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UNDERSTANDING GENERAL SURGERY

THE GOOD, THE BAD AND THE RIGHT WAY TO FAST

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A STUDY IN SCARLET

ECZEMA IS NOT SO MUCH A SINGLE disease as it is a broad group of itchy inflammatory skin rashes. While atopic eczema is probably the most well-known, other types of eczema include discoid eczema, seborrhoeic eczema, contact dermatitis and vesicular eczema of hands and feet.

All forms of eczema are characterised by itchiness, redness, skin oedema (swelling), scaliness, papules (small bumps), oozing and crusting. If the eczema has been there for a long period of time, being chronic, the patient's skin typically becomes red, scaly and thickened with the accentuation of skin lines. There may also be colour changes in the form of hyperpigmentation (where the skin becomes darker) or hypopigmentation (where the skin becomes paler).

We can broadly classify the different types of eczema into two main groups: exogenous eczema, where the cause is external, or endogenous eczema, where the cause is internal. Exogenous eczema is fairly straightforward to treat: as long as the stimulus causing the outbreak is identified and removed from the patient's environment, it should go away with treatment and stay away. This is why dermatologists are so incessant and dogged about history taking, so they may identify potential external causes.

When the eczema is endogenous, however, things become slightly more complex as the exact cause tends to be unknown. Most dermatologists however believe that such eczemas are caused by an abnormal response of the skin's immune system and impaired skin barrier function. This response is often determined genetically, but a few common aggravating factors include stress, skin dryness, irritating soaps, detergents or chemicals, scratchy clothing (such as wool or metallic threads), changes in temperature or humidity, certain foods, or an overgrowth of certain bacteria or yeast.

A permanent cure for endogenous eczema has not been identified to date. However, each episode can usually be successfully calmed down or brought into remission through the application of appropriate topical steroids, the treatment of infections (if any), and good general skin care. Patients should also take care to use gentle skin cleansers and anti-inflammatory moisturisers, and avoid scratching wherever possible.

It is important to note that topical steroids, especially the more potent ones, can sometimes cause skin thinning and other side effects. For this reason, it should only be used in the long run under the supervision of a doctor experienced in the treatment of skin conditions.

If topical steroids are insufficient, specialist care by a dermatologist is recommended. Depending on the patient's profile, alternative management options such as UVB phototherapy or oral medications - which range from oral antibiotics and short-term oral steroids to oral immunomodulatory medication - may be used.

In recent years, there has been a paradigm shift from reactive treatment to proactive treatment. This is analogous to the difference between firefighting and fire prevention: where the first reacts to an eczema outbreak when it occurs, the latter tries to prevent the outbreak from even happening in the first place through the use of skin barrier-repairing moisturisers in conjunction with intermittent topical steroids or steroid-free topical immunomodulators. Such treatment methods have been shown to prolong the interval between outbreaks, thereby reducing the frequency of outbreaks. ■

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