from 50 mg every 3 days to 100 mg daily. A complete remission (CR) rate of 56% was noted in this cohort, with CR defined as complete clearing of mucosal disease within 1 month of treatment onset and maintenance of this CR during the second month of treatment. All patients underwent a baseline sensory nerve action potential test before initiating thalidomide. Five of 16 patients subjectively reported transient peripheral neuropathy. There was objective evidence of mild length-dependent axonal sensory neuropathy in 2 of 16 patients, with treatment cessation occurring in an isolated case due to persistent neuropathy.

Conclusions: Within this cohort, thalidomide demonstrated a favorable efficacy/safety ratio with long-term use. It remains a viable treatment option for cases of refractory oral ulceration. Given the history of adverse effects associated with thalidomide, informed consent with regard to embryofetal toxicity and contraceptive counseling are pivotal to safe prescribing. Counseling with respect to other common adverse effects, including peripheral neuropathy and venous and arterial thromboembolism, is mandatory, and these adverse effects need to be understood.

XEROSTOMIA SYMPTOMS AND TREATMENT STRATEGIES ASSOCIATED WITH SALIVARY FLOWS

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Objectives: We sought to analyze the types and quantity of dry mouth products patients use as well as the reported dry mouth symptom severity and frequency in relation to salivary flows. We hypothesized that respondents with higher stimulated flow would report better responses to products that stimulate flow.

Methods: Patients with complaints of dry mouth who had documented unstimulated and stimulated whole salivary flows (UWS and SWS, respectively) completed a questionnaire to assess dry mouth products used, current symptoms, and response to therapy. Statistical analyses included descriptive analyses and associations between dichotomized (low/normal) salivary flow levels, and symptom severity was assessed using nonparametric Wilcoxon rank-sum tests.

Results: Eighty-seven patients completed the questionnaire; 38 patients had a diagnosis of Sjögren syndrome. More than half of patients (55%; n = 48) reported using 4 or more dry mouth products. The most common product used was water (n = 78), followed by rinses (n = 54) and lozenges (n = 48). Twenty-five patients (29%) reported use of parasympathomimetics. More than half (56%) of patients using parasympathomimetics reported that their mouth felt "much better" compared with less than one-third of patients using other methods: water (29%), gum (23%), lozenges (27%), candies (4%), rinse (26%), spray (24%), or gel (20%). Among parasympathomimetic users with normal SWS, 71% reported their mouth felt "much better" compared with 36% of those with low SWS. For water, gum, lozenges, candies, and sprays, greater than 50% of respondents reported improvement lasting less than 1 hour. Regarding rinses, gels, and parasympathomimetics, greater than 50% of respondents reported improvement lasting greater than or equal to 1 hour. The dichotomized level of UWS rate was not associated with any measures of symptom severity, whereas the low SWS rate was associated with the following measures: dryness of the mouth ($P = .004$), difficulty speaking due to dryness ($P = .03$), and difficulty swallowing due to dryness ($P = .004$).

Conclusions: Different treatment categories for dry mouth symptoms provided varying degrees of relief. Patients with normal vs low stimulated flow who used parasympathomimetics reported the greatest treatment response and longest relief of dry mouth symptoms. Assessment of salivary flow levels may be a useful guide for more targeted recommendations of dry mouth products.

COMPARISON OF THE IMMUNOLOGIC RESPONSE TO HERPES SIMPLEX VIRUS TYPE 1 ENTRY GLYCOPROTEINS INDUCED IN HUMANS AFTER PRIMARY INFECTION OF ORAL OR GENITAL SITES

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Objectives: We sought to determine potential differences in the humoral immune response to herpes simplex virus type 1 (HSV-1) in patients after primary infection in either oral or genital sites.

Methods: Serum samples from 20 patients with primary HSV-1 infection (10 oral, 10 genital) were compared. A neutralization assay categorized samples by their ability to inhibit virus entry into cells. An enzyme-linked immunosorbent assay determined the quantity of antibodies against each of the major HSV-1 glycoproteins (gD, gB, gC, gH/gL). Surface plasmon resonance imaging (SPRi) was used to estimate the quality of the response by determining the epitope specificity of antibodies against the receptor-binding glycoprotein gD. Information from these assays was combined to develop a comprehensive profile of immunologic response to HSV-1 infection.

Results: All 10 oral site serum samples contained significant levels of virus-specific antibodies to block virus entry and demonstrated excellent immune response to the major virion glycoproteins. In contrast, only 4 of the 10 genital site serum samples were able to block virus entry. The 6 genital site sera that failed to block entry had markedly reduced antiglycoprotein antibody levels, indicating a poor overall HSV-1 immunologic response. The quantity of antiglycoprotein antibodies in the 4 genital (protective) sera mirrored that induced by oral infection. Subsequently, SPRi was used to determine whether the qualitative response was equivalent between the oral and genital site sera. All 10 oral site sera targeted gD epitopes at levels significantly higher and more varied than those generated for the 4 protective genital site samples. Interestingly, the gD epitope profiles of the 6 nonprotective genital site samples were directed at a single non-neutralizing antigenic site on gD that is involved in cell-to-cell spread.

Conclusions: Based on a comprehensive profile of immunologic response to HSV-1 infection for individuals