

## Letter to the Editor

### Off-label use of Betnovate cream for the symptomatic management of erosive lichen planus

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Sir,

We write in response to the letter published in the *BDJ* by Kanatas and Brotherton "*Erosive lichen planus*; *BDJ* 2014 216:545". Erosive and ulcerative lesions of oral lichen planus (OLP) can be persistent and painful (1); therapy is warranted when patients have painful disease that may adversely impact upon quality of life, but effective management of OLP can be challenging (2). The authors presented their recent preliminary experience with betamethasone valerate 0.05% cream (Betnovate®), which, they report, seems beneficial in controlling painful symptoms and worthy further investigations.

This is perhaps not unexpected, as a wide spectrum of corticosteroid formulations including mouthwashes, creams, ointments, sprays and intralesional injections have been reported in the treatment of symptomatic OLP (3-5). Nevertheless there remains a lack of well designed clinical trials in this field, with a relatively recent systematic review indicating that there is little robust evidence for the efficacy of any single treatment for the management of erosive OLP (6).

Although we are grateful to Dr Kanatas and Brotherton for their preliminary report on betamethasone therapy, we would like to highlight that comprehensive management of OLP can be a significantly more complex matter, as it encompasses a number of

issues that go beyond the far too simple question of which topical corticosteroid is most effective in controlling painful symptoms of OLP.

For example, we would like to draw readers' attention to the medicolegal responsibility that falls on healthcare professionals when prescribing, dispensing and administering an agent outwith its licensed indication. It is important that clinicians inform patients of the off-label use of these agents and detail possible adverse side effects (7). Certainly patients should be carefully reviewed for such events.

Perhaps the most important aspect of OLP management remains its malignant potential and the associated increased risk of oral cancer development (8). A recent systematic review suggests that the overall prevalence of oral cancer in the OLP population (regardless of type, patient characteristics or mode of management of the disease) may be up to 3.5% (9). As the risk of oral squamous cell carcinoma in OLP is often unpredictable, the long-term monitoring of patients with OLP is a crucial issue so to attempt to identify and diagnose early dysplastic and malignant changes (10). Again there remains little robust evidence but perhaps long-term surveillance warrants shared care between the primary and secondary health care providers. Undoubtedly, despite the best efforts of attending clinicians, some patients with OLP will develop oral mucosal dysplasia or malignancy, although early diagnosis can lessen the need for complex therapy and may ultimately improve the prognosis of affected individuals.

Any patient with possible OLP should be initially referred to specialists to ensure that (i) the diagnosis is formally confirmed, (ii) appropriate treatment is provided and (iii) adequate and evidence-based information is given. Simply telling a patient that they are likely to have OLP is often unhelpful and sometimes they can become alarmed after surfing the World Wide Web. Patients' perspective and expectation are also important, as conversations regarding the chronic nature of the disease and associated increased risk of cancer may sometimes become difficult.

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