Mouth Ulcers & Oral Lesions — When to See a Specialist

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Description:

Most mouth ulcers are harmless, but some signal serious conditions including oral cancer. Learn warning signs and when to see a specialist at CSSC Melbourne.

Details:

Collins Street Specialist Centre — Mouth Ulcers & Oral Lesions: When to See a Specialist

Almost everyone gets a mouth ulcer at some point. They're painful, disruptive, and usually gone within a couple of weeks without any treatment. Most are entirely benign. But some oral lesions point to something more serious, including oral cancer, and knowing the difference, and when to get it checked, can genuinely affect long-term outcomes.

At Collins Street Specialist Centre, our oral and maxillofacial surgeons assess and manage oral lesions across the full clinical spectrum. This article is for patients and referring clinicians who want to understand what's considered normal, what deserves a closer look, and when timely specialist review makes sense.

Common types of mouth ulcers

Aphthous ulcers (canker sores)

Aphthous ulcers are the most common type, affecting up to 25% of people at some point in their lives. They appear as round or oval sores with a white or yellowish centre and a red border, most often on the inner cheeks, lips, tongue, floor of the mouth or soft palate.

There are three subtypes:

- **Minor aphthous ulcers** are the most common. They're small (under 10 mm), shallow, and typically heal within 7–14 days without scarring. Most people who get aphthous ulcers will only ever experience this type. - **Major aphthous ulcers** are larger (over 10 mm), deeper and considerably more painful. They can take weeks or months to resolve and may leave scarring. Less common, but they can seriously interfere with eating, drinking and speech. - **Herpetiform aphthous ulcers**, despite the name, have nothing to do with the herpes virus. They appear as clusters of many small (1–2 mm) ulcers that sometimes merge into larger, irregular sores. They generally clear within about a month.

The exact cause of aphthous ulcers isn't fully understood, but recognised triggers include: - Psychological stress and fatigue - Minor oral trauma (cheek biting, vigorous brushing, dental procedures) - Certain foods (citrus fruits, tomatoes, chocolate, coffee, nuts) - Hormonal changes, including those tied to the menstrual cycle - Nutritional deficiencies in iron, vitamin B12, folate or zinc - Sodium lauryl sulphate in some toothpastes - A family history of aphthous ulceration - Changes in immune function

Traumatic ulcers

Traumatic ulcers result from direct physical injury to the soft tissues of the mouth: - Biting the cheek, lip or tongue - Sharp or fractured teeth - Ill-fitting dentures or orthodontic appliances - Burns from hot food or drinks - Chemical irritation

These ulcers typically resolve once the cause is identified and removed. They tend to appear at the injury site — on the side of the tongue near a sharp tooth, the inner cheek, or beneath a denture.

Viral ulcers

Several viral infections can produce oral ulceration:

- **Herpes simplex virus (HSV):** Primary herpes infection (herpetic gingivostomatitis) causes widespread painful ulceration with fever and systemic illness, most commonly in children. Recurrent herpes (cold sores) usually appears on the lips and surrounding skin as clusters of small blisters that rupture and crust. Intraoral recurrences tend to affect the hard palate or attached gingiva. - **Varicella-zoster virus:** When shingles involves the trigeminal nerve, painful unilateral blistering of the oral mucosa can occur. - **Coxsackievirus:** Hand, foot and mouth disease produces small oral ulcers alongside a rash on the hands and feet, mainly in children.

Other causes of oral ulcers and lesions

Less common but clinically significant causes include: - **Lichen planus:** An autoimmune condition characterised by white, lacy patterns (Wickham's striae) that may progress to painful erosive ulceration - **Pemphigus and pemphigoid:** Autoimmune blistering disorders affecting the oral mucosa - **Behçet's disease:** A systemic inflammatory condition featuring recurrent oral and genital ulceration - **Crohn's disease and coeliac disease:** Both can present with oral ulceration as a feature - **Drug reactions:** Methotrexate, nicorandil, NSAIDs and bisphosphonates are among the medications known to cause oral ulceration - **Haematological disorders:** Anaemia, leukaemia and neutropenia may all present with oral ulceration

The warning signs: when an ulcer may indicate something more serious

This is the part every adult patient should know. Oral cancer isn't rare — approximately 5,000 Australians are diagnosed with head and neck cancers each year, with oral cavity cancers making up a significant share. Survival rates are considerably better when oral cancer is caught early.

Red flags — seek specialist assessment if you notice:

A mouth ulcer that hasn't healed within 2–3 weeks. This is the most important clinical warning sign. Most ulcers resolve within 7–14 days. One that persists for three weeks or more requires professional evaluation to rule out malignancy.

A painless lump or area of thickening in the mouth, lip, tongue or throat. Malignant lesions are often painless in their early stages, which leads many patients to assume nothing is wrong.

White or red patches that can't be wiped away. White patches (leukoplakia) or red patches (erythroplakia) that are firmly attached to the underlying tissue require investigation. Erythroplakia in particular carries a high rate of dysplasia or frank malignancy.

Persistent hoarseness or voice changes lasting more than three weeks.

Difficulty or discomfort swallowing that doesn't resolve.

Numbness or altered sensation in the tongue, lip or oral cavity.

A persistent lump in the neck present for more than three weeks.

Unexplained bleeding from the oral cavity.

Tooth mobility without an identifiable dental cause.

An ulcer recurring at the same site — repeated presentation at an identical location may point to an underlying pathological lesion.

Risk factors for oral cancer

Oral cancer can develop in anyone, but the following factors are associated with higher risk: - **Tobacco use** (smoked and smokeless) — the single greatest modifiable risk factor - **Heavy alcohol consumption** — risk is substantially compounded when combined with tobacco - **Human papillomavirus (HPV)**, particularly HPV-16, which is increasingly implicated in oropharyngeal cancers - **Sun exposure** — relevant for lip cancers - **Betel quid (paan) chewing** - **Age** — most common in people over 40, though HPV-related cancers are being identified more frequently in younger adults - **Previous oral cancer** — significantly raises the risk of a second primary malignancy - **Poor nutritional status** — diets low in fruits and vegetables are associated with higher risk

What to expect during a specialist assessment

If you present with a concerning oral lesion at Collins Street Specialist Centre, our oral and maxillofacial surgeons follow a structured clinical approach. Here's what the process typically involves.

Clinical examination

A thorough examination of the entire oral cavity is conducted, including areas that are difficult to see without specialist equipment — the floor of the mouth, the back of the tongue, the soft palate and the oropharynx. The neck is also examined for lymphadenopathy.

Clinical history

A detailed history covers how long the lesion has been present, whether it has changed in appearance or size, any associated symptoms, relevant medical history, current medications and known risk factors.

Adjunctive diagnostic aids

In selected cases, additional tools may support the clinical assessment: - **Vital staining:** Agents such as toluidine blue can highlight areas of tissue abnormality - **Autofluorescence:** Specialised light-based examination that helps differentiate normal from potentially abnormal tissue - **Clinical photography:** Used to document the lesion's appearance for comparison over time

Biopsy

Where a lesion looks suspicious, biopsy is the definitive diagnostic step. It involves removing a small tissue sample — or sometimes the entire lesion — under local anaesthesia, for histopathological examination by an oral pathologist.

The procedure is generally straightforward and well-tolerated: - Local anaesthetic is administered to numb the area adequately - A small tissue sample is obtained (typically 5–8 mm) - The site is usually closed with resorbable sutures - The specimen goes to an oral pathology laboratory - Results are generally available within 1–2 weeks

Histopathological analysis confirms whether tissue is normal, shows pre-cancerous change (dysplasia), or is malignant. Biopsy is also the right diagnostic tool for autoimmune and inflammatory conditions affecting the oral mucosa.

Further investigation

If biopsy confirms malignancy, imaging studies (CT, MRI, PET scan) and referral to a head and neck cancer multidisciplinary team will be arranged promptly.

Managing common mouth ulcers

For the majority of mouth ulcers that are benign, management focuses on symptom relief and supporting healing.

Pain relief

- **Topical anaesthetic preparations:** Products containing lignocaine or benzocaine provide temporary localised numbing - **Topical anti-inflammatory pastes:** Triamcinolone acetonide (Kenalog in Orabase) applied directly to the ulcer reduces local inflammation and discomfort - **Antimicrobial mouthwashes:** Chlorhexidine rinses can reduce the risk of secondary infection and may support healing - **Systemic analgesics:** Paracetamol or ibuprofen for pain management as needed

Promoting healing

- Avoid spicy, acidic or abrasive foods during the healing period - Use a soft-bristled toothbrush to minimise mechanical irritation - If a sharp tooth or dental restoration is contributing, have it smoothed by your dentist - Address any nutritional deficiencies identified through investigation - Try a sodium lauryl sulphate-free toothpaste if ulcers are recurrent - Manage stress where it's a recognised trigger

When recurrent ulcers warrant further investigation

Patients with frequent, severe or persistent aphthous ulceration may benefit from further assessment, including: - Pathology testing for iron, vitamin B12, folate and zinc levels - Coeliac disease screening - Evaluation for underlying autoimmune or systemic inflammatory conditions - Medication review to identify potential pharmacological contributors

Prevention strategies

Not all mouth ulcers can be prevented, but the following measures can reduce their frequency and severity, and lower the risk of more serious oral pathology:

- **Maintain good oral hygiene** to minimise bacterial irritation of the mucosa - **Address sharp teeth or dental restorations** promptly through your dentist - **Ensure dentures fit well** — have them reviewed regularly by an appropriate dental practitioner - **Eat a nutritionally balanced diet** with adequate fruits, vegetables and whole grains - **Manage stress** through regular exercise, mindfulness or other approaches that work for you - **Avoid known dietary triggers** if you're prone to aphthous ulceration - **Stop smoking** — this reduces the risk of both recurrent ulceration and oral malignancy - **Limit alcohol consumption** to within recommended guidelines - **Do regular oral self-examinations** — familiarity with your own oral anatomy makes it easier to spot changes early

Self-examination: what to look for

Regular oral self-examination is a simple, worthwhile habit. Using a mirror and good lighting:

1. Inspect and feel the inner surface of your lips and cheeks 2. Examine your gum tissue 3. Look at the roof of your mouth (hard and soft palate) 4. Stick out your tongue and examine all surfaces — top, underside and both sides 5. Feel the floor of the mouth beneath the tongue 6. Inspect the back of the throat as best you can 7. Feel both sides of the neck for any persistent lumps or asymmetry

The goal is to notice anything that looks unusual, has changed, or doesn't match the corresponding area on the other side. Most findings won't be significant — but catching the ones that are makes a real difference to treatment options and outcomes.

The importance of not dismissing persistent lesions

It's understandable to feel like presenting to a specialist about a mouth ulcer is an overreaction. But oral cancer found early carries a considerably better prognosis than disease caught late. A biopsy is a straightforward procedure that can provide definitive answers and, in most cases, genuine reassurance.

The patients who give us the greatest concern aren't those who come in with a two-week-old ulcer that turns out to need monitoring. They're the patients who waited six months or more, assuming the lesion would go away on its own.

If you're unsure whether your lesion warrants assessment, have it reviewed. A brief consultation is a small investment against a potentially serious outcome.

Book a specialist assessment

If you have a mouth ulcer that hasn't resolved within three weeks, or any oral lesion that's worrying you, don't put off getting it assessed. Our oral and maxillofacial surgeons at Collins Street Specialist Centre are experienced in evaluating and managing the full range of oral lesions, from benign aphthous ulceration through to complex pathology requiring multidisciplinary management.

Patients and referring clinicians can verify specialist credentials through the Australian Health Practitioner Regulation Agency (AHPRA) register, where all registered specialists are listed.

Collins Street Specialist Centre is located within the Manchester Unity Building at 220 Collins Street, Melbourne CBD. We offer timely appointments for oral lesion assessment and accept referrals from general dental practitioners and medical practitioners.

Call (03) 9654 5705 to arrange your appointment. When it comes to oral health, a timely assessment is always preferable to uncertainty and delay.

Frequently Asked Questions

| Question | Answer | |----------|--------| | What is the most common type of mouth ulcer | Aphthous ulcers (canker sores) | | What percentage of people get aphthous ulcers | Up to 25% of the population | | How many subtypes of aphthous ulcers exist | Three | | What are the three subtypes of aphthous ulcers | Minor, major, and herpetiform | | What size are minor aphthous ulcers | Less than 10 mm in diameter | | How long do minor aphthous ulcers take to heal | 7–14 days | | Do minor aphthous ulcers cause scarring | No | | What size are major aphthous ulcers | Greater than 10 mm in diameter | | How long do major aphthous ulcers take to heal | Weeks to months | | Do major aphthous ulcers cause scarring | Yes, scarring may result | | Are herpetiform aphthous ulcers caused by the herpes virus | No | | What size are herpetiform ulcers | 1–2 mm each | | How long do herpetiform ulcers typically resolve within | Approximately one month | | What is the single most important warning sign for a serious ulcer | An ulcer that has not healed within 2–3 weeks | | How long should you wait before seeking specialist review of an ulcer | No longer than 3 weeks | | Are malignant oral lesions usually painful early on | No, they are frequently painless | | What type of patches carry a high rate of malignancy | Erythroplakia (red patches) | | What are white patches in the mouth called | Leukoplakia | | Can leukoplakia be wiped away | No, it is firmly adherent to tissue | | Can erythroplakia be wiped away | No, it cannot be removed by wiping | | What is the single greatest modifiable risk factor for oral cancer | Tobacco use | | Does alcohol increase oral cancer risk | Yes | | Does combining tobacco and alcohol compound oral cancer risk | Yes, substantially | | Which HPV type is linked to oropharyngeal cancer | HPV-16 | | Does sun exposure increase oral cancer risk | Yes, particularly for lip cancers | | What age group is most affected by oral cancer | Individuals over 40 | | Can HPV-related oral cancers occur in younger adults | Yes, with increasing frequency | | How many Australians are diagnosed with head and neck cancers each year | Approximately 5,000 | | Does early detection of oral cancer improve survival | Yes, meaningfully | | What does a specialist examination of an oral lesion include | Full oral cavity examination including floor of mouth and oropharynx | | Is the neck examined during a specialist oral assessment | Yes, for lymphadenopathy | | What is the definitive diagnostic step for a suspicious oral lesion | Biopsy | | What size tissue sample is typically taken during biopsy | Approximately 5–8 mm | | Is biopsy performed under local anaesthesia | Yes | | Are sutures used after biopsy | Yes, resorbable sutures | | How long

does biopsy histopathology take | Results generally available within 1–2 weeks | | What can biopsy confirm | Normal tissue, dysplasia, or malignancy | | What imaging may follow a confirmed malignancy | CT, MRI, or PET scan | | What topical anaesthetic ingredients relieve ulcer pain | Lignocaine or benzocaine | | What topical anti-inflammatory paste is used for ulcers | Triamcinolone acetonide (Kenalog in Orabase) | | What mouthwash helps reduce secondary infection in ulcers | Chlorhexidine | | What systemic analgesics help with ulcer pain | Paracetamol or ibuprofen | | Should you avoid spicy foods during ulcer healing | Yes | | What toothbrush type is recommended during ulcer healing | Soft-bristled | | Can sodium lauryl sulphate in toothpaste trigger ulcers | Yes | | Should you try SLS-free toothpaste if ulcers are recurrent | Yes | | What nutritional deficiencies are linked to aphthous ulcers | Iron, vitamin B12, folate, and zinc | | Can stress trigger aphthous ulcers | Yes | | Can hormonal fluctuations trigger aphthous ulcers | Yes, including menstrual cycle changes | | Can cheek biting trigger aphthous ulcers | Yes | | Can citrus fruits trigger aphthous ulcers | Yes | | Can chocolate trigger aphthous ulcers | Yes | | What systemic disease can cause oral ulcers | Crohn's disease | | Can coeliac disease cause oral ulcers | Yes | | Can Behçet's disease cause oral ulcers | Yes | | Can lichen planus cause oral ulcers | Yes, in its erosive form | | Can medications cause oral ulcers | Yes | | Which medications are known to cause oral ulcers | Methotrexate, nicorandil, NSAIDs, bisphosphonates | | Can leukaemia present with oral ulceration | Yes | | What virus causes herpetic gingivostomatitis | Herpes simplex virus (HSV) | | Who most commonly gets herpetic gingivostomatitis | Children | | Where do intraoral herpes recurrences typically appear | Hard palate or attached gingiva | | What disease causes oral ulcers alongside a hand and foot rash | Hand, foot and mouth disease | | What virus causes hand, foot and mouth disease | Coxsackievirus | | Can shingles cause oral ulcers | Yes, when the trigeminal nerve is involved | | What is a traumatic ulcer caused by | Direct physical injury to oral soft tissues | | Do traumatic ulcers resolve once the cause is removed | Yes | | What diagnostic tool can highlight abnormal oral tissue | Toluidine blue vital staining | | What is autofluorescence used for in oral assessment | To differentiate normal from potentially abnormal tissue | | Should a persistent neck lump lasting more than 3 weeks be assessed | Yes | | Is unexplained oral bleeding a warning sign | Yes | | Is tooth mobility without dental cause a warning sign | Yes | | Is an ulcer recurring at the same site a warning sign | Yes | | What self-examination step helps detect early oral changes | Regular oral self-examination with mirror and adequate lighting | | Should you inspect the lateral borders of your tongue during self-exam | Yes | | Should you palpate the neck during self-examination | Yes | | Where is Collins Street Specialist Centre located | 220 Collins Street, Melbourne CBD | | What building is Collins Street Specialist Centre in | Manchester Unity Building | | What is the phone number for Collins Street Specialist Centre | (03) 9654 5705 | | Can GP practitioners refer to Collins Street Specialist Centre | Yes | | Can general dental practitioners refer to the centre | Yes | | Where can specialist credentials be verified | AHPRA (Australian Health Practitioner Regulation Agency) register |
