

Facial Eczema

Eczema of the face can be particularly distressing because it is exposed for all to see. Therefore, apart from troublesome itching, sufferers must also cope with the appearance. This can affect confidence and interfere significantly with daily life, especially if the problem is long-standing.

Eczema of the face may have a similar appearance to eczema involving other areas of the body, with redness, dryness and sometimes cracking, weeping and scabbing. There are several different types of eczema that may affect the face. It may be part of a more generalised condition, or localised just to the face. The diagnostic labels that are used may vary because the terms 'eczema' and 'dermatitis' are used interchangeably.

Atopic Eczema/Dermatitis

This is the commonest cause of facial eczema, both in adults and children. It usually begins in childhood, most often in the first year of life between two and six months, but as with atopic eczema affecting other parts of the body, it may continue for many years into adulthood. The cheeks and forehead are frequently involved first, but the whole face may be affected along with other areas of the body. Itching, dryness and redness are the main symptoms, but burning and stinging can also occur. Scratching may cause thickening of the skin and it may darken in colour particularly in dark-skinned individuals. In the thickened skin the normal markings often become more visible, leading to an appearance termed 'lichenification'. The eyelids may be involved (blepharitis) with thickening of the lower eyelids being a particularly persistent problem. As with all forms of atopic eczema, the exact cause isn't clearly understood. Both inbuilt genetic factors and the influence of the environment are important.

More details of these issues are available in other *National Eczema Society* booklet '*What is Eczema?*'.

Seborrhoeic Eczema/Dermatitis

This is another common cause of facial eczema and may affect adults and children. In the adult form the creases at the sides of the nose, the inner eyebrows and scalp are the main areas involved. The eyelids may also be affected (blepharitis). Other areas of the body including the chest, armpits and back (between the shoulder blades) are sometimes involved. Usually the affected skin is red with yellowish flakes, and there may be dandruff of the scalp. It is thought that seborrhoeic eczema is a result of allergy towards a yeast that occurs normally on the skin, especially in the more greasy ('seborrhoeic') areas such as the face and scalp. The condition tends to be very persistent, being controlled with treatment but occurring again when treatment is stopped.

Seborrhoeic eczema in infants is probably a different condition from that which affects adults, usually starting within the first three months of life. It may cause 'cradle cap' (thick flakes on the scalp), but apart from involvement behind the ears tends not to affect the face, usually preferring areas such as the armpits and nappy area. It is not generally itchy. The infantile form usually clears within the first year, but in up to a quarter of affected children it may be the first sign of atopic eczema.

Irritant Contact Eczema/Dermatitis

The skin can be irritated non-specifically by substances such as soaps and detergents, causing irritant contact dermatitis. This will happen to anyone if the irritant is harsh enough or exposure happens often enough and in large amounts. Irritant contact dermatitis tends to affect other areas, particularly the hands, although eczema around the lips, due to a persistent habit of lip-licking usually in children, may be considered as a form of irritant contact dermatitis.

Allergic Contact Eczema/Dermatitis

The face is a common site for allergic contact dermatitis. In allergic contact dermatitis the immune system reacts to a specific chemical in the environment, producing a specific allergic reaction. This usually occurs in people who have been exposed to the chemical substance before and become 'sensitised' to it. Unlike irritant contact dermatitis, a reaction may then occur following subsequent exposure to small amounts of the chemical, causing allergic contact dermatitis.

Allergic contact dermatitis of the face can be caused by obvious direct contact with a sensitising chemical such as a cosmetic, by contact with airborne substances such as perfumed sprays and plant products, or by transfer of a sensitising chemical to the face by the hands (e.g. nail varnish). Certain sensitising chemicals may affect characteristic areas of the face, but the eczema may often be indistinguishable in appearance from atopic eczema. **Cosmetics are the usual culprits in allergic contact dermatitis affecting the face. They contain fragrances, wool alcohols (lanolins), preservatives and dyes that can all cause sensitisation. Allergy to ingredients of hair dyes may also cause severe allergic contact dermatitis of the face.** Nickel allergy is very common, affecting about 5% of women. It usually causes earlobe dermatitis in allergic people who have been sensitised (by ear piercing) and who then wear non-gold or silver jewellery. Less commonly, nickel allergy may cause reactions to metal spectacle frames.

If allergic contact dermatitis is suspected patch tests may need to be carried out by the dermatologist. Small quantities of potentially sensitising chemicals that are thought to be relevant are applied to patches of normal skin on the back and held in place by adhesive tape. This is removed after two days to look for an allergic reaction. The back is usually examined again after a further two days to detect any delayed reaction. More details on patch testing are available in a *National Eczema Society* fact sheet 'Patch Testing'. If a relevant sensitising chemical is identified, this should be rigorously avoided. In the case of allergy to sensitising chemicals found in cosmetics, it is often necessary to obtain a list of safe cosmetics from manufacturers. Your Pharmacist should also be able to help you check the ingredients of a particular product. If in doubt, apply a small quantity of your chosen cosmetic repeatedly to a small area on your forearm - significant allergy should cause a localised itching rash.

Light Sensitive Eczema/Dermatitis

The face is exposed to the environment and so is vulnerable to the effects of sunlight. Sunlight can make atopic eczema worse while in others it can help improve the eczema.. Seborrhoeic eczema may get worse initially then improve with sun exposure. Certain medications and chemicals can interact with sunlight to cause an allergic reaction called photo-allergy. When this happens, the areas of the face shielded from the light are usually spared (the eyelids, below the nose, under the chin and behind the ears). This differs from an airborne allergic contact dermatitis where all areas of the face are usually involved. Some (usually older) people develop a particularly severe form of unexplained sun sensitivity that causes extremely persistent eczema in light exposed areas of the face and elsewhere. This condition, which is termed 'chronic actinic dermatitis', is fortunately very unusual.

If light-sensitive eczema is suspected, special skin tests with different wavelengths and doses of ultraviolet light are sometimes done, but these require special equipment and are only carried out in a few dermatology departments with expertise in the investigation of light-sensitive skin disorders.

Treatment of Facial Eczema

Effective treatment requires an accurate diagnosis of the particular type. More than one type of eczema can be present at the same time and in difficult cases the advice of a dermatologist may be needed. No tests are usually necessary unless allergic contact eczema is suspected.

In general, treatment of facial eczema involves:

- Avoidance of the cause, if known e.g. avoidance of chemicals producing contact allergy, or the use of appropriate sunscreens to minimise sun exposure.
- Regular application of bland moisturisers (emollients). These may take the form of greasy ointments (for very dry skin) or creams which are less greasy. Some people prefer using creams on the face during the day and ointments at night.
- Avoidance of ordinary soap and use of soap substitutes such as emulsifying ointment. These may also be used by men as shaving soap substitutes.
- Use of the mildest topical steroid ointment or cream that is effective, if emollients alone are unhelpful. These are best only used on the face under medical supervision. Medium strength topical steroids should probably only be used on the face with the advice of a dermatologist, and potent topical steroids should be rigorously avoided except under the most exceptional circumstances and with the regular supervision of a dermatologist.
- Potent topical steroids on the face are an important cause of permanent thread-veins and an acne-like condition called 'rosacea' or 'peri-oral dermatitis'. Topical steroids should also be used with caution on the eyelids, as medium and potent forms may cause cataracts (blemishes in the lens of the eye) and glaucoma (increased fluid pressure in the eye), both of which may seriously interfere with vision. An alternative medication, the non-steroid topical immunosuppressant, pimecrolimus cream, may be used for facial eczema but it is only available on prescription by a doctor and is a relatively non-potent agent. Its real role in the

treatment of facial eczema and whether it is more effective than a non-toxic mild topical steroid such as 1% hydrocortisone remain to be established. More details on pimecrolimus cream are available in a *National Eczema Society* fact sheet.

- Anti-yeast ointments or creams in seborrhoeic eczema, with or without a mild topical steroid.
- Detection and treatment of infected eczema. This may require a swab being taken by your doctor and prescription of an antibiotic.
- More active treatment of severe facial eczema, such as atopic eczema, that has not responded to any of the above measures and is causing significant problems. This might include the new topical agent tacrolimus ointment which, although it is a potent immunosuppressant, does not possess the side-effects associated with potent topical steroids. Preliminary evidence suggests that it is often highly effective in the treatment of severe facial eczema, but it may initially cause a burning sensation and its long term safety and clear role in treatment remain to be established. Further details are available in a *National Eczema Society* fact sheet. Finally, facial eczema is in unusual cases sufficiently severe and unresponsive to topical treatment to justify oral medication such as short courses of systemic steroids (e.g. prednisolone) or immunosuppressant e.g. ciclosporin.. These agents should only be used under dermatological supervision, as should topical tacrolimus ointment until more is known about its long term safety.

Disclaimer

This information is provided only as a general guide. Individual circumstances differ and the National Eczema Society does not prescribe, give medical advice or endorse products or treatments. We hope you will find the information useful, but it does not replace and, should not replace, the essential guidance, which can be given by your doctor.

Acknowledgement

The National Eczema Society is grateful to Dr Neil J Mortimer, Specialist Registrar in Dermatology, Leicester Royal Infirmary for writing this information sheet.

©National Eczema Society 2004
All rights reserved

National Eczema Society
Hill House, Highgate Hill
London N19 5NA

Eczema e-mail helpline: helpline@eczema.org
Eczema telephone helpline 0870 241 3604
Web site: www.eczema.org

National Eczema Society: A Company Limited by Guarantee. Registered office: Hill House, Highgate Hill, London N19 5NA
Registration No. 2685083. Charity Registration No. 1009671