal IgM positivity in Civatte bodies. These findings were consistent with OLP.

Treatment was initiated with Zamen® (deflazacort) 30 mg daily for one week, followed by gradual tapering to a maintenance dose of 6 mg, together with nightly rinses using 5 mL nystatin oral suspension (100,000 IU/mL) to prevent secondary fungal infection. At one-month follow-up, complete healing of oral lesions was observed (Figure 3), with no signs of recurrence. The patient reported restored oral function and comfort, maintaining daily use of the recommended oral hygiene regimen.

Over the past two years, the patient has remained clinically stable, although he has experienced occasional ulcerative areas in the buccal mucosa associated with local trauma or stress related to academic activities. These episodes have resolved with topical application of Oddent® hyaluronic acid gel, with favorable outcomes and no complications.

The patient provided written informed consent for publication of this case.

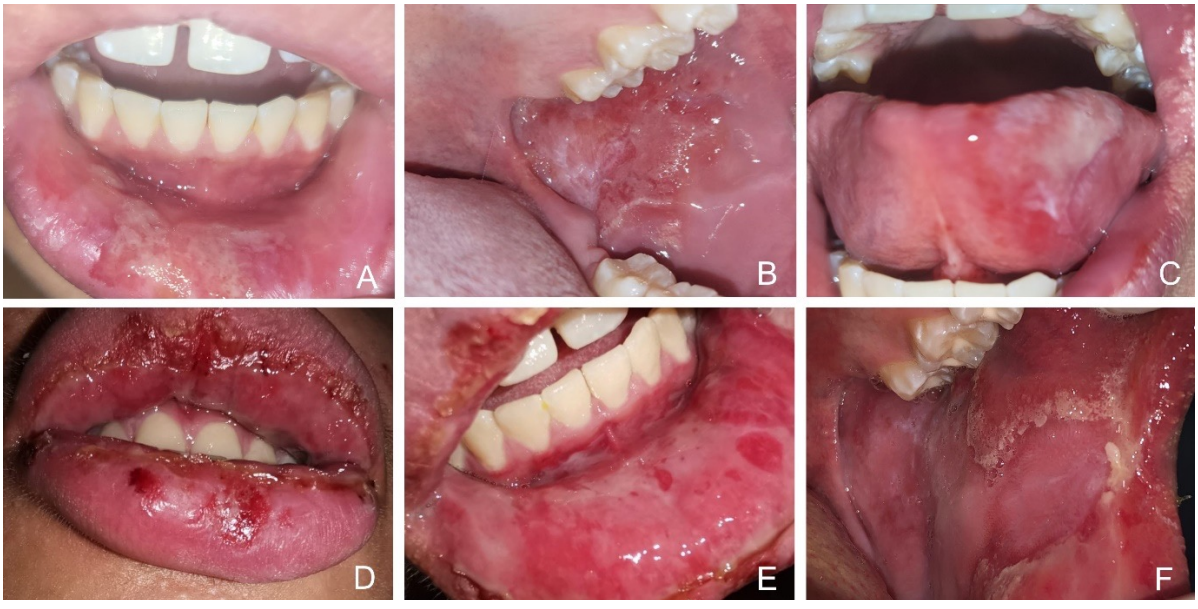


Figure 1. Clinical examination. Initial lesions documented through patient-provided photographs: multiple erosive and ulcerative areas with diffuse distribution and irregular borders involving the labial mucosa (A), buccal mucosa (B), and tongue (C). At presentation: marked involvement of both lips with inflammation and extensive ulcerated and crusted areas extending from the vermilion border to the labial mucosa (D), as well as atrophic-erythematous areas on the lower labial mucosa (E) and buccal mucosa (F).

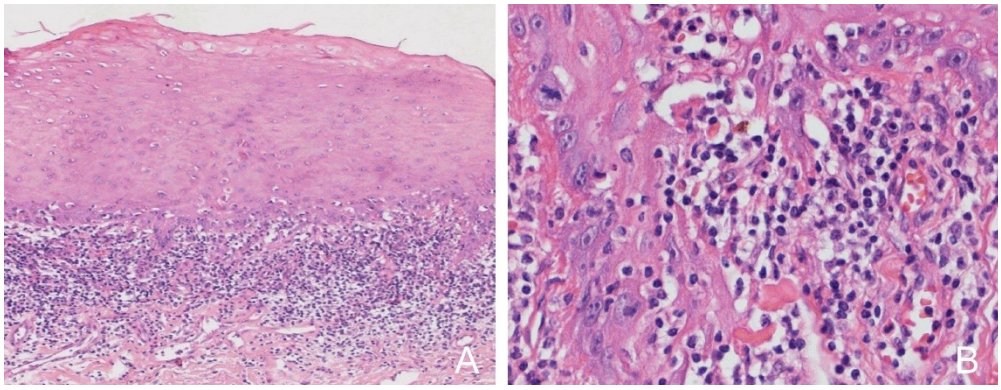


Figure 2. Epithelium showing acanthosis and band-like lymphocytic infiltrate with interface changes, 100 µm (A). Detail of basal layer showing vacuolization, keratinocyte loss, focal exocytosis, and Civatte bodies, 20 µm (B).



Figure 3. One-month follow-up showing complete resolution of lesions.

DISCUSSION

Various inflammatory conditions of the oral mucosa may present clinical features similar to oral candidiasis, leading to diagnostic errors and empirical use of antifungal therapy (20). Among these entities, OLP is one such condition that may present in reticular, atrophic, or erosive clinical forms (8,17).

The etiopathogenesis of OLP remains unknown; however, it is considered a multifactorial immune-mediated disorder in which genetic, infectious, pharmacological, immunological, neurological, and psychological factors may trigger T-cell–mediated apoptosis of basal epithelial keratinocytes (21). Clinically, it is characterized by pain, burning sensation, and discomfort, which negatively impact patients' quality of life and may

predispose them to stress, anxiety, and depression (13,21,22).

Erosive and atrophic forms of OLP may clinically resemble erythematous oral candidiasis, particularly when erythematous areas predominate in the oral mucosa, often associated with corticosteroid or broad-spectrum antibiotic use (3,23,24). However, erythematous candidiasis typically presents as red, smooth areas that commonly affect the dorsal tongue and palate, producing so-called "mirror lesions," although the buccal vestibules may also be involved (25). In the present case, although erythematous areas were observed, their localization on the buccal mucosa and the presence of peripheral white striae supported a diagnosis of OLP.

In contrast to pseudomembranous candidiasis, which is frequent in infants and chronically ill or immunocompromised patients and presents as easily removable white plaques leaving an erythematous surface (3,26), OLP lesions do not exhibit detachable pseudomembranes. Bilateral and symmetrical involvement of the buccal mucosa is a characteristic clinical feature that may aid in diagnosis (16,24). Furthermore, pseudomembranous candidiasis is more commonly observed in neonates or immunocompromised individuals (7) and was not present in this patient, who also lacked predisposing factors such as immunosuppression or prolonged antibiotic use, thereby reducing the likelihood of candidiasis as the primary diagnosis.

Another relevant aspect of this case is the patient's age. OLP most commonly affects middle-aged adults, typically between the fourth and sixth decades of life, and is more prevalent in women, making its occurrence in young patients relatively uncommon (10,27). Therefore, its presentation in a 19-year-old patient underscores the importance of including OLP in the differential diagnosis of oral mucosal lesions across all age groups.

Accurate diagnosis in oral pathology is essential to ensure appropriate patient management, avoid unnecessary treatments, and optimize outcomes (20). Recent literature highlights the importance of proper histopathological interpretation, as the oral and maxillofacial region may be affected by a wide range of diseases with distinct clinical and biological behaviors (28). In this case, histopathological evaluation was crucial for diagnosis. Despite frequent diagnostic confusion, combined clinical, histopathological, and direct immunofluorescence assessment is often overlooked when OLP is suspected (27).

Definitive diagnosis of OLP is established through correlation of clinical and histopathological findings (29). Characteristic microscopic features include basal cell degeneration, a band-like lymphocytic infiltrate at the epithelial-connective tissue interface, and variable hyperkeratosis (30). Therefore, as in the present case, incisional biopsy is a fundamental diagnostic tool in persistent or unclear lesions.

In this case, the initial diagnosis of oral candidiasis led to antifungal therapy with nystatin, without clinical improvement. Persistence and progression of lesions prompted referral to oral pathology and oral medicine specialists, where detailed clinical evaluation suggested erosive OLP, later confirmed by biopsy.

Treatment of OLP is primarily based on corticosteroids. Mild localized lesions may be managed with topical dexamethasone or triamcinolone, while more severe cases may require systemic corticosteroids or alternative therapies such as immunosuppressants, retinoids, laser therapy, or curcumin, which have shown efficacy in reducing inflammation and symptoms (24,31). Prophylactic antifungal therapy with nystatin may be indicated in patients receiving long-term corticosteroids due to the complex interaction between Candida

species and the oral microbiota in OLP patients (32). In this case, systemic corticosteroid therapy combined with antifungal prophylaxis resulted in complete resolution of lesions and improved patient quality of life.

This case highlights the importance of careful clinical evaluation of oral mucosal lesions and the integration of complementary diagnostic tools such as biopsy. It also emphasizes the educational value of case reports in improving clinical practice in medicine and dentistry. Healthcare professionals, particularly physicians and dentists, should be familiar with the clinical features of oral candidiasis and OLP to ensure timely diagnosis and avoid delays in appropriate management.

CONCLUSIONS

This case highlights the importance of differential diagnosis between erosive OLP and oral candidiasis in primary care, given their potential clinical similarity and the consequent risk of midiagnosis. Histopathological confirmation by biopsy was essential to establish the definitive diagnosis and guide appropriate treatment, emphasizing the need for complementary diagnostic approaches to prevent diagnostic errors in oral mucosal lesions.

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