Eczema or Dermatitis

Eczema may present for the first time in adulthood or as a continuation of childhood eczema.

For eczema in children, see the Eczema in Children pathway.

Assessment

1. History

   History

   - Body sites affected, pattern, and severity
   - Circumstances of flare
   - Previous treatments used
   - Current daily routine, bath or shower, and current treatment regimen
   - Family history of eczema, hay fever, or asthma

2. Examination

   Examination

   - Eczema is characterised by dry, irritated skin which over time may become thickened or infected.
   - Check for distribution and estimate body percentage affected.
   - Look for signs of infection. During flares the skin may become red, weepy, shiny, and blistered.
   - Patients with more heavily pigmented skin will develop darkening of the affected skin which may become temporarily hypo- or hyperpigmented after the inflammation settles.
   - Most commonly affected areas include the face, neck, skin flexures, nipples, and hands but may be present either diffusely or locally.

3. In atopic dermatitis there is often a family history of eczema, hay fever, or asthma. This may be absent in other types of dermatitis. Consider:

   - other types of dermatitis e.g., seborrhoeic, nummular or discoid, contact irritant, contact allergic, asteatotic, or varicose.

- conditions such as tinea, psoriasis, vasculitis, malignancy, and scabies.
- an occupational cause. Occupational hand dermatitis can be hard to control and may threaten employment.

Management

Most adult patients with eczema can be managed in general practice by encouraging them to avoid irritants, use moisturisers, and correctly use corticosteroid creams.

1. General measures

General measures

- Avoid:
  - irritants, e.g., soaps, detergents, solvents, ink, vegetable juice, gardening, flour.
  - scratching.
  - overheating.
  - wool and scratchy fabrics next to the skin.
- Keep nails short.
- Use cotton bedding and underclothes.
- Keep alcohol intake to within recommended daily limits.

2. Emollients:
   - The principal treatment is using emollients as moisturisers and soap substitutes.
   - Avoid aqueous cream as it can worsen eczema in certain patients.
   - There is a fire risk with all paraffin-containing emollients, regardless of paraffin concentration, and it also cannot be excluded with paraffin-free emollients.
3. Bathing

Bathing

Advise the patient:

- Daily bathing or showering helps rehydrate the skin. Ensure the water is not too hot and the bathing time limited to 10 to 15 minutes.
- Avoid soap and liquid soap.
- If using normal shampoo wash hair in the sink, rather than shower or bath. Wear plastic gloves if there is eczema or dermatitis on hands.

- After bathing, pat the skin dry and immediately reapply moisturisers.

4. Topical steroids:
    - Apply topical steroids a maximum of once a day, preferably at night.
    - Beware of steroid skin atrophy. Avoid prolonged continuous use of betnovate and dermovate, especially on inner arms, thighs, axilla, face, and breasts.
    - Steroid ointments are more effective than creams of an equivalent potency. Prescribe creams only for patients who are grease-intolerant or for hair-bearing areas.
    - Consider treatments for different body areas.

      Treatments for different body areas

      Start with the weakest option.

      Torso and legs:

      - Hydrocortisone 1%
      - Betnovate RD 0.025%
      - Betnovate 0.1%
      - Dermovate – often used with discoid eczema

      Face:

      - Hydrocortisone 1%
      - Eumovate – Can use for 1 month. If not settling after 1 month, consider infection or contact allergy and request non-acute dermatology assessment.

      Scalp:

      - Betnovate scalp application
      - Betamousse foam
      - Dermovate scalp application

      Hands and feet:

      - Betnovate 0.1%
      - Diprosalic ointment
      - Dermovate

5. Request non-acute dermatology assessment for consideration of topical calcineurin inhibitors (tacrolimus, pimecrolimus) if:

- eczema of eyelids and peri-orbital skin.
- regularly using topical steroids on the face.
- elderly patient or at risk of leg ulcers, and regularly using topical steroids on the lower legs.
- any signs of skin atrophy.

6. Oral antipruritics – If of benefit, use a sedating antihistamine at night to reduce itch. Use non-sedating oral antihistamines only if urticaria is suspected.

Bacterial infection

- Eczematous skin is susceptible to infection and infection aggravates eczema. A flare in eczema is frequently due to *Staphylococcus aureus* super-infection. Consider swabbing active eczema even in the absence of overt signs of impetiginisation or pustules.
- Treat promptly with oral antibiotics to control infected flares of eczema. Avoid prolonged courses of antibiotics in eczema as there is little evidence of benefit and an increased risk of bacterial resistance.

Oral antibiotics

- First-line – Flucloxacillin 500 mg 4 times a day for 7 days
- If allergic to penicillin, clarithromycin 500 mg twice a day for 7 days. Avoid in pregnancy

- *Staphylococcus aureus* may be carried in the nostrils leading to reinfection of the skin. If frequent flares are a problem, swab the nostrils of patient and carers and treat with Bactroban if positive.
- Infected eczema will usually be weepy, crusted, and erythematous. There may be vesicles, bullae, or fissuring of the skin.
- Consider the use of potassium permanganate to help dry out weepy skin.
- If extensive herpes simplex virus infection (eczema herpeticum), request acute dermatology assessment.

Failure to respond to treatment

1. Reconsider diagnosis e.g., scabies, psoriasis, fungal infections, drug reactions. If uncertain about diagnosis, request non-acute dermatology assessment .
2. Ensure the patient is moisturising their skin enough and applying the active treatment.
3. If poor control despite the above measures and compliance to therapy, request non-acute dermatology assessment .
4. Consider contact dermatitis and request non-acute dermatology assessment for patch testing if:

- facial eczema.
- unusual or asymmetrical pattern.
- exposure to an occupational allergen or strong history of triggering.

5. Further therapy – If systemic therapy, phototherapy, or immunosuppressants may be required, request non-acute dermatology assessment .
6. Do not prescribe prednisone for undiagnosed rashes.

Request

- If extensive herpes simplex virus infection (eczema herpeticum), request acute dermatology assessment.
- Request non-acute dermatology assessment if:
    - systemic therapy is required.
    - poor control despite the above measures and compliance to therapy.
    - further therapy is necessary, e.g., phototherapy or immunosuppressants.
    - uncertainty about diagnosis.
    - facial eczema, if not settling after 1 month using eumovate.
    - possible contact dermatitis where patch testing may be required.
    - considering calcineurin inhibitors.
- Ensure requests include:
    - the body percentage affected by eczema or dermatitis.
    - if hands, feet, or face are affected.

Information

For health professionals

- BMJ Learning (requires registration) – Eczema: a Guide to Management
- Newcastle Upon Tyne Hospitals:
    - Eczema
    - Top Tips Eczema
    - Worsening Eczema or Psoriasis

For patients

- National Eczema Society
- Patient:
    - Atopic Eczema
    - Moisturisers (Emollients) for Eczema

SEND FEEDBACK

SOURCES

PAGE INFORMATION

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