Review of Therapies for the Treatment of Oral Chronic Graft-Versus-Host Disease

Margaret Harvey Granitto, MSN, RN, CRNP, Jane M. Fall-Dickson, PhD, RN, AOCN®, Colleen K. Norton, PhD, RN, CCRN, and Colleen Sanders, MS, RN, FNP

Oral chronic graft-versus-host disease (GVHD) is a frequent complication of allogeneic hematopoietic stem cell transplantation, contributing to patient morbidity and mortality. Although an optimal treatment is not available, several systemic and topical or local therapies have shown efficacy in treating the disease. New therapies are being tested through clinical trials. This article examines the efficacy and safety of reported treatment modalities studied from 2006–2012. Nurses will encounter patients with oral chronic graft-versus-host disease suffering from pain, discomfort, and a decreased quality of life. Knowledge of new therapies found to be effective in managing these symptoms is imperative. Nurses play a key role in the assessment and management of this complex oral disease.

The most frequent sites involved in cGVHD at time of diagnosis are the skin, mouth, liver, and eyes (Lee & Flowers, 2008). Standard treatment of cGVHD consists of systemic immunosuppressive therapy, usually with steroids, for periods of two to seven years. That therapy, in addition to the chronic immunodeficiency and organ damage caused by the cGVHD, contributes to increased morbidity and mortality (Lee & Flowers, 2008). Although optimal treatment is not yet available for cGVHD manifesting in the oral cavity, patients with oral cGVHD need to receive the best available therapy to decrease disease severity and related symptoms, as well as to minimize the associated negative effects on their health-related quality of life (HRQOL) and nutritional status (Fall-Dickson et al., 2010).

Clinical Presentation

Oral involvement often is the first manifestation of the disease (Imanguli et al., 2006). Almost 80% of patients with cGVHD have oral clinical signs, including atrophy, edema, erythema, lichenoid changes, ulcerations, and late fibrosis, which often lead to poor jaw range of motion (Imanguli et al., 2006). Lichenoid changes are similar in clinical presentation to oral lichen planus and have a