THE EDITOR'S CORNER

We'll Always Have Perlèche

Perlèche is a skin condition characterized by painful sores at the labial commissures or corners of the mouth. It was first described in 1855 by the French physician Lemaistre, who named it after the word *pourlècher* (to lick one's lip). Today, perlèche is better known as angular cheilitis. Orthodontists should familiarize themselves with this oral condition, because it occurs frequently in adolescent and young-adult patients.

The signs and symptoms of angular cheilitis are straightforward. The sores usually appear bilateral and symmetrical. They may crust, crack, blister, or bleed, and they feel worse when opening the mouth. The skin around the vermillion border might redden or darken. Common risk factors include Crohn's disease, diabetes, and low levels of B vitamins. Because of its location, angular cheilitis is sometimes mistaken for cold sores, which are a different condition caused by the herpes virus.

Angular cheilitis is actually created by salivary pooling. Essentially, saliva collects in the labial commissures and dries, causing the tissue to crack. This cracking, in turn, causes the patient to lick the lips and exacerbate the condition. The macerated tissue stays moist, making it a fertile place for yeast and bacteria. *Candida albicans* is the primary invading pathogen—found in more than 90% of the cases of angular cheilitis—followed by *Staphylococcus aureus*.

Orthodontic patients are at a much higher risk of developing angular cheilitis because their appliances promote salivation and thus change the commensal oral microbiota, including an increased colonization of *Candida albicans*. In my office, I frequently see angular cheilitis immediately after delivering a Forsus appliance or Class III elastics, but I have also seen it with clear aligners. The patient often returns a few days later complaining of painful lip sores.

There are a variety of medications for treating angular cheilitis, but the most common options involve a combination of topical antifungal and corticosteroid, along with an over-the-counter, unflavored petroleum-based ointment to be used between applications of the medicine. The antifungal agent treats the Candida, while the corticosteroid reduces the inflammation. The petroleum-based ointment soothes the sores and forms a barrier to protect the skin from saliva.

Personally, I like to prescribe Nystatin and Triamcinolone Acetonide cream and over-the-counter Aquaphor ointment. My typical prescription is: "Rx: Nystatin Triamcinolone Acetonide cream. Quantity: 30g tube. Sig: Apply to the affected areas of the skin twice a day." The medicine should be discontinued after two weeks. In a pinch, any over-the-counter antifungal cream, such as Lotrimin (clotrimazole), Lamisil (terbinafine), or Monistat (miconazole), will work fine, and Vaseline can be substituted for Aquaphor.

Even with diligent application of the medicine, the angular cheilitis may not resolve until the orthodontic appliance is removed. After the symptoms subside, in about two weeks, a modified version of the appliance can be reinstalled. For example, if a Forsus appliance is the irritant, I will place extra short push-rods and crimp them between the lower premolars, or just switch to Class II elastics.

Lemaistre believed that perlèche was contagious, which it is not, but the condition can easily come back if not treated properly. If you detect it, try Nystatin and Triamcinolone Acetonide cream with Aquaphor ointment, and let me know how that works. You may still need to remove the irritating orthodontic appliance. The French have a friendly saying, *"à tout de suite,"* which means "see you very soon." When dealing with angular cheilitis, I much prefer the more definitive *"au revoir"!*

NDK