Perioral Lesions and Dermatoses

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KEYWORDS

• Perioral • Seborrheic keratosis • Warts • Actinic keratoses • Actinic cheilitis • Squamous cell carcinoma • Basal cell carcinoma • Perioral dermatitis

KEY POINTS

- Neoplasms, infections, and inflammatory dermatoses may present around or near the mouth.
- Dental professionals are well positioned to evaluate perioral skin conditions.
- Early recognition and treatment of perioral lesions and dermatoses provide best clinical outcomes.

INTRODUCTION

The purpose of this article is to review the common neoplasms, infections, and inflammatory dermatoses that may present around or near the mouth. Dental professionals are well positioned to evaluate perioral skin conditions, further contributing to patients' general health. This article includes a review of seborrheic keratosis, warts, actinic keratoses, actinic cheilitis, and squamous cell carcinoma, among several other perioral cutaneous lesions.

SEBORRHEIC KERATOSIS

Introduction

Seborrheic keratoses are very common and usually multiple, presenting as oval, slightly raised, tan or light brown to black, sharply demarcated papules or plaques that usually measure less than 3 cm in diameter.[1]

Cause

The pathogenesis of seborrheic keratosis is unknown. In about one-third or more of cases, mutations in FGFR3 and PI3K have been implicated.[2] Advanced age is a

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well-established risk factor, although the relationship between seborrheic keratosis and sun exposure has been debated.[3–6]

Epidemiology

The age of onset usually falls within the fourth to fifth decade,[3] and males and females are equally affected.[7]

Prognosis

These lesions are benign with no risk of malignant transformation.

Clinical Features

Seborrheic keratoses have a characteristic stuck-on appearance and are often described as waxy and smooth. When removed, the underside of the warty lesions reveals a raw, moist base. Although most are asymptomatic, some lesions cause itching, bleeding, or pain. The chest and back tend to be the primary sites affected; but seborrheic keratosis commonly involves the scalp, face, neck, and extremities.[3,7] Some patients, particularly Caucasians, may have hundreds of these lesions on the trunk.[7] A variant of the central face, known as *dermatosis papulosa nigra*, is common in African Americans and Asians.[7,8]

Because of its classic appearance, the diagnosis of seborrheic keratosis is primarily clinically based. Although the histology does vary, seborrheic keratoses universally show a proliferative process, with hyperkeratosis and acanthosis without dysplasia.[4] Biopsy is rarely indicated unless lesions are difficult to distinguish from melanoma.[4,7] Clinicians should also be aware that the sudden onset of multiple seborrheic keratoses has been thought to represent a paraneoplastic syndrome from an occult malignancy, such as stomach or colon cancer.[9–11] However, this phenomenon, known as the *sign of Leser-Trélat*, has recently been questioned.[12]

Management

As a benign lesion, seborrheic keratosis may be treated electively. The primary indication for surgical removal is cosmetic, though chronic bleeding, irritation, and blistering may warrant treatment. Removal is also considered when the diagnosis is unclear. Shave excision, electrodessication and curettage, and cryotherapy are common surgical options but may be associated with recurrence, scarring, and changes in pigmentation.[4] Consequently, the use of lasers (erbium YAG, carbon dioxide [CO_2], and 532 diode) has become more popular.[13] Medical therapies, such as topical and systemic vitamin D, have shown limited efficacy.[4]

WARTS

Introduction

Warts (verrucae) are caused by human papillomaviruses (HPVs), small DNA viruses of the papovavirus family, with more than 100 different HPV types being described.[14] Cutaneous lesions often present as small papules, single or multiple, throughout all age groups.

Cause

HPVs are classified according to mucosal and cutaneous types caused by HPV 1, 2, and 4.[14,15] Planar or flat warts on the face are caused by HPV-3 and 10.[14,15] Mucosal types are divided into low risk and high risk. Low risk (HPV-6, 11) is defined by never being found in invasive squamous cell carcinomas (SCC), whereas high-risk types, such as HPV-16, 18, and others, are prevalent in this instance.[14–16]