

## SKIN FOCUS

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### PERIORAL ECZEMA AND PERIORAL DERMATITIS

#### *Perioral eczema*

Perioral eczema should be differentiated from perioral dermatitis because it is a scaly eczematous rash that affects children mainly. On the other hand perioral dermatitis presents as an acneform eruption in young adult females.

Perioral eczema is common in atopsics, but can also occur in young children with no known atopic history. The lips and perioral area often become dry, fissured, crusted and secondarily infected (Figs. 1 & 2). Aggravating factors include habits of lip-licking, thumb sucking and dribbling. Saliva often becomes trapped between the thumb and the mouth of thumb suckers. Saliva is an irritant, associated with drooling from teething. In infants, perioral erythema can occur from contact dermatitis due to citrus foods. Perioral eczema can easily be transformed into perioral dermatitis by the application of potent topical steroids. In adults, perioral eczema may also be related to the habit of lip licking. In addition, patients on oral retinoids (vitamin A analogues) (Fig. 3) including isotretinoin and acitretin present with cheilitis and perioral eczema in 90% of patients. In these patients the cheilitis is often secondarily infected with *Staphylococcus aureus* and this responds well to topical treatment with fucidic acid (Fucidin) or mupirocin (Bactroban).



*Fig. 1. The dry cracked appearance of the lips with crusting is due to repeated lip sucking and low humidity.*

The management of perioral eczema is to avoid the trigger factors and use emollients as well as a lip balm. If perioral eczema is severe, dilute topical steroids including 1% hydrocortisone may be used for a short period. This must not be continued long term because of the possibility of perioral dermatitis erupting. Pimecrolimus cream, a non-steroidal topical immune



*Fig. 2. Perioral eczema with associated xeroses and lichenification.*



*Fig. 3. Cheilitis characterised by dry lips and fissuring in a patient on retinoids (isotretinoin).*

modulator has been found to be quite effective for perioral eczema. It has the advantage of not causing telangiectasia, atrophy or acneform eruption.

#### *Perioral dermatitis*

Perioral dermatitis is a common acneform condition affecting mainly young adult females. It presents as erythematous papules and papular pustules around the mouth on a background of erythematous scaling (Fig. 4). There is sparing of the lip margins. Symptoms include pruritus and burning. Although the aetiology of perioral dermatitis is not known, the use of potent topical steroids may be an important factor. Also contact sensitivity to toothpaste containing fluoride has been postulated as a contributory factor.

The differential diagnosis of perioral dermatitis includes:

- Rosacea – flushing is present in rosacea.
- The lesions of acne vulgaris include comedones and this is not present in perioral dermatitis.
- In seborrhoeic dermatitis the scaling also involves the perinasal region, the eyebrow, ear and scalp.
- Allergic contact dermatitis can be distinguished by patch testing.



Fig. 4. Irritant contact dermatitis involving the perioral region as well.



Fig. 7. Molluscum contagiosum in the perioral region (lips).



Fig. 5. Herpes simplex virus infection – grouped blisters on an erythematous background presenting as erosive.



Fig. 8. Underlying perioral eczema with superimposed fungal infection – tinea. There is also post-inflammatory hypopigmentation.



Fig. 6. Herpes simplex virus infection – superimposed on eczema in an atopic patient – eczema herpeticum lesions.



Fig. 9. Angular cheilitis.

The treatment options of perioral dermatitis include the use of topical antibiotics (erythromycin and sulphur-based creams), metronidazole gel and in more severe cases oral antibiotics including tetracycline, doxycycline, minocycline and erythromycin. If perioral dermatitis is due to the use of potent topical steroids, patients should be warned of an initial flare-up upon discontinuation of the steroid.

Finally, I have included photographs of other types of lesions which may involve the perioral region. These include viral infections like herpes simplex type 1 (Fig. 5), herpes simplex superimposed on eczema (Fig. 6), and molluscum contagiosum (Fig. 7). Dermatophyte infection may be superimposed on underlying perioral eczema leading to tinea incognito (Fig. 8). Therefore microscopy with K-OH for fungal hyphae needs to be done (and/or fungal culture). If fungal infection is confirmed, it needs to be treated with antifungal agents. *Candida albicans* can also complicate perioral eczema.

In angular cheilitis (Fig. 9) saliva streams into skinfolds of the elderly, and repeated wetting-drying cycles chap and inflame the skinfold. This may be secondarily infected with *Candida albicans*.

#### Declaration of conflict of interest

The author declares no conflict of interest.

#### ACKNOWLEDGEMENT AND FURTHER READING

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