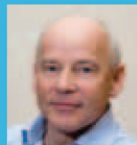
Ask the expert



Dr George Moncrieff
GP

Dr Moncrieff is a GP with a special interest in skin. He is a partner in a GP practice in Bicester and set up an interface dermatology clinic for patients in North-east Oxfordshire in 2000.

Young adult eczema

Q My name is Tilly and I am 21 years old. As a small child I had eczema. I remember it well as I always seemed to be itching at primary school. Then, when I started senior school, my eczema magically disappeared and I thought I was rid of it for good! However, 6 months ago my eczema returned with a vengeance. It is really bad – my arms and legs are covered and I am devastated because it is on my face too – a part of my body that was never affected by eczema before. Why has my eczema returned? (I thought children grew out of it.) Do you think it is allergy–related?

Dr George Moncrieff says: Your story is not unusual. Atopic eczema typically improves beyond early childhood, often settling completely by the teenage years, although the underlying tendency is lifelong. The top layer of the skin – the epidermis – has a critical 'barrier' function, conserving water and preventing bacteria and allergens from penetrating the skin. We now understand that this barrier is compromised in patients with eczema, partly due to genetic factors, resulting in the skin becoming dry, inflamed and itchy. Scratching further aggravates the damage and inflammation.

Most people can tolerate the excessive washing of our modern lifestyle. However in individuals with a tendency to eczema, washing with detergents damages the skin barrier catastrophically. Not only do all detergents (soaps, shower gels, shampoos etc.) wash off the natural grease on the skin, they also render the surface strongly alkaline (it is normally quite acidic). This activates agents

Julie Carr
CHILDREN'S DERMATOLOGY SPECIALIST NURSE

Julie has more than 20 years' experience in dermatology nursing. She is a Senior Children's Dermatology Nurse Specialist at Sheffield Children's Hospital and has an active teaching role as well as working alongside GPs, health visitors, school nurses and social workers.

Julie Van Onselen
DERMATOLOGY NURSE

Julie is an independent dermatology nurse and educator. Her clinical work is at Oxfordshire PCT dermatology clinic. She also works with the National Eczema Society providing training for healthcare professionals as well as patient education sessions and writing information articles and booklets.

that split the skin cells from one another, further compromising the skin barrier. After one application of a detergent, it takes ***normal*** skin over 2 days to recover!

Once this skin barrier is weakened, the skin becomes even more inflamed, inhibiting the skin barrier protection, and a vicious cycle rapidly ensues. An intact barrier is the best defence against exposure to a potential allergen, so it is possible that you may now have developed an allergy. One of the most likely culprits could be a biocide called methylisothiazolinone – it is present in many household products, including face wipes, eyeliner and mascara, shampoos, body lotions and creams, etc. There are clearly many other potential allergens and I would encourage you to ask your GP to refer you for appropriate patch testing.

You must stop allowing any detergents coming into contact with your skin (be careful to ensure that when you shampoo your hair, none washes onto your body) and use soap substitutes instead of soap. Hopefully, you will then break any itch–scratch–itch cycle and regain control of your eczema. **This is the most important message for the rest of your life.** From your description, I am also concerned that your eczema could now be infected and, if so, this will need to be addressed. Bringing your flares under control with either a topical steroid or a topical immunomodulator is also likely to be necessary.

Infected eczema in a child

Q My son Jamie is 4 years old and his eczema seems to be getting worse. He always used to have a dry type of eczema, but recently it has become wet and weepy in places. Sometimes it can be covered with yellow crusts, which we wash off in the bath. My doctor tells me this is a normal pattern of eczema and has prescribed some antibacterial washes and an antibiotic cream to use. The problem is that his skin appears to be less weepy for a while but remains very red – and then he starts scratching a lot because he is itching, and the wet and weeping eczema returns. I know we are in a vicious cycle, but have been told that we have all the right treatment creams. Can you advise on how to get on top of this wet and weepy eczema?

Julie Carr says: Unfortunately, infection is a very common reason for eczema flaring. The usual culprit is the bacterium *Staphylococcus aureus*, which is found in greater numbers on eczematous skin than on normal skin. Damage caused by scratching allows it to penetrate and cause inflammation. This then becomes a vicious cycle, of itch–scratch–damage–infection.

Topical antibiotic creams, including those combined with topical steroids, are recommended by NICE for localised areas of infected eczema – use them for a maximum of 2 weeks to prevent resistance becoming an issue. Antiseptic washes and bath oils can also be helpful when skin is infected or flaring but should not be used long term. If *Staph. aureus*-infected eczema is widespread, a 1–2 week course of oral antibiotics is recommended.

Problems can occur due to other types of bacteria, such as streptococcus, or even viral infections – most commonly, the herpes simplex (cold sore) virus. These can be trickier for GPs to detect. As a rule of thumb, if any infection is not showing signs of clearing within 2 weeks of treatment, get a review and perhaps ask the GP or healthcare professional to take skin and nasal swabs.

If Jamie were to become unwell, have a painful burning sensation in his skin and a high temperature, this could be a sign of eczema herpeticum (from the herpes simplex virus). **This needs prompt attention with correct medication, either orally or intravenously in hospital if the rash is widespread.** The rash looks different from 'normal' eczema and has grouped, blistered, deep and painful lesions, which spread quickly on the body.

Remembering to do all the basics is also essential. For example, ensure that Jamie has a good supply of emollients and correct topical treatments and is using them appropriately. Don't put your fingers in any open or round-neck pots as these will become contaminated easily. Opt for pump dispensers if Jamie is prone to infections, as these are more hygienic. Avoid bandages and wet wraps when eczema is infected, as occlusion increases the amount of bacteria on the skin. Also, bandages are notorious for sticking to skin and causing pain on removal, if it is oozing or sore.

If you are still struggling, ask for a referral to your nearest dermatology centre. The team there can investigate fully why Jamie has been unresponsive to current treatments and give you appropriate advice and support.

Emollient or topical corticosteroid – which should you apply first?

Q I am a middle-aged woman with lifelong eczema. I try my best to keep it under relatively good control but, like lots of people, I feel that my flare-ups come around quickly. I have one burning question to which no healthcare professional has been able to give a simple answer. My question is: should you apply your emollient first, or your topical steroid? It seems to me to be such a simple question but I can't seem to get a straightforward answer – so I thought I would ask your experts.

Julie Van Onselen says: Thank you for asking this question, which does cause considerable debate amongst people with eczema, parents and healthcare professionals. Emollients and topical steroids are first-line eczema treatments and, when eczema is flaring, they need to be used in conjunction with each other. It is extremely important to use emollients and topical steroids separately and never mix the two preparations together. This is in order to avoid altering chemical formulations, which could lead to ineffective treatment.

Applying emollients and topical steroids at the same time to areas of eczema has raised concerns that topical steroids will be diluted and be less effective.

So, all guidelines recommend leaving a 'gap' between applying an emollient and topical steroid. The length of this gap depends on the dryness of the skin and the formulation of emollient (lotion, cream or ointment) – generally this works out as 15–20 minutes for a lotion or cream and 30 minutes for an ointment.

The question of order – whether to apply an emollient or topical steroid first or second – is based on practical, clinical advice rather than research-based evidence. If the skin is very dry, applying emollient first removes dead skin cells, and topical steroids are absorbed more easily into the well-moisturised skin surface, thereby treating the target area (rather than skin scale) more effectively. Alternatively, applying the topical steroid first means that the active areas of eczema are treated, without emollients occluding the target area (this is another reason for leaving a gap). However, there are concerns that applying an emollient after a topical steroid can lead to a risk of spreading the steroid onto unaffected skin.

The most important issue for the parent of the child or person with eczema is that treatments need to be acceptable and manageable, fitting in with family life. In short, there is no correct order for emollients and topical steroids, but adhering to the 'gap principle' when using both emollients and topical steroids is key to successful treatment.