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Fig. 7.18 Protective tubular gauze dressings being applied over a topical steroid ointment.

transient burning sensation being the most common side-effect; however, it decreases with usage. Some use topical steroids briefly, to improve the eczema, before starting tacrolimus ointment, hoping in this way to decrease the incidence and severity of this burning sensation. Systemic absorption is low, and skin atrophy is not a problem. Local infection might be troublesome and the development of skin cancer, especially on exposed treated areas, is a concern when the drug is used for prolonged periods. Perhaps more information and experience are required before tacrolimus can be hailed as a revolutionary new treatment for the treatment of inflammatory skin disorders—but the results so far look highly impressive. Topical tacrolimus is now available as Protopic ointment (Formulary 1, p. 334).

Pimecrolimus (Formulary 1, p. 334) is another topical immunosuppressant and a derivative of askamycin. Clinical trials in moderate atopic eczema have been encouraging and it can be used in patients older than 3 months. Its action is very similar to that of tacrolimus and time will tell if either preparation is superior.

- The regular use of bland emollients, either directly to the skin or in the form of oils to be used in the bath. Some of these can also be used as soap substitutes. A list of suitable preparations is given in Formulary 1 (p. 328). Some rules governing the use of emollients are given in Table 7.7.
- Those with an associated ichthyosis should generally use ointments rather than creams.
- The scratch-itch cycle can often be interrupted by occlusive bandaging, e.g. with a 1% ichthammol paste bandage. Nails should be kept short.

Table 7.7 Winning ways with emollients.

Make sure they are applied when the skin is moist
Prescribe plenty (at least 500 g/week for the whole skin of an adult and 250 g/week for the whole skin of a child) and ensure they are used at least 3–4 times a day
For maximal effect, combine the use of creams, ointments, bath oils and emollient soap substitutes

- Sedative antihistamines, e.g. trimeprazine or hydroxyzine (Formulary 2, p. 345) are of value if sleep is interrupted, but histamine release is not the main cause of the itching, so the newer non-sedative antihistamines help less than might be expected.
- Acute flares are often induced by the surface proliferation of staphylococci, even without frank sepsis. A month's course of a systemic antibiotic, e.g. erythromycin, may then be helpful.
- Allergen avoidance: prick tests confirm that most sufferers from atopic eczema have immediate hypersensitivity responses to allergens in the faeces of house dust mites. Sometimes, but not always, measures to reduce contact with these allergens help eczema. These measures should include encasing the mattress in a dustproof bag, washing the duvets and pillows every 3 months at a temperature greater than 55°C, and thorough and regular vacuuming in the bedroom, where carpets should preferably be avoided.
- Do not keep pets to which there is obvious allergy.
- The role of diet in atopic eczema is even more debatable, and treatments based on changing the diet of sufferers are often disappointing. Similarly, it is not certain that the avoidance of dietary allergens (e.g. cow's milk and eggs) by a pregnant or lactating woman lessens the risk of her baby developing eczema. It may still be wise to breastfeed children at special risk for 6 months.
- Routine inoculations are permissible during quiet phases of the eczema. However, children who are allergic to eggs should not be inoculated against measles, influenza and yellow fever.
- Those with active herpes simplex infections should be avoided to cut the risk of developing eczema herpeticum.
- In stubborn cases UVB, UVA-1 (340–400 nm) or even PUVA therapy may be useful.
- Cyclosporin: severe and unresponsive cases may be helped by short courses under specialist supervision (Formulary 2, p. 347).

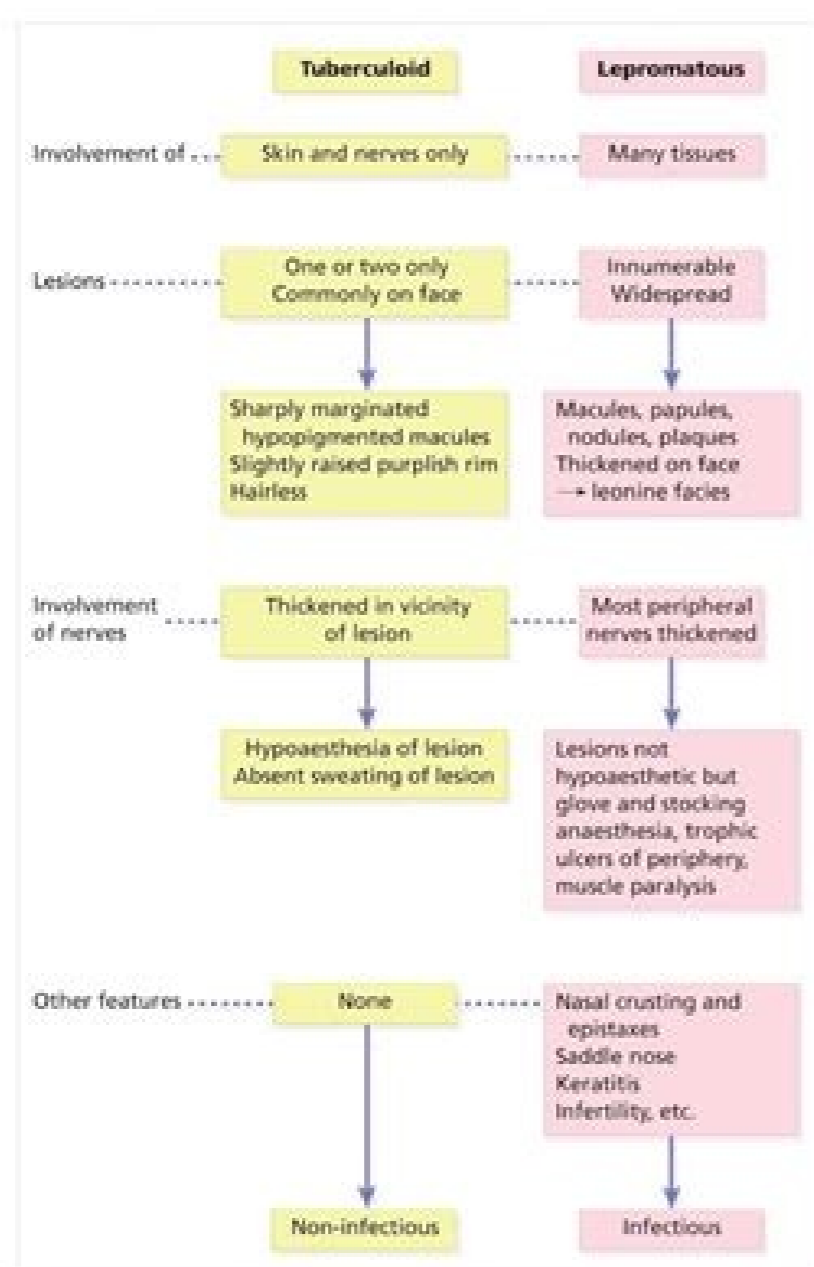


Fig. 14.12 Tuberculoid vs. lepromatous leprosy.

Differential diagnosis

Tuberculoid leprosy. Consider the following—in none of which is there any loss of sensation.

- Vitiligo (p. 246)—loss of pigment is usually complete.
- Pityriasis versicolor (p. 221)—scrapings show mycelia and spores.
- Pityriasis alba—a common cause of scaly hypopigmented areas on the cheeks of children.
- Postinflammatory depigmentation of any cause.

- Sarcoidosis, granuloma annulare, necrobiosis lipoidica.

Lepromatous leprosy. Widespread leishmaniasis can closely simulate lepromatous leprosy. The nodules seen in neurofibromatosis and mycosis fungoides, and multiple sebaceous cysts, can cause confusion, as can the acral deformities seen in yaws and systemic sclerosis. Leprosy is a great imitator.



Psoriasis is not the only skin disease that is thought to be mediated by autoantibodies. Table 1 lists some of the most common ones. Exams can also be normal and subtle, but it usually needs specialized and sensitive tests or techniques (Chapter 7). Psoriasis is discussed in Chapter 7.

Psoriasis rosacea

Cause

The cause of psoriasis rosacea is not known. An infection agent has always been linked but has not yet been proven. Bacteria responsible for the infection are: *Staphylococcus aureus*, *Streptococcus pyogenes*, and *Corynebacterium minutissimum*.

Presentation
Psoriasis rosacea is common, particularly during the winter. It mainly affects children and young adults.

Table 1. Some important papulosquamous diseases.
Psoriasis
Psoriasis erythrodermic
Psoriasis pustular
Psoriasis guttate
Psoriasis inverse
Psoriasis pustulosa
Psoriasis pustulosa generalisata
Psoriasis pustulosa generalisata
Schönlein-Henoch
Syphilis
Drug eruptions

and several attacks are rare. Most patients develop one plaque (the "halo" or "halo" plaque) before the others (Fig. 4-1). It is larger (2-3 cm in diameter) than the other plaques, but smaller, older, and more subtle. After several days, smaller plaques appear, usually on the trunk, but some also on the neck and extremities. About half of the patients complain of itching. An ichthyoid plaque on the neck and trunk shows a diffuse scaling, without peripheral redness. The configuration of such plaques is rather characteristic. Their longitudinal axes run down and out from the nose (Fig. 4-2), along the lines of the ribs. Psoriasis rosacea can recur.



Fig. 4-1 The central plaque of psoriasis rosacea is usually on the trunk and is larger than the other lesions. Its satellite configuration is characteristic.

69

Spanish guidelines for diagnosis management treatment and prevention of dress syndrome.

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