“Low power laser in the prevention of induced oral mucositis in bone marrow transplantation patients: a randomized trial”

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Running Head: Laser and prevention of oral mucositis.

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Abstract

We investigated the clinical effects of low power laser therapy (LPLT) on prevention and reduction of severity of conditioning-induced oral mucositis (OM) for hematopoietic stem cell transplant (HSCT). Were randomized 38 patients submitted to autologous (AT) or allogeneic (AL) HSCT. An diode InGaAlP was used emitting light at 660 nm, 50 mW and 4 J/cm² measured at the end of fiberoptic with 0.196cm² of section area. The evaluation of OM was done by OMAS and WHO scale. In the LPLT group 94.7% of patients had OM (WHO) Grade ≤ 2, including 63.2% with Grade 0 and 1, whereas in the controls group 31.5% of patients had OM Grade ≤ 2 (p<0.001). Remarkably the HR for grade 2, 3 and 4 OM was 0.41 (0.22-0.75, p = 0.002) and for grade 3 and 4 was 0.07 (0.11-0.53, p<0.000). Using OMAS by the calculation of ulcerous area, 5.3% of laser group presented ulcerous of 9.1 to 18 cm², whereas 73.6% of the control group presented ulcers from 9.1 to 18 cm² (p=0.003). Our results indicate that the use of upfront LPLT in HSCT patients is a powerful instrument in reducing the incidence of OM and is now standard in our center.

Keywords: Low power laser therapy, Hematopoietic stem cell transplantation, Oral mucositis, Radiotherapy, Chemotherapy.
Introduction

High-dose chemotherapy administered as part of the preparative regimens prior to HSCT has a direct cytotoxic effect on the oral epithelium, connective tissue and matrix extracellular leading to injury or disruption of the mucosal barrier. Oral and gastrointestinal mucositis may occur in up to 100% of the patients undergoing high-dose chemotherapy (CT) with HSCT. Oral mucositis is associated with an increase in the incidence of systemic infections because of disruption of the natural mucosal barrier and impacts both the on length of hospital stay and on the complications associated with HSCT.

Oral mucositis clinical presentation consists of mucosal blending, erythema, edema and progresses to ulceration with or without pseudomembrane formation, that develop most commonly on the non-keratinized mucosa of the floor of the mouth, tongue, buccal mucosa, and soft palate. The initial stage of tissue injury occurs rapidly following the administration of radiation (RT) or chemotherapy who trigger both DNA and non-DNA damage. DNA strand breaks result in direct cellular injury that targets cells in the basal epithelium as well as cells within the submucosa. Although the mucosa seems to be absolutely normal at this stage, a cascade of events is ongoing in the submucosa that ultimately results in mucosal destruction. The current management of such oral mucositis is directed at prevention, palliation, infection prevention and treatment.

LPLT have been used in an attempt to reduce the incidence of oral mucositis and its associated pain in patients who are receiving high-dose CT or chemoradiotherapy prior to HSCT. Over the last several years, appropriate laboratory and clinical evidence has been accumulating steadily to also support the use of LPLT to promote biomodulation. It has been reported that LPLT promotes wound healing and reduces pain and inflammation. Different effects appear to be related to laser characteristics and the particular type of tissue being treated. Helium-neon (He-Ne) laser (632.8 nm) treatment has been the most frequently studied form of LPLT for the prevention or reduction of oral mucositis and oral pain associated with cancer therapy (including HSCT). Research currently is underway on the use of diode lasers with wavelengths ranging from 650 to 905 nm. It appears that laser therapy produces no toxicity and is atraumatic to patients.
In the current trial we investigated the clinical effects of InGaP (660nm) laser on prevention and reduction of severity of conditioning-induced oral mucositis for HSCT patients.

**Patients and Methods**

**Patients**

This was a randomized, placebo-controlled, quantity and prospective clinical trial. Between January 4th, 2004 and May 20th, 2005, 38 patients were evaluated and submitted to HSCT in Centro de Transplante de Medula Óssea (CEMO). The research was performed in compliance with the Resolution nº 196/96 of the National Health Counsel of Brazil, and was submitted to both the Ethics Committee of the Instituto Nacional de Câncer (INCA) and of the Universidade do Vale do Paraíba (UNIVAP). Patients were randomized on the day admission for the transplant between receiving lasertherapy (laser or experimental group), or not receiving the lasertherapy (placebo or control group).

**Inclusion Criteria**

Age ≥ 18 years old, hematologic disease nominate HSCT, oral mucous intact in the first day of the conditioning (D-7), absence of visible plaques on the teeth upon inspection, capacity to cooperate with the treatment, patients that after the information and instruction section have signed the consenting text giving free confirmation and being elucidated.

**Exclusion criteria**

Patients who did not fulfill the inclusion criteria (e.g. allogeneic or autologous not myeloablative transplant), patients who were receiving drugs for the treatment and/or prevention of mucositis, patients who were not previously evaluated and released by the author.

**Oral care**

Performed by the dentist before admission for the HSCT. Dental care included education about oral hygiene, panoramic radiograph, oral examination with attention to soft tissues, bones, tooth and periodontal exam, removal of sub and supragingival calculus. Eliminate sources of trauma caused by orthodontic bands and brackets, tooth or prosthesis, extraction of teeth with signs or symptoms indicative of potentially bad prognosis (active
periodontal disease, teeth requiring endodontic treatment or with extended caries and coronary destruction)\textsuperscript{17-18}. All the patients had carried out oral hygiene with extra-soft toothbrushes, dental paste with peroxidase system after every meal and mouth rinses with an ethanol-free 0.12 % chlorhexidine solution\textsuperscript{19,20,21} containing xylitol from D -7 until neutrophil recovery (granulocytes > 500/mm\textsuperscript{3}), three times a day (morning, afternoon and night).

Methods

Conditioning Regimens

The characteristics of the conditioning regimens are summarized in table 1. Patients received Fluconazole 200 mg IV 12/12 h from D-2 and Acyclovir 500 mg/m\textsuperscript{2} IV 8/8 h from D-2 until neutrophil recovery.

Samples for blood cultures were collected by central catheter and peripheral veins in case of febrile episodes followed by empiric therapy with broad-spectrum antibiotics.

Laser Application

LPLT was started on the first day of the conditioning (D-7) and stopped on the day of the neutrophil recovery. The dentists were the only members of the team who knew to which group the patient was randomized to. The same equipment was used in all applications. The irradiation used was a 50 mW InGaAlP diode-laser, emitting continuous light at 660 nm, with a real power output of 46.7 mW and energy density (ED) of 4 J/cm\textsuperscript{2} measured at the end of fiberoptic with 0.196cm\textsuperscript{2} of section area during the experiment. It was applied in a punctual form, side by side, touching the material, during 16.7s per point, totalizing 15 points per region. The oral cavity regions previously treated were: upper lip, lower lip (redness and lip mucosa), buccal mucosa, dorsum, ventral and lateral tongue, floor of mouth, hard and soft palate. Before the application of the laser the tip was wrapped with a PVC film and after this procedure was desinfected with 70% alcoholic solution. For protection all patients received eyeglasses with total blocking of the light, to be used during the application of the laser.
A crossover was allowed for patients from the control group who presented a Grade 4 oral mucositis index of the World Health Organization (WHO)\textsuperscript{22} and/or an ulcer area $\geq 12$ cm according to the Oral Mucositis Assessment Scale (OMAS)\textsuperscript{23}. From this moment, therapeutical laser with $8J/cm^2$ per point was applied to these patients. The patients in the laser group who had presented erythema or ulcers continued to receive the preventive laser with $4J/cm^2$.

**Laser therapy Evaluation**

With the purpose of minimizing interobserver variation and familiarizing the team with the measurements scales for mucositis a CD-ROM containing the research protocol, as well as photographic examples of normal and damage oral mucosa (mucositis) was given to all the professionals involved in the application of LPLT and on the evaluation of patients. One dentist and three nurses (blinded for the study), performed daily oral evaluation of the patients from day -7 until the neutrophil recovery. The results were catalogued and analyzed according with WHO’s scale, OMAS and Visual Analogue Scale (VAS)\textsuperscript{23}.

**Statistics Analysis**

For the WHO’s scale and OMAS the chi-square test ($\chi^2$) was applied. Correlation between the scores in the WHO scale and OMAS was assessed by the F-test in analysis of variance (ANOVA), and Bonferroni’s test. Mucositis-free survival was calculated from the first day of conditioning trough the neutrophil recovery by the Kaplan-Meier method. The concordance index (CI) between the evaluators was measured (CI=$81.7\%\pm 1.96\sqrt{81.7\times 18.3/520}$). The first day and the duration (in days) of mucositis were compared between both groups, using the Mann-Whitney test. The VAS scores of pain were compared using Student’s test. All $p$ values <0.05 were considered as statistically significant.

**Results**

All the 38 patients completed the study and none were lost to follow-up or excluded for failure to complete the laser application protocol. The treatment was well tolerated and no toxicity from LPLT was recorded. Patients characteristics are summarized in table 2.
Mucositis evaluation by WHO criteria

Using the WHO’s scale it was observed that the laser group patients presented less intense oral mucositis (WHO Grade 0-1; Figure 1). The proportion of patientes in the LPLT and placebo groups who developed Grade 0 or 1 mucositis (without ulcers) was 63.2% (12 of 19) including 3 patients submitted to total body irradiation (TBI) and 10.5% (2 of 19), respectively (p<0.001). Six patients in the LPLT group (31.5%) had small ulcers, (WHO Grade 2), totalizing 94.7% of the patients in this group with a WHO Grade between 0 and 2. The control group behaved in the opposite way (p<0.001). In order to better estimate the impact of LPLT, the mucositis-free survival was analyzed separately in the strata of patients with Grades 2, 3 and 4 and Grades 3 and 4 patients, respectively. The hazard ratio for Grades 2, 3 and 4 mucositis was 0.41 (0.22-0.757; p = 0.002), whereas for Grade 3 and 4 only it was 0.07 (0.11-0.53; Figure 2 and 3).

Oral mucositis evaluation by OMAS criteria

The evaluation by OMAS criteria was done both by using the calculation of the weighted average of the ulcerous area plus erythema’s intensity and by ulcerous area only. Sixteen patients from the laser group (84.2%) stayed on the weighted average zone of 0-2.9, while only 5 patients from the control group (26.3%) stayed in the same zone (p=0.007; Figure 4). It was observed that the patients of the laser group presented small extension of the ulcerous area. with (p=0.003; Figure 5). In addition, it was observed that the control group patients showed mucositis earlier D +5 than the laser group D +6 (U* = 0.42 with p=0.67); stayed more time with mucositis, laser and control groups with an average of 6 and 9 days, respectively (U* = 1.52 with p=0.13) and, therefore, needed more time for it to heal, comparing to the laser group (U* = 1.45 with p=0.15), being observed that the average time for the laser application in the control group was 6 days. In total 24 patients presented ulcer in the oral cavity and the most affected areas were: buccal mucosa with 20.5 patients (85.4%), lateral of the tongue with 19 patients (79.1%) and ventral of the tongue with 17 patients (70.8%).

Correlation between WHO’s scale and OMAS

In this analysis arithmetic averages and standard deflection were used for comparison of the WHO’s scale with the OMAS weighted average (WA). A significant difference was
detected between the Grade 1 (WA=1.25) and Grade 2 (WA=2.07); Grade 1 (WA=1.25) and Grade 3 (WA=3.72); Grade 1 (WA=1.25) and Grade 4 (WA=3.5); Grade 2 (WA=2.07) and Grade 3 (WA=3.72) and Grade 2 (WA=2.07) and Grade 4 (WA=3.5), with “F”=149.98 (p<0.001). However a significant difference was not observed between Grades 3 (WA=3.72) and 4 (WA=3.5).

**Level of agreement among evaluators and pain evaluation**

A significant agreement between the evaluators occurred, with an agreement index of 81.7%. Regarding the presence and intensity of pain, a significant difference was not noticed since 14 (73.7%) patients from the laser group (VAS 7) and 16 (84.2%) patients from the control group (VAS 8) reported pain (p=0.13).

**Impact of LPLT on clinical outcomes**

Concerning the results of the blood cultures, overall 28 (73.8%) patients presented negative blood cultures and 10 (26.3%) positive blood cultures. However no differences between LPLT and control group were observed. Further among the positive blood cultures no *Streptococcus* were identified and no tooth and gingival complication detected. Although not planned, an analysis of the impact of LPLT on survival and treatment related mortality was performed. Marginal differences in survival (p = 0.04) but not in treatment related mortality (TRM) favoring the LPLT group were detected (data not shown).

**Discussion**

The potential positive effects from LPLT as a preventive treatment method for patients with high probability to develop OM such as those submitted to HSCT has been postulated 8,10,12. However confirmatory randomized trials with more appropriate design are lacking. The study presented here differs from two previous randomized trials in 3 ways: the population included, the LPLT and the criteria (scores) used for analysis.
The majority of our patients were submitted to allogeneic transplant (Table 2), whereas both Cowen\textsuperscript{10} and Barasch\textsuperscript{8} studies enrolled only HSCT autologous except for one patient. Since allogeneic transplant lead to a more severe OM, our population may be considered more vulnerable and the results more remarkable. However the fact that TBI was applied to 100\% of Cowen’s patients study, but only to 10\% of our patients may have counterbalanced the previous difference making comparisons among the population described here and elsewhere even harder.

Despite the use of preventive LPLT a high incidence of ulcers was still observed in previous randomized studies\textsuperscript{8,10}. In one study laser illumination continuous with 632.8 nm wavelength, power 25 mW, energy density of 1 J/cm\textsuperscript{2}, from day -1 to +3 was applied\textsuperscript{8}. It should be highlighted that in that study 20 patients served as their own control since the randomization was done between right and left of the buccal mucosa midline. Cowen\textsuperscript{10} applied laser illumination continuous with 632.8 nm wavelength, power 25 mW, energy density of 1.5 J/cm\textsuperscript{2}, from day -5 to -1 to 30 patients. In our trial both a higher energy density (4 J/cm\textsuperscript{2}) and a longer administration (from day -7 until de neutrophil recovery) were applied. In marking contrast to previous data, this strategy showed to be highly effective since 63.2\% of the patients did not present OM, whereas Barasch\textsuperscript{8} and Cowen\textsuperscript{10} report that 100\% of the patients presented OM after HSCT. Further Migliorati\textsuperscript{12} applied laser illumination continuous with 780 nm wavelength, power 60 mW, energy density of 2 J/cm\textsuperscript{2}, from day -5 to + 5 to 11 patients and report that 63.7\% of the patients presented OM Grades 3 and 4 (WHO) and 9\% of the patients presented OM Grade 2 after HSCT and high-dose QT. Our data suggest that both higher laser energy density and length of the application may be pivotal for the outcome of LPLT preventive treatment. In line with that, recent data from a randomized clinical in which 60 children received LPLT (780 nm wavelength, power 60 mW and energy density of 4 J/cm\textsuperscript{2}) for a short period of time (days 1 to 5) showed no difference between LPLT and control groups. It should be highlighted that the groups treated are heterogeneous including both patients treated with both conditioning and conventional chemotherapy regimens\textsuperscript{24}.

Following the same rationale, a higher ED (8J/cm\textsuperscript{2}) was applied with therapeutic intention for patients of the control group who only received LPLT when they achieved OM Grade 4 or 12 cm of ulcerous area. This unprecedented strategy was successful since
patients recovered in 6 days counting from the start of the laser application, whereas in previous report\textsuperscript{8} this recovery took 16 days. Of note, the faster recovery from OM in our study cannot be attributed to neutrophil recover, since the medium score of neutrophils in this group was 94 mm\textsuperscript{3}.

In contrast to the scores selected in previous randomized trials, here both WHO’ scale and OMAS were used. The WHO’s scale was selected due to its easy handling, straightforward applicability and previous validation, while the OMAS was picked because it measures and quantifies both ulcers and erythema. This is an important characteristic because some patients mention difficulty in swallowing due to pain in oropharyngeal even without presenting lesions on the oral cavity, what may mask the evaluation of WHO’s scale or any other scale that mix signs and symptoms. The fact that both WHO’s scale and OMAS showed a strong difference between LPLT and control groups in favor of the experimental arm coupled to the correlation between the two scales strengthen our data. Previous studies\textsuperscript{8,10} did not evaluate the quantity and extension of the areas attacked by ulcers, but in the current study 7 patients from the laser group who presented ulcers had it in smaller proportion than the 17 patients from the control group. This fact confirms the methodological option for the use of OMAS. Theses results support OMAS as an instrument capable to portray the clinic condition of the patient and suggest that WHO and OMAS scale may be complementary in the evaluation of OM. It is worth to point out that none of the previous randomized studies used OMAS. Barach\textsuperscript{8} used the modified Oral Mucositis Index Scale (OMI) and the Eastern Cooperative Oncology Group Oral Toxicity Scale (ECOG) and Cowen\textsuperscript{10} used the scale published from Walsh\textsuperscript{25}.

Although it was expected a delay in the beginning of OM in patients from laser group, it was not observed a significant statistical difference between laser and control group, what deserves further investigation. Further no significant statistical difference was seen between the laser and control group related to the total time with OM. It should be highlighted that control group patients who reached OM Grade 4 or a total area of OM of 12 cm, started to receive the therapeutic laser with 8J/cm\textsuperscript{2} on the ulcerous areas. This crossover may have masked a true difference between the groups. In contrast to our trial Cowen\textsuperscript{10} reported an increase in the time of mucositis Grade 0 and Grade 1 in the patients that received laser (17 days) compared to the control group (14 days). Here the comparison of the whole time of
OM between the groups did not show significant statistical difference, probably due to the above mentioned crossover.

Previous studies using VAS for pain report both a decrease in pain and in the use of morphine in patients receiving preventive laser. In contrast to that, no difference between the two arms was noted in our series. It is important to emphasize that the initial idea was to use this scale to evaluate pain in the oral cavity. However it was observed that the pain started and was predominant in the oropharyngeal triggering the start of narcotics. Since these events preceded the onset of ulcers in the oral cavity, patients were already taking morphine when the oral lesions appeared and this may have been an important bias in the analysis of the VAS. Further it was observed that morphine provides a better pain control for oral cavity than for oropharyngeal lesions. These observations are unprecedented and should be taken into account and confirmed in future studies. Moreover no statistical difference was seen between Grade 3 and Grade 4, what probably reflects both the difficulty in the evaluation of the symptoms (subjective) and the administration of narcotics that masks the pain. This observation shocks the observation mentioned by Sonis.

The presence of OM associated to the infection increases the hospital confinement time of the patient submitted to HSCT in 5 days increasing hospital costs. The negative results of the blood cultures for Streptococcus in 38 patients indicate that the mouth environment adaptation method used was effective. The method adopted objectified supplying an eventual alteration in the quality and quantity of saliva, using a toothpaste with the lactoperoxidase enzime, lysozyme and glucoseoxidase and the lactoferrim protein, bactericides, which in normal conditions are produced by the salivary glands, in association with the solution for mouthfuls containing chlorhexidine 0.12%, without ethanol. This approach is in harmony with Karthaus who reported a positivity of Streptococcus viridans in blood cultures in 70% of the patients with severe OM; with Barker and Meurman, who referred to a possibility of a reduction of the quantity and quality of the saliva. Chlorhexidine (0.12%) has been regarded as a powerful antibacterial.

It should not be neglected that our study was not blinded to one of the evaluators. This may have been balanced by the three additional evaluators who were not aware to which treatment arm the patients had been allocated and mainly by the fact that the method
adopted for evaluator’s calibration proved to be efficient, since there was a concordance of 81.7% among them. Another caveat of the present study is the fact that it does not address if the high efficacy of the strategy adopted was due to the higher energy density, the length of application or the combination of both. In addition, this study did not assess a potential impact of LPLT on GvHD, days on antibiotics, use of total parenteral nutrition, and hospital confinement time. Additional studies with these endpoints as well as quality of life and cost-effectiveness analysis are warranted and should be pursued in future studies with preventive LPLT. Other endpoints that deserve further studies is survival. Although a marginal difference was observed in our study favoring the LPLT, these data should be analyzed with caution since our trial was not powered to detect these differences and confounding factors may be hampering the analyses.

In conclusion, our results indicate that the upfront use of LPLT in HSCT patients is a powerful instrument in reducing the incidence of OM and is now standard in our center.
## Table 1

Conditioning Regimens

<table>
<thead>
<tr>
<th>Conditioning</th>
<th>Dose</th>
<th>Period</th>
<th>Laser Group</th>
<th>Control Group</th>
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<tbody>
<tr>
<td>Cyclophosphamide</td>
<td>1800 mg/m²/day</td>
<td>D -6 and D -3</td>
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<td>Carmustine</td>
<td>450 mg/m²/day</td>
<td>D -2</td>
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<tr>
<td>Ethoposide</td>
<td>2400 mg/m²</td>
<td>D -7 (34 hours)</td>
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<tr>
<td>Cyclophosphamide</td>
<td>60 mg/Kg/day</td>
<td>D -3 and D -2</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>TBI</td>
<td>22 Gy 12/12 hours</td>
<td>D -7 to D -5</td>
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<tr>
<td>Anti-Thymocyte</td>
<td>15 mg/Kg/day</td>
<td>D -5 to D -4</td>
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<td>Globuline</td>
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<td></td>
</tr>
<tr>
<td>Cyclophosphamide</td>
<td>60 mg/Kg/day</td>
<td>D -3 and D -2</td>
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<tr>
<td>Bussulfan</td>
<td>4 mg/Kg/Day</td>
<td>D -7 to D -4</td>
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TBI- total body irradiation
Table 2

Patients characteristics

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<td>Related Allogeneic with TBI</td>
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<tr>
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<tr>
<td>Autologous</td>
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<tr>
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<tr>
<td>Acute lymphoblastic leukemia</td>
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<tr>
<td>Myelodisplasic Syndrome</td>
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</table>

TBI- total body irradiation
Figure 1

Mucositis incidence / WHO

WHO SCALE

p<0.001
Figure 2

Kaplan – Meier mucositis free- survival
Figure 3

Kaplan-Meier mucositis free- survival(Grade 3- 4)
Figure 4

**Mucositis incidence / OMAS**

p = 0.007

(WA = 2.5 x [(Σui : 3 x Nu) + (Σei : 2 x Ne)], in which Σui = sum of the ulcerous area, Nu = number of ulcerous areas, Σei = sum of erythema’s intensity and Ne = number of areas with erythema’s.)
Figure 5
Ulcerous area extension

Ulcerous area extension / OMAS

P = 0.003
References


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