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Case Report

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Pediatric Case of Miescher's Cheilitis Treated with Clarithromycin

S Boujloud*, FZ El Fatoiki, F Hali and S Chiheb

Dermatology and Venereology Department, Chu IBN ROCHD Casablanca

***Corresponding Author**
S Boujloud, Dermatology and Venereology Department, Chu IBN ROCHD Casablanca.

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Melkersson-Rosenthal syndrome is a rare condition classically characterized by orofacial edema, furrowed tongue, and peripheral facial paralysis. Miescher's cheilitis or granulomatous macrocheilitis represents the monosymptomatic form of this syndrome. It is rare in childhood, more common in young adults, and its etiopathogenesis remains poorly understood. We report a pediatric case of monosymptomatic granulomatous cheilitis treated with clarithromycin.

A 7-year-old patient with no significant medical history, particularly no history of atopy, presented with macrocheilitis evolving for 3 months (Figure 1). History and clinical examination revealed no cough or exertional dyspnea, no abdominal pain or diarrhea. A lip biopsy was performed, concluding with a diagnosis of Miescher's granulomatous cheilitis. Infectious cause, sarcoidosis, and Crohn's disease were ruled out before confirming the diagnosis. The patient was treated with clarithromycin 15mg/kg/day in two divided doses for 10 days per month, with partial improvement noted after 2 months of follow-up (Figure 2). The treatment will be continued for other 4 months with regular check-ups.

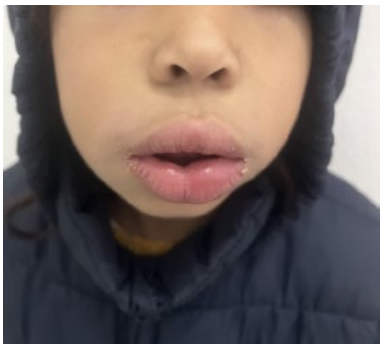

Figure 1: A 7-Year-Old Patient with Macrocheilitis

Figure 2: Evolution After 2 Months, Treated with Clarithromycin

Granulomatous cheilitis was first reported by Miescher in 1945. It can be isolated or associated with orofacial edema, furrowed tongue, and facial paralysis, constituting Melkersson-Rosenthal syndrome. The etiopathogenesis of this condition is still poorly understood, but several observations suggest an immunological origin. Other suggestions include infection, genetic predisposition, and allergies [1].

Miescher's cheilitis is rare in childhood, more common in young adults. Clinically, it presents as lip swelling, evolving in flares, often asymmetrically affecting the lips. The swelling is soft to firm in consistency and elastic, sometimes associated with erythema and tend to become persistent over time. In some cases, the swelling may extend to the chin, cheeks, periorbital region, and eyelids. Intraorally it may cause gingival hypertrophy and erosions. The tongue may develop fissures, erosions, edema, paresthesia or taste alterations [2,3].

Dermoscopy of various granulomatous diseases is characterised by a common feature of diffuse or localised yellow-orange areas and their disappearance indicates a good treatment response [4]. Histopathology can reveal epithelioid and giant-cell granulomas, without central caseous necrosis. Witch can also be found in sarcoidosis and Crohn's disease.

The treatment of Miescher's granulomatous cheilitis is challenging [5]. Proposed treatments that have shown promise principally consist of agents with anti inflammatory activity such as oral corticosteroids at a dosage of 0.1 to 1mg/kg, and intralesional corticosteroid injections. However, relapses are common, with the use of corticosteroids, and long-term treatment may be required. Other therapies have been used, including clofazimine, colchicine, doxycycline, minocycline, hydroxychloroquine, metronidazole, dapsone, and macrolides. Cheiloplasty is reserved for resistant or complicated cases with a major lip deformation.

It is important to note that recurrences are common even with combined treatment. Clinical monitoring is therefore necessary as macro cheilitis can precede Crohn's disease digestive manifestations by several years.

Granulomatous cheilitis is a rare condition. Its diagnosis requires lip biopsy revealing the presence of epithelioid histiocytic granulomas with angiotropism. The treatment remains challenging and requires individualized adaptation for each case. Clarithromycin seems to be an effective remedy for successful response in granulomatous cheilitis, especially in children. Although randomized controlled studies are still needed to establish a universally accepted protocol for the management of cheilitis granulomatosa.

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