A 52-year-old female patient reported with a chief complaint of sore ulcers in left and right cheek regions, tongue, and palate associated with severe burning sensation of mouth. History of painful small ulcers initially started in left and right cheek region inside the mouth 4 months back. Later, she developed small ulcers on tongue and palate since 3 months. There is history of severe burning sensation since 1 month. Burning sensation aggravates by contact of any food.

On past medical history, she is treated for Rheumatoid arthritis since 10 yrs and she is under medication Tab Prednisolone (Omnacortil) 7.5 mg to 10 mg twice daily based on severity of presenting signs and symptoms along with Tab Folic acid 5mg (FOLVIT). She was also given Tab Methotrexate 10mg (Mexitate) once a week since 1 yr. There is history of Hypertension since 10 yrs and she is under medication Tab Prednisolone 10mg morning and 5 mg in the evening (OMNACORTIL) for 2 weeks. There is history of severe burning sensation since 10 yrs and she is under medication Tab Carlo 10 mg (Carvedilol). She also gives 13.710 Once daily for 15 days.

Treatment plan advised patient was:-

1. Oral corticosteroids (OCS), Methotrexate, Antifungal therapy, supportive therapy along with modification of oral corticosteroids (OCS) which has given very good prognosis and same is presented in this article.

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Final diagnosis was given as oral lesions due to overlap syndrome associated with SLE and RA.

Evidence of vacuolar basal cell degeneration, focal areas of prominent eosiophilic zone on epithelial connective tissue interface. Juxtaepithelium showed extensive edema; diffuse inflammatory cell infiltrate- lymphocytes, plasma cells, macrophages. Area of ulceration showed neutrophilic infiltrate. [Figure 6]

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Patient was recalled once in 15 days. On second visit there is reduction in size of lesion and reduced burning sensation [Figure 7, 8, 9]. NRS for pain was 5. Third [**10**] revealed complete reduction in lesions [Figure 10, 11]. Burning sensation aggravates only on having very spicy foods. Topical and systemic steroid dosage was tapered gradually after one month. Patient was followed up once in a month for a period of one year, there was no recurrence of oral lesions till date.

**DISCUSSION:**
SLE is a great mimicker. Its disease process resembles other diseases to such an extent that it is misdiagnosed and treated as some other disorder[2]. It can affect any cell or any tissue or any organ[2]. SLE causes anemia, leucopenia and infection if it affects RBC’s, WBC’s, platelets and other cells and can produce same disorders as SLE. Arthritis is bilateral and erosive in RA, while in SLE it’s asymmetric and non-erosive[6].

In the same way RA affects not only bones but, it can also affect extra-articular tissues like RBC’s, WBC’s, platelets or other cells and can produce same disorders as SLE. Arthritis is bilateral and erosive in RA, while in SLE it’s asymmetric and non-erosive[5].

In present case, patient had RA and anemia since 10yrs. She developed diabetes, hypertension, anaemia,sicca syndrome with slight loss of vision and interstitial lung disease later Diabetes could be immune related or due to corticosteroids. Previous blood investigation revealed increased levels of ANA - 13.710 compared to the normal reference range (<1.0 – negative, >1.0 positive)

The oral lesions when presented in our dental clinic were similar to the oral lesions of Lupus Erythematosus (LE). The lesions on palate were coin shaped and hence, the name discoid lesions was used here. These are similar to skin lesions seen in SLE/DLE. The occurrence of such discoid lesions is very rare in oral cavity. The patient would have developed SLE as many autoimmune conditions are inter related. So, we can say that this is an overlap syndrome[7]. The overlap syndrome was first described by Dr. Toone in 1960. Later Dr. Schur et al in 1971 reported and described and named the overlap syndrome of RA and SLE as RHUPUS SYNDROME[4].

Based on The Systemic Lupus International Collaborating Clinics (SLICC) Group Proposed Revised American College of Rheumatology (ACR) Systemic Lupus Erythematosus (SLE) Classification Criteria, classify a patient as having SLE if 4 of the 11 clinical and immunologic criteria are satisfied[1]. As patient is having Immunologic criteria - ANA level above laboratory reference range, oral ulcers, synovitis involving more than 2 joints, anemia, respiratory involvement (history of breathlessness due to interstitial lung disease ), and a diagnosis of Overlap syndrome involving SLE and RA was given. The oral ulcers were associated with SLE and RA[8].

The drugs prescribed were topical trimcinolone acetonide 0.1%, Tablet Prednisolone 10mg as corticosteroids has immunosuppressant and anti-inflammatory action[6]. Topical antifungal was given as we know candida albicans superimposes on other oral lesions as it is opportunistic commensal[9]. Also long term corticosteroids cause fungal infection as side effect, it was used prophylactically[10]. Also this might reduce burning sensation of mouth as candidiasis cause stomatopyrosis/burning sensation of mouth[9,11].

She was already on methotrexate which has immunomodulatory action and methotrexate will also cause folic acid deficiency. Therefore 5mg folic acid tablet was prescribed by medical practioner. She had continued with drugs prescribed by us. Antioxidants were given for antioxidant action, as nutritional supplements for generalized well being even though RA and SLE are not potentially malignant[11].

To conclude, autoimmune disorders are not totally curable. But symptomatic/palliative treatment can be given and long term effects of drug should be kept in mind. Oral lesions associated with other disorders like overlap syndrome can sometimes pose challenge to oral physician during diagnosis, but through medical history and clinical examination can reveal the underlying cause for the multiple ulcerative lesions. At the end, same list of drugs can be used to treat autoimmune disorders in general.