Opinion
Volume 9:7, 2022

Journal of Dermatology and Dermatologic Diseases

ISSN: 2684-4281 Open Access

Differential Cheilitis Diagnosis: How to Classify it?

Eleni Georgakopoulou*

Department of Histology and Embryology, Athens School of Medicine, NKUA, Athens, Greece

Introduction

Although the term "cheilitis" to describe inflammation of the lips has been around for a long time, there haven't been any clear guidelines for how to diagnose or classify it. Local infections (such as herpes and oral candidiasis) or systemic diseases such as anemia caused by vitamin B12 deficiency or iron deficiency may accompany the disease. Cheilitis can also be a sign of an allergic or irritating reaction to contact, or it can be caused by sun exposure (actinic cheilitis) or taking drugs, especially retinoids. Angular, contact (allergic and irritant), actinic, glandular, granulomatous, exfoliative and plasma cell cheilitis are typically the forms that have been reported in the literature the most. However, subtypes are grouped and referred to in a variety of ways and variable nomenclature is utilized. As per our experience and clinical practice, we propose arrangement in view of essential contrasts in the span and etiology of individual gatherings of cheilitis) predominantly reversible (simplex, precise/infective, contact/eczematous, exfoliative, drug-related);)primarily irreversible (plasma cell, actinic granuloma, glandular); and) cheilitis associated with skin conditions and systemic illnesses like lupus, lichen planus, pemphigus/pemphigoid group, angioedema, xerostomia and others [1].

Description

Atopic cheilitis, contact allergy and actinic cheilitis were among the differential diagnoses based on clinical features and history Granulomatous cheilitis was also considered in two cases. All of the patients had previously seen a dermatologist and all of them had a history of inflammatory dermal disease All of the referring dermatologists were aware that the condition on the lips was probably "lip dermatitis, " which is part of the atopic skin tendency. Six patients received corticosteroids and one received pimecrolimus, both of which were applied topically, but their lip lesions persisted. A second opinion regarding diagnosis and treatment was provided by an oral medicine specialist to the patients [2,3].

The majority of cases were diagnosed based on their medical history and findings. A lip biopsy from the border of the lip vermilion and the mucosa was performed with the consent of one patient. Due to his severe and persistent lip swelling, it was necessary to rule out cheilitis granulomatosa in this instance. Atopic cheilitis was confirmed by the histology results All patients received topical tacrolimus ointment containing 0. 03% twice daily for two weeks They were told not to go outside in the sun, especially right after applying the ointment After 15 days, the dosage was reduced to once daily. They were told to apply a small amount of the ointment to the affected lip vermilion and perioral skin. Two patients used a galenic preparation of tacrolimus 0. 03% in oral gel (FAGRON HELLAS), while the majority of patients used commercially available tacrolimus 0. 03 percent ointment. Every one of the patients recuperated a typical lip appearance after the treatment (demonstrative clinical pictures. In support of the atopic nature of the lesions, a response to treatment was also used as a diagnostic criterion. Patients' attributes are summed up [4,5].

Angulus infectiosus is another name for angular cheilitis, which can also be referred to as perleche, cheilosis, angular stomatitis, or angular cheilitis. Patients who are prone to licking the corners of their lips and have deep wrinkles in their lip angles are more likely to develop the disease. For the most part, the sickness begins during nutrient and mineral insufficiencies (B nutrients, iron, zinc and so on.), or is brought on by other conditions and diseases (such as drooling and poorly fitting dentures, celiac disease, etc.). The disease is also influenced by saliva production, which includes increased secretion and drooling. Dryness, on the other hand, encourages cracking, desquamation and the invasion of Candida albicans with the onset of angular cheilitis inflammation during hyposalivation, or decreased salivary secretion Angular cheilitis is more common in diabetics, people with some psychiatric disorders (like lip trauma in bulimics or anorexics), people taking certain drugs (like isotretinoin) and people with primary hypervitaminosis A It is also more common in the elderly and during the winter, when more lip licking makes the condition worse. Patients with inflammatory bowel diseases like Crohn's disease and ulcerative colitis may experience it.

Conclusion

A group of symptoms, such as atrophic glossitis, esophageal webs or strictures and microcytic hypochromic anemia (Plummer-Vinson syndrome), may occasionally include this subtype. Primary and secondary bacterial or candidal infections frequently occur together. Secondary bacterial infections (staphylococcal and beta-hemolytic streptococcal) on damaged lip corners most frequently affect children, particularly those with atopic dermatitis. Patients with macroglossia (congenital hypothyroidism and Down syndrome) frequently also experience angular cheilitis with secondary infections

References

1. Critchlow, William Austin and David Chang. "Cheilitis granulomatosa: A review." *Head Neck Pathol* 8 (2014): 209-213.
2. Sarkar, Somenath, Sarmistha Ghosh and Dipayan Sengupta."Clinically granulomatous cheilitis with plasma cells. " *Indian Dermatol Online J* 7 (2016): 96.
3. Banks, T. and S. Gada."A comprehensive review of current treatments for granulomatous cheilitis. " *Br J Dermatol* 166 (2012): 934-937.
4. Friedrich, Reinhard E. and Thomas Löning."Cheilitis glandularis: Case report with respect to immunohistochemical findings. " *Am J Dermt* 5 (2016).
5. Yamaguchi, Yasuyuki, Wataru Nishie, Takamasa Ito and Hiroshi Shimizu, et al. "Plasma cell cheilitis successfully treated with topical calcineurin inhibitors." *Euro J Dermt* 26 (2016): 609-610.

***Address for Correspondence:** Eleni Georgakopoulou, Department of Histology and Embryology, Athens School of Medicine, NKUA, Athens, Greece; E-mail: elenigeo@yahoo. gr*

Date of submission: 30 June, 2022, Manuscript No JPD-22-80938; **Editor Assigned:** 01 July, 2022, PreQC No P-80938; Reviewed: 15 July, 2022, QC No Q-80938; **Revised:** 20 July, 2022, Manuscript No R-80938; **Published:** 27 July, 2022, DOI: 10.37421/2684-4281.2022.9.356

How to cite this article: Georgakopoulou, Eleni. "Differential Cheilitis Diagnosis: How to Classify It?." J Dermatol Dis 9 (2022): 356.