

WAYS TO IMPROVE DIAGNOSIS, TREATMENT AND PREVENTION OF DISEASES OF CHILDREN WITH ATOPIC CHEILITIS

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Many dentists have difficulty making a diagnosis and choosing a treatment method for people with atopic cheilitis . Clinical picture of atopic Cheilitis is characterized by the involvement of the red border of the lips in the pathological process and damage to the skin of the perioral part of the lips, most intense in the area of the corners of the mouth, which manifests itself in the form of its infiltration and lichenification . In this article we talked about the diagnosis, treatment and prevention of atopic cheilitis .

Keywords: atopic cheilitis , skin lesions, dentist, immunity, allergies, treatment.

This article is devoted to an urgent problem - the diagnosis and treatment of atopic dermatitis in dental practice. Unfortunately, for dentists this topic seems quite complicated and often doubting the correct diagnosis, they refer patients to other specialists (allergists . dermatovenerologists) . In many countries around the world, there is a tendency to increase the frequency of allergic diseases, the skin manifestations of which are most often represented by atopic dermatitis. The prevalence of atopic dermatitis among children is up to 20%, among adults - 2-8% [5]. The role of allergies to house dust mites, Staphylococcus aureus enterotoxins , mold fungi, as well as IgE autoreactivity in the mechanisms of disease development is considered to be proven [15]. Genetic factors for the development of atopic dermatitis include the presence of a filaggrin gene mutation in dysfunction of the epidermal barrier in atopic dermatitis, as well as a family history of allergic diseases [8, 13, 16]. Patients with atopic dermatitis have elevated levels of total IgE , the concentration of which correlates with the severity of the disease [17,19].

In 1980, JM Hanifin and G. Rajka proposed major and minor diagnostic criteria for atopic dermatitis; cheilitis , an inflammation of the skin of the lips or their red border , was proposed as one of these criteria [12]. Atopic cheilitis -x chronic disease of an allergic nature, which can occur independently or accompany the general picture of atopic dermatitis - a chronic lichenifying inflammation of the skin that occurs as a result of an allergic reaction, which is triggered by both atopic and non-atopic [1,4]. Clinical picture of atopic cheilitis is characterized by the involvement of the red border of the lips in the pathological process and the inevitable damage to the skin of the perioral

part of the lips, most intense in the area of the corners of the mouth, which manifests itself in the form of its infiltration and lichenification with impaired lip closure [4, 6].

A number of authors note that local factors influencing the course of atopic cheilitis, refers to maceration of the corners of the mouth with saliva due to improper closing of the lips and contact with toothpaste and medications can cause allergic reactions in this category of patients [11, 14]. The dentist should consider the symptoms of atopic cheilitis, perioral dermatitis, fissures of the oral commissures in children, as possible manifestations of the allergic process. It is necessary to recommend that parents contact a pediatrician and allergist for examination of the child [4].

Some authors point out the need for differential diagnosis of atopic cheilitis with contact allergic, actinic, eczematous cheilitis, cheilitis in Crohn's disease and ulcerative colitis, collagenosis, iron deficiency anemia, exudative erythema multiforme, diabetes mellitus, HIV infection and Down syndrome [6,7,9,10, 18].

Algorithm for diagnosing atopic cheilitis includes microbiological examination, blood tests, and determination of blood glucose levels [2, 9]. Atopic cheilitis occurs in the autumn-winter period, remission occurs in the summer. By the end of puberty, most patients undergo self-healing, however, in the future they may experience relapses of the disease. A number of authors indicate that the duration of remission of an isolated form of atopic cheilitis averaged 4-6 months, and remission of atopic cheilitis against the background of atopic dermatitis is only 2-3 months [4].

Three fundamental positions are the main ones, according to I.K. Lutskey et al. (2012), in the treatment of atopic dermatitis: elimination of causative factors causing exacerbation (allergenic and non-allergenic triggers), therapeutic and cosmetic skin care, external anti-inflammatory therapy. Substances that can cause sensitization of the body should be excluded from the diet [2]. A number of authors indicate that for the treatment of atopic cheilitis, the following groups of drugs should be used:

- 1) antihistamines
- 2) glucocorticosteroids, mainly topical
- 3) topical use of tacrolimus and pimecrolimus
- 4) topical keratoplasty and regenerative agents
- 5) topical immunomodulatory therapy
- 6) antibacterial or antifungal drugs, mainly topical [1,4,5].

Due to the fact that atopic cheilitis is often combined with bronchial asthma, allergic rhinitis, drug and food allergies, general treatment of atopic cheilitis, according to I.K. Lutskey et al. (2012), requires the appointment of hyposensitizing therapy, in particular the use of antihistamines [6]. For 2 - 3 weeks, the patient must be on a strict diet with the exclusion of all foods that can cause an allergic reaction. Against the background of diet therapy, vitamins and antihistamines are prescribed

orally. With persistent atopic cheilitis for 2 - 3 weeks, the dermatologist prescribes corticosteroids by mouth: prednisolone (children 8-14 years old 10-15 mg/ day , adults 15-20 mg/ day) or dexamethasone , which is more effective. Corticosteroid ointments are used locally; spicy, salty, spicy foods should be excluded from the diet, and the amount of carbohydrates should be sharply limited.

According to V.M. Elizarova and V.V. Repina (2013) an integral part of the complex treatment of atopic cheilitis is an external therapy that had not only a local, but also a general effect on the body through the neuroreceptor apparatus as a result of skin absorption, which led to the disappearance or reduction of skin rashes and subjective sensations such as itching, pain, burning, which had a beneficial effect on general and psycho-emotional condition of patients [4]. Externally on the lips of persons suffering from atopic cheilitis , the authors prescribed the following ointments: 0.05% Alclomethasone and 0.1 % methylprednisolone aceponate ; For dry facial skin , 1% pimecrolimus cream was used . The drugs were applied in a thin layer to the affected surface 2 times a day and gently rubbed until completely absorbed, ointments were used until the symptoms completely disappeared. In persons with atopic cheilitis with the addition of streptostaphylococcal infection, crusts, scales and dry red lips were softened using proteolytic enzymes. To do this, a gauze pad moistened with a 0.1% solution of trypsin or chymotrypsin was applied to the red border of the lips and the skin of the perioral area. Enzyme exposure was 10-15 minutes, ointments were prescribed : 0.05% Alclomethasone and 2 % fusidic acid in equal parts, the drugs were applied to the affected areas of the skin 3 times a day for 10 days. A good effect from treatment with external therapy was achieved by 62 (62%) patients, a satisfactory effect by 31 (31%), and no effect was observed in 7 (7%) children [4].

Many authors point out the need for differential diagnosis of atopic cheilitis with contact allergic, actinic, eczematous cheilitis , cheilitis in Crohn's disease and ulcerative colitis, collagenosis, erythema multiforme , iron deficiency anemia, HIV infection and Down syndrome, diabetes mellitus [18]. Patients are advised to undergo a thorough microbiological examination, blood tests, and determination of blood glucose levels [4, 11]. The cellular profile of the inflammatory infiltrate of smear-imprints of the mucous membrane of the red border of the lips is characterized by the dominance in the cellular composition of plasma cells, which are a marker sign of the generalization of the process, which is based on the immune mechanism of development, which is atopic dermatitis [1]. In patients with atopic With cheilitis, a violation of systemic immunity is manifested by dysglobulinemia , a decrease in the concentration of IgA and IgM and an increase in the concentration of IgE , as well as changes in cellular immunity (changes in the ratio of cellular fractions, especially lymphocytes) [3]. Atopic cheilitis occurs in the autumn-winter period, remission occurs in the summer. By the end of puberty, most patients undergo self-healing,

however, in the future they may experience relapses of the disease. Hereditary burden of atopy was identified in 79% of children with atopic cheilitis [2]. L.N. Drobotko et al. (2013) note that the combination of atopic cheilitis with allergic diseases of the eyes, nose, upper and lower respiratory tract was observed in 73% of children. All those examined had clear manifestations of atopic cheilitis: swelling of the skin around the mouth; infiltration and peeling of the red border of the lips; lichenification, radial striations, peeling, papular rashes in the corners of the mouth. Children felt pain when eating food and constant itching of the lips. The authors report a good effect of using the drug "Immudon" in children with atopic cheilitis [2]. Pathomorphological changes in atonic cheilitis are determined in the epithelium (acanthosis, parakeratosis) and connective tissue (perivascular infiltration predominantly with lymphocytes and eosinophils) [2].

Treatment of atopic cheilitis includes drugs to influence the secondary infection (*S. aureus* combination of fusidic acid and 1% hydrocortisone cream, (*Candida*) - ketoconazole, which will lead to a decrease in the intensity of the inflammatory process and will help prevent complications [5,11]. In some cases, antibiotics are used alone, or in double (glucocorticosteroid and antibiotic or antifungal agent), as well as in triple combination with glucocorticosteroid (glucocorticosteroid, antibiotic and antifungal agent), these drugs are represented by various official creams and ointments, such as "Pimafucort", "Triderm", "Akriderm GK". For 2 - 3 weeks, the child should be on a strict diet with the exclusion of all foods that can cause an allergic reaction. Against the background of diet therapy, vitamins A, B, B2, B6, folic acid, calcium pantothenate, and antihistamines are prescribed internally. Corticosteroid ointments are used locally ("Ftorokort", "Flucinar", "Lorinden", "Sinaflan", "Oxycort"), which must be applied 4-5 times a day. Substances that can cause sensitization of the body should be excluded from the diet [2, 4]. Treatment with external glucocorticosteroids is the most effective method of treating children with atopic dermatitis, so therapy should be carried out for a long time, until complete remission of the disease occurs. A.V. Woodpecker (2015) recommends the following general treatment regimen for atopic cheilitis: selective anxiolytic "Afobazol" in the form of sublingual tablets according to the scheme: 1 tablet 3 times a day after meals, course of treatment is 2-4 weeks; blocker H₁ histamine receptors "Telfast" in the form of tablets according to the scheme: 1 tablet at night, regardless of food intake, course of treatment for 7 days; sublingual tablets "Trumeel S" according to the scheme: 1 tablet 3 times a day, course 7-10 days; "Milgama" 2 ml IM 2 times a week, for a course of 10 injections; immunomodulator "Imudon" according to the scheme: 5-8 tablets per day, course of treatment 21 days; complex of B vitamins "Neuromultivit" according to the scheme; 1 tablet orally 1/3 times a day, after meals, with a small amount of liquid, course 7-10 days. Local treatment: applications of Traumeel S gel according to the scheme: 2-3 or

3-4 times a day, for a course of 7-10 days. The author believes that the general treatment of atopic dermatitis and the prescription of glucocorticosteroid drugs of general and local action should be carried out by a dermatologist.

Analysis of the clinical effectiveness of the proposed treatment regimen for patients showed a low purity of relapses of clinical manifestations in this group of patients.

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