A 44- year-old male, with a history of severe psoriasis, presents with a three-month history of erythema and inflammatory papules on the forehead, glabella, eyelids, and periorbital area (Figure 1). The lesions are non-pruritic. The patient has been treated with multiple topical corticosteroids with increasing potency, but the symptoms recur once the treatments have been discontinued.

What is your diagnosis?

Periorificial dermatitis is a common eczematous eruption on the face. It appears more commonly in females, who account for an estimated 90% of the population.
Onset of efficacy seen as early as WEEK 1...¹⁻³‡

In a 12-week double-blind, randomized trial:¹,²†

✓ 25.7% reduction in mean inflammatory lesion counts with TACTUOTM at Week 1
  ✓ 13.6% with gel vehicle (p<0.001)

✓ TACTUOTM significantly reduced all lesion counts at Week 12 (p<0.001)
  ✓ Mean percent reduction from baseline: inflammatory (TACTUOTM, 52.4%; vehicle, 31.8%), non-inflammatory (TACTUOTM, 45.9%; vehicle, 27.8%) and total lesion counts (TACTUOTM, 48.6%; vehicle, 29.7%)

...with results sustained up to 52 WEEKS,¹,³‡

In a 52-week open-label, single-arm study with TACTUOTM:¹,³‡

✓ 21.5% reduction in mean inflammatory lesion counts was observed at Week 1
✓ Mean percent reduction from baseline was 64% or greater for all lesion counts at Week 52
  ✓ Inflammatory (66.4%), non-inflammatory (64.6%) and total lesion counts (65.1%)

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cases. This condition is also commonly seen in the pediatric population.

The lesions of periorificial dermatitis are rarely pruritic, but patients may report subjective symptoms of irritation and burning sensation. A chronic course is not uncommon in some patients.

Clusters of follicular papules, vesicles, and pustules on an erythematous base are usually found in a perioral distribution. The lesions tend to spare the vermilion border. Other common locations include the nasolabial folds and perocular area. Rarely, this condition may affect the genital and perianal areas.

An underlying cause may not be found in all cases, but the use of topical corticosteroids on the face may precede onset of symptoms. There is no clear correlation between the risk of symptom development and the potency or the duration of corticosteroid use. Rarely, nasal steroids and steroid inhalers have been reported to trigger periorificial dermatitis. Other potential causative factors include skin care products containing petrolatum, paraffin, and isopropyl myristate; fluorinated toothpaste, and sunblocks. Candidiasis has been suggested as a provoking factor. Symptom deterioration has been observed before menses and after exposure to ultraviolet light, extreme heat and wind.

Periorificial dermatitis is diagnosed clinically and no specific investigation is required. Lesions of periorificial dermatitis may appear similar to that of acne vulgaris, eczema, rosacea and lupus; these conditions should be ruled out.

Topical anti-inflammatory therapies (such as metronidazole and erythromycin) in a non-greasy base (such as cream, lotion, gel) are appropriate in mild cases. Ointments should be avoided. In severe cases, systemic treatments such as tetracycline or one of its derivatives are appropriate. Systemic erythromycin can be used in the pediatric population with severe or refractory symptoms. It may be beneficial for patients to discontinue the use of all topical skin care products, medications and cosmetics on the face to eliminate the potential trigger when the etiology is not clear on history.
Patients should be warned that symptoms might worsen before improvement is apparent. This complication is more commonly seen when topical corticosteroids are withdrawn; gradual weaning to a low potency topical corticosteroid, such as 0.5% or 1% hydrocortisone cream, may be appropriate. Topical calcineurin inhibitor such as pimecrolimus cream appears to be effective in steroid-induced periorificial dermatitis. Oral isotretinoin may be considered in recalcitrant cases with granulomatous manifestation.

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References