

Angular Cheilitis (Perleche)

Angular cheilitis, also known as perleche, is a common inflammatory condition that affects the corners of the mouth, characterized by erythema, fissuring, scaling, and maceration of the skin. The pathogenesis of angular cheilitis is largely associated with the accumulation of saliva at the labial commissures (the angles of the mouth), which is facilitated by anatomical changes such as redundant skin folds or sagging skin at the perioral region. This trapped moisture creates an ideal environment for the development of irritation and microbial growth. The repeated moistening of the affected area in an attempt to alleviate irritation often exacerbates the condition, promoting the growth of pathogens such as *Candida albicans* and *Staphylococcus aureus*. As the lesion progresses, patients often present with symptoms of erythema, scaling, maceration, and fissuring in the affected regions.

Background

Angular cheilitis can occur across all age groups, from infants to the elderly, and is a frequent concern in dermatology clinics. The incidence and severity of this condition may vary depending on various predisposing factors, such as poor-fitting dentures, malocclusion of teeth, and significant weight loss, which can cause sagging perioral skin and exacerbate the trapping of moisture. Behavioral factors such as repeated lip-smacking or thumb-sucking can also contribute to the accumulation of saliva in the oral commissures. Additionally, nutritional deficiencies, particularly B vitamin deficiencies, have been identified as risk factors for angular cheilitis. Immunosuppressed individuals, including those with diabetes mellitus, inflammatory bowel disease, or those undergoing immunosuppressive therapies, may also be at greater risk for developing this condition.

Diagnosis and Management

Diagnosis of angular cheilitis is primarily clinical, based on the characteristic appearance of the lesions, and no specific laboratory tests are required unless a secondary infection is suspected. The differentiation of microbial etiology may be achieved through culture swabs if necessary, particularly when *Candida* species or bacterial infections are suspected.

Management of angular cheilitis focuses on controlling the moisture at the commissures and addressing the underlying inflammatory processes. Treatment typically includes the application of topical antifungal agents, such as clotrimazole or nystatin, especially when a fungal infection is suspected. If secondary bacterial infection is evident, mupirocin ointment may be used to target *Staphylococcus aureus*. In some cases, topical corticosteroids may be prescribed to reduce inflammation, but these should be used with caution to avoid exacerbating fungal growth.

Maintaining dryness is crucial, and patients are advised to apply a protective lip balm frequently to prevent further irritation. If nutritional deficiencies are identified, they should be promptly addressed with appropriate supplementation. For patients with significant anatomical defects contributing to the condition, cosmetic fillers may be considered to improve the shape of the lateral lips, reducing the tendency for saliva accumulation.

Conclusion

In summary, angular cheilitis is a multifactorial condition that involves both local irritation and secondary infection. Early recognition and appropriate management of the underlying factors, including moisture control and treatment of infections, are essential for effective resolution of the condition.

References

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