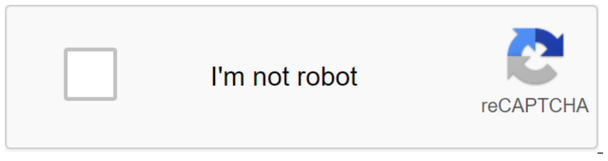

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Candida albicans oral pdf

Established in 2003 by Dr. Amanda Oakley, Dermatologist, Hamilton, New Ealand. Last updated by Dr. Jannet Gomez, March 2017. Oral candidiasis is often known as thrush because its white spots resemble the breasts of a bird of the same name. Although candidiasis is present in 50% of the normal flora of healthy mouths, it causes infection (candidosis) when an increase in the number of yeast cells invades the mucous membrane (the name of the wet skin inside the body opening). What are the predisposing factors to candida infection? Infant or old age In a newborn child's maternal vaginal yeast infection Serious comorbidities such as cancer, primary immunodeficiency or human immunodeficiency virus infection Candida elsewhere, for example, in a baby, wipes dermatitis Dry mouth due to salivary gland disease or medications, such as antihistamines, diuretic prostheses, especially if they are not regularly cleaned or suitable for poorly smoking mouth injuries Wide range of antibiotics Food deficiency, such as iron or B-vitamin deficiency of inhaled corticosteroids used to treat asthma, such as beclometas C. dubliniensis is also reported in HIV-infected people. See non-albicans candida infections. More images of oral candidiasis. What are the clinical features of oral candida infection? Candida can occur suddenly as an acute infection or persist for long periods of time as a chronic infection. Classification of oral candida infectionAcute pseudomembranosis candidiasis. There are white spots on the gums, tongue and inside the mouth that can be cleaned leaving a damp area. Acute atrophic candidiasis. There are smooth red shiny spots on the tongue. My mouth hurts a lot. Chronic atrophic candidiasis. This is common in those with prostheses. The main mucous membrane is red and swollen. Corner heilit. There is pain in the red splits on each side of the mouth, most likely if there is a overhang of the upper lip over the lower lip causing a moist deep furrow. Angular heilitis due to candidiasis and/or Staphylococcus aureus often occurs in those taking the medication isotretinoin for acne; This medicine dries lips. Chronic hyperplastic candidiasis. It is a type of oral leukoplakia (white spot) inside the cheeks or on the tongue with persistent nodules or lumps. This usually affects smokers and pre-malignant. Red spots (erythroplakia) as well as white spots may indicate malignant changes. Chronic mucokutan candida is a chronic pseudo-mtembran infection. Skin and nails also suffer. Medium diamond glossitis - in the back of the tongue there is diamond-shaped inflammation. Candida can cause secondary infection of other skin diseases such as lichen or geographical language. Severe infections can spread down the throat (oesophagus (oesophagus) cause difficulty swallowing. How is the diagnosis of oral candidiasis? Microscopy and skin smear culture and scrapes help in diagnosing candidal infections. However, candida can live on a mucous surface completely harmless. It can also infect the underlying disorder in the second degree. In extensive oral candida, an endoscopy is performed to see the extent of the gastrointestinal tract. How to prevent oral candidiasis? Practice good oral hygiene. Brush your teeth regularly. Use warm salt water to wash your mouth. Avoid using/excessive use of antiseptic mouthwashes as they change the flora of the mouth. When using a steroid inhaler to treat asthma, drink water and rinse your mouth after inhalation. Owners of Denture Clean prostheses with an anti-candid drug such as 1% sodium hypochloric solution. Remove the prostheses at night. What is the treatment of oral candidiasis? Mouthwashes with anti-frank activities include: Triclosan chlorhexidine gluconate Essential oil compositions. Topical antifungal drugs for oral candidiasis include: Oral suspension of nystatin (1 ml 4 times a day), or pastyl (for dental stomatitis) Amfothericin B (5 ml or 1 10 mg lollipop 4 times a day) Mykonazole gel (2.5 ml after eating 4 times a day). Treatment should continue for 1-4 weeks or until the symptoms are clear for 7 days. Fungal Infection Oral candidiasisTher namesoral candidiasis, oral thrush, y1 oropharyngeal candidiasis, moniliasis, y2 candidiasis stomatitis, muguetOral candidiasisPecial-infectious disease, dermatology Of oral candidiasis, also known as oral thrush among other names, that is oral candidiasis is a mycosis (yeast/fungal infection) of the species Candida. Candida Albicans is the most frequently implicated body in this condition. C. albicans is carried out in the mouths of about 50% of the world's population as a normal component of oral microbiota. This condition of frank transportation is not considered a disease, but when Candida species become pathogenic and invade the host tissues, oral candidiasis can occur. This change is usually an opportunistic infection, usually harmless microorganisms due to local (i.e. mucous) or systemic factors that alter host immunity. Classification Traditional classification of oral candidiasis. Acute candidiasis: pseudomembranosis candidia (oral thrush) atrophic candidia Chronic candidiasis Chronic candidiasis: atrophic candidia hyperplastic candidia chronic oral candidia (Candida leukoplakia) candida endhropathy syndrome chronically localized mucous Classification of oral candidiasis. Primary oral candidiasis (group I) (acute or chronic) erythemato (acute or chronic) Hyperplastic: plaque-like, node Candida-associated lesions: Dentre-related stomatitis, stomatitis, Stomatitis, medium romboid glossitis, linear gingivala erythema Secondary oral candidiasis (group II) Oral manifestations of systemic mucous candidiasis (due to diseases such as tymical aplasia and candidiasis syndrome) Oral candidiasis is a mycosis (fun infection). Traditionally, oral candidiasis is classified using the Lehner system, originally described in the 1960s, into acute and chronic forms (see table). Some subtypes are almost always found as acute (e.g., acute pseudomembrane candidia), while others are chronic. However, these typical presentations are not always correct, which has created problems with this system. The recently proposed classification of oral candidiasis features primary oral candidiasis, where the condition is limited to the mouth and perioral tissues, and secondary oral candidiasis, where there is the involvement of other parts of the body in addition to the mouth. The global pandemic of the human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS) is an important factor in the transition from traditional classification, as it has led to the formation of a new group of patients with atypical forms of oral candidiasis. In appearance, three main clinical occurrences of candidiasis are recognized: pseudomembrane, erythema (atrophic) and hyperplastic. Most often affected people show a clear type, but sometimes in the same person can be several clinical options. Pseudomembran candidiasis in the mouth and orofaring. Pseudomembranosis candidiasis in a person with HIV Pseudomembranous acute pseudomembrane candidia is a classic form of oral candidiasis, commonly referred to as thrush. In general, it is the most common type of oral candidiasis, which accounts for about 35% of cases of oral candidiasis. It is characterized by coating or individual spots of pseudo-membran white sludge, which can be easily wiped to reveal erythema (reddened), and sometimes minimal bleeding, mucous membrane under it. These areas of pseudomembrane are sometimes referred to as curd milk, or curd. The white material consists of debris, fibrin and unokwamatified epithelium that has been captured by yeast cells and gifs that invade the depths of the spinozoum layer. As the erythemamatous surface is revealed under pseudomembranes, some consider pseudo-memmbrane candidiasis and erythemato stages of candidiasis of the same entity. Some sources will say that if there is bleeding when pseudomembrane is removed, then the mucous membrane is likely to have been affected by the underlying process, such as lichen planus or chemotherapy. Pseudomembran candidiasis can include any part of the mouth, but it usually appears on the tongue, bucal mucosae or palate. It's a classically acute state, in infants, people taking antibiotics or immunosuppressants, or immunocompromizing diseases. However, sometimes it can be chronic and intermittent, even lasting for years. The chronicle of this subtype usually occurs in immunocompromized conditions (e.g. leukemia, HIV) or in people who use corticosteroids locally or aerosol. Acute and chronic pseudomembrane candidia is indistinguishable in appearance. Erythemato erythema (atrophic) candidiasis is when the condition appears as a red, raw lesion. Some sources consider stomatitis associated with prosthesis, angular stomatitis, medium rombiod glossitis and stomatitis caused by antibiotics as subtypes of erythemato candidia, as these lesions are usually erythemato/atrophic. This may precede the formation of pseudomembrane, be left when the membrane is removed, or occur without prior pseudomembrane. Some sources will say that erythema accounts for 60% of cases of oral candidiasis. Where it is associated with inhaled steroids (often used to treat asthma), erythemaitis usually appears on the taste or back of the tongue. The tongue loses the linothy nipples (depapilation), leaving a smooth area. Acute erythematosis usually occurs on the spinal cord in people taking long-term corticosteroids or antibiotics, but sometimes this can occur after only a few days of using topical antibiotics. This is commonly referred to as antibiotic sore mouth, antibiotic sore tongue, or antibiotic-induced stomatitis because it is usually painful as well as red. Chronic erythemamatosis candidiasis is most often associated with the wearing of prostheses (see stomatitis associated with the prosthesis). Hyperplastic This variant is also sometimes referred to as a plaque, like candidiasis or node candidiasis. The most common occurrence of hyperplastic candidiasis is persistent white plaque, which is not erased. Defeat can be rough or knotty in texture. Hyperplastic candidiasis is rare, accounting for about 5% of cases of oral candidiasis, and is usually chronic and occurs in adults. The most common place of participation is the commissioner's area of the lining of the mucosa, usually on both sides of the mouth. Another term for hyperplastic candidiasis is candid leukoplakia. This term is largely a historical synonym for this subtype of candidiasis, rather than true leukoplakia. Indeed, it may be clinically indistinguishable from true leukoplakia, but a tissue biopsy shows that candida gif invades the epithelium. Some sources use the term to describe leukoplakia lesions, which become colonized in the second degree by Candida species, thus distinguishing it from hyperplastic candidiasis. that Candida is more often found in the mucous membrane, which changes, for example, may occur in dysplasia and in the Leukoplakia area. Associated candida-related lesions are primary oral candidiasis (limited mouth), where the causes are thought to be multiple. For example, bacteria as well as Candida species may be involved in these lesions. Often, antifungal therapy alone does not address these lesions permanently, and the underlying predisposing factors must be addressed, in addition to the treatment of candidiasis. Angular cheilitis Angular cheilitis Main article: Angular cheilitis Angular cheilitis inflammation at the corners (corners) of the mouth, very commonly including Candida species, when sometimes the terms Candida-bound angular cheilitis, or less commonly monilial perl'che are used. Only Candida organisms are the cause of about 20% of cases, and mixed infection of C. albicans and Staphylococcus aureus is about 60% of cases. Signs and symptoms include soreness, erythema (redness) and cleavage of one, or more often both corners of the mouth, with swelling (swelling) seen intraorally on commissariats (inside the corners of the mouth). Angular heilitis is commonly found in the elderly and is associated with a prosthetic-related stomatitis. Dental stomatitis Main article: dentistry-related stomatitis This term refers to mild inflammation and erythema mucosa under the denture, usually the upper prosthesis in elderly edents (without natural teeth remaining). Some report that up to 65% of prosthetic owners have this condition to some extent. About 90% of cases are related to Candida species, which sometimes use the terms candida denture stomatitis or Candida-associated stomatitis (CADIS). Some sources have said that this is by far the most common form of oral candidiasis. Although this condition is also known as toothache in the mouth, pain rarely occurs. Candida is associated with approximately 90% of denture cases associated with stomatitis. Median romboid glossitis Median romboid glossitis Main article: Median romboid glossitis This elliptical or diamond lesions in the center of the dorsal tongue, only front (front) near-automatic soussions. The area is depapillated, flushed (or red and white) and rarely painful. There is often Candida species in defeat, sometimes mixed with bacteria. Linear erythema gums Main article: Linear erythema gums It is a localized or generalized, linear strip of erythemaic gingivitis (inflammation of the gums). It was first seen in HIV-infected people and called HIV-gingivitis, but the condition is not limited to this group. Candida species are involved and in some cases the lesion responds to antifungal therapy, but it is believed that there are other factors such as oral and human hygiene This condition can develop into necrotizing ulcerative periodontitis. Other Chronic multifocal oral candidiasis is an unusual form of chronic (more than one month duration) candida infection involving multiple areas in the mouth, with no signs of candidiasis on other mucous or cokenzie areas. Defeats are variatively red and/or white. Unusual for candida infections, there is a lack of predisposing factors such as immunosuppression, and this occurs in apparently healthy people, usually older men. Smoking is a known risk factor. Chronic mucous membrane of the main article: Chronic mucous candidiasis This refers to a group of rare syndromes characterized by chronic candida lesions on the skin, mouth and other mucous membranes (i.e. secondary oral candidiasis). These include localized chronic mucoctutan candidiasis, diffuse mucoctutan candida (Candida granuloma), candida-endorinopathy syndrome and candidia syndrome. About 90% of people with chronic mucous candidiasis have candidiasis in their mouth. Signs and symptoms Signs and symptoms depend on the type of oral candidiasis. Often, other than the appearance of lesions, there are usually no other signs or symptoms. Most types of oral candidiasis are painless, but burning can occur in some cases. Thus, candidiasis can sometimes be misdiagnosed as burning syndrome in the mouth. The burning sensation is most likely with erythemato (atrophic) candidiasis, while hyperplastic candidia is usually completely imptomatic. Acute atrophic candidia may seem to be scalded with hot liquid. Another potential symptom is metallic, sour, salty or bitter taste in the mouth. The pseudomembrane type rarely causes any symptoms other than possible discomfort or poor taste due to the presence of membranes. The patient sometimes describes the raised pseudomembrane as blisters. Sometimes there may be dysphagia (difficulty swallowing), which indicates that candidiasis involves the mouth or esophagus as well as the mouth. Trachea and larynx can also be involved where there is oral candidiasis, and this can cause the ouri-creation of the voice. Causes Species Causal Organism Are Usually Candida Albicans, or less common other types of Candida such as (in reducing frequency order) Candida tropicalis, or other species (Candida stellatoidea, 17 Candida pseudotropicalis, 17 Candida famata, 17 Candida rugosa, 17 Candida geotrichium, 13 Candida dubliniensis, and Candida guilmondii). C. albicans account for about 50% of cases of oral candidiasis, and together C. albicans, C. tropicalis and C. glabrata account for more than 80% Candidosis caused by non-C. Candida albicans (NCAC) are more associated with immunodeficiency. For example, in HIV/AIDS, C. dubliniensis and C. geotrichium can become pathogenic. About 35-50% of people possess C. albicans as part of their normal oral microbiota. With more sensitive detection methods, this figure is reported to rise to 90%. This candid carrier condition is not considered a disease, as there are no lesions or symptoms of any kind. Candida oral transportation is a prerequisite for the development of oral candidiasis. For candida species to colonize and survive as a normal component of the oral microbiota, organisms must be able to adhere to the epithelial surface of the mucosa lining the mouth. This adhesion includes adhesions (e.g. hyphalsten protein 1) and extracellular polymeric materials (e.g. mannoprotein). Thus, Candida strains with greater adhesion capacity have more pathogenic potential than other strains. Candida's traffic prevalence varies depending on geographic location and many other factors. Higher transportation is reported during the summer months, 6 in women, 6 in hospitalized individuals, 6 in men with blood group O and in non-secret blood group antigens in saliva. Increased Candida transport rates can also be found in people who eat a high-carb diet, people who wear prostheses, people with xerostomia (dry mouth), people taking broad-spectrum antibiotics, smokers, and people with weakened immunity (e.g. due to HIV/AIDS, diabetes, cancer, Down syndrome or malnutrition). Age also affects oral transportation, with the lowest levels occurring in newborns, increasing dramatically in infants and then decreasing again in adults. The investigation carried out the quantitative oral transport of candida albicans in 300-500 colonies, forming units for healthy people. More Candida is detected in the early morning and late at night. The largest number of Candida species is sheltered on the posterior dorsal tongue, followed by palatial and beech mucous. The mucous membrane covered with an oral device, such as a denture, feeds far more types of candidiasis than an undisclosed mucous membrane. When candida causes lesions - the result of the invasion of the host tissues - it is called candidiasis. Some consider oral candidiasis to be a change in the normal oral environment, rather than an exposure or true infection per se. The exact process by which Candida species move from normal oral compensatory (saprophytic) state in the carrier to action as a pathogenic organism (parasitic state) is not fully understood. Several species of Candida are polymorphogenic, i.e. able to grow in various forms depending on the conditions Wednesday. C. albicans can appear in the form of yeast (blastospors), which are believed to be Relatively harmless; and a hypchal form associated with the invasion of the host tissues. In addition to the true gif, Candida can also form pseudohyfs - elongated thread cells aligned from end to end. Typically, candidiasis, present with white lesions, is mainly caused by Candida species in hyphal-shaped and red yeast lesions. C. albicans and C. dubliniensis are also capable of forming germ tubes (nascent gifs) and chlamydospor under the right conditions. C. albicans are classified serologically by serotypes A or B. Prevalence is roughly equal in healthy people, but type B is more common in people with weakened immunity. Predisposing factors Are Common local and systemic predisposing factors. Local Taking Factors Dentures Corticosteroid Inhalers Reducing Salivary Flow High Sugar Diet System Factors-Host Extremes of Age Endocrine Disorders (e.g. Diabetes) Immunosuppression Wide range of antibiotics (e.g. tetracycline) Nutritional deficiencies Host protection against opportunistic infections of candida species are oral epithelium, which acts as a physical barrier preventing microorganisms from entering tissue, and is the site of a cellular mediated immune response. Competition and inhibition of interaction between candida species and other microorganisms in the mouth, such as many hundreds of different types of bacteria. saliva, which has both mechanical cleansing effect and immunological action, including salival immunoglobulin A antibodies, which aggregate candidal organisms and prevent them from attaching to the epithelial surface; and ensimatic components such as lysozim, lactoperooxidase and antileukoprosthesis. Violation of any of these local and systemic mechanisms of master protection is a potential susceptibility to peroral candida, which rarely occurs without predisposing factors. It is often described as a sick disease that occurs in a very young, very old or very sick. Oral candidiasis in a baby. At a very young age, the immune system is not yet fully developed. Immunodeficiency immunodeficiency is a state of reduced immune system function that can be caused by disease or treatment. Acute pseudomembrane candidiasis occurs in about 5% of newborns. Candida species are purchased from the mother's vaginal canal during childbirth. At a very young age, the immune system is not yet fully developed, and there is no individual immune response to candida species, the antibodies of infants to the fungus are usually supplied by the mother's breast milk. Other forms of immunodeficiency that can cause oral candidiasis include HIV/AIDS, active cancer and treatment, chemotherapy or radiotherapy. Corticosteroid drugs may contribute to the appearance of oral because they cause suppression of the immune system system systemically or at the local/mucous level, depending on the route of management. Locally injected corticosteroids in the mouth can take the form of mouthwash, rotting lollipops or mucous gels; is sometimes used to treat various forms of stomatitis. Systemic corticosteroids can also lead to candida. Inhalation corticosteroids (e.g. for the treatment of asthma or chronic obstructive pulmonary disease) are not intended for local administration in the mouth, but inevitably have contact with the oral and oropharyngeal mucosa as it is inhaled. In asthmatics, treatment with inhaled steroids, clinically detectable oral candidiasis can occur in about 5-10% of adults and 1% of children. Where inhaled steroids are the cause, frank lesions tend to have erythemas variety. Candidosis appears in areas where the steroid is contacted with the mucous membrane, usually the spinal tongue (medium romboid glossitis), and sometimes tastes. Candidal lesions in both areas are sometimes referred to as kisses because they approach when the tongue is in contact with the sky. Prosthesis wearing a prosthetic worn and poor hygiene of the denture, especially wearing a prosthesis constantly rather than removing it during sleep, is another risk factor for both frank transportation and oral candidiasis. Prostheses provide a relative acidic, moist and anaerobic environment because the mucous membrane covered with a prosthesis is protected from oxygen and saliva. Free, ill-fitting prostheses can also cause minor mucous membrane injuries, which are thought to increase the permeability of the mucosa and increase the ability of C. albicans to invade tissue. All these conditions favor the growth of C. albicans. Sometimes the prostheses become very worn out, or they were built to allow insufficiently low height of the face (occlusion vertical measurement), which leads to excessive closure of the mouth (the appearance is sometimes described as a collapse of the jaws). This causes the skin folds to deepen at the corners of the mouth (nosolyabial fold), essentially creating intertriginal areas where another form of candidiasis, angular heilitis, can develop. Candida species are able to stick to the surface of dentures, most of which are made of polymethylacrilate. They use micro-cracks and cracks on the surface of dentures to help hold them. Thus, prostheses can be covered with biofilm and act as reservoirs of infection, constantly re-infecting the mucous membrane. For this reason, dental disinfection is a vital part of the treatment of oral candidiasis in individuals who wear prostheses, as well as correcting other factors such as inadequate lower facial growth and seizure of prostheses. Dry mouth How the quantity and quality of saliva are important oral protection against candida. Reducing salivary flow or a change in saliva composition, collectively referred to as saliva hypofunction or hyposalivation is an important predisposing factor. Xerostomia is often cited as the cause of candidiasis, but xerostomia can be subjective or objective, i.e. a symptom present with or without actual changes in saliva sequence or flow speed. Diet malnutrition, or malabsorption, or poor diet, especially hematinal deficiencies (iron, vitamin B12, folic acid) can predispose to oral candidiasis, by causing reduced host defense and epithelial integrity. For example, iron deficiency anaemia is thought to cause suppressed cellular immunity. Some sources will say that vitamin A or pyridoxine deficiencies are also linked. There is limited evidence that a high-carb diet predisposes to peroral candidiasis. In vitro and studies show that candid growth, adhesion and biofilm formation are enhanced by the presence of carbohydrates such as glucose, galactose and sucrose. Smoking, especially heavy smoking, is an important predisposing U.S., but the causes of these relationships are unknown. One hypothesis is that cigarette smoke contains nutritional factors for C. albicans, or that local epithelial changes occur that facilitate the colonization of candida species. Broad-spectrum antibiotics (e.g. tetracycline) eliminate competing bacteria and disrupt the normally balanced ecology of oral microorganisms, which can cause candidiasis caused by antibiotics. Other factors several other factors may contribute to infection, including endocrine disorders (e.g. diabetes with poor control) and/or the presence of some other mucous lesions, especially those that cause hyperkeratosis and/or dysplasia (e.g. planus lichen). Such changes in the mucosa predispose it to secondary infection with candidiasis. Other physical mucous changes are sometimes associated with overgrowth candida, such as split tongue (rarely), language piercing, atopic, and/or hospitalization. Diagnosis can usually be made only from a clinical appearance, but not always. As candidiasis can be variable in appearance, and present with white, red or combined white and red lesions, differential diagnosis can be extensive. In pseudo-membran candidiasis, membranous slough can be destroyed to reveal the erythema to the surface beneath it. This is useful in distinguishing pseudomembred candidiasis from other white lesions in the mouth that cannot be wiped, such as lichen planus, oral hairy leukoplakia. Erythematosis can mimic a geographical language. Erythematosis usually has a diffuse border, which helps distinguish it from erythroplakia, usually has a well-defined boundary. Special studies to detect the presence of candida candida include oral tampons, oral rinses or oral smears. The smears are collected by gently scraping the damage with a spatula or a tongue blade and the resulting debris directly stretched onto the glass slide. Oral tampons are accepted if culture is required. Some recommend that tampons be taken from 3 different oral sites. Oral rinse involves rinsing the mouth with a phosphate buffer of saline solution for 1 minute and then spitting the solution into the vessel, which is considered in the pathology lab. Oral rinse technique can distinguish between commensal frank transportation and candidiasis. If a biopsy is suspected of candida leukoplakia. Smears and biopsies are usually colored with periodic acid-schiffs, which are stained with carbohydrates in the walls of fungal cells in purple. Gram coloring is also used as Candida spots strongly Gram positive. Sometimes a underlying disease is required, and this may include blood tests for a full blood test and hematics. If you do a biopsy, histopathological appearance can be variable depending on the clinical type of candidiasis. Pseudomembranous candidiasis shows a hyperplastic epithelium with a superficial parakeratotic decvamaty (i.e. separating) layer. The gif penetrates into the depths of the layer's spinozum and appears as weak basophilic structures. Polymorphonuclear cells also penetrate the epithelium, and chronic inflammatory cells penetrate the lamine proprya. Atrophic candidia looks like a subtle, atrophic epithelium that is not keratinized. Gifs are rare, and inflammatory cell infiltration of epithelium and laminate proprius cells. In fact, atrophic candidiasis looks like pseudomembranosis without a superficial desquamatous layer. Hyperplastic candidiasis is a variable. Usually there is hyperplastic and acatonic epithelium with parakerate. There is an inflammatory cell penetrating and the gif visible. Unlike other forms of candidiasis, hyperplastic candidia can show dysplasia. Treatment of oral candidiasis can be treated with topical antifungal drugs such as nystatin, myconazole, gentian violet or amphotericin B. Surgical excision of lesions may be required in cases that do not respond to antifungal drugs. Basic immunosuppression can be managed medically as soon as it is detected, and this helps prevent the recurrence of frank infections. Patients with weakened immunity, either with HIV/AIDS or as a result of chemotherapy, may need systemic prevention or treatment with oral or intravenous antifungal drugs. However, there is strong evidence that drugs that are absorbed or partially absorbed from the gastrointestinal tract can prevent candidiasis more effectively than drugs that absorbed in the same way. If candidiasis is secondary to corticosteroid or antibiotic use, use may be discontinued, although this is not always the case Option. Candidosis secondary to the use of inhaled steroids can be treated by rinsing your mouth with water after taking steroids. Using an astronaut to reduce contact with the oral mucosa can significantly reduce the risk of oral candidiasis. In recurrent oral candida, the use of antifungal drugs azola risks the selection and enrichment of drug-resistant strains of candida organisms. Drug resistance is becoming more common and is a serious problem in people with weakened immunity. Preventive use of antifungal drugs is sometimes used in people with HIV infection, during radiation therapy, during immunosuppressive or long-term antibiotic therapy, as the development of candida infection in these groups may be more serious. Candidal pressure in the mouth can be reduced by improving oral hygiene measures such as regular toothbrush and the use of antimicrobial mouthwash. Since smoking is associated with many forms of oral candidiasis, cessation can be beneficial. (Medical quote is needed) Hygiene of the denture See also: Dentistry-related stomatitis - Treatment Good dental hygiene includes regular cleaning of dentures, and leaving them out of the mouth during sleep. This gives the mucous membrane a chance of recovery, while wearing a prosthesis during sleep is often compared to sleeping in shoes. In oral candida, prostheses can act as a reservoir of Candida species, constantly over-infecting the mucous membrane after the antifungal drugs are stopped. Therefore, they need to be disinfected as part of the treatment of oral candidiasis. There are commercial prosthetics of pure drugs for this purpose, but this is easily carried out by soaking the prosthesis overnight in a 1:10 solution of sodium hypochlorite (Milton, or household bleach). Bleacher can corrugate metal components, so if the denture contains metal, soaking it twice a day in a solution of chlorhexidine can be performed instead. An alternative method of disinfection is the use of 10% of the solution of acetic acid (vinegar) as night soaking, or microwave prostheses in 200 ml of water for 3 minutes at 650 w. Microwave sterilization is suitable only if there are no metal components in the prosthesis. Antifungal drugs can also be applied to a suitable prosthesis surface before being put back into the mouth. Other problems with prostheses, such as inadequate occlusion vertical measurement, may also need to be corrected in the case of angular cheilitis. The prognosis of the severity of oral candidiasis is subject to great variability from one person to another and in the same person from one case to another. such an infection is usually excellent after the use of topical or systemic treatments. However, oral candidiasis can be recurrent. People are still at risk of the condition if major factors such as reduced saliva speed or immunosuppression cannot be corrected. Candidosis can be a marker of the underlying disease, so the overall prognosis may also depend on it. For example, transient erythema developed after antibiotic therapy is usually allowed after antibiotics stop (but not always immediately), and therefore carries an excellent prognosis, but candidiasis can sometimes be a sign of more sinister undiagnosed pathologies such as HIV/AIDS or leukemia. It is possible for candidiasis to spread to/from the mouth, from places such as the throat, oesophagus, lungs, liver, angogenital area, skin or nails. The spread of oral candidiasis to other areas usually occurs in weakened people. It is also possible that candidiasis is spread through sexual contact. Rarely, a superficial candida infection, such as oral candidiasis, can cause invasive candidiasis and even prove fatal. The observation that Candida species are generally harmless on the one hand, but also sometimes capable of causing deadly invasive candidisms led to the description of Dr. Jekyll and Mr. Hyde. The role of thrush in the hospital and ventilated patients is not entirely clear, but there is a theoretical risk of positive candida interaction with topical bacteria. Epidemiology in humans, oral candidiasis is the most common form of candidiasis, is by far the most common fungal infection of the mouth, and it is also the most common opportunistic oral infection in people with lesions occurring only when the environment is conducive to pathogenic behavior. Candidosis is oropharyngeal common during cancer care, and it is a very common oral sign in people with HIV. Oral candidiasis occurs in about two-thirds of people with AIDS and esophageal candidiasis. The incidence of all forms of candidiasis has increased in recent decades. This is due to the development of medicine, more invasive medical procedures and surgeries, increased use of broad-spectrum antibiotics and immunosuppression therapy. The global HIV/AIDS pandemic is the largest contributor to the increase in the incidence of oral candidiasis since the 1980s. The incidence of candidiasis caused by NCAC species is also increasing, again believed to be due to changes in medical practice (e.g. organ transplantation and the use of indwelling catheters). The history of oral candidiasis has been recognized throughout history. The first description of this condition is thought to have occurred in the 4th century BC in the Epidemic (a treatise that is part of the hippocratic enclosure), where descriptions of what sounds like oral candidiasis are said to occur with severe underlying disease. The colloquial term thrush refers to a similarity of white spots present in some forms of candidiasis псевдомембранозный кандидоз), с грудью одной и той же птицы. Общество и культура Многие псевдонаучные претензии сторонников альтернативной медицины окружают тему кандидоза. Устные кандидоз иногда представлен таким образом, как симптом широко распространенной системной кандидоз, синдром гиперчувствительности кандида, дрожжевой аллергии, или желудочно-кишечного кандидоза разрастание, которые являются медицински непризнанных условиях. (См.: Альтернативная медицина в Кандидозе) Ссылки на б Джеймс, Уильям Д.; Бергер, Тимоти Г.; и др. (2006). Эндрюс болезни кожи: Клиническая дерматология. Филадельфия: Сондерс Эльсвьер. стр. 308. ISBN 978-0-7216-2921-6. OCLC 62736861. a b c d e f g h Scully, Crispian (2008). Устная и челюстно-челюстно-лицевой медицина: основа диагностики и лечения (2-й прим. Эдинбург: Черчилль Ливингстон. стр. 191-199. ISBN 9780443068188. a b c d e f g h Kerawala C, Ньюлендс С (редакторы) (2010). Устная и челюстно-челюстно-лицевой хирургии. Оксфорд: Издательство Оксфордского университета. стр. 446, 447. 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