

A Guide to Eczema

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'Eczema' is a Greek word meaning 'to boil over' and, when used descriptively, means the same as 'dermatitis', another Greek word meaning 'inflammation of the skin'. In practice, the term 'eczema' is used when the cause comes from within the body and the term 'dermatitis' is used for symptoms arising as a result of external factors.

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Atopic eczema

Introduction

Eczema is a common inflammatory condition of the skin. There are several types of eczema; the most common form is atopic eczema, which presents as an itchy, red rash. It is characterised by flare-ups, during which time the skin may be weepy, or dry and scaly, and periods of remission.

Atopic eczema usually appears in childhood (before the age of 5 in 85% of cases¹) and affects as many as 15-20% of school-aged children.² However, around 75% of children 'out grow' eczema by the time they become teenagers.³ People with atopic eczema often have other allergic conditions (such as asthma and perennial/seasonal rhinitis)⁴ and/or family history of allergy.^{1,5}

Although eczema is a common condition, it can have a severe impact on quality of life for both a person with eczema and the parents and/or carers of children with eczema.

Diagnosis

Atopic eczema presents as an itchy rash.² The following are common findings:

- Distribution
 - On the face in very young patients⁴
 - On flexure surfaces such as inside of elbows and behind the knees²
 - Can be very widespread¹
- Dry, or weeping and crusty¹
- Areas that have been rubbed become lichenified¹
- Other clues include a personal or family history of eczema and/or other atopic conditions²



Atopic eczema is typically found on the cheeks of young children and flexure surfaces. Eczema may be dry and cracked or weeping and crusty.

Treatment

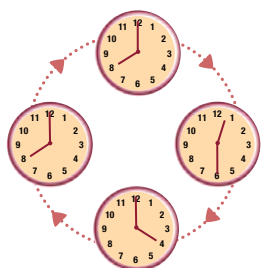
Eczema is characterised by increased trans-epidermal water loss and reduced hydration due to a breakdown of the skin barrier function.^{6,7} As a result of moisture loss, cracks appear within the skin structure which allow allergens such as bacteria (or viruses) and irritants to penetrate, aggravating the condition.^{6,7} Chronic long-term itching and scratching may lead to multiple cracks in the skin and a leathery thickening called lichenification. Therefore the aim of treatment is to keep the skin well moisturised with emollients to reduce the frequency and severity of flare-ups.

Emollient therapy

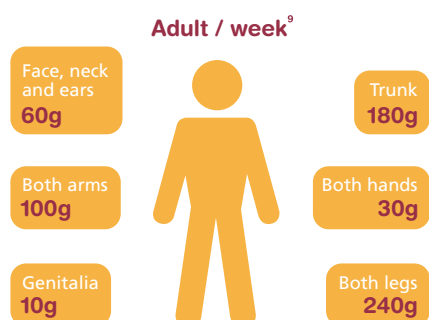
Emollients are available in a number of different preparations; ointments, creams, lotions and gels. Ointments provide the most effective protection and some contain only a mixture of white soft paraffin and liquid paraffin, with no preservatives or other excipients, making them potentially a more suitable emollient preparation. Creams are the most widely used emollient preparations and are absorbed more easily than ointments making them more cosmetically acceptable; they can also be used for washing or bathing.⁸ Lotions and gels are easily absorbed, but provide a much thinner layer of protection, so are a useful option for hairy areas.

To be fully effective, emollients must be used regularly, frequently and in sufficient volumes:²

- **Regularly** – Used every day, between and during flare-ups, even when the skin looks clear^{2,8}
- **Frequently** – Applied every 3 to 4 hours²



- **Sufficient volume** – NICE/BAD guidelines recommend 250-500g per week for a child, and 600g per week for an adult^{2,8}



“Many children with mild/moderate eczema can be controlled by using the complete emollient therapy regimen alone.”⁶

Helping your patients to build emollient application into their daily routine will encourage them to get into the habit of applying their emollient.

It is important that people with eczema are prescribed enough emollients to be able to apply the correct volume as part of their daily routine:

- Prescribe large enough quantities^{2,8}
 - Between **2-4 x 500g pump dispensers a month** for children



- Up to **5 x 500g pump dispensers a month** for adults.



- Consider giving the people in your care a combination of preparations⁹ and sizes of emollient:
 - An ointment for use at night and a cream for use during the day
 - Pump dispensers help to avoid cross contamination. Where it is not possible to use a pump dispenser, such as with ointments, patients should use something other than their hand to scoop out the ointment⁹
 - A tube of cream to enable treatment to continue away from the home⁴
 - A bath/shower emollient for washing⁴



Diprobase and Diprobath do not contain perfume, lanolin, parabens or sodium lauryl sulphate, which are potential sensitisers or irritants.¹⁰

Topical steroids

During flare-ups, people with eczema will need more than emollient therapy alone. There are a number of very effective treatments available that will quickly relieve the acute symptoms and clear the flare-up. The most widely used of these are topical steroids.

Topical steroids come as creams and ointments, and in a range of different strengths (mild, moderate, potent and very potent). When prescribing a topical steroid, it is preferable to choose one that needs application only once a day.¹¹ A step-wise approach should be used – starting with the correct potency based on the severity of the eczema, then:

- **Stepping down** as the severity decreases¹¹
- Or **stepping up** to more potent steroid or a twice-daily application if no improvement is seen¹¹

Product		Severity of eczema			
Brand	Generic	Potency	Mild	Moderate	Severe
Efcortelan	Hydrocortisone 0.1%	Mild	✓		
Synalar	Fluocinolone acetonide 0.0025%	Mild	✓		
Betnovate RD	Betamethasone valerate 0.025%	Moderate		✓	✓
Eumovate	Clobetasone butyrate 0.05%	Moderate		✓	✓
Modrasone	Alclometasone dipropionate 0.05%	Moderate		✓	✓
Betnovate	Betamethasone valerate 0.1%	Potent			✓
Cutivate	Fluticasone propionate 0.05%	Potent			✓
Diprosone	Betamethasone dipropionate 0.05%	Potent			✓
Elocon	Mometasone furoate 0.1%	Potent			✓
Dermovate	Clobetasol propionate 0.0525%	Very potent			✓ Adults only

A full list of topical steroids can be found on the British National Formulary¹²

The location of the eczema should also be considered; for example, mild potency steroids should be used for the face and neck, except for short-term (3–5 days) use of moderate potency for severe flares.⁸

Unlike emollients, steroids should be applied only to the inflamed area, used sparingly and only for as long as necessary to calm the flare-up. Fingertip units are commonly used to indicate how much topical steroid should be used. This table shows how many adult fingertip units are normally required for each area of the body.¹³

Area of body	Fingertip units per day
Face and neck	2½
Trunk (front and back)	14
Both arms	6
Both hands	2
Both legs	12
Both feet	4

Don't forget that your patients will need to keep using their emollient during flare-ups, so it's important that they understand how to apply both treatments appropriately.

Other treatments

In addition to emollient and topical steroid therapy, there are a series of other treatment options available to people with eczema. Competent healthcare professionals may initiate some of these in primary care:

- **Wet wraps** – Useful with topical steroid for severe eczema in young children, particularly when itching interferes with their sleep at night,⁴ as the evaporation process cools the skin. Parents and carers may need specialist advice on treatment application.⁸
- **Bandaging (SC)** – Occlusive dressings increase absorption of topical preparations.⁴ Bandages impregnated with therapeutic substances such as tar or ichthammol may be applied over topical preparations.⁴ Bandaging also offers protection from scratching.

Occlusive medicated dressings and dry bandages should not be used for infected eczema.⁸

- **Immunomodulator therapy** – An alternative to topical steroids which may be used for long-term maintenance therapy.¹⁴ Whilst they do not cause skin thinning,⁴ the potential risks and benefits of therapy should be fully discussed with a patient before treatment is initiated.⁴

Other specialist treatments are available or initiated in secondary care:

- **Phototherapy** – Given either with ultraviolet A or B (UVA, UVB) or with psoralen plus ultraviolet A (PUVA), phototherapy is thought to involve immunosuppression, although its mode of action is not fully understood. Exposure to UV rays from a course of phototherapy is thought to pose a low to negligible health risk.⁴
- **Systemic therapy** – Includes treatments such as oral steroids or immunosuppressants such as azathioprine and ciclosporin.⁴ Treatment should only be initiated under specialist dermatological supervision, and after formal assessment and documentation of the severity of someone's eczema and their quality of life.⁴

Practical advice on reducing exposure to triggers

Atopic eczema can be triggered by a wide variety of factors, and there are strategies and practical advice you can offer your patients:

- **Dust mites** – Strategies to reduce dust mites include protective covers for bedding/mattresses, vacuuming/dusting regularly, replacing carpet with laminate or stone flooring and freezing cuddly toys overnight.¹⁵
- **Pets** – Contact with cat/dog dander or saliva can be reduced by discouraging pets from licking, by washing hands after stroking the pet, by regularly washing pet bedding and keeping them off furniture and out of bedrooms.¹⁶
- **Clothing** – Wool can be irritating. Clothes made from cotton or silk may be preferable.¹⁶
- **Dietary allergens** – Keeping an eczema diary can help patients to identify any food that may be responsible for triggering their eczema.¹⁷ However, eliminating foods is not recommended unless there is a clear link between the food and a patient's eczema.¹⁷

Complications of eczema

People with atopic eczema are more susceptible to picking up bacterial and viral infections as a result of damage from inflammation and scratching. This allows bacteria and viruses to penetrate the epidermal skin barrier,^{1,4} setting up an infection which can in turn exacerbate the eczema.⁴

Bacterial infections

Look for: Broken, inflamed skin with heavy yellowish crusting which rapidly gets worse.⁴

Cause: Infections, e.g. impetigo, are usually caused by *Staphylococcus aureus* or *Streptococcus pyogenes*.⁴

Treatment: Oral antibiotics such as flucloxacillin should be prescribed for one or two weeks. If the patient has a known hypersensitivity to penicillin, erythromycin can be used instead.⁴



Eczema herpeticum

Look for: Rapidly progressive, widespread, crusted papules, vesicles and erosions which may become systemic and occasionally life threatening.⁴

Cause: Herpes simplex virus (commonly presents as cold sores).⁴

Treatment: If diagnosis is suspected, speak to the on-call dermatologist as infection can spread rapidly.⁴



Referral for specialist dermatological advice

It is important to recognise what aspects of care you feel confident to manage and where specialist support is required. You may need to seek specialist dermatological advice for:

- **Questions around diagnosis**
 - You are uncertain about the diagnosis⁸
 - You suspect contact allergic dermatitis⁸
- **Infection**
 - You suspect eczema herpeticum (requires same-day referral, and talk to an on-call dermatologist)⁸
 - Someone has not responded to bacterial infection treatment⁸
 - Someone is experiencing severe and recurrent infections⁸
- **Treatment**
 - Someone has not responded satisfactorily to optimal topical therapy⁸
 - Eczema on the face has not responded to appropriate treatment⁸
 - Concerns about the amount of topical steroids being used²
 - Someone may benefit from specialist advice on treatment application such as wet wraps⁸
 - Someone is experiencing significant social or psychological problems (e.g. sleep disturbance, numerous days off school or work)⁸

Contact dermatitis

Contact dermatitis may be irritant or allergic in form, and both are commonly found in those with atopic eczema.

Irritant contact dermatitis

As this is not an allergic reaction it can affect anyone whether they have eczema or not. Many household products may irritate the skin¹⁸ making it dry, sore, red or itchy with poorly defined edges to the redness.¹⁹ Many people find the liquid soaps at their place of work or in public places cause irritation after repeated use.¹⁸

Look for: A poorly-defined rash, usually limited to the immediate site of exposure,²⁰ such as under rings on the fingers from where the irritant has not been properly rinsed off.

Appearance may vary from slightly scaling and itching to extensive epidermal damage. Lesions may become lichenified through intensive scratching.¹⁹

Cause: Direct, irritant action of a substance on exposed skin – so there may be an improvement if there is a change of activity or environment (e.g. at weekends, or on holidays from work).¹⁸

Treatment: Avoidance of cause.²⁰

Frequent use of emollients (preferably every time the hands are washed) to rehydrate the skin.¹⁸

Topical steroids for localised inflammation.¹⁸

When dermatitis persists despite exclusion of suspected irritants or allergens refer for patch testing.²⁰

Tips: A history of exposure may help to identify the cause, but people are often unaware that common substances can cause irritation or allergic reactions.²⁰

If water or detergents are the cause, patients could consider avoiding/changing a career where there is frequent contact, i.e. nursing, hairdressing, catering, or engineering.¹⁸



Examples of occupations which have repeated exposure to potential irritants	
Hairdressers, nurses and cleaners	Soap and detergents, acid, alcohol and cleaning liquids
Builders	Cement
Garage mechanics and those working in industry	Oils and petrol

For household chores, rubber gloves with cotton lining should be used to prevent sweating.

Allergic contact dermatitis

Unlike irritant contact dermatitis, the allergic variety is a true (type IV) allergic reaction to an external agent.¹⁸

Look for: A rash that normally appears where the contact has taken place. With repeated exposure, the rash may develop elsewhere¹⁴ or recur at previously exposed sites.¹⁹

The location of the rash may suggest the cause – e.g. a rash on the ear would suggest a reaction to nickel in earrings, or a rash under the arm, hypersensitivity to deodorant.¹⁹

Cause: Common causes include:

Allergen	Found in
Nickel ^{18,19}	Jewellery; underwear; jeans studs; watch strap buckles
Rubber ^{18,19}	Rubber gloves; tyres; condoms; insoles; hoses; elastic in underwear
Perfumes ¹⁹	Cosmetics; soap; shampoos; toiletries; aftershave; household products
Paraphenylenediamine ¹⁹	Hair dyes; textile dyes; dark cosmetics; photographic developers; printing inks
Plants ¹⁸	Primula; poison ivy; chrysanthemums
Balsam of Peru (Myroxylon pereira) ¹⁹	Cosmetics; perfumes; toiletries
Lanolin ^{18,19}	Wool; skin creams; emollients; cosmetics; furniture polish; shoe polish
Preservatives ^{18,19}	Cosmetics; medical creams; emollients; dressings; foods

Treatment: Avoidance of cause.^{18,20}

Emollients and topical steroids for acute attacks.¹⁸

Tips: Patch testing is often helpful,¹⁸ especially if it appears that the patient may have to seek re-employment in a new career.

Allergic contact dermatitis can sometimes result from treatments used in eczema.⁸

The development of a contact allergy can sometimes arise a long time after the patient has been using the offending material.²¹



Other forms of eczema

Asteatotic eczema (eczema craquelé)

- Look for:** Very dry, red, scaly, cracked skin with superficial fissuring which may create a 'crazy paving' pattern. Usually seen on the lower legs of the elderly who have poor circulation and sometimes associated with a loss of fat on the legs.¹⁸
- Cause:** May occur more readily in the winter when central heating is turned on leading to a dry atmosphere.¹⁸
- Treatment:** Treat with copious emollient.¹⁸
- Tip:** Ensure that the humidity levels in the living environment are adequate to avoid exacerbation by dry atmosphere.

Discoid eczema (nummular eczema)

- Look for:** Very dry and itchy, round or oval (as the name suggests), red lesions that may be several centimeters in diameter. May have surface exudate and crust. Often found on the limbs and trunk in adults.¹⁸
- Treatment:** Emollients to rehydrate the skin.¹⁰
Topical steroids to prevent lesions developing into large plaques.¹⁸



Varicose eczema (stasis eczema)

- Look for:** Dry, itchy skin with brown or purple patches on the lower legs.¹⁸
- Cause:** Develops in sites of venous congestion due to varicose veins where the skin is poorly oxygenated.¹⁸
- Treatment:** Emollients are the main stay of treatment.¹⁸
Topical steroids must only be used on the lower legs if absolutely necessary and for short periods of time.¹⁸
It is vital to treat the cause such that venous insufficiency should be managed with compression hosiery or bandaging. Dopplers should be checked to make sure that the arterial supply can withstand compression. Surgical treatment of the varicose vein may be necessary.¹⁸



Juvenile plantar dermatosis

- Look for:** Shiny, red skin on the forefoot, which may scale or crack.¹⁸
- Cause:** Possibly associated with:
- Wearing socks made from man-made fibres²¹
 - Wearing synthetic shoes or trainers, which retain sweat²¹
- Treatment:** Emollients usually help over a period of time – patience is needed.¹⁸
Topical steroids usually do not help.¹⁸
- Tip:** Advise the patient to wear cotton socks and to take their shoes off at home if possible.²¹
Juvenile plantar dermatosis is common in childhood but usually resolves by the early teens.²¹



Pityriasis alba*

- Look for:** White patches, often on the face of children with pigmented or suntanned skin. May be more conspicuous on dark skins.²¹
- Cause:** Patches of hypopigmentation and dry skin.²¹
- Treatment:** Emollients. May occasionally require mild topical steroids. The patches will re-pigment.²¹
- *Alba = white



Pompholyx

- Look for:** A blistering rash on the hands and/or feet, which often occurs in bouts.²¹ The blisters may be very tiny (1-2mm across), especially on the sides of the fingers but occasionally may become large. Some splitting and fissuring may occur as the lesions progress.¹⁸
- Treatment:** Usually responds to potassium permanganate 1:10,000 soaks.¹⁸
Otherwise a potent topical steroid may help.¹⁸



Other itchy skin conditions

Dermatitis herpetiformis

Look for: Very itchy papules and vesicles most commonly arising on extensor surfaces such as the elbows, buttocks and knees but also the shoulders and scalp. If the itch is very severe the lesions may be excoriated to such an extent that the vesicles may not be apparent. Symptoms are persistent but severity can vary from week to week. Most commonly found in the second to fourth decade but can be found at any age.¹⁹



Cause: A rare autoimmune blistering condition associated with a gluten-sensitive enteropathy.¹⁹ Up to 90% of patients with dermatitis herpetiformis will have gluten enteropathy although symptoms of coeliac disease such as abdominal discomfort, diarrhoea and tiredness are frequently absent, and the diagnosis is only evident on endoscopic examination.¹⁸

Treatment: Patients should be referred to a dietician for a gluten-free diet. The condition responds very quickly to dapsone (an oral antibacterial) with reduction in itch within a few days. Adverse effects of dapsone include a haemolytic anaemia and monitoring is necessary.^{18,19}

Tip: Patients with suspected dermatitis herpetiformis are best referred to a dermatologist.

Two biopsies are required to confirm the diagnosis:¹⁸

- A biopsy of an active lesion needs to be sent for histology and reveals a sub-epidermal blister
- A second biopsy of normal skin for direct immunofluorescence reveals IgA immunoglobulin in dermal papillae

Patients with confirmed disease should then be referred to a gastroenterologist to look for evidence of coeliac disease.¹⁸

Lichen planus

Look for: Itch, which is usually very marked. Onset usually insidious but occasionally develops rapidly. The rash can affect any part of the body but is most common on the flexural aspects of the wrists, the ankles and the lumbar region.^{18,19} Lesions are shiny, flat-topped violaceous papules and have white lines on the surface known as Wickham's striae.¹⁹ Linear grouped lesions can grow in scratch marks (Koebner phenomenon).¹⁹ Papules tend to flatten after a few months and are replaced by hyper-pigmentation, which can be intense. Mucous membrane involvement is common with a white lacework pattern on the buccal mucosa¹⁹ and involvement of the genitalia.²¹



Cause: Lichen planus is thought to be an immunologically mediated disorder.²¹

Treatment: Most patients require treatment of the symptoms as the rash tends to be very itchy and symptoms can persist for months.²¹

Potent to super-potent topical steroids may be required and used with care on very itchy lesions.¹⁸

Tip: Lichen planus can present in many ways. It is important to check for evidence of hair involvement.¹⁸ Patients with aggressive disease that is widespread or associated with scarring, alopecia, nail destruction or ulcers should be referred early for consideration of second-line therapies.¹⁸



Lichen simplex

Look for: Intensely itchy lesions. They are dry, scaly; thickened with creases (lichenified); well demarcated and have a roughened surface. Often appears on the neck, forearms or shins – usually within easy reach of the dominant scratching hand.¹⁸ Often a solitary patch, may be several centimetres across, but may be widespread.¹⁸

Cause: Repeated scratching and rubbing, in an ‘itch-scratch cycle’, results in skin thickening.¹⁸

Treatment: Potent topical steroid under occlusion with medicated bandages,¹⁸ as lichenification reduces the penetration of topical steroids.

Occlusive bandaging can help absorption of topical steroid.⁴

Continue with maintenance treatment of emollients and intermittent topical steroids.¹⁰

Tip: Keeping the fingernails short can help to reduce the damage caused by scratching.



Scabies

Look for: Diagnosis is by the history. In children and adults look for burrows on the borders of the hands and feet, wrists, sides and webs of fingers and male genitalia. In infants there may be papules and pustules on the palms and soles.¹⁸ Often other family members / close contacts are affected, but this may not always be apparent, especially early in the history.¹⁸

Cause: The female scabies mite burrows into the skin laying eggs behind her. After 4-6 weeks itching begins as the body sets up a hypersensitivity reaction. The routes of transmission are classically “institutional, prostititional or familial”.¹⁸

Treatment: First-line treatment is with permethrin 5% cream – two treatments should be given one week apart.¹⁸

Tip: All household and other close contacts should be treated with one treatment, whether symptomatic or not.¹⁸



Seborrhoeic dermatitis in adults

Look for: Dandruff on the scalp with greasy, itchy scales. A greasy, scaly, red rash around the eyebrows, eyelashes, ears, sides of the nose and the mouth.¹⁸

The rash can also affect the chest, upper back, groin and axillae (armpits).¹⁸

Cause: It is thought to be caused by an infection with a yeast (*Pityrosporum ovale*) in its spore form, which is usually present on the skin but thrives in areas of certain sebaceous glands. The exact mechanism is unknown.¹⁸

Treatment: Scalp treatment is with ketoconazole shampoo. Selenium sulphide and zinc pyrithione are also helpful.¹⁸

Skin lesions also respond well to ketoconazole cream and emollients. Occasionally short spells of a mild-moderate topical steroid may be needed to reduce inflammation.¹⁸

Severe unresponsive cases occasionally require oral treatment with itraconazole 200mg, taken daily for seven days.¹⁸

Tip: It occurs most frequently in young men, but can occur in either sex at any age after puberty.¹⁸

Patients need to be warned that the condition will recur and requires repeated treatment.¹⁸



Seborrhoeic dermatitis in infants/children

Look for: Yellow-brown, greasy scales on the scalp (cradle cap), and as a red, scaly rash in localised areas of the body, such as in the nappy area, on the trunk and flexures. Unlike nappy rash, seborrhoeic dermatitis goes into the groin flexures.¹⁸

It usually starts in the first few weeks of life and lasts for a few months.¹⁸

Treatment: Scalp scales can be softened with olive oil and gently lifted off with a finger nail. In more severe cases, use 2% salicylic acid in aqueous cream or shampoo.¹⁸

The skin is best treated with emollients or 1% hydrocortisone ointment.¹⁸

Tip: Unlike eczema it is non-irritating.¹⁸



Urticaria

Look for: Itchy, oedematous, raised pink plaques without scale. Lesions often last for less than 2 hours. Can be associated with angioedema where there is dramatic swelling of the lips and other areas.¹⁸

Cause: Urticaria can be divided as follows:

- Acute urticaria is of recent onset (hours or days)¹⁸ and may result from an allergy to a medication, food or other common allergen.¹⁸
- Physical urticaria refers to urticaria induced by external physical influences. There are many different causes such as dermatographism where the urticaria is induced only after scratching the skin, and cold urticaria that occurs after exposure to the cold. Cholinergic urticaria results from sweating and presents with large numbers of small red papules.¹⁸
- Chronic urticaria persists for several months or years. It is not caused by allergy. In many patients no cause is found and it is felt to be an autoimmune process.¹⁸ It is worth checking a FBC, PV, TFT and thyroid autoantibodies.

Treatment: If physical factors (e.g. heat, cold, water and sunlight) are causing the problem they should be managed.¹⁸

If possible avoid aspirin, NSAIDs and ACE inhibitors, which can exacerbate symptoms.¹⁸

Start with a non-sedating antihistamine, e.g. fexofenadine 180mg daily or loratadine 10mg daily.¹⁸

If there is no benefit after 14 days, add in a sedative antihistamine e.g. Hydroxyzine 25-50mg to be used at night – warn that patients may feel tired the following morning.¹⁸

Children can be treated in a similar way but use appropriate doses for their age.²²

Tip: Patients may take antihistamines for as long as is required.²²

Patients presenting with patches of urticaria that last for more than 24 hours and which fade with a rather bruised appearance may have an underlying vasculitis and so further investigation is needed.¹⁸



Other pruritic conditions

Look for: Itching anywhere on the skin surface.¹⁸ Examination reveals secondary changes such as excoriations, scars and thickening but with limited erythema or other signs of a primary dermatology pathology.¹⁸

Cause: There are many causes. Look for subtle signs of skin disease such as dry, asteatotic skin in older people. Review any new medication. Depression and anxiety is a common cause of itch. Possible systemic causes include:¹⁸

- Haematological disorders:
 - Iron deficiency
 - Polycythaemia rubra vera
- Liver disease
- Chronic renal failure
- Thyroid disease (either hypo- or hyperthyroidism)
- Lymphoma and other internal malignancies

Treatment: Treat any underlying cause.

Cooling emollients¹⁸ and sedating antihistamines used at night will often help.¹⁸

Any underlying anxiety/depression needs to be addressed and managed appropriately.¹⁸

Tip: In patients without an apparent cause for pruritus a thorough examination is needed. Investigations are as follows:

- All patients need FBC, PV and standard biochemistry. A ferritin level is needed even if the FBC is normal. Plasma electrophoresis and immunoglobulins are required for older patients. A CXR is needed in all patients to look for lymphoma and paraneoplasia.¹⁸
- In well patients with normal tests, further investigations are probably unnecessary. However, patients who are clearly unwell with weight loss or other alarming symptoms will require further investigations.¹⁸

Diprobase®

Emollient

Diprobath®

Light liquid paraffin,
isopropyl myristate

References

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Diprobath Abbreviated Product Information

Uses: Diprobath Cream and Ointment are emollients, with moisturising and protective properties, indicated for follow-up treatment with topical steroids or in spacing such treatments. They may also be used as diluents for topical steroids. Diprobath products are recommended for the symptomatic relief of red, inflamed, damaged, dry or chapped skin, the protection of raw skin areas and as a pre-bathing emollient for dry/eczematous skin to alleviate drying effects. **Dosage:** The cream or ointment should be thinly applied to cover the affected area completely, massaging gently and thoroughly into the skin. Frequency of application should be established by the physician. Generally, Diprobath Cream and Ointment can be used as often as required. **Contra-indications:** Hypersensitivity to any of the ingredients. **Side-effects:** Skin reactions including pruritus, rash, erythema, skin exfoliation, burning sensation, hypersensitivity, pain, dry skin and bullous dermatitis have been reported with product use. **Package Quantities:** Cream: 50g tubes, 500g pump dispensers; Ointment: 50g tubes. **Basic NHS Costs:** Cream: £1.28 (50g), £6.32 (500g); Ointment: £1.28 (50g). **Legal Category:** GSL. **Marketing Authorisation Numbers:** Cream: 0201/0076; Ointment: 0201/0075. Further information available upon request from Schering-Plough Ltd, Shire Park, Welwyn Garden City, Herts, AL7 1TW. **Date of Revision:** November 2009.

MSD Welwyn Garden City, Herts, AL7 1TW
Diprobath® is a registered trademark.

Code: DIP/10-707
Date of preparation: June 2010



Diprobath Abbreviated Product Information

Diprobath is a liquid preparation for external use as a bath additive. It contains Light Liquid Paraffin Ph.Eur 46% w/w and Isopropyl Myristate BP 39% w/w. **Uses:** As a bathing emollient for the treatment of dry skin conditions and hyperkeratoses including dermatitis and eczema. **Dosage:** 25ml (2.5 capfuls) to an adult size bath (approx. 100 litres) or 10ml (1 capful) for children's baths (approx. 25-30 litres). For particularly dry skin, these quantities may be doubled. The frequency and duration of bathing will depend on the nature of the condition. **Contra-indications, Warnings:** Hypersensitivity to the ingredients contra-indicates use. Patients should be advised to use care when entering or leaving the bath which may be more slippery than usual. **Package Quantities:** 500ml bottle. **Basic NHS Costs:** £6.74 **Legal Category:** P. **Marketing Authorisation Number:** 0201/0174. Further information available upon request from Schering-Plough Ltd, Shire Park, Welwyn Garden City, Herts, AL7 1TW, England. **Date of Revision:** January 2009

Please refer to the full SPC text before prescribing this product. Adverse events should be reported. Reporting forms and information can be found at www.yellowcard.gov.uk. Adverse events should also be reported to Schering-Plough Drug Safety Department on +44 (0)1707 363773