

ANGULAR CHEILITIS V2.0

Comments from the Expert Advisory Group

- Angular cheilitis is inflammation of the angles of the mouth, characterised by fissures, scaling, erythema and/or crusting.
- The cause is usually multifactorial, due either to a primary infection or to a non-infectious entity such as:
 - Ill-fitting dentures
 - Nutritional deficiency
 - Dermatologic condition
 - Inflammatory bowel disease

Furthermore, underlying systemic disease such as diabetes, immunodeficiency can result in recurrent infection.

Identifying and treating all contributing factors is necessary for successful treatment.

- Where the cause is non-infectious, addressing the underlying cause will result in resolution without the need for antimicrobial treatment.
- In those who wear dentures, angular cheilitis is often associated with candida infection. Dentures with an inadequate occlusion vertical dimension can also contribute and construction of new dentures to increase the occlusal vertical dimension may be required.
- Angular cheilitis may also be caused by infection with staphylococci or streptococci bacteria.
- Miconazole is effective against both candida and gram-positive cocci and is the recommended first-line agent when candida is the suspected cause. Where the condition is clearly bacterial in nature, sodium fusidate cream or ointment can be used.
- A swab for microbial culture and sensitivity testing is usually only recommended after treatment failure. Consideration should be given to possible underlying causes.
- The reservoir for infection should also be treated.
 - In the case of candida, this is the mouth. For eradication of fungal reservoir in the mouth, follow link to [fungal infections](#).
 - In the case of staphylococci, this is the anterior nares. For eradication of staphylococci from the anterior nares follow link to [Staphylococcal Nasal Carriage](#).
- Combined antimicrobial and steroid preparations are very rarely indicated and should not be prescribed in routine practice.
- A topical barrier (e.g. lanolin cream, emollients or lip balm) may be applied to reduce maceration of the affected area.
- Patients who wear dentures should be instructed on appropriate denture hygiene as a preventative measure.

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Treatment

ANGULAR CHEILITIS ANTIMICROBIAL TREATMENT TABLE			
Drug	Dose	Duration	Notes
1st choice options (Adults and Children)			
Miconazole 2% cream (30g tube)	Apply to angles of mouth every 12 hours	10-14 days	Avoid if patient taking warfarin, phenytoin or sulphonylurea. Consider Terbinafine 1% cream every 12 hours for 10-14 days as alternative. Wash hands before and after application of the cream.
Sodium Fusidate 2% cream/ointment (15g tube)	Apply to angles of mouth every 6 hours	7 days	Wash hands before and after application of the cream.
If failure of first line options:			
A swab for microbial culture and sensitivity testing is suggested to guide treatment and blood tests should be considered to exclude possible underlying causes. In cases of recurrent angular cheilitis, repeated courses of topical antimicrobial agents should be avoided and referral to a specialist should be considered.			

For eradication of fungal reservoir in the mouth, see [fungal infections](#)

For eradication of staphylococci from the anterior nares see [Staphylococcal Nasal Carriage](#).