Among suspected irritant and allergic reactions localized to the face, involvement of the eyelids and lips may be among the most common, most challenging, and most frustrating presentations. Typical tools, such as standard patch-testing with the T.R.U.E. Test (Allerderm), may not prove particularly useful in these presentations, since in my experience it often does not identify a relevant allergen. Many of these cases of eyelid and lip dermatitis appear to be caused by exposure to irritants, and successful management typically requires a methodical review of products used and in some cases a lengthy trial-and-error process to uncover the offending agent.

Initial Steps
When a patient presents with eyelid and lip dermatitis, evaluation begins with careful questioning about the history of the current presentation, previous experiences of irritation and inflammation of the eyelids, lips, or other areas, and, of course, history of allergy or irritant reactions in general. Occasionally, a patient with a known allergy or his-
Irritant reaction to a specific agent may be unwittingly applying that agent to the face. Also question patients about a history of atopic disease, including but not limited to atopic dermatitis, and/or a history of psoriasis. As discussed below, this information may be relevant to the differential diagnosis of eyelid dermatitis.

Frequently, despite taking an extensive history, a specific cause of the dermatitis is not readily apparent. A patch test series is indicated in most patients. However, as noted above, standard testing frequently does not reveal relevant positive patch reactions, and even extended testing with cosmetic series is often unrevealing. Therefore, a period of avoidance of suspected allergens and irritants becomes necessary. Without avoidance of offending agents, long-term clearance is impossible. However, symptomatic treatments are available for both lip and eyelid involvement.

### Lip Dermatitis

In my clinical experience, a few particular agents are commonly implicated in lip dermatitis. These include cinnamon and mint flavored toothpastes, whose flavorings may act as non-immune contact urticants. Advise patients to avoid these flavored toothpastes and to instead use children's fruit or bubble gum flavored toothpastes.

Lip cosmetics are obviously frequently implicated. On review of the products being used by patients, “plumpers” are frequently noted, as are glosses. I advise patients that the more liquid, shinier, and glossier a product is, the more likely it is to be an offending irritant. Instead of these products, patients should opt for “waxy” lip cosmetics.

There is a remarkable variety of products sold for use on the lips for women and for men, including colored lipsticks, lip glosses, lip balms, etc. Given the number of products available, identifying the offending agent in any particular case may become time-consuming. Once potentially causative agents are identified, patients must completely avoid those, and any similar, products. It often takes at least six weeks of complete avoidance before the patient begins to see resolution of the dermatitis. During this period, and for several months after resolution, the lips continue to be extremely susceptible to irritation, and even a single application of a “plumper” or a liquid, glossy, or shimmery product can lead to a relapse.

In addition to avoidance strategies, treatment strategies may be implemented to help quell the dermatitis and improve patient comfort. Patients insistent on using lip coloring agents may be advised to use solid lipsticks in traditional colors, which tend not to be irritating. To provide moisture to the lips and support healing, patients may apply unscented petroleum jelly or Biafine (Ortho Dermatologics). The latter is designated for use in wound healing and burn management but has provided good results in a number of my lip dermatitis patients. Also, advise patients to minimize lip licking. One pearl when dealing with suspected lip-lickers - do not ask about licking at the onset of the visit, instead simply observe the patient during the interview. I have observed many patients who lick their lips frequently during the interview, but are

### Table 1. Eyelid Dermatoses: Principles and Management

<table>
<thead>
<tr>
<th>Seborrheic Dermatitis of the Eyelids</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exclude other diagnoses as much as possible.</td>
</tr>
<tr>
<td>Check retroauricular areas; supports diagnosis.</td>
</tr>
<tr>
<td>Treat with corticosteroids, antifungals, TCIs, as appropriate.</td>
</tr>
<tr>
<td>Wash face with dandruff shampoo.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Atopic Dermatitis and Lichen Simplex Chronicus of the Eyelids</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients are usually an obvious atopic, although not necessarily affected by atopic dermatitis.</td>
</tr>
<tr>
<td>Most patients have seasonal allergies.</td>
</tr>
<tr>
<td>LSC favors central eyelid, but can affect entire upper and lower lids.</td>
</tr>
<tr>
<td>Consider oral or ophthalmic antihistamines (Zaditor, ketotifen fumarate ophthalmic solution, Novartis).</td>
</tr>
</tbody>
</table>

Irritant Eyelid Dermatitis Treatment Principles

- If chronic/continuous use a TCI.
- For short-term or intermittent therapy, steroids may be used with caution. Excess use is associated with risk of glaucoma.
- Rinse eyelids very well after washing face.
- Wash face with Cerave or Cetaphil after shampooing.
- Consider anti-itch or barrier repair moisturizers.
unaware of the habit and deny it when asked, even after I have watched them lick their lips over a dozen times during a 30 minute interview!

For short-term management of lip dermatitis, patients may apply a low-potency topical corticosteroid. For more long-term medical treatment, consider Protopic ointment (tacrolimus, Astellas Pharma).

Eyelid Dermatitis
The approach to eyelid dermatitis may be somewhat more complicated, primarily due to the number entities in the differential diagnoses that must be considered. Common conditions include:

- Allergic contact dermatitis
- Irritant contact dermatitis/psoriasis
- Seborrheic dermatitis
- Atopic dermatitis
- Lichen Simplex Chronicus

Certain characteristics of the presentation may point to one of these diagnoses over another. For example, asymmetrical involvement may indicate an ectopic allergic or irritant contact dermatitis due to transference of a substance from the patient’s hands to the eyelids. That is, rather than introducing an allergenic product or agent directly to the eyes or face through conscious application of products to these areas, the patient introduces the allergen to the eyelid inadvertently when touching or rubbing the eye, and if one eye is touched more than the other, as is usually the case, an asymmetric dermatitis can result.

If the dermatitis spreads beyond the eyelid, it is most likely an allergic contact reaction to a product that contacts the entire face, either via direct application to the entire face or via rinsing down over the face, especially of shampoos. By contrast, if involvement is limited to the medial upper eyelid, this may be an indication of lichen simplex chronicus, most commonly related to ocular pruritus related to allergies to airborne allergens, such as pollen, dust mite, or mold.

If the patient has a history of atopic dermatitis or current eczema at another body site, consider the likelihood that the eyelid dermatitis is actually atopic dermatitis.

Erythema and scale and/or retroauricular involvement absent any significant edema is suggestive of psoriasis or seborrheic dermatitis (SD) affecting the eyelids. Involvement of the nasolabial folds and/or the presence of scale on the eyebrows is more likely with SD.

In the event that any of these primary etiologies is suspected, appropriate targeted therapy should be implemented (see Table 1). Following are recommendations regarding the management of allergic and irritant etiologies.

**Asymmetric Eyelid Dermatitis: Allergic.** As noted, asymmetrical eyelid dermatitis is likely a sign of a reaction to a transferred agent-usually one initially or primarily applied to the hands. As such, causative agents may include: nail polish containing toluene/sulfonamide formaldehyde resins; “gel nails,” “solar nails,” and nail wraps containing methacrylates; hand moisturizers containing lanolin, methylchloroisothiazolinone/methylisothiazolinone (MCI/M1), formaldehyde, fragrances, or parabens; or hand soaps, which also may contain fragrance, MCI/M1, formaldehyde, as well as betaines (such as cocamidopropyl betaine or CAPB).

Transference is not the sole source of allergic contact reactions of the eyelids. Agents applied to the face and/or-as is more common to the hair-bearing scalp, may migrate to the eyelids and other anatomic sites, producing the dermatitis. Therefore, an important diagnostic clue, as noted above, is occurrence of eyelid dermatitis “beyond the eyelid.” The anterior neck is also commonly affected, as this skin has simi-
Eyelid and Lip Dermatitis

Above: “Eyelid dermatitis” (left) that has “moved” beyond the eyelids (right). The patient had a CAPB allergy.
Right: Peri-auricular scaling of seborrheic dermatitis.

Differences to the eyelid skin in terms of thickness and folds. Patients may not complain about dermatitis of the neck or associate it with the eyelid complaint, so it is important during the exam to question patients about any other current “rashes” and to visualize the neck and retroauricular areas. Commonly implicated products include soaps and shampoos containing betaines, fragrance, formaldehyde, MCI/MI; hair dyes containing para-phenylenediamine (PPD); and/or rubber in make-up applicators. Commonly implicated products include: shampoos, volatile solvents in mascara, facial soaps, antioxidants in “creamy” eye make-up, and/or abrasive powders. Irritant eyelid dermatitis tends to be chronic, as irritant-containing products like shampoos and soaps are usually introduced daily or multiple times per week and may be retained in the eyelid fold.

Irritant Eyelid Dermatitis. Given the number of differential diagnoses and potential sources of allergen exposure, the diagnosis of irritant eyelid dermatitis largely becomes one of exclusion. In addition to visible erythema and the typical complaint of itch, the patient may describe the eyelid as burning, tight, or irritated.

Commonly implicated agents include: shampoos, volatile solvents in mascara, facial soaps, antioxidants in “creamy” eye make-up, and/or abrasive powders. Irritant eyelid dermatitis tends to be chronic, as irritant-containing products like shampoos and soaps are usually introduced daily or multiple times per week and may be retained in the eyelid fold.

Treatment options for eyelid dermatitis include short-term topical corticosteroids or topical calcineurin inhibitors (TCI). Steroids should be considered for short-term or intermittent use. In the case of chronic or recurrent dermatitis, carefully consider the use of corticosteroids, as these agents have been associated with a risk of glaucoma, and that risk is increased with application to the ocular area. For long-term consistent application, consider a TCI. Sarna Sensitive Lotion (Stiefel) can be helpful to relieve itch and it suitable for application to the eyelids. CeraVe (Coria) or EpiCeram (Promius) creams may be applied daily, as well. Several pearls related to the TCIs are useful—the burning sensation associated with these agents has been shown to be due to substance P release, so when describing it to patients, it can be helpful to explain that the sensation may be similar to the sensation that occurs on the tongue when a hot pepper is eaten. Also, it has been my experience that patients who experience burning are more consistent responders to TCIs than those who do not experience burning. Finally, given that the burning is due to substance P release and that it ceases when substance P depletion occurs, the burning typically resolves more quickly (within 3-4 days) if the patient applies the TCI at least twice daily, as opposed to once a day, which may not be frequent enough to lead to substance P depletion.

Obviously, patients must avoid known or suspected irritants. Instruct affected individuals to wash their face and neck with a gentle cleanser after shampooing in order to help prevent any irritant from remaining in contact with the skin. A few important principles guide management of eyelid dermatitis.

Dr. Zirwas is on the Speaker’s Bureau for Coria Laboratories and Astellas Pharma.