Eczema—Atopic, Contact, and Non-specific Dermatitis

DIAGNOSIS:

Eczema is an acute, sub-acute, or chronic itchy inflammation of epidermis and dermis often occurring in persons with a family history or personal history of atopy.

In acute cases, lesions are ill-defined erythematous patches or papules often with scale and edema. Erosions may appear crusted. Excoriations can be present. Sometimes it is superinfected.

In chronic cases, lesions are lichenified—thick, hyperlinear skin secondary to scratching. Fissures, hair loss, and periorbital pigmentation may be observed.

These lesions are commonly found on flexures, side of neck, face, wrists, and dorsa of feet. In the case of contact dermatitis, look for linear lesions often with blisters and sparing covered areas.

REFERRING PROVIDER:

Acute: oral anti-histamine for itching, copious use of emollients QID, and a potent steroid-like fluocinonide (0.05% cream) for 2 weeks BID. For infants and young children consider hydrocortisone 2.5%.

Chronic: as above except use mid-potency steroid such as triamcinolone 0.025% cream, fluticasone propionate 0.05% cream or Locoid 0.1% cream in 2-week bursts. Use Elidel (1% cream) or Protopic (0.1% ointment) if steroids are insufficient. Rotating topical corticosteroids may be helpful.

Acute contact dermatitis: use Prednisone approximately 2 week course from 1mg/kg tapering by 10mg every 3 days.

Secondary therapy: consider therapy for superinfection such as oral antibiotics (e.g., cephalosporin). This may be helpful even when patients do not look grossly infected.

WHEN TO REFER:

- If not responding to above therapies
- Refer children (<18 years) to Pediatric Dermatology
- Refer teens (>18 years) and adults to Medical Dermatology
- Ultraviolet light therapy, oral steroids, other systemic immunosuppressants, and inpatient therapy are treatments that might be offered in Dermatology