Psoriasis is a chronic inflammatory dermatosis, which progresses by relapses-remissions, of a multifactorial etiology which involves genetic, immunological, and environmental factors. Skin lesions are mainly localized in areas of friction: elbows, knees, pre-tibial, lumbosacral regions, scalp, and nails. Although the appearance of the skin lesions is sufficient for a diagnosis, diagnostic difficulties may be found in case of unusual topography. We report a case of a 45-year-old female patient with psoriatic cheilitis with a review of the literature.
found diffuse mild erythema, adherent white scales, and fissuring on both upper and lower lips, with extension over the vermilion border. The remaining oral mucosa appeared normal. Moreover, there were erythematos plaques with white thick scales on the scalp.
Dermoscopic examination showed dots and globular vessels, diffuse, and monomorphic with a white scale (Fig. 2, 3). Dermoscopic of the scalp’s lesions also showed dots and glomerular vessels with homogeneous distribution and thick white scales. Thus, on the basis of the clinical and dermoscopic appearance, the diagnosis of psoriasis of the lips and scalp was made.

The cheilitis was treated by hydrocortisone aceponate, and the scalp was treated by betamethasone associated with salicylic acid. At the 15 days control, she reported a great improvement.

### Table 1. Summary of psoriatic cheilitis cases reported in the literature

| Authors                  | Cases, n | Sex      | Age | Extra-labial involvement | Intraoral involvement | Treatment                                      |
|--------------------------|----------|----------|-----|--------------------------|-----------------------|------------------------------------------------|
| Tosti et al. [4]         | 1        | Female   | 24  | No                       | No                    | Triamcinolone acetonide                        |
| Rahman et al. [3]        | 1        | Female   | 20  | Yes                      | No                    | Triamcinolone acetonide                        |
| Sehgal et al. [10]       | 1        | Female   | 16  | No                       | No                    | Tacrolimus + Calcipotriol + dipropionate betamethasone |
| Ersoy-Evans et al. [8]   | 1        | Female   | 19  | No                       | No                    | Fluticasone propionate 0.05%                   |
| Baz et al. [2]           | 1        | Female   | 22  | No                       | No                    | Mometasone fuorate 0.1%                        |
| Apalla et al. [12]       | 2        | 1 Male, 1 Female | 20 | No                       | No                    | Tacrolimus + salicylic acid                    |
| Blankinship et al. [9]   | 1        | Male     | 20  | No                       | No                    | Tacrolimus + Calcipotriol + dipropionate betamethasone |
| Yamamoto et al. [5]      | 1        | Male     | 65  | Yes                      | No                    | Calcipotriol                                    |
| Gül et al. [7]           | 1        | Male     | 45  | Yes                      | No                    | Methotrexate                                    |
| Migliari et al. [6]      | 1        | Female   | 13  | No                       | Yes                   | Vitamine A derivates + topical steroid           |
| Marti et al. [1]         | 1        | Male     | 38  | Yes                      | No                    | Mometasone fuorate 0.1%                        |
| Purzycka-Bohdan et al. [11] | 1    | Female   | 37  | Yes                      | No                    | Methotrexate + fluticasone propionate 0.05%     |
| Bouslama et al. [13]     | 1        | Female   | 21  | No                       | No                    | Dipropionate betamethasone                     |
| Current case             | 1        | Female   | 45  | Yes                      | No                    | Hydrocortisone aceponate                        |
Discussion

Intraoral psoriasis and psoriasis of the lips remain a poorly recognized entity, especially in the absence of associated skin involvement [1]. Psoriasis of the lips can be the only clinical presentation of psoriasis, preceding the appearance of typical psoriasis lesions or as in our case occurring after the appearance of skin lesions [1].

The localization of psoriasis in the lips has been rarely reported in the literature, to our knowledge since 2000 and until now only fifteen cases have been reported in the literature including our case. Ten of the cases were female and 5 male, the mean age of the patients was 28.86 years (13–65 years), extra-labial involvement was found in 6 patients with typical skin lesions in 4 cases, vulva involvement in one case, nail involvement in one case and scalp involvement in 2 cases. Only the case reported by Migliari et al. had intraoral involvement [1–13] (Table 1).

Brenner et al. [14] reported a case with lip psoriasis, which was triggered by protruding teeth. Their case did not clear with any type of dermatological treatments including topical corticosteroids and calcipotriol; however, the lesions on the lips completely resolved after replacement of the protruding teeth by a nonirritating prosthesis.

Psoriasis of the lips can be clinically confused with chronic eczema, actinic cheilitis, chronic candidiasis, and leukoplakia [2]. Dermoscopy is a noninvasive tool that allows the diagnosis of many cutaneous dermatoses and reduces the need for biopsies. The most striking dermoscopic features of psoriasis are the evenly distributed red dots or globules over a pale red erythematous background along with white scaling of the lesion [15].

An additional dermoscopic finding of high relevance for psoriasis is the white scaling, which can be very helpful clue for the differential diagnosis between psoriasis and other inflammatory skin diseases. Specifically, the white color of psoriatic scales is of particular value for the diagnosis of psoriasis compared with the yellow scales or crusts that are usually suggestive of dermatitis [15]. Several treatments have been used in the literature: topical strong to very strong topical steroid, calcipotriol, tacrolimus, vitamin A derivatives, salicylic acid, and methotrexate with good outcome in most cases [1–13].

Conclusion

Through our case, we report the utility of the dermoscopic examination in the diagnosis of psoriasis even in unusual locations.

Statement of Ethics

The study was conducted in accordance with the Declaration of Helsinki. Written informed consent for the publication of this report, including images, was obtained from patient.

Conflict of Interest Statement

The authors have no conflicts of interest to declare.
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Author Contributions

R.C. admitted and examined the patient in consultation, performed dermoscopic examination, and treated the patient. The patient still followed in consultation by R.C. in the Department of Dermatology, University Hospital Hassan 2, Agadir, Morocco. Moreover, R.C. has written and submitted the manuscript in the journal.

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