

Atopic Dermatitis (Eczema) – Evaluation and Management

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ECHO

Growing the Ability to Deliver Quality Healthcare to American Indian and Alaska Native People.

LEADING THE WAY

Objectives



- I. Recognize the common presentation of eczema
- II. Become comfortable with classic eczema management and patient counseling
- III. Pearls and pitfalls of helping patients
- IV. Plan next steps when patients aren't improving

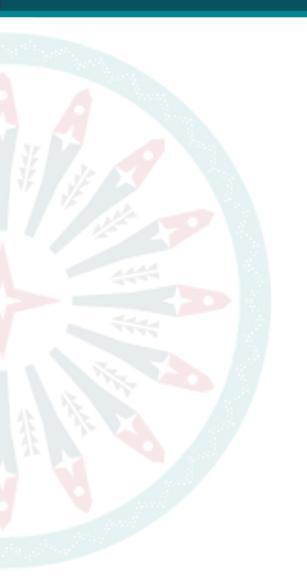
Background



Eczema is COMMON

- ~20% of the US population
- Associated with "atopic" conditions
 - Food allergies = correlation NOT causation
- Often starts in childhood
- Huge span of severity
- Significant impact on QoL

Presentation



Infancy (0-6 months)

Face, elbows, ankles

Childhood

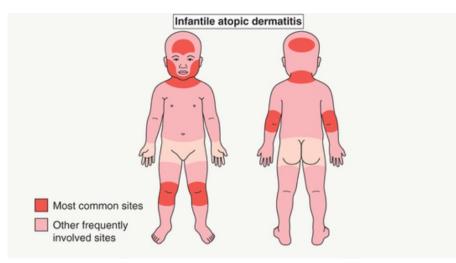
Flexors and hands

Adulthood

Dry and lichenified

Infancy









Childhood



and palms DermNetNZ.org

Head and neck dermatitis: primarily of face and neck after puberty; may be triggered by Malassezia overgrowth

Ear eczema: erythema, scaling and fissuring

under earlobe and/or in retroauricular region, ± bacterial superinfection

Eyelid eczema*: often has prominent lichenification

Dryness (chapping) of vermilion lips, ± peeling, fissuring, angular cheilitis

Erythema and scaling surrounding vermilion lips, often due to irritation from licking (lip licker's eczema)

Dyshidrotic eczema: deep-seated vesicles favoring sides of fingers

Juvenile plantar dermatosis: glazed erythema, scaling and fissuring of plantar forefeet

of clothing (e.g. in

Most common sites

Specific variants

Other sites of predilection

favoring extensor extremities

Nipple eczema:

joggers/athletes)

eruption: multiple, small, flat-

Frictional lichenoid

topped pink to skin-

colored papules on

classically in atopic boys

elbows > knees,

in spring/summer

Prurigo-like lesions:

firm, dome-shaped

papulonodules with

central scale-crust,

Atopic hand eczema*: often superimposed irritant contact dermatitis

Nummular lesions†:

coin-shaped eczematous plaques, often with oozing/crusting, favoring extremities

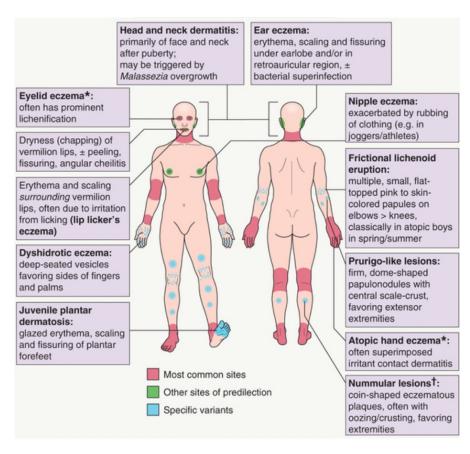




Adult





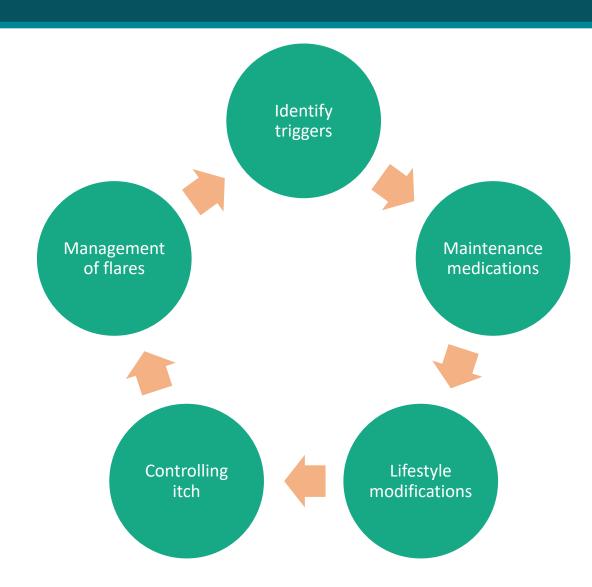






Treatment





Treatment



Steroids

Two-week rule, prefer ointment, provide large jar!

- Low potency face, intertriginous, high BSA, peds
 - Hydrocortisone 2.5%, triamcinolone 0.05%
- Medium potency
 - Triamcinolone 0.1%
- High potency hands, feet, scalp, recalcitrant
 - Clobetasol 0.05%

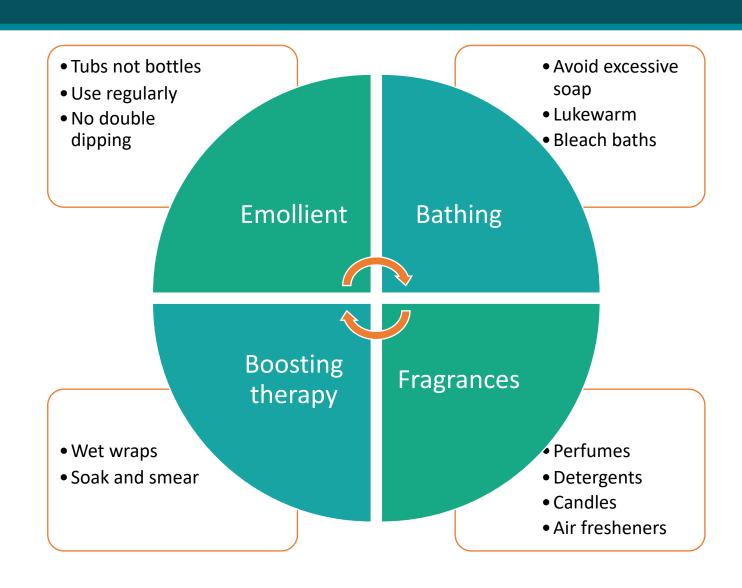
Steroid Sparing

Safe for long-term use, safe for use on sensitive areas

- Tacrolimus
- Pimecrolimus
- Crisabarole
- Ruxolitinib

Lifestyle, lifestyle, lifestyle!





Steroid Risks



- Increased duration
- Increased potency
- Increased BSA

Remember, with small children, BSA adds up quickly



Irreversible thinning of the skin



Irreversible striae



Hypopigmentation



Systemic effects

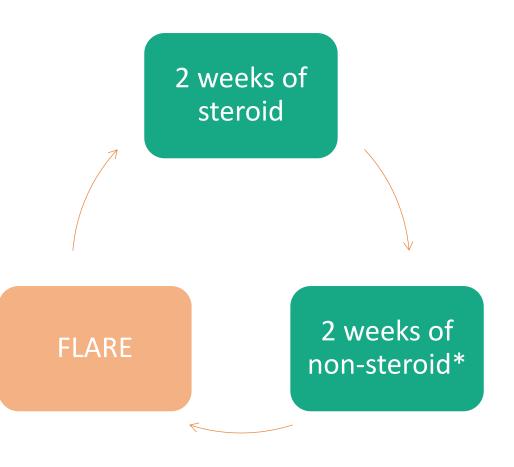
- Cushing Syndrome
- Adrenal insufficiency



"Steroid phobia"



- Two-week rule
- Assess understanding and buy-in
- Assess adherence



What if the patient is not getting better?



Consider SYSTEMIC TREATMENT

- Dupilumab
- Phototherapy
- Prednisone
- Methotrexate

What if the patient is not getting better?



Consider the DIFFERENTIAL DIAGNOSIS

Think about the distribution, the patient, the response to therapy, the trajectory

- Contact dermatitis
- Seborrheic dermatitis
- Lichen simplex chronicus
- Scabies
- Psoriasis
- Cutaneous lymphoma
- Others!

What if the patient is getting worse?



Consider INFECTION

- Infection is common
 - Most common: staph aureus, HSV, coxsackie
- Challenging to discern which is the cause based on exam
 - SWAB: exudative/wet spots, perianal
- May require inpatient admission for IV antibiotics, antivirals, and fluids







A 2-year-old patient presents to the office with "fussiness" and decreased appetite.

Exam shows the following:

What are the next steps for evaluation and management?



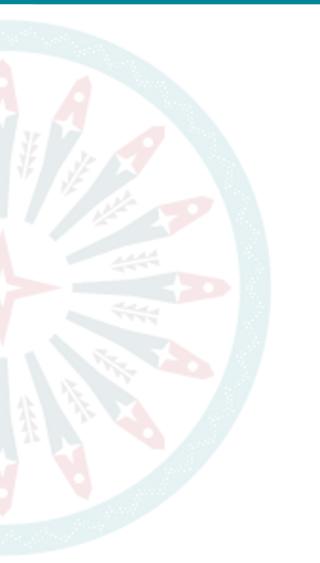


A 2-year-old patient presents to the office with "fussiness" and decreased appetite.

After a few days of antibiotics and wet wraps, he is feeling much better.

What will your plan be for discharge?

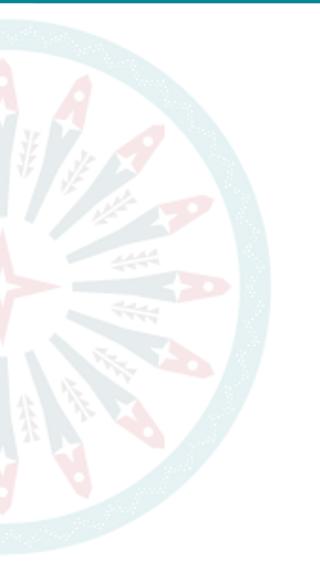




At his 4 week follow up, he is feeling much better. He continues to have a bothersome, itchy rash.

What questions might you have?





At his 4 week follow up, he is feeling much better. He continues to have a bothersome, itchy rash.

What are some options you might consider for treatment?





At his 4 week follow up, he is feeling much better. He continues to have a bothersome, itchy rash.

Together, you decide to start him on dupilumab.

What other recommendations might you make for the patient?



Take home points

- Eczema is COMMON and there is no cure
- Pick a high, medium, and low potency steroid to default to
- Take time to counsel patients on triggers and lifestyle modifications
- If patients aren't improving, think about medication adherence and infection





Visit: IndianCountryECHO.org

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