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## ORIGINAL RESEARCH

# Angina Bullosa Haemorrhagica: A Rare Case Report

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**ABSTRACT**
**Angina bullosa haemorrhagica is a benign sub-epithelial mucosal blister in oral cavity. The blisters are filled with blood but not associated with any systemic disease or haemostatic illness. It is a disorder of elderly and lesions heal spontaneously without scarring. Exact etiopathogenesis is not known. Common causes include trauma, dental procedures or use of steroid inhalers.**
**Key words: Angina bullosa haemorrhagica; steroid inhalers; blood filled blister**

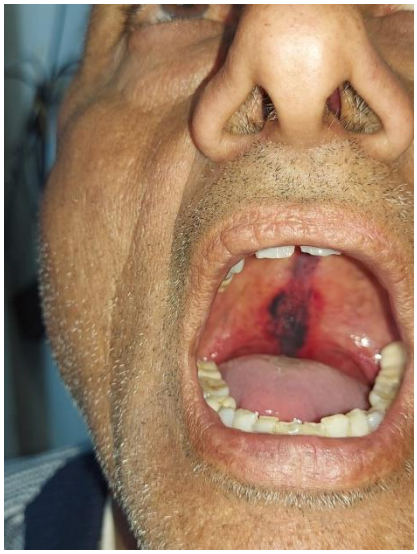
## INTRODUCTION

"Badham" for the first time described oral blood- filled vesicles as Angina bullosa haemorrhagica, not associated with any vescico-bullous disorders or any systemic illness. [1]. This is an acute condition characterized by formation of blood filled blisterin oral or oro-pharyngealmucosa. It is the pathology of elderly people involving mainly soft palate. Few cases have been reported in literature are associated with trauma. We are reporting here case of Anginabullosa haemorrhagica(ABH) because of its rare occurrence and spontaneous in nature

## CASE REPORT

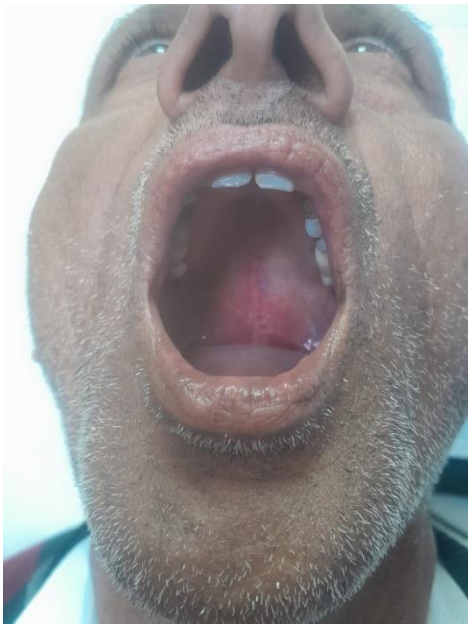
A54Yearoldmalepatientcametodepartment of dermatology with chief complaints of sudden appearance of oral blisters filled with blood which ruptured easily and leaving behind raw areas in palate. It was associated with mild burning sensation. There was no history of any kind of trauma. Patient was non- smoker, non-alcoholic and not in the habit of chewing any betel nut or pan masala. There was no history of dental problem or procedure. No history suggestive of significant systemic illness. No significant past or family history was found. On clinical examination, there was hemorrhagic erosion of size1.0 x3.0 cm, which was extended from hard palate to soft palate. The surface was smooth on touch and red in colour (Figure1).

**Figure 1: Showing the Lesion**



It was non-tender and non–indurated. It bled on manipulation. The patient didn't take any treatment for blood dyscrasiaor other systemic illness or anticoagulant therapy. No other skin lesions or mucosal lesions were observed. He was in good health otherwise. Hematological investigations were within normal limits and coagulation profile was also normal. Patient was advised biopsy from oral mucosa but he refused to give consent. Patient was counseled about self limiting nature o illness. Haematological blood cell count, prothrombintime and activated partial thromboplast in time tests were carried out and the findings were within normal limits. Patient was counseled regarding the self-limiting nature of illness. He was advised to dosaline gargles after meals and avoid hot and spicy food. Patient came for follow up after 10 days and the lesion was healed spontaneously without scarring and was diagnosed as a case of Anginabullosa haemorrhagica(Figure 2).

**Figure 2: Healed Lesion**



## DIFFERENTIAL DIAGNOSIS

Based on history of acute onset and clinical examination, we came to aprovisional diagnosis of ABH, differential diagnosis were made to exclude other mucosal or cutaneous diseases like erythema multiforme, bullouslichen planus and other vescico-bullous disorders.

## DISCUSSION

Angina bullosa haemorrhagica was 1st described by Badham in 1967. It is characterized byacute formation of blood filled blisters in oral cavity. It mainly affects soft palate, but lesions can also develop in buccal mucosa, lip and lateral surface of tongue. [1] It is disease of elderly. There is no apparent gender predominance.[2] It is considered as an idiopathic condition. It is usually sudden in onset and minor mucosal insults may be involved in pathogenesis. It may also follow trauma, caused by eating hot spicy meals and dental procedures. It is proposed that mastication significantly increases blood flow in soft palate via para sympathetic reflex vasodilatation and hard crispy food may injure the palate resulting information of hemorrhagic blisters'[3] The use of steroidin halers by asthmatic patient has a possible role and development of ABH. In47% patients no precipitation factor was found in a published study.[4] Hosian et al reported a case of post operative ABH.[5] The diagnosis of ABH is mainly clinical, by excluding other possible causes of oral ulceration. The histopathological examination shows sub-epithelial separation from under line lemina propria. Erythrocyte filled vesicles are seen superficially. On immune-fluorescence study, there is no evidence of IgG, IgA or C3 antibodies deposition.[6] The history of acute blistering in absence of any other dermatological or systemic illness lead to a diagnosis of ABH. The normal hematological and coagulation profile will differentiate from hematological pathology like thrombocytopenia and Von Willebrand's disease.[7] The absence of skin lesions rule out other dermatological pathology. The management of patients presenting with oral blood filled blisters should be thoroughly examined and investigated to rule out serious systemic illness and the treatment should be symptomatic. Long term follow up is required to exclude other conditions.

## CONCLUSION

It was concluded that the patient is diagnosed as a case of ABH based on history, clinical examination and hematological investigation. He was advised to come for regular follow up and the case is sent for publication because of its rare occurrence.

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