STANDARD TREATMENT WORKFLOW (STW)

Eczema/Dermatitis

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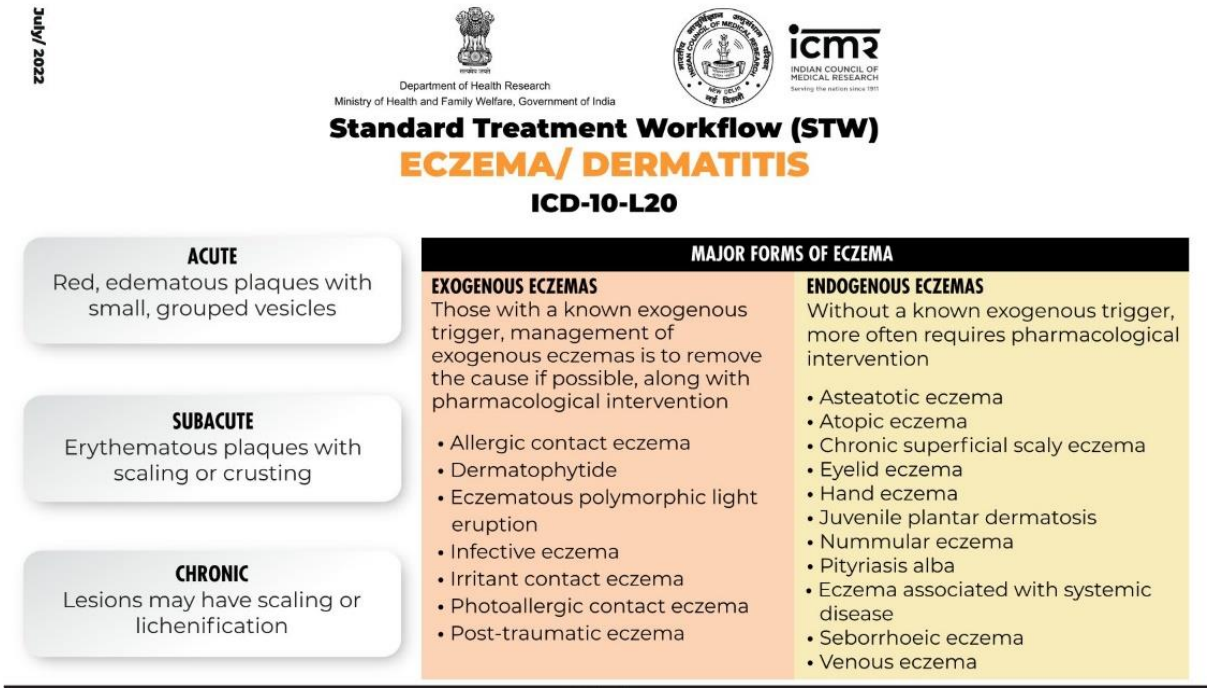
CITATION

Khaitan BK, Pandhi D, Khurana A, De D, Mahajan R, George R, Gupta V. Eczema/Dermatitis. Journal of the Epidemiology Foundation of India. 2024;2(1Suppl):S89-S90.
DOI: https://doi.org/10.56450/JEFI.2024.v2i1Suppl.045



July/ 2022

Department of Health Research
Ministry of Health and Family Welfare, Government of India

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Standard Treatment Workflow (STW)

ECZEMA/ DERMATITIS

ICD-10-L20

ACUTE
Red, edematous plaques with small, grouped vesicles

SUBACUTE
Erythematous plaques with scaling or crusting

CHRONIC
Lesions may have scaling or lichenification

MAJOR FORMS OF ECZEMA

EXOGENOUS ECZEMAS
Those with a known exogenous trigger, management of exogenous eczemas is to remove the cause if possible, along with pharmacological intervention

- Allergic contact eczema
- Dermatophytide
- Eczematous polymorphic light eruption
- Infective eczema
- Irritant contact eczema
- Photoallergic contact eczema
- Post-traumatic eczema

ENDOGENOUS ECZEMAS
Without a known exogenous trigger, more often requires pharmacological intervention

- Asteatotic eczema
- Atopic eczema
- Chronic superficial scaly eczema
- Eyelid eczema
- Hand eczema
- Juvenile plantar dermatosis
- Nummular eczema
- Pityriasis alba
- Eczema associated with systemic disease
- Seborrhoeic eczema
- Venous eczema

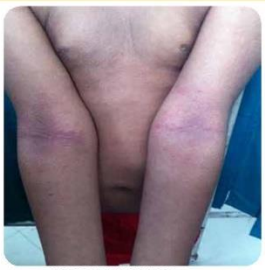
HISTORY

- Associated history of atopy, allergic rhinitis or asthma in patient and family members
- Age of onset is usually early(less than 5 years) in atopic dermatitis
- Site of onset- predominant flexural involvement in atopic dermatitis
- Possible allergens implicated
- High risk occupations with increased exposure to allergens or irritants such as agricultural work, masons, hair-dressers etc.
- Associated photosensitivity, especially in parthenium dermatitis
- Change in severity with season; summer exacerbation in parthenium dermatitis
- Winter exacerbation in atopic dermatitis

EXAMINATION

ATOPIC DERMATITIS

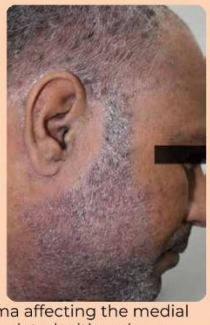
- **Infantile:** Most commonly on the face, followed by involvement of extensors of the knees and elbows
- **Childhood/ Adult phase:** Pattern changes to flexural involvement (cubital and popliteal fossa)



ATOPIC DERMATITIS

ENDOGENOUS ECZEMA

- **Nummular dermatitis/eczematous:** Circular or oval, commonly affecting neck, hands and feet
- **Seborrhoeic dermatitis:** Involvement of the scalp and other seborrhoeic areas and skin folds; ranging from mild flaking to thicker, yellow, greasy scales and crusts

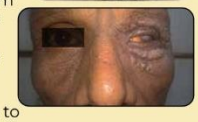


- **Venous eczema:** Eczema affecting the medial aspect of ankles associated with varicose veins/ venous incompetence

CONTACT DERMATITIS

- It can be irritant or allergic
- Eczema pattern corresponds to the pattern of allergen/ irritant exposure
- It can be localized or widespread

EXAMPLE:
Parthenium dermatitis
contact dermatitis to nickel
contact dermatitis to hair dye



DIAGNOSIS

- Most cases of eczema can be diagnosed clinically
- Secondary infection is common, may cause eczema to flare and can be confirmed by taking swabs for culture and sensitivity
- Patch tests are designed to detect allergens in cases of suspected allergic contact dermatitis
- Potassium hydroxide (KOH) preparation or biopsy when dermatophyte infection or other diagnoses are suspected

DIFFERENTIAL DIAGNOSIS

- Tinea corporis
- Psoriasis
- Cutaneous t-cell lymphoma (CTCL)

TREATMENT

GENERAL PRINCIPLES

- Avoidance of allergens and irritant materials
- Daily bath with mild soap, keep nails short, avoid scratching
- Moisturizer are cornerstone in the management of eczema; to be applied immediately after bathing while the skin is still damp and apply multiple times during the day
- Antihistamines for (eg. levocetirizine) for control of pruritus
- Topical corticosteroids (TCS) mild – Over face/ flexures genitals. Mid potent TCS over palms, soles and lichenified lesions
- Topical calcineurin inhibitors (TCIs)- Face/ flexures genitals and/or as maintenance treatment
- If secondary infection (pain, pus discharge, yellow crust)- Treat with topical/ oral antibiotic as needed

SPECIFIC MANAGEMENT

Primary/Secondary Level

- Treatment of active eczema: Daily use of TCS of appropriate strength until completely clear ± antihistamine (for sedative/antipruritic effects) ± oral antibiotic course (if superinfection) - (refer to STW on rational use of topical therapy)
- Maintenance treatment for area where lesions are more resistant to treatment or there is propensity for relapse, like flexural skin- Intermittent use of mid-potency TCS (e.g. 2-3 days/week) and/or TCI (e.g. 3–5 days/week)

Tertiary Level

- Severe disease in addition to above may require phototherapy or systemic treatment (Short course of oral corticosteroids, cyclosporine, azathioprine etc.)

AVOIDANCE OF PROVOKING AGENTS, MOISTURIZERS AND EARLY TREATMENT ARE THE AIM OF ECZEMA MANAGEMENT