Adult Eczema

Eczema – Adult – Primary Care Treatment Pathway

What is Eczema?

Eczema (also known as atopic eczema or atopic dermatitis) is a common, chronic, relapsing, inflammatory skin disorder. The skin function is impaired leading to porous and dry skin that easily becomes inflamed, susceptible to infection and itchy. Chronically scratched skin may become thickened (lichenified)

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Assessment

An holistic approach is essential

- History of itchy rash often with onset in childhood
- Relevant family/social history – eczema, asthma, hayfever, smokers, pets
- Distribution and clinical signs
- Impact on quality of life and sleep
- What treatments are being and have been used; how long for; what helped and what did not

Other Considerations

- No evidence of benefit with non-sedating anti-histamines
- Sedating anti-histamines **short-term** may aid sleep and break the itch-scratch cycle
- Directing to patient support groups eg National Eczema Society
- Complications – suspect infections in rapidly deteriorating eczema (bacterial or viral), take swabs, consider oral antibiotics or antivirals. Avoid long-term use of combination topical agents (eg clotrimazole or fucidic acid with a topical steroid)
- No good evidence for alternative therapies

For further information:

Primary Care Dermatology Society:
www.pcds.org.uk

National Eczema Society:
www.eczema.org

Management Principles – ABC Rule

A **A**void triggers; soaps or anything that lathers, cigarette smoke, irritant clothing

B **B**land moisturisers; an absolute essential part of treatment. Should be fragrance free. Applied ideally 3-4 times a day; prescribe adequate quantities (at least 500g/week); patient choice improves concordance; bath additives are not recommended; use emollients to wash (apply before wetting the skin). Ideally wash hair over the sink to avoid shampoo on skin causing irritation

C **C**ontrol inflammation

- Topical steroids matched to severity and anatomical site – mild (face & flexures), moderate, potent
- Topical steroids use once daily for 1-6 weeks until settled, decreasing to twice weekly use for maintenance if frequent flares
- Step-up use to daily during a flare, then wean back down for maintenance therapy (reduces frequency of flares)
- Calcineurin inhibitors (eg topical tacrolimus or pimecrolimus) are useful as second line and particularly useful in delicate sites (eyelids, face, flexures)

When to Refer

- Diagnostic uncertainty
- Failure to respond to treatment
- Cutaneous atrophy from chronic topical steroid use
- Suspicion of allergic contact dermatitis (especially if new onset of eczema of face and hands) for patch testing
- **Refer urgently:** severely infected eczema eg bacterial or HSV in a systemically unwell adult or erythroderma (>90% body surface)

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Stasis (Varicose) Eczema

Clinical Features

- Bilateral erythematous, scaly, pruritic, rash of lower legs, often oedematous
- Commonly misdiagnosed as bilateral cellulitis which is extremely rare. Cellulitis is unilateral, associated with ascending erythema, patient may have systemic signs of infection
- May co-exist with contact dermatitis from dressings

Specific Treatment

- Full emollient regime
- Consider potent steroid 2-4 weeks then step down to twice weekly maintenance or use tacrolimus 0.1%
- Consider paste or compression bandages

Discoid Eczema

Clinical Features

- Multiple round shaped plaques that are sometimes weepy with exudative crusts
- Often misdiagnosed as impetigo, or more commonly, a fungal infection. Scrape any scale and send mycology if in doubt
- Usually **extremely** itchy

Specific Treatment

- Full emollient regime
- Potent topical steroids 4-6 weeks
- May need super-potent topical steroids up to 2 weeks
- Consider maintenance therapy twice weekly

Pompholyx

Clinical Features

- Extremely itchy clear vesicles on hands and feet

Specific Treatment

- Full emollient regime
- Super-potent topical steroids for 2 weeks. May need to use under occlusion with clingfilm overnight
- Then twice weekly maintenance regime
- Treat any co-existing athlete's foot after confirming with skin scrapings

Contact Dermatitis

Clinical Features

- Worsening eczema at defined sites secondary to a contact allergen

Specific Treatment

- Full emollient regime
- Take detailed history eg occupational & recreational
- Consider potent steroid 2-4 weeks then step down to twice weekly maintenance or use tacrolimus 0.1%
- Refer for patch testing if contact allergen cannot be identified accurately from history

Asteatotic Eczema (also known as eczema craquelé)

Clinical Features

- Often seen in the elderly
- Dry skin with superficial cracked (dried-up riverbed) appearance
- Areas of excoriation, erythema and bleeding may be evident due to rubbing or scratching

Specific Treatment

- Full emollient regime
- Steroids rarely needed
- Ideally avoid an overly warm environment

Please note this guidance is the views of the contributors and does not consider costs of treatments

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