



MOUTH ULCERS/ STOMATITIS

Topical high-potency corticosteroids (e.g. clobetasol, dexamethasone)

Nonsteroidal antiinflammatory druds (e.g. amlexanox paste)

Anaesthetics (e.g.viscous lidocaine) may be used. (1)(2)(3)



Persistent or recurrent stomatitis:

Intensive topical, intralesional or systemic corticosteroids.

Systemic colchicine, pentoxifylline or azathioprien. (2)(4)



Very painful stomatitis that may cause restriction of oral intake of nutrients:

Sirolimus dose reduction or cessation may be required. (2)(3)

→ If lesions persist after aggressive treatment and withdrawal of sirolimus, the patient should be referred to an oral surgeon to exclude cancer. (5)

- (1) Chuang P, Langone AJ (2007). Clobetasol ameliorates aphthous ulceration in renal transplant patients on sirolimus. Am J Transplant 7: 714–717.
- (2) Pilotte AP, Hohos MB, Polson KM, Huftalen TM, Treister N. Managing stomatitis in patients treated with Mammalian target of rapamycin inhibitors. Clin J Oncol Nurs 2011;15:E83–9
- (3) de Oliveira MA, Martins e Martins F, Wang Q, et al. Clinical presentation and management of mTOR inhibitor-associal stomatitis. Oral Oncol 2011;47:998–1003.
- (4) Pilotte, A. P., Hohos, M. B., Polson, K. M. O., Huftalen, T. M., & Treister, N. (2011). Managing Stomatitis in Patients With Mammalian Target of Rapamycin Inhibitors. Clinical Journal of Oncology Nursing, 15(5), E83–E89.
- (5) Campistol JM, de Fijter JW, Flechner SM, Langone A, Morelon E, Stockfleth E. mTOR inhibitor-associated dermatologic and mucosal problems. Clin Transplant 2010;24:149–56.