Seborrhoeic dermatitis in adults factsheet

Seborrhoeic dermatitis is a common scaly rash that often affects the face, scalp and chest, but it can affect other areas. 'Dermatitis' is another word for 'eczema'. 'Seborrhoeic' (pronounced seb-or-a-ik) simply means that the condition appears in those areas of the skin with large numbers of grease (sebaceous) glands, such as the scalp and sides of the nose. There are two types: adult and infantile. This factsheet is for adults with seborrhoeic dermatitis. Infant seborrhoeic dermatitis (known as cradle cap) differs from the adult form and is discussed in a separate National Eczema Society factsheet.

Who gets it and why?

The condition affects 1-3% of the adult population and is more common in men than women. The adult form of seborrhoeic dermatitis can develop from puberty but more usually occurs in adulthood – prevalence rises sharply over the age of 20, with a peak at 30 years for men and 40 years for women.

Although this condition affects the areas of skin with grease glands and can lead to the development of a greasy-looking scale, greasy skin is not the cause of seborrhoeic dermatitis. Typically, the skin is, in fact, quite dry, as in all forms of eczema. Adult seborrhoeic dermatitis is believed to be an inflammatory reaction related to an overgrowth of normal skin inhabitants – species of *Malassezia* yeasts (*Malassezia furfur*, also known as *Pityrosporum ovale*). The yeasts are part of normal skin flora but for an unknown reason they trigger seborrhoeic dermatitis in certain individuals.

Seborrhoeic dermatitis is not contagious or related to diet, but it may be aggravated by illness, psychological stress, fatigue, change of season and a general deterioration of health. Those with an immunodeficiency (especially infection with HIV), heavy alcohol intake, and neurological disorders such as Parkinson's disease and stroke are particularly prone to it. It may or may not be itchy and can vary from day to day.

Psoriasis is another common skin condition and often co-exists with seborrhoeic dermatitis. Psoriasis frequently causes a very scaly scalp (it is estimated that 80% of sufferers have some scalp involvement). Unfortunately, the irritation caused by seborrhoeic dermatitis aggravates psoriasis and this can produce a particularly difficult condition that does not settle unless the seborrhoeic dermatitis element is controlled. Sometimes this is referred to as 'sebo-psoriasis'.

Once the skin has become inflamed with any form of eczema, any exposure to detergents, soaps, shampoos etc. will aggravate the irritation in the skin and scalp. This can be a major factor in causing the seborrhoeic dermatitis to become more severe and persistent.

Similarly, many skin irritants can make the condition worse. Care should therefore be taken to limit exposure to DIY materials such as solvents and chemicals.

What does it look like?

Seborrhoeic dermatitis appears as faintly red areas of inflamed skin with a greasy-looking white or yellowish scale on the surface. In flexural areas such as the armpits or groin, the scale may be absent and the skin can look a bit more glazed. On more exposed areas, the scale can become quite marked and yellowish. It can be itchy and, if more severe, sore.

Usually, one or two areas of skin are involved, but seborrhoeic dermatitis can be quite extensive, involving:

- **Scalp**: On the scalp it can range from a mild flaking of the skin (dandruff) to extensive red and scaly areas, which can sometimes weep.

- **Face**: Typically, the skin around the sides of the nose and in the creases, and sometimes the cheeks, can become red and scaly. The inner half of the eyebrows can develop 'dandruff'. Sometimes the eyelids and eyelashes become involved, a condition known as 'blepharitis'.
- **Ears**: Seborrhoeic dermatitis may occur around the ears. Eczema can occur in the ear canal (otitis externa), on the earlobe or behind the ears. National Eczema Society has a factsheet on Ear Eczema, which covers this condition in more detail.
- **Generalised**: Very rarely, the dermatitis can become severe and extensive, covering large areas of the body and needing more aggressive management.

How is it diagnosed?

The diagnosis is usually made from the history and appearance of the skin in the affected area. Normally there is no need for any particular tests, unless the doctor thinks it may be a fungal infection, in which case skin scrapings are taken to test for fungus. If there is some doubt about the diagnosis, a biopsy may be necessary, but this is rare.

How is it treated?

Seborrhoeic dermatitis cannot be cured, because once an individual has become allergic to *Malassezia* on the skin, exposure to it will always cause a problem. The only way to keep it under control is to use anti-yeast treatments, which will suppress seborrhoeic dermatitis but not eradicate it. However, it is usually not difficult to keep seborrhoeic dermatitis under control, and topical treatments are safe to use long-term. Milder cases are often managed with over-the-counter remedies, and pharmacists should be able to advise on these.

The major reservoir for the yeast is the scalp, so a medicated anti-yeast shampoo should be used. Even if all signs of the condition have disappeared, it is advisable to use an anti-yeast shampoo once a week as an ongoing preventative measure. After treating the scalp, it may still be dry, so emollients should be used.

Moisturising the scalp

Moisturising creams or spray-on oils can be applied to the scalp by parting the hair and massaging them into the skin (ointments are not suitable as they are grease-based and difficult to wash out). Medical emollients in lotion, gel and spray-on oil forms, for example, Diprobase lotion, Doublebase gel, and the spray-on oil Emollin, may be suitable. Coconut oil is another option, which, like emollient creams, can be bought in pharmacies. It comes as a solid form that melts at skin temperature. Olive oil is no longer recommended as it has been found to damage the skin barrier; as an alternative, non-fragranced mineral oil (baby oil) is recommended.

Scalp

There are many over-the-counter anti-yeast shampoos that can be used. These include:

- Dandrazol (ketoconazole)
- Nizoral (ketoconazole) – also available on prescription
- Selsun – be beware that the selenium can stain cheap metals and jewellery black.

Use these shampoos as a treatment rather than as a hair wash. Leave them on for 5-10 minutes and then rinse off. Try not to use more than twice a week as there is a risk of irritation.

For more severe seborrhoeic dermatitis affecting the scalp, a scalp application or lotion containing a steroid and salicylic acid (e.g. Diprosalic scalp application) may be prescribed. This will help to control symptoms of redness and scale.

Tar-based shampoos or Dermax (not tar-based) are good for keeping symptoms of flaking and scaling at bay, and they can be alternated with something like ketoconazole shampoo. Tar-based shampoos include:

- T-gel
- Capasal.

As with the treatment shampoos above, try not to use these more than twice a week as there is a risk of irritation.

If the scalp becomes very scaly, you may need a de-scaling agent such as salicylic acid along with the shampoo. Alternatively, Capasal shampoo is a tar-based shampoo which contains a de-scaling agent.

Elsewhere on the body

The dermatitis is typically quite mild elsewhere and responds well to a mild topical steroid cream combined with an anti-yeast ingredient – for the face and around the ears. The imidazole group is highly effective and includes:

- Ketoconazole (Nizoral/Daktarin Gold)
- Clotrimazole (Canesten/Canesten HC)
- Miconazole (Daktarin/Daktacort/Daktarin Aktiv).

Sometimes doctors may suggest that anti-yeast shampoos are used on the body as well as on the scalp. This can be a good way of treating large areas such as the chest. Leave the shampoo on the body area for 5-10 minutes before rinsing off (since this can irritate dry skin, only twice a week is recommended). In between, emollients can be used if the skin is dry.

It is better to use a cream on smaller areas (such as the face). Sometimes anti-yeast eardrops are prescribed for the ear canals.

Mild topical steroids – either on the face or in the flexures – should be used for short-term bursts of treatment. The steroid treats the skin redness, and once any irritation has settled and the dermatitis is controlled, it is wise to use just the anti-yeast agent. Mild topical steroids can also be prescribed or purchased from the pharmacist as a combination treatment, recommended as a 7-day treatment course (e.g. Daktacort or Hydrocortisone cream).

Very rarely, an oral anti-yeast treatment may be needed (e.g. Itraconazole or Fluconazole) if the seborrhoeic dermatitis becomes severe or extensive.

The important message is that long-term treatment is needed to keep this condition at bay. If it recurs, it is not because the treatment has failed – it is because of the persistent nature of the condition, due to sensitivity to *Malassezia* yeasts. Therefore ongoing treatment with anti-yeast measures is vital.

If you live in England and you pay for your prescription, it may be worth investing in an NHS prescription pre-payment certificate (FP95), which you can apply for online or at some registered pharmacies. Ask your pharmacy about obtaining a PPC (FP95) form. Most of the treatments are available from your pharmacist without a prescription, although some are quite expensive.

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