LEARNING OBJECTIVES
Chelitis Granulomatosa (CG) is a rare, idiopathic disorder characterized by persistent swelling of the lips. When present with facial nerve palsy and fissured tongue, it is referred to as Melkersson-Rosenthal syndrome. Histologically, it's granulomatous inflammation appears identical to sarcoidosis and Crohn's so these disorders must be ruled out. It is important to have knowledge about not only this entity, but its differential in the setting of non-acute lip swelling.

CASE SUMMARY
A 62-year-old Caucasian male with recurrent periodontal infections presented with a 1-year history of progressive upper and lower lip swelling. Patient denied pruritus or pain, but admitted to difficulty in speaking as well as eating. He was previously treated by an allergist with no improvement. Patient had required multiple dental extractions in the past and also had a history of T2DM and hypertension for which he took amlodipine. Clinically, the patient was found to have non-pitting, non-tender, irregular edema of both the upper and lower lips as well as poor dentition. Labwork was obtained that showed no pertinent positives. Punch biopsy of the lower labial mucosa was performed which revealed granuloma formation in the lamina propria with no organisms found on special stains. Due to the histological appearance and exclusion of Crohn's and sarcoidosis based upon negative labwork and review of systems, the patient was diagnosed with chelitis granulomatosa. The patient was treated with intralesional kenalog starting up to 12.5mg/cc. Patient noticed mild improvement, however, lip edema remained and the patient reported “flares” of swelling that would recur then remit. Oral treatment was then initiated with doxycycline, which also yielded only mild improvement.

DISCUSSION OF CHELITIS GRANULOMATOSA
Chelitis granulomatosa (CG) is an uncommon disease that presents with persistent or recurrent lip swelling. It is considered a manifestation of orofacial granulomatosis (OFG), a clinical term describing orofacial swelling caused by noncaseating granulomatous inflammation in the absence of systemic disease. Other signs include ulceration, gingival enlargement, mucosal tags and lymphadenopathy. CG is a monosymptomatic form of Melkersson-Rosenthal syndrome which includes CG, facial nerve palsy and fissured tongue. Both sarcoidosis and Crohn’s have very similar histology, so these conditions must be excluded.

The incidence of CG has been estimated at 0.08% in the general population, being more common in the second decade of life with slight female predominance. The precise etiology is unknown for CG. Some theorized etiological factors include and immune response to infections (Mycobacterial), food/preservative allergies (cinnamon/benzoate) and dental materials. There is a significant increase of IFN-y expression in oral lesions together with increased levels of IL-12. Increased levels of Th1 chemokines (RANTES/MIP-1a) and chemokine receptors (CCR5, CXCR3) have also been noted.

Some skin conditions share similar features to CG. These include other granulomatous diseases such as a foreign body reaction, mycobacterial infection, sarcoidosis, Crohn’s disease, Wegener’s granulomatosis, and histoplasmosis. Other conditions that should be considered include amyloidosis and angioedema, which is caused by a hypersensitivity reaction to certain allergens, medications including ACE inhibitors, or hereditary deficiency of C1 esterase inhibitor.

REFERENCES

WORKUP/MANAGEMENT
Histology of CG is characterized by noncaseating granuloma formation with epitheloid and Langerhan type giant cells and admixed lymphocytic infiltrate. Mycobacterial stains as well as polarization must be completed to rule out other types of granulomatous inflammation. Cutaneous crohn’s disease as well as sarcoidosis should be excluded and appropriate referrals made if symptomatology is present. Management includes removal of offending agents if one is found and often intralesional corticosteroids to relieve edema. Systemic therapy may be necessary in resistant cases which includes doxycycline, clofazimine, sulfasalazine, hydroxychloroquine, TNF-alpha, infliximab, thalidomide and steroids. Surgically, cheiloplasty has shown effectiveness in chronic cases resistant to therapy.

CONCLUSIONS
Recognition of Granulomatous Cheilitis and other clinical entities similar can aid the general dermatologist be more prepared to treat less common mucosal disorders.