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MELKERSSON-ROSENTHAL SYNDROME ASSOCIATED WITH *PSORIASIS VULGARIS* AND *OROFACIAL IMPETIGINIZATION*

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Abstract
Melkersson-Rosenthal syndrome (MRS) is a disease of unknown etiology, usually restricted to the orofacial region, characterized by reccurent orofacial swelling, relapsing facial palsy and plicated tongue. We report case of MRS associated with psoriasis in a 25-year-old woman. The patient has been treated with satisfying results with a combination of Cetirizine, Cefuroxime axetil and Mupirocin ointment; psoriatic eruptions were successfully treated with 10 % salicylic-sulphuric ointment twice a day. MRS syndrome is a rare disease and should be considered in the differential diagnosis of labial swelling and facial palsy.

Key words: Melkersson-Rosenthal syndrome; psoriasis; plicated tongue

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Introduction

Melkersson-Rosenthal syndrome (MRS) is a rare disorder of unknown etiology, characterized by recurrent orofacial swelling, relapsing facial palsy and plicated tongue. Diagnosis is usually made by clinical and histopathologic criteria. Furthermore, diagnosis of the condition can be difficult, as incomplete forms are not infrequent [1].

Case Report

In this paper we present a 25-year-old Caucasian girl presenting with a 2 -year history of swelling of the upper lip and biopsy-proven psoriasis.
On examination, there was cheilitis with local angioedema, persistent swelling and considerable enlargement of the upper lip. The lower lip was slightly swollen and perioral bacterial infection was observed. Moreover, there was lower motor neuron right-sided facial palsy (Fig. 1)

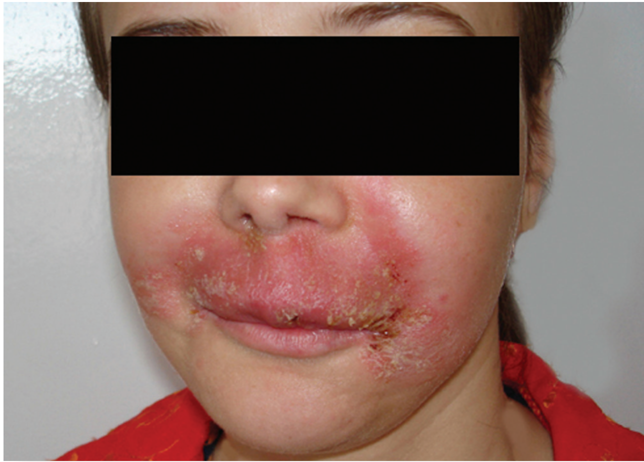

Figure 1. A 25-years-old woman with right-sided facial palsy, swelling of the lips and orofacial impetiginization.

The tongue was fissured. On extensor surfaces the patient exhibited psoriatic eruptions represented as an erythematous, scaly inflamed patches and papules. The patient had no history of atopy or inflammatory bowel disease and there were no gastrointestinal symptoms. Laboratory tests, including blood examinations, sedimentation rate, complement levels, anti-DNA, anti-nuclear antibodies, thyroid function test, C-reactive protein, IgE and chest roentgenogram were normal. Sections from biopsy of the lower lip showed edematous squamous mucosa with underlying fat. The submucosa was edematous with dilated blood vessels and inflammatory cellular infiltration - composed of lymphocytes, plasma cells - mainly marked around blood vessels and no sarcoid-like granulomas were identified.

Discussion

Although facial edema is usually nonresponsive to antihistamines [2], we have administered a combination of Cetirizine, Cefuroxime axetil and topically Mupirocin, which have produced satisfactory improvement of bacterial lesions, but mild enlargement of the upper lip has persisted. Psoriatic lesions were successfully treated with topical 10% salicylic-sulfuric ointment twice a day. Pharmacological treatment was sufficient, thus lip reduction cheiloplasty was unnecessary [3].

Biopsy did not reveal granulomas, which are present in classic picture of MRS [4], but granulomatic changes not always occur in MRS, and nonspecific edema and inflammation might dominate in the early phase [1].

Our case confirms previous observations which suggest association of MRS with psoriasis [5]. Although psoriasis is a relatively common chronic skin disease (affects 2-3 % of the US population) [6], we think psoriasis in association with the MRS is not coincidental. Plicated tongue, which is believed to be a physiological variant (incidence is estimated about 10-15 % of normal population) [4] – is at the same time a part of the classic MRS triad and is more frequent in psoriatic patients [7].

Melkersson-Rosenthal syndrome is a rare disorder and should be considered in the differential diagnosis of labial swelling and facial palsy.

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